



Health Policy for Low-Income People in Florida

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About the Series

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

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one

must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

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Highlights of the Report

Health policy issues have been a priority for Florida under the leadership of Governor Lawton Chiles. The Florida Health Security Plan, which Governor Chiles proposed in 1992 and which was ultimately rejected by the state legislature, represented an expansion of insurance coverage together with a managed competition approach to controlling health costs. Governor Chiles was successful in winning passage of insurance reforms in the private insurance market. In 1997, the governor made expansion of coverage to children through Medicaid and the state's Healthy Kids Program his top health priority. He also brought suit against the U.S. government to seek relief from changes in welfare laws that affected many legal noncitizens in Florida and opposed the formula for distributing federal block grant funds in 1995 because of its likely negative impact on the state of Florida.

Florida has a number of health care problems. It has one of the highest uninsured rates in the country, 19.2 percent (vs. 15.5 percent for the nation). Per capita spending on Medicaid ranks as one of the lowest in the country (46th nationally) despite having the fourth largest Medicaid enrollment, about 2.2 million. The state ranks near the bottom (i.e., worst) on a number of measures of health status, including the number of premature deaths per capita, prevalence of cancer, number of AIDS cases, and rate of violent crime.

Medicaid enrollment and expenditure growth accelerated in the 1990s. Between 1990 and 1995, enrollment grew by 12.7 percent annually, expenditures, by 18.7 percent. Spending grew by 27.2 percent between 1990 and 1992, and by 13.4 percent per year between 1992 and 1995. Florida's eligibility standards remain low by national standards. In 1994, 39.6 percent of the low-income population below 150 percent of the federal poverty level (FPL) had Medicaid coverage compared with 51 percent nationally. The state has a somewhat restrictive benefit package and spends less per enrollee than the national average for all eligibility groups except children. Expenditures on long-term care are low despite a large elderly population. The number of nursing home beds per elderly person is well below the national average, and there is minimal coverage of home and community-based services.

Managed care is the cornerstone of the state's efforts to control Medicaid acute care expenditures. Florida now contracts with 19 health maintenance organizations (HMOs) and has implemented a primary care case management program (MediPass) throughout the state. The state now requires mandatory enrollment in managed care for most recipients—two-thirds of Medicaid beneficiaries are in either MediPass or capitated managed care plans. Florida has had a history of marketing and enrollment abuses and problems with quality of care in managed care programs. Recently, the state prohibited direct marketing, increased resources for beneficiary education, and added staff to monitor quality of care. It has also enacted a competitive bidding system to drive down capitation rates, hoping to reduce rates to 92 percent of fee-for-service rates.

The state also faces problems resulting from the impact of recent welfare reform legislation on future legal immigrants. At the time of the site visit, it was estimated that 54,000 current Supplemental Security Income (SSI) recipients in Florida would lose their SSI and Medicaid benefits, and another 3,062 immigrants who were receiving Medicaid were also expected to lose coverage. The state filed suit asking the federal court to declare that denying SSI and food stamp benefits to otherwise eligible, lawful, permanent resident aliens is unconstitutional. Legislation was introduced by the Dade County delegation to maintain coverage for these individuals at state or local expense. The cost to the state (or to local areas) was estimated at \$222 million. While the Balanced Budget Act of 1997 ensures that most of these individuals will retain their benefits, future immigrants will not be covered.

To reduce the number of uninsured children, the governor has proposed expanding Medicaid to cover children ages 0 to 3 old years in households with income up to 185 percent of the FPL. The state is also expanding its Healthy Kids Program. The Healthy Kids Program is a

school enrollment-based insurance program that currently provides comprehensive health insurance coverage to 26,400 children. Additional funding has been granted to increase the number of children in the program to 60,000. The legislature recently granted the Agency for Health Care Administration the authority to seek a Section 1115 waiver to cover children in households with income up to 185 percent of the FPL through the Healthy Kids Program. The cost of the program averages about \$600 per child. The program is able to keep the costs below Medicaid because of limits on the number of plans, because of some restrictions on benefits, and because the population served is relatively healthy.

Florida has enacted a series of insurance reforms. The reforms require insurers offering policies in the small-group market to guarantee issue of policies without regard for health status or preexisting conditions, provide for portability of plans between employers, and require the use of modified community rating. The legislation does not affect the individual insurance market. Florida also created 11 regional Community Health Purchasing Alliances (CHPAs) in an attempt to reduce the costs of health insurance in the small-group market. Currently 18,000 small businesses representing 76,000 individuals receive coverage through the CHPAs. It appears the state is experiencing a certain amount of adverse selection in the CHPAs. The CHPAs are also prohibited from negotiating rates with insurers, limiting their ability to take advantage of their market power. As a result, premiums for CHPA-sponsored insurance plans are reportedly only about 6 percent less than premiums for the same plans offered outside of the CHPAs.

Managed care has been growing rapidly in the private market in Florida. As of 1995, 25 percent of the state's population was enrolled in an HMO. Much of the growth has been among for-profit HMOs. Although the largest HMOs remain profitable, many of the smaller HMOs have experienced losses. As a result, mergers and acquisitions are now occurring frequently in the commercial HMO market. State policy has generally been supportive of the growth of managed care. A number of bills to regulate managed care have been introduced in the legislature, but to date few have been enacted. The 1997 legislative session is expected to include increased efforts to enact legislation to set standards for HMO practices.

The hospital market has a considerable amount of excess capacity. As a result, HMOs and other managed care plans have successfully negotiated deep discounts. There has also been considerable growth in for-profit hospital systems, although some nonprofit hospital systems are also developing rapidly. However, to date there has been little impact on the number of hospitals and number of beds. While there is concern over the implications of the growing number of for-profit hospital beds on the provision of charity care, no action has been taken. In fact, Columbia/HCA and the South Florida Hospital Association have challenged the tax-exempt status of nonprofit hospitals, arguing that many nonprofits provide little charity care but still receive tax benefits not available to for-profit hospitals.

Safety net hospitals face significant competitive pressures as the growth in Medicaid managed care increases the interest of private hospitals in the Medicaid market. Nonetheless, they appear to be doing reasonably well in general. One reason is an increase in local funding for indigent care. In both Dade and Hillsborough Counties, local funding for indigent care has risen considerably as a result of increases in sales taxes. In addition, hospitals are either developing their own HMOs or prepaid health plans, joining with other HMOs or prepaid health plans, or developing networks with other health care providers to achieve greater efficiencies.

Although the infusion of funds and their continuance are important to the safety net's success, the manner in which the funds are distributed is also important. Hillsborough County has used the new tax revenues to fund an insurance program that distributes funds across several types of providers. Nonetheless, Tampa General Hospital, the major public hospital, is losing its Medicaid patient base and is increasingly reliant on state financial support. Dade County's new revenues are largely targeted to Jackson Memorial Hospital, the county's major public hospital. These revenues are permitting the hospital to survive the loss of Medicaid revenues. Community clinics did not receive any of these new funds and are facing serious problems. The big question is whether local revenues will remain adequate and continue to support care

for the indigent in these counties, as well as in other sites throughout the state.

Despite its large elderly population, Florida has relatively low expenditures on long-term care. Long-term care is 28 percent of the state's Medicaid budget, compared with the national average of 34 percent. Long-term care spending is low in Florida because its nursing home bed supply (30 beds per 1,000 people over age 65) is one of the lowest in the country and because it has been slow to expand home and community-based services. The state now has a few home and community-based waiver programs and is experimenting with increases in the provision of these services. Increases in expenditures for long-term care seem inevitable but could place added pressures on Medicaid spending for other groups.

Overview of Florida

Sociodemographic

Florida has one of the country's biggest and most diverse state populations. In 1995, Florida had a population of 14.1 million, which had increased 9.5 percent since 1990, or 1.7 times faster than the growth rate of the U.S. population (table 1). One in six people (16.2 percent) in the state had income below the federal poverty level (FPL) in 1994, compared with about one in seven people (14.3 percent) nationwide. Compared with the United States as a whole, Florida has a higher proportion of Hispanics (16.5 percent vs. 10.7 percent in 1995). The Miami area is notable for its large concentration of Cubans. Overall, 15.1 percent of the state's population in 1995 were immigrants, compared with 9.3 percent for the nation.

In 1995, 2.7 million people, or 16.7 percent of the state's population, were over the age of 65, substantially higher than the national average of 12.1 percent and higher than in any other state. Its elderly population is also one of the fastest growing in the country; the state projects a 35 percent growth in the age-80-and-older population in the next 10 years. The majority of the state's population resides in a half dozen major urban centers (e.g., Miami/Fort Lauderdale, Tampa/St. Petersburg, Orlando, and Jacksonville). Although the state has large rural areas, there are very few places located more than an hour from a medium-sized city.

Economic

Florida's economy is healthy and growing at a faster rate than the U.S. economy as a whole. Job growth during FY 97-98 is projected to be 2.9 percent, more than double the U.S. rate of 1.3 percent. ¹ Beyond that, Florida's state budget assumes a slight deceleration of output and spending, which will result in somewhat slower growth in its economy. The unemployment rate was slightly less than that for the United States as a whole in 1996 (5.1 percent versus 5.4 percent). Per capita income (\$23,061) is about on a par with the national average (\$23,208) as was the increase in per capita income from 1990 to 1995—20.7 percent in the state versus 21.2 percent in the nation (table 1). In part because of the strong economy, Aid to Families with Dependent Children (AFDC) caseloads have declined in each of the last three fiscal years, dropping from about 220,500 families in October 1995 to 186,600 families in December 1996. These declines have continued since the implementation of the state's welfare reform program.

Political

Governor Lawton Chiles, a Democrat, has been in office since 1991 and won reelection in 1994; his current term expires in 1998, and Florida law prohibits him from running for a third consecutive term. Florida's legislature has historically been led by Democrats, but that has changed recently. The Florida Senate was evenly split prior to the 1994 election, when Republicans gained a majority of the seats. In 1996, Republicans also gained majority control of the House, with a two-seat lead (61 to 59). Republicans retained control over the Senate in

1996 and now have a six-seat margin over Democrats (23 to 17).

Between 1994 and 1996, Governor Chiles's relations with the split-control legislature were marked by some tension. While there has been bipartisan support for spending on corrections and education throughout the 1990s, the legislature has recently opposed some of the governor's health initiatives. The legislative agenda was dominated by a debate over funding priorities, cast largely as a trade-off between social and health services versus education and corrections. The legislature took funds proposed for Medicaid and transferred them to corrections and education. With a change in legislative leadership and a takeover of the House by Republicans, it was a matter of some speculation whether the governor would be able to have any of his health initiatives approved.

Health policy issues have been a particularly high priority of the governor. He sought passage of two pieces of legislation (the Health Care Reform Act of 1992 [Chapter 92-33] and the Health Care and Insurance Reform Act of 1993 [Ch. 93-129]), which together promised to ensure for all Floridians "access to a basic health care benefit package . . . by December 31, 1994." The Health Care Reform Act of 1992 created the Agency for Health Care Administration (AHCA) to help ensure that that goal was reached. The Health Care and Insurance Reform Act of 1993 provided the authority to create Community Health Purchasing Alliances (CHPAs), fund rural health network initiatives, and seek federal waivers to expand Medicaid eligibility to those with incomes up to 250 percent of the FPL. Both acts included insurance market reforms. The CHPAs were established in 1994, a number of rural health networks have been certified by AHCA, and there has been significant reform in the small-group insurance market. However, the Florida Health Security Act, the state's Section 1115 waiver that emerged from the 1993 act, never received funding from the legislature.

The governor, although an ally of the Clinton administration, has not hesitated to challenge federal policies that adversely affect Florida. For example, in April 1997 he filed suit against the U.S. government, seeking relief from changes in federal welfare laws that restrict essential federal benefits for many legal noncitizens in Florida. He was a supporter of federal welfare reform, but he expressed great concern about the spending caps in the 1995 Medicaid block grant proposal. He believed the caps would be unfair to Florida and other high population-growth states or those that had low per capita expenditures, because those states would have a harder time finding savings.

Although it is often thought that Cubans and other Latin Americans constitute the largest source of immigrants to the state, "immigrants from the North" (the snowbelt states) constitute a much larger proportion of the state's growing population. Nonetheless, the delegates from the Miami area are considered a powerful group in the legislature.

About 72 percent of the state's general revenue (\$15.6 billion in FY 96-97) comes from sales tax collections.² The state does not have an income tax, and only counties can impose ad valorem (property) taxes. For FY 97-98, the Florida Consensus Estimating Conference projects the state's general revenue growth at 4.7 percent, or \$757 million more in recurring general revenue, and projects an overall revenue growth of 5 percent. This is down, however, from the average annual rate of 8 percent in the last 10 years, when the introduction of the Florida lottery and an infusion of federal funds because of rising Medicaid and AFDC caseloads contributed to a higher growth rate.

Roadmap to the Rest of the Report

The remainder of this report lays out the major issues, initiatives, and challenges in health care facing the state policymakers in the spring of 1997. It describes the state's current health care agenda and recent spending trends, describes the organizational structure of state health programs, and gives some sense of prevailing state and local attitudes toward meeting the health care needs of the poor. It then delves into the details of Medicaid eligibility, managed care programs, provider reimbursement, and long-term care policy. The report describes how state policies are affecting the health care delivery system for poor people in two

communities—Dade County, home to Miami, and Hillsborough County, which includes Tampa. It concludes with a discussion of the major challenges facing the state.

Setting the Policy Context

Overview of the State's Health Care Agenda

Three significant health care issues consumed the attention of state officials and advocates at the time of the site visit: (1) awards of new Medicaid capitated managed care contracts and attempts to shift MediPass program participants into capitated plans; (2) a number of children's health initiatives, including an expansion of the Healthy Kids Program, which subsidizes insurance premiums for low-income, school-aged children, and expansion of Medicaid eligibility to children ages 1 through 3 in families earning up to 185 percent of the FPL; and (3) concerns about the impact of federal welfare reform and immigration laws on Medicaid eligibility for legal immigrants.

Florida's Medicaid managed care program experienced significant problems two years ago when contracting plans' marketing abuses, quality of care problems, and charges of excess profit-taking were the focus of a series of articles in the Fort Lauderdale *Sun Sentinel*. The publicity led to several legislative changes in 1995, including prohibitions on direct marketing, rate rollbacks of between 8 and 18 percent, and the addition of Medicaid staff to monitor health plans' quality of care. In 1996, the legislature mandated assignment into either MediPass, the primary care case management program, or a health maintenance organization (HMO) or prepaid health plan (PHP) (previously recipients were required to enroll only in MediPass). The legislature also mandated a competitive bidding process for HMOs, setting a maximum capitation rate of 92 percent of fee-for-service (FFS) rates, and it authorized more enrollee education regarding managed care choices. Both the administration and the legislature have focused on implementing these changes, addressing, in particular, problems with the schedule and outcome of the bidding process.

In his FY 97-98 budget, the governor's biggest priority was a set of children's initiatives that included 22 separate programs.³ The most important was the expansion of the Healthy Kids Program and Medicaid for young children, consistent with the governor's previous attempts to expand insurance coverage. Despite his focus on children, who generally garner more support across the aisle, the governor faced some roadblocks. Republican leaders in the legislature expressed their strong opposition to creating any new "middle-class entitlements," and they seemed more interested in further Medicaid budget cuts than in anything that would increase Medicaid spending.

Federal welfare reform legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996—PRWORA) restricted immigrants' eligibility for a wide range of benefits, including Medicaid. Prior to welfare reform, legal noncitizens were eligible for Medicaid on the same basis as citizens. The new law bars immigrants arriving after passage of the law (August 22, 1996) from receiving Medicaid for their first five years in the country. It also gives states the option of providing Medicaid to immigrants already in the United States.

At the time of the site visit, the state had made clear its intent to continue Medicaid coverage for legal immigrants residing in the state who qualify for Supplemental Security Income (SSI) or AFDC/Temporary Assistance to Needy Families (TANF) or who meet other Medicaid eligibility requirements. Nonetheless, the state estimated that about 3,062 current Medicaid recipients (not including SSI recipients) would likely be ineligible for Medicaid (66 percent of whom reside in Dade County) under the federal welfare reform law, even after accounting for those who would remain eligible because of exceptions, naturalization, or state options. About 54,000 people would have lost SSI benefits, with approximately 74 percent living in Dade County.⁴ However, the passage of the Balanced Budget Act of 1997 grandfathered SSI

recipients present in the United States as of August 22, 1996. As a result, most of the estimated 54,000 will not lose their benefits. Nonetheless, future immigrants will not be covered by Medicaid for their first five years in the country, which will put pressure on the state and local areas.

Observers were very concerned that many of those people who would have lost coverage under the old rules would end up in nursing homes because they could not afford rent or food to stay in the community. A legislative staffer estimated that changes in Medicaid rules for legal immigrants before the enactment of the Balanced Budget Act would have cost the state around \$243 million; if a quarter of the people losing SSI coverage moved into a nursing home, state expenditures could have increased by about \$432 million. Some believed Miami nursing home representatives would successfully lobby the legislature for such funds; others said it would depend on the state budget situation and the way in which the media covered the issue. Similar uncertainties regarding coverage of immigrants can be expected in the future under the new rules.

State Health and Health Care Indicators

Florida's nonelderly uninsured rate of 19.2 percent is among the highest state rates in the nation, exceeding the national average of 15.5 percent (table 1). This may be attributable to the state's service-dominated and small employer-based economy. The rate has not decreased very much in the last few years, despite the state's overall strong economy. According to one source, Florida ranks 38th lowest out of the 50 states with respect to an aggregation of health indicators. Florida performs poorly on a number of health status measures: It ranks in the bottom fifth of the country in the prevalence of infectious diseases, motor vehicle deaths, and premature death rate and is ranked lowest (i.e., worst) with respect to the prevalence of cancer. The state has twice the rate of AIDS cases as the national average and a 56 percent higher rate of violent crime. Florida is closer to the U.S. average for such measures as low-birth-weight births, infant mortality rates, and smoking among the adult population.

Health Care Spending and Coverage

Between FY 90-91 and FY 96-97, total average monthly caseloads under the Medicaid program grew from 992,038 to 1,526,823—a 54 percent increase.⁵ Most of the growth, however, occurred between FY 90-91 and FY 92-93, because of recession-induced increases in AFDC caseloads and large increases in the expanded eligibility groups—for instance, AFDC-Unemployed Parent (UP), the medically needy program, poverty-related pregnant women and infants (with income up to 185 percent of the FPL) and children, optional coverage of elderly and disabled populations, and qualified Medicare beneficiaries. Despite its eligibility expansions, Florida's Medicaid program is still in the bottom 10 states in percent of total low-income population covered.

The state has restricted benefits in order to limit acute and long-term care costs; inpatient days are limited to 45, except for children, and the state does not cover nursing home services for the medically needy. The state also does not cover five optional services for the medically needy that it does cover for the categorically needy: inpatient hospital services for persons over age 65 in institutions for mental disease, Intermediate Care Facility for the Developmentally Disabled (ICF/DD) services, nursing facility services for individuals under age 21, case management services, and tuberculosis-related health services.

Florida's Medicaid spending has increased as a share of all state expenditures throughout the 1990s. Out of a total state 1995 budget of approximately \$35.9 billion, Medicaid's share was \$5.9 billion, or 16.5 percent, an increase from 10.7 percent in 1990 (table 2). Medicaid's share of state spending (excluding federal funds) also increased over this same period, from \$812 million (7.0 percent of state-only spending) to \$1.9 billion (13.1 percent of state-only spending). During the same period, state expenditures on elementary and secondary

education and higher education fell as a share of all state expenditures.

Medicaid annual growth rates declined from over 20 percent in the late 1980s and early 1990s to an estimated 3.8 percent between FY 94-95 and FY 95-96, "due in large part to the economic recovery."⁶ During the next four years, the average growth per year was estimated by administration officials to be about 6.7 percent.

In 1995, state general revenues made up 70.5 percent of the nonfederal share of Medicaid expenditures; the remainder came from a variety of sources, primarily the Public Medical Assistance Trust Fund (PMATF) (17 percent of the nonfederal share).⁷ The PMATF was created in 1984 to provide an ongoing funding source for indigent health care programs. It raises funds from a 1.5 percent assessment on each hospital's net operating revenue and from other selected health care providers, in addition to a portion of the cigarette tax. PMATF funds have been used to finance Medicaid eligibility expansions, disproportionate share hospital (DSH) payments, and county primary care programs.

Increases in Florida's Medicaid expenditures, both federal and state, in the early 1990s were similar to those at the national level—27 percent average annual growth rates between 1990 and 1992 (table 3). These increases were caused largely by growth in AFDC and Medicaid enrollment, in part due to the economic recession of the early 1990s, and by the expansion of Medicaid eligibility to additional groups. Average annual growth rates in the state's Medicaid spending between 1992 and 1995 dropped significantly—to 13.4 percent on average—but were still in excess of the national average of 9.9 percent during that period. This higher-than-average spending was primarily due to much greater spending increases in long-term care, primarily for the elderly. As a percent of total 1995 expenditures, Florida spent more on acute care than the national average (64 percent versus 50 percent), less on long-term care (28 percent versus 34 percent), and less than half as much on DSH payments—5 percent versus 12 percent.

The average growth in Medicaid expenditures per beneficiary in Florida from 1992 to 1995 was 7.0 percent versus 5.5 percent for the United States as a whole, and the excess rate of growth appeared to be concentrated on the elderly and children (table 4). Nonetheless, the level of Medicaid expenditures per enrollee was 16.1 percent below the national average in 1995. Largely because of low levels of long-term care spending, expenditures per enrollee for the elderly and disabled were 20.0 percent and 28.1 percent below the national average, respectively. Average expenditures per child enrollee were 15.4 percent above the national average.

Organizational Structure of State Health Programs

The state has undergone several reorganizations of its health and human services programs during this decade. Prior to 1992, the Department of Health and Rehabilitative Services (DHRS) housed all health programs, including Medicaid, public health, and mental health, as well as welfare and a range of other social service programs. In the Health Care Reform Act of 1992, the state removed Medicaid from this enormous umbrella department and placed it in the newly created Agency for Health Care Administration, which reports to the governor. AHCA also has authority over a number of health regulatory functions, including hospital budget review, licensing and regulation of health facilities (including certificate of need), and health care-related professional licensure. Furthermore, it oversees health care purchasing for state employees and the newly created CHPAs for small firms and self-employed individuals seeking coverage. DHRS retained authority over public health and mental health in addition to other health-related programs such as Children's Medical Services, which operates clinics and coordinates services for 80,000 children with disabilities throughout the state.⁸

By 1996, the arrangement of health and social services was once more found to be

unsatisfactory. DHRS was still an immense human services bureaucracy, and many believed that public health was being shortchanged. Thus, the state created a separate Department of Health, which was given responsibility for the divisions of family health, environmental health, and disease control, as well as Children's Medical Services from the former DHRS. At the same time, DHRS was given a new name: the Department of Children and Family Services. It still has control over Medicaid eligibility rules, as well as the mental health, substance abuse, and developmental disability programs.

Florida's 67 counties are responsible for administering health services programs. Each county operates a county public health unit, which is an administrative and delivery unit of the state Department of Health. While local health department directors report to the county commissioners, county health departments are essentially state franchises; in fact, all staff are employed by the state. Nonetheless, decisions regarding the types of services to be provided and how to provide them are determined by each county public health unit. Nearly all of the state's 67 counties supplement the funds received from the state to support their county public health department, though the amount varies tremendously by county. Counties also share in the financing of Medicaid; they pay \$55 per month for each nursing home resident and 35 percent of the nonfederal share for inpatient days 13 through 45. ⁹

Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

General State Philosophy toward the Poor

Governor Chiles has made a concerted effort to expand health insurance coverage for low-income people. But in a state that has built-in limits on tax revenues, a tax expenditure cap, and a fiscally conservative legislature, he has had to settle for less than his ambitions. The legislative agenda in 1996 was dominated by a debate over funding priorities, which was cast as a trade-off between social and health services on the one hand and education and corrections on the other. As in the previous year, the legislature explicitly took funds proposed for Medicaid and transferred them to corrections and education. There is concern in the legislature over Medicaid spending growth and its impact on expenditures for education, job creation, economic development, and criminal justice. In recent years, policymakers have resisted expanding entitlements and have made regular attempts to constrain growth in the Medicaid program. Perhaps because Medicaid eligibility and benefits are lower than the national average, there has been little concern about attracting out-of-state low-income residents.

It was surprising not to find greater support for long-term care spending, which seems inconsistent with the large number of elderly who make up the state's electorate. Interviewees attributed this apparent contradiction to the fact that many elderly have higher incomes or assets that shield them from reliance on publicly supported services. The predominance of Latinos, whose culture expects families to take care of their elderly parents, may also be a factor.

Medicaid-Specific Issues

According to a spokesperson for the governor, the per capita Medicaid spending cap proposed by President Clinton earlier in 1997 would be acceptable if it gave the state some additional flexibility to run its Medicaid program. In particular, the state would like to be less subject to the federal courts, which are "acting as legislators." The spokesperson also indicated that the

state has applied for a number of waivers, some of which have been under consideration by the Health Care Financing Administration (HCFA) for a long time. If the state had not had to obtain approval for these waivers, it might have been able to implement some innovative and potentially cost-saving programs more quickly.

Some sources said the state wanted to have the Boren amendment ¹⁰ repealed, as some of the Boren-related suits have forced the state to pay more than it would have liked on a number of occasions. Others agreed that a repeal of the Boren amendment would help the state most by relieving it from having to fight provider lawsuits, though rates would probably not change significantly.

Florida has not been as aggressive as some other states in maximizing federal funds. The state has not "abused" provider taxes and DSH spending as much as other states have done, according to many sources. However, the state continues to lobby extensively at the federal level to ensure "that Florida receives a more equitable share of available federal assistance."

¹¹

Providing Health Coverage for Low-Income People

Medicaid Eligibility

Florida is less generous in its eligibility standards for Medicaid than the average state; in 1994, 39.6 percent of the low-income population below 150 percent of the FPL had Medicaid coverage, compared with 51 percent nationally. ¹² Under Florida's Medicaid program, families with children receiving AFDC, intact families with children, and families with unemployed parents are eligible for coverage if their family income is below 28 percent of the FPL; the national average for eligibility is 41.9 percent of the FPL. Florida has taken advantage of the option to cover pregnant women and infants up to 185 percent of the FPL, and it has a medically needy program that covers individuals whose medical expenses bring their income down to 28 percent of the FPL (though the state could have extended this to 37 percent of the FPL but did not). In addition, Florida Medicaid covers aged and disabled individuals with incomes up to 90 percent of the FPL and has an institutional care program that provides nursing home and ICF/DD services to individuals with incomes up to 300 percent of the SSI standard.

Table 5 shows that Medicaid enrollment increased from 1.2 million in 1990 to 1.8 million in 1992 (a 23.3 percent increase per year) and to 2.2 million by 1995 (another 6.2 percent increase per year). Increases in Medicaid-AFDC enrollment averaged 24.9 percent per year between 1990 and 1992; it slowed dramatically thereafter, averaging only 2.9 percent per year between 1992 and 1995. Medicaid-SSI enrollment grew by 8.4 percent per year from 1990 through 1995. By far the greatest increases in enrollment occurred as a result of expanded eligibility groups—AFDC-UP, the medically needy program, poverty-related pregnant women and infants (up to 185 percent of the FPL) and children, optional coverage of elderly and disabled populations, qualified Medicare beneficiaries, and specified low-income Medicare beneficiaries, which combined to account for 44 percent of the increase in the total Medicaid caseload. Among these groups, the largest increase, both in percentage terms and actual numbers, was for poverty-related children. State data indicate that average monthly caseloads for this group grew from 65,277 in FY 90-91 to 220,918 in FY 96-97—an increase of 238 percent, accounting for more than 58 percent of the growth in expanded eligibility groups. ¹³

The improved economy appears to have contributed to declines in average monthly caseloads over the past three years. Average monthly Medicaid cases dropped from a high of 1.6 million in FY 93-94 to 1.5 million in FY 96-97. The improved economy has also been reflected in declines in Medicaid-related AFDC caseloads, which went from a high of 832,942 people in FY 93-94 to 738,955 in FY 95-96, and was projected to fall below 650,000 in FY 97-98.

The state received approval of its Section 1115 waiver application in 1994. That program, had the legislature authorized it, would have subsidized private health insurance to uninsured people earning up to 250 percent of the FPL who were without coverage for the previous 12 months or had just left Medicaid. Health insurance would have been available through the CHPA's. The state proposed to finance this expansion in eligibility through savings from enrolling more people in Medicaid managed care plans and from phasing out the medically needy program, decreasing institutional provider rates, and reducing DSH payments. An estimated 1.1 million persons could have enrolled, according to projections. One of the major objections to the program in the Senate (the bill was passed by the House but not the Senate) was that the income level was too high, leading to "middle class welfare." ¹⁴

The state's welfare reform program is called WAGES (Work and Gain Economic Self-sufficiency). It builds on the previous Family Transition Program (FTP), which began in 1993 as a two-county pilot project in Alachua and Escambia Counties. Under the pilot project, most AFDC recipients had a two-year time limit for cash assistance and were allowed to keep more of their earnings in order to create savings accounts. The project also broadened eligibility in JOBS (Job Opportunity and Basic Skills) participation, and offered case management support to families.

Consensus that FTP's approach was the right direction for the state resulted in 1996 legislation authorizing WAGES. WAGES put stricter limits on the time recipients were allowed to receive cash assistance. It also placed a 48-month lifetime limit on benefits, required adults to work or engage in work-related activities as a condition of receiving benefits, established immediate sanctions for people who do not comply with work requirements, and required teen parents to live at home under adult supervision and stay in school.

The Department of Children and Family Services is responsible for recommending policies related to Medicaid under the federal welfare reform law. The state has an integrated eligibility system to assure that all TANF recipients will be enrolled in Medicaid. Several interviewees believed that the biggest challenge for welfare reform would be a national economic recession: They thought that Florida would then be more seriously affected because during economic hardship, people who are unemployed often move from cold areas to places like Florida, where it can be cheaper to live. At the same time, few in the state were worried about state welfare benefits serving as an attraction to those from out of state; these benefits are already near the bottom relative to other states and are expected to remain there.

Other Public Financing Programs

Florida does not have a statewide General Assistance program, and thus it has no General Assistance medical program either. Only one state program other than Medicaid provides assistance to low-income, otherwise uninsured people—the Healthy Kids Program.

The Healthy Kids Program is a school enrollment-based insurance program that provides comprehensive health insurance coverage to approximately 39,300 school-aged children and their younger siblings as of August 1997. ¹⁵ The program has won national awards for innovation in government, and the Robert Wood Johnson Foundation has recently committed a significant amount of funds to help other states replicate the program. It began in 1991 as a three-year Medicaid Section 1115 waiver demonstration, financed with state and federal funds. When the demonstration ended, federal financing also stopped; as of FY 96-97, the program relies on financing from the state (about 49 percent), participating families (about 35 percent), and local governments (about 16 percent). ¹⁶

As of this writing, the Healthy Kids Program is operating in 17 counties throughout the state (an increase from 9 counties in the previous year), covering approximately half of the uninsured children in the state. ¹⁷ To participate, local school districts, which in Florida correspond to counties, must contribute an increasing share of total program costs over time,

usually obtained from ad valorem taxes.

All school-aged children and their younger siblings are eligible for the Healthy Kids Program. Of participating children, 71 percent come from households with incomes below 133 percent of the FPL; 15 percent, from households with incomes between 134 and 185 percent of the FPL; and 14 percent, from households with incomes above 185 percent of the FPL. The Healthy Kids Program encourages parental responsibility by requiring families to contribute to the costs of providing health insurance for their children. Each local area develops a sliding-scale premium schedule, with eligibility for reduced premiums tied to eligibility for the free- and reduced-lunch programs. There are also copayments for some services. The average monthly cost of the Healthy Kids Program is \$51.00. Participating health plans are selected based on competitive bids, and only one health plan is chosen in each county.

In 1996, Governor Chiles requested \$36 million for Healthy Kids from the legislature and received \$13 million to expand the program. In 1997, he requested and received an additional \$16 million, which will expand the program to serve a total of 60,000 children. (This averages \$450 per child, less than the average cost of the program because of (1) local government and family contributors and (2) differences in the expected costs of the new target population.) In addition, the legislature granted ACHA the authority to seek a Section 1115 waiver to cover children with incomes up to 185 percent of the FPL through the Healthy Kids Program. According to Healthy Kids officials, if this waiver is approved, it would allow the program to cover 118,000 children and thus 15.7 percent of the state's estimated 750,000 uninsured children.

Insurance Reforms

Florida's health insurance reforms were enacted as part of the 1992 and 1993 health care reform laws. Both laws regarded reform of small-group health insurance as an important component of promoting competition in health care and using managed care to achieve cost savings. The 1992 law defined small groups as including 50 employees or less, and all insurers offering policies to small groups were mandated to offer basic and standard benefit plans defined by the Department of Insurance. The 1993 law required all insurers offering policies to small groups to guarantee issue of policies without regard to health status, preexisting conditions, or claims history; provided portability of plans between employers; and required the use of modified rating on all small-group products, with adjustments allowed for age, gender, family composition, tobacco usage, and geographic location. Neither law affected the individual market.

Since 1993, there has been no legislative action with respect to insurance reform in the small-group or individual market. At the time of the site visit, Florida legislative staff were working to implement an alternative mechanism for the individual insurance market portability reforms to meet federal provisions of the Health Insurance Portability and Accountability Act. According to respondents, the state had two options: (1) Mandate that group or individual carriers offer coverage, or (2) Reopen the state's high-risk pool. ¹⁸ Group insurance carriers were prodding individual market carriers to offer some products, while individual carriers were trying to convince the state to reopen its high-risk pool.

As part of its "managed-competition" health care reform laws, Florida created 11 regional Community Health Purchasing Alliances in 1993 as state-chartered, nonprofit private purchasing organizations. CHPA membership is available to, though not mandated for, firms that have 50 or fewer full-time employees, including the self-employed. All policies provided through the CHPAs must be issued through an insurance agent. In 1995, there were 64 registered carriers in the small-group market. ¹⁹ Forty are designated as Accountable Health Plans (AHPs), which are allowed to offer HMO, preferred provider organization (PPO), point-of-service (POS), and extended provider organization (EPO) products through the CHPAs. Since the inception of CHPAs, there has been significant growth in the number of individuals covered; by January 1997, 18,000 small businesses were participating,

representing more than 76,000 covered lives.²⁰ Though the program does not directly subsidize insurance premiums, slightly less than half of the 76,000 enrollees were previously uninsured. This proportion is higher than that in other states' purchasing cooperatives for small businesses—almost double that in the Health Insurance Plan of California, for example—because Florida allows groups of one (the self-employed) to enroll.

Despite the potential of CHPAs to lower uninsurance rates among small firms, several factors limit their ability to provide more affordable insurance. According to the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA), CHPAs may suffer from adverse selection; that is, those who need insurance because they have medical conditions are more likely to purchase it.²¹ The majority of enrolled firms had only one to two employees, whereas only 1 percent had 20 to 50 employees. This suggests a fair amount of adverse selection, leading insurers to charge higher premiums. In addition, CHPAs are prohibited from negotiating rates with insurers so that the CHPAs cannot take advantage of their market power. Because of these factors, premiums for CHPA-sponsored insurance plans were only about 6 percent less than premiums for the same plans offered outside of the CHPAs, according to a 1995 report commissioned by OPPAGA. This is less than the cost advantage expected for group purchasing.

Financing and Delivery System

Florida's health care market is one of the most competitive and entrepreneurial in the country. Most HMOs are for-profit and are in a period of instability; mergers and acquisitions are occurring at a fast pace. In addition, more hospitals are for-profit than in most other states. There has been little apparent public concern over issues raised by conversions from nonprofit to for-profit status. However, the recent emergence of alliances between public hospitals and investor-owned organizations and the potential conversion of some of the bigger public hospitals to private ownership (such as Tampa General) are likely to increase interest in this issue.

Hospitals, and in particular hospitals in the larger systems, are faring relatively well, perhaps because of the large Medicare market. (Medicare is generally seen as a better payer than private managed care plans.) The hospital industry remains over-bedded, which means that HMOs can still negotiate significant discounts. Safety net institutions are in relatively good financial health, in large part because of local financing arrangements that exist in many of the metropolitan areas with large low-income populations.

Commercial Managed Care

Commercial managed care has been growing rapidly in Florida, as more purchasers of health care switch to managed care as a lower cost insurance alternative. As of 1995, 25 percent of the state's population was enrolled in an HMO.²² HMO market penetration, however, varies considerably across the state. Tallahassee, dominated by state employees who have incentives to enroll in managed care plans, has the highest HMO penetration, at 42.1 percent. Dade County has the second highest, at 40.8 percent, and the Tampa-St. Petersburg area has approximately 28.1 percent HMO penetration. As of 1992, 26.7 percent of the state's population was enrolled in a PPO.

Enrollment in commercial managed care is concentrated in a few HMOs. As of 1996, 10 HMOs accounted for approximately 81 percent of commercial enrollment, and 5 HMOs (Blue Cross/Blue Shield's [BC/BS] Health Options, Humana Medical Plan, United Health Care Plans of Florida, Prudential Health Care Plan, and Cigna) accounted for almost 60 percent of the market.

The Florida HMO market has been a profitable one, but it has become less so in the last few

years, particularly for the smaller HMOs. In 1995, with a few exceptions, the top 10 HMOs fared quite well, recording net revenues in excess of \$125 million, or 86 percent of total HMO profits. ²³ The remaining 28 HMOs, with approximately 20 percent of the market, garnered only 14 percent of the profits. More recent data show that about half of the state's HMOs had losses in the last quarter of 1996. Medicaid HMOs showed particular signs of financial distress as state rate reductions and increasing competition have made their margins much smaller. Consolidation in the market is expected, as smaller, struggling HMOs are attractive acquisitions for larger Florida-based and national HMOs.

In the last decade, state policy has generally favored the growth of managed care. Yet, as in the rest of the country, the last two years have seen a spate of new legislation to regulate managed care. In 1996, the state enacted Senate Bill (SB) 886, which included a number of changes to state regulations of managed care organizations. First, the bill required the Department of Insurance to publish the medical loss ratios of all plans, although there continues to be debate around how to categorize certain expenses (medical expense vs. administration and profit). SB 886 also required HMOs to pay for emergency room screening tests that are consistent with symptoms. The law further required a minimum length of stay for maternity cases.

At the time of our visit, the 1997 legislative session appeared likely to see another round of legislation. According to the Florida Association of HMOs (FAHMO) ²⁴ and state legislative staff, likely bills included greater access to certain specialists; prohibitions on gag clauses (though most HMOs have already adopted the "patient rights" principles of the American Association of Health Plans); requirements that HMO medical directors be licensed in Florida; written standards on referrals, quality, and access indicators; uniform customer satisfaction surveys; establishment of an early and periodic screening, diagnosis, and treatment (EPSDT) target of 90 percent versus the current rate of 60 percent for Medicaid HMOs; expedited grievance procedures; medical necessity processes; provider credentialing requirements; and ownership of patients' medical records by physicians. ²⁵ None were considered by FAHMO to be worth a serious fight, given the negative publicity that HMOs have been receiving. There have been concerns about HMO quality, especially among Medicaid HMOs. (These issues are discussed below in the Medicaid managed care section.)

Hospital Market and Regulatory Issues

The Florida hospital market is considered over-bedded. As of 1996, hospitals averaged only a 51 percent occupancy rate. ²⁶ The competitive pressures exerted on hospitals by HMOs and other managed care plans through negotiated discounts have forced hospitals to change rapidly. Their responses have included consolidating through acquisitions and mergers to attain greater efficiencies and market leverage, aligning with physicians either in physician-hospital organizations that can contract with managed care plans or buying physician practices outright, developing or becoming part-owner in an HMO, and attempting to convert acute care beds to subacute or nursing-care beds.

It is in this last area that state policy has been most influential. The state's certificate-of-need program—which attempts to maintain nursing home occupancy rates at 91 percent—makes redeploying excess acute beds to nursing-care beds difficult. The nursing home industry has fought the hospital association's attempt to deregulate conversion of beds from acute to subacute, leading to legislative defeats for hospitals in both 1995 and 1996. Both sides agreed that it could once more become a legislative issue in 1997.

Mergers and For-Profit Conversions

Reflecting trends in the rest of the country, Florida HMOs are consolidating through acquisitions and mergers. In total, there were 18 mergers or acquisitions between 1993 and 1996. ²⁷ Most of the big HMOs in Florida are members of national chains. Hospitals also have been consolidating, and in the process, the hospital market in Florida has changed from one of

independent hospitals to one dominated by several large hospital systems. According to the Florida Hospital Association, 77 transactions have occurred involving an acquisition or merger of a hospital or group of hospitals since 1990, peaking in 1994. By 1996, 76 percent of the beds and hospitals were in a hospital system. The resultant market is dominated by three hospital systems, Columbia/HCA, Tenet HealthCare, and Adventist Health System/Sunbelt, which together account for 45 percent of the hospitals and beds in the state. While for-profit systems have been driving the consolidation movement, nonprofit systems are growing as well. Although consolidation activities have been high, the actual impact on the number of hospitals and beds has been relatively small. Between 1990 and 1995, a net reduction of only 213 acute-care hospital beds occurred.

An interesting development in Florida has been the discussion or formation of joint ventures and coalitions between public and for-profit institutions. Public hospitals in both Jacksonville and Miami have proposed or discussed a joint venture with Columbia/HCA. The University Medical Center in Jacksonville has planned to enter into an operating agreement with for-profit Columbia/ HCA to operate the hospital. The joint venture would continue to provide city-sponsored care but would be operated by Columbia/HCA. Interviewees in Miami indicated that Jackson Memorial Hospital had approached Columbia/ HCA regarding a potential relationship, which had yet to be disclosed. Tampa General has proposed privatization, though it is not clear whether or not this would be in partnership with an existing private entity.

The state attorney general's office has taken an interest in such deals because of the potential loss of community assets. The attorney general filed a motion (*Butterworth v. University Medical Center*) in 1996 after the University Medical Center (UMC) in Jacksonville refused to provide documents regarding the relationship between UMC and Columbia/HCA. The attorney general's office is also deciding whether or not it should review Tampa General's privatization plan.

At the same time that the attorney general's office and consumers are worried about the loss of community assets, Columbia/HCA and the South Florida Hospital Association have publicly challenged the tax-exempt status of nonprofit hospitals that they argue provide little community benefit. A 1994 proposed bill would have required nonprofit hospitals either to provide more than 3.7 percent of revenues in charity care and bad debt or to pay the state's 6 percent sales tax. The South Florida Hospital Association is currently gathering data on the community benefits provided by nonprofit hospitals to determine whether or not they equal or exceed the tax benefit the hospitals receive.

Medicaid Provider Reimbursement (including DSH Payments)

While Florida has moved to enroll more Medicaid enrollees in capitated managed care, at the time of the site visit, the majority of hospital and physician services were provided on a fee for service (FFS) basis through the state's primary care case management program, MediPass. Thus, although the importance of FFS reimbursement may wane in the future, a significant portion of hospital and physician services is still reimbursed on an FFS basis.

The generosity of Medicaid hospital FFS payments in Florida relative to the rest of the nation has declined. According to data from the American Hospital Association, for the nation as a whole, Medicaid payments as a percent of costs increased considerably, from 78 percent in 1989 to 93 percent in 1993. In Florida, however, the ratio remained relatively constant at 82 to 83 percent, changing only one percentage point between 1989 and 1993. ²⁸ Nonetheless, representatives from the state hospital association and various hospitals indicated that the level of Medicaid payments was not viewed as a serious problem because competition has driven down private rates to the point where Medicaid rates appear good. Currently, no Boren amendment suits are being brought against the state by hospitals.

Compared with other states, Florida has a relatively modest disproportionate share hospital

program, spending about \$334 million in 1995 (table 3) and \$369 million in FY 96-97. As of 1995, DSH spending represented only 5 percent of total Medicaid spending, considerably lower than that for the United States as a whole (12 percent). Moreover, since 1992, DSH has remained at approximately 5 percent of total state Medicaid expenditures.

Florida currently maintains five DSH programs: (1) regular DSH, which provides payments to those hospitals that treat a disproportionate share of charity and Medicaid patients; (2) mental health DSH for hospitals that serve patients requiring psychiatric services, regardless of their ability to pay; (3) a DSH program that supports graduate medical education; (4) DSH payments to regional perinatal intensive care centers (RPICCs), which have exceptionally high costs or long lengths of stay for infants; and (5) rural hospital DSH payments. As of FY 96, the mental health DSH program was the largest component (49 percent), followed by the regular program (41 percent), teaching hospitals (5 percent), rural hospitals (2 percent), and the RPICCs (2 percent). ²⁹

The regular DSH program began in 1988 and was funded largely through provider taxes, which were deposited into the Public Medical Assistance Trust Fund, and general revenues. In 1990, state lawmakers expanded the Trust Fund's revenues by increasing the cigarette tax; in 1991, by expanding the base to include ambulatory surgical centers, clinical laboratories, freestanding radiation therapy centers, and diagnostic imaging centers; and in 1992, by imposing a \$1.50 assessment for each patient-day provided by nursing homes. Between 1988 and FY 92-93, some of these funds were used to leverage federal funds and provide specific hospitals—those that treated a high percentage of Medicaid and indigent patients—with additional revenues. These funds were also used to support graduate medical education (begun in FY 91-92), RPICC (begun in FY 89-90), and rural hospital DSH programs (begun in FY 93-94).

In response to changes in DSH rules contained in the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the state created a new intergovernmental transfer program to help finance DSH payments. To pay for the regular DSH program, a few publicly owned hospitals provide the lion's share of state revenues through intergovernmental transfers. As of 1993, approximately \$88 million in intergovernmental transfers came from Dade, Duval, and Hillsborough Counties. ³⁰ According to state officials, the eligibility criteria and payment formulas were designed so that the large public hospitals in these counties receive a significant portion of regular DSH monies. As a result, the three hospitals receive about 81 percent of the state's regular DSH dollars, and all other DSH-qualifying hospitals receive the rest.

In further response to OBRA 93, the state aggressively expanded its mental health DSH program, managing to spend up to the allotment allowed under OBRA legislation. The state transferred approximately \$81 million that was previously used to fund the state-owned mental health institutions to the DSH program to draw down federal matching funds. Although the mental health DSH program represented only 27 percent of DSH in FY 92-93, it has been a vehicle for growth in DSH. By FY 96-97, the mental health DSH program accounted for almost 50 percent of total DSH expenditures.

As of 1993, Medicaid physician fee levels in Florida were roughly equivalent to the national average Medicaid fee levels and 78 percent of Medicare fees. Between 1990 and 1993, fees for obstetric services increased considerably. For example, the fee for a vaginal delivery increased by 60 percent, while a common primary care visit increased by only 7.5 percent. Between 1993 and 1996, fees increased by over 80 percent for the same primary care visit, while obstetric fees remained the same. ³¹

Changes in fee levels in Florida between 1993 and 1996 were largely driven by the implementation of the Medicare resource-based relative-value scale (RBRVS). The state's Medicaid program began reimbursing physicians using the RBRVS in 1995. The state maintained budget neutrality by creating a conversion factor that led to no change in total

expected expenditures for physician services. The movement to RBRVS shifted 10 percent of expenditures from medical and surgical specialty visits to evaluation and management visits. Since that time, there have been few changes in physician fees.

Recently, the governor has recommended an across-the-board reduction in fees to fund retroactive payments to physicians who successfully sued the state because they had been paid the Medicaid rate rather than the Medicare rate for their services to dual eligibles. The governor has recommended a reduction in the conversion factor that would cut rates by an average of \$7.09 per procedure. This amount represents approximately 19.2 percent of the \$453 million budget for physician services expenditures. ³²

Medicaid Managed Care

Florida's history with Medicaid managed care dates back to 1977, when the legislature granted authority to the Medicaid agency to contract with HMOs. However, there was little interest on the part of HMOs. In 1978, Medicaid also obtained authorization to contract with county public health units on a prepaid basis, which resulted in one demonstration program in Palm Beach County. The pace of managed care contracting picked up in 1983, when the legislature authorized Medicaid to contract with prepaid health plans (PHPs), which are health care organizations that accept capitation payment but, as federal law permits, do not have to obtain a state HMO license until three years from the start of the contract. The state contracted with four PHPs. Despite efforts to solicit interest among plans on a case-by-case basis, by 1989 the state still had no contracts with commercial HMOs, and there were only about 50,000 enrollees in PHPs out of about 900,000 total beneficiaries.

Further Medicaid HMO growth was spurred through state policies in the early 1990s that made it easier for HMOs to enter the market. Among the most important policies were those allowing door-to-door marketing, as well as marketing in welfare and food stamp offices; establishing relatively generous rates, based on 95 percent of FFS payments, which in turn were higher because of updated fee schedules; and lowering capitalization requirements for PHPs to only \$250,000 in reserves. These changes led to a substantial increase in small PHPs and HMOs contracting with Medicaid—14 in 5 counties by 1990 and 29 in 48 counties by 1995. Many of the HMOs were out-of-state companies that got their start by acquiring small Medicaid PHPs.

In 1991, the state launched a primary care case management (PCCM) program called MediPass. Like many other PCCM programs, it pays a \$3.00 monthly case management fee to physicians or clinics to coordinate all the care for patients and to authorize all services, which continue to be paid on a FFS basis. While some assert that AHCA developed MediPass because not enough HMOs would participate in Medicaid, others believe that MediPass provides enrollees with an alternative to HMOs and ensures that HMOs have some competition.

The state passed a law in April 1993 that required enrollment in managed care for much of the Medicaid population. As a result, the state began efforts to implement MediPass in all areas of the state. The state submitted a revised 1915(b) waiver proposing statewide expansion, which was subsequently approved by HCFA.

The state's passage of the 1993 law requiring mandatory enrollment in some type of managed care program was driven by two forces. The most important was budgetary. With annual Medicaid program growth rates in the 20 percent range, the legislature was desperately seeking relief, and managed care seemed to hold the key to cost savings for the nonelderly population. ³³ Second, AHCA believed that expansion in managed care and the resulting savings were essential to financing the Florida Health Security Program. Although the legislature turned down Florida Health Security's proposed eligibility expansion, partly because of concerns that managed care savings might not be sufficient to cover all those eligible, it still wanted to harness some of the savings to hold down annual growth rates.

Enrollment

As a result of state policies and successful HMO marketing tactics, Florida's Medicaid managed care market grew rapidly between 1991 and 1995. ³⁴ In 1991, about 123,000 (13 percent) Medicaid beneficiaries were enrolled in some form of managed care: HMOs, PHPs, or the MediPass program. By 1996, nearly one million (66 percent) Medicaid beneficiaries were enrolled in some form of managed care. As a result of the 1995 enrollment freezes and rate reductions, however, enrollment in Medicaid HMOs or PHPs actually dropped between 1995 and 1996 by about 37,000, and the number of Medicaid HMOs or PHPs dropped from 29 in FY 94-95 to 19 in FY 96-97. Enrollment in the MediPass program has increased every year because of the 1993 mandate to implement the program in every county.

Until recently, the state's 1915(b) waiver allowed statewide mandatory enrollment in MediPass of all newly eligible AFDC and SSI populations (or those coming back onto Medicaid after a 90-day exit period), if they do not choose to enroll in an HMO or PHP. This recently changed, however, as a result of SB 886, the law passed in 1996 that allows the state to mandate assignment into either MediPass or an HMO or PHP. Effective February 1, 1997, the state began assigning new AFDC-related enrollees according to a ratio established in SB 886: 60 percent of those who do not select either program voluntarily will be assigned to HMOs or PHPs and 40 percent, to MediPass. ³⁵ SSI recipients were to be assigned starting May 1, 1997 (and notified of the requirement to choose or be assigned on March 1, 1997). The only exceptions to mandatory enrollment are for dual eligibles, presumptively eligible pregnant women, medically needy, and those in skilled nursing facilities (SNFs) or ICFs/DD. ³⁶

The rapid growth in Medicaid HMOs and PHPs during the early 1990s came at some cost. In December 1994, a yearlong investigation into Medicaid HMOs in South Florida led to a weeklong series of articles in the Fort Lauderdale *Sun Sentinel* that exposed poor-quality care and flagrant marketing abuses. In response to public outcry, the state placed a moratorium on the licensing of any new Medicaid HMOs in January 1995. It also froze enrollment in the 28 Medicaid HMOs that were already licensed until the AHCA could conduct on-site visits to assess plan compliance with patient medical records requirements, quality-of-care standards, and marketing practices. ³⁷

Based on AHCA's findings, the state made substantial modifications to Medicaid HMO contracts commencing after July 1995, many of which were subsequently incorporated into law in 1996. Medicaid HMOs and PHPs are now prohibited from door-to-door marketing, marketing in Food Stamp and AFDC offices, "give-aways," and subcontracts with brokerage firms or independent agents. Plans must also submit marketing materials to AHCA for approval, and all such materials must contain the state's toll-free HMO complaint hotline. Marketing commissions were limited to 40 percent of total compensation. The state's role in marketing and beneficiary education, which has been minimal, will increase as a result of SB 886, which authorized a choice-counseling program to be implemented during 1997. AHCA received \$15 million to implement this program. ³⁸ At the time of the site visit, it was developing the request for proposal (RFP) for an enrollment broker, which would allow face-to-face counseling and interactive kiosks.

Contracting Issues

In August 1995, Medicaid began adjusting capitation rates by age for the first time. According to HMO association representatives, the adjustment had the effect of reducing rates by 14 percent on average. There was a perception that more could be squeezed from HMO/PHP rates, despite an assessment by AHCA that the current financial status of many HMOs/PHPs is tenuous. In SB 886 and corresponding FY 96-97 budget language, the legislature set a target of \$17 million savings (out of \$700 million spent annually on HMOs), by cutting capitation rates from 95 percent to 92 percent of FFS rates. To achieve this, SB 886 mandated a competitive bidding process for HMOs, with a maximum rate of 92 percent of FFS rates allowed, over HMO opposition. HMOs were allowed to bid as low as 87 percent. In February

1997, 25 bidders were announced in the notice of intent to award contracts. Among the existing contractors, only two did not choose to submit bids. Nine new plans won awards, including Humana, which is entering the Medicaid market for the first time in Florida. Alpha Health Plan, composed of many of the state's Federally Qualified Health Centers (FQHCs), also won an award.

The legislature's targeted level of savings for FY 96-97 is unlikely to be achieved for two reasons. First, the law assumed that the bidding process and awards would be made shortly after the start of the fiscal year (July 1996), but the process took considerably longer.³⁹ Second, HMOs and PHPs claimed that the rewards for low bids, that is, more enrollees, were not sufficient to make a difference, so only one of them bid at less than 92 percent of FFS rates.

The RFP was portrayed by AHCA as the first time that contract awards would be based on the quality of care delivered by the plans. Plans would be awarded points, with 80 percent of the points depending on quality measures, such as service delivery and benefit enhancements, and only 20 percent on price.⁴⁰ Plans would be awarded more enrollee slots as the number of points increased. Plan representatives believed the importance of quality was overstated, since any plan with an existing contract needed only to document its service delivery, patient service, and quality assurance procedures. Thus, only the new plans had to prove their ability to provide high-quality care.

Even before the contracts were signed, the plans contested AHCA's capacity limits. Bidders that scored high enough to win contracts were given "enrollment capacity awards," based on their final scores. The number of Medicaid eligibles in each county as of July 1996 times 110 percent was used as the measure of overall enrollment capacity. The state determined enrollment slots allocated to each plan based on its share of the points awarded and the total enrollment capacity in the county. Because points did not vary much among plans, the result of this complicated scoring system is only a little more capacity for the highest scoring plans than for the lowest scoring plans.

Another problem with the new contracting system is that the state's capitation rate methodology is not very sophisticated, as one AHCA official readily admitted. As a result, if rates are set too high, HMOs may get windfall profits; if too low, quality of care and plan solvency are threatened. AHCA would like to implement a risk adjustment system to correct the current system's flaws but believes that the HMO industry will fight it. A private consultant study estimated that \$60 million would need to be transferred among plans to even out the risk levels—an amount too great to be ignored. The study found that virtually all of the difference was due to some plans having more SSI enrollees than others. If risk adjustment occurs, it will probably have to be legislatively mandated.

Those plans that sign contracts will, for the first time, be required to be commercially licensed. SB 886 requires Medicaid HMOs and PHPs to have a certificate of authority from the Florida Department of Insurance or to obtain one within a year of signing a contract. Exceptions are still made for plans owned and operated by a county, a county public health unit, a county-owned-and-operated hospital, or one or more FQHCs.⁴¹ By having to obtain a commercial HMO license, all Medicaid contracting plans are subject to greater oversight of their financial status by the Department of Insurance, which helps AHCA monitor HMO and PHP finances. Furthermore, AHCA requires all contracting plans to maintain at least 25 percent commercial enrollment (not Medicare or Medicaid) unless the plan has a waiver from HCFA. It was noted, however, that even when plans have both Medicaid and commercial enrollees, they often have separate provider networks. Thus, the 75-25 rule may not achieve what was intended. Finally, all Medicaid contractors are required to report HEDIS 2.5 (Health Employer Data and Information Set) measures, and AHCA has also designed a member satisfaction survey that all Medicaid HMOs and plans participating in the CHPAs must use.

Elderly Managed Care

AHCA and the Department of Elder Affairs are trying to implement a pilot project in Palm Beach County called the "long-term care diversion waiver." It involves capitation of an integrated set of long-term care and acute-care services for 600 elderly persons. Although the program is not yet operational, the FY 97-98 budget bill proposes a doubling of the program. Advocates and policymakers both acknowledge that the program is very limited in scope relative to the needs of the elderly population in Florida. Nonetheless, it is considered an important first step toward managed care for the elderly population.

Delivering Health Care to the Uninsured Population

State and County Public Health Programs

Historically, county public health units in Florida served as the major health care delivery system for the poor—Medicaid enrollees and uninsured alike. As branches of the state health department, all county health departments at some point provided maternal and child health services; Women, Infants and Children (WIC) services; family planning; and sexually transmitted disease screening and treatment. A few county health departments provided more comprehensive primary care services. Most of these services were Medicaid-reimbursable for Medicaid clients, and county public health units received cost-based reimbursement for them, according to state law. Some counties, such as Dade, have closed their primary care clinics and have shifted their focus to core public health activities, such as communicable disease control, maternal and child health support services, and environmental health.

Counties also have the primary responsibility for financing health care for the poor who are ineligible for Medicaid. However, the extent of county effort varies considerably. Since the 1930s, Florida has allowed localities (cities, counties, and special districts) to establish special health care taxing districts. There are currently 21 in the state. Through the establishment of the taxing district, some cities in Florida have been able to expand their tax base to include suburban areas, which increases the flow of money considerably. In some cases the money raised is quite significant, representing half of all money used to fund care for the medically indigent.

Most of the taxing districts use their revenues to support public hospitals (as in Dade and Broward Counties), although some distribute the funds more broadly among hospitals providing uncompensated care or to private hospitals that have leases with the district. In Hillsborough County, the taxes are used to support a unique program providing insurance to many of its uninsured, low-income residents (discussed further below).

Impact of Government Policies and Market Changes on Safety Net Providers in Dade and Hillsborough Counties

While the major safety net providers face tremendous competitive pressures, particularly for Medicaid patients, many of the organizations visited have weathered the storms of change reasonably well over the past few years. A major reason for this success is an increase in local support for indigent care. In both Dade and Hillsborough Counties, local support for indigent care has increased considerably with the implementation of a half-cent sales tax in each locale. In addition, part of the success of the safety net providers stems from their ability to adapt to the requirements of a competitive managed care environment. Hospitals and FQHCs have developed their own HMOs or PHPs, partnered with other HMOs and PHPs, developed networks with other health care providers to achieve greater efficiencies, or refocused on their core missions.

Not all safety net providers in the sites visited are faring well, particularly community clinics. In the present relatively rosy fiscal environment, how well safety net providers have survived

seems partly a function of the manner in which increases in local funds are distributed to those providers. In Hillsborough County, where the revenues have been used to fund systems of care across many different types of providers, most safety net providers seem to be doing remarkably well. In Dade County, where the revenues are centralized in the large public hospital, some community clinics are not faring so well. Without local subsidies, clinics have less maneuvering room in such a highly competitive market.

Competition for Medicaid patients and potential reductions in Medicaid reimbursement levels have raised the level of concern among safety net providers. While increases in reimbursement and eligibility in the early 1990s have helped safety net providers considerably, providers and advocates are worried that planned reductions in Medicaid rates or a further loss of patients to other providers will undermine the financial viability of the safety net providers and will re-create the access problems that existed in the 1980s. Safety net providers recognize that many Medicaid patients currently receive care through other institutions when they have Medicaid coverage. However, they are less certain that those institutions will continue to provide care to individuals who lose their coverage. If the safety net providers fail or scale back services as a result of losses in revenue, then at the very least, quality of care for the uninsured (both the chronically uninsured and those who fall on and off Medicaid or other third-party coverage) may decline. At worst, the uninsured may be forced back into the emergency room as a primary source of medical care.

Tampa/Hillsborough County

Hillsborough County, which encompasses the city of Tampa and the surrounding suburban and semirural areas, has a population of 879,000. The market was characterized as very competitive, with Columbia/HCA and BayCare having emerged as major players in the hospital market. The HMO penetration rate now stands at 25 to 30 percent, a rapid jump from 14 percent in 1994. This increase was prompted in part by the entry of United HealthCare and Health Plan of Florida into the market in 1993-94 and by their subsequent marketing to small businesses that dominate the economy. Their growth has created both pressure for hospitals to discount their fees to hospitals and tighter provider networks.

The Hillsborough County Health Care Plan (HCHCP), which provides health coverage to otherwise uninsured, low-income people, was developed to reduce the double-digit growth rate in uncompensated-care costs. Before HCHCP, \$34 million in property taxes supported the county's obligations for indigent care, the majority of which was used to subsidize Tampa General Hospital (TGH), a publicly owned facility. According to respondents, as a result of a rapid rise in indigent care costs to the county (about 20 percent per year) and to other area hospitals (about 10 percent per year), a County Board of Commissioners advisory board recommended a plan to provide and finance health care services for the county's indigent population based on managed care principles. By September 1991, the Florida legislature and the county board approved a half-cent sales tax to finance the program, which began in 1992. In FY 95, the HCHCP spent approximately \$63 million providing services to 27,000 individuals.

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HCHCP provides insurance coverage to a relatively small pool of individuals at little cost to enrollees. Individuals with income below 100 percent of the FPL and who are not eligible for Medicaid or other health insurance are eligible for HCHCP without any premium contributions. 43 A catastrophic plan is also available for people earning up to 200 percent of the FPL, but it requires premium sharing. The program offers a comprehensive benefit package, including primary care, inpatient and outpatient surgical services, mental health, dental care, substance abuse services, and home health services. Cost sharing is limited; patients have a small copayment for prescribed medical equipment, vision care, and dental care.

The program contracts on a risk-basis with four provider networks (one per geographic area within the county) to provide inpatient and outpatient services to HCHCP beneficiaries within a global budget negotiated annually with the county. Participating network providers include TGH (which participates in all four networks), two private nonprofit hospitals, two for-profit

hospitals, the University of Florida faculty, two FQHCs, the county public health units, and private community physicians. Enrollees are given an HCHCP card and can choose any participating provider as their primary care physician. At the time of eligibility review, enrollees can request a change of provider.

The HCHCP program has grown considerably since inception and has had a significant impact on the county's indigent care costs. From 1993 to 1995, the caseload increased by 23 percent, from 21,000 to 27,000 patients. Respondents estimated that the program provided coverage to 66 percent of the population eligible for HCHCP. According to most respondents, the program has been very successful. First, the program has redistributed the delivery of indigent care among providers and relieved some of TGH's indigent care load. Second, it has reduced emergency room use by program participants by nearly 25 percent, saving the county more than \$8 million.⁴⁴ Third, the program has reduced the average length of stay by more than 30 percent, resulting in estimated inpatient hospital savings of \$2 million. Finally, HCHCP has expanded the number of community care sites.

Despite its successes, the HCHCP could become somewhat unstable, given its funding source. The significant growth in reserves (in excess of \$100 million) has led some politicians to suggest that the program does not require such extensive tax support.⁴⁵ In the event that the tax used to fund the program is repealed or reduced, the safety net providers could find themselves in serious financial trouble.

The major safety net hospitals in Hillsborough County are TGH and St. Joseph's Hospital. Besides having a system of family care centers, TGH has the region's only Level 1 trauma center, two aeromedical helicopters, a regional burn center, and many other specialty programs. TGH also owns and operates its own Medicaid HMO, called Healthease. Over the past five years, St. Joseph's-St. Anthony's Health System has grown from a single hospital to a complete system, which also includes Women's Hospital, Tampa Children's Hospital at St. Joseph's, and other services, such as home health and diagnostic centers.

TGH provides the bulk of care to the uninsured, and St. Joseph's handles a growing share of the Medicaid market. According to AHCA annual hospital reporting data, TGH's charity care in 1995 was \$52.4 million; St. Joseph's reported \$21.3 million that same year. The competition for Medicaid patients is putting financial pressure on TGH. St. Joseph's-St. Anthony's Health System now serves more of the Medicaid market than TGH. TGH reports that it went from serving 60 percent of the Medicaid market to 30 percent (and dropped from 5,600 to 3,000 deliveries per year). Meanwhile, St. Joseph's went from 19 percent to 38 percent of the Medicaid market by luring pregnant women to a newly acquired women's hospital; it is now building a new children's hospital to gain more of the children's market.

The loss of Medicaid revenue means that TGH is increasingly reliant on state and local support and its own initiative in developing strategies to increase the organization's efficiency and market viability. Despite the fact that St. Joseph's provides a sizable amount of care to the low-income population, TGH receives the lion's share of public support for care for the medically indigent. In FY 95-96, St. Joseph's received \$10,000 from the state in DSH payments, a small fraction of the \$18.3 million TGH received.⁴⁶ Other state policies are helpful to TGH as well. For example, while TGH's HMO (Healthease) had only about 4,000 Medicaid members in early 1997, it was awarded 37,000 slots in the latest Medicaid RFP process, which TGH believes reflects an effort by the state to assist safety net hospitals. Furthermore, the state's certificate-of-need process prohibits the proliferation of tertiary and quaternary services, thus protecting the interests of TGH. Locally, TGH has an advantage because all four HCHCP geographic networks contract with TGH for specialty services.

There are two FQHCs in Hillsborough County: Tampa Community Health Centers (TCHC) and Suncoast Community Health Centers. TCHC opened in 1986 with one site, but it has grown to five clinical sites. Suncoast is located in a more rural area of the county. It began as a program of the county health department serving Hispanic migrant farm workers, and it has added two

more sites and is expanding its staff and clientele. Because of the growth in Medicaid HMOs, Suncoast has lost 4,000 Medicaid patients in the last three years, harming its ability to provide a full range of services to its patients.

As survival strategies, the two FQHCs have become very involved in Medicaid managed care and HCHCP. For example, both TCHC and Suncoast are the designated "gatekeepers" for two different HCHCP networks. TCHC has contracts with several Medicaid HMOs, yet it says it is losing money on all these contracts. For this reason, Suncoast has not become part of one of the leading Medicaid HMOs' network, but nonparticipation has hurt it. To try to regain Medicaid patients, both TCHC and Suncoast were two of 17 FQHCs in Florida that allied to form the Alpha Health Plan. Alpha recently won a contract in the most recent round of Medicaid HMO awards. Alpha will pay the FQHCs better rates than other Medicaid HMOs and will also pursue commercial contracts to comply with the 75-25 rule.

The Hillsborough County Health Department decided in 1994 that it would withdraw from the HCHCP and divest from directly providing primary care services, even though it still needs Medicaid business to support health services to the uninsured who are ineligible (e.g., undocumented aliens) or who do not sign up for HCHCP. The health department instead contracts with a group of midwives and pediatricians to provide primary care to uninsured and Medicaid-covered children and pregnant women. Most of the funds for these services are generated from Medicaid FFS payments under MediPass. The health department also has a few Medicaid managed care contracts.

Miami/Dade County

Dade County, which includes the city of Miami and the surrounding urban (South Beach) and suburban areas, had a population of more than 2.1 million in 1995, with 1.7 million people under the age of 65. Respondents indicated that although access to care for low-income individuals has improved considerably since the early 1990s, problems remain. According to advocates, a large number of women and children are still not receiving health care services, especially undocumented immigrants from Central and South America and Haiti. The county has unique health problems as well, such as hanta virus, tuberculosis, malaria, cholera, and hepatitis, which are attributable to some extent to Miami's status as an immigration center.

The Miami-Hialeah metropolitan area had the second-highest HMO penetration rate in the state, at 37.8 percent.⁴⁷ With a bed-to-population ratio of 4.1 per 1,000, the hospital market is over-bedded. The hospital market is concentrated in two for-profit systems and a nonprofit hospital system. Together, for-profit Columbia/HCA and Tenet control almost 40 percent of the beds in the market. The Dimension System, which is technically a physician-hospital organization comprising for-profit and nonprofit hospitals, controls almost 26 percent of the beds.

The county's dominant source of care for the indigent is Jackson Memorial Hospital, a publicly owned hospital that receives substantial subsidies from the Dade County Public Health Trust (the public hospital taxing district). According to Jackson Memorial officials, although the Trust and Jackson Memorial Hospital are separate entities, they are regarded as one, since all of the Trust funds are allocated to Jackson Memorial Hospital and its affiliated centers. The Trust is funded through a variety of revenue streams: (1) a half-cent sales tax that was passed by Dade County voters in September 1991 and raises \$96 million annually; (2) ad valorem taxes, which in FY 95-96, totaled \$84 million; and (3) federal and state grants, which total about \$10 million annually. The remainder of the \$750 million budget is generated through DSH payments and through commercial, Medicaid, and Medicare revenues. (Jackson Memorial receives approximately 50 percent of state DSH payments.)

Jackson Memorial is the major safety net hospital in Dade County, accounting for 50 percent of all Medicaid inpatient days in the market in 1993 and 55 percent of all charity care and bad debt (\$124 million in 1995).⁴⁸ Whether or not there are other safety net hospitals is a subject of debate. While certain hospitals provide significant amounts of care to Medicaid-eligible

people, they provide relatively little charity care compared with Jackson Memorial. These facts have called into question the manner in which local, state, and federal funds are distributed. The mayor's office and the South Florida Hospital Association argue that other hospitals in Dade County, which together provide about 50 percent of the care to the low-income and uninsured population, should receive some of the funds from the half-cent tax. The mayor's office would like to decentralize health care along lines similar to those in Hillsborough. ⁴⁹

In the past few years, Jackson Memorial's share of the Medicaid market has declined because of increasing competition for Medicaid patients. According to Jackson Memorial officials, between 1990 and 1995, Medicaid inpatient days dropped from 484,000 to 391,000, a 20 percent decline. Whereas Jackson Memorial once provided 90 percent of obstetrics care to low-income patients, its share has dropped to 50 percent. A priority for Jackson Memorial has been to maintain patients, primarily Medicaid patients, in its system. To do so, it has expanded its primary care patient referral base; it now owns or affiliates with six primary care clinics. It has also expanded an existing managed care plan (Jackson Memorial Hospital Health Plan), which recently won a contract in the Medicaid managed care bidding process. It created a new managed care plan (with a private managed care plan and University of Miami Hospital) to capture more of the Medicaid and commercial capitated market. In addition, it is lobbying the state to modify the certificate-of-need regulations so that it can convert hospital beds into swing beds. Finally, the hospital is attempting to reduce costs through cuts of up to 1,000 full-time employees.

Nine primary care centers in Dade County provide care to low-income people. The growth of Medicaid managed care has resulted in a loss of revenues for all community clinics, creating substantial financial problems. In some cases, clinics have lost Medicaid patients and the revenues that they provided, resulting in a loss of some capacity to subsidize care for the uninsured. In other cases, clinics have lost Medicaid revenues but have continued providing care to Medicaid patients assigned to other primary care providers and uninsured patients, presumably with funds provided in their grants from the federal Bureau of Primary Health Care. Some are reconsidering their mission in light of these changes; while federal grants and FQHC cost-based reimbursement have served as a cushion, some clinics believe they are at the end of their rope.

Community clinics in Dade County have pursued a variety of strategies to maintain their competitiveness and Medicaid patient base. A group of four major clinics banded together to form Health Choice Network to conduct joint purchasing, integrate management information and fiscal systems, coordinate medical directorships, and create market power to negotiate with managed care plans. Health Choice has been fairly successful in negotiating contracts with hospitals and health plans because of its large Medicaid obstetrics patient base. It has referral relationships with several hospitals, but not with Jackson because Jackson does not refer patients back to the clinics and does not offer admitting privileges to Health Choice's physicians. In addition, Jackson opposes having the Trust, or any county funds, provide financial support to the clinics.

Like other county public health units, Dade County's health department had for many years provided both traditional public health services and comprehensive primary care services. Between 1993 and 1995, Medicaid encounters decreased by about 30 percent, causing the department to rethink its mission. Seeing a rise in communicable diseases, such as AIDS and tuberculosis, the county decided that it should not continue to provide primary care services. It issued an RFP for an organization to take over its maternity and pediatrics services in four clinics. Jackson Memorial's bid was accepted in part because of its assurance that it would maintain a commitment to providing care to the uninsured, including documented and undocumented aliens. The county has maintained two clinics, which provide family planning, immunizations, and other traditional public health services.

Long-Term Care for the Elderly and Persons with Disabilities

The need for long-term care services for older adults is potentially enormous in Florida. In 1995, 2.7 million people, or 19 percent of the state's population, were over the age of 65, which is substantially higher than the national average of 12.7 percent and makes Florida the state with the greatest proportion of elderly. Given this, there is substantial pressure to develop a larger, but low-cost, system of long-term care.

Supply, Expenditures, and Utilization

As in other states, long-term care in Florida is heavily financed by the Medicaid program, and long-term care services are an important part of the total Medicaid budget, though less than in many other states. For example, in 1995, the state spent 28 percent of its total Medicaid budget on long-term care services, compared with a national average of 34 percent. Medicaid spending on long-term care in the state grew slightly more rapidly than other components of the Medicaid program between 1992 and 1995, at an annual rate of 14.7 percent, about twice the national rate (table 6). However, long-term care spending per elderly and blind and disabled recipient was still 36 percent lower than the national average in 1995, primarily because of a low supply of nursing-home beds and relatively little spending on home and community-based care.

In 1996, there were 699 certified nursing homes and 79,000 long-term care beds in Florida. Occupancy rates in Florida nursing homes are about 91 percent. While the state's certificate-of-need law allows the number of beds to rise if the occupancy rate increases, Florida's ratio of 30 beds per 1,000 people over age 65 was one of the lowest in the country in 1994, compared with a national average of 53.3 per 1,000 elderly.⁵⁰ As of 1994, there were 1,450 licensed home health care agencies in Florida. There were also 120 licensed adult day care centers and 2,364 licensed residential care facilities in 1994, including assisted living facilities and adult family-care homes.⁵¹

Other types of facilities serve the developmentally disabled. These include four state-operated Developmental Services Institutions. Most of the beds in these facilities are certified as ICF/DD and serve approximately 15,500 individuals at any given time. In addition, there are 2,200 beds in privately operated ICFs/DD and 804 long-term residential care facilities with 5,778 licensed beds. In 1994, 44 percent of persons with developmental disabilities in institutional settings were in facilities with more than 16 beds.

Long-Term Care for the Elderly

Florida spent \$1.1 billion in 1995 on long-term care for the elderly (table 6). The state relies more heavily on nursing home care to provide long-term care services to the elderly than do most other states. In 1995, 94 percent of long-term care expenditures for the elderly under the Medicaid program were for nursing home services, compared with 84 percent nationally. Spending on nursing home care for the elderly rose more rapidly than the national average, at an annual rate of 11.2 percent between 1992 and 1995. (The national rate was 7.6 percent.) While nursing home bed supply is allowed to increase, it is carefully regulated by the state.

Reorganizing the Delivery System

Although there appears to be growing interest in expanding home and community-based care for the elderly and disabled, Florida continues to lag behind most states in doing so. Advocates and policymakers acknowledge that the current system of nursing home care, with its low number of beds, may be unsustainable and that there is likely to be huge demand in the long run. Yet policymakers remain concerned that offering home and community-based services will be unaffordable. The nursing home industry supports alternatives to nursing

homes, including the small waiver programs the state has implemented, because it believes that if the state purchases services more cost effectively, it can stretch current long-term care dollars further.

Florida operates a state-funded long-term care program called Community Care for the Elderly (CCE), which helps functionally impaired elderly live in the least restrictive environment suitable to their needs. In FY 96-97, the state will spend a projected \$41 million in state general revenues to provide community-based services to approximately 38,500 functionally impaired older people, including those served under a Medicaid home and community-based services waiver. ⁵² All CCE clients are screened annually for Medicaid waiver eligibility (see below); those found eligible and meeting level-of-care conditions are transferred to the waiver program, allowing the Department of Elder Affairs to maximize federal funding. According to the Department of Elder Affairs, another 8,000 to 11,000 are on the waiting list. Priority is given to those who are at risk of entering an institution or those who have been abused, neglected, or exploited.

The Department of Elder Affairs and AHCA share responsibility for administering the state's several home and community-based care waivers that serve the elderly. The primary home and community-based care waiver for the elderly is a 1915(c) waiver that diverts disabled adults and elderly from nursing facilities. Elderly individuals qualifying for Medicaid and assessed by a health professional as frail, functionally impaired, and at risk of nursing home placement are eligible for services under the waiver. The FY 96-97 estimated budget for all services under this waiver was \$36.1 million. The federally assigned maximum enrollment cap in this waiver program for FY 96-97 is 16,943, but only 9,550 individuals are expected to receive services under the program, because the state has not appropriated the required matching funds. ⁵³

While the nursing home bed supply in Florida is quite low, the state has more licensed residential care beds per 1,000 elderly population than the rest of the nation (24.2 beds, compared with 20.1). Residential care facilities include both assisted living facilities and adult family-care homes. ⁵⁴ Assisted living facilities are residential options for the elderly and disabled that provide housing, meals, and supportive services. Currently, there are more than 1,800 assisted living facilities statewide, serving more than 60,000 residents (averaging 33 residents each); another 600 adult family-care homes serve about 1,200 residents. Most residents cover the cost of their own care in these facilities, but the state provides a subsidy for some low-income residents. ⁵⁵ There is no state certificate-of-need requirement for assisted living facilities. Thus, the state cannot regulate their growth. According to the Florida Commission on Aging with Dignity, occupancy rates range from 70 percent to 80 percent, suggesting ample capacity.

Although Florida's apparent dearth of nursing home beds relative to its proportion of elderly citizens has raised concerns about access, nursing home industry representatives speculate that assisted living facilities and adult family-care homes may be serving as providers to those not able to secure a nursing home bed. They also speculate that the elderly in Florida may have more financial resources than those in other states and less need for public support for nursing home care.

Traditional Cost Containment Methods

Nursing homes receive Medicaid reimbursement according to an adjusted cost-based methodology, with rates determined prospectively on a per diem basis. They are not case-mix adjusted. Medicaid currently pays on average \$92 per day, higher than the national average of about \$83 per day. Annual target limits on increases are very low; the state did not recognize cost increases resulting from changes contained in the federal Omnibus Budget Reconciliation Act of 1987, for example.

The state regularly cuts funds from institutional care line items in the Medicaid budget. Over

the past five years, Medicaid has absorbed over \$1 billion in budget reductions, a substantial amount of which was in the area of institutional provider payments. For example, modifications to nursing home reimbursement policy in 1991 resulted in a \$31 million cut, followed by a \$20 million cut in FY 92-93, a \$13 million cut in FY 95-96, and a \$17 million cut in FY 96-97. Despite these reductions, nursing homes have not filed any Boren amendment lawsuits, largely because they believe such suits consume too many resources and have not produced the desired results.

The nursing home industry has made Medicaid reimbursement a perennial priority issue. According to the Florida Health Care Association, 80 percent of nursing homes report that their costs are not covered by Medicaid. The industry reports that "high Medicaid homes" (those with more than two-thirds Medicaid patients) are almost four times as likely to be under conditional status (those with identified problems) than "low Medicaid homes." Several nursing home chains have been in administrative hearings with AHCA over July 1996 rate reductions (rather than Boren suits, which are filed in federal court). Industry representatives predict that as budget reductions for institutional long-term care continue, the state will see an erosion in the quality of patient care.

Certificate-of-Need Restrictions

As mentioned earlier, Florida has one of the lowest nursing-home bed supplies in the country. Nursing home bed growth is carefully regulated by the state. The bed supply increases by about 1,800 to 2,400 beds each year, based on allowable growth limits under the state's certificate-of-need law. According to AHCA officials, there are 8,000 more long-term care beds currently in the construction pipeline (under previous certificate-of-need approvals).

Medicaid Eligibility for Nursing Home and Home Care Services

Florida's medically needy program does not cover institutional services (nursing homes, ICFs/DD, and state mental hospitals), preventing qualification for Medicaid through spend-down on nursing home expenses.

Many Miami nursing homes were concerned about the impact of the welfare reform law on their Medicaid residents who are legal aliens. The state, however, elected to continue Medicaid eligibility for those who entered the country prior to August 1996, ensuring that the Medicaid nursing home benefit is secure for most people. The general sense in the industry is that influential Miami legislators will support funding of legal immigrants in nursing homes who will still not qualify for Medicaid, estimated at 2,000 to 3,000 people.

Medicare Maximization

In 1996, the legislature required AHCA to ensure that home health care beneficiaries exhaust all Medicare benefits before using Medicaid coverage. It also required prior authorization for home health care.

Limits on Transfer of Assets and Estate Recovery

The leader of an advocacy group for low-income elderly has publicly complained that approximately 5 percent to 10 percent of new Medicaid applicants become eligible through "artificial impoverishment schemes."⁵⁶ While Florida has yet to address this problem, in FY 96-97, the AHCA planned to expand its estate recovery efforts.⁵⁷ SB 886 allows the Department of Revenue to share estate information with AHCA's Medicaid Estate Recovery Program, which may increase recovery rates.

Younger People with Disabilities

Responsibilities for younger persons with disabilities are spread across a number of agencies,

including the Developmental Services Program, Department of Mental Health and Substance Abuse, and Children's Medical Services within the Department of Health. The overall strategy for providing services to this population has been to reduce the reliance on institutional settings and increase community-based care. However, for the developmentally disabled and the mentally ill, the need for both institutional and community-based services outpaces the supply of services and state resources to purchase such services.

Institutions and Community-Based Services for the Mentally Ill and Developmentally Disabled

In the early 1990s, Florida explicitly sought to maximize federal revenues for covering the developmentally disabled through its Medicaid home and community-based services waivers. According to officials in the Developmental Services program, two main waivers are used by the state of Florida for disabled nonelderly populations: a Developmental Services waiver that covers almost 11,000 individuals and a smaller Aged/Disabled Assisted Living waiver that covers about 1,300 people. The state currently has approval from HCFA for 20,000 individuals in the Developmental Services waiver, and the state has authorized funding for 11,000 individuals. Increased use of these waivers has allowed the state to serve individuals in community settings at a lower cost than serving them in institutions. The movement to serve this population in the community is seen as advantageous to the clients as well. Finally, the shifting of the financing of care from the state to the federal government has allowed the state to serve more clients with the same amount of state resources. ⁵⁸

Despite the greater reliance on community-based care, of the 28,000 persons served by the Developmental Services program (including through waivers), more than 9,000 have been identified as having unmet needs. More than 90 percent of these individuals are eligible for home and community-based waiver services. A similar situation exists for persons with mental illness. According to the governor's budget recommendations, only 32 percent of the need for mental health services in the state is being met.

A number of recent lawsuits have tested the issue of whether long-term care services for the disabled are entitlements. In *Does v. Chiles*, plaintiffs alleged that the state's policy of rationing ICF/DD services by limiting ICF/DD beds and putting qualified persons on waiting lists violates federal law and that the state is not providing services with "reasonable promptness." In July 1996 the courts ruled that the waiting lists violated the reasonable promptness requirement and ordered the state to address this in their Medicaid plan and limit waiting list time to no more than 90 days. The state estimates that it would cost \$700 million to comply, and it has appealed the decision. This suit essentially will determine whether ICF/DD services are an entitlement.

In the 1995-96 session, the legislature determined that ICF/DD services (which are optional) are a "runaway cost item" and decided that the state would no longer fund services in privately owned ICF/DD facilities. With the change in legislation, the state also removed \$34 million from the Developmental Services program budget. In response, the *Cramer v. Chiles* suit was filed, with plaintiffs contesting the legislation. The plaintiffs alleged that there was no plan to transition the 2,200 individuals currently in privately owned ICFs/DD into other programs, namely the home and community-based services waiver program. The court granted a preliminary injunction that the state continue to pay for 100 percent of the costs of those individuals currently in privately owned ICFs/DD until the state completes a plan to transition these individuals into a community-based setting approved by HCFA.

The outcomes of the state's appeals of these two decisions will likely set the tone for the provision of long term-care services for disabled persons over the next few years.

Challenges for the Future

Florida faces a number of major challenges in the near future. A primary concern is the size and scope of the Medicaid program. Governor Chiles has proposed the expansion of Medicaid coverage for children under age 3 with household incomes up to 185 percent of the federal poverty level; he has also requested authorization to increase the number of children covered by the Healthy Kids program to more than 100,000. However, growth in Medicaid expenditures in the past decade has made the Medicaid program a serious target for budget cutters interested in allocating more funds to education and corrections. Reductions in Aid to Families with Dependent Children caseloads and a number of other factors have mitigated the impact of these cuts on the program in the past. However, any change in the rosy economic situation in Florida could create problems, forcing state officials to make decisions regarding the core of the Medicaid program: eligibility levels and benefits. At the same time, over 19 percent of the state's population lacks health insurance of any kind, despite rapid growth in Medicaid enrollment in recent years. With the passage of its State Child Health Insurance Program, the state is likely to expand coverage further for children. But given recent cuts in the program, Medicaid expansions to cover other uninsured populations are unlikely.

Moreover, the state faces a challenge with respect to both welfare reform and long-term care. Welfare reform provisions will end Medicaid assistance to future legal immigrants in Florida. Although some interest has been shown in extending state-funded coverage to those individuals already in the United States who were made ineligible for Medicaid, it will come at some cost to the state. Failure of the state to act will mean costs to local areas.

Florida has the largest elderly population in the country, yet it currently spends comparatively little on long-term care; demand for these services is expected to rise considerably. The nursing home bed supply is low by national standards, and the state has restricted increases in nursing home payment in recent years, raising concerns about the impact on the quality of care. The state is also under pressure to expand long-term care services at home and in the community.

The state's attempt to expand coverage through insurance reform has been only partially successful. The state had hoped, with reform in the small group market and the development of Community Health Purchasing Alliances (CHPAs) to reduce the cost of health care and expand insurance coverage. To date, there has been little downward pressure on premiums. Moreover, the CHPAs have been only partially successful at expanding coverage to small businesses, in part because of legislative constraints on their bargaining ability. Florida faces a challenge in making the CHPAs more efficient, as well as in expanding insurance reform to the individual market.

In general, the Florida provider market is experiencing rapid change. The state has experienced considerable growth in commercial managed care. At the same time, Florida's health care market is experiencing rapid growth in for-profit health maintenance organizations (HMOs) and for-profit hospitals. Further consolidation among both HMOs and hospitals can be expected. It is unclear whether or not this will lead to improved efficiency in the marketplace and lower health care costs, and if so whether or not the lower costs come at the price of quality. Equally important, it is unclear whether nonprofit hospitals faced with increasing competitive pressures will continue to be able to provide services to low-income populations.

Alongside the rapid growth in commercial managed care, the state has embarked on a path of dramatic increase in the number of individuals in Medicaid managed care, the results of which are uncertain. Enrollment abuses and quality-of-care problems have led to calls for increased regulation of the Medicaid managed care industry. In Florida as in other states, there are likely to be a number of proposals for managed care regulation in the near term, which could have important implications for Medicaid as well as for the nature of market competition in the state.

With strong antitax sentiment throughout the state, prospects for expanding the state role in health care financing are uncertain. (Enactment of the State Child Health Insurance Program in August 1997, with the offer of substantial new federal funds, will alter these prospects.)

Safety net institutions, both hospitals and community health centers, are facing serious competitive pressures. They are finding it more difficult to compete for Medicaid patients because of the increase in Medicaid managed care. The growth in Medicaid managed care, coupled with the large uninsured rate, places a large burden on local providers and on local governments. In Dade and Hillsborough Counties, local taxes have been increased to fund a small insurance program (Hillsborough) and to support a major hospital (Dade). The safety net could be threatened if a recession occurs or if the local areas are unable to sustain public support for these institutions and their mission. The state has increased its support of Tampa General Hospital and may have to play a greater role in supporting the safety net throughout Florida in the future.

Notes

1. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.
2. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.
3. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.
4. Department of Children and Families, *Impact of Restrictions on Legal Immigrants*, February 1997.
5. Agency for Health Care Administration, *Medicaid Statistics: Florida Medicaid Program*, November 30, 1996.
6. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.
7. Agency for Health Care Administration, *Medicaid Statistics: Florida Medicaid Program*, November 30, 1996.
8. Eligibility is based on Medicaid criteria for children up to age 13; older children must be in families earning under the federal poverty level. The program has 23 local offices and numerous providers under contract who provide services to children with physical disabilities that traditional providers may not be qualified to treat. Services are funded largely through Medicaid revenues (72 percent to 73 percent), with federal Title V and some state funds covering the costs of the uninsured.
9. *Legislators Guide to Medicaid*, 1997.
10. The Boren amendment required states to pay hospitals and nursing homes the costs associated with an economically and efficiently operated facility (that meets quality and safety standards). The Boren amendment was repealed by the Balanced Budget Act of 1997.
11. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.
12. Urban Institute calculations based on HCFA 2082 data and projections from the March 1994 Current Population Survey, in "Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends: 1984-1994," Kaiser Commission on the Future of Medicaid, November 1996, page 31.
13. Florida Agency for Health Care Administration, Medicaid Services Budget Forecasting System Reports. These figures are less than the number of enrollees in 1995 reported in the Urban Institute's analysis of HFCA 2082 data, which counts all of those enrolled at any time during the year.
14. For further details, see Ku, Leighton, "Florida Health Security Program," in *Increasing Insurance Coverage through Medicaid Waiver Programs: Case Studies*, Urban Institute, November 1994, pages 79-93.
15. Healthy Kids, 1997 *Annual Report*, February update.
16. Healthy Kids, 1997 *Annual Report*, February update.
17. These counties are Alachua, Broward, Collier, Dade, Duval, Escambia, Flagler, Hardee, Hendry, Highlands, Hillsborough, Okeechobee, Palm Beach, Pinellas, St. Lucie, Santa Rosa, and Volusia. Another 12 counties have been designated as planning sites, and 3 counties are designed as future sites.
18. The Florida Comprehensive Health Association is the state's high-risk pool, which was designed to cover individuals whose prior medical conditions made it difficult for them to obtain coverage. It caps premiums at 200 percent to 300 percent of the standard low-risk individual rate and is funded through enrollee premiums and assessments on insurance carriers. There are currently 2,387 enrollees, but enrollment was closed in July 1991 to

new enrollees because insurers did not want to pay for anticipated losses. If the pool were reopened, one possible source of funding would be an assessment on health care providers.

19. Office of Health Policy, AHCA, *Request for Proposals: Health Care Practice in a Reformed Market*, June 1995.

20. Community Health Purchasing Alliance, Monthly Program Report.

21. Office of Program Policy Analysis and Government Accountability, *Review of the Status of Community Health Purchasing Alliances in Florida*, Report No. 96-5, September 1996.

22. Florida Hospital Association, *FHA Eye on the Market: Health Care in the Sunshine State*, 1996.

23. Department of Insurance, *Annual Ranking Report of Licensed HMOs in the State of Florida*, December 31, 1995.

24. FAHMO members are largely commercial HMOs. FAHMO does not include some licensed plans that have chosen not to join, nor does it include several HMOs that primarily enroll Medicaid clients, which created their own association. The two groups sometimes split on issues related to managed care.

25. Many of these bills did pass the legislature, but at the time of this report, were awaiting action by the governor. See HB 297 and HB 325—Managed Health Care Entities, SB 244—Direct Access to Dermatologists. An update can be obtained on the World Wide Web: <http://www.leg.state.fl.us/senate/summary/health.html>.

26. Florida Hospital Association, *FHA Eye on the Market: Health Care in the Sunshine State*, 1996.

27. Florida Hospital Association, *FHA Eye on the Market: Health Care in the Sunshine State*, 1996.

28. One interviewee indicated that current Medicaid payments represented only 72 percent of costs. The reason for the discrepancy in measures of generosity may be a function of variations in period, different data sources, or a hospital-specific issue.

29. Agency for Health Care Administration, *Medicaid Services: Summary of Disproportionate Share Hospital Payments*, Fiscal Years 1987-88 through 1996-97.

30. According to FY 96-97 state budget documents, intergovernmental transfers account for only \$72.4 million of DSH revenues. The reason for the decline is not clear.

31. Norton, Steve, "Medicaid Fees and the Medicare Fee Schedule: An Update," *Health Care Financing Review*, vol. 17, no. 1, pp. 167-87.

32. State of Florida, *The Governor's Budget Recommendations, FY 1997-98, Summary*, January 1997.

33. A study by Florida State University showed that MediPass saved 13 percent over traditional FFS. Barrilleaux, C. et al., "Florida MediPass Evaluation Report," submitted to Florida Agency for Health Care Administration, December 1995.

34. Information from various sources: Agency for Health Care Administration. *Medicaid Statistics. Florida Medicaid Program*. November 30, 1996. Legislators Guide to Medicaid. Health Care Financing Administration Managed Care Report, 1995 and 1996.

35. SB 886 specified that new assignees who had not made a choice between MediPass or a Medicaid HMO would be equally distributed between the two programs and allowed them 90 days to make a choice. However, the "Cut Bill" changed this to a 30-day period and required that in the first quarter 60 percent of enrollees who have not made a voluntary choice be assigned to Medicaid HMOs and 40 percent be assigned to MediPass. AHCA's plan is to look at the actual ratio of voluntary preference for four quarters and revisit the assignment ratio at that point.

36. A separate Section 1115 waiver request is being prepared that would allow the state to lock Medicaid recipients into either an HMO/PHP or MediPass for a period of one year, after a Medicaid recipient has been given 30 days to make a choice and 60 days to switch plans.

37. In April 1995, the state lifted enrollment caps for eight Medicaid HMOs that were found to meet 90 percent to 98 percent of all 46 contract standards. Those meeting less than 90 percent of quality standards were subject to fines and penalties, enrollment caps at previous levels, or a halt on expansion into other counties.

38. Until recently, only \$1 million was available for enrollee education; this was just enough to print brochures and operate a hotline (which opened in November 1996).

39. The RFP was issued at the end of August 1996, with a submittal deadline of October 4, 1996. The RFP called

for posting notices of intent to award on December 2 and awarding contracts by January 1, 1997. But the process was held up for a couple of months by a protest against the RFP, filed by one of the major Medicaid HMOs. A settlement was reached that allowed the process to continue, and the notice of intent to award was issued on February 12, 1997. However, as of mid-April, contracts had still not been signed, again due to some protests.

40. Agency for Health Care Administration, *1996-97 Medicaid Prepaid Health Plan: Model Contract*.

41. A bill passed by the legislature in 1997, but not yet signed by the governor, would extend from July 1, 1997, to January 1, 1998, the time period for FQHCs and county plan providers that contract with Medicaid as prepaid plan providers to be licensed by the Department of Insurance as HMOs. It also prohibits the FQHCs from receiving prepaid reimbursement during this interim period.

42. "Nationally Honored Health Care Plan Rates County Legislators' Strong Support," editorial, *Tampa Tribune*, 1/10/97.

43. Undocumented aliens are not eligible for the program.

44. Hillsborough County, *Hillsborough County Health Care*, 1997.

45. On May 1, 1997, it was reported that the Florida legislature passed a bill on April 29 allowing Hillsborough County "to continue collecting a sales tax to pay for its health plan for the poor," according to the *Tampa Tribune*. The bill, "now certain to win approval from Gov. Lawton Chiles (D)," represents a compromise in which the county's half-cent sales tax would be extended until 2005, but the county commission "is expected to cut the tax in half for four years to spend down part of a \$114 million surplus." The measure would also allow the county "to roll back" its \$26.8 million property tax to support the program. This turn of events is likely to mean no expansion in the program, and it may even have to cut back somewhat.

46. Agency for Health Care Administration, *Medicaid Services: Summary of Disproportionate Share Hospital Payments*, FY 1995-96.

47. Florida Hospital Association, *FHA Eye on the Market: Health Care in the Sunshine State*, 1996.

48. Agency for Health Care Administration Hospital Financial Data, 1995. American Hospital Association Annual Hospital Survey Data, 1993.

49. On January 16, 1992, then-County Commissioner Alexander Penelas published *Health Net*, a report that described a decentralized indigent care program modeled after the Hillsborough plan. No new plan has been developed, but respondents indicated that this plan was still considered a plausible option.

50. American Association of Retired Persons, *Across the States*, 1996.

51. American Association of Retired Persons, *Across the States*, 1996.

52. Florida Department of Elder Affairs, Resource Manual, 1997.

53. Florida Department of Elder Affairs, Resource Manual, 1997.

54. American Association of Retired Persons, *Across the States*, 1996.

55. Florida Department of Elder Affairs, Resource Manual, 1997.

56. H. James Towey, "Millionaires on Medicaid," commentary in *St. Petersburg Times*, December 8, 1996.

57. *Legislators Guide to Medicaid*, 1997.

58. Department of Health and Rehabilitative Services, *Monthly Data Report*, September 1996.

APPENDIX

List of People Interviewed

TALLAHASSEE

State Government
Agency for Health Care Administration

Tom Arnold
Doug Cook
Marilyn Y. Evert
Kate Morgan
Sally Morton
Nancy Ross
Bob Sharpe
Dyke Snipes
Celeste Putnam-Tanzy

Department of Children and Families

John Bryant
Susan Dickerson

Department of Elder Affairs

Charlie Liem

Department of Health

Donna Barber
James Howell, M.D.
Rick Hunter, M.D.

Department of Insurance

Michele Newell
Tom Warring

Office of the Governor, Planning and Budgeting Office

Paul Belcher

State Legislators and Legislative Staff

Representative George Albright
Lynn Dixon
Michael Hansen
John Wilson

Provider/Plan Associations

William Bell, Florida Hospital Association
Greg Glass, Florida Primary Health Care Association
Erwin Bodo, Florida Health Care Association (nursing homes)
Richard Dorff, Florida Association of HMOs

Advocacy Groups

Marcia Beach, Advocacy Center for Persons with Disabilities
Jack Levine, Florida Center for Children and Youth
James Towey, Florida Commission on Aging with Dignity

Others

Rose Naff, Florida Healthy Kids Corp.

TAMPA/HILLSBOROUGH COUNTY

Hospitals

David Rogoff, St. Joseph's Hospital
Bruce Siegel, M.D., Tampa General Hospital

Community Health Centers

Burt Parmer, Suncoast Community Health Centers, Inc.
Gloria Elliott, Tampa Community Health Centers
Terrence Shirley, Tampa Community Health Centers

City/County Officials

Phyllis Busansky, Former County Commissioner
Douglas Holt, Hillsborough County Department of Health and Social Services
Cretta Johnson, Hillsborough County Department of Health and Social Services
Victor Martinez, M.D., Hillsborough County Department of Health and Social Services
Pat Bean, Deputy County Administrator

Others

Cynthia Sampson, Community Health Purchasing Alliance District 6
Charles Mahan, University of South Florida School of Public Health
Jay Wolfson, University of South Florida School of Public Health

MIAMI/DADE COUNTY

Hospitals

Joseph Rogers, Jackson Memorial Hospital
Harold Rohrer, Jackson Memorial Hospital
Sandy Sears, Jackson Memorial Hospital
Cliff Bauer, Hialeah Hospital
Linda Quick, South Florida Hospital Association

Community Health Centers

Stanley P. Balsley, Stanley C. Myers Community Health Center, Inc.
Betsy Cooke, Health Choice Network
Beverly Press, Stanley C. Myers Community Health Center, Inc.
Fatima Zafar, M.D., Economic Opportunity Family Health Center

City/County Officials

Lillian Rivera, Dade County Public Health Department
Joseph Romallo, Dade County, Office of the Mayor

Others

Modesto Abety, Dade County Children's Services Council
Jenni Bergal, Fort Lauderdale Sun Sentinel

Gary Clarke, PCA Family Health Plan
 Fred Schulte, Fort Lauderdale Sun Sentinel

Tables & Figures

Table 1 State Characteristics		
	Florida	United States
Sociodemographic		
Population (1994-95) ^a (in thousands)	14,103	260,202
Percent under 18 (1994-95) ^a	24.6%	26.8%
Percent 65+ (1994-95) ^a	16.7%	12.1%
Percent Hispanic (1994-95) ^a	16.5%	10.7%
Percent Non-Hispanic Black (1994-95) ^a	15.4%	12.5%
Percent Non-Hispanic White (1994-95) ^a	66.5%	72.6%
Percent Non-Hispanic Other (1994-95) ^a	1.6%	4.2%
Percent Noncitizen Immigrant (1996) ^a	10.0%	6.4%
Percent Nonmetropolitan (1994-95) ^a	6.9%	21.8%
Population Growth (1990-95) ^b	9.5%	5.6%
Economic		
Per Capita Income (1995) ^c	\$23,061	\$23,208
Percent Change in Per Capita Personal Income (1990-95) ^{c,d}	20.7%	21.2%
Percent Change in Personal Income (1990-95) ^{c,e}	31.3%	27.7%
Employment Rate (1996) ^{f,g}	58.8%	63.2%
Unemployment Rate (1996) ^f	5.1%	5.4%
Percent below Poverty (1994) ^h	16.2%	14.3%
Percent Children below Poverty (1994) ^h	25.9%	21.7%
Health		
Percent Uninsured—Nonelderly (1994-95) ^a	19.2%	15.5%
Percent Medicaid—Nonelderly (1994-95) ^a	13.2%	12.2%
Percent Employer Sponsored—Nonelderly (1994-95) ^a	59.2%	66.1%
Percent Other Health Insurance—Nonelderly (1994-95) ^a	8.5%	6.2%
Smokers among Adult Population (1993) ⁱ	22.0%	22.5%
Low Birth-Weight Births (<2,500 g) (1994) ^j	7.7%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) ^k	7.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993) ^{l,m}	59.6	54.4
Violent Crimes per 100,000 (1995) ⁿ	1,071.0	684.6
AIDS Cases Reported per 100,000 (1995) ^o	56.9	27.8
Political		
Governor's Affiliation (1996) ^p	D	
Party Control of Senate (Upper) (1996) ^q	17D-23R	
Party Control of House (Lower) (1996) ^q	59D-61R	

- a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
- b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (118th edition). Washington, D.C., 1996. 1995 population as of July 1, 1990 population as of April 1.
- c. *State Personal Income, 1969-1995*. CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.
- d. Computed using mid-year population estimates of the Bureau of the Census.
- e. Personal contributions for social insurance are not included in personal income.
- f. U.S. Department of Labor, *State and Regional Unemployment, 1996 Annual Averages*. USDOL 97-88. Washington, D.C., March 1997.
- g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
- h. CPS three-year average (March 1994-March 1996 where 1995 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
- i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.
- j. Normandy Branger, Danielle Holahan, Amanda H. McCluskey, and Evelyn Yiss, *Reforming the Health Care System: State Profiles, 1996*. Washington, D.C.: American Association of Retired Persons, 1996.
- k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke, "Advance Report of Final Natality Statistics, 1994," *Monthly Vital Statistics Report*, vol. 44, no. 11, suppl. Hyattsville, MD: National Center for Health Statistics, 1996.
- l. National Center for Health Statistics, "Births, Marriages, Divorces, and Deaths for 1995," *Monthly Vital Statistics Report*, vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.
- m. ReliaStar Financial Corporation, *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition. Minneapolis, MN: ReliaStar, 1996.
- n. Race-adjusted data, National Center for Health Statistics, 1993 data.
- o. U.S. Department of Justice, FBI, *Crime in the United States, 1995*. October 13, 1996.
- p. National Conference of State Legislatures, *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

Source of Area Shaded Blue: Current Population Survey (CPS) three-year average (March 1996-March 1998, where 1996 is the center year)

Table 2 Florida Spending by Category, 1990 and 1995 (\$ in Millions)						
Program	State General-Fund Expenditures ^a			Expenditures ^b		
	1990	1995	Annual Growth	1990	1995	Annual Growth
Total	\$11,619	\$14,649	4.7%	\$22,481	\$35,907	9.8%
Medicaid ^c	812	1,921	18.8	2,407	5,931	19.8
% of Total	(7.0)	(13.1)	—	(10.7)	(16.5)	—
Corrections	709	1,398	14.5	864	1,472	11.2
% of Total	(6.1)	(9.5)	—	(3.8)	(4.1)	—
K-12 Education	5,808	5,907	0.3	6,431	6,715	0.9
% of Total	(50.0)	(40.3)	—	(28.6)	(18.7)	—
AFDC	162	312	14.0	403	782	14.2
% of Total	(1.4)	(2.1)	—	(1.8)	(2.2)	—
Higher Education	1,536	1,663	1.6	2,321	1,999	(2.9)
% of Total	(13.2)	(11.4)	—	(10.3)	(5.6)	—
Miscellaneous ^d	2,592	3,448	5.9	10,055	19,008	13.6
% of Total	(22.3)	(23.5)	—	(44.7)	(52.9)	—

Source: National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

- a. State spending refers to general-fund expenditures plus other state fund spending for K-12 education.
- b. Total spending for each category includes the general fund, other state funds, and federal aid.
- c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., is included in state spending because states cannot separate them. Florida reported other state funds of \$237 million in 1990 and \$650 million in 1995.
- d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation) as "other health" rather than Medicaid; third, local contributions to Medicaid are not included, but would be part of Medicaid spending on the HCFA 64.
- e. This category includes all remaining state expenditures [e.g., environmental projects, transportation, housing, and other cash-assistance programs] not captured in the five listed categories.

Table 3 Medicaid Expenditures by Eligibility Group and Type of Service, Florida and United States (F

	Florida					United		
	Expenditures			Average Annual Growth		Expenditures		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$2,657.4	\$4,298.1	\$6,274.7	27.2%	13.4%	\$73,662.2	\$118,926.0	\$157,000.0
Benefits								
Benefits by Service	\$2,490.5	\$3,958.1	\$5,799.9	26.1%	13.6%	\$69,168.7	\$97,602.4	\$133,000.0
Acute Care	1,626.2	2,784.7	4,030.7	30.9%	13.1%	36,904.5	55,059.9	79,000.0
Long-Term Care	864.4	1,173.4	1,769.3	16.5%	14.7%	32,264.2	42,542.5	53,000.0
Benefits by Group	\$2,490.5	\$3,958.1	\$5,799.9	26.1%	13.6%	\$69,168.7	\$97,602.4	\$133,000.0
Elderly	\$887.0	\$1,229.4	\$1,755.0	17.7%	12.6%	\$23,334.3	\$31,757.9	\$40,000.0
Acute Care	307.8	432.5	637.5	18.5%	13.8%	4,925.4	6,911.5	9,000.0
Long-Term Care	579.2	796.9	1,117.5	17.3%	11.9%	18,408.9	24,846.4	30,000.0
Blind & Disabled	\$779.3	\$1,272.4	\$1,908.6	27.8%	14.5%	\$25,771.6	\$35,684.6	\$51,000.0
Acute Care	497.1	908.7	1,276.1	35.2%	12.0%	12,929.2	19,483.6	29,000.0
Long-Term Care	282.2	363.8	632.5	13.5%	20.3%	12,842.4	16,201.0	21,000.0
Adults	\$370.3	\$438.5	\$505.9	8.8%	5.0%	\$8,765.0	\$12,710.1	\$16,000.0
Children	\$453.9	\$1,019.8	\$1,630.5	49.9%	16.9%	\$11,297.8	\$17,449.8	\$25,000.0
DSH	\$44.3	\$191.4	\$334.2	107.9%	20.4%	\$1,340.9	\$17,525.6	\$18,000.0
Administration	\$122.6	\$148.5	\$140.6	10.1%	-1.8%	\$3,152.6	\$3,797.9	\$5,000.0

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 4 Medicaid Expenditures per Enrollee by Eligibility Group, Florida and United States

	Florida					United		
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$2,099	\$2,195	\$2,686	2.2%	7.0%	\$2,397	\$2,729	\$3,000
By Group								
Elderly	\$5,300	\$6,277	\$7,793	8.8%	7.5%	\$6,839	\$8,422	\$10,000
Cash	3,066	3,175	3,585	1.4%	4.1%	3,329	4,017	4,000
Noncash	8,061	9,612	11,902	9.2%	7.4%	10,377	12,192	15,000
Blind and Disabled	\$4,251	\$5,475	\$5,767	13.5%	1.8%	\$6,378	\$7,320	\$7,000
Cash	3,785	5,060	5,535	15.6%	3.0%	4,969	5,927	6,000
Noncash	7,765	7,820	6,801	0.3%	-4.5%	12,047	12,574	10,000
Adults	\$1,417	\$1,252	\$1,250	-6.0%	0.0%	\$1,301	\$1,518	\$1,500
Children	\$790	\$993	\$1,360	12.1%	11.0%	\$770	\$931	\$1,000

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 5 Medicaid Enrollment by Eligibility Group, Florida and United States (Enrollment in Thousands)

	Florida					United States		
	Enrollment			Average Annual Growth		Enrollment		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	1,186.3	1,803.4	2,159.3	23.3%	6.2%	28,856.7	35,765.1	41,111.1
By Group								
Elderly	167.4	195.9	225.2	8.2%	4.8%	3,412.2	3,771.0	4,111.1
Cash	92.9	101.5	111.3	4.5%	3.1%	1,713.1	1,739.2	1,811.1
Noncash	74.5	94.4	113.9	12.6%	6.5%	1,699.1	2,031.8	2,300.0
Blind and Disabled	183.3	232.4	330.9	12.6%	12.5%	4,040.9	4,875.1	6,111.1
Cash	161.9	197.5	270.2	10.5%	11.0%	3,236.8	3,853.4	4,111.1
Noncash	21.4	34.9	60.8	27.6%	20.3%	804.1	1,021.7	2,000.0
Adults	261.3	348.6	404.6	15.5%	5.1%	6,738.7	8,373.3	9,111.1
Cash	159.0	237.4	278.3	22.2%	5.4%	4,651.6	5,342.5	5,111.1
Noncash	102.3	111.2	126.2	4.2%	4.3%	2,087.2	3,030.9	4,000.0
Children	574.3	1,026.5	1,198.6	33.7%	5.3%	14,664.9	18,745.7	21,111.1
Cash	381.7	606.7	641.9	26.1%	1.9%	9,946.2	11,281.8	11,111.1
Noncash	192.6	419.8	556.7	47.6%	9.9%	4,718.7	7,463.9	10,000.0

Source: The Urban Institute, 1997. Based on HCFA 2002 data.

Table 6 Medicaid Long-Term Care Expenditures by Eligibility Group, Florida and United States (Expenditures in Millions of Dollars)

	Florida					United States		
	Long-Term Care Expenditure			Average Annual Growth		Long-Term Care Expenditure		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$864.4	\$1,173.4	\$1,769.3	16.5%	14.7%	\$32,264.2	\$42,542.5	\$53,111.1
Elderly	\$579.2	\$796.9	\$1,117.5	17.3%	11.9%	\$18,408.9	\$24,846.4	\$30,111.1
Nursing Home Care	560.2	766.5	1,052.9	17.0%	11.2%	15,131.3	20,542.9	25,111.1
ICFs/MR ^a	2.0	2.7	6.8	16.3%	36.0%	348.9	452.0	500.0
Mental Health	9.1	11.9	13.3	14.3%	3.8%	973.0	1,266.0	1,500.0
Home Care	7.9	15.8	44.5	41.2%	41.2%	1,955.7	2,565.6	3,000.0
Blind and Disabled	\$282.2	\$363.8	\$632.5	13.5%	20.3%	\$12,842.4	\$16,201.0	\$21,111.1
Nursing Home Care	87.2	117.1	157.0	15.9%	10.3%	3,161.3	3,968.0	4,111.1
ICFs/MR ^a	155.1	179.0	239.8	7.4%	10.2%	7,241.3	8,360.4	9,111.1
Mental Health	0.8	1.4	1.4	30.4%	-0.5%	457.9	682.1	700.0
Home Care	39.1	66.2	234.4	30.1%	52.4%	1,982.0	3,170.5	6,000.0
Adults and Children	2.9	12.8	19.2	108.2%	14.6%	1,012.9	1,495.1	1,111.1

Source: The Urban Institute, 1997. Based on HCFA 2002 and HCFA 04 data.

a. Intermediate care facilities for the mentally retarded.

About the Authors

Debra J. Lipson, currently a health policy consultant in Geneva, Switzerland, at the World Health Organization, continues her work on projects related to safety net providers. She was formerly associate director of the Alpha Center, where she managed research studies on state and local health care reform, with an emphasis on the financing and organization of health services for the poor and uninsured.

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Health Policy for Low-Income People in Massachusetts

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The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Series

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

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income

population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

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Highlights of the Report

Massachusetts has a large, high-quality and high-cost health system and a strong public sector commitment to supporting health services for the low-income population. Massachusetts is a very high-income state (fourth in the nation in median family income per capita) with a long progressive political tradition. It has relatively high rates of health insurance coverage; only 12.6 percent of the nonelderly are uninsured versus 15.5 percent for the nation. The state has a tradition of high-quality education and health services, excellent medical schools, and support of government programs.

The state has been a pioneer in health care reform. It enacted a universal coverage law in 1988, which included a "pay-or-play" mandate on most employers. Although the mandate gradually lost the support of key constituencies and was never implemented, the universal coverage law also included a number of other public programs to expand coverage to individuals outside the labor force, most of which are still in place. The state also has a system of redistributing hospital funds from hospitals providing little free care to those providing a substantial amount through an uncompensated care pool.

The Weld (now Cellucci) administration and the legislature have pursued a number of objectives in health care. They repealed the employer mandate for universal coverage and ended the state's hospital rate-setting system. They have slowed Medicaid growth through cuts in provider payments, reduced welfare case loads, and managed care. At the same time, they have received approval for a Section 1115 waiver that will result in a substantial increase in coverage through both Medicaid and employer-based coverage. Finally, they have managed the restructuring of the state's underfunded uncompensated care pool. The administration has been very successful in obtaining federal matching funds to support these initiatives.

The Massachusetts Medicaid program is large by national standards, spending \$5.7 billion in 1995. Massachusetts spending per low-income person is \$4,254 versus \$2,041 for the nation. Only New York and Connecticut spend more per low-income person. On a per enrollee basis, Massachusetts spends more (\$6,189) than any state other than New York (\$6,194). Seventy-five percent of Massachusetts' expenditures are on the elderly, blind, and disabled, in contrast to 69 percent of expenditures nationally for these groups.

Medicaid enrollment for the low-income population is extensive principally because the program's eligibility income standards are quite generous and because the state has adopted most federal optional eligibility categories. As a result, the state covers 64 percent of the population below 150 percent of poverty versus 51 percent for the nation. Enrollment growth has been slow in recent years. In fact, there has been a decline in Aid to Families with Dependent Children (AFDC) participation because of an improved economy and the state's welfare reform efforts. However, Medicaid rolls have been stable, suggesting that many of those losing AFDC benefits are retaining health care coverage.

The most important development in the Massachusetts Medicaid program in 1997 will be the

expansion of coverage under its Section 1115 waiver program. The waiver program, termed MassHealth, will extend coverage to new population groups and absorb two of the previously state-funded programs—the CommonHealth program for the disabled and the Medical Security program for the short-term unemployed. MassHealth will extend coverage in a number of ways. In addition to retaining current coverage of pregnant women and infants up to 185 percent of poverty, it will expand coverage to all children through the age of 18 to 133 percent of poverty (and perhaps to 200 percent of poverty, depending on the outcome of the current legislative debate). It will then establish a New State Benefit Plan that will extend coverage to long-term unemployed individuals and other adults whose gross incomes are no more than 133 percent of the poverty level. The most important and most controversial component of the waiver request is the Insurance Reimbursement Program for low-income workers. This program will provide subsidies to workers with incomes below 200 percent of poverty and provide subsidies to employers in small firms (fewer than 50 workers) that contribute at least 50 percent of the cost of premiums for plans that meet state standards.

The other major component of Massachusetts' support for the safety net is its policy of subsidizing hospitals that provide disproportionate amounts of uncompensated care. The former hospital rate-setting system established an uncompensated care pool to distribute the burden of uncompensated care and to reduce the incentives to underserve the uninsured. The pool was later tapped to contribute to the state's large network of community health centers as well. Three problems with the pool have emerged. First, the amount of money in the pool was frozen at about \$315 million in 1988. As the cost of health care and the number of uninsured grew, the resources in the pool became increasingly inadequate. Second, the distribution of the funds in the pool heavily favored the major public hospitals in the state, particularly Boston Medical Center and the Cambridge Hospital. Finally, hospitals were finding it increasingly difficult to pass the cost of their pool assessments on to insurers in rate negotiations. A Special Commission on Uncompensated Care recently addressed these problems.

The solutions recommended by the commission and supported by the state's Section 1115 waiver application involved expansions of coverage through MassHealth and new supplemental payments (outside the pool) to Boston Medical Center and the Cambridge Hospital. Eliminating disbursements from the uncompensated care pool to these two hospitals freed \$70 million of pool resources that could be distributed to other hospitals. Finally, the direct assessment on hospitals was reduced by \$100 million and replaced by requiring direct contributions of all third-party payers to the pool.

The health care marketplace in Massachusetts is undergoing dramatic changes. Hospital rates were deregulated in 1991, permitting insurers and managed care plans to negotiate directly with hospitals. Hospital competition is becoming more intense as a result of the continuing growth of managed care and the deregulation of rates. One result has been a considerable number of hospital mergers and consolidations. However, the aggressive cross-cutting competition seen elsewhere is absent, perhaps because aggressive for-profit hospitals have only recently entered the metropolitan Boston marketplace. The weakness of competitive forces has been exacerbated by consolidation among the strongest academic medical centers. Essentially, insurers and managed care plans need affiliations with these networks in order to offer competitive insurance products.

The Medicaid program is attempting to rapidly expand managed care. Of 650,000 Medicaid enrollees, 378,000 are now in mandatory managed care for most services. About 75 percent of managed care enrollees are in the Primary Care Clinician (PCC) program, a fee-for-service gatekeeper model. Approximately one-fourth of the managed care enrollees are in health maintenance organizations (HMOs). The state wants to move toward greater reliance on HMOs and may phase out its PCC program. The primary issue is whether the HMOs in the state will be willing to take on substantially more Medicaid beneficiaries at rates the state would like to pay. HMOs are thought to control utilization better but to reimburse providers at higher rates than the state does under its PCC program. As a result, the state is reaping few savings with existing HMOs. HMOs offer the state the advantage of management expertise as well as the ability to exclude high-cost physicians and hospitals. Thus, the state believes

HMOs offer more promise for the future even though it has not been realized to date.

Because of high expenditures for long-term care services, the state has focused considerable energy on long-term care policy in recent years. As a result, long-term care services grew by only about 4 percent between 1992 and 1995. Long-term care strategy includes attempts to substitute community-based long-term care services for institutional services whenever possible and appropriate. The state has reduced nursing home expenditures by restructuring admissions criteria, tightening nursing home reimbursement rates, and freezing nursing home bed supply. Massachusetts has developed ambitious plans to integrate acute and long-term care services through managed care. It has also made a concerted effort to have nursing home and home health agencies bill Medicare whenever possible. Finally, the state has moved large numbers of patients out of state mental hospitals and large state intermediate care facilities for the mentally retarded.

Overview of Massachusetts: Thumbnail Sketch of the State

Sociodemographic Portrait of Massachusetts

Massachusetts' population of 6.0 million (table 1) makes it the 13th largest in the nation. Population density is high, as the state is small and heavily urbanized; fully 96 percent of its population resides in urban areas. With a population of about 3 million, greater Boston dominates the state and most of New England.

Population grew by 0.9 percent between 1990 and 1995, much slower than in the rest of the nation (5.6 percent). The state's population is older than that of the average state, with a smaller proportion of children and a larger proportion of elderly. Massachusetts has fewer blacks and Hispanics than average, and a slightly lower share of immigrants. Immigrants constitute 5.4 percent of the population, compared with 6.4 percent at the national level.^{*}

Economic Status

The Massachusetts economy struggled in the 1970s but boomed in the 1980s as information-based high-tech industries prospered, to some degree aided by high defense spending. ¹ This "Massachusetts Miracle" helped fund expansion of public services and create support for mandatory universal health care. The recession hit late in the 1980s, cutting jobs and state revenues. The recession forced cuts in state spending and aid to localities and forced hikes in taxes. The drop in employment bottomed out in 1991, and economic growth returned the next year. ² Tax revenues were continuing to exceed policymakers' expectations at the time of this study (late 1996) and through the rest of the legislative 1998 budgeting cycle as well. ³

Despite ups and downs in growth, Massachusetts remains a high-income state. Its annual per capita income of over \$28,000 is 20 percent above the national average (table 1). The economic expansion of the 1990s has raised incomes sharply, though slightly less than in the nation overall. The unemployment rate is about 20 percent below the national average, and the employment rate is slightly above the norm. The poverty population is 10.9 percent, versus 14.3 percent for the nation. A higher share of children, 17.2 percent, live in poverty, a figure that is still well below the national average of 21.7 percent.

Political Characteristics

Massachusetts has a long, liberal political tradition, especially in its support for health care. Yet even many Democrats have supported severe budget cutting under fiscal pressure. ⁴ As a

rule, active governors have taken most initiatives in health policy, but the legislature often makes changes. As shown in [table 1](#), both houses of the legislature are heavily Democratic. The Speaker of the House is the single most powerful legislator; the leading committee is House Ways and Means.

Politics is serious business in Massachusetts. Government, particularly state government, plays a large role, and the public sector has been a route to success for several waves of immigrants. The state remains heavily Democratic in voter registration, though the party has become more suburban and less based in old-time industrial unionism, ethnic associations, or big-city machines. There are urban-rural differences, but the state is overwhelmingly urbanized and so are its politics. Interest groups, of course, include strong representation of business entities, but also of health providers and well-organized "consumer" or "beneficiary" classes.

Republican Governor William F. Weld was in the middle of his second term at the time of our site visits. He had just lost a 1996 bid for the U.S. Senate and had not yet announced for re-election in 1998. A fiscally conservative, private-sector-oriented Republican, he is perceived as rather libertarian on social issues. Governor Weld subsequently accepted President Bill Clinton's offer to be ambassador to Mexico.⁵ Lieutenant Governor Paul Cellucci has become acting governor and thereby the 1998 Republican front-runner, but he will face a strong Democratic challenge, likely from Attorney General L. Scott Harshbarger.⁶ The 1998 election may reshuffle political leadership, with unclear implications for policy.

Roadmap to Rest of Report

The rest of this report provides a descriptive analysis of the current situation and emerging developments in health markets and state policy relevant to the safety net population. We cover:

- the basics of the state policy agenda,
- a sketch of Medicaid and other state health programs,
- how Massachusetts may respond to increased administrative freedom and funding constraint,
- how Medicaid and other coverage reforms affect the poverty population,
- health care delivery and finance, market changes, and state policy toward managed care,
- effects on safety net providers and other deliverers of health care to the poverty population, and
- long-term care for the elderly and disabled.

Setting the Policy Context

Overview of State's Health Agenda

Governor Weld originally campaigned in 1990 to roll back the public sector expanded by his predecessor, Democrat Michael S. Dukakis.⁷ The electorate voted for Weld's promises to cut taxes and control spending but decisively against a ballot measure to repeal all 1989-90 tax and fee increases, which Weld supported but which would have required more cuts in services. In office, Weld's top priorities were to cut taxes and streamline state government, privatizing where possible. He also moved quickly to deregulate health care and to rein in Medicaid cost increases.

The state legislature was heavily Democratic ([table 1](#)) but supported these initiatives. It later also approved most of Governor Weld's ambitious Section 1115 Medicaid waiver. The legislature nonetheless has shown some inclination to shelter government programs, resisting wholesale privatization and government reorganization. In health care, the strongest difference

has been over how to expand coverage to the uninsured, notably children. Additionally, the governor has favored subsidies to employers who provide coverage to low-income workers, while the legislature supported direct public coverage. The governor also unsuccessfully sought to move the Department of Public Health, widely perceived as a patient advocate, into Medicaid, which is seen as much more fiscally conservative. Still, these differences relate to means, not ends—and they seem small in light of the state's unusual commitment to maintaining the safety net and expanding coverage for the near poor. Even strong consumer advocates recognize the state's unusual generosity.

Governor Weld achieved almost all of his objectives in health care, including repeal of the employer mandate to provide health insurance, ending state hospital rate setting and deregulating prices. The Weld/Cellucci administration has slowed Medicaid cost growth due to cuts in provider payments, reduced welfare caseloads, and placed greater reliance upon managed care. The administration has gained approval of its Section 1115 waiver, which will assure Massachusetts continued large federal financial contributions because of generous assumptions about what spending would have been under baseline conditions, continued disproportionate share hospital (DSH) spending at high levels, and refinancing of the uncompensated care pool. The waiver will also permit the state to pursue a substantial increase in coverage through Medicaid and private insurance and continued subsidies for safety net hospitals.

The principal remaining goal for the Weld/Cellucci administration is implementation: to do a good job of expanding Medicaid managed care by moving to capitated plans from noncapitated gatekeepers. A similar challenge is implementing payment to safety net hospitals via capitation rather than fee-for-service methods. For their part, legislative leaders have helped maintain support for disadvantaged populations and for the Department of Public Health as an important public agency in its own right. The Weld/Cellucci agenda seems likely to continue, even with future changes in leadership, because fiscal conservatism seems pervasive, the federal waiver locks in the promised state approach, and both parties are supportive of safety net institutions.

New difficulties seem most likely to emerge over regulation of *private* health care, not over the *public* beneficiaries who have received the most attention so far. Emerging concerns include (1) continuing consolidation of HMOs (Harvard-Pilgrim has over 40 percent of the HMO market and recently bought the leading Medicaid plan), (2) rapid sale of nonprofit hospitals to for-profit enterprises and large nonprofit networks, (3) implementation of the federal Kassebaum-Kennedy insurance market reforms, (4) phasing in of Massachusetts' rules on continuing access to private health coverage for those able to pay, and (5) maintaining quality of care and access to providers in the managed care era. These issues have received relatively little attention from the administration to date. More attention has come from the attorney general. The attorney general has no budgetary or programmatic authority over health matters, but he has actively exercised his powers of legal-regulatory oversight, making health care a key part of his own policy and political agenda.

State Health and Health Care Indicators

Massachusetts ranks high in extent of insurance coverage, including Medicaid ([table 1](#)). But the uninsured population grew steadily in the late 1980s and early 1990s, after years of decline. By 1995, about one-eighth of the under-65 population was uninsured, heavily concentrated among the poor and among workers in small firms. This decline in coverage may have halted in 1996, but it remains a policy concern. ⁸ Massachusetts scores well on standard measures of health, often substantially better than the national average ([table 1](#)).

Despite the absence of unusual health problems or insurance needs, Massachusetts seems to give health care such high-profile policy attention for a variety of reasons. The state has a political philosophy and long-standing tradition of promoting health care and aiding the needy. The state has a large, high-quality, and respected health care sector. In addition, the state has focused attention on Medicaid due to that program's high cost and rate of growth.

State Health Programs

In Massachusetts most health care initiatives fall under the Executive Office of Health and Human Services, an umbrella agency that oversees, among others, the Division of Medical Assistance, the Department of Public Health, the Department of Mental Health, the Department of Mental Retardation, and the Division of Health Care Finance and Policy. Considerable policy control also is exercised by the Executive Office of Administration and Finance. Control of health care funding and policy rests very much at the state level, with a small role reserved for local governments and health boards. This situation is in part due to Proposition 21/2, which limits the capacity of municipalities to generate new property tax revenues for local services. This limit has placed local health care in greater competition with other local services, such as schools and public safety.⁹ In contrast to local limits, the state offers extensive health care programs, and very few geographic areas in Massachusetts are viewed as underserved.

Medicaid

Medicaid is the largest of the state's health programs. State government plays the predominant role in administration and funding of the Medicaid program. Counties do not contribute to the cost of the program, aside from intergovernmental transfers used for Medicaid DSH payments to city hospitals. The Division of Medical Assistance oversees both acute and long-term care aspects of the Medicaid program, with the exception of activities in the Departments of Mental Health and Mental Retardation.

Medicaid follows elementary and secondary education as the second largest item in the state's general-fund budget (table 2). It accounted for 13 percent of state general revenue spending in 1995, or 22 percent of the entire state budget including federal and other sources. From 1991 to 1995, Medicaid spending from the state's general revenues grew more slowly than state spending on Medicaid from all sources including federal aid (4.2 percent annually versus 9.0 percent). Medicaid, while growing faster than the state budget overall, has not been the state's fastest growing spending category. Elementary and secondary education leads, with growth rates of 8.5 percent for state funds and 13.2 percent if state and federal funds are combined.

Generous eligibility rules, high provider payments, and a broad definition of covered services have resulted in a costly Medicaid program. Medicaid spending in Massachusetts was \$5.7 billion in 1995 (table 3). However, in the past five years, the state's total Medicaid budget grew more slowly than the national average, growing 16.1 percent annually from 1990 to 1992 and 9.4 percent from 1992 to 1995, compared to the national average growth rates of 27.1 percent and 9.9 percent, respectively. Expenditures grew more slowly in Massachusetts than in the rest of the United States for each enrollment group except children from 1992 to 1995.

Massachusetts' spending per enrollee was almost twice as high as the national average in 1995 (\$6,189 versus \$3,202—see table 4); only New York was higher (\$6,194). The state reports spending about twice as much per enrollee on children and about 50 percent more per enrollee in each of the other enrollment categories. Spending per child enrollee grew more than 16 percent per year from 1990 to 1995; in contrast, the national average growth in spending per child enrollee was 9.9 percent from 1990 to 1992 and 8.2 percent from 1992 to 1995. This difference may be partly due to higher growth in health care costs in the state, but similar patterns are not seen among nondisabled adults.

In 1990, Massachusetts Medicaid spent more funds on long-term care (52 percent) than on acute care (48 percent). Since then, acute care expenditures have grown more quickly than long-term care expenditures. Nonetheless, Medicaid spending in Massachusetts continues to

be weighted more toward long-term care (46 percent of total) than exists nationally (40 percent). As a result, more of the state's expenditures on Medicaid services are for the elderly and disabled (75 percent) than in the rest of the nation (69 percent).

Other Financing Programs

Aside from Medicaid, the state has several large programs that provide health care coverage or pay for health care services for low-income populations. They include subsidized insurance programs such as the Children's Medical Security Plan; prescription drug coverage for seniors; CommonHealth, which covers persons with disabilities; and the Medical Security Plan, which covers the short-term unemployed. However, by far the largest non-Medicaid subsidy program is the uncompensated care pool (\$330 million) that funds hospital care to the uninsured. Even greater coverage plus employer insurance subsidies are contemplated under the Section 1115 waiver.

Cigarette taxes have become a favored mechanism for funding several of the state's health initiatives. In 1992, the state's voters passed the Massachusetts Tobacco Control Program, which raises \$56 million annually toward public health and tobacco education programs. The cigarette tax was increased again in 1996, this time by the legislature to fund individual health care coverage, rather than population-based tobacco prevention programs. Specifically, this significant increase in the tobacco tax (approximately \$100 million per year) is earmarked for expansion of the Medicaid program, the Children's Medical Security Plan, and a prescription drug coverage program for seniors.

Public Health

The state Department of Public Health (DPH) oversees four major areas: laboratory and communicable disease; health quality management; state-owned hospitals; and community health services, including AIDS, substance abuse, and family health programs. The state currently has four chronic care hospitals operated by the DPH. A small number of other DPH hospitals have been closed.

Unlike some states, Massachusetts has no county health department system. Instead, there are 351 local boards of health, one for each municipality, with varying expertise. They typically are responsible for animal control, disease prevention and reporting, environmental health, hazardous substances, and community sanitation.¹⁰ Funding for local boards comes from local taxes and fees. Most services to communities are state-funded and provided by a network of providers on contract with the state. Rather than distributing state funds on a formula basis, the state mainly treats local health departments as vendors that compete for funds alongside other providers. Approximately half the department's total budget is contracted out on a competitive basis to about 600 public agencies and private providers.

Department of Mental Health

The Department of Mental Health oversees both treatment and research programs. These programs include emergency and crisis intervention, outpatient and inpatient care, vocational programs, and programs targeted at emotionally disturbed children and adolescents, including case management, day and residential treatment, and inpatient services. The state has identified comprehensive community support systems, or areas, where service delivery is coordinated and where services can be accessed. Service delivery has shifted to the community setting; the state has closed four of the psychiatric hospitals it once operated. Six state hospitals and two community mental health centers remain. The department also has worked closely with the Division of Medical Assistance to maximize the federal matching payment and to coordinate the mental health and substance abuse managed care programs. Medicaid DSH payments have become an important source of funding for the state-owned facilities.

Department of Mental Retardation

The Department of Mental Retardation oversees the majority of Medicaid-funded long-term care services to persons with disabilities. The department's 1996 budget was \$714 million, of which 29 percent was spent on state-operated facilities for the developmentally disabled. ¹¹ The department currently operates seven such facilities, having closed three since 1992. Concerted efforts have been made to move care into community settings. Funding for this initiative has been made possible largely through a Medicaid home- and community-based care waiver program. Funding for the waiver grew from \$37.3 million in 1992 to \$124.4 million in 1996. ¹²

Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

General Philosophy Regarding Public Responsibility for the Poor

Massachusetts is a very high-income state with a long progressive political tradition. It has historically provided substantial support for Medicaid and other health and welfare programs. Massachusetts has been a pioneer in health reform and enacted a universal health care law (known as Chapter 23) in 1988. This legislation called for a phase-in of universal coverage through a "pay or play" employer mandate, reformed the Massachusetts hospital rate-setting system, and created other programs to expand public coverage. The bill was enacted with the support of the large business community. Business was concerned about increasingly high hospital costs because of the shifting of uncompensated care costs to businesses through higher hospital charges. Because of these concerns, businesses agreed to a mandate on all employers to provide health insurance or to pay a tax to the state. Business support did not last, however. When the economy declined in the 1990-1992 recession, business opposition to the employer mandate grew, and the legislation was never implemented. During this period, more businesses began to move to managed care, believing they could save on health care costs on their own.

Government policies of supporting health and welfare policies have generally continued under the Weld/Cellucci administration. Policies of the administration could be characterized as attempts to change but not undermine the safety net. The issue in Massachusetts seems to be not whether to support the low-income population but rather how to do it. The Weld administration submitted a waiver pursuing coverage expansion in part through Medicaid but also through the private sector—extending vouchers to low-income individuals and tax credits to employers to provide coverage to their low-wage workers. The legislature agreed to the Medicaid expansion, deferred action on the subsidy plan, and added its own plans in summer 1996 to expand Medicaid coverage of children and to establish a program covering prescription drugs for the low-income elderly.

There is some evidence that at least in recent years health care is somewhat better protected than the cash welfare programs. Public support for AFDC waned in the early 1990s, and the state enacted its own welfare reform plan. While the state's coverage of its AFDC population is very generous by national standards, AFDC rolls fell from 335,100 in 1993 to an expected 250,987 in 1997, in part because of a toughening of work and job training requirements. At the same time, Medicaid rolls remained relatively stable. Many individuals who left AFDC seem to have been able to retain health care coverage through Medicaid. The state also has an array of health programs to cover the disabled, the unemployed, and children outside of traditional

Medicaid.

Block Grants and Flexibility

Under federal proposals in 1995 to convert Medicaid to block grants, administration officials believed the state would have done quite well. They were eager for increased flexibility in how health care services could be delivered. Weld administration officials believed that with the cost containment policies adopted in both acute care (e.g., managed care) and long-term care (e.g., deinstitutionalization and Medicare maximization), Massachusetts could live with reduced federal revenue growth. State officials believed that they would respond to increased flexibility by providing different sets of services to different groups. The result would be that the state could better target benefits to individuals with different needs than it could with the current structure, under which a broad benefit package must be available to all enrollees.

Advocacy organizations were concerned about allocation decisions that would be made with more limited budgets. Some were concerned that the richer service package available to the elderly in Massachusetts would make those services an attractive target for cuts. However, this was not a universal concern: many responded that the nursing home industry and the elderly advocates were the strongest politically in the state, followed by advocates for the mentally retarded/developmentally disabled and advocates for younger persons with physical disabilities. The AFDC population seemed to have the least political strength in the state and therefore seemed the most vulnerable.

Medicaid Maximization

State officials take considerable pride in their ability to maximize federal Medicaid financial participation. Mandates imposed by the federal government to expand Medicaid contributed to the program's becoming the fastest rising item in the state budget. The result was increased interest in finding ways to bring state and locally funded services into Medicaid to obtain federal matching dollars. The state has used some of the Department of Mental Retardation and Department of Mental Health appropriations as the state share of financing services that could qualify for Medicaid. The Department of Medical Assistance reimburses for these services and then obtains Medicaid matching funds from the federal government. (In other words, the appropriations for the Department of Mental Retardation and the Department of Mental Health are passed through the Medicaid budget.) Medicaid is also used to help fund school-based services to disabled children. In this case, the local school systems contribute the state share, but because Medicaid pays for the services, the state receives federal matching funds.

The state also attempts to obtain federal financial participation for any activity that the state or a locality was funding that parallels a Medicaid-funded service. To qualify, it must be a parallel activity used by Medicaid-eligible persons. This practice allows the state to fund care provided in school health clinics, public health clinics, and case management services, as well as to cover administrative costs of other agencies and smoking cessation programs. Federal matching thus provides a large amount of fiscal relief to local governments.

There is now concern about the implications for localities as Medicaid managed care expands. If Medicaid managed care plans are not willing to finance local providers, the amount of local aid achieved through Medicaid revenue maximization will decline.

Another source of Medicaid maximization is the use of funds in the uncompensated care pool to obtain federal matching payments. The uncompensated care pool imposes a uniform assessment but essentially redistributes money from hospitals with low levels of uncompensated care to hospitals with substantial levels. The state distributes these funds as Medicaid DSH payments and collects \$157 million in federal matching funds, all of which is returned to the state treasury, not to hospitals.

Providing Third-Party Coverage for the Low-Income Population

Medicaid

Medicaid eligibility standards in Massachusetts are quite generous by national standards. The maximum annual income that a family of three can have and remain on AFDC is \$6,948 in Massachusetts, versus \$5,231 for the nation. The maximum income as a percentage of poverty in Massachusetts is 56.4 percent, versus 41.9 percent for the nation. Massachusetts has extended coverage for pregnant women and infants to 185 percent of the poverty level (133 percent is mandatory) and covers children ages one to five up to 133 percent of poverty (the federal minimum). Its medically needy income limits are also well above the national average. Not surprisingly, then, Massachusetts covers a very high percentage of its low-income population. For example, in 1994 Massachusetts covered 64 percent of the low-income population, defined as those with income below 150 percent of the federal poverty line. The national average was 51 percent.

Table 5 shows that despite the fact that Massachusetts has large numbers of people on Medicaid by national standards, its growth rates in recent years have been well below the national average. For example, the overall Medicaid enrollment growth between 1990 and 1992 averaged 5.3 percent, versus 11.3 percent for the nation. Enrollment growth between 1992 and 1995 was 1.8 percent in Massachusetts, versus 5.2 percent for the nation. Recent enrollment growth for the elderly, as well as for adults and children, was well below the national average. Growth among the blind and disabled in Massachusetts was more in line with growth in this population throughout the country.

The Massachusetts Medicaid program provided data on enrollment growth since 1995. These data, shown in table 6, reflect average monthly caseloads, while data in table 5 provide numbers of individuals enrolled at any time during the year. These data show that Massachusetts had average monthly caseloads of 654,688 individuals in 1995. The state's caseload is expected to be virtually unchanged between 1995 and 1997. However, the composition of the state's caseload is expected to change to some degree. The number of adults and children in families (AFDC and related enrollees) is expected to decline and the number of disabled, to increase. The number of elderly will be virtually unchanged.

The small decline in Medicaid coverage of adults and children masks a much greater drop in the AFDC population. From 1995 to 1997, there were increases in the Medicaid-only population, both those covered through the poverty-related expansions for pregnant woman and children and the medically needy. It is also believed that many who lose AFDC are retaining their Medicaid coverage as medically needy. AFDC rolls fell from 308,900 in 1995 (335,200 in 1993 was the high point) to 273,600 in 1996, an 11.4 percent decline. AFDC rolls are projected to decline by another 23,000 people, or 8.3 percent, in 1997. Most of this decline has been offset by a growth in the number of Medicaid-enrolled adults and children who are not cash recipients, which grew from 109,800 in 1995 to 130,200 in 1996, an 18.6 percent increase. This population is expected to continue to rise by another 23,000 in 1997, again roughly offsetting the decline in the AFDC population.

The decline in the AFDC population, as noted earlier, is attributed both to Massachusetts' improved economy and to its welfare reform initiatives. The state has received an AFDC waiver to institute an employment and job training program, but the drop in AFDC recipients began before the work program was implemented. A year before the waiver program was implemented, the state sent out an information packet indicating what would be expected of recipients after implementation of the work and training programs. Many individuals appeared to drop off the rolls because of the perception of the cutback rather than the reality.

The disabled population continued to grow rapidly, much as it did nationally. The Supplemental Security Income (SSI) disabled population grew from 111,300 in 1994 to 126,800 in 1996 (13.9 percent). The entire Medicaid disabled population grew from 139,500 to 162,700 (16.7 percent) between 1994 and 1996. Another 3 percent growth in the disabled population is expected in 1997. The growth rates among the disabled are slowing as they have nationally, largely because the phase-in of disabled children covered through the Zebley court decision and the Health Care Financing Administration (HCFA) liberalization of the list of covered impairments are largely completed. The number of elderly on Medicaid has stayed virtually unchanged since 1994, about 83,700 people. The number of SSI elderly has declined slightly, and the number receiving eligibility as medically needy has increased by a roughly similar amount.

In addition to Medicaid, Massachusetts has three other programs that cover different low-income groups. These plans were all enacted as part of Chapter 23, Massachusetts' ill-fated plan for universal health insurance coverage. The first program, known as CommonHealth, provides health insurance to working adults with disabilities and to children with disabilities who are not eligible for Medicaid. CommonHealth provides full or supplementary health benefits to about 3,500 enrollees (April 1997) depending on their insurance coverage and requires paying a monthly premium according to an income-related sliding fee scale. CommonHealth benefits are equivalent to Medicaid coverage except that long-term care services are limited.

Second, the Medical Security Plan covers 16,000 persons (March 1997) receiving state and federal unemployment benefits. Individuals can be eligible with incomes up to 400 percent of the federal poverty line. The plan offers either a direct purchase of insurance coverage or partial reimbursement for insurance premiums.

Third, the Children's Medical Security Plan provides primary care and preventive services to about 33,000 uninsured children not eligible for Medicaid. The plan also provides outpatient mental health care and specialty services if approved by a primary care physician. There are no premiums for those below 200 percent of poverty, and premiums rise as incomes increase.

MassHealth: Expansions and Consolidation

Massachusetts has planned a major expansion of its health care coverage under a program called MassHealth, to be implemented in July 1997. MassHealth would extend the current Medicaid program under a Section 1115 waiver to new population groups and absorb two currently state-funded programs—the CommonHealth and Medical Security programs. MassHealth would retain the current coverage of pregnant women and infants to 185 percent of poverty and expand coverage to all children through the age of 18 up to 133 percent of poverty. (Governor Cellucci now supports expansion of coverage to 200 percent of poverty for children, and legislative approval is expected.) It would then establish the New State Benefit Plan, which would extend coverage to long-term unemployed individuals whose gross income is no more than 133 percent of the poverty line. Individuals who are between 18 and 64 and not institutionalized, not eligible for unemployment benefits, and not full-time students would be eligible. These expansions are expected to provide coverage to 75,000 adults and 53,000 children. The state would move the CommonHealth program for disabled persons and the Medical Security Plan for the short-term unemployed into the MassHealth program. These components were part of Massachusetts' original waiver request and have remained part of the plan through the legislative debate. The waiver was submitted by the governor and approved by the federal government, but portions still await authorizing legislation as of 1997.

More controversial was the proposed Insurance Reimbursement Program (IRP) for low-income workers. The administration wanted to provide a strong incentive for employers either to begin or retain coverage for low-income workers, those with incomes below 200 percent of poverty. Employers would get tax subsidies if they contributed at least 50 percent of health insurance premiums for plans that met state standards. At the same time, the state

would subsidize low-income employees' share of the premiums. Low-income, self-employed persons would receive both the employer and employee shares of the subsidies.

The legislature, controlled by Democrats, believed that the IRP would largely crowd out existing private coverage and provide subsidies at public expense mainly to individuals who would have had coverage anyway. The legislature preferred to expand Medicaid coverage of all children to 200 percent of poverty. This debate, along with a number of issues over the state's uncompensated care pool, led to the formation of a Special Commission on Uncompensated Care in August 1996 legislation.

The legislature also required the administration to examine a variety of options for extending coverage that would be consistent with the budget neutrality provisions agreed on between the state and HCFA. The budget neutrality provisions permitted Medicaid spending per enrollee to increase by over 7 percent per year. The administration was required to develop alternatives to allow the state to live within this budget. A later administration report concluded that several alternatives would be consistent with budget neutrality. ¹³

After reviewing this report and considering issues of the size and distribution of uncompensated care pool funds, the commission made several recommendations. First, the commission recommended that the state adopt a limited form of the IRP, making it available only to firms with fewer than 50 workers and subject to appropriation by the legislature. HCFA had only agreed to provide the subsidies to firms for workers who otherwise would have been uninsured. This situation was viewed as being more likely in small firms. With this restriction, about 100,000 adults and 34,000 children were expected to benefit from the subsidies. The legislature's Joint Committee on Health Care amended the commission's recommendation to call for an extension of Medicaid coverage to children up to 200 percent of poverty, which according to administration estimates could be done within budget neutrality. The Weld administration opposed this expansion because of its concerns over crowding out private coverage. The Cellucci administration is now supportive.

The waiver coverage expansions are related to solving problems of the uncompensated care pool. Essentially, as part of the waiver, HCFA agreed to provide \$70 million in additional support to Boston City Hospital and the Cambridge Hospital because of their role in providing a large share of the free care in the state. This support allowed the state to allocate \$70 million in the charity care pool to other hospitals. The "additional" federal payment to these hospitals, however, still "fit" within the budget neutrality cap. (The issues in the uncompensated care pool debate are discussed in greater detail below.)

The final piece of MassHealth was the extension of the Children's Medical Security Plan (CMSP), which provides preventive and primary care services to all uninsured children. This program, entirely funded by the state and administered separately from Medicaid, will be expanded to add about 35,000 children, more if the expansion of Medicaid to 200 percent of poverty is not implemented.

The cost implications of the compromise plan are illustrated in table 7. The table shows the uses and sources of funds by year and illustrates how the expansions described above will be financed. For example, in the year 2000, Massachusetts will spend \$200 million for the expansion to cover children and adults up to 133 percent of poverty; 50 percent of this expansion, or \$100 million, will be federally matched. Second, it will spend \$72 million on insurance vouchers to low-income workers (below 200 percent of poverty) in firms with fewer than 50 workers whose employers pay 50 percent of the cost of their insurance; again, the federal government will contribute half, or \$36 million. Third, the plan will provide tax credits to these firms; the federal government will only contribute to the tax credits for workers who otherwise would not have been insured. This amount is assumed to be 50 percent; thus, the federal contribution will be about \$10 million. Fourth, supplemental payments to Boston City Hospital and the Cambridge Hospital will cost \$70 million, all federal funds. Fifth, the CommonHealth and Medical Security Plan will cost \$79 million, half of which will be federal funds. Sixth, the pharmacy assistance program, the new drug benefit program for elderly

recipients, will cost \$30 million, all state funds. Seventh, the CMSP will cost \$26 million and will be fully financed by the state. If the Medicaid expansion to 200 percent of poverty is adopted, Medicaid expenditures (and federal matching funds) will increase, but the costs for CMSP will fall. Finally, there will be \$8 million in administrative expenses.

The pool funds that will be distributed to hospitals throughout the state will be \$253 million in the year 2000. This is a decline from \$330 million in 1996, because hospitals are expected to need less support as a result of the coverage expansion. Hospitals other than Boston City Hospital and the Cambridge Hospital will receive a higher share of the \$253 million because they will be receiving \$70 million in federal funds through the supplemental payments (see chapter on "Delivering Health Care to the Uninsured and Low-Income Population.").

The lower half of table 7 indicates that expansions will be financed through a combination of the \$130 million in current state revenues forecast for Medicaid and \$96 million from a cigarette tax enacted in 1996. The uncompensated care pool will still generate \$330 million—the same as currently. There will be new federal revenues of \$225 million—less than the amount that Massachusetts could spend and still remain budget neutral.

Table 8 shows how Massachusetts will be able to expand coverage and provide additional support to two public hospitals and be budget neutral to the federal government. The Massachusetts Medicaid program estimated that enrollment for families would not grow over the five-year period. It predicted an approximately 6 percent annual growth rate for the disabled. It was assumed that expenditures per enrollee would grow by 7.7 percent for families and 5.8 percent for the disabled. DSH expenditures were assumed to grow by 6.8 percent per year between 1995 and 2002. The baseline projection became the budget neutrality cap under which the state must operate. Expenditure growth was projected to increase over time, from 8.6 percent in 1997-1998 to 9.2 percent in 2001-2002.

The state assumes that it can do considerably better than this projection under the waiver, which will allow it to finance the expansions. The enrollment growth assumptions for the traditional eligibility groups were the same as without the waiver. Perhaps the most important assumption is that the state can hold actual spending growth per enrollee to 4 percent per year through the use of managed care and other cost-containing efforts. Overall, the state expects that expenditures under the waiver will grow by only 5.8 percent in 1998 and slightly more than 6 percent thereafter. The result is a considerable amount of money with which to finance the coverage expansion. For example, there would be \$403.2 million in 1998, \$611.1 million in 2000, and \$873.7 million in 2002.

Welfare Reform

Massachusetts currently has waiver authority for transitional Medicaid coverage. It allows Medicaid coverage to continue for up to one year after leaving welfare if income is related to work and there is a dependent child in the family. Federal welfare reform also made changes in Medicaid coverage for immigrants. Massachusetts has elected to implement the federal options by keeping legal immigrants eligible for Medicaid where federal financing is available. It will provide Medicaid benefits to those in the United States before August 1996, and cover new legal immigrants after a federal five-year ban on coverage. Newly arriving legal immigrants banned from Medicaid for five years by federal law will probably also be covered at state expense, though with a somewhat reduced benefit package. The governor and the legislature have agreed to cover with state funds other immigrants receiving Medicaid or Commonwealth benefits who lost eligibility under the federal law, including many who are in nursing homes.

Insurance Reforms

Traditionally, Massachusetts relied on Blue Cross/Blue Shield (BCBS), which in exchange for a statutory exemption from the premium tax and other considerations served as insurer of last resort. As an indemnity insurer with a very large market share, BCBS could afford to

cross-subsidize higher cost enrollees. The state has never had a "high risk" pool. Deregulation and the decline of BCBS (see chapter on "Financing and Delivery System") prompted regulatory attention to the availability of insurance.

Small-group insurance reform was enacted in late 1991 and implemented in 1992. The reforms include guaranteed issuance and renewal (for all products the company sells in this market), limits on pre-existing conditions, and portability (reduced waiting period for coverage). Further, they include modified community rating with adjustments allowed for age, sex, geographic location, industry, group size, and participation rate, and rate bands within geographic areas. The highest rate was to be no more than four times as high as the lowest, reduced to a 2:1 ratio over a three-year phase-in. Finally, there was a mandatory statutory reinsurance pool. Association coverage was exempted and evidently attracted many small businesses. (The Division of Insurance did little to monitor the market, much less to enforce the statute.) Additional reforms were enacted in July 1996. The stringent new provisions removed the exception for associations, increased the maximum size of covered groups to 50, eliminated the previously allowable use of gender for rating, and tightened the rate bands.

Individual reforms were enacted in the same 1996 statute. The legislation removed the old BCBS open enrollment rule, making the Blues subject to the same rules as commercial insurers, and applied the small-group reforms to individual policies: guaranteed issuance and renewal, modified community rating (without gender), limits on pre-existing conditions, and rate bands. It also made reinsurance available, but on a voluntary basis. Any company selling any small-group coverage must sell individual coverage. This is a "play or else" law, not "play or pay" as in New Jersey, where a company may make a cash payment rather than sell coverage.

The effectiveness of these reforms is unclear. There are no baseline data or information from the early years of small-group reform. Observers think the small-group reform probably changed the composition of the insured more than it increased the numbers. Anecdotally, since the 1996 changes, some insurers have exited from the regulated markets.

Financing and Delivery System

Background: Indemnity Coverage and Independent Hospitals under Rate Setting

Health care financing in Massachusetts has traditionally meant generous fee-for-service coverage, especially from Blue Cross/Blue Shield. BCBS covered about 60 percent of the privately insured as late as 1985. ¹⁴ BCBS had to contract with all willing hospitals and physicians, and hospital rates were regulated by the state beginning in the mid-1970s. In 1982, rate setting was expanded to an "all-payer" system initially including Medicare. In 1985 the uncompensated care pool was created, with funding from a uniform hospital assessment, which was incorporated into the regulated rates.

Hospital care came from nonprofit community institutions and prestigious teaching hospitals. Hospitals were plentiful and of high quality: Boston hospitals consistently appear on national "best" lists. But care was expensive because of high prices and high levels of utilization. ¹⁵ Massachusetts patients receive more inpatient care per 1,000 population than their neighbors in Connecticut or Maine, and much more than on the West Coast.

State rate setting had the side effect of discouraging for-profit hospitals, as the national chains had policies of not entering regulated states. It also encouraged the state's fledgling HMOs by exempting them from price controls and the direct pool contribution and allowing them to

negotiate directly with hospitals. The high-water mark of regulation was the 1988 universal coverage plan of then-Governor Dukakis to mandate universal workplace-based coverage while continuing to control prices through rate setting.

The Medicare component of rate setting was dropped in 1985, when it became apparent that hospitals were better off under federal diagnosis-related group (DRG) rules. But the uncompensated care pool was continued, as well as regulation of other rates. Everything changed with the election of Governor Weld. All regulatory rate controls were repealed in December 1991, freeing all insurers, not just HMOs, to negotiate directly with hospitals. Medicaid continued to dictate its own rates, and the uncompensated care pool was restructured but retained. HMO growth, hospital deregulation, and market restructuring have since significantly altered financing and delivery of care.

Managed Care

Since the mid-1980s, Massachusetts has been a leading state in the extent of managed care. Managed care in Massachusetts usually involves HMOs, whether operating as fully insured HMOs or as purveyors of preferred provider organization (PPO) or point-of-service (POS) coverage. Harvard Community Health Plan (HCHP), a staff model HMO created in 1969, came first. The second major plan was an independent practice association (IPA) started by Tufts University in 1976. Still, HMOs had only about 3 percent market share in 1980. ¹⁶ Thereafter they grew rapidly, able to economize substantially on hospital care compared with regulated indemnity insurers. Yet HMOs were not tainted by a cut-rate image, due to nonprofit status and high-quality university names. HMOs were also sheltered from strong price competition because of the dominance of expensive BCBS and the lack of vigorous for-profit competition. To this day, US Healthcare remains the only major for-profit HMO in the state, and after years of trying, it still has a small market share, mainly in western Massachusetts.

By the 1990s, HMOs had risen to about 30 percent of the private market, while BCBS's market share had plummeted to about 35 percent. ¹⁷ This shift transformed hospitals' finances and their expectations. In Worcester, for example, indemnity payment went from 25 percent or so of hospital revenues to about 5 percent in only a few years.

Managed care is somewhat regulated. The Division of Insurance currently enforces some financial and disclosure rules on insured managed care plans, focusing mostly on solvency issues. These traditional powers are not unimportant. The division had to use them to intervene in the financial troubles of Bay State Health Care, a large IPA, helping to broker its acquisition by BCBS in the early 1990s. Today it is BCBS that is in difficult financial straits, and the insurance commissioner has announced plans for strong intervention into the giant insurer's day-to-day operations. ¹⁸

The attorney general created additional standards in early 1996, calling on HMOs voluntarily to report on the community benefits they provide in a format agreed to by the industry. The state also has an "any willing provider" statute, but it is limited to pharmaceutical coverage and is not effectively enforced. Some very specific limits on utilization controls have recently been passed (e.g., minimum maternity stays), and more quality-oriented rules are proposed. The attorney general's February 1997 report called for new legislation, and legislators had filed about 30 to 40 managed care bills as of February 1997. The bills are not supported by the administration and passage is quite uncertain in the face of HMO opposition. As elsewhere, whether and how to regulate rapidly evolving managed care is a hot issue in the state.

Hospital Downsizing, Consolidations, and For-Profit Acquisitions

The hospital market has been downsizing and consolidating since the early to mid-1980s. In 1988-91 came more aggressive HMO competition, recession, deregulation, and new rate cuts from BCBS and Medicaid—all in quick succession. Altogether, between 1986 and 1995, some

35 Massachusetts hospitals closed, 16 of them by conversion to other services; mergers affected 16 more hospitals. ¹⁹ Worcester, where the Fallon Community Health Plan HMO dominates insurance, is probably the most extreme example. It has gone from having 14 independent hospitals in the 1980s to only two systems in the wake of the latest merger in February 1997. ²⁰ Statewide, the acute care bed supply fell rather steadily from 1984 through 1994—but not as fast as inpatient days, so that occupancy rates still declined. ²¹

For a time, its huge teaching hospitals seemed to insulate Boston from the market changes occurring elsewhere. But today the area is in the midst of a series of mergers, alliances, and consolidations, especially among hospitals. Unusually, change has been led by asset-rich tertiary hospitals, starting with a strategic alliance between two of the five leading academic hospitals announced in 1993. Change was triggered by deregulation but seems driven more by expectations of continuing change: Several interviewees spoke of expecting "California to come to Massachusetts," meaning even more wrenching pressures in the future.

By mid-1996, the top four Boston hospitals had paired up into two competing systems and were adding other components as well and spreading beyond Boston. The two main public safety-net hospitals in Boston and adjacent Cambridge also merged with neighboring hospitals in 1996. The fifth and last tertiary facility is Tufts-New England Medical Center, which in January 1997 announced a merger with Lifespan, a nonprofit chain from Providence, Rhode Island, rejecting an offer from Columbia-HCA. The merger activity extends to physician offices and community health centers (CHCs), some of which are expanding their services and forming alliances to claim larger shares of expected capitation.

For-profit hospital chains are becoming active, although as yet only on the fringes of the metropolitan Boston area. The state has never officially barred for-profit hospitals, but it never had one until very recently. Rate regulation and certificate of need surely have been deterrents, as has the general culture favoring not-for-profit entities (including HMOs, universities, and other institutions).

Meanwhile, consolidation has also occurred in managed care, notably with the merger of the staff model HCHP with Pilgrim IPA. Each had previously merged with smaller plans, but the new combination was huge, with nearly a million members in Massachusetts and Rhode Island. Harvard-Pilgrim soon announced plans to merge with a New Hampshire HMO as well, to give it over a million members and even greater regional presence. It recently purchased the largest Medicaid HMO, Neighborhood Health Plan, run by a consortium of CHCs. ²²

The rash of consolidation has raised concerns about the continued competitiveness of markets for managed care and for hospital services or hospital-based integrated delivery systems. The office of the attorney general considers itself to have sufficient authority to oversee mergers and acquisitions under existing law of antitrust and charities. The attorney general has not yet had to act, in light of the continuing surplus of hospitals, even after mergers, and the inability of for-profits to acquire a major hospital. Investigations of Harvard-Pilgrim's threat to competition are currently under way, and hearings will be held soon on a pending Columbia-HCA bid for a local hospital. ²³ Increased economizing among hospitals also raises fears about the ability of institutions to continue to fund indigent care, although the generosity of government and the presence of the uncompensated care pool makes this a less pressing concern than in most states.

Uncompensated Care and Disproportionate Share Payments

The uncompensated care pool was established in 1985 to distribute the burden of uncompensated acute hospital care, reduce cost shifting, and eliminate incentives to avoid serving the uninsured. ²⁴ Rate setting financed the pool through a uniform surcharge on private payers. Hospitals whose total surcharges exceeded their uncompensated care costs forwarded funds to the pool. These funds were then redistributed to hospitals whose surcharges fell short of uncompensated care. The surcharge rose along with uncompensated

care; by 1987 it was 13.1 percent. ²⁵

The 1988 health reform legislation retained the pool but capped the aggregate amount of the surcharge on the assumption that expanded coverage would reduce hospitals' uncompensated care burden. The cap was set at \$325 million in FY 88 and was phased down to \$315 million for FY 90 and later years. ²⁶ Because the total allowed surcharge was capped but hospital costs continued to rise, the percentage surcharge dropped to 6.25 percent of private insurance charges by FY 96. ²⁷

Because pool costs exceeded revenues, this shortfall had to be distributed across hospitals. At first it was distributed evenly, so that all hospitals received an equal percentage of their uncompensated care costs. In 1991 the state changed the distribution formula and instituted a "greater proportional requirement method" that favored hospitals providing proportionately more charity care. Under this method the shortfall is distributed based on a hospital's size (i.e., operating costs). Larger hospitals are responsible for a greater share of the unreimbursed shortfall costs. ²⁸

Although the entire hospital portion of the pool is \$315 million, only 15 of 84 hospitals in Massachusetts are net receivers from the pool. The bulk of payments, nearly \$150 million of the \$315 million, go to two public hospitals, Cambridge Hospital and Boston City Hospital. ²⁹ These two facilities are heavily dependent on pool funds and, combined, received approximately 38 percent of their total revenue from the pool in 1995. ³⁰

Massachusetts distributes its funds from the uncompensated care pool as DSH payments and receives federal Medicaid matching payments. The state determined in 1990 that the pool surcharge met the test of an acceptable provider tax; it was broad based, uniformly applied, and no one was held harmless. Initially, the state then claimed federal financial participation for the DSH payments made from the pool to hospitals that were above the median level of uncompensated care. This translated to about \$135 million in federal match for the \$315 million in expenditures. In 1993 the state began claiming the entire \$315 for federal matching funds, resulting in about \$157 million in federal match annually, which goes to general revenues. The state pays \$15 million a year to the pool from general funds.

Three major issues around the pool were addressed in fall 1996 by the Special Commission on Uncompensated Care. First, the amount of money in the pool was believed to be inadequate. The shortfall grew as hospital costs and the number of uninsured grew. By 1996 the state hospital association estimated the shortfall at \$166 million, while the state estimated it at \$153 million. ³¹ The growing gap between the amount in the pool and the estimated total uncompensated care burden became a concern for many hospitals and clinics. Second, the shortfall in the pool was exacerbated by the distribution of the pool revenues. With 85 percent of the pool revenues going to 15 hospitals, many hospitals whose uncompensated care burdens were increasing received few or no revenues from the pool. The net contributing hospitals became strongly opposed to the proportional distribution formula in the face of growing hospital competition.

Finally, the hospitals were having increasing difficulty in passing on the mandatory surcharge to third-party payers. As noted above, hospitals are assessed a surcharge on their private payer charges. Hospitals were expected to negotiate the assessment into rates paid by private payers. Hospitals have argued that the payers are increasingly unwilling to accept the surcharge.

The January 1997 recommendations of the commission had four major components. First, implementation of the expanded Medicaid and Insurance Reimbursement programs was expected to reduce the need for and the cost of uncompensated care provided by hospitals and CHCs. This was expected to significantly reduce the amount of pool funds needed to fund uncompensated care.

Second, the federal Medicaid waiver permitted the state to make \$70 million in supplemental, non-pool annual payments to Boston Medical Center and the Cambridge Hospital for the provision of uncompensated care through capitated rates. HCFA was concerned that the reallocation of pool funds for the expansion of Medicaid through the waiver would cause a large loss of revenue to these two hospitals. Because the state could only increase DSH payments at the same rate as its increase in its total expenditures, it was limited in how much it could increase its DSH payments to hospitals and receive federal matching payments.

The Section 1115 waiver allowed the state to reduce the pool payments to Boston Medical Center and Cambridge; instead, these two hospitals would establish capitated managed care plans for uninsured individuals. The managed care plan would be paid capitation rates at an enhanced rate; essentially \$70 million formerly in pool payments would be paid instead as supplemental payments to the managed care plans set up by these hospitals.³² Half the funding would come from the respective cities through an intergovernmental transfer, the other half from federal matching payments.³³ Federal payments would still be under the budget neutrality cap to which HCFA had agreed. In this way the federal government would contribute to Boston City Hospital and Cambridge Hospital as before, but the contribution would not come out of the pool. Thus, the payment would also not be characterized as a DSH payment and would not count toward the 1991 aggregate DSH caps for states. The payment would also circumvent the Medicaid upper payment limits on managed care capitation rates, because HCFA has provided a waiver of that limit. Finally, the state could now increase the payments from the pool to other hospitals by about \$70 million.

Third, funding into the pool was to be continued at \$315 million. Hospitals' payments into the pool, however, were reduced from \$315 million to \$215 million. Private third-party payers, including commercial insurers, HMOs, BCBS, and self-funded plans, would contribute \$100 million to the pool. The state would increase its contribution to the pool from \$15 million to \$30 million.

Fourth, payments from third-party contributors could be made as a surcharge on hospital charges or be made directly to the pool. The Division of Health Care Finance and Policy (DHCFP) (the former Rate Setting Commission) would estimate payments from private purchasers to hospitals and freestanding ambulatory surgery centers. The DHCFP would divide \$100 million by the estimated payments to determine an assessment percentage. Hospitals and ambulatory surgery centers would make estimates of their cash payments from each payer. The DHCFP would then bill each payer for an amount equal to the assessment percentage multiplied by the statewide estimate of the expenditures of that payer for hospitals and ambulatory surgery centers.

Medicaid Hospital and Physician Payment

Hospital reimbursement under Medicaid is paid on a prospective per discharge basis. The state established efficiency standards by excluding data from hospitals with costs above the 75th percentile in setting rates; the result is that the state pays the full costs of hospitals at or below the median. Data from the Prospective Payment Assessment Commission indicate that the Massachusetts Medicaid program pays 83 percent of Medicaid hospital costs, versus 93 percent for the nation. The hospital industry, not surprisingly, views the rates as inadequate.

In addition to claiming \$330 million distributed through the uncompensated care pool as DSH payments, the state has a number of other, smaller DSH programs. One (\$11.7 million) is directed to hospitals that have over 63 percent of their revenues from Medicare and Medicaid or another public payer. Ten out of 84 hospitals receive these payments. Payments of \$42 million go to the Cambridge Hospital, Boston Medical Center, and the University of Massachusetts Medical Center, with the state share financed by intergovernmental transfers from local government. The final significant DSH expenditure goes to seven state-owned long-term chronic care hospitals and psychiatric hospitals. DSH payments are made for otherwise nonreimbursable expenses associated with low-income individuals.

Massachusetts pays physicians on the basis of the Medicaid relative value scale but makes special adjustments for pediatric and obstetric rates. Data from a 1993 Urban Institute survey of 28 services indicate that Massachusetts pays 21 percent above the national average of state Medicaid programs. Massachusetts Medicaid paid on average 90 percent of Medicare rates for the same 28 services. ³⁴

Medicaid Managed Care

Coverage. Massachusetts Medicaid has had statewide mandatory enrollment in managed care for select populations since 1992, when it received a Section 1915(b) waiver. Of approximately 650,000 Medicaid beneficiaries, 378,000 are subject to mandatory managed care enrollment for most care. ³⁵ The beneficiaries include AFDC and related groups as well as SSI and related groups. Mandatory enrollment excludes beneficiaries over age 65 or with other third-party coverage, the medically needy, and individuals who are in institutions or receiving hospice care. Those required to enroll in managed care must choose a primary care clinician (PCC) or enroll in one of several HMOs. Individuals with severe disabilities or AIDS have the choice of two additional HMOs specially designed for their needs. Approximate enrollment is 290,000 in the PCC program and 87,000 in regular HMOs. Enrollment in HMOs is voluntary, and the number choosing HMOs has been relatively flat since 1993. In addition, Massachusetts contracts with a behavioral health managed care organization for mental health and substance abuse services. All nonelderly beneficiaries not in HMOs, or about 369,000 individuals, are in effect in the mental health HMO if they need to use mental health services. ³⁶

The initial movement toward mandatory managed care emphasized increased access and care coordination. The PCCs are not capitated or otherwise rewarded for controlling utilization. However, the state's emphasis has increasingly been on cost savings. Payment rates for HMOs have been cut, and the state is seeking to better control utilization in the PCC program. The state is also considering phasing out the program entirely, moving PCC enrollees into HMOs.

The Primary Care Clinician Program. Beneficiaries not in HMOs must designate a PCC. A PCC can be a physician, clinic, or outpatient department. PCC providers offer preventive and primary care and must authorize most other medical services for their patients. Gatekeeping is viewed as loose, with relatively open access to emergency room and specialty care.

Payment to PCC providers is not risk based. Instead, providers receive an additional \$10 per enrollee visit, regardless of the number of visits. The state is able to measure and improve quality in the program and believes it has increased access for patients. The state is contemplating phasing out the PCC program, believing that administering both an HMO program and a PCC program is burdensome. Additional oversight of PCC utilization is viewed as desirable but would add to the administrative burden. Furthermore, to better control utilization, the state might need to selectively contract with fewer providers.

Contracting with HMOs. The number of participating HMOs has declined from thirteen to eight, although this decline is attributed more to HMO consolidation than to plans dropping out. One for-profit plan discontinued its contract, and the remainder today are nonprofits. At one time, plans were required to bid for Medicaid in order to bid for state employees, but this is no longer the case.

The largest share of Medicaid HMO enrollment is in the Neighborhood Health Plan, a plan formed by community health centers with support of the Medicaid agency. In September 1995, 29,905 of the 87,288 Medicaid enrollees in HMOs (34 percent) were with Neighborhood Health Plan. ³⁷ So far, the major commercial HMOs have not aggressively pursued the Medicaid market. In fact, Medicaid enrollment is less than 10 percent of total plan enrollment for all plans except the Neighborhood Health Plan. Recently a large commercial plan,

Harvard-Pilgrim, agreed to purchase the Neighborhood Health Plan. ³⁸

Enrollment. The Medicaid agency has enlisted an enrollment broker to assist beneficiaries with their choice of PCC or HMO. The broker also educates beneficiaries about their right to disenroll from an HMO and revert to the PCC program at any time. Direct (i.e., face-to-face) marketing and enrollment by plans are prohibited. Plans may only advertise, use mail campaigns, or distribute information during state-approved health fairs. ³⁹ Marketing at provider locations (physician offices, clinics, hospitals) is prohibited. All marketing materials must be approved by the state.

Before 1995, beneficiaries who did not select a PCC or an HMO were assigned to the PCC program. The enrollment broker selected a PCC based on claims history, geography, language, and age of the client. Since 1995, the auto-assignment procedure also defaults clients to HMOs, continuing to use demographic and claims information.

Benefits and Quality Monitoring. Since 1992, all Medicaid HMOs have been required to cover most Medicaid-covered services, including all medically necessary mental health and substance abuse services (not just those typically covered in commercial contracts). Plans also must coordinate with school-based health centers, although they are not required to contract with them. Plans do not cover long-term care, although they must cover acute-level chronic care and rehabilitation, up to \$1,500 in durable medical equipment, and up to 100 days of skilled nursing facilities care. Pharmacy benefits are typically not included in the capitated contract.

Massachusetts Medicaid has developed an extensive oversight and quality monitoring system for HMOs. Plans are required to collect and report utilization and quality data both for Medicaid and non-Medicaid enrollees. ⁴⁰ Plans must conduct annual member satisfaction surveys, monitor voluntary disenrollment rates, and collect clinical indicator data, as well as develop clinical practice guidelines and special initiatives for certain conditions (e.g., prenatal care outreach, asthma management, and HIV/AIDS services). ⁴¹

HMO Payment Rates. The state negotiates rates with HMOs. The state calculates upper payment limits (UPLs) for each rating category of enrollees (except the rating category for dual eligibles). UPLs are based on experience in fee-for-service and in the PCC program with adjustments for differences in population and geography. For each rating category, the state calculates a per member per month (PMPM) expense, which is adjusted to be actuarially equivalent to the HMO-enrolled population for the set of HMO-covered services. ⁴² Separate UPLs for each rating category are then calculated by geographic area, a PMPM administrative expense is added, and the UPL is trended forward to the current year. The state uses five rating categories to pay HMOs: AFDC, disabled, severely disabled, AIDS, and dual eligibles who are enrolled in risk plans. ⁴³

For the disabled categories only, the state conducts a year-end reconciliation process, whereby the utilization experience and demographic characteristics of a plan's specific enrollees are compared with the data used to estimate the original UPLs. An adjusted UPL is calculated, and plans are reimbursed if their actual incurred benefit expenses exceeded the adjusted UPL. ⁴⁴ Plans likewise must return funds if they fall below 98 percent of the adjusted UPL.

The state does not publicize the UPLs. If a plan bids above the UPL, the state negotiates with that plan individually. Typically, the HMO bids have come in above the UPL. In the past two years the state has brought down HMO rates by 10 percent per year to a level roughly corresponding to its upper limits. HMOs appear to have made a small profit before 1995, based on data submitted to the state by HMOs. However, payment rates were cut in 1995, and HMOs on average showed losses the following year. Because the state cut rates again in 1996, HMOs are expected to be even less profitable.

At the moment, the state is not saving on HMO contracts relative to the PCC program despite the apparent HMO losses on Medicaid. HMOs were viewed as controlling utilization better than the PCC program but paying higher rates to network physicians. The state would like to see plans pay lower rates to network providers to lower costs; plans are permitted to pay Medicaid rates, but typically do not.

While most observers considered access and capacity in Medicaid managed care to be good, there was some concern about the future, particularly in light of reduced payment rates to HMOs. Under the Section 1115 waiver request submitted in April 1994, Massachusetts seeks to expand Medicaid coverage to about 220,000 previously uninsured individuals.⁴⁵ Many, although not all, of the newly eligible individuals would have HMO coverage. In addition, the state is contemplating moving the 290,000 PCC enrollees to HMOs. Some argued that most PCC providers already were participating in the HMOs; thus, patient access would not be significantly affected by eliminating the PCC program. However, the combined impact of both changes would be a large increase in HMO enrollment by Medicaid beneficiaries. It is not clear whether HMOs would embrace such a large increase at current payment rates.

Special Provisions for Persons with Specific Disabilities. In Massachusetts, PCC and fee-for-service beneficiaries must obtain mental health and substance abuse services through a specialized behavioral health HMO. However, persons enrolled in an HMO for their general medical care receive mental health benefits through that HMO.

Persons with severe disabilities or end-stage AIDS who live in the community may elect a PCC provider, one of the commercial HMOs, or one of two specially designed managed care plans. These two experimental programs, the Community Medical Alliance and a program through the Neighborhood Health Plan, serve Medicaid clients almost exclusively. (The Community Medical Alliance has announced its intention to merge with the Neighborhood Health Plan.⁴⁶) Beneficiaries have an incentive to enroll in these specialty plans because they cover a broader range of services, including home health care, enhanced case management, and alternative care services (such as physician extenders or adult day health care). Other commercial plans must demonstrate that they have sufficient specialized providers, case management programs, and ties to clinical research to serve persons with severe disabilities. If they do not, they must give individuals with disabilities the option to disenroll. Even if the individual does not disenroll, the plan will not receive the higher capitation rate.

Delivering Health Care to the Uninsured and Low-Income Population

Public Health

The total budget for the Department of Public Health was approximately \$520 million in 1997, with a significant portion of the budget targeted at personal health care services.⁴⁷ Federal grants make up \$129 million, or about a quarter of this budget. The largest federal grant is for nutrition programs, but other grants support personal health care services, such as maternal and child health grants (\$13 million), early intervention programs for children (\$10 million), and vaccination programs (\$9 million).

The major portion of state funds goes to personal health care services (38 percent) and the operation of the DPH hospitals (26 percent). Other major state-funded activities include smoking cessation (14 percent) and nutrition programs (9 percent). Overall, state appropriations to public health have grown faster than federal sources. Personal health care services have been the fastest growing segment; these include, in particular, new AIDS drug therapies, substance abuse services, and family health.⁴⁸

The state funds personal health care services by paying providers directly for certain services and by purchasing third-party coverage. In 1997, the largest programs with personal health care services components were AIDS (\$41 million), ⁴⁹ substance abuse (\$38 million), family health (\$31 million), the Children's Medical Security Plan (\$12 million), immunizations (\$11 million), and Healthy Start (\$6 million). Some prevention programs have small health services components (e.g., breast cancer screening or prostate cancer screening), but these are not included above. Many of these services are targeted at low-income persons. The Children's Medical Security Plan and CenterCare programs were recently transferred from another department and complement DPH efforts to reach pregnant women and enroll them in the Healthy Start program.

Because the state has been expanding health coverage under a variety of programs, including the Medicaid Section 1115 waiver programs and Children's Medical Security Plan, the DPH is shifting some of its other program priorities, particularly in maternal and child health. It plans to focus less on medical services and more on supportive services, such as case management, social services, and transportation. (Prior to the expansion of health coverage, DPH hesitated to shift away from medical services out of concern for both access to services and the overall financial stability of safety-net providers.)

DPH funding has increased with the passage of the Massachusetts Tobacco Control Program in 1993. Of the \$56 million that supports Tobacco Control and Comprehensive Education Programs, more than half goes to the DPH. (The remainder goes to the Departments of Education and Public Safety.) Tobacco programs also are contracted out; more than 250 local health departments have become contractors with the state to pursue tobacco control initiatives.

County and City Governments' Safety-Net Role

Local Health Departments (LHDs). LHDs are run by cities and towns in Massachusetts. (County governments do little other than administer justice; legislation is even proposed to abolish them. ⁵⁰) LHDs act as contractors for the state and sometimes band together to undertake initiatives. For the most part, the focus is public health activities rather than primary health services to the poor. For that, the state relies on a well-developed set of community health centers. CHCs are concentrated in Boston and other older, formerly industrial cities, where the state's uninsured are also concentrated. LHDs mainly focus on population-based health (data collection, standard setting, communicable diseases, etc.). They do provide some primary care, but typically only "wrap-around" services (e.g., home visits and extensive services for at-risk pregnant women and young children up to age two) and limited gap-filling where they identify unmet clinical needs (e.g., school-based services for at-risk students not reached in other ways). They may or may not try to bill Medicaid for such services.

In Boston, the LHD once ran Boston City Hospital (BCH). When BCH merged with Boston University Hospital Center (BU) in July 1996, the LHD retained public health functions and emergency medical services, which serve the public at large. Many LHDs in Massachusetts, as elsewhere, appear to suffer from an excess of responsibilities and a dearth of funding. Public health often loses out in battles for the local resources available under the property tax limits set by Proposition 21/2. In many localities, the public health officer is only a part-time position, assisted by a public health nurse and some clerical help. Yet all LHDs in principle have similar basic legal responsibilities, regardless of size.

Public Hospitals. For community hospital care, the uninsured poor are supported by the uncompensated care pool. Interviewees report that there is good access to inpatient care at most institutions, even after some years of fiscal stress. As a rule, the state does not run public hospitals; it is withdrawing from those psychiatric and chronic care institutions it once did operate, having closed or converted a number of them in recent years. Some cities, notably Boston and Cambridge (below), run public hospitals. Hospital officials and outsiders say that both these hospitals maintain a truly "open door" policy for uninsured patients, often

drawing them from afar.

Impact of Government Policies and Market Changes on Safety-Net Providers

The Boston-Cambridge Site—Background. Boston has a significant poverty population, many uninsured, many immigrants, and a high share of the elderly. The Boston-Cambridge safety net is extensive and consists of two core public hospitals, numerous nonprofit hospitals with large Medicaid and free-care patient loads, and many CHCs dedicated to neighborhood service. Between them, the leading Boston and Cambridge hospitals account for a majority of all uncompensated pool care in the state; a quarter of the state's total uncompensated care charges come from the two public hospitals, BCH and the Cambridge Hospital (TCH) (table 9).

Impact of Managed Care on Safety-Net Facilities and Beneficiaries. The immediate issue for providers under managed care is how to make do with payment levels that have been cut through negotiated discounts. There is often little negotiation as such. Just as Medicaid and Medicare simply dictate prices administratively, BCBS moved after deregulation to impose large payment cuts essentially on a "take it or leave it" basis, even under indemnity plans. The insurance giant also stopped making any explicit allowance in rates for hospitals' uncompensated-care-pool assessments. Similarly, CHC executives complain that HMOs simply offer them physician office rates, not recognizing their qualitatively different services (e.g., after-hours access, multilingual services) or their higher cost caseload (multiple health problems exacerbated by socioeconomic conditions).

Truly vigorous managed care and provider price competition seem not to have arrived in Boston, but they are clearly expected. One executive noted, for example, that his prestigious hospital could command a higher price for its (qualitatively different) care and still fill its beds. He expected that premium to drop to about a 10 percent increment for those services (about 70 percent) that any hospital can provide.

Longer term, selective contracting with only limited networks probably has the largest potential impact for providers, as losing a contract means losing a big chunk of patients all at once. So far, most plans feel obliged to contract with both big new hospital systems (Partners and CareGroup), ⁵¹ but this may change. Already, Tufts-New England Medical Center (NEMC) was badly hurt by being dropped by Harvard-Pilgrim Health Plan. Some observers say that NEMC would have closed already without its access to Tufts HMO patients. NEMC's merger partner Lifespan has a long-standing contract with Pilgrim in Rhode Island, and NEMC wants Harvard-Pilgrim to include it in Boston after the merger goes through. Harvard-Pilgrim has refused, which may halt the merger. There has been adverse commentary in the press, and the state attorney general is investigating the mergers for possible antitrust violations.

Impact of Welfare and Immigration Reforms. It is too early to see effects of the 1996 federal changes. They seemed of little concern to providers interviewed. Federally mandated welfare reform had only just begun, and the state is protecting old immigrants from cuts. Substantial "reform" had already occurred, moreover, in the form of greatly reduced AFDC caseloads even before federal reform. This shift apparently did not much trouble providers, either; or perhaps it was obscured by the magnitude of other changes.

Impact of Market Changes and Related Policy Changes. Here, too, it is too soon to discern clear impacts. Deregulation only occurred at the end of 1991, and its impacts are still playing out. Other big changes in Boston are also recent. It will be hard to disentangle what provider reactions and impacts on patients are due to what factors, as so much is happening at once. It does seem that Medicaid and charity patients are likely to be well served by enhanced competitiveness. Already, many interviewees comment that public enrollees have benefited from having an assigned primary doctor (or CHC), even under the limited managed care of the PCC program. Competition appears to have been healthy for hospitals as well, on average, as their net operating revenues have risen since deregulation. ⁵² Their ability to finance

uncompensated care thus seems unimpaired. The uncompensated care pool clearly helps here, too, and all interviewees emphasized their opinion that patient "dumping" is extremely rare in Boston. Finally, for the future, it appears that health plans and providers alike are positioning themselves to compete for public beneficiaries under increased managed care. This could change if payment rates are too low or administrative and regulatory burdens too high. But the early signs are encouraging.

Hospitals' most basic goals are easily summarized: They want to increase revenues and reduce costs. Strategically, most hospitals seem to be simultaneously "bulking up" to build clout with big payers and offer patients broader access to better care and "slimming down" to improve cost-effectiveness and offer better value for money. A number of common strategies are emerging, though the public hospitals and Children's Hospital seem to be seeking a separate niche from the big nonprofits. Most providers are trying to consolidate, and some also want to move "upstream" into health care financing, getting all or almost all of the premium contributions made by employers and enrollees by accepting capitated risk or its functional equivalent.

Revenue enhancement is sought by formal *networking* or *consolidating* with other providers, horizontally or vertically, and by simple *customer service*, catering better to health plans, patients, and referring providers. Much of the Boston consolidation of hospitals appears to be aimed at increasing market share. The two leading tertiary hospital-based systems seem initially to be trying to leverage their reputations for high quality—having such a strong referral base that no purchaser will dare omit them from its network of providers. So far, this strategy seems to be working, but hospitals seem to be seeking out efficiencies in production as well. In the future, a broad network may also be needed to accept global capitation from payers or self-insured employment groups.

Children's Hospital, in contrast, has decided to be fiercely independent and is reaching out to referral physicians and hospitals with better service, more integrated data systems, and more feedback. It is also trying to increase paying referrals from out of state and internationally. The public hospitals have been quite successful in getting funds from both city and state governments. BCH and TCH also successfully lobbied HCFA to impose advantageous conditions on the state's Section 1115 waiver. The public hospitals' 1996 mergers also had revenue effects: Boston Hospital Center (BHC) joined next-door Boston University (BU) Hospital Center to create Boston Medical Center (BMC), a private nonprofit. TCH merged with nonprofit Somerville Hospital in neighboring Somerville, and the combined entity became a more independent hospital authority. The mergers gave the private partners an immediate fiscal boost in that their uncompensated care payments rose to the higher rates allowed for the two big-city hospitals.

Market share of course also depends on perceived *quality*, and all hospitals are trying to upgrade facilities and technology, information systems, clinical outcomes monitoring, and consumer satisfaction at the same time. All this costs money up front, though efficiencies are hoped for down the road. Consolidation, especially merging with a more financially secure entity, is often seen as a way to improve access to capital for these upgrades.

Cost cutting and efficiencies are sought in many ways. For Boston hospitals, this means closing beds and reducing staffing—but also building clinic capacity by acquiring or linking to CHCs and physician practices. Merger or consolidation can be a strategy for achieving efficiency as well as building market share. An "easy" efficiency is to combine administrative functions and improve economies of scale in purchasing. Consolidating clinical services is harder but probably brings larger savings. Where merged hospitals are adjacent, like BMC and Beth Israel-Deaconess, shutting down duplicative plants is feasible. At BMC, all of BU is expected to move physically into the new BCH facility.

Why hospital price competition lags in Boston is something of a puzzle, given the very high penetration of HMOs and other managed care. In part, Massachusetts seems to be different from other states. Contributing factors include the state's long history of rate regulation and

BCBS hegemony, the friendly cooperation of so many teaching hospitals with shared clinical rotations and interlocking referral patterns, and the nonprofit status and quality consciousness of HMOs. Boston also lacks for-profit hospitals that compete for those patients not needing tertiary care by offering good quality and convenience at standard prices. In late 1996, Columbia-HCA pursued the NEMC's trustees, offering quite favorable terms for a takeover. The trustees rejected the offer in favor of remaining nonprofit and New England-based by merging with Providence's Lifespan system, to the evident relief of the local medical establishment.⁵³ It will be interesting to see how much future competition will change local culture and how much local culture will shape a Massachusetts style of competition. For now, strong public support and a strong medical culture help maintain support for the safety net in Boston-Cambridge.

Long-Term Care for the Elderly and Persons with Disabilities

Long-term care for the elderly and persons with disabilities is a critical component of the state's involvement in health care and has a dominant role in the Medicaid program. The state's overall strategy has been to lower the cost of long-term care services by substituting, wherever appropriate, community-based long-term care services.

Supply, Expenditures, and Utilization

Massachusetts spends a substantial amount on long-term care and has a large supply of services. As shown in table 3, long-term care accounts for 46 percent of Massachusetts Medicaid non-DSH expenditures; table 10 shows that the vast bulk of these expenditures are for nursing facilities. Through a variety of initiatives, growth in Medicaid spending has been kept to about 5 percent per year per elderly enrollee and less for persons with disabilities between 1992 and 1995 (table 4).

The state has a large supply of nursing homes and home health agencies; it has a shrinking supply of institutional mental health and mental retardation services. In 1995, Massachusetts had 56,912 nursing facility beds, or 66 beds per 1,000 elderly, which is above the national average. As a result of the shift in focus to short-term, postacute care, nursing facility lengths of stay have fallen from 2.4 years in 1988 to 1.4 years in 1994. In 1997, there were approximately 160 Medicare-certified home health agencies. Home care is funded both by the Medicaid program and the Executive Office of Elder Affairs, which focuses on individuals ineligible for Medicaid. In 1997, there were 1,200 state hospital beds and between 900 and 1,000 clients residing in state hospitals. There are 1,781 clients in state intermediate care facilities for the mentally retarded (ICFs/MR).

Long-Term Care for the Elderly

Major activities include a strong program of Medicare maximization for skilled nursing facility and home health care, expansion of home and community-based services, plans to integrate acute and long-term care services through managed care, and aggressive efforts to control nursing home costs by narrowing admission criteria, tightening reimbursement rates, and freezing the nursing home supply. Through these efforts, the state has been able to keep spending for nursing facilities and home care relatively flat.

Maximizing Medicare and Private Resources

The Weld/Cellucci administration firmly believes that Medicaid should be targeted on low-income people and that other payers should be pursued aggressively. As such, a significant part of Medicaid's long-term care strategy is to bill Medicare whenever possible for

nursing facility and home health services. Partly as a consequence of various initiatives, the proportion of Massachusetts nursing home residents receiving Medicare reimbursement increased from 2 percent in 1990 to 11 percent in 1996.

A corollary of the notion that Medicaid should be the payer of last resort is that Medicaid should be a program for low-income people, not the middle class. As a result, rules prohibiting transfer of assets in order to qualify for Medicaid nursing home benefits and recouping Medicaid institutional expenditures through estate recovery are vigorously enforced. Moreover, the so-called "public-private partnerships" for long-term care insurance initiatives popularized by the Robert Wood Johnson Foundation that would allow the middle class easier access to Medicaid have not been favored, although they were during the Dukakis administration.

Reorganizing the Delivery System

Massachusetts funds a broad array of home and community-based services through the Medicaid program and the Executive Office of Elder Affairs. Part of the state's long-term care strategy is to gradually increase the availability of home and community-based long-term care services as a way of diverting people from inappropriate and costly institutional care. The state's goal is to provide care in the most cost-effective and least restrictive setting possible. Medicaid-covered services include private-duty nursing, personal care services, case management, hospice services, home health care, adult day health, adult foster care, and group adult foster care (an assisted living-like model).

Unlike some other states, Massachusetts' use of Medicaid home and community-based waivers for the elderly is very limited (less than \$9 million in 1996). Medicaid officials believe that the HCFA waiver form for home and community-based waivers is very cumbersome and that the need to obtain waivers at all is a "pain in the neck." However, given the relative ease of obtaining waivers in the Clinton administration, the state is considering using them to finance more services for the elderly. The ability to limit demand to a predetermined number of "slots" is particularly attractive.

Because most home- and community-based services under Medicaid are offered as an open-ended entitlement, the Division of Medical Assistance (DMA) actively manages the "woodwork effect" (induced demand) through the use of "medical necessity" criteria and the prior approval process. According to one official, if the service is for respite care or if it is a social support and not fulfilling some larger medically related goal, the service is denied payment by Medicaid. In addition, as part of this process, prior approval is now required (as of April 1, 1997) for a wide range of home health services after a relatively brief period or number of visits.

Integrating Acute and Long-Term Care through Managed Care. Massachusetts is strongly committed to extending its managed care program to include the elderly and to integrate acute and long-term care services. The state believes that the current health care system is "horrible" for persons who are in need of both acute and long-term care services and who are eligible for both Medicare and Medicaid. The financing and delivery system is believed to be confusing to beneficiaries, overly expensive because it encourages the use of costly, inappropriate services, and lacking accountability and quality control.

Massachusetts' plans involve two projects. One initiative is an effort to design an integrated system for elderly people who are dually eligible for Medicare and Medicaid. In negotiations with HCFA over research and demonstration waivers, two issues have been sticking points. First, Massachusetts wants to pool Medicare and Medicaid funds into a single capitation payment by Medicaid to managed care organizations, but HCFA has steadfastly maintained that it will not "block grant" the Medicare program to the states. Second, Massachusetts would like enrollment to be mandatory, while HCFA insists that freedom of choice for Medicare beneficiaries must be maintained and enrollment for dual eligibles must be voluntary.

Separate but closely related is the proposed Medicaid Senior Care Plan, which will implement

Medicaid managed care for acute and long-term care services in Massachusetts. Under existing rules, the elderly will have a choice of enrolling in a senior care organization (SCO) or remaining in the fee-for-service system. SCOs that provide extensive long-term care benefits do not exist in the marketplace.

The DMA wants to contract with only a limited number of SCOs in order to improve the state's ability to monitor these organizations, reduce its involvement with direct care providers, and lower its administrative costs. Long-term care providers and elderly advocates are worried that this strategy of restricting the number of SCOs will limit participation to large HMOs, which have little or no experience with the disabled elderly or long-term care services.

Community-based home care and nursing home providers are anxious about potentially being "cut out" of funding by the SCOs or having their rates cut by them. A key issue has been what the relationship will be between the SCOs and the new, legislatively mandated Aging Single Access Point, which is under the direction of the Executive Office of Elder Affairs; both entities are envisioned to have a service coordination function, but they are the creations of different agencies.

Traditional Approaches to Cost Containment

Massachusetts has also tried to control its nursing facility expenditures by tightening eligibility criteria for admission, imposing a moratorium on nursing facility construction, and reducing the rate of increase in reimbursement rates.

Eligibility for Nursing Home Care. Aside from providing home and community-based services, Massachusetts has attempted to limit nursing home use by tightening eligibility for admission. The Home Care Corporations, funded by the Executive Office of Elder Affairs, do preadmission screening of all Medicaid clients seeking nursing home care, with the goal of diverting them to the community. Consistent with its concept of Medicaid as a "medical" program, the DMA has attempted to raise the level of disability needed to qualify for nursing home care and to eliminate the ability of nursing home residents to leave the facility occasionally. These initiatives were opposed by the nursing home industry and consumer advocates, and the legislature adopted language prohibiting Medicaid from implementing these changes.

Moratoriums on New Nursing Home Construction. Construction of new and replacement nursing homes requires a certificate of need in Massachusetts. To control expenditures, the state has had a moratorium on new nursing home construction since 1989; in 1995, a moratorium was placed on applications for renovation and replacement of existing nursing homes. However, because a large number of beds were approved in the late 1980s but are not yet licensed, the nursing home bed supply will probably continue to increase until 2000. As a result of the influx of new beds and somewhat lower (although still high) occupancy rates than before, both government and industry representatives report that access to nursing facility beds is not a problem.

Reimbursement. Massachusetts Medicaid reimburses nursing homes using a prospective, cost-based, case-mix adjusted, resident-specific rate methodology. Care for each resident is paid based on one of ten rates per facility, determined by the individual's disability. In 1993, average nursing home reimbursement rates were \$99.46 per day, the seventh highest in the country. ⁵⁴

The DMA has been very aggressive in negotiating Medicaid nursing home payment rates. For example, over the past six years, there have been several freezes in the base year used to calculate subsequent rates. In addition, inflation factors are aggressively negotiated by the state rather than fixed by formula.

The nursing home industry has yet to file a Boren amendment lawsuit, but it came close in 1993 after the base year for calculating rates had been frozen for three years. The industry has shied away from lawsuits because they are expensive, time-consuming, and unlikely to be

resolved for years. Although Medicaid officials said that they would like to see the Boren amendment repealed (which occurred in the 105th Congress), they believed that they had been so successful in controlling the rate of increase in reimbursement rates that it would not make much difference.

Younger People with Disabilities

Responsibilities for younger people with disabilities are spread among 15 state agencies under four secretariats. Those with a major role related to the provision of long-term care services are the DMA, the Massachusetts Commission for the Blind, the Department of Mental Retardation (DMR), the Department of Mental Health (DMH), and the Rehabilitation Commission. The overall strategy is to provide benefits that are consumer-directed, individualized, and cost-effective and allow consumers to receive their services in the least restrictive setting possible.

Institutions and Community-Based Services for the Mentally Ill and Developmentally Disabled/Mentally Retarded

Massachusetts continues to move toward community-based options and to decrease its reliance on institutional services. Since 1992, this effort has been pursued primarily through the implementation of two major initiatives. First, the state closed three large state ICFs/MR and four state mental hospitals, consolidating resources at the remaining eight state ICFs/MR and six mental hospitals. The state has also connected 77 small ICFs/MR to community residences. Further reductions may be more difficult because of opposition within the legislature, the affected communities, state employee unions, and some parents with children in the state ICFs/MR. Since much of the growth in community-based services has been financed by the fiscal "dividend" obtained by closing state facilities, the lack of future progress on this front may mean that additional funding for these services will not be available.

Second, the state has made a significant effort to maximize federal sources of revenue (e.g., Medicaid) whenever possible. For example, the state operates a large Medicaid home and community-based waiver for persons with developmental disabilities/mental retardation and has tentative plans to request a tripling of the number of people who can be served under the waiver. The state has also implemented a procedure whereby the lead program agencies (e.g., the DMR) provide the state share of certain Medicaid-covered services, thus increasing federal funds without increasing the state portion of the Medicaid budget.

As a result of these activities, the state has been able to significantly shift the provision of long-term care services from institutions to the community. For example, in 1990, 51 percent of "priority" mental health clients were served in inpatient settings and 49 percent in outpatient settings.⁵⁵ As of December 1996, 65 percent of priority mental health clients were receiving outpatient services, and 35 percent were receiving inpatient services.

Relative to developmental disability services, in FY 91, 51 percent of the DMR budget went for the provision of community-based services, and 44.5 percent went toward funding institutional services, with the remainder going for administration. By FY 96, 66 percent of the DMR budget went for community-based services, while 29 percent went for institutional care.

Despite these increases in home and community-based services, there continue to be large underserved and unserved populations. Both the DMR and DMH continue to have significant waiting lists of clients in need of community-based residential and day services, including almost 1,400 persons residing in nursing homes.

Although DMR and DMH budgets have grown substantially in recent years, they are not projected to increase much in the near future. Additional funding for community-based services will depend primarily on a "fiscal dividend" from closure of additional state facilities and growth of the Medicaid home and community-based waiver.

Managed Care

The state is actively pursuing the use of managed care for persons with disabilities. As part of MassHealth, disabled Medicaid clients who are not also Medicare beneficiaries are required to enroll in HMOs or sign up with a PCC. For those enrolled in the PCC option, the state implemented a statewide managed mental health carve-out program called the Mental Health and Substance Abuse Program. HMOs are responsible for providing behavioral health services. In addition, as discussed in the section on long-term care for the elderly, the state is pursuing a Medicaid research and demonstration waiver to use managed care to integrate acute and long-term care services. Once the program is implemented for the elderly, the state would like to expand it to include younger persons with disabilities.

Personal Care Assistance

A major long-term care service used by younger persons with disabilities is personal care assistance. For the past 20 years, Massachusetts has operated two highly consumer-directed personal assistance programs that provide personal care attendant services to persons with disabilities. Under the programs, clients hire, direct, and fire their own attendants; the state views the attendants as independent contractors. The Medicaid Personal Care Attendant (PCA) program serves persons of all ages with disabilities and chronic conditions, although 85 percent of the roughly 3,700 beneficiaries are under the age of 65. The state-funded PCA program is for severely disabled individuals who are able to work but unable to pay for attendant care services.

The Medicaid PCA program has faced a number of challenges as it has grown. In 1988, the program's regulations were changed to enable persons who required "surrogates" to obtain PCA services.⁵⁶ While the DMA argues that most PCA services for people with cognitive impairments constitute a form of respite and are, therefore, not "medically necessary," disability advocates argue that people with cognitive impairments unfairly face limited access to these services.

At the same time, the DMA has expressed growing concern about the lack of controls in the program. It is concerned about the possibility of fraud and abuse related to cash payments to consumers; it is also concerned about the prospect of liability for employment-related taxes (e.g., income, Social Security, Medicare, and unemployment taxes), as the independent contractor status of the attendants has been challenged by the Internal Revenue Service and the state's Department of Employment and Training.

As a result of these issues, the DMA is looking to modify the program in ways that could make it less consumer directed. However, the resistance of the disability community has been formidable, and it was able to convince the legislature to pass language prohibiting the DMA from changing the program for a year.

Challenges for the Future

Massachusetts has a high-cost health care system with a high proportion of academic medical centers and a large supply of specialists. There seems to be a bipartisan consensus on the importance of retaining government support for health care for its low-income populations, particularly if the state can remain successful in tapping a large amount of federal dollars to help finance it. The state currently covers a higher share of its population on Medicaid and has higher rates of insurance coverage than most other states. Its plan for coverage expansion under MassHealth is among the most ambitious in the nation. As a result, the safety net in Massachusetts should be better protected than in most other states.

Nonetheless, the state faces some serious challenges. A major part of the MassHealth

strategy would be to provide subsidies to low-wage workers and tax credits to small business. There is no real evidence on how this will work. MassHealth should provide answers to questions such as: How do workers and employers respond to subsidies? How much will coverage expand? Will expansion be among the previously uninsured? Will many individuals drop their employer-sponsored coverage? Will employers be more likely to continue offering health insurance coverage to their employees?

The uncompensated care pool should now be adequately supported with the recommendations made by the Special Commission on Uncompensated Care and subsequent legislation that will result in new sources of revenue and changes in the distribution of funds. Because of the support for uncompensated care, particularly for that provided by public hospitals, access to acute care is likely to be good in Massachusetts even for the uninsured. The major threat to the pool, at this point, would be the federal cuts in DSH payments now being considered by Congress.

The major question facing the state in implementing the MassHealth program is whether it can, in fact, be budget neutral. The state has assumed that it can hold its expenditure growth to 4 percent per year. The state will have to be very successful in implementing the expansion of managed care to achieve this low rate of growth. The central problem is that the state has an array of relatively high-cost HMOs. The state to date has not found contracting with HMOs to be any less costly than operating its own PCC program. It now hopes to expand its contracting with commercial HMOs and achieve a low growth rate at the same time. This may prove to be a difficult challenge. If the state cannot limit its expenditure growth as planned, the coverage expansions may need to be scaled back.

In part, the state's success in controlling its own costs will depend on what happens in the health care market in general. A key question facing the state is whether the market will become more competitive. The health care system in Massachusetts is relatively high cost because of the dominance of outstanding teaching hospitals and the large number of medical and surgical specialists. Will competition bring health care costs down, or will the merger activity, particularly among the academic medical centers (e.g., Partners and Care Group), exert such substantial market power that costs will not be altered significantly?

The current evidence suggests that pressures to maintain high levels of quality and access make it unlikely that health care costs will decline significantly. This could in turn affect the ability of the state to achieve savings through managed care. If, because of market forces over which it has no control, the state cannot continue to control cost growth, the coverage expansion that it envisions could be threatened. In turn, if coverage does not expand, the rate of uninsurance may not decline as envisioned. The result would be more pressure on the uncompensated care pool and the hospitals that depend on it.

Massachusetts spends a substantial amount of funds to provide a fairly rich array of long-term care services. Although it has successfully controlled expenditures in recent years, it may not be able to sustain this low level of spending growth in the future, especially with an aging population. To control expenditures and improve care for the future, the Weld/Cellucci administration is depending heavily on finding ways to integrate acute and long-term care services through managed care. Pursuing this strategy will not be easy. Federal law, regulations, and policies limit the state's ability to merge Medicare and Medicaid funding. Moreover, elderly Medicare beneficiaries, while joining HMOs in record numbers, are still mostly in the fee-for-service system. For their part, managed care organizations have little experience with persons with disabilities, raising questions about their ability to serve this population. Finally, the relationship between HMOs and long-term care providers is extremely uneasy and not well developed.

Notes

* Please note that these numbers have been corrected since the original printing of this report.

1. Laura Barrett, "Fiscal Health of Massachusetts: Overview," in *Background Paper—Assessing the New Federalism* (Commonwealth Center for Fiscal Policy, August 16, 1996).
2. Massachusetts Department of Economic Development, *Key Economic Indicators*, April 2, 1997, edition.
3. Adrian Walker and Frank Phillips, "Senate Endorses \$18.3 Billion State Budget," *Boston Globe*, 22 May 1997, C16.
4. Barrett, 1996.
5. Adrian Walker, "Weld Vows to Pursue Mass. Agenda," *Boston Globe*, 30 April 1997, A30. On September 15, 1997, Weld withdrew his nomination for the post.
6. Frank Phillips, "Clinton Aide: AG Weighed for Post," *Boston Globe*, 9 May 1997.
7. Barrett, 1996.
8. *Report of the Special Commission on Uncompensated Care* (Boston: The State House, February 3, 1997).
9. Executive Office of Health and Human Services, Department of Public Health, The Commonwealth of Massachusetts, *Report of the Local Health 2000 Commission* (Boston: Department of Public Health, September 10, 1996).
10. Executive Office of Health and Human Services, Department of Public Health, The Commonwealth of Massachusetts, 1996.
11. Commonwealth of Massachusetts, Joint Legislative Committee on Human Services and Elderly Affairs, "Programs and Issues Addressed by the Legislative Committee on Human Services and Elderly Affairs," February 1995, and information provided by the Department of Mental Retardation, December 1996.
12. D. Braddock and R. Hemp, *Towards Family and Community* (Chicago: Institute of Disability and Human Development, University of Illinois, 1996).
13. Division of Medical Assistance, Commonwealth of Massachusetts, "Chapter 203 Budget Neutrality Analysis," January 22, 1997.
14. John E. McDonough, "Mass Retreat: The Demise of Massachusetts Hospital Rate Regulation," *Journal of American Health Policy* (March/April 1992): 40-44.
15. Note the title of one report: Alan Sagar, Deborah Socolar, and Peter Hiam, *The World's Most Expensive Hospitals: One-Fifth of Massachusetts Hospitals Costs Appear Unjustified* (Boston: Boston University School of Public Health, Access and Affordability Monitoring Project, February 1, 1991).
16. McDonough, 1992. By 1984, HMO market penetration was 10 percent. Jason R. Barro and David M. Cutler, *Consolidation in the Medical Care Marketplace: A Case Study from Massachusetts* (Cambridge, MA: National Bureau of Economic Research, Working Paper 5957, March 1997).
17. McDonough, 1992. Barro and Cutler (1997) report HMO penetration of about 30 percent in 1991, rising to 35 percent in 1994.
18. Alex Pham, "State Seeks Oversight of Ailing Blue Cross," *Boston Globe*, 22 May 1997, A1.
19. Special Commission. 1997. Massachusetts Medical Society, 1996. Barro and Cutler (1997) counted 77 closures or mergers during 1980-96.
20. American Health Line, "UMass Medical Center to Merge with Memorial Health Care," February 13, 1997, citing *Boston Globe* article of the same date.
21. Barro and Cutler, 1997.
22. "Harvard-Pilgrim Plans Link," *Modern Health Care*, April 14, 1997, p. 32.
23. Alex Pham, "HMO in Antitrust Probe: Attorney General Eyes Harvard Pilgrim," *Boston Globe*, 20 March 1997, C1. Alex Pham, "AG Will Hold Hearing on Columbia/HCA Buy," *Boston Globe*, 8 May 1997.
24. Division of Health Care Finance and Policy, "Healthpoint," vol. 2, no. 1, September 1, 1996, Boston, MA.

25. Division of Health Care Finance and Policy, 1996.
26. There is one exception. In 1992 the surcharge was below \$315 million.
27. *Report of the Special Commission on Uncompensated Care*, p. 5.
28. Two hospitals of equal size will be allocated an equal portion of the shortfall, i.e., unreimbursed care. Therefore, the hospital with more free care will have more of its free care reimbursed, because the absolute dollar amount of the shortfall is the same for both hospitals.
29. Boston City Hospital has since merged with Boston University hospital and is now part of the private, nonprofit Boston Medical Center.
30. *Report of the Special Commission on Uncompensated Care*, p. 32.
31. *Report of the Special Commission on Uncompensated Care*.
32. The state would contribute nothing on net to the enhanced portion of the capitated rates, but would fully fund the rate up to the upper limit imposed by federal regulations for capitated rates.
33. The financing would work as follows: The state would pay \$140 million dollars in enhanced capitation rates to the hospitals. It would receive \$70 million in intergovernmental transfers from the cities and collect \$70 million in federal financial participation. The net gain to the hospitals would be the \$70 million in federal funds.
34. Stephen Norton, "Medicaid Fees and the Medicare Fee Schedule," *Health Care Financing Review*, vol. 17 (Fall 1995): 167-181.
35. Urban Institute analyses of HCFA data, HCFA 2082, HCFA 64, and Medicaid managed care data. Estimate of total number of beneficiaries was provided by Massachusetts, Division of Medical Assistance, and reflects average monthly enrollment.
36. HCFA, data as of June 30, 1996.
37. Division of Insurance, data from September 1995, in Massachusetts Medical Society, *Massachusetts Health Care: A 1996 Profile* (Waltham, MA: July 1996).
38. American Health Line, "Managed Care Monitor—Harvard-Pilgrim Acquires Neighborhood Health Plan," April 3, 1997, based on reports in the *Boston Globe*.
39. Division of Medical Assistance, 1995-1997 contract.
40. Division of Medical Assistance, 1995-1997 contract.
41. These initiatives typically must address identifying enrollees, educating providers, developing care programs, and ensuring access to services both within and outside of the network.
42. An independent actuary then certifies the equivalence between HMO-enrolled and non- HMO enrolled populations, by rating category, based on demographic and claims data from both groups.
43. Severely disabled, generally speaking, is defined as quadriplegia, quadripareses, or triparese associated with severe cerebral palsy, spinal cord injury, or degenerative neurologic illness. Payments for severe disability are only made to the two specialized plans for persons with severe disabilities and end-stage AIDS. Division of Medical Assistance, 1995-1997 contract.
44. Division of Medical Assistance, 1995-1997 contract.
45. Authorizing legislation was not passed until 1996.
46. American Health Line, "Inside the Industry—Managed Care: Merged HMO Focuses on Poor, Chronically Ill," June 14, 1996.
47. Commonwealth of Massachusetts, Department of Public Health, FY 1997 Spending Plan documents.
48. Commonwealth of Massachusetts, Department of Public Health, FY 1997 Spending Plan documents.
49. Funding refers to state dollars only.
50. Walker and Phillips, 1997.

51. Partners Health Care was formed by Brigham and Women's Hospital and Massachusetts General Hospital in 1994; CareGroup was founded by the mergers of Beth Israel, Deaconess, and Mt. Auburn hospitals in 1996.

52. *Report of the Special Commission on Uncompensated Care.*

53. Walker and Phillips, 1997.

54. American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*. (Washington, D.C.: 1996).

55. The Department of Mental Health serves two priority populations: adults with a diagnosis of mental illness that is serious (e.g., schizophrenia) or of greater duration than one year, and emotionally disturbed children and adolescents.

56. Surrogates are people (either family or nonfamily members) who act on behalf of the person with the disability. In some cases, this may mean hiring, paying, and supervising a consumer's PCA.

APPENDIX

List of People Interviewed

State Government

Department of Mental Health

Paul Barreria
Michelle Goody
Gary Pastva

Department of Public Health

Kathy Atkinson
Sally Fogherty
Paul Jacobson
Joy Rosen
Deborah Walker

Division of Medical Assistance

Meryl Friedman Adelson
Ngoc Bui-Tong
Bruce Bullen
Jeremiah Cole
Ellie Shea Delaney
Diane Flanders
Elizabeth Greene
Joanne McDonald
Tammy O'Donnell
Christopher Perrone
Elizabeth Pressman
Jean Sullivan

Executive Office of Elder Affairs

Barbara Chandler
Lilian Glickman
Patricia Rivard

Executive Office of Health and Human Services

Lou Bertonazzi

Betty Ann Ritcey

State Budget Office

Steve Barnard
Patricia Flaherty
Kristin Keel

Others

Charles Baker, Executive Office
Kevin Beagen, Consumer Affairs and Business Regulation Executive Office
Philip Campbell, Department of Mental Retardation
George Weber, Attorney General's Office
Barbara Weinstein, Division of Health Care Finance and Policy

State Legislators and Staff

Susan Lovelace, Office of Rep. Paul Kollios
Carol Malone, Office of Rep. Paul Kollios
Rep. John McDonough, Massachusetts House of Representatives

Local Government

Lillian Shirley, Boston Department of Health

Provider Associations

Association of Massachusetts Homes and Services for the Aging

Paul Lanzikos
Monica LeBlanc
Jeff Melin

Massachusetts Medical Society

Charles Alagero
Harry Greene
Yael Miller

Others

Laurie Allen, Massachusetts HMO Association
Matt Fishman, Partners Health Care System, Inc.
James Hunt, Massachusetts League of Community Health Centers
Patricia Kelleher, Home Health Care Association of Massachusetts, Inc.
Joe Kirkpatrick, Massachusetts Hospital Association
Peggy Munro, Massachusetts Council for Home Care Aide Services
Scott Plumb, Massachusetts Extended Care Federation

Advocacy Groups

Massachusetts Developmental Disabilities Council

Daniel Shannon
Ruth Smith

Others

Jetta Bernier, Massachusetts Committee for Children and Youth
Neil Cronin, Massachusetts Law Reform
Phyllis Gallante, Massachusetts Association of Older Americans
Robert Restuccia, Health Care for All

Hospitals and Other Health Care Providers

Tritam Blake, Southend Community Health Center
 Myles Coverdale, Children's Hospital
 Jack Cradock, East Boston Health Center
 James Mongan, Massachusetts General Hospital
 John O'Brien, Cambridge Hospital
 Thomas Taylor, Boston Medical Center

Experts

James Callahan, The Heller School, Brandeis University
 Nancy Kane, Harvard School of Public Health
 Alan Sagar, Boston University School of Medicine

Miscellaneous

James Hooley, Neighborhood Health Plan

Tables & Figures

Table 1 State Characteristics		
	Massachusetts	United States
Sociodemographic		
Population (1994-95) ^a (in thousands)	6,002	260,202
Percent under 18 (1994-95) ^a	24.2%	26.8%
Percent 65+ (1994-95) ^a	12.3%	12.1%
Percent Hispanic (1994-95) ^a	4.4%	10.7%
Percent Non-Hispanic Black (1994-95) ^a	6.1%	12.5%
Percent Non-Hispanic White (1994-95) ^a	86.6%	72.6%
Percent Non-Hispanic Other (1994-95) ^a	2.9%	4.2%
Percent Noncitizen Immigrant (1996) ^a	5.4%	6.4%
Percent Nonmetropolitan (1994-95) ^a	23.8%	21.8%
Population Growth (1990-95) ^b	0.9%	5.6%
Economic		
Per Capita Income (1995) ^c	\$28,021	\$23,196
Percent Change in Per Capita Personal Income (1990-95) ^{c,d}	20.8%	21.2%
Percent Change in Personal Income (1990-95) ^{c,e}	21.9%	27.7%
Employment Rate (1996) ^f	64.6%	63.2%
Unemployment Rate (1996) ^f	4.3%	5.4%
Percent below Poverty (1994) ^g	10.9%	14.3%
Percent Children below Poverty (1994) ^g	17.2%	21.7%
Health		
Percent Uninsured—Nonelderly (1994-95) ^h	12.6%	15.5%
Percent Medicaid—Nonelderly (1994-95) ^h	8.9%	12.2%
Percent Employer Sponsored—Nonelderly (1994-95) ^h	73.7%	66.1%
Percent Other Health Insurance—Nonelderly (1994-95) ^h	4.8%	6.2%
Smokers among Adult Population (1993) ⁱ	21.2%	22.5%
Low Birth-Weight Births (<2,500 g) (1994) ^j	6.4%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) ^k	5.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993) ^{l,m}	42.2	54.4
Violent Crimes per 100,000 (1995) ⁿ	687.2	684.6
AIDS Cases Reported per 100,000 (1995) ⁿ	23.8	27.8
Political		
Governor's Affiliation (1996) ^o	R	
Party Control of Senate (Upper) (1996) ^o	33D-7R	
Party Control of House (Lower) (1996) ^o	130D-29R-1I	

- a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
- b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (116th edition), Washington, D.C., 1996. 1995 population as of July 1, 1990 population as of April 1.
- c. *State Personal Income, 1969-1995*, CD-ROM, Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.
- d. Computed using mid-year population estimates of the Bureau of the Census.
- e. Personal contributions for social insurance are not included in personal income.
- f. U.S. Department of Labor, *State and Regional Unemployment, 1996 Annual Averages*, USDL 97-83, Washington, D.C., March 10, 1997.
- g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
- h. CPS three-year average (March 1994-March 1996 where 1995 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
- i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.
- j. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yoo, *Reforming the Health Care System: State Profiles 1996*, Washington, D.C.: American Association of Retired Persons, 1996.
- k. S.J. Ventura, L.A. Martin, T.J. Mathews, and S.C. Clarke, "Advance Report of Final Natality Statistics, 1994," *Monthly Vital Statistics Report*, vol. 44, no. 11, suppl., Hyattsville, MD: National Center for Health Statistics, 1996.
- l. National Center for Health Statistics, "Births, Marriages, Divorces, and Deaths for 1995," *Monthly Vital Statistics Report*, vol. 44, no. 12, Hyattsville, MD: Public Health Service, 1996.
- m. ReliaStar Financial Corporation, *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition, Minneapolis, MN: ReliaStar, 1996.
- n. Race-adjusted data, National Center for Health Statistics, 1995 data.
- o. U.S. Department of Justice, FBI, *Crime in the United States, 1995*, October 13, 1996.
- p. National Conference of State Legislatures, *1997 Partisan Composition, May 7 Update*. D indicates Democrat, R indicates Republican, and I indicates Independent.

Sources: Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the

Table 2 Massachusetts Spending by Category, 1991 and 1995 (\$ in Millions)						
Program	State General-Fund Expenditures ^a			Expenditures ^c		
	1991	1995	Annual Growth	1991	1995	Annual Growth
Total	\$11,147.9	\$13,281.8	4.5%	\$15,128.9	\$18,112.8	14.6%
Medicaid ^{b,d}	1,442	1,700	4.2	2,765	3,900	9.0
% of Total	(12.9)	(12.8)	—	(18.3)	(21.5)	—
Corrections	404	285	(8.4)	444	285	(10.5)
% of Total	(3.6)	(2.1)	—	(2.9)	(1.6)	—
K-12 Education	1,458	2,020	8.5	1,458	2,398	13.2
% of Total	(13.1)	(15.2)	—	(9.6)	(13.2)	—
AFDC	387	389	0.1	758	693	(2.2)
% of Total	(3.5)	(2.9)	—	(5.0)	(3.8)	—
Higher Education	609	704	3.7	654	909	8.6
% of Total	(5.5)	(5.3)	—	(4.3)	(5.0)	—
Miscellaneous ^e	6,847	8,183	4.6	9,049	9,927	2.3
% of Total	(61.4)	(61.6)	—	(59.8)	(54.8)	—

Sources: National Association of State Budget Officers (NASBO), *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K-12 education.

b. Total spending for each category includes the general fund, other state funds, and federal aid.

c. States are requested by NASBO to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., is included in state spending because states cannot separate them. Massachusetts did not report these provider payments to NASBO.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation, as other health rather than Medicaid; third, local contributions to Medicaid are not included, but would be part of Medicaid spending on the HCFA 64.

e. This category includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

Table 3 Medicaid Expenditures by Eligibility Group and Type of Service, Massachusetts and United States (Expenditures in Millions of Dollars)

	Massachusetts					United States		
	Expenditures			Average Annual Growth		Expenditures		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$3,239.2	\$4,364.9	\$5,711.4	16.1%	9.4%	\$73,662.2	\$118,926.0	\$157,872
Benefits								
Benefits by Service	\$3,159.0	\$3,811.9	\$4,990.7	9.9%	9.4%	\$69,168.7	\$97,602.4	\$133,434
Acute Care	1,525.2	1,969.6	2,682.0	13.6%	10.8%	36,904.5	55,059.9	79,438
Long-Term Care	1,633.8	1,842.4	2,308.7	6.2%	7.8%	32,264.2	42,542.5	53,996
Benefits by Group	\$3,159.0	\$3,811.9	\$4,990.7	9.9%	9.4%	\$69,168.7	\$97,602.4	\$133,434
Elderly	\$1,292.2	\$1,361.7	\$1,639.3	2.7%	6.4%	\$23,334.3	\$31,757.9	\$40,087
Acute Care	281.5	274.4	336.9	-1.3%	7.1%	4,926.4	6,911.5	9,673
Long-Term Care	1,010.7	1,087.3	1,302.4	3.7%	6.2%	18,408.9	24,846.4	30,413
Blind and Disabled	\$1,248.7	\$1,560.0	\$2,097.6	11.8%	10.4%	\$25,771.6	\$35,684.6	\$51,379
Acute Care	637.3	837.4	1,134.8	14.6%	10.7%	12,929.2	19,483.6	29,760
Long-Term Care	611.4	722.7	962.8	8.7%	10.0%	12,842.4	16,201.0	21,618
Adults	\$262.6	\$362.5	\$414.0	17.5%	4.5%	\$8,765.0	\$12,710.1	\$16,556
Children	\$355.4	\$527.7	\$839.7	21.8%	16.8%	\$11,297.8	\$17,449.8	\$25,410
DSH	\$0.4	\$457.3	\$609.6	3281.3%	10.1%	\$1,340.9	\$17,525.6	\$18,988
Administration	\$79.8	\$95.6	\$111.1	9.4%	5.1%	\$3,152.6	\$3,797.9	\$5,449

Source: The Urban Institute, 1997. Based on HCFA 2002 and HCFA 64 data.

Table 4 Medicaid Expenditures per Enrollee by Eligibility Group, Massachusetts and United States

	Massachusetts					United States		
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$4,582	\$4,963	\$6,189	4.3%	7.5%	\$2,397	\$2,729	\$3,202
By Group								
Elderly	\$13,197	\$13,797	\$16,113	2.2%	5.3%	\$6,839	\$8,422	\$9,738
Blind and Disabled	\$12,090	\$11,891	\$12,437	-0.8%	1.5%	\$6,378	\$7,320	\$8,022
Adults	\$1,666	\$2,044	\$2,408	10.8%	5.6%	\$1,301	\$1,518	\$1,728
Children	\$1,075	\$1,475	\$2,306	17.1%	16.1%	\$770	\$931	\$1,178

Source: The Urban Institute, 1997. Based on HCFA 2002 and HCFA 64 data.

Note: The figures in tables 3 and 4 likely overstate actual spending per enrollee in 1993 because the data include initial payments to certain contractors but not a during reconciliation.

Table 5 Medicaid Enrollment by Eligibility Group, Massachusetts and United States (Enrollment in Thousands)

	Massachusetts					United States			
	Enrollment			Average Annual Growth		Enrollment			Avg
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1990-95
Total	689.4	765.0	806.4	5.3%	1.8%	28,856.7	35,765.1	41,672.0	11.1%
By Group									
Elderly	97.9	98.7	101.7	0.4%	1.0%	3,412.2	3,771.0	4,116.6	5.1%
Blind and Disabled	103.3	131.2	168.7	12.7%	8.7%	4,040.9	4,875.1	6,405.2	9.1%
Adults	157.6	177.4	171.9	6.1%	-1.0%	6,738.7	8,373.3	9,584.2	11.1%
Children	330.6	357.7	364.1	4.0%	0.6%	14,664.9	18,745.7	21,566.0	13.1%

Source: The Urban Institute, 1997. Based on HCFA 2002 data.

Table 6 Division of Medical Assistance Caseload Summary, FY 95–FY 97			
	FY 95	FY 96	FY 97 (estimated)
Families			
AFDC	308,936	273,589	250,987
Other	109,805	130,221	153,150
Subtotal	418,741	403,810	404,177
% Change from previous year	-1.3%	-3.6%	0.1%
Disabled			
SSI	119,816	126,816	130,333
Other	32,228	35,917	37,353
Subtotal	152,044	162,734	167,686
% Change from previous year	9.0%	7.0%	3.0%
Elderly			
SSI	34,769	33,392	32,698
Other	49,134	50,308	50,523
Subtotal	83,903	83,700	83,221
% Change from previous year	0.6%	-0.2%	-0.6%
Total Medicaid	654,688	650,244	655,083
% Change from previous year	1.1%	-0.7%	0.7%
CommonHealth	3,116	3,064	3,208
% Change from previous year	-2.1%	-2.0%	5.0%

Source: Data provided by Massachusetts Division of Medical Assistance.

Table 7 Five-Year Analysis of the Proposed Commission Recommendation (\$ in millions)^a					
	FY 98	FY 99	FY 00	FY 01	FY 02
Uses of Funds					
Medicaid expansions to 133% ^b	\$106	\$193	\$200	\$208	\$217
Children's Medical Security Plan	18	25	26	28	29
Voucher	0	35	72	75	78
Tax credit	0	21	42	42	42
Pharmacy Assistance Program	30	30	30	30	30
Administration ^c	5	7	8	8	8
Federal payment to BCH and TCH	70	70	70	70	70
CommonHealth and Medical Security Plan ^d	73	76	79	82	86
Residual pool	330	330	253	242	231
Subtotal	\$632	\$787	\$781	\$785	\$790
Sources of Funds					
Existing state funding	\$119	\$125	\$130	\$135	\$141
New federal revenue	167	235	225	227	228
Cigarette tax revenue	102	99	96	93	91
Pool funding	330	330	330	330	330
Subtotal	\$718	\$788	\$781	\$785	\$790
Surplus/(Shortfall)(s)	\$86	\$1	\$0	\$0	\$0

Source: Massachusetts Division of Medical Assistance, "Chapter 202 Budget Neutrality Analysis," January 22, 1997.

a. Assumes 4 percent inflation per year for all programs except the tax credit. State appropriations are assumed to increase 4 percent per year from FY 96. FY 98 is based on preliminary estimates. No caseload increases are assumed, as these estimates are based on merged 93/94 CPS data, and the 95 CPS data include the fact that the low-income population declined slightly.

b. Estimates are provided on an annual basis.

c. Net state cost.

d. Assumes a \$37.6 million FY 98 CommonHealth appropriation.

Table 8 Massachusetts Expenditures and Enrollment with and without the Section 1115 Waiver						
	FY 97	% Change 97-98	% Change 98-99	% Change 99-00	% Change 00-01	% Change 01-02
Without Waiver						
Member Months						
Families	4,875,144	0.0%	0.0%	0.0%	0.0%	0.0%
Disabled	1,881,425	5.0%	6.0%	6.0%	6.0%	6.0%
Total	6,809,015	1.4%	1.7%	1.8%	1.9%	1.9%
Per Member per Month						
Families	\$186.70	7.7%	7.7%	7.7%	7.7%	7.7%
Disabled	\$452.03	5.8%	5.8%	5.8%	5.8%	5.8%
Total	\$358.01	7.2%	7.2%	7.2%	7.2%	7.1%
Expenditures (000s)						
Families	\$910,183	7.7%	7.7%	7.7%	7.7%	7.7%
Disabled	\$850,460	11.1%	12.2%	12.2%	12.2%	12.2%
DSH	\$656,066	6.8%	6.0%	6.8%	6.3%	6.8%
Total	\$2,437,675	8.6%	9.0%	9.1%	9.1%	9.2%
With Waiver Before Expansion						
Member Months						
Families	4,875,144	0.0%	0.0%	0.0%	0.0%	0.0%
Disabled	1,881,425	5.0%	6.0%	6.0%	6.0%	6.0%
Total	6,809,015	1.4%	1.7%	1.8%	1.9%	1.9%
Per Member per Month						
Families	\$153.52	4.0%	4.0%	4.0%	4.0%	4.0%
Disabled	\$404.00	4.0%	4.0%	4.0%	4.0%	4.0%
Total	\$311.47	4.0%	4.0%	4.0%	4.0%	4.0%
Expenditures (000s)						
Families	\$748,451	4.0%	4.0%	4.0%	4.0%	4.0%
Disabled	\$760,100	9.2%	10.2%	10.2%	10.2%	10.2%
DSH	\$590,445	4.0%	4.0%	4.0%	4.0%	4.0%
Total	\$2,120,833	5.8%	6.3%	6.4%	6.5%	6.6%
Savings	\$316,841	\$403,201	\$500,967	\$611,098	\$714,811	\$873,668

Source: Massachusetts Division of Medical Assistance, "Chapter 203 Budget Neutrality Analysis," January 22, 1997.

Table 9 Massachusetts Safety-Net Hospitals, 1997 Projected Care Pool Data (\$ in millions)					
Hospital	Uncompensated Charges	Private Charges	Ratio Private/ Uncompensated	Cost/ Charge Ratio	Net Payment from or to (+/-) the Pool
Boston City	\$134.7	\$41.4	0.31	.985%	\$111.4
The Cambridge	\$49.3	\$13.0	0.26	.850%	\$39.0
Somerville	\$6.4	\$7.8	1.22	.621%	\$2.9
Mass General	\$36.6	\$369.8	9.83	.607%	-\$11.6
Brigham and Women's	\$45.9	\$323.6	7.05	.531%	-\$5.2
Beth Israel-Deaconess	\$30.4	\$351.9	11.68	.600%	-\$13.3
Mt. Auburn	\$5.2	\$90.2	17.35	.544%	-\$4.9
New England Medical Center	\$16.6	\$229.7	13.84	.585%	-\$10.8
Children's	\$13.5	\$214.5	15.89	.735%	-\$1.1
State Total	\$691.0	\$5,034.2	7.29	—	-\$5.6

Notes: In 1996, BCH merged with Boston University Medical Center (data unavailable); TELH with Southern Ill. Mass General and Brigham and Women's and BWH affiliate as Partners Health Care; Beth Israel-Deaconess and Mt. Auburn as Good Samaritan. Total net liability to pool pays mainly for administration.

Table 10 *Medicaid Long-Term Care Expenditures by Eligibility Group, Massachusetts and United States (\$ in Mill.*

	Massachusetts					United States		
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$1,633.8	\$1,842.4	\$2,308.7	6.2%	7.8%	\$32,264.2	\$42,542.5	\$51,996.7
Elderly	\$1,010.7	\$1,087.3	\$1,302.4	3.7%	6.2%	\$18,408.9	\$24,846.4	\$30,413.7
Nursing Home Care	949.8	1,026.5	1,206.7	4.0%	5.5%	15,131.3	20,542.9	25,571.1
Mental Health & ICFs/MR ^a	23.2	25.1	43.2	3.8%	19.9%	1,321.9	1,738.0	1,723.1
Home Care	37.6	35.8	52.4	-2.4%	13.6%	1,955.7	2,565.6	3,119.1
Blind and Disabled	\$611.4	\$722.7	\$962.8	8.7%	10.0%	\$12,842.4	\$16,201.0	\$21,618.0
Nursing Home Care	119.2	147.1	192.5	11.1%	9.4%	3,151.3	3,968.0	4,813.1
Mental Health and ICFs/MR ^a	372.3	368.9	342.5	-0.5%	-2.4%	7,699.1	9,062.5	10,202.4
Home Care	120.0	206.7	427.9	31.3%	27.4%	1,982.0	3,170.5	6,603.0
Adults and Children	11.7	32.4	43.5	65.3%	10.4%	1,012.9	1,495.1	1,963.7

Sources: The Urban Institute, 1993. Based on HCFA 2062 and HCFA 64 data.
 a. ICFs/MR = intermediate care facilities for the mentally retarded.

About the Authors

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Health Policy for Low-Income People in Washington

by

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The Urban Institute

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Series

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

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

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Highlights of the Report

Washington is proud of its long tradition of guaranteeing access to health care for most working and nonworking residents. Its Medicaid program is more generous than most in terms of income eligibility and the set of benefits covered. Washington is pragmatic about its service generosity, however: Medicaid benefits paid per beneficiary are slightly lower than average. Washington also supports a number of state-only health programs, including a large, subsidized health insurance program targeted specifically to the working poor and near poor. In addition, Washington has implemented health insurance reforms designed to improve access and affordability in both the group and the individual markets. Finally, Washington is in the forefront of using organized state purchasing leverage and regulatory authority to establish standards and to monitor health plan quality performance as the health care system evolves.

By virtue of these efforts, Washington's rate of health insurance coverage of the nonelderly is high by national standards, and the state also compares favorably across a broad array of health status and outcomes indicators. These measures reflect generous Medicaid eligibility and successful outreach, the non-Medicaid health insurance subsidy program, a strong economy and a higher than average degree of private coverage, and a well-functioning health care safety net for the remaining uninsured.

Summary of Findings

Washington has been a leader in trying to fashion a bipartisan path to universal coverage and health reform at the state level. In 1993, it passed comprehensive legislation with employer mandates and substantial insurance reforms, among other politically controversial techniques for achieving universal coverage and health care cost control. In 1995, the employer mandate/universal coverage core of that law was repealed, but important elements remained in place and are now being implemented. Preceding and remaining steadfast throughout that debate was Washington's commitment to low-income populations. Medicaid eligibility for children and the non-Medicaid health insurance subsidy program for the working poor were both expanded considerably.

In some ways, state politics and important participants in the health care system are still reacting to the passage of comprehensive reform and the abrupt retreat from its implementation. The health and fiscal policy issues inherent to this debate figured prominently in both the 1994 and the 1996 elections, when Washington voters expressed a preference for a more limited role for government by electing a Republican majority, first in the House (1994) and then in the Senate (1996). The political reversal was not complete, however, as the newly elected governor is a Democrat. Perhaps more important, the preference for smaller government was concretely expressed through a ballot referendum that passed in 1994. Initiative 601 constrains the rate of growth of total state spending out of the general fund to inflation plus population growth. It remains to be seen exactly how this will affect health programs specifically, but it is clear that recent historical growth rates, especially for Medicaid but also for other health programs, cannot be sustained if the 601 constraints are to be satisfied across the board. Still, the new Washington legislature passed financial protections for many immigrants whose benefits were cut by federal welfare reform in a continuation of their bipartisan progressive tradition.

Many states are looking to newly discovered market efficiencies to help reconcile health policy

goals with fiscal constraints. Although Washington did not originally set out to save Medicaid money through managed care, that has now become an important goal. Washington's Medicaid program has proceeded on schedule with its pre-comprehensive reform plans to shift nondisabled adults and children into managed care plans (around 400,000 beneficiaries). It currently plans to move the disabled population (another 70,000) into managed care by 1999.

The non-Medicaid health insurance subsidy program, the Basic Health Plan, has 195,000 enrollees, 130,000 of whom are receiving subsidies from the state alone. The state maintains a strong preference for keeping this program state-only and not Medicaid. The program operates on managed competition principles (e.g., standard benefit packages, enrollees pay the marginal cost of a higher than average cost plan) and contracts with practically all of the managed care plans used by Medicaid and the public employees health benefits plan. The Basic Health Plan, through coordination with the state Medicaid agency, also provides a seamless web of coverage to families with women and children who may become Medicaid eligible because of health status or income fluctuations. All told, the state of Washington purchases health care plans or services for over 20 percent of the total population. Thus, total state leverage over managed care plans and the ultimate shape of the health care delivery system is considerable.

Other State Activity in Health Policy

Insurance Reforms

Washington has preserved and implemented the bulk of the insurance reforms that passed in 1993. Most are targeted at access and affordability of coverage for the small-group and individual markets, but there are also benefit mandates and limits on preexisting condition exclusions that apply to plans of all sizes (except the self-insured). The Washington employer-sponsored health insurance market is a bit larger than average nationwide, covering two-thirds of the under-65 population. The group reforms appear to be working reasonably well, but the individual market is undergoing some turmoil because carriers are embroiled in disputes with the insurance commissioner over premium increases. This market is being watched very closely. The consequences could spill over into the Basic Health Plan, since anyone can purchase insurance there (although there are income limits above which purchasers receive no state subsidy). Washington's individual health insurance market is also larger than average but still covers only about 8 percent of the total nonelderly population.

Long-Term Care

Washington has relatively high long-term care expenditures per elderly recipient. The state places a high priority on enabling the elderly to avoid nursing homes if possible, for both political and fiscal reasons. The state uses Medicaid home and community-based waiver programs to provide nursing options to long-term care recipients. Still, two-thirds of the overall long-term care budget is devoted to nursing homes, and so the state continues searching for innovative alternatives for this type of care.

Mental Health and Developmental Disabilities

Three principles underlie state policy for those with serious mental illness or developmental disabilities: community-based care, managed care, and maximized federal support. Washington has been more successful than most states in deinstitutionalizing mentally ill and developmentally disabled persons and delivering care in community settings. Enrollment in a capitated Regional Support Network is required for Medicaid beneficiaries to receive most outpatient mental health services. Federal Medicaid disproportionate share hospital funding is particularly important to Washington's overall delivery of mental health services.

Public Health

The state Department of Health carries out a broad range of activities, from traditional

population-oriented activities to direct services. Two large block grants and 63 categorical grants provide federal support for Washington's public health programs. Most funds and considerable (although monitored) discretion are transferred to local health departments, which are typically organized along county or multicounty lines. The expansion of Medicaid and the Basic Health Plan have reduced the need for local health departments to provide direct health services to the poor, but many still do, and many coordinate with the state Medicaid agency to maximize the draw of federal funds.

Challenges for the Future

With a strong economy; above-average commitments to funding the poor, near-poor, and safety net providers; and a low overall uninsurance rate, Washington's health system is currently quite strong. The major challenges for the future are similar to those faced elsewhere: Can Medicaid save enough from managed care and other market-based efficiencies to avoid enrollment or benefit cuts? Can the health care safety net survive aggressive market competition and state budget constraints? Will funding for Basic Health Plan expansions be forthcoming or will the current waiting list be allowed to grow? Will insurance reforms help most small groups and individuals purchase and keep private insurance? Will organized purchasers, public and private alike, be able to ensure that high-quality health care is delivered in the managed care settings of the future? All these areas will require constant vigilance and may call for policy intervention in the next few years.

Thumbnail Sketch of Washington

Sociodemographic

Washington is the eighteenth largest state in the United States, with a population of 5.3 million (table 1). It has lower than average elderly and young populations, but its overall population has been growing at more than twice the national rate since 1990, suggesting that immigration of working-age adults is the primary factor behind Washington's recent population growth. Washington has about the same percentage of its population living in urban areas (78.4 percent) as the nation as a whole. Washington's racial mix is disproportionately white, 86.8 percent versus 72.6 percent for the nation, with much smaller than average black and Hispanic populations. It does have a larger than average proportion of "non-Hispanic other" (7.7 percent vs. 4.2 percent for the United States), largely of Asian, Pacific Islander, and Native American origin.

Economic

Washington has a slightly higher per capita income and lower poverty rates than average (table 1). Both the employment rate and the unemployment rate are higher than the nation's, reflecting a population with a higher than average proportion of working-age adults. Recent growth in per capita income has been on a par with the nation, but growth in total personal income has been much higher, suggesting that the Washington economy has been creating average wage jobs faster than the nation overall for the past five years.

Currently, the Washington economy is very strong. The unemployment rate fell from 9.5 percent in January 1993 to 6.4 percent in December 1996. Over the same period, the unemployment rate dropped from 7.1 percent to 4.4 percent in Seattle.¹ Thus, Seattle's economy is even stronger than the state's as a whole. Much of this strength comes from Boeing (aerospace) and Microsoft (computer software), which are doing very well. General economic growth has increased the total resource base available for private and public purposes throughout Washington.

Political

Washington is one of the few states with a long progressive tradition that does not also have a state income tax. Therefore, it relies on state sales and state property taxes. It has also become relatively adept at obtaining federal funding, both for federal purposes, which contributes to Washington's economic base (defense) and to pursue state goals (social and infrastructure spending). The political climate could be described as socially liberal and fiscally conservative. Washington's congressional delegation has been relatively prominent (Henry Jackson, Tom Foley) and largely Democratic over the past 30 years, as has been control of the state legislature and governor's mansion. Recently, however, Republicans have achieved a majority in both state houses (26-23 in the Senate and 56-42 in the House), and the congressional delegation has become majority Republican as well. The political reversal was not complete, however, as the newly elected governor, Gary Locke, is a Democrat. While fiscal restraint is now a high priority, the recent legislative session did not reverse any major initiative or commitment in health care that the state has undertaken over the past few years. In fact, in response to federal welfare reform, the legislature appropriated state funds to replace lost federal support of some benefits for some populations (discussed below).

Perhaps because of the progressive tradition without a state income tax, there appears to be a consensus that bipartisan cooperation and agreement are essential. This pragmatism has permeated both parties and the state's bureaucracy, and it engenders bipartisan support for the public programs that are in place. Another way of saying this is that political leadership in Washington state politics on both sides of the aisle has been relatively moderate ideologically, compared with that observed at the national level in recent years. Washington saw brinksmanship and sustained vetoes in the spring of 1997, but no major shifts in policy have occurred yet.

Setting the Policy Context

Overview of Health Policy Agenda

Policymakers, the public, and the health care industry are still defining how far they want to retreat from the ambitious goals enacted in 1993. That year Washington expanded on its traditional commitment to health care access by seeking universal coverage through employer mandates and household subsidies, cost control through managed care, and a thoroughly reorganized health insurance market. These reforms were controversial at the time, and most Washington leaders expected the federal government to follow soon with similar reforms and subsidies. At the same time, Medicaid eligibility for children was liberalized considerably (up to 200 percent of poverty), Washington began moving most Medicaid recipients into managed care plans, and additional funding was provided to expand enrollment in the Basic Health Plan (BHP). The state developed a public health improvement plan (PHIP) that promised to move local health departments out of direct service provision (assuming universal coverage) and into a renewed focus on core public health concerns.²

The elections of 1994, in which the Republicans took control of the House and reduced the Democratic margin in the Senate to one vote, reflected a far less expansive view of the proper role of government. In 1995 and 1996, much of the 1993 law was repealed, including the commitment to universal coverage and employer mandates. Substantial insurance reforms were retained, however (guaranteed issue, limits on preexisting condition restrictions, portability, modified community rating for small groups, guaranteed access to all types of licensed providers,³ state approval of premium increases), so that Washington remains among the nation's leaders in overall health insurance reforms. Health plans and providers had already prepared for the anticipated implementation of comprehensive reforms by the time they were repealed, and the movement to Medicaid managed care and organized state health insurance purchasing strategies continued. These policies and responses were all designed to increase the cost-effectiveness of health care in Washington within reformed insurance

markets, and they have set in motion market forces that are not likely to be reversed. To some, the universal coverage goals contemplated during 1993-94 remain a benchmark against which current policy is judged. To everyone, health care markets in Washington have been permanently altered in the past four years.

The structure of and commitment to existing programs serving low-income populations were retained in 1995-96 as well. In some ways, there is now more state policy emphasis on serving the poor and the working poor than there would have been had universal coverage and managed competition reforms gone into effect. In that event, considerable bureaucratic resources and political capital would have been devoted to helping the vast majority of already insured middle-class citizens adjust to the brave new world of thoroughly managed competition, necessarily emphasizing health plan and provider choice and quality more than basic cost and access issues.

The policy outlook for the immediate future is dominated by two issues: impending budget constraints and rising concern about quality of care. A ballot initiative passed in 1994 (Initiative 601) limits the growth rate in state expenditures financed out of the general fund to the sum of population growth and inflation beginning July 1, 1995 (roughly 4 percent per year in the 1995-97 biennium). Since state Medicaid spending has been growing at about 8 percent per year, this constraint could require hard choices between enrollment declines and service reductions. While the state has resisted cutting Medicaid, there is general recognition that, in the long term, Medicaid spending growth must be curtailed. The state's major non-Medicaid, heavily subsidized coverage expansion program, BHP, has attracted enough enrollment to exhaust the revenue sources currently dedicated to it, and the waiting list for enrollment is large and growing. Competition for state resources promises to be sharper in the years to come than it has been in the recent past, although it is not certain that health care will be relatively harder hit than other areas. Overall, Initiative 601 represents a departure from Washington's long-standing tradition of expanding social service spending along with economic growth.

In addition to new budget constraints, maintaining the quality of health care in Washington is high on many officials' agendas. Different players are devising ways to use state regulatory and purchasing powers to institutionalize and standardize health plan accountability for both private and public payors. Managed care in Washington, while long present, has recently grown rapidly, and many employees and dependents are encountering restrictions on provider choice or strong financial incentives to use specific network providers for the first time. With that exposure has come a recognition of the value in standardizing provider network adequacy requirements, outcomes and satisfaction reporting, and quality assurance procedures across all health plans and newly emerging risk-bearing entities. This evolving effort includes numerous state government agencies, providers, consumers, and employer/purchasers. Three agencies currently coordinate health plan reporting requirements and site visits to health plans serving state clients, and will plan joint procurement and quality improvement efforts for managed care services in the future. Given the scientific complexity of obtaining and interpreting quality measurements and the huge financial stakes, quality-of-care issues are unlikely to be resolved soon and without controversy.

Washington has established some of the most generous policies of all the states in terms of immigrant eligibility for Medicaid and other programs under welfare reform. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) bars new immigrants from Medicaid for their first five years in the country and gives states new options for determining immigrants' eligibility for Medicaid. In the Spring of 1997, the Washington legislature passed and the new governor signed legislation that enables all new legal immigrants to receive state-funded Medicaid benefits during the federal five-year bar, after they meet a one-year state residency requirement. Washington has also adopted the federal option to provide coverage to legal immigrants in the United States prior to the passage of PRWORA and to new immigrants following the five-year bar. In addition, Washington is creating a state-funded program to replace legal immigrants' food stamp benefits lost as a result of the federal welfare reforms. Apparently, passage of these state provisions was facilitated somewhat by the fact

that new state expenditures in response to federal program changes do not count against Initiative 601 spending limits.

State Health and Health Care Indicators

Washington has a high rate of health insurance coverage by national standards and compares favorably across a broad array of health status and outcomes indicators. The relatively low uninsurance rate (12.9 percent of the nonelderly population [see table 1]) is largely attributable to a higher percentage of private coverage than in other states, although Washington's Medicaid program is relatively generous toward the near-poor (those between 100 percent and 200 percent of poverty) and the state-only subsidized plan (BHP) targets this population as well. Reflecting both underlying sociodemographics and relatively broad access to care, Washington state has lower than average rates of teen pregnancy, low birth weight, infant mortality, and premature death as well as low incidences of both AIDS and tuberculosis.

Health Care Spending and Coverage

Medicaid spending in Washington was \$3 billion in 1995, about half of which was financed by the federal government. On a per enrollee basis, Washington spends 8 percent less than the national average. Medicaid spending has been growing faster than other components of state spending recently, increasing from 9 percent to 13 percent of state general fund expenditures between 1990 and 1995 (table 2). The primary reason for expenditure growth has been enrollment expansions. Washington has also pursued a very effective Medicaid maximization strategy, substituting federal dollars for state dollars in many areas. The federal share of medical assistance payments increased from 46 percent in FY 1986 to 56 percent in FY 1996, and the federal share of mental health spending went from 16 percent to 45 percent over that same period.⁴ Today about 12.3 percent of the nonelderly population and 57.9 percent of the poor are insured through Medicaid.⁵ Overall, roughly 15 percent of the population has state-subsidized health insurance, mostly through Medicaid or the Basic Health Plan.⁶

Organization of State Health Programs

The Department of Social and Health Services (DSHS) is an umbrella human services agency established in 1970 that houses both Medicaid and the majority of the state's health service programs. DSHS accounts for 25 percent of the state general-fund spending, and the secretary of DSHS has cabinet status. DSHS administrations and their shares of the 1995-97 DSHS operating budget, including federal funding, include the following: Children's Services, 5.7 percent; Juvenile Rehabilitation, 1.7 percent; Aging and Adult Services, 15.7 percent; Medical Assistance (mostly Medicaid), 35.5 percent; Health and Rehabilitation (includes mental health), 18.6 percent; Economic Services (e.g., Aid to Families with Dependent Children [AFDC]), 21.2 percent; and Management Services, 1.6 percent.⁷ The Aging and Adult Services Administration (AASA) administers long-term care services for the aged in Medicaid and related aging programs.

The Health Care Authority (HCA), whose administrator also has cabinet status, has administrative responsibility for the state's own program for the low-income uninsured, the Basic Health Plan (BHP). This program interacts with Medicaid in important ways—creating a seamless coverage web for pregnant women and children, for example. The HCA also runs the state employee health insurance program, and a number of synergies (e.g., health plan requirements and audits) are achieved because the HCA purchases health insurance on behalf of different populations. Overall, the HCA accounts for about 1 percent of state spending from all sources.

The Department of Health, a relatively new agency whose secretary also has cabinet status, has authority over population-based services and some direct services provided through the local public health departments. The Department of Health is also involved with the monitoring of DSHS/Medicaid health plans. The Department of Health accounts for 1.3 percent of total state spending from all sources.

Medicaid

The Medicaid budget in Washington state is split across several subunits of DSHS:

- Medical Assistance Administration, or MAA (53 percent of total Medicaid funds), administers the medical care component of Medicaid and related insurance programs.
- Aging and Adult Services Administration (24 percent) administers long-term care services for the aged in Medicaid and related aging programs.
- Mental Health Division (11 percent) administers community mental health and residential and institutional mental health services, including disproportionate share hospital (DSH) payments to mental health hospitals.
- Developmental Disabilities Division (9 percent) administers residential, community-based, and institutional developmental disabilities services.
- Other (3 percent) includes Children and Family Services, Alcohol and Substance Abuse, Central Administration, and Veterans Affairs.

Table 2 examines spending on Medicaid and other services that are financed from the state's general fund as well as total spending from general, other state, and federal funds. Table 2 shows that Medicaid is the fastest-growing spending category, but K-12 education still makes up a far larger portion of the state budget. Since 1990, Medicaid has replaced higher education as the second-largest state expenditure by growing more than 16 percent per year. Because of its relatively high federal matching rate, Medicaid represents a larger percentage of total spending (federal and state funds) than of general fund spending. Given the relative constancy of the other shares, one can infer from table 2 that increased Medicaid spending has been partially financed with moneys that might otherwise have gone to support education or lower taxes.

Table 3 shows that Medicaid spending in Washington has been growing a bit faster than in the rest of the nation in the 1990s: 28 percent during 1990-92, compared with the U.S. average of 27 percent, and 13 percent during 1992-95, compared with 10 percent. The most recent faster-than-average growth has been the result of increased DSH payments, acute care spending on the under-65 population (especially children), and long-term care services for the elderly. Administrative costs have increased dramatically faster than the national average as well. Table 3 also shows that Washington has slightly more acute care spending (and less long-term care spending) as a percentage of total service expenditures (62 percent) than the nation as a whole (60 percent).

Table 4 illustrates that Medicaid spending per enrollee in Washington was 8 percent lower than the national average in 1995 and that it has grown more slowly per year than the national average since 1990 (5.4 percent vs. 6.0 percent). Overall spending per enrollee reflects the distribution of enrollee types as well as cost per enrollee of each type. Washington spends more than other states do per enrollee on the elderly, the blind and disabled, and nondisabled adults (mostly AFDC mothers and pregnant women ineligible for AFDC but eligible for Medicaid because of federal and state expansions). It spends less on children than the national average. These spending patterns reflect service-specific payment and utilization rates as well as benefit packages relative to other states.

Health Care Authority

The Health Care Authority administers the Basic Health Plan (BHP), which is an insurance program primarily aimed at uninsured lower-income working families. The BHP subsidizes individuals, families, or employers to purchase managed care plan coverage, with plans

selected in a managed competition framework. Adults pay a minimum of \$10 per month to join, and there is a sliding fee scale so that persons above 200 percent of the federal poverty level pay the full age-adjusted premium (\$116 to \$242 per month in 1996). Employers can sponsor BHP participation by their employees by paying \$45 per month per worker. Persons over age 65 can join only if they are not eligible for Medicare coverage. Children under age 19 who are eligible for Medicaid may join BHP Plus, which essentially enrolls the children in Medicaid with no premium, although they are assigned to the same BHP health plan as their parents to enhance familiarity with providers and continuity of care. BHP is not an entitlement program, and funding levels are capped.⁸ In November 1996, the existing appropriation was exhausted, and as of December 1996, more than 60,000 people were on the waiting list.⁹ Funding for 8,000 more subsidized enrollees was appropriated during the 1997 legislative session.

Department of Health

The Washington State Department of Health carries out a broad scope of public health care activities, ranging from traditional population-oriented activities to direct services. The department consists of several divisions, including Epidemiology and Health Statistics; Environmental Health Programs; Public Health Laboratory; Health Systems Quality Assurance; and Community and Family Health, which administers, among other programs, maternal and child health services. The latter two divisions administer programs that are most relevant to the delivery of health care. Moreover, their budgets are the largest of all the divisions, with Health Systems Quality Assurance comprising 14 percent and Community and Family Health comprising 64 percent of the department's 1995-97 appropriation.¹⁰

The Department of Health is a relatively new agency, having been elevated to cabinet status only seven years ago. The intent of this change was to move public health issues more to the forefront, emphasizing health promotion and health protection.

County Autonomy

Over the past 30 years, local health departments in Washington, as in other states, have assumed some responsibility for providing clinical services to many of the uninsured, particularly mothers and children. More recently, however, most local health departments in the state have begun to shift their focus from the delivery of personal health services to core public health activities. A primary reason for this change is the expansion of Medicaid coverage for women and children and the institution of the BHP. Expanded coverage under these plans and enrollment of participants in managed care has gradually reduced the need for health departments to offer clinical services, such as well child care and prenatal care, to the poor. In a few cases, local health departments have been included in Medicaid managed care networks as primary care providers (e.g., Seattle-King County); but in general, the state merely requires that managed care plans "cooperate" with local health departments, for example, in ensuring that immunizations are provided on schedule.

Assessing the New Federalism

Washington has had a sustained commitment to social and health care safety nets through Medicaid and other state programs. The BHP and recent expansions of Medicaid eligibility for children are good examples of that continuing commitment. The decision to use the BHP—a state-only program—as the major vehicle to expand health insurance coverage to the low-income working population reflects a strong desire to avoid federal control and a willingness to use state funds to preserve that autonomy. Because of the strength of Washington's economy and state policy choices, the percentage of nonelderly Washington residents who are uninsured has been lower than the national average for some time, and Washington's health status indicators consistently rank among the top half of states in most

categories.

At the same time, Washington is not immune to the current political emphasis on fiscal discipline and a reduced role for government. In terms of legislation, however, so far this has translated into scaling back some (but not all) of the ambitious universal reforms of 1993, rather than a reversal of Washington's long-standing commitment to maintaining access to health care for its low-income residents. Initiative 601, the referendum on state budget spending that passed in 1994, is a departure from Washington's tradition of expanding social service spending along with economic growth. But even here, the goal is to limit growth, not to achieve absolute reductions in spending.

Still, given recent health spending trends, especially regarding Medicaid, the hard choices required to satisfy the constraints imposed by Initiative 601 are much more on policymakers' minds than New Federalism initiatives coming out of the federal government. The original Medicaid block grant formula proposed in 1995 would have hurt Washington relatively more than most states. Washington would have been effectively penalized for having had a relatively strong economy, for having successfully pursued a Medicaid maximization strategy over the years, and for deciding to keep the BHP subsidy program a totally state-funded program. The formula was changed in subsequent proposals, and final passage of a Medicaid block grant was judged to be of sufficiently low probability (which continued to decline throughout the 104th Congress) that no serious contingency planning exercises were undertaken by state Medicaid officials. Of course, the prediction of no federal action turned out to be accurate.

Therefore, it is by no means clear how Washington will respond to federal Medicaid reform in the 105th Congress, especially given the 1996 election results in the state. On welfare reform, Washington's traditional commitment to a social safety net was manifested, even by this more conservative legislature, through the appropriation of state funds to restore certain health and social support (food stamp) benefits for immigrants that might have been lost as a result of federal welfare reform. Since the Medicaid savings recently passed by the 105th Congress are sufficiently modest compared with both welfare reform and with the block grant and per capita cap proposals of the 104th Congress, it seems unlikely that federal policy will precipitate major changes in Washington's Medicaid program in the near future. However, since cuts were made in the disproportionate share hospital (DSH) portion of Medicaid spending and since Washington effectively uses this money to finance a variety of state health spending, some programs might have to be curtailed, or additional nongeneral revenue state financing will have to be found.

Just as elsewhere, Washington Medicaid officials would enjoy increased flexibility that might come with federal Medicaid reform. Some were particularly interested in implementing a sliding scale premium or copayment schedule for Medicaid recipients who have incomes above the federal poverty level (thus making Medicaid more like BHP). They were also interested in repeal of the Boren amendment, which repeal did, in fact, pass in the 105th Congress. The Boren amendment propped up hospital and nursing home payment rates by providing a market-based standard against which to compare Medicaid payment levels in a federal court. Both of these reforms are viewed as dangerous by advocates for low-income populations, for either could reduce access if pushed too far.

Providing Third-Party Health Coverage for the Low-Income Population

A smaller percentage of the low-income population is uninsured in Washington than in the rest of the country (22.9 percent vs. 25.3 percent).¹¹ This is the result of both generous optional

Medicaid coverage for pregnant women and children and the Basic Health Plan's targeting of the working low-income population.

Medicaid Eligibility and Enrollment Trends

Table 5 presents state data on trends in enrollment levels for Medicaid and other medical assistance programs (aside from BHP) from state FY 1990 to FY 1995 and projections for state FY 1996 and FY 1997 (compiled by legislative staff as of April 1996). These data are shown as the average number of monthly enrollees and are lower than levels in comparable federal reports, which are based on the number of enrollees who are ever on Medicaid in a given year (see table 6).¹² The state and federal Medicaid statistics are otherwise broadly consistent. Both show that the number of Medicaid enrollees rose about 12-13 percent from 1990 to 1992 and 8-9 percent per year from 1992 to 1995 and that there was a particularly large increase in the number of non-AFDC children (called "other children" in table 5 and "#noncash children" in table 6). From 1992 to 1995, Washington's Medicaid enrollment levels grew about 3 percentage points faster than the national average rate, and the rate of growth for noncash children in Washington was 2.6 times the national average rate (table 6). The major factor in this enrollment growth was the state's 1994 expansion of Medicaid eligibility for children under the age of 19 up to 200 percent of the federal poverty level, using a 1902(r)(2) state plan amendment. The expansion for children was enacted as part of the 1993 Health Services Act and is funded through the earmarked Health Services Account. The state has conducted active outreach to children.

The other explicit policy change was eliminating AFDC-related medically needy (not including the elderly or disabled medically needy) eligibility in January 1996. This was a legislative change made to reduce Medicaid spending; it was expected that most of these people would be able to enroll in BHP instead. Those already participating were grandfathered, so caseload levels will decline gradually.

Moderate increases in the number of aged and disabled cash assistance enrollees occurred between 1994 and 1996—2,000 aged and 13,000 disabled. The reasons for these increases were not clear. At least part of the reason might be that the state has actively been trying to identify General Assistance recipients who may be eligible for Supplemental Security Income (SSI) and, thus, Medicaid.

The state had no major welfare reform waivers in place at the time of the site visit. Major welfare reform legislation was debated in 1995 and 1996 but not passed until 1997, after federal legislation was enacted. AFDC caseloads (as reported under the AFDC program) declined slightly between 1994 and 1996, in part because the state's overall economic condition improved over those two years.

Washington has relatively generous Medicaid eligibility limits, especially for pregnant women (up to 185 percent of the federal poverty level) and children under age 19 (up to 200 percent of the federal poverty level). The state's AFDC and medically needy income criteria are also more generous than the national average. Moreover, the state extends family planning eligibility to poverty-related pregnant women for 12 months postpartum, as compared with the standard 60-day postpartum eligibility. To serve the aged and disabled, the state has both a medically needy program related to SSI and eligibility for people with incomes up to 300 percent of the SSI benefit level for those requiring institutionalized care. And, as mentioned in the long-term care section of this report, there are other programs for the aged and disabled.

Other Medical Assistance Programs

As shown in table 5, one sign of Washington's dedication to health care for needy populations is the diversity of small medical care coverage programs, in addition to Medicaid and the BHP. Few, if any, states have so many "gap-filling" programs to serve special populations. The gap-filling programs include the following: (1) General Assistance-Unemployable (GA-U) and

Alcoholism and Drug Abuse Treatment and Support Act (ADATSA) medical assistance programs, which provide basic medical services to General Assistance clients; (2) Refugee Assistance, which provides Medicaid-type coverage to refugees; (3) the Medically Indigent program, which provides emergency reimbursement for uninsured people (not eligible for other programs) with high medical expenses incurred in hospitals (this is essentially an uncompensated care program for hospitals); and (4) the State Children's Health Program, which provides Medicaid-type coverage to children under age 18 in households with incomes under the federal poverty level who are not otherwise eligible for Medicaid—essentially, undocumented alien children. The total number of people served in these programs is modest (28,000 in 1996) but was growing as of 1996. The GA-U program has recently assumed greater importance, since elderly and disabled immigrants who lose SSI benefits because of the federal welfare reform law will generally be eligible for GA-U cash assistance and medical coverage. While in principle these programs would be described as state funded, state officials acknowledge that they are largely funded by additional federal funds earned by the state's disproportionate share hospital (DSH) program.

The Basic Health Plan

BHP participation has grown substantially since 1994 because of deliberate policy changes. Total participation more than doubled from 69,000 in July 1995 to 195,000 in December 1996.¹³ Prior to this increase, the state was concerned that BHP participation levels were much lower than expected (compared with estimates of the number of uninsured and relative to funds available in the Health Services Account), so it reduced premium levels to boost participation. This strategy was successful. However, the state particularly wanted to increase participation in employer-sponsored BHP plans, but it found that employers were slow to join. Washington based its budget appropriation on expectations that there would be about 100,000 individual members and 100,000 employer-sponsored members; the number of individual members is higher than expected but the number of employer-sponsored members (about 700) is much lower than hoped. Some hypothesize that this is because employers know they can let their workers join as individuals, which only costs a fully subsidized individual \$10 per month, and incur no employer liability at all. In addition to making it easier for employers to offer employment-related health insurance, the state had planned on employer contributions reducing the necessity for state subsidy dollars.

The high ratio of individual to employer-sponsored members led to the exhaustion of appropriated BHP funds by the end of 1996. Still, the state did appropriate enough funds for 8,000 more enrollees in the 1997-99 biennium, and this expansion in a general time of fiscal retrenchment is a reflection of the bipartisan support the BHP has in Washington. Support for the BHP is wide because many lower-income working class people of all political persuasions are insured through it. And support is deep because it is not free to anyone—payments are based on a sliding scale for those who can pay more—and the plans are commercial plans with private enrollees. The total number of BHP participants today is about 195,000, with 130,000 being subsidized by the state. The remainder represents individuals who pay the full premium (13,000) or children who are eligible for and financed by Medicaid (52,000).

High-Risk Pool

The state created a high-risk pool in 1987 that allows individuals denied coverage to buy standard policies at 150 percent of the average premium charged by the six largest carriers. All carriers, whether they sell in the individual market or not, are assessed in proportion to their total premium revenue to cover the losses in this high-risk pool. Since the 1994 expansions of the BHP, enrollment in the high-risk pool has dropped from more than 4,000 to fewer than 1,000 persons. Assessments average about \$2,100 per high-risk enrollee; thus, about \$2.1 million was assessed on total health insurance premiums sold in 1995 of over \$4 billion.¹⁴ This amounted to less than 0.05 percent of commercial insurance business as a whole. The shift of former high-risk pool enrollees into the BHP has raised some concern about adverse selection effects there, but as of December 1996 there has been no directly attributable effect on BHP

premiums.

Insurance Reforms

Private health insurance markets and regulations affect a large number of citizens. Table 7 reports three basic realities about health insurance coverage for the nonelderly in Washington and in the United States as a whole. First, there are more people between 100 and 200 percent of the federal poverty level (near-poor) than there are below it (poor). Second, more low-income (poor and near-poor) citizens in Washington and in the United States have private insurance than have Medicaid. Third, about a quarter of all low-income nonelderly individuals are uninsured. Since 85 percent of the uninsured have at least one worker in the family, most are likely to have access to at least one private group offering or to the individual market. Consequently, the rules that affect what types and under what conditions private group and nongroup insurance may be sold will directly affect the health insurance and health care access alternatives of most low-income people in Washington and in the United States as a whole.

While repealing the more ambitious elements of the 1993 law—for example, the employer mandate—the Washington legislature in 1995 and 1996 kept or strengthened some reforms: guaranteed issue for individuals and groups, a three-month limit on preexisting condition restrictions, group-to-group and group-to-individual portability, and modified community rating for small groups (smaller than 50). Each insurer in the individual and small-group markets must offer the BHP-model benefit package to all would-be purchasers. Carriers are required to reimburse enrollees for services rendered by any category of provider (e.g., naturopath or acupuncturist) as long as these services are within their statutorily determined scope of practice and covered by the BHP package. Finally, the (elected) insurance commissioner retained the power to grant or deny premium rate increases in the individual and small-group markets. Overall, Washington is among the nation's leaders in comprehensive health insurance reforms. Compared with the 1993 law, however, this still represents considerable retrenchment.

Recent estimates suggest that between 10 and 13 percent of Washington residents are uninsured.¹⁵ The Health Care Policy Board (HCPB) estimates that about 65 percent of residents are insured through private plans—57 percent through employer-based coverage and 8 percent through the individual market. Thirteen percent have Medicare as their primary coverage, 11 percent have Medicaid, almost 1 percent receive care from the Indian Health Service, and 0.7 percent are insured through the BHP. As many as half of those insured through employer-sponsored plans may be in self-funded plans and outside the reach of state regulators, although this estimate is unavoidably uncertain.¹⁶ Note that all of Washington's new insurance rules affect the individual market and most affect the entire (not just the small-group) commercial group market. They do not affect the market for self-insured plans.

There are three types of health insurance carriers in Washington: health care service contractors (HCSCs), HMOs, and commercial indemnity insurers. HCSCs are Blue Cross or Blue Shield plans. There are now 22 HCSCs throughout Washington, with a combined market share that increased from 41 percent in 1993¹⁷ to 50 percent of the commercial market in 1995.¹⁸ Preferred provider organizations (PPOs) are HCSCs' most popular products in the private market. HCSCs also offer fully capitated products to Medicaid, BHP, and public employees.

HMOs are a separate licensed category of insurer in Washington. There were 10 HMOs operating in 1996, down from 14 in 1994.¹⁹ Group Health of Puget Sound is the largest (15 percent overall market share) and is one of the oldest staff-model HMOs in the country. A number of the newer HMOs are owned or controlled by indemnity insurers or by Blues plans. Most HMOs in Washington (7 of 10) offer products in the individual market as well as the group market. HMOs have about 32 percent of the commercial market.²⁰

Most pure indemnity insurers are disability insurers in Washington, selling with a life and disability insurance license. The Office of the Insurance Commissioner lists 16 "major" indemnity carriers in its current brochure for insurance purchasers. It is difficult to estimate their share of the market, since current reporting requirements allow them to combine the premiums of many products (disability, accidental death, Medicare supplements, long-term care) with comprehensive health insurance premiums. Most observers think they comprise less than 20 percent of the commercial health insurance market and that their share has been declining over time.²¹

The small-group market appears to be working reasonably well in the wake of the reforms. Of course, 1996 was the first year of modified community rating, so perhaps more of an effect will be felt than is currently anticipated. The general level of competition among carriers appears to be high, partly because of favorable prices resulting from excess capacity in hospital beds and specialists, as exists in many other areas of the country. For HCSC and HMO products combined, commercial premiums per enrollee rose only 0.3 percent between 1994 and 1995.²² The HCPB surveyed small businesses (less than 50 employees) in 1996, and 63 percent reported no change in their premiums from the previous year when no reforms were in place. Seven percent dropped health insurance coverage, 29 percent had rate increases of 1 percent to 25 percent, and 1 percent had rate decreases.²³

Currently, by far the greatest concern about health insurance in Washington state is focused on the individual market. Carriers are worried about adverse selection, particularly in response to the new guaranteed issue requirements and limits on preexisting condition restrictions. Requests for rate increases have turned into protracted battles with the insurance commissioner. Tensions are always high in these cases, but these fights are intense by any standard. The insurance commissioner was recently reelected by a 52-48 margin, and her actions in the individual market were much discussed in a very hard-fought campaign. Threats to pull out of the individual market have been voiced, and some analysts are concerned that stability in this market may yet be a long way off.

The HCPB conducted a study of the individual market, which focused on the six largest carriers.²⁴ The HCPB concluded that the carriers lost \$58 million on the individual market in 1995, compared with losing \$21 million in the large-group market and making \$22 million in the small-group market. Worried about the long-run stability of the individual market, the HCPB recommended that the state adopt mandatory reinsurance to stem the losses in this market.

Health Insurance Market Prospects

Washington uses managed competition theory and practice to advantage for the public employee and BHP programs. Aggressive competitive bidding for Medicaid capitation contracts may soon be the norm as well. Managed care is well established and accepted, although PPOs, not HMOs, appear to be the most popular products, judging by recent growth.

The perceived competitive need to keep premiums down explains the widespread concern over legislated benefit mandates (e.g., any category of provider, women's direct access to specialists). Each plan fears the mandates will hurt them more than their competitors. In general, there is a sense that the really fierce competition has not begun yet, but the day of reckoning is widely perceived, at least by health plans, to be close at hand. By extension, the provider community is wary, for cutthroat health plan competition will only depress service prices more and increase the stringency of utilization controls. An interesting development that will be watched closely is that Boeing, long a self-insured employer, this year offered its workers a choice of a commercial HMO product and provided a strong financial incentive to select the HMO plan. This signals a belief that some commercial market products in Washington are proving at least as successful at containing costs as self-insured arrangements.

Many actors in Washington, in particular the Office of the Insurance Commissioner but also

the Health Care Authority, Department of Social and Health Services, and Department of Health, are developing health plan quality standards and reporting requirements. Concerns over quality may very well be the mechanism to level the playing field of competition among different types of health plans. Quality reporting requirements may also be the path by which ERISA (self-funded) plans are brought back under the partial jurisdiction of state insurance regulators; for as managed care grows, concern about quality assurance and improvement, as well as physician incentives to undertreat, will grow as well, at least until quality reporting standards are institutionalized and accepted.

Delivery System and Medicaid Hospital and Physician Payment Rates

Managed care has long had a substantial presence in Washington with Group Health of Puget Sound, one of the first and largest staff-model HMOs in the country. HMOs as a group cover about one-third of the commercially insured population. Selective contracting is a standard competitive technique HMOs use to manage costs, and its use typically expands with growth in HMO market share. The provider community expects competitive pressures to be even more intense in the future and is preparing for that day through cost-reduction strategies, mergers, and alliance formation with complementary providers and health plans. This process has been accelerated by the need to construct partners to qualify for capitated Medicaid managed care contracts, especially for community health centers and teaching hospitals.

At the same time, the entry of for-profit hospital chains has been minimal, although rumors about negotiations with them abound. In general, there is considerable bracing for the expected shakeout to come.

Medicaid and state purchasing power generally have played an important catalytic role in the transformation of the Washington health care delivery system. The decision to move most Medicaid enrollees into managed care plans was made in the early 1990s, with implementation beginning in 1993; this change reflected a philosophical shift from "paternalism to purchaser." Today, 380,000 Medicaid enrollees (of approximately 660,000 noninstitutionalized beneficiaries) are in fully capitated, closed-panel managed care organizations (MCOs).²⁵ Another 195,000 Washington residents are insured through MCOs participating in the BHP. Finally, 225,000 public employees, dependents, and retirees are enrolled in MCOs through the state's Public Employees Benefits Board, and 59,000 are enrolled in the state's own self-insured PPO. Thus, more than 800,000 Washington residents are in more than 25 managed care plans purchased or administered by the state. This compares with approximately 3.7 million residents covered in the Washington commercial insurance market overall, and a total state population of 5.3 million. The state accounts for well over one-third of all of Washington's considerable managed care enrollment; thus, its potential leverage over health plans and the ultimate shape of the health delivery system is considerable.

All health delivery systems are local, and Washington's can be characterized as (1) the Seattle/Tacoma metropolitan area; (2) a few distinct mid-sized cities (Spokane, Olympia, Yakima, Walla Walla, Richland/Pasco/Kennewick); and (3) everywhere else. Outside the Seattle area, most communities have only one hospital, but three-quarters of the state's population live in counties in which hospital competition is possible. Competition has been increasing in intensity lately, as in other markets around the country. Competition is often fiercest where there is an excess supply of hospital beds. While Washington has the second fewest beds per 1,000 persons in the nation, admission rates are very low and lengths of stay are short. Thus, although Seattle's occupancy rates are slightly higher than the national average, many local observers consider that market to be in excess supply by about one-third.

As in many modern health care marketplaces, mergers among providers have occurred and

may be increasing in Washington. Some mergers may reduce redundancies, increase clinical integration, and increase overall efficiency, while others are more likely to increase the market power of the merged entities and reduce competitive pressures in the long run. Mergers among hospitals and conversions of nonprofit hospitals to for-profit status, especially amid a systemwide drive toward cost efficiency, also raise questions about continued commitments to community-based uncompensated care, a vital element of the health care safety net anywhere there are large numbers of uninsured people.

In general, HCPB staff are satisfied that the Washington health service markets are competitive and that so far the operating joint ventures do not appear to be a vehicle for general price fixing. The state passed a nonprofit conversion process law in the spring of 1997. Nonprofit conversions are not a major issue yet, despite considerable speculation (and fear) that for-profit hospital chains are poised to make a major move in the Seattle market.

Medicaid Reimbursement for Inpatient Hospital Care

While most Medicaid beneficiaries, especially mothers and children, are in managed care plans, most Medicaid expenditures take place in fee-for-service (FFS) arrangements, on behalf of aged, blind, disabled, and other adults. Two of the largest FFS expenditure categories are inpatient hospital and physician care (25 percent and 12 percent of total medical assistance payments in FY 1995, respectively). We discuss them in turn.

Two factors affect inpatient hospital reimbursement for those under the FFS system. First, a settlement agreement between the state and the Washington State Hospital Association from a Boren amendment lawsuit in 1991 shapes payment policies. Second, the state has a selective contracting system for hospitals in many areas of the state. The state believes that its payment rates are generally adequate relative to cost. While hospital representatives did not necessarily concur, they did not protest vigorously either.

Medicaid uses three principal payment methods for inpatient hospitals:²⁶ (1) a regular Diagnosis-Related Groups (DRG) system (called PPS-4), (2) a modified DRG system used for hospitals under the selective contracting system, and (3) a ratio of cost to charges system used when the first two do not apply.²⁷

The selective contracting system governs about 55 percent of hospital payments and applies to eight selective contracting areas of the state, which include Seattle and most major cities. Thirty-one hospitals (of 90 nonfederal community hospitals in the state) participate. Hospitals bid a DRG conversion factor. Overall, the state estimates about 8 percent to 10 percent savings through the selective contracting system but acknowledges that it could probably extract more by accepting only the lowest bidders. Recent policy has been to refrain from such aggressive purchasing behavior.

PPS-4 covers most of the hospitals outside the selective contracting system. Per the Boren amendment settlement agreement, hospital-specific DRG conversion factors are computed in a multistep fashion, which includes historical cost data, including Medicaid costs, indirect medical education adjustments, caps based on hospital "peer groups," and outlier adjustments. Factors are updated using the Data Resources Incorporated health care cost index.²⁸ There is an additional outlier payment pool.

The ratio of cost to charges method is used for certain hospitals outside the DRG system, or for procedures not included in the system. Hospitals paid this way include out-of-state, military, and psychiatric hospitals, among others. A few services—such as certain neonatal, AIDS-related, bone marrow transplant, and chemical dependency/alcohol treatment—are also exempt from the DRG system.

Data from the American Hospital Association (AHA) indicate that Medicaid payments have improved greatly since the Boren amendment settlement, although in 1993 they still appeared

to average only 88 percent of costs in Washington compared with 93 percent of costs nationally.²⁹ The AHA data are not perfect, particularly because of changes over time concerning provider taxes and DSH programs, but they provide at least a rough view of Medicaid payments to hospitals. A representative from the state hospital association indicated that the level of Medicaid payments was not viewed as a serious problem compared with major discounts that were being required in private health insurance. It seemed that recently negotiated private payment rates were still generally higher than Medicaid rates but occasionally fell below Medicaid levels. (Sometimes Medicaid rates have been used as benchmarks for negotiating private insurance rates, since the firms can point to Medicaid rates as rates previously accepted by the hospitals.) If the Boren amendment were repealed (which did occur), one state official felt that the state would probably try to reduce hospital rates slightly but not substantially. There is still a general reluctance to maximize leverage from state purchasing power, out of concern for the long-term consequences of reducing the number of provider participants in Medical Assistance Administration programs.

Physician Reimbursement

Since 1993, the state has used the Medicare Resource-Based Relative Value Scale to pay physicians on a fee-for-service basis, although the state does not use the Medicare conversion factors. Based on earlier analyses of 1993 rates,³⁰ the state paid 89 percent of Medicare rates on average.

Updating the conversion factors is based on legislative fiat. The legislature sets "vendor payment" rate increases that apply across the board in a variety of areas, including home care or job training. In the 1995-97 biennium, the rate increase was 2 percent per year. MAA may deviate from these as long as rate changes average 2 percent. They have deliberately increased payments for OB/GYNs and pediatricians at a much higher rate (about 5 percent per annum), while other physicians' rate increases were held below 2 percent. The state believes that Medicaid payments to OB/GYNs and pediatricians are now competitive with private payment rates.

The staff of the Washington State Medical Association consider Medicaid to be a poor payer and assert that fee-for-service payment levels are about 50 percent lower than private market levels. However, their larger concern is the growth of managed care in general and its implications for physicians.

Disproportionate Share Hospital Payments

Medicaid's DSH program was designed to provide financial relief to hospitals that serve large numbers of low-income patients, on the theory that hospitals often lose money on them, even if they are covered by Medicaid. Specific payment formulas allow states to earn federal matching funds for DSH payments, and hospitals in turn can be at least partially reimbursed for delivering such care. Washington uses several Medicaid DSH programs to address various needs. In general, its goals have been to assist certain hospitals or to generate surplus funds for the state to support non-Medicaid medical services, including the state-only Medically Indigent and GA-U (General Assistance-Unemployable medical assistance) programs. Table 8 presents national data on DSH expenditures for Washington and the United States from 1988 to 1995.

Acute Care DSH Payments

Since 1990, there has been a "regular" DSH program that distributes \$30 to \$35 million per year to assist hospitals serving higher than average volumes of low-income or Medicaid patients. The state share of the payments comes from the general fund. Since 1992, this program has received a relatively small fraction of total DSH payments; in 1996, it constituted about one-tenth of all DSH payments.

There are three other acute care DSH programs (initiated in 1992 or 1993):

- The Medically Indigent program, which uses local funds (intergovernmental transfers) for the original state share of payments. The program payments are essentially uncompensated care payments for uninsured patients with high inpatient costs (there is a \$2,000 deductible).
- The GA-U program, which also uses local funds for nonfederal payments. The surplus generated from federal funds in excess of those needed for some patients supports medical insurance for GA-U recipients.
- The Small Rural Hospital Assistance Program, which uses intergovernmental transfers from public rural hospitals to generate a federal match for DSH payments to rural hospitals.

These three programs totaled about \$32 million in 1996, also about one-tenth of all DSH payments.

In 1992 and 1993, before the 1991 federal legislation that placed restrictions on the DSH program was fully implemented, the state also had four short-lived DSH programs: the Harborview Medical Center donation program, the Children's/Mary Bridge donation program, a hospital settlement program (related to the 1991 Boren amendment lawsuit), and a Medicaid tax and donation program. These programs were eventually declared to be in violation of federal DSH reform law, which banned donations, restricted the use of provider taxes, and limited federal DSH payments to 12 percent of the state's medical assistance payments. Since 1993, the state has tried to ensure that it receives no less than the maximum allowed percentage and has created new programs to replace those declared invalid. This allows the state to continue helping certain public hospitals (especially Harborview, the largest public hospital in Seattle, and state psychiatric hospitals) and to maintain other programs with minimized net state dollars.

In 1996, the implementation of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) requirements created a new problem for the state's DSH programs. Because DSH payments, under OBRA 93, cannot exceed hospitals' documented losses on uncompensated care and Medicaid, the level of DSH funds that can be disbursed to some hospitals is curtailed.

The state believes that its DSH programs are legitimate, because they are primarily used to help targeted hospitals, such as Harborview, or to earn surpluses to fund other state medical assistance. Washington does not use DSH money for nonhealth purposes, as some states have been accused of doing. Yet some people in the state acknowledge that money is fungible, so that easing pressure on state health care spending ultimately helps other sectors of the state's budget. While the new limits imposed by OBRA 93 will require some adjustments by the state, this is viewed as a manageable problem.

Mental Health DSH Payments

The Mental Health Division of the Department of Health and Social Services (DSHS) is responsible for all payments to three state-owned mental health hospitals (two adult hospitals and one pediatric hospital). MAA handles the relatively few DSH payments made to six private mental health hospitals in the state. There is some coordination of DSH payments between the two DSHS agencies, to ensure that the state obtains the maximum allowed federal payment.

The mental health DSH program began in 1992; the goal was to cover uncompensated care costs of state psychiatric hospitals. Total mental DSH payments were approximately \$103 million in FY 1996 and a similar amount in 1997. These DSH payments go to the two adult mental health hospitals as single annual payments; the pediatric facility receives regular Medicaid payments. The level of DSH payments was much higher in 1995 (as shown in table

8), because OBRA 93 permitted, on a temporary basis, states to pay up to 200 percent of uncompensated care costs.

Overall, the three state mental hospitals have a 1996 budget of around \$140 million, of which about \$120 million is state and federal Medicaid funds and about \$20 million is a combination of Medicare, patient collections, and private insurance (which includes Medicare deductibles and Medicaid spend-down). Thus, federal DSH funds have become very important to the state as a means of covering well over half the total cost of the state mental health hospitals. Medicaid DSH payments are particularly important for adult mental health hospitals; their services were traditionally totally state funded before the Medicaid DSH program because federal law bars regular Medicaid coverage of mental health inpatient services in psychiatric hospitals for adults 22 to 64 years of age.

Medicaid Managed Care

History and Context

Washington applied for and received a 1915(b) waiver to operate a Medicaid managed care demonstration in 1986. The demonstration project operated in three counties, with approximately 14,000 enrollees. Washington decided in 1992 to expand Medicaid managed care to all counties for the AFDC and pregnant women and children expansion groups. The original motivation behind the move to Medicaid managed care, which predated the comprehensive reform legislation of 1993, was to be able to cover more people cost-effectively, not to save money per se.

Recent Policy

Between 1992 and 1994, about 380,000 Medicaid enrollees were moved from fee-for-service coverage to fully capitated managed care plans. The initial concerns were how to prepare the clients for managed care rules and how to recruit enough managed care organizations (MCOs) to accept capitation for the Medicaid population, to ensure plan choice (a federal requirement and a policy goal of the MAA) and competition in each county. The name of the Medicaid managed care program—Healthy Options—signifies Washington's emphasis on choice for enrollees.

To prepare enrollees, outreach meetings were held in each county. The state also devoted considerable effort to training caseworkers to prepare their clients for the gatekeeping and referral norms of capitated managed care. Medicaid managed care benefit fairs were held in each county at least three months before implementation.

Engendering capitation bids from an adequate number of MCOs in each county was an even larger concern and was addressed with three strategies. First, the state let it be known that premium bids as high as the traditional fee-for-service average cost would be acceptable. This reassured plans that extreme cost pressures would not be forthcoming, at least not until both the state and the MCOs had experience with managed care for the Medicaid population. In the absence of a risk-adjustment mechanism, this was probably necessary, at least initially, to elicit numerous willing bidders. The state did institute incentives for lower bids, but no plan was denied access if it bid the fee-for-service average, which was around \$130 per month for the AFDC population in FY 1995. Second, the state used a three-year grace period granted by the Health Care Financing Administration (HCFA) to avoid the requirement that no more than 25 percent of any health plan's total enrollment be made up of Medicaid enrollees. And third, the state initially sold stop-loss insurance to new MCOs that formed for the purpose of bidding on Medicaid contracts.

The last two strategies allowed a number of community and migrant health centers to band together and satisfy the requirements for prepaid health plans, which permitted traditional providers for the low-income population to continue to serve that population even as the state converted to managed care. At this writing, there are 16 managed care vendors with 19 plans

in the Healthy Options program, and at least two plans are in each of Washington's 39 counties (the average is four). Currently, 90 percent of the state's primary care providers participate in Healthy Options plans, so access would not appear to be a problem for Medicaid enrollees. If capitation rates are substantially cut in the future, of course, plans and providers may drop out, but that outcome is not anticipated at present.

Benefit Package

The Healthy Options benefit package is more generous than the Basic Health Plan benefit package: It includes dental and vision services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and transportation. Medicaid also pays for a number of services (e.g., inpatient mental health care, substance abuse services, interpreter services, and transplants) on a fee-for-service basis outside the Healthy Options plans. Adult mental health services are capitated and coordinated through Regional Support Networks. The state plans to include inpatient mental services in the capitated rate in 1997. Overall, the combined benefits package is quite generous.

Enrollment

The enrollment process is central to how effectively a Medicaid program reaches its target populations. Upon eligibility determination, two Healthy Options information packets are mailed to the beneficiary, with a two-week interval. If the client declines to submit a preference for a particular plan within a month of the first mailing, the Healthy Options program assigns that person to a plan. Plans with the lowest bids receive the most assignments. About 40 percent of all enrollees are assigned. This rate is perhaps inflated by children, new family members, and those who cycle in and out of Medicaid eligibility. About 15 percent of longer-term Medicaid enrollees are assigned. After assignment, enrollees have two weeks to select a different plan, and they can disenroll from or enroll in plans monthly. Still, the program observes relatively little plan switching.

Plans are not allowed to market directly to clients, although providers may advise patients about different plans. There is a toll-free enrollment phone line, and enrollment forms and counselors are available in 21 languages. Plans must supply each member with a handbook that lists providers and facilities, including local "essential community providers."

Interaction with Other State Programs

Children under age 19 in families eligible for BHP subsidies (incomes at or below 200 percent of the federal poverty level) are enrolled in BHP Plus, a Medicaid program. They remain members of their parents' BHP health plan to preserve continuity of care and familiarity with providers. Medicaid simply pays the premium costs for these children. Also, pregnant women eligible for BHP subsidies are enrolled in Healthy Options plans, because the premium costs for these women will be shared with the federal government. This cross-enrollment requires coordination between MAA and the Health Care Authority. The agencies now use almost all the same vendors, and coordinate their site visits to the MCOs and MCO reporting requirements. A condition of being a BHP vendor is that one must bid for Medicaid contracts and supply BHP Plus products, although it is not clear that any health plans would avoid Medicaid without this constraint.

Some Medicaid clients have unique needs; these clients include homeless, illiterate, and non-English speaking persons. Contract decisions for 1996 favored plans with enhanced enrollee education and health promotion activities that address some of these unique needs. In addition, incorporating essential community providers into their provider networks earns plans points in the request-for-proposals process. Rural Health Clinics and Federally Qualified Health Centers that participate in Healthy Options receive cost-based reimbursement.

Capitated Rate Setting

Plans bid for Medicaid contracts, but until 1997 all or most bids were accepted. Rates are bid by eligibility group and adjusted by MAA for age and sex. Again, the state was originally more interested in building capacity to provide Medicaid managed care services than in saving money. And, in the absence of widely available, clinically meaningful, and auditable outcomes data, encouraging more than one plan per county may have been a wiser client protection strategy than a low-bidder-takes-all approach. In any event, the state made it clear that bids at the fee-for-service average cost level (for the Healthy Options population) were acceptable. Most bids were apparently at or near this level, based on historical claims data and actuarial projection techniques. As more of the Medicaid population has moved into managed care plans, the fee-for-service claims data that supported this benchmark calculation are no longer available or relevant. This, plus a strong legislative interest in saving money, has led Healthy Options to study a competitive bidding process. The Washington legislature commissioned a study that strongly recommended adoption of a low-bidder-take-all strategy and predicted that this could save Healthy Options 20 percent per enrollee within a few years.³¹ Most analysts think 20 percent savings is unlikely without significant reductions in the Medicaid benefit package. Also, winner-take-all bidding could drive some plans out of business altogether, which could reduce competition in the long run. The state has not decided yet whether to adopt the recommendation.

Quality

Capitation generally, and the prospect of low-bidder-take-all capitation especially, has heightened concern about how effectively the state can monitor the quality of care delivered to Healthy Options enrollees. Medicaid has responded to this concern in a number of ways. First, the contract imposes certain outcomes reporting requirements on Healthy Options vendors, although not all plans have the information systems to permit full reporting yet. Healthy Options has brought Department of Health staff into the vendor proposal evaluation process to help sharpen the focus on quality of care issues. Healthy Options is conducting a provider survey to assess, among other things, the extent to which providers feel new financial arrangements are affecting decisions about care; it will use the results of this survey in negotiations with specific health plans. Healthy Options, BHP, and Department of Health personnel conduct joint, yearly health plan site visits to assess the quality of care. An Oregon clinical quality control firm has been retained to evaluate outcomes of Healthy Options plans in three areas: obstetrics, immunizations, and EPSDT. The overall results of an initial evaluation were fairly impressive, but there is still enough variance in outcomes for officials to be concerned. The Healthy Options program is an active participant in a very ambitious interagency quality assessment and improvement effort that will make recommendations about a common set of reporting requirements that would be required of all state vendors. This effort complements the rule drafting efforts under way at the Office of the Insurance Commissioner that would standardize network adequacy, quality assurance, and reporting requirements across all types of private health insurers in Washington.

Medicaid Managed Care Issues for the Near Future

Two issues are paramount. First, the state intends to move the SSI population into capitated health plans by 1998. (The original target date was 1996; it was pushed back because neither the state nor the vendors were ready.) This beneficiary group is much more complicated to serve than the AFDC/pregnant women and children population that now makes up the bulk of Washington's Medicaid managed care enrollees. The state does have a managed care SSI demonstration project under way in Clark County. No doubt partly because of the considerable resources devoted to the Clark County experiment early on, it now has 75 percent voluntary selection and 25 percent assignment in its SSI managed care plans. Since vendors are naturally very concerned about adverse selection with the SSI population, the state wants to risk-adjust these contracts. Part of the reason for the postponement from 1996 to 1998 is to take the time to develop an effective risk-adjustment mechanism.

The second major issue for the future is cost containment. Initiative 601 now requires reductions in the rate of growth of spending out of the general fund. Medicaid managed care is

a candidate for savings. Medicaid has the bargaining power to achieve some—perhaps significant—savings, at least of a one-time nature, by negotiating lower prices with managed care plans. Whether cost reductions can be sustained over many years by reducing the volume and intensity of services is a question many Medicaid managed care programs will be asking themselves in the next few years. What is clear is that there are costs to cost reductions. The first cost is that low-bidder-take-all strategies will limit the choice of plans in each area and will require a precision of quality monitoring that some doubt is feasible right now. This could jeopardize public acceptance of a strictly competitive strategy. Some officials would prefer to pursue a strategy of "cost reduction with a human face." By that they mean that the state as a purchaser must be mindful that pieces of a health care delivery infrastructure that go bankrupt are not likely to come back. Since some of the high-cost pieces of that system are precisely those providers who have served the low-income and Medicaid populations faithfully over the years, the state should be careful about driving as hard a bargain as it arguably could in the near term. Whether this strategy will yield sufficient savings to satisfy the political forces calling for savings remains to be seen and probably depends on many forces outside the control of the Medicaid managed care program.

Delivering Health Care to the Uninsured and Low-Income Population

State and Local Public Health Departments

The Department of Health (DoH) consists of several divisions that carry out a broad scope of public health activities, ranging from traditional population-oriented activities to direct services. The total budget was \$446 million in the 1995-97 biennium; the majority of the funding is for community and family health (64 percent), including the Women, Infants, and Children (WIC) program and Maternal and Child Health (MCH) programs, and for health systems quality assurance (14 percent). Overall, federal funds underwrite 53 percent of DoH programs and well over two-thirds of community and family health programs. The DoH receives 63 federal categorical and 2 federal block grants (Maternal and Child Health Services Block Grant and the Preventive Health and Health Services Block Grant). The single largest federal payment by far is for WIC: more than \$130 million in the biennium.³² Most of these federal dollars, as well as state funds, are transferred to local health departments through a consolidated contract between the state and the local health departments.³³

Much of the work of the Washington State Department of Health, both program design and delivery, is carried out by the 36 local public health departments.³⁴ Most are organized along county or multicounty geopolitical lines, but three are county-city health departments, including the Seattle-King County Health Department, which serves over 30 percent of the state's population. Almost half the state's local health departments serve jurisdictions of less than 50,000 persons and have average annual budgets well under \$1 million.

As important as state and federal pass-through grants are to local health departments (25 percent of the typical budget), in 1992-93, the largest single share of funding (34 percent) was from local tax revenue. Medicaid dollars, both federal and state, constituted another 8 percent of local health departments' budgets, and direct (non-pass-through) federal grants accounted for 4 percent.³⁵ Local health departments are expected to coordinate with the Medical Assistance Administration to maximize the draw of federal Medicaid matching funds. In some cases, local health departments must provide matching funds for Medicaid-eligible services.

Local health departments have for the past 30 years served as safety net providers in many communities, especially for uninsured or Medicaid-covered women and children. However, this has begun to change. Even though the legislative commitment to universal coverage was

short-lived, the state remains committed to shifting the emphasis from local health department delivery of health services to the Public Health Improvement Plan (PHIP). This DoH initiative outlines 88 standards that local health departments must seek to fulfill, with a proposed six-year phase-in period. The standards fall into the categories of community health assessment, development of public health policy, ensuring community access to quality health care services, protecting the community against public health threats, and promoting health within the community. In the future, these standards will serve as the basis for contractual arrangements between the state and local jurisdictions (i.e., performance-based contracting). To support this effort for 1995-97, \$15 million from the Health Services Account was earmarked for local health departments.

Maternal and Child Health

The MCH program is one of the largest in the Division of Family and Community Health. In 1995, the budget was more than \$25 million for the Maternal and Child Health Block Grant Program alone, which included programs for children with special health care needs, maternal and infant health, and child and adolescent health. Federal block grant funds increased by 23 percent (in nominal terms) from 1989 to 1995.³⁶ Over this period, the state used Health Services Account funds (e.g., for a teen pregnancy project and immunization program) and Medicaid to minimize the drain on general fund revenues. The state qualifies for federal Medicaid dollars via intergovernmental transfers to local public health jurisdictions: State general fund money is passed through to health departments, which in turn expend it on Medicaid-eligible services and thereby qualify for a federal match. This is called leveraging state dollars or Medicaid maximization, depending on one's point of view. Because of Medicaid expansions and BHP, the MCH program is funding fewer well-child clinics and is instead assuming monitoring and assessment responsibilities as well as case management of children with special health care needs, many of whom will be enrolled in managed care when the SSI population is enrolled. The MCH program also provides some gap services not covered by Medicaid to children with special needs. In general, financial commitment to the MCH program has been bipartisan.

The Safety Net in Seattle

Safety net providers are institutions that, by statutory or self-defined mission, provide a significant amount of free care to uninsured or underinsured persons. Although Seattle-King County is a well-off community with a strong economy, it also has a large absolute need for subsidizing its health care safety net. Seattle-King County is a relatively high-income area³⁷ with a relatively low poverty rate.³⁸ But it has 30 percent of the state's population, which includes 25 percent of the state's poverty population, or 157,314 people in 1993. Seattle-King County also has the largest nonwhite population in the state, 18 percent overall, of which 11 percent are Asian and Pacific Islanders.³⁹ Minorities and the low-income population (those with household incomes below 200 percent of the federal poverty level) are at the greatest risk of being uninsured and are most likely to need uncompensated medical care.

In Seattle, five hospitals,⁴⁰ the local health department, and eight Federally Qualified Health Centers (FQHCs) provide a significant share of care to the low-income population and together form a safety net of health care services. Community, migrant, and homeless health clinics—FQHCs and FQHC look-alikes—provide many primary care services to the safety net population. FQHCs also serve very specific multicultural populations that some private providers and physicians may not serve as well. Unlike many other local health departments in the state, the Seattle-King County Health Department has maintained its role in providing primary care services, especially in low-access areas within King County.

Expansions in insurance coverage through the Medicaid and BHP programs have reduced the demand for free care from safety net providers all over Washington. As a result, the amount of services that they can provide has grown, and the safety net providers are considered either adequately financed or, at least, better off financially than in the past. Part of the safety net

providers' recent good fortune is a function of their ability to maintain or increase their share of the newly capitated public market.

Medicaid managed care has provided safety net providers with significant incentives to develop cost-effective managed care products or to affiliate themselves with organizations that provide managed care products. Interviewees indicated that the movement toward managed care forced providers to find new ways of internally managing care in a cost-effective manner, create networks of providers that can serve as a primary care referral base, establish health plans, or affiliate themselves with existing health plans.

While managed care is sometimes feared and loathed in the low-income advocate community, Medicaid and BHP managed care in Washington have helped efficient safety net providers in Seattle-King County that formed or joined Medicaid and BHP managed care plans because they are able to keep the residual. Capitation pays a fixed amount per person, which to date has been pegged to a fee-for-service average (for Medicaid), and the health plan is responsible for providing reasonable care for that fixed amount per person. But if services can be delivered for less than this payment, the health plan keeps the savings, the residual. Under fee-for-service payment, Medicaid would keep the savings from reduced utilization or lower provider payment rates. These savings can now be used by safety net providers that have formed their own health plans to finance additional services for the uninsured. But there are fewer uninsured persons than in the past, so the safety net providers, in general, are feeling less strained than they have in the past and less strained than many of their counterparts in other parts of the country.

Part of this lack of strain has to do with the virtual monopolies that Harborview has on trauma and some tertiary care and that Children's has on all pediatric secondary and tertiary care, and the excellent reputations of both hospitals. At the same time, the community health centers in Seattle that joined together to bid for Medicaid and BHP contracts enjoy a client base that became insured with a capitated payment attached practically overnight. Financial success has clearly rewarded those safety net providers that established affiliations with specialists and hospitals. Overall, the safety net is financially stable, and while advocates indicate that there are some problems for very specific subgroups, access to care is adequate for the vast majority of Seattle's low-income population.

Long-Term Care

The Elderly and Functionally Disabled

Long-term care services for the elderly and functionally disabled adults are administered by the Aging and Adult Services Administration (AASA) in the Department of Social and Health Services. As of fall 1996, AASA served more than 37,000 clients: ⁴¹ percent in nursing homes, 47 percent in their own homes, and 12 percent in community residential care.⁴¹ The agency's 1995-97 budget is \$1.58 billion, approximately half of which is derived from federal funds—primarily Medicaid. Over the past decade, "real" AASA expenditures have doubled, growing twice as fast as the total state budget, mostly because of increasing costs per person served.⁴² Two-thirds of AASA's budget is allocated for nursing homes.⁴³

Despite the fact that growth of Medicaid long-term care costs has moderated, expenditures per elderly recipient remain high—\$8,489 in 1995 versus \$7,238 for the nation overall. Table 9 shows that Medicaid long-term care spending for the elderly is mostly for nursing home care: 93 percent versus 6 percent for home and community-based care. In contrast, 43 percent of Medicaid long-term care spending for the disabled is for home and community-based care versus only 16 percent for nursing home care.

The state continues to place a high priority on enabling the elderly and functionally disabled to

avoid nursing homes if possible, both to respond to client preferences and to save public dollars. Overall, waiver programs are the state's primary vehicle for providing nonfacility options to long-term care recipients. In 1994, 71 percent of Medicaid home and community-based care expenditures were on waivers, while the remainder paid for the optional services of personal care and home health.⁴⁴ The state's main Medicaid home and community-based care waiver—Community Options Program Entry System (COPES)—serves 8,900 elderly and disabled recipients. COPES offers adult residential care, adult family home care, assisted living, personal care, and case management.⁴⁵

There is some evidence that the shift away from nursing home care has reduced the state's overall long-term care costs.⁴⁶ It has certainly reduced the number of recipients who are in a nursing home and the number of nursing home beds (slightly), and increased the number of residential care facilities and home health agencies considerably.⁴⁷ At the same time, the state is mindful of the need to remain steadfast in its pursuit of quality standards and care coordination. In particular, the state is trying to strengthen case management at the point of hospital discharge and further develop residential and nursing facility case management.

A rapid and sustained rate of growth of home care costs for the elderly and functionally disabled has led to some fears that the "woodwork effect"—more generous policies inducing people to seek home health services that they would not have sought if institutionalization were the only alternative to family care—will lead to high-cost growth. So far, there appear to be net savings, primarily because home and community-based services are much cheaper to provide—perhaps by as much as two-thirds—than nursing home stays.⁴⁸ Still, conclusions regarding program savings remain debatable, and varying opinions are held by state officials and stakeholders.

The state's goal is to further reduce its nursing home Medicaid census to 12,000 by July 2003.⁴⁹ Partly due to certificate-of-need policies for nursing home beds (which raise barriers to entry and expansion of nursing home providers), Washington has been able to hold nursing home beds per 1,000 elderly to only 46 versus a national count of 53 beds per 1,000 elderly.⁵⁰ At the same time, AASA's assisted living caseload grew 106 percent.⁵¹ It should be noted that access to nursing home care, even for Medicaid patients, has apparently not presented a problem.

While Initiative 601 has led to talk of seriously restricting the growth of nursing home payment rates, they are currently viewed as at least adequate and perhaps generous vis à vis other states. Payment reform (shifting from simple cost-plus to case-mix adjusted fee-for-service payments) is scheduled for implementation in 1998. Selective contracting authority could also help the state place its clients in cost-effective institutions, but the authority has not yet been granted by the legislature. Other strategies, including the integration of acute and long-term care and the promotion of long-term care insurance, have been pursued, but both are in the early stages of development.

Younger Persons With Disabilities

The Department of Social and Health Services houses the Division of Developmental Disabilities (DD) and the Division of Mental Health (MH). At least three broad approaches to delivering and financing services for the DD and MH populations are being pursued by the department: (1) community-based care, (2) managed care, and (3) maximized federal support. Perhaps the clearest indication of Washington's strategy for the disabled is the increase of the ratio of Medicaid home and community spending on the blind and disabled to Medicaid Intermediate Care Facility for the Mentally Retarded (ICF-MR) spending on this same population: The ratio increased from 0.26 to 1.52 between 1990 and 1995.⁵² The impact of the state's efforts is also apparent in the ongoing closure and downsizing of state institutions for persons with mental illness.

Developmental Disabilities

The Division of Developmental Disabilities operates and funds residential and other support services for more than 23,000 eligible clients, which represents an increase of nearly 3,000 since 1994. The fastest-growing segment of the population being served is children, a group that has increased at an average rate of 11 percent over the past five years. Overall DD caseload growth exceeds 7 percent, which exceeds Initiative 601 limits. The division is essentially an arm of the Medicaid program, as almost 43 percent of its budget is composed of federal matching funds.

Legislation was enacted that requires any savings from deinstitutionalization to revert to DD programs. The division has experienced difficulty moving rapidly ahead with deinstitutionalization, in part because of pressure from the strong state employees union that fears job losses and from advocates for the institutions. And state law prohibits moving clients out of an institution against their wishes. Nevertheless, because of the division's reliance on Medicaid dollars to support ICFs-MR, future reductions in the state's Medicaid budget would inevitably speed up deinstitutionalization.

Federal effects on state DD policy are evident in the state's service coverage: Washington has generously funded its three home and community-based waiver programs for the DD population, while those outside the waiver are not provided benefits that could potentially maintain them in their homes. These services include assistive technology and supported living, which do not qualify for a federal match payment. Still, Washington's system of residential services reflects its commitment to placing persons in noninstitutional settings. In 1994, nearly two-thirds of persons in residential settings were in living arrangements with six or fewer beds, compared with only 47 percent for the United States. In 1992, only 40 percent of the state's DD clients were in congregate care settings (including large state-owned facilities) compared with a national average of 76 percent. The majority of clients live in their own homes and receive personal assistance as needed or live in a "foster home" with a person or family unrelated to them.

Mental Health

The Division of Mental Health administers a system of care for adults and children who are seriously mentally ill or emotionally disturbed. The Division of MH is similar to the Division of DD in three main respects: (1) it operates as a branch of the state's Medicaid program, (2) its service orientation is gradually shifting away from providing institutional care to providing community-based outpatient care, and (3) managed care is playing an increasing role in the delivery of its services. In 1995, more than 90,000 persons were served through the division, up from 50,000 in 1990. Although the system was originally designed to serve adults, an increasing number of outpatient clients have been children—29 percent in 1995. Another 13 percent of clients were elderly.

In 1993, Washington ranked fourteenth in the nation in per capita expenditures on mental health.⁵³ The state's ability to successfully draw down federal dollars via the Medicaid program has undoubtedly contributed to the increased spending. In 1985, the legislature instructed the Division of MH to maximize federal funding of mental health, and the division has since obtained federal matching funds for almost all its services. This has led to some substitution away from services and clients not covered by Medicaid, as state resources are required for matching payments. From 1988 to 1992, Medicaid spending on mental health care experienced an average annual growth of 49 percent compared with a 15 percent average annual growth for the nation. Between 1992 and 1994, mental health spending continued to climb at an average of 16 percent per year compared with a 3 percent decline for the nation.⁵⁴

Washington has made significant strides in the treatment of mental illness in community settings. In 1993-95, the state spent 65 percent of its total state mental health program dollars on community mental health, compared with less than half for all states combined.⁵⁵

Washington's most recent budget goes even further, increasing community spending to 69 percent of total mental health expenditures. Community mental health spending includes outpatient care as well as supported housing and residential facilities. Most of the remaining state expenditures are for psychiatric hospitals.

Since 1992—when HCFA made it legal—Washington has used its state psychiatric hospitals to qualify for relatively large DSH payments. In 1992, DSH payments for mental health totaled \$58 million; by 1995, DSH payments linked to mental health were \$176 million.⁵⁶ A portion of these DSH payments support the state psychiatric hospitals; 60 percent of state psychiatric hospital financing is derived from Medicaid, both DSH and other payments.⁵⁷

Regional Support Networks and Managed Care

In 1989, Washington's legislature enacted the Mental Health Reform Act, consolidating outpatient mental health services and granting responsibility for these services to 14 Regional Support Networks (RSNs) that serve one county or contiguous counties. RSNs frequently subcontract with private agencies to deliver services.

Beginning in 1993, the state, through a 1915(b) waiver, began a system of capitated managed care for outpatient mental health services for Medicaid-eligible individuals. Each of the RSNs was awarded the contract to serve as the mental health managed care plan for its region. Enrollment with an RSN is mandatory for all Medicaid beneficiaries, including those not currently mandated to enroll in managed care, for example, SSI recipients.⁵⁸ The RSNs are responsible for all mental health services delivered to this population, with a few exceptions.

In addition to delivering capitated outpatient care, the RSNs also serve as gatekeepers for inpatient care, authorizing the use of state hospitals. Beginning in 1997, the state plans to incorporate inpatient psychiatric care for Medicaid beneficiaries into the RSN prepaid health plan, which requires an additional federal waiver.⁵⁹ State psychiatric hospitals will not be included in the capitation arrangement since Medicaid reimbursement to these hospitals is restricted, as explained above in the DSH discussion.

Opinions vary regarding the effectiveness of RSNs in delivering capitated mental health services to Medicaid beneficiaries. Some Medicaid officials and patient advocates are concerned about the performance of RSNs. Advocates stated that movement toward managed care in mental health has been problematic; they noted that coordination of services has been difficult because of the involvement of many state agencies and vendors who are unfamiliar with the type of care needed for the mentally ill.

Washington's efforts to downsize its state mental hospitals have been propelled through the risk pool agreements it has established with RSNs. The state gives each RSN a target number of bed days it can use. If the RSN meets the target, it receives a percentage of the money saved for use on other programs. If it does not, the state imposes financial penalties. A target was also set for eliminating state psychiatric wards (the equivalent of 30 beds). Four wards have closed thus far, saving the state an estimated \$7.5 million per ward, \$2 million of which was returned to the RSNs. The impact of the changes is apparent in the declining hospital census. Division officials explained that the risk pool arrangement has not changed the number of short-term intensive stays; rather, it has decreased the number of long-term patients in residence in the hospitals.

Challenges for the Future

With plenty of good hospitals and physicians; a strong economy; above-average financial commitments to the poor, near-poor, and safety net providers; and a low overall uninsurance rate, Washington's health care system is currently quite strong. The major challenges for the

future are similar to those faced elsewhere, although the particulars vary: Can Medicaid save enough from managed care and other market-based efficiencies to avoid enrollment or benefit cuts? Can the health care safety net survive aggressive market competition and state budget constraints? Will organized purchasers, public and private alike, be able to ensure that high-quality health care is delivered in the managed health care settings of the future? All these areas will require constant vigilance and may call for policy intervention in the next few years.

Medicaid Savings

How much Medicaid savings is enough? This depends on two somewhat unrelated parameters: the underlying rate of increase in health care costs for the Medicaid population and the sustainability of the political commitment to the spirit of Initiative 601. The growth rate of health care costs is unlikely to be lower than that obtained in the private sector for the nonelderly population, and this minimum rate of growth is unknown. Treatment options for the Medicaid populations, especially the elderly and disabled, could progress in such a way as to lower or raise the minimum Medicaid cost growth rate. This means that however aggressively the state embraces winner-take-all competitive bidding strategies, selective contracting, and mandatory managed care, there is no guarantee that the underlying Medicaid cost growth rate will be less than population growth plus general inflation, as required by Initiative 601. If the Medicaid rolls continue to grow faster than general population growth, the 601 constraints on aggregate state spending out of the general fund will likely force state policymakers to eventually consider reductions in Medicaid enrollment or benefit levels.

If the spirit of 601 is stronger than Washington's traditional commitment to maintaining and expanding access to health care with economic growth, then cutbacks in the Medicaid program will occur. Most likely Washington would reduce benefits (such as adult dental care) as well as provider and health plan payment rates before reducing enrollment growth or enrollment, but the latter could occur if 601 remains in place long enough. If policymakers are unwilling to make these cuts in Medicaid growth, they must cut other programs or increase earmarked taxes (e.g., taxes on tobacco, alcohol, or health providers, which do not go into the general fund). There is no way to predict the exact outcome of this choice, for the world will surely look different in another couple of years after yet another election cycle and perhaps with a different economy. Still, at the present time, it is hard to imagine Washington cutting Medicaid very much. The response of state elected officials to federal welfare reform this spring (restoring benefits for immigrants) suggests the strength of the social consensus regarding low-income programs in Washington.

Federal Medicaid reform in the 105th Congress, especially DSH reforms, could pose a financing problem for a number of Washington state health programs. DSH funding is extraordinarily important to Washington's mental health programs. State officials are clearly currently substituting federal dollars for state funds in many cases. Thus, nonfungible reductions in federal DSH moneys, especially if specifically tied to mental health services, may force Washington to find other state financing sources or reduce services. More state resources may be feasible since Initiative 601 limits would not strictly apply in the case of federal policy changes. But it is not possible to predict how the state will respond to this scenario.

Safety Net Concerns

While the balance of any safety net is tenuous, at present the health care safety net in Seattle is strong. High Medicaid and Basic Health Plan (BHP) enrollment have provided solid funding sources. Community health centers that joined together to obtain Medicaid and BHP capitated contracts have become relatively efficient providers, and they allocate the savings created by that efficiency to services for the uninsured and underinsured. Also, the fraction of the population that is actually uninsured is relatively low in Seattle, a relatively high-income area with considerable philanthropic fund-raising capacity as well. Safety net hospitals such as Children's and Harborview also benefit from unique marketing and quality advantages.

The first threat to this fine balance is genuinely fierce health plan competition. There is a widely perceived surplus of hospital beds and an oversupply of physicians in Seattle. Medicaid is under increasing pressure to generate savings from managed care; it may soon stop paying so generously. At the same time, private employers are increasingly organized and aggressive purchasers of health insurance. This can only reduce payment rates, constraining the ability of providers to cross-subsidize care for the uninsured by charging the privately insured more than costs. This in turn will lead to potentially even stronger competition for Medicaid enrollees, which will make it easier to achieve Medicaid savings at provider expense. Finally, the legislature may be hard pressed to continue to finance BHP expansions: This year's funding for 8,000 new enrollees falls far short of the known waiting list. If the private individual insurance market does not stabilize and the small-group market does not remain stable as a result of the recent reforms, the BHP will become an even more popular choice for Washingtonians. Will the legislature return to its earlier commitment to expand coverage and appropriate money commensurate with waiting list growth over time? Without more financial resources from the state, the percentage of uninsured could increase, placing added pressure on safety net providers. These pressures will be greater, of course, if Medicaid is also cutting enrollment or enrollment growth.

Quality

The cost efficiencies of managed care mean that it is here to stay, but the degree of trust that was inherent, rightly or wrongly, in fee-for-service medicine has proved difficult to transfer. Thus the clamor for outcomes and process quality measurement, reporting, and accountability of health plans and managed care providers. The good news is that the state has been leading the way in this area for its own employees, BHP enrollees, and Medicaid managed care enrollees, and the private sector is learning that it can piggyback on state-induced information and reporting systems. The bad news is that, nationwide, the entire movement is in its infancy, especially for outpatient and chronic care. Organized purchasers, in particular Medicaid, are increasingly called upon to practice selective contracting before the science of clinical outcomes measurement can support refined criteria for selecting. The perceived relative performances of Medicaid, the Health Care Authority, and the private sector in monitoring and maintaining high-quality care over the next few years may have considerable influence on the types of health plans, purchasing strategies, and regulatory frameworks that survive in the long run, in Washington state and elsewhere.

Notes

1. Bureau of Labor Statistics World Wide Web site at <http://stats.bls.gov/lauhome.htm> (1997).
2. Core public health functions include health promotion (e.g., health education) and community health protection (e.g., immunization, infectious disease surveillance and control, water purification, sewage treatment, inspection of food service operations, and environmental quality).
3. These include acupuncturists and naturopaths.
4. Department of Social and Health Services budget documents. State budget totals for medical assistance payments encompass more than Medicaid. They also cover some state-only programs such as general assistance and substance abuse treatment.
5. Table 7.
6. Health Care Policy Board (HCPB) estimates. The HCPB is appointed by the governor and the legislature to monitor, report, and make recommendations about health care policy issues facing Washington.
7. DSHS World Wide Web site (www.wa.gov/dshs/bfacts.html).
8. The state has a separate high-risk insurance pool that caps premiums at 150 percent of the standard rate. Subsidies are funded through a surcharge on insurers. In 1995, about 4,400 people were in the program. By 1997,

fewer than 1,000 remained, and it is believed that many of these people are now in the BHP.

9. Not all of these people may have been eligible for subsidies.

10. Department of Health budget, 1995-97.

11. This report uses the term "low-income" to mean those with income below 200 percent of the federal poverty level. The percentages were computed from the data in table 8.

12. The federal data derive from the HCFA-2082 report, as edited by The Urban Institute. The key difference is that people come on and off Medicaid during the course of a year, so that the number who are ever enrolled during a year is much higher than the level in any particular month. In addition, the state data correspond to the state fiscal year of July to June, compared with the October to September federal fiscal year, leading to small time-related discrepancies.

13. This includes children in BHP *Plus*, who are enrolled in Medicaid. It also includes unsubsidized enrollees and some special categories, such as home care workers enrolled in BHP. The number of subsidized regular members was 44,000 in July 1995 and 104,000 in July 1996.

14. Health Care Policy Board (HCPB) Annual Report, 1995.

15. HCPB, Annual Report, 1995, p. 45. (HCPB documents from 1996 show 10 percent.) Current Population Survey, 1995 and 1996.

16. All of these estimates came from the 1995 HCPB Annual Report.

17. HCPB Annual Report, 1995, p. 10.

18. Office of the Insurance Commissioner (OIC) Annual Report, 1994-95, p. G1.

19. OIC Annual Report, 1994-95 data; OIC Web pages for 1996 data.

20. OIC Annual Report, 1994-95, p.G1.

21. OIC 1994-95 Annual Report data support the conclusion that the smaller indemnity insurers had about an 18 percent market share in 1995.

22. Computed from OIC 1994-95 Annual Report data.

23. HCPB Annual Report, 1996.

24. HCPB Annual Report, 1996.

25. An MCO is not necessarily an HMO license holder but must satisfy the network adequacy, financial, and reporting requirements set by the Washington State Department of Social and Health Services.

26. Medical Assistance Administration, "PPS-4 Inpatient Hospital Reimbursement System Document," July 1, 1996.

27. These rates do not apply to the Medically Indigent and other small state-only programs, which provide much lower reimbursement levels. Taking into account the \$2,000 deductible, state officials estimated that Medically Indigent payment rates were roughly 75 percent below Medicaid levels. In principle, the deductible means that the patient should be responsible for the first \$2,000, but in practice it often means that the hospital must have an initial loss of \$2,000 for the uninsured patient before any payment is made.

28. Data Resources Incorporated is a consulting and economic forecasting firm in Lexington, Massachusetts. Its indexes are widely used by governments and the private sector.

29. Prospective Payment Assessment Commission: *Medicare and the American Health Care System: Report to Congress* (June 1995).

30. S. Norton.

31. The Lewin Group, "The Impact of Selected Medicaid Cost Containment Options on Program Costs, Patient Access and Quality of Care," prepared for the Washington State Legislature Fiscal Study Group on Medicaid, 1996.

32. All data in this paragraph are contained in the Department of Health budget documents, 1995-97.

33. Private agencies are also recipients of federal grant dollars via the DoH. These include Planned Parenthood, Children's Hospital in Seattle, and WIC agencies.
34. For example, 81 percent of MCH funds are distributed to local organizations.
35. National Association of City and County Health Officials, 1995.
36. Department of Health budget documents, 1995-97.
37. Per capita income in 1994 (\$29,295) was 30 percent higher than the state average and 35 percent higher than the national average. U.S. Census Bureau, U.S. Department of Commerce.
38. In 1993 (the last year for which county figures are available), only 9 percent of King County residents had incomes below poverty, compared with 12 percent statewide (Census estimates). Today, Washington state has a 13.7 percent poverty rate, which still compares favorably to that of the nation as a whole at 15 percent ([table 1](#)).
39. Census data, taken from Washington State Office of Financial Management, "Population Estimates by Race and Hispanic Origin by County Racial Classifications Based on OMB Directive 15," April 1, 1996.
40. Harborview Medical Center, Children's Hospital, University of Washington Medical Center, Swedish Medical Center, and Providence Medical Center provide over \$60 million in uncompensated care each year. Harborview provides twice as much as any other hospital, over \$23 million in 1994.
41. Aging and Adult Services Administration (AASA) Progress Report: LTC Options for Adults and Seniors with Disabilities, Fall 1996.
42. AASA budget documents, 1995-97.
43. As reported in Final Bill Report: E2SHB 1908. See [tables 3](#), [6](#), and [9](#) for additional budget and caseload information.
44. American Association of Retired Persons, Profiles of Long-Term Care Systems, 1996.
45. The state licenses three categories of residential alternatives to nursing homes: boarding homes (three or more persons in a "facility"); adult family homes (two to six persons in "homes"); and assisted living (a combination of housing, health services, and assistance with personal care provided by a licensed boarding home in accordance with the assisted living services contract). The term "adult residential care" is a Medicaid reimbursement term rather than a licensure term and generally refers to care delivered in boarding homes.
46. "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," GAP/HEHS-94-167, August 1994. The Lewin Group and AARP, "Estimated Cost Savings From the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States," November 1996.
47. Nursing home beds: declined from 29,379 to 28,869 between 1991 and 1995; residential care facilities: 624 new facilities and 3,544 new beds between 1994 and 1995; home health care agencies: increased from 155 in 1994 to 166 in 1995 (AASA).
48. AASA.
49. AASA Strategic Plan, July 1996.
50. Of the 29,000 nursing home beds in the state, 22,000 are in for-profit facilities. One-third of nursing homes are small and locally owned; however, national chains are purchasing many of these small facilities as well as in-state multifacility chains.
51. AASA Progress Report, Fall 1996.
52. Computed from data in [table 9](#).
53. National Association of State Mental Health Program Directors, 1995.
54. These expenditures do not include disproportionate share hospital payments.
55. Division of Mental Health Data; National Association of State Mental Health Program Directors Research Institute, Inc., *Funding Sources and Expenditures of State Mental Health Agencies*, FY 1993.
56. HCFA data.
57. Division of Mental Health materials. Note that state psychiatric hospitals cannot qualify for regular Medicaid

payments for patients ages 22 to 64.

58. Populations exempted from enrolling with an RSN are residents of state-owned institutions and Native Americans who opt to receive care through the tribal health system.

59. The waiver—a second 1915(b) waiver—was submitted to HCFA in December 1996.

APPENDIX

List of People Interviewed

Olympia

Department of Social and Health Services

Bobbe Andersen
Joan Bantz
Tom Bedell
Jane Beyer
Ken Cameron
Kathleen Connor
John Cordy
Dave Dula
Joyce Duran
Roger Gantz
Jan Hoppler
David Langenes
Judy McGinnis
Wolfgang Opitz
Charles Reed
Joanie Scotson
John Stern
Bruce Treichler
John Whitbeck

Health Care Authority

Gary Christenson
Vicki Wilson

Department of Health

Joan Brewster
Georgia Britt
Verne Gibbs
Alice James
Maxine Hayes
Lucy Phillips
Jackson Williams

Legislature Representative Philip Dyer

Senator Kevin Quigley
Representative Mike Sherstad
Don Sloma
Tim Yowell

Health Care Policy Board

Tom Ansart

Bernadine Dochnahl
Tom Hilyard
Dwayne Thurman

Others

Sue Crystal, Governor's Office
John Conniff, Department of Insurance

Provider Associations

Greg Vigdor, Washington State Hospital Association
Len Eddinger, Washington State Medical Association
Robert Perna, Washington State Medical Association
Gerald Reilly, Washington Health Care Association
Donna Cameron, Home Care Association of Washington
Dennis Braddock, Washington Primary Care Association

SEATTLE***Hospitals***

Cheryl Ellsworth, Children's Hospital
John M. Neff, Children's Hospital
Kelly Wallace, Children's Hospital
Elise Chayet, Harborview Medical Center
Peter Bigelow, Sisters of Providence Hospital
Bruce Ferguson, University Hospital

Community Health Centers

Dennis Braddock, Community Health Plan of Washington
Karen Bosley, Puget Sound Neighborhood Health Centers
Dorothy Wong, International District Community Health Center

Health Department

Kathy Carson, Seattle/King County Department of Public Health
Susan Oatis, Seattle/King County Department of Public Health
Alonzo Plough, Seattle/King County Department of Public Health

University Experts and Others

Robert Crittenden, University of Washington/Harborview
Aaron Katz, University of Washington
James McIntire, University of Washington
Richard Brandon, University of Washington Kids Count
Sally Fox, City of Seattle
Lonnie Johns-Brown, Partnership for Washington's Future
Tony Lee, Freemont Public Association
Diane Sasne, SEIU
Liz Schot, Columbia Legal Services

Tables & Figures

Table 1 State Characteristics

	Washington	United States
Sociodemographic		
Population (1994-95) ^a (in thousands)	5,301	260,202
Percent under 18 (1994-95) ^a	25.9%	26.8%
Percent 65+ (1994-95) ^a	10.4%	12.1%
Percent Hispanic (1994-95) ^a	3.0%	10.7%
Percent Non-Hispanic Black (1994-95) ^a	2.4%	12.5%
Percent Non-Hispanic White (1994-95) ^a	86.8%	72.6%
Percent Non-Hispanic Other (1994-95) ^a	7.7%	4.2%
Percent Noncitizen Immigrant (1996) ^a	4.3%	6.4%
Percent Nonmetropolitan (1994-95) ^a	21.6%	21.8%
Population Growth (1990-95) ^b	11.6%	5.6%
Economic		
Per Capita Income (1995) ^c	\$23,774	\$23,208
Percent Change in Per Capita Personal Income (1990-95) ^{c,d}	21.4%	21.2%
Percent Change in Personal Income (1990-95) ^{c,e}	34.5%	27.7%
Employment Rate (1996) ^{f,g}	64.4%	63.2%
Unemployment Rate (1996) ^f	6.5%	5.4%
Percent below Poverty (1994) ^h	12.6%	14.3%
Percent Children below Poverty (1994) ^h	17.3%	21.7%
Health		
Percent Uninsured—Nonelderly (1994-95) ^a	12.9%	15.5%
Percent Medicaid—Nonelderly (1994-95) ^a	12.3%	12.2%
Percent Employer Sponsored—Nonelderly (1994-95) ^a	66.6%	66.1%
Percent Other Health Insurance—Nonelderly (1994-95) ^a	8.2%	6.2%
Smokers among Adult Population (1993) ⁱ	22.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994) ^j	5.3%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) ^k	4.7	7.6
Premature Death Rate (Years Lost per 1,000) (1993) ^{l,m}	43.7	54.4
Violent Crimes per 100,000 (1995) ⁿ	484.3	684.6
AIDS Cases Reported per 100,000 (1995) ^o	16.4	27.8
Political		
Governor's Affiliation (1996) ^p	D	
Party Control of Senate (Upper) (1996) ^p	23D-26R	
Party Control of House (Lower) (1996) ^p	42D-56R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States, 1996* (116th edition). Washington, D.C., 1996. 1995 population as of July 1, 1990 population as of April 1.

c. *State Personal Income, 1989-1995*. CIO-ROML. Washington, D.C.: Regional Economic Measurement Division (RE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor, *State and Regional Unemployment, 1996 Annual Averages*. OSHA 97-464. Washington, D.C., March 19, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994-March 1996) where 1994 is the center year edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy, Brangan, Danielle Holahan, Amanda H. McCoskey, and Evelyn Yee, *Reforming the Health Care System: State Profiles 1996*. Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke, "Advance Report of Final Natality Statistics, 1994," *Monthly Vital Statistics Report*, vol. 44, no. 17, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics, "Births, Marriages, Divorces, and Deaths for 1995," *Monthly Vital Statistics Report*, vol. 44, no. 12, Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation, *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition. Minneapolis, MN: ReliaStar, 1996.

n. Racially-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI, *Crime in the United States, 1995*, October 11, 1996.

p. National Conference of State Legislatures, *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

Source of Area Shaded Blue: Current Population Survey (CPS) three-year average (March 1996-March 1998, where 1996 is the center year)

Table 2 Washington Spending by Category, 1990 and 1995 (\$ in Millions)

Program	State General-Fund Expenditures ^a			Expenditures ^a		
	1991	1995	Annual Growth	1991	1995	Annual Growth
Total	\$6,171	\$8,809	7.4%	\$11,032	\$15,923	7.6%
Medicaid ^{b,c}	555	1,183	16.3	1,209	2,887	19.0
% of Total	(9.0)	(13.4)	—	(11.0)	(18.1)	—
Corrections	249	352	7.2	253	405	9.9
% of Total	(4.0)	(4.0)	—	(2.3)	(2.5)	—
K-12 Education	2,826	3,986	7.1	3,025	4,188	6.7
% of Total	(45.8)	(45.2)	—	(27.4)	(26.3)	—
AFDC	171	244	7.4	376	516	6.5
% of Total	(2.8)	(2.8)	—	(3.4)	(3.2)	—
Higher Education	925	951	0.6	1,614	1,835	2.6
% of Total	(15.0)	(10.8)	—	(14.6)	(11.5)	—
Miscellaneous ^d	1,445	2,093	7.7	4,555	6,092	6.0
% of Total	(23.4)	(23.8)	—	(41.3)	(38.3)	—

Sources: National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K-12 education.

b. Total spending for each category includes the general fund, other state funds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them. Massachusetts did not report these provider payments to NASBO.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation, as other health rather than Medicaid; third, local contributions to Medicaid are not included, but would be part of Medicaid spending on the HCFA 64.

e. This category includes all remaining state expenditures (i.e., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

Table 3 Medicaid Expenditures by Eligibility Group and Type of Service, Washington and United States (\$ in Mill

	Washington					United States		
	Expenditures			Average Annual Growth		Expenditures		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$1,299.0	\$2,115.6	\$3,033.7	27.6%	12.8%	\$73,662.2	\$118,926.0	\$157,872.1
Benefits								
Benefits by Service								
Acute Care	\$1,198.9	\$1,792.2	\$2,482.2	22.3%	11.5%	\$69,168.7	\$97,602.4	\$133,434.1
Long-Term Care	651.7	1,048.6	1,547.8	26.8%	13.9%	36,904.5	55,059.9	79,438.1
Benefits by Group								
Elderly	\$449.1	\$719.8	\$973.1	26.6%	10.6%	\$25,771.6	\$35,634.6	\$51,379.1
Acute Care	221.1	380.0	647.5	31.1%	12.9%	12,929.2	19,483.6	29,760.1
Long-Term Care	228.0	339.8	425.7	22.1%	7.9%	12,842.4	16,201.0	21,618.1
Adults	\$206.3	\$332.8	\$431.8	27.0%	9.1%	\$8,765.0	\$12,710.1	\$16,556.1
Children	\$171.2	\$261.5	\$470.0	23.6%	21.6%	\$11,297.9	\$17,449.8	\$25,410.1
DSH	\$28.0	\$230.9	\$318.0	187.0%	14.6%	\$1,340.9	\$17,525.6	\$18,988.1
Administration	\$72.1	\$92.5	\$203.5	13.2%	30.1%	\$3,152.6	\$3,797.9	\$5,449.1

Sources: The Urban Institute, 1997. Based on HCFA 2002 and HCFA 64 data.

Table 4 *Medicaid Expenditures per Enrollee by Eligibility Group, Washington and United States*

	Washington					United States			
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			A
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1995
Total	\$2,253	\$2,670	\$2,933	8.8%	3.2%	\$2,397	\$2,729	\$3,202	6
By Group									
Elderly	\$7,755	\$9,171	\$10,653	8.7%	5.1%	\$6,839	\$8,422	\$9,738	11
Cash	3,531	4,328	4,607	10.7%	2.1%	3,329	4,017	4,818	9
Noncash	10,048	11,694	14,373	7.9%	7.1%	10,377	12,192	13,521	8
Blind and Disabled	\$6,869	\$8,092	\$8,525	8.4%	1.8%	\$6,378	\$7,320	\$8,022	7
Cash	5,520	6,611	7,490	9.4%	4.2%	4,969	5,927	6,696	9
Noncash	12,302	14,639	13,301	9.1%	-3.1%	12,047	12,574	12,660	2
Adults	\$1,396	\$1,825	\$2,044	14.3%	3.9%	\$1,301	\$1,518	\$1,728	8
Children	\$632	\$752	\$1,014	9.1%	10.5%	\$770	\$931	\$1,178	9

Source: The Urban Institute, 1997. Based on HCFA 2062 and HCFA 64 data.

Table 5 *Average Monthly Enrollment in Medicaid Assistance Programs*

	Actual						
	FY90	FY91	FY92	FY93	FY94	FY95	FY96
Total	394,992	441,115	507,377	553,157	591,912	648,243	707,236
Categorically Needy	362,143	403,437	462,095	509,658	548,369	606,168	646,518
AFDC-R	208,108	219,197	230,746	238,151	244,365	245,168	242,159
AFDC-E	44,495	54,384	71,014	81,348	85,366	83,948	78,860
Aged	32,414	33,198	34,397	35,365	35,850	37,076	38,153
Disabled	53,103	58,834	67,904	77,335	85,437	91,607	97,746
Others—Women	23,755	37,383	14,201	15,734	17,836	18,186	18,515
Others—Children	—	—	42,669	59,511	76,583	126,290	166,571
OMB	268	441	1,164	2,214	2,937	3,953	4,512
Medically Needy	15,020	15,798	17,616	18,151	16,950	14,264	11,820
AFDC-R	5,397	5,229	4,802	4,791	3,852	2,698	928
AFDC-E	1,500	1,687	2,132	2,335	1,960	1,182	389
Aged	4,188	4,469	5,169	5,163	5,192	4,747	4,718
Disabled	3,341	3,911	4,752	5,246	5,514	5,507	5,699
Others—Women	594	502	761	616	432	130	86
State Only LT 18	1	3,227	11,127	10,911	12,360	12,792	13,221
GA-U	13,767	13,831	12,243	10,368	10,057	10,960	11,429
GA-U	7,110	11,221	11,081	9,617	7,729	7,610	8,384
ADATSA	2,546	2,750	2,626	2,639	2,447	2,576	2,549
Medically Indigent	2,411	2,700	2,472	2,640	2,630	2,397	2,388
Refugees	1,650	2,122	1,824	1,429	1,546	1,662	1,860

Source: Data reported by the Budget Section, Medicaid Assistance Administration, Washington, April 23, 1996.
Does not include enrollment in Basic Health Plan, which is under the Health Care Authority.

Table 6 Medicaid Enrollment by Eligibility Group, Washington and United States (Enrollment in Thousands)

	Washington					United States			
	Enrollment			Average Annual Growth		Enrollment			A
	1990	1992	1995	1990-92	1992-95	1990	1992	1995	1996
Total	532.0	671.3	846.2	12.3%	8.0%	28,856.7	35,765.1	41,672.0	11
By Group									
Elderly	48.0	52.1	57.0	4.2%	3.0%	3,412.2	3,771.0	4,116.6	5
Cash	16.9	17.9	21.7	2.8%	6.7%	1,713.1	1,739.2	1,789.2	0
Noncash	31.1	34.3	35.3	5.0%	1.0%	1,699.1	2,031.8	2,327.3	5
Blind and Disabled	65.2	89.0	114.1	16.8%	8.7%	4,040.9	4,875.1	6,405.2	9
Cash	52.0	72.5	93.8	18.1%	8.9%	3,236.8	3,853.4	4,973.5	9
Noncash	13.2	16.4	20.3	11.7%	7.4%	804.1	1,021.7	1,431.7	12
Adults	147.8	182.4	211.3	11.1%	5.0%	6,738.7	8,373.3	9,584.2	11
Cash	101.7	120.2	122.2	8.7%	0.6%	4,661.6	5,342.5	5,441.4	3
Noncash	46.1	62.2	89.1	16.2%	12.7%	2,087.2	3,030.9	4,142.8	20
Children	271.0	347.8	463.8	13.3%	10.1%	14,664.9	18,745.7	21,566.0	13
Cash	213.9	243.4	241.8	6.7%	-0.2%	9,946.2	11,281.8	11,314.6	6
Noncash	57.2	104.4	222.0	35.2%	28.6%	4,718.7	7,463.9	10,251.4	25

Source: The Urban Institute, 1997. Based on HCFA 2002 data.

Table 7 Health Insurance Coverage of the Nonelderly Population (population in thousands)

	Washington			United States		
	Below Poverty	100-200% of Poverty	All	Below Poverty	100-200% of Poverty	All
Population	680	725	5,301	35,146	41,262	260,202
% of population in income class covered by:						
Uninsured	20.4%	25.3%	12.9%	22.9%	27.4%	15.5%
Medicaid	57.9%	18.3%	12.3%	54.9%	16.4%	12.2%
Employer Sponsored	13.2%	47.6%	66.6%	17.3%	47.9%	66.1%
Other	2.5%	8.9%	8.2%	4.9%	8.3%	6.2%
Low income (<200%) covered by:						
Uninsured	322	19,351				
Medicaid	526	26,081				
Employer Sponsored	434	25,864				
Other	122	5,111				

Source: Two year concatenated March CPS files, 1995 and 1996. These files are edited by the Urban Institute's Blaz microsimulation model. Excludes those in families with active military members.

"Other" includes persons covered under CHAMPUS, VA, Medicaid, military health programs, and privately purchased coverage. The vast majority of these persons are covered by private, individual market plans.

Table 8 *Disproportionate Share Hospital Spending, 1988–1995 Total and as a Percent of Total Spending, Washington*

Year	DSH			DSH as a Percent of Total Spending		
	Inpatient	Mental Health	Total	Growth	Washington Benefits	United States Benefits
1988	11,149,608	—	11,149,608	—	1.1%	0.8%
1989	15,059,000	—	15,059,000	35%	1.4%	1.1%
1990	28,038,000	—	28,038,000	86%	2.2%	1.9%
1991	24,594,000	—	24,594,000	-12%	1.5%	5.7%
1992	173,197,000	57,732,000	230,929,000	839%	10.9%	14.7%
1993	213,872,554	43,169,786	257,042,340	11%	10.7%	13.0%
1994	264,696,110	44,176,803	308,872,913	20%	11.3%	11.8%
1995	171,725,815	176,233,324	347,959,139	13%	12.3%	12.6%

Table 9 *Medicaid Long-Term Care Expenditures by Eligibility Group, Washington and United States (\$ in Million)*

	Washington					United States		
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures		
	1990	1992	1995	1990-92	1992-95	1990	1992	1995
Total	\$547.2	\$743.6	\$934.4	16.6%	7.9%	\$32,264.2	\$42,542.5	\$53,996.
Elderly	\$310.2	\$384.3	\$483.9	11.3%	8.0%	\$18,406.9	\$24,846.4	\$30,413.
Nursing Home Care	276.6	346.6	448.4	11.9%	9.0%	15,131.3	20,542.9	25,571.
ICFs/MR ^a	3.9	6.7	6.9	32.3%	0.7%	348.9	452.0	615.
Mental Health	0.0	0.2	1.1	104.4%	77.6%	973.0	1,286.0	1,107.
Home Care	29.7	30.7	27.4	1.6%	-3.7%	1,955.7	2,565.6	3,119.
Blind and Disabled	\$228.0	\$339.8	\$425.7	22.1%	7.8%	\$12,842.4	\$16,201.0	\$21,618.
Nursing Home Care	43.4	52.2	70.2	9.6%	10.4%	3,161.3	3,968.0	4,813.
ICFs/MR ^a	137.2	174.8	121.7	12.9%	-11.4%	7,241.3	8,380.4	9,321.
Mental Health	11.7	26.5	48.8	50.6%	22.6%	457.9	682.1	881.
Home Care	35.7	66.3	184.9	55.5%	28.9%	1,982.0	3,170.5	6,603.
Adults and Children	8.9	19.4	24.8	47.4%	8.4%	1,012.9	1,495.1	1,963.

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 60 data.
a. Intermediate care facilities for the mentally retarded.

About the Authors

Len Nichols is a principal research associate in the Urban Institute's Health Policy Center. His recent work includes health insurance reform, Medicare reform, and medical savings accounts. Prior to joining the Health Policy Center, he was senior advisor for health policy at the Office of Management and Budget, and chair of the Economics Department at Wellesley College.

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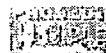
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Here are the Qs + As we put together.

Please call with any questions. Thanks!

Chris

IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS

Questions & Answers

1/14/99 6:35 PM

Q1: What are you announcing? Is this new?

A1: The President's FY 2000 budget will propose a \$1 billion federal grant program to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services create networks that foster comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into more a "seamless" system of care for low-income working families.

The President will request \$25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Q2: What does this proposal mean for uninsured people?

A2: The uninsured, low-income worker who relies on these health services will receive higher quality and more coordinated care. For instance, if an uninsured person began experiencing chest pains, she might seek care at a public hospital. Depending on her condition, she may stay at the hospital for treatment or may be referred through a system of coordinated care, to another hospital, community health clinic, or academic health center that could better treat her and provide follow-up care.

Coordinated care will also help uninsured workers get better preventative care. Without a system of coordinated care, many without health insurance wait until they are extremely sick to seek medical care. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. When they get health care services, the uninsured often rely heavily on expensive emergency rooms where there is little or no follow-up. Coordinated care will increase referrals for annual check-ups and other preventive services so that people can learn how to control health conditions before they end up sick in the emergency room.

Q3: What is the goal of this proposal?

A3: We want uninsured, low-income workers to have a place to go for preventive care and treatment. Better coordinated care will help ensure that the uninsured will know how to access all of the services available to them in their communities. We also want to build up the health care infrastructure so that providers have the technology necessary to do business with the government and private health care organizations. Finally, we support this initiative because it has the potential to

save money. When a patient is given options other than the emergency room for non-emergency care, costs go down and more uninsured get the services they need.

Q4: Doesn't this simply add a new bureaucracy to the many federal, state, and local, programs that deliver health care to the uninsured?

A4: No. We intend to make grants to community health clinics, public hospitals, academic health centers, and other public and private providers for developing infrastructure and providing services. We are taking this approach precisely because each community has different needs and different service delivery systems. Whatever the needs and types of providers in a community, uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. We plan to fund innovative proposals that support a community's own efforts to enhance services to the uninsured.

A number of communities have already developed successful models that coordinate care and expand services. These models will serve as examples for other communities working to improve cooperation among its providers.

Q5: Are you saying that this proposal is a substitute for extending health insurance to uninsured workers?

A5: No. This new program will complement, not supplant, existing vital programs that support providers of free or low cost health care services. Those programs fund needed services for the uninsured, but they are focused at specific problems or populations. This new program attempts to coordinate their efforts to ensure that patients are served within a more coordinated setting. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. Our proposal also strengthens the providers served by these existing programs by enabling them to be more efficient and competitive in a changing health care environment.

It is also intended to compliment our on going efforts to expand the number of people with health insurance. We continue to support proposals that will extend health insurance to more Americans. By permitting those ages 55 to 65 buy into Medicare, enabling purchasing cooperatives to help people who have been denied insurance, and allowing the working disabled to keep their medical benefits, we will extend insurance to more Americans. This new initiative supports those who are not insured, but is not a substitute for health insurance.

Q6: Who will actually benefit from this program? How many?

A6: This program is directed at uninsured working Americans with income just above the poverty level. Over five years, we plan to fund projects in at least one

hundred communities. Those projects will eventually reach millions of low-income, uninsured workers.

Q7: Aren't you just trying to find a way to implement the massive Clinton health reform program—one element at a time?

A7: No—but we are trying to give more Americans better health care. Since 1993, we have taken some important steps to increase health insurance coverage. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This program recognizes that despite these efforts, there are still millions of uninsured adults who receive health care from locally funded health care providers. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. It supports existing, vital programs in coordinating efforts to ensure that patients are served in a more coordinated setting. It also strengthens providers served by existing programs by enabling them to be more efficient and competitive in a changing health care environment.

Q8: What makes you think you can follow through on such a massive commitment at a time when resources are limited? (Postponing implementation of the BBA, addressing the Y2K problem, administrative changes)

A8: We are committing ourselves to making funds available because this is a vital need for our health care system. Support for the nation's providers of health care access to the uninsured represents a good investment in the future of the health of the American people. These needs are real, and many of them are being met in less efficient settings because of the lack of coordination of vital services. Episodic, crisis oriented care, the kind of care that many uninsured people are forced to seek — if they can get care at all — represents a major drain on our health resources. We cannot afford to neglect the health needs of the uninsured.

In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks" for linking rural health services. While our proposal is similar, it would actually help even more people. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Members of Congress from both parties agree that coordinating care for the uninsured is important and we cannot ignore this need because of other challenges we face.

Q9: How much will this cost? Why are you requesting so little in the first year?

A9: We are proposing an investment of \$1 billion over 5 years, with FY 2000 funding of \$25 million. We recognize that communities need time to plan for effective use of these funds and that some communities will be more prepared to begin than others. Funding at this level will be sufficient to begin to support capital and infrastructure improvements.

Q10: The fact that uninsured people can not get comprehensive care is not a new phenomenon. Why have you waited so long to address this issue?

A10: We haven't. This Administration has a strong record of helping America's uninsured, low income workers over the last six years. HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. The President signed the Kennedy-Kassebaum bill, which ensured that Americans could take their health care with them when they changed jobs. Under the Balanced Budget Act, the Administration successfully worked to pass the Children's Health Insurance Program (CHIP). Since then, 48 states and territories have had their CHIP plan approved by the Department of Health and Human Services.

Last year we won \$100 million from Congress for the Community Health Center program where over 40 percent of patients are uninsured. Similarly, we gained major increases in the Ryan White programs, which also serve many uninsured, low income workers. Last year Ryan White funding reached a record \$1.4 billion.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. The coordination of services supported by our proposal will help uninsured workers receive more efficient and higher quality care and move toward a more "seamless" system of care for low-income working families.

Q11: As health services in a community begin sharing information on their uninsured patients, don't they begin to impede on a patient's right to have his or her records kept private?

A11: Increasingly, health care information will be shared and we are concerned about protecting the confidentiality of all health information, including that patient information that would reside in data systems funded through this initiative. HHS will continue to work with Congress to enact federal privacy protections. But many cities and states are already moving toward coordinated record keeping in an effort to improve care.

Q12: Do you really think you are going to get this or any of these big-ticket budget items from a Congress that has impeached and is considering the removal of the President?

A12: We think Congress will be interested in a proposal that helps 32 million uninsured workers. The President is working on behalf of the American people to present proposals that address real problems. There is strong popular support for the FY 2000 initiatives that have been announced so far. Our FY 2000 budget addresses such important problems as support for caregivers, food safety and improving health care access for the uninsured. Our budget is a strong blueprint for addressing the challenges that our country faces and we are confident that Congress will step up to the plate and work with us.

Q13: With only a percentage of uninsured taking advantage of the CHIP program, does it make sense to keep throwing money at a group that has not taken advantage of current programs?

A13: Of course it does. The CHIP program is geared exclusively to children. It is a new program and in some states is just getting off the ground. While some states initially proposed modest programs, many of them are now returning to us with more ambitious plans that will cover many more children. Already, states have submitted plans to us that, when implemented, will provide insurance to 2.8 million children. Many states are only now beginning their outreach campaigns.

But there are 32 million uninsured adults, 17 million of them are below 200 percent of the federal poverty level, who aren't eligible for CHIP. This proposal is aimed at them.

Q14: How much does the federal government spend on health services and programs for the uninsured?

A14: There's no easy answer to this question. Medicare and Medicaid disproportionate share payments are partially used to support care for this population. On the discretionary side, over 40 percent of Community Health Center program (funded for FY 1999 at \$925 million) users are uninsured. Other programs providing support for services many of which are received by uninsured people include the Ryan White programs (\$1.4 billion in FY 1999), the Maternal and Child Health Block grant (\$700 million in FY 1999) and the Substance Abuse and Mental Health Performance Partnership grants (\$1.6 billion and \$289 million respectively in FY 1999). However, funds from these programs are used for other purposes besides services and some of those who benefit from program activities may have Medicaid or some other form of insurance.

Q15: Is this similar to proposals by the Blue Dog Democrats in the House and others?

- A15: Yes. In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks." These systems that would have linked rural hospitals and rural health care providers to other hospitals, so that patient care could be coordinated as they traveled between different facilities with different resources. Our proposal is similar, and would help even more people.

In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. The history of coordinating community services for the uninsured has been bipartisan, and we look forward to building that kind of consensus around our new initiative.

[Background: A Medicare reimbursement bill containing the telehealth networks proposal was sponsored by Republican Congressman Combest of Texas (HR966) and Democratic Senator Conrad (S385) in March of 1997. Senator Baucus reintroduced the telehealth line item of former bill as a separate bill in October of 1998. All efforts were unsuccessful.]

Senator Dole sponsored a bill (S2374) supporting grants for community-based networks in 1994 as part of his legislative response to the Health Security Act of 1993. Our 1993 health care reform legislation included a similar provision. As you know, both bills were no longer under consideration by the Fall of 1994.]

- Q16: Who applies for the money – the locality or a consortium of providers?**

- A16: Either would potentially be eligible. We see local governments, consortia of providers, or individual providers on behalf of a group, such as a teaching hospital, all as possible grantees. The creative models that we have looked at, like the Marshfield Family Health Center or the Wishard Plan in Indianapolis, take many forms. Ultimately, grants would be awarded to those governments or providers who show the greatest capacity to build community-based networks and expand and improve services for low-income uninsured.

- Q17: Is this just a reaction to the fact that the Medicare Commission is talking about phasing out DSH?**

- A17: No. This new program is not intended as a substitute for DSH. DSH payments reimburse hospitals for some of the costs they incur in treating the uninsured. There is also federal support for providers like Community Health Centers and Ryan White programs. But our program is different. It does not focus on a single type of provider. It is intended to help the array of providers who serve low-income uninsured people work together so that the care they provide is not episodic, but coordinated and comprehensive, and is delivered effectively and efficiently.

The Medicare Commission is charged with developing long-range proposals for Medicare financing and service delivery. We look forward to their proposals, but reserve the right to take steps now to improve and expand health care access for the uninsured.

Q18: How would this really be an incentive for providers to get over their natural disinclination to work together, since it isn't very much money?

A18: There are tremendous incentives to coordinate care in a community, not just for the patient's benefit, but also for the provider's bottom line. We want to build up the health care infrastructure so providers have the technology necessary to do business with the government and private health care organizations. We also support this initiative because it has the potential to save money. When a patient is given options other than the emergency room for non-emergency care, costs go down. We think providers understand that if they do not keep current business practices and ensure efficient care giving through network referrals, they'll be out of business. We want to strengthen the health care infrastructure so that uninsured workers don't just have a place to go now, but in the future as well. We believe that \$1 billion will make a real difference in the 100 communities that receive these funds.