

# California Medi-Cal Waiver Options

*Supplemental Chart Pack:  
State Waiver Comparison*

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## **About the Paper**

This paper has been developed as technical assistance to the State of California. As such, it presents a range of options on different paths that could be taken by the state in a waiver request to the federal government. The paper makes no recommendations. Rather, this paper was developed with the understanding that it will be used as the beginning of a process with stakeholders to discuss waiver options. As part of this public process, the concepts presented here were previously presented by the consulting team at a three-hour public event sponsored by the California Senate Office of Research in early June 2009. While the paper is an initial step in waiver development, it is worth noting that the language can still be highly technical and is designed for audiences with background in health care policy and financing.

## **About Harbage Consulting**

Harbage Consulting is an independent health policy consultancy. Peter Harbage, President of Harbage Consulting, has more than a decade of experience working to improve health policy at the federal, state and local level. Working almost exclusively with government agencies and non-profit foundations, Harbage Consulting has published extensively on health reform concepts, the public financing of health care, Medicaid and California-specific health policy issues. Hilary Haycock has held senior communications positions dealing extensively with health care issues. She is currently a graduate student studying health policy at Georgetown University and holds an undergraduate degree with high honors from the University of California at Berkeley.

## **About Health Management Associates**

Health Management Associates is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors. Theresa Sachs is a nationally known expert on design and financing of Medicaid and SCHIP waiver programs with more than 20 years experience in health care. Jim Frizzera worked at CMS (formerly HCFA) for the last twenty years; most recently and is a national expert on Medicaid reimbursement and state financing. Stan Rosenstein has 31 years experience with government health care programs, with the emphasis on Medicaid and was the long time California Medicaid Director with over 13 years as the Medicaid Director or Deputy Medicaid Director and over 21 years as an executive appointee with the State of California.

## **About the Blue Shield of California Foundation**

Blue Shield of California Foundation is committed to making health care effective, safe, and accessible for all Californians, and to ending domestic violence. The Foundation blends community-based philanthropy with strategic innovation to move our state forward. As one of California's largest health philanthropies, the Foundation serves as a catalyst for change, promoting new solutions and bringing together a diverse array of stakeholders.

## 6. Comparison to Other State Waivers

	<b>Florida – Florida Medicaid Choice</b>
<b>Current approval period</b>	7/1/06 – 6/30/2011
<b>Five year spending cap</b>	No. Per member per month x caseload; only at risk for cost. Sub-cap: Low-Income Pool - lesser of agreed upon costs or \$1 billion.
<b>Populations included</b>	<p>(i) Persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL, asset limit for an individual is \$2,000); includes children eligible under SSI; <b>Benefits:</b> Medicaid Reform Plans have the flexibility to provide customized benefit packages for enrollees. The customized benefit packages must cover all mandatory services specified in the State plan, including medically necessary services for pregnant women and EPSDT services for children under age 21. All benefit packages are subject to prior approval by the State and must be at least actuarially equivalent to the services provided under the State plan.</p> <p>Enrollees may use funds available through “Enhanced Benefit Accounts” for health care related expenditures.</p> <p>Employer sponsored insurance program – Medicaid Reform enrollees may voluntarily opt-out of Medicaid Reform Plans into employer sponsored insurance (ESI) or a private plan. The benefit package under the ESI plan must meet minimum State licensure standards, but may be more restrictive than Medicaid coverage.</p> <p>(ii) State plan populations:            (1) Families whose income is below the TANF limit;            (2) Poverty-related children whose family income exceeds the TANF limit as follows: up to age 1, up to 200% FPL; age 1-5 up to 133% FPL; age 6-21, up to 100% FPL;            (3) Pregnant women with incomes up to 200% FPL.</p> <p><b>Benefits:</b> Medicaid Reform Plans have the flexibility to provide customized benefit packages for enrollees. The customized benefit packages must cover all mandatory services specified in the State plan, including medically necessary services for pregnant women and EPSDT services for children under age 21. All benefit packages are subject to prior approval by the State and must be at least actuarially equivalent to the services provided under the State plan.</p> <p>Enrollees may use funds available through “Enhanced Benefit Accounts” for health care related expenditures.</p> <p>Employer sponsored insurance program – Medicaid Reform enrollees may voluntarily opt-out of Medicaid Reform Plans into employer sponsored insurance (ESI) or a private plan. The benefit package under the ESI plan must meet minimum State licensure standards, but may be more restrictive than Medicaid coverage.</p>
<b>State’s policy goals</b>	<p>(i) Move a greater proportion of Florida’s Medicaid population into managed care.            (ii) Increase the number of health plan choices for beneficiaries, increase access to services and providers, and increase access for the uninsured.            (iii) Establish low-income pool to support coverage of uninsured.</p>
<b>Federal goals</b>	<p>(i) Establish greater transparency to Medicaid supplemental hospital payment streams;            (ii) Limit the entitlement nature of Medicaid.</p>
<b>Eligibility expansion</b>	None.
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditure related to guaranteed eligibility;            (ii) Expenditures to reimburse the self-employed or employers share of premiums paid;            (iii) Expenditures for supplemental payment pools;            (iv) Expenditures for enhanced benefit accounts.</p>
<b>Regional variation</b>	Implemented in Broward and Duval Counties in July 2006; expanded to Baker, Clay, and Nassau Counties in July 2007.
<b>Ways in which budget neutrality was achieved</b>	Managed care savings.
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General funds and local/district tax dollars. Establishment of the Low-Income Pool – supplemental payments reconciled to defined costs.
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	Reconciliation of low-income pool to specific Medicaid and uninsured cost. Potential loss of hospital

	Medicaid supplemental revenue.
<b>Likelihood of replication</b>	Given the caps on benefits to enrollees, it seems unlikely that this is something the Obama Administration would support in additional States.
<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	California and Florida operate their Medicaid programs very differently. It is our understanding that enrollment in the new limited benefit coverage plans has been relatively low. Florida uses managed care savings to obtain the authority to claim costs otherwise not matchable.

	<b>Indiana – Healthy Indiana Plan</b>
<b>Current approval period</b>	1/1/2008-12/31/2012
<b>Five year spending cap</b>	Estimated at \$10.6 billion (consisting of a portion of the DSH allotment plus a PMPM amount that is subject to change based on enrollment).
<b>Populations included</b>	<p>(i) Parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State Plan and resources less than or equal to \$1,000; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(ii) All children eligible for Medicaid under the Medicaid State Plan; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iii) Pregnant women up to and including 200% of the FPL; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iv) Uninsured custodial parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State Plan with resources in excess of \$1,000, and uninsured custodial parents and caretaker relatives of Medicaid and SCHIP children with family income above the AFDC income limit specified in the State Plan through 200% of the FPL (no resource limit); <b>Benefits:</b> Health savings account type coverage with high deductible health plan.</p> <p>(v) Uninsured non-custodial parents and childless adults (age 19 through 64) who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200% of the FPL (no resource limit); <b>Benefits:</b> Health savings account type coverage with high deductible health plan.</p>
<b>State’s policy goals</b>	<p>(i) Ensure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals;</p> <p>(ii) Encourage individuals to stay healthy and seek preventive care;</p> <p>(iii) Give individuals control of their health care decisions and incentivize positive health behaviors;</p> <p>(iv) Make individuals aware of the cost of health care services; and</p> <p>(v) Encourage provision of quality medical services to all enrollees.</p>
<b>Federal policy goals</b>	<p>(i) New coverage;</p> <p>(ii) Diversion of funds that would otherwise be paid out as DSH;</p> <p>(iii) Test the HSA/HDHP model.</p>
<b>Eligibility expansion</b>	<p>(i) Parents and caretaker relatives above the current standard up to 200% of the FPL (including those below the income standard who exceed the resource limit); and</p> <p>(ii) Childless adults up to 200% of the FPL.</p>
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditures for health care related costs for uninsured adults who are custodial parents and caretaker relatives of children eligible for Medicaid and SCHIP with family income up to and including 200% of the FPL who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a \$1 million lifetime maximum on benefits;</p> <p>(ii) Expenditures for health care related costs for uninsured adults who are non-custodial parents of childless adults, age 19-64 with family income up to and including 200% of the FPL, who meet other criteria as described in (i) above;</p> <p>(iii) Expenditures related to enrollment in a health plan that does not comply with the normal Medicaid rules regarding enrollment and disenrollment; and</p> <p>(iv) Payments to the HIP Indiana Comprehensive Health Insurance Association (ICHIA), a prepaid inpatient health plan, that would exceed what Medicaid would have paid on a fee-for-service basis. Payments shall not exceed Medicare reimbursement rates. ICHIA is the coverage vehicle for HIP enrollees with extraordinary health care needs.</p>
<b>Regional variation</b>	N/A
<b>Ways in which budget neutrality was achieved</b>	Managed care savings; diversion of DSH.
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds.
<b>Current budget neutrality status</b>	On track, although the State has made some adjustments to ensure that the program does not go over budget.
<b>Issues or problems</b>	Two issues have been higher than expected enrollment of childless adults and higher than expected expenditures for individuals with extraordinary health care needs.
<b>Likelihood of replication</b>	It is unknown whether the current Federal administration would be supportive of an HSA/HDHP model for low income individuals.

<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	One important similarity is that Indiana, like California, had existing 1915(b) managed care programs that generated significant savings. The State was able to get CMS agreement to include a component of an existing 1915(b) program in the waiver for the purpose of counting ongoing savings, although it was unsuccessful in getting credit for prior years' savings.
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	<b>Iowa – IowaCare</b>
<b>Current approval period</b>	7/1/2005 – 6/30/2010
<b>Five year spending cap</b>	Yes. \$587.7 million.
<b>Populations included</b>	<p>(i) Children from birth to age 18 who have serious emotional disorders and who (1) would be eligible for State plan services if they were in a medical institution and (2) need home and community-based services in order to remain in the community and who (3) have incomes at or below 300% of the Federal SSI benefit; or (4) have net family income at or below 250% FPL for family size;  <b>Benefits:</b> Full Medicaid benefits – plus case management, respite care, environmental modifications and adaptive devices, in-home family therapy and family/community support services.</p> <p>(ii) Individuals 19-64 with family incomes below 200% FPL who do not meet eligibility requirements of the Medicaid State plan or other waivers except the Family Planning waiver under title XIX, and parents whose incomes are below 200% FPL, and are used to determine the eligibility of a child under titles XIX and XXI who are not otherwise Medicaid eligible;  <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies, and transportation services to the extent covered under the State plan.</p> <p>(iii) Newborns and pregnant women with income at or below 300% FPL with incurred medical expenses for all family members that reduce available family income to 200% FPL or less.  <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies, and transportation services to the extent covered under the State plan.</p>
<b>State’s policy goals</b>	<p>(i) To preserve \$65 million in Federal funding as a result of agreeing to terminate certain Medicaid financing arrangements;</p> <p>(ii) To provide home and community-based services to children with chronic mental illness and moves toward community-based settings for delivering State mental health programs.</p>
<b>Federal goals</b>	<p>(i) Expansion of coverage;</p> <p>(ii) To eliminate Medicaid financing arrangements whereby health care providers did not retain their Medicaid payments.</p>
<b>Eligibility expansion</b>	Same as list in section titled “Populations Included.”
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditures for the Demonstration populations;</p> <p>(ii) Expenditures for mental health services in any of the 4 State mental health institutions not otherwise covered under the Medicaid State plan - provided to individuals in Demonstration populations (i) and (ii);</p> <p>(iii) Expenditures for care and services furnished by or through the Department of Human Services under the Mental Health Transformation Pilot that would not otherwise be covered under title XIX or this demonstration subject to annual caps.</p>
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	<p>(i) Federal match provided on State-only IMD costs;</p> <p>(ii) Federal match provided on home and community-based services to children (expansion of coverage).</p>
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds.
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	None. IMD component of waiver phasing out.
<b>Likelihood of replication</b>	Unlikely. The waiver was utilized to resolve certain hospital financing arrangements in Iowa.
<b>Key similarities or differences compared to California (comparison of the state’s situation)</b>	California and Iowa established their 1115 waivers at the same time and with the same purpose of maintaining Federal funding that had been supported by IGT payments. Iowa only has 2 public hospitals and it could not follow the same funding model that California used. Instead Iowa got special provisions to use its funding to Federally claim for the cost care for people 21 to 64 in IMDs, which are normally not matchable in Medicaid. As this was done when CMS was phasing out “bad” IGTs, no other state is likely to get this agreement. Further, Iowa was only allowed to continue to access the existing level of Federal commitment it was receiving under its IGT arrangement. California was actually afforded an increased Federal commitment under the current waiver. It is highly unlikely that California could claim for IMDs under its current safety net care pool fund. If California was able to claim for IMDs, this would generate savings, most of which would go to the county mental health programs.

	<b>Massachusetts – MassHealth</b>
<b>Current approval period</b>	7/1/1997 – 6/30/2011
<b>Five year spending cap</b>	No. Per member per month x caseload; at risk for cost; Sub-cap: Safety Net Care Pool – aggregate amount with growth – under recent renewal spending out of pool to be directed toward premiums and away from hospitals. Growth of pool permitted in order to not restrict premium growth.
<b>Populations included</b>	<p>(i) Medicaid eligible infants through 200% FPL, children aged 1 through 18 through 150% FPL, pregnant women through 200% FPL, parents and caretaker relatives through 133% FPL, children with disabilities through 150% FPL, and adults with disabilities through 133% FPL; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(ii) Medicaid eligible women under the Breast and Cervical Cancer Treatment Program through 250% FPL; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iii) Medicaid eligible non-working disabled adults above 133% FPL who must spend down to medically needy income standard; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iv) Higher income children with disabilities, infants above 200% FPL, children ages 1 through 18 above 150% FPL; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(v) Higher income adults with disabilities above 133% FPL; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(vi) Medicaid eligible “Non-qualified aliens,” “protected aliens” or “aliens with special status” as otherwise eligible under the State plan; <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – emergency services only.</p> <p>(vii) Medicaid eligible pregnant women ages 19 and older considered presumptively eligible through 200% FPL; <b>Benefits:</b> Services are reduced under the State plan during the period of presumptive eligibility.</p> <p>(viii) Children ages 1 through 18 150% through 200% FPL; <b>Benefits:</b> Employer sponsored insurance program – premium assistance is provided toward the purchase of ESI or direct coverage, no additional wrap-around services are provided.</p> <p>(ix) Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a qualified small employer and purchase ESI; <b>Benefits:</b> Employer sponsored insurance program – premium assistance is provided toward the purchase of ESI or direct coverage, no additional wrap-around services are provided. Small employers also receive a subsidy.</p> <p>(x) Adults aged 19 through 64 who are long-term unemployed individuals through 100% FPL; <b>Benefits:</b> Restricted benefit package.</p> <p>(xi) Families receiving unemployment benefits through 400% FPL; <b>Benefits:</b> Premium assistance to continue current coverage, for a new product or for COBRA.  Employer sponsored insurance program - Premium assistance to continue current coverage, for a new product or for COBRA.</p> <p>(xii) Individuals with HIV/AIDS through 200% FPL; <b>Benefits:</b> Targeted benefit package.</p>

	(xiii) Individuals aged 19 and older not otherwise eligible per above, without access to ESI through 300% FPL. (Connector) <b>Benefits:</b> Premium assistance for the purchase of commercial benefit package.
<b>State's policy goals</b>	(i) Initially designed to utilize a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to individuals who would otherwise be without health insurance. In 2006, adopted legislation designed to provide access to affordable health insurance coverage to all Massachusetts residents; (ii) Directing more Federal and State health dollars to individuals and less to institutions; (iii) Subsidizing the purchase of private insurance for low-income individuals to reduce the number of uninsured in Massachusetts.
<b>Federal goals</b>	(i) Expand health care coverage; (ii) Improve the fiscal integrity of the MassHealth program; (iii) Direct more Federal and State health dollars to individuals and less to institutions.
<b>Eligibility expansion</b>	Same as list in section titled "Populations Included."
<b>Other items of spending for cost not otherwise matchable</b>	(i) Expenditures related to Demonstration populations; (ii) Expenditures for Medicaid Eligibility Quality Control; (iii) Expenditures for the Safety Net Care Pool; (iv) Expenditures for Diversionary Behavioral Health Services.
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	Managed care savings and redirection of a portion of DSH funds to provide health care coverage. In 1997, Massachusetts moved almost its entire Medicaid program into managed care. Over the years Massachusetts has accumulated significant savings but has been limited by State budgetary constraints. Under the renewal, Massachusetts was allowed to access a large portion of prior savings.
<b>Financing-sources of non-federal share and types of reimbursement</b>	(i) State General Funds; limited use of intergovernmental transfers. (ii) Establishment of the Safety Net Care Pool – supplemental payments funded by legislature.
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	Potential loss of Medicaid supplemental revenue for hospitals.
<b>Likelihood of replication</b>	Massachusetts' waiver was recently renewed and could serve as a good model for California to follow. Massachusetts' waiver provides coverage and a Safety Net Care Pool, which California also adopted under the Hospital Financing Waiver.
<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	<p>Massachusetts uses its waiver for key Federal funding of its health care reform. It also uses its waiver to support the safety net. California modeled its Safety Net Care Pool (SNCP) after Massachusetts', including using the same name. California's waiver has a budget neutrality calculation that is a fixed amount while Massachusetts has a budget neutrality calculation that grows based on trend rates. Savings achieved within the trend rates provides Massachusetts with additional spending authority. Both States were limited to a fixed amount of spending under their SNCP pools.</p> <p>Under the recent waiver renewal, Massachusetts utilized historical budget neutrality savings to establish additional spending authority. Massachusetts reestablished the boundaries of their SNCP pool within the historical budget neutrality savings. Under the renewal, growth will be recognized in the SNCP pool to recognize increase growth in premium subsidies. In order to utilize this authority, Massachusetts must demonstrate an increase in premium spending and a reduction in payments to hospitals over a 3-year period. Massachusetts must also reduce overall uncompensated care.</p> <p>Massachusetts' DSH allotment is \$306 million for 6.5 million residents (\$47 per resident). California's DSH allotment is \$1.1 billion for 36.7 million residents (\$30 per resident). Given Massachusetts' relatively high DSH allotment and low rate of uninsured, Massachusetts is much more able to redirect DSH from the State plan to the waiver than California. Per Kaiser Family Foundation, Massachusetts' Medicaid spending per enrollee is \$6,961 compared to \$2,740 in California.</p>
<b>Rhode Island – Global Consumer Choice Demonstration</b>	

Current approval period	Approved 1/16/09; implementation 5/1/2009 – 12/31/2013
Five year spending cap	Yes. Approximately \$12 billion.
Populations included	<p>(i) Pregnant women with incomes between 185% and 250% FPL. Family income is counted based on existing legal/financial responsibility;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(ii) Children ages 0 to 1 with family incomes between 185% and 250% FPL; children ages 1-5 with family incomes between 133% and 250% FPL; children ages 6 to 18 with family incomes between 100% and 250% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(iii) Parents of Medicaid eligible children with income up to 175% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(iv) Children ages 0 to 1 with family incomes up to 185% FPL; children ages 1-5 with family incomes up to 133% FPL; children ages 6 to 18 with family incomes up to 100% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(v) Children with special health care needs eligible for Medicaid through SSI eligibility, the Katie Beckett provision, or the adoption subsidy program, and enrolled in RItCare on a mandatory basis;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(vi) Pregnant women with incomes up to 185% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(vii) Aged, blind, and disabled individuals eligible for Medicaid;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RItShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(viii) Women up to 250% FPL who would otherwise lose Medicaid eligibility at the end of the 60-day post partum period, for up to 24 months.  <b>Benefits:</b> Family planning related services only.</p>
State’s policy goals	<p>(i) Long-term care reform;</p> <p>(ii) All Medicaid funded services on the continuum of care – including preventive care in the home and community, care in high-intensity hospital settings, long-term care, and end-of-life care – will be organized, financed, and delivered through the Demonstration.</p>
Federal goals	Support reform of long-term care system.

<b>Eligibility expansion</b>	(i) Subsumed RlTeCare; (ii) Aged, blind, and disabled individuals eligible for Medicaid.
<b>Other items of spending for cost not otherwise matchable</b>	(i) Expenditures for payments to non-HMO MCOs; (ii) Expenditures related to eligibility expansions; (iii) Expenditures for family planning services; (iv) Expenditures for special programs or initiatives; (v) Expenditures for non-traditional Medicaid services.
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	<p>Rhode Island was experiencing a significant budget deficit. The Rhode Island waiver effectively creates a budget amount/ceiling – Rhode Island projected the cost of enrollment (i.e., estimated the number of enrollees x an estimate of the cost) to establish an aggregate target – can cut if necessary.</p> <p>Since there were no significant savings remaining in RlTeCare program, Rhode Island had to include the long-term care (LTC) population into their demonstration. (Rolled nine 1915 (c) HCBS populations into waiver).</p> <p>Rhode Island has an approximately 96% nursing home occupancy - Rhode Island's demonstration will attempt to move people away from nursing homes to HCBS environment.</p>
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds.
<b>Current budget neutrality status</b>	Not yet implemented.
<b>Issues or problems</b>	Need legislative approval to implement terms and conditions. No benefit or eligibility changes unless legislature approves.
<b>Likelihood of replication</b>	Potential replication of long-term care.
<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	Rhode Island's waiver hinges on saving money in long-term care. California has long sought to improve the delivery of long term care and to move people away from nursing homes into home and community based settings. This again raises the question of whether California can be credited for the success it has had in reducing long-term care expenditures and this be allowed to spend the Federal savings already achieved.

	<b>Rhode Island – RiteCare</b>
<b>Current approval period</b>	Approved 11/1/93; implementation 8/1/1994 – 9/30/2011
<b>Five year spending cap</b>	No. Per member per month x caseload; only at risk for cost.
<b>Populations included</b>	<p>(i) Pregnant women with incomes between 185% and 250% FPL. Family income is counted based on existing legal/financial responsibility;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(ii) Children ages 0 to 1 with family incomes between 185% and 250% FPL; children ages 1-5 with family incomes between 133% and 250% FPL; children ages 6 to 18 with family incomes between 100% and 250% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(iii) Parents of Medicaid eligible children with income up to 175% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(iv) Children ages 0 to 1 with family incomes up to 185% FPL; children ages 1-5 with family incomes up to 133% FPL; children ages 6 to 18 with family incomes up to 100% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(v) Children with special health care needs eligible for Medicaid through SSI eligibility, the Katie Beckett provision, or the adoption subsidy program, and enrolled in RiteCare on a mandatory basis;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(vi) Pregnant women with incomes up to 185% FPL;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(vii) Aged, blind, and disabled individuals eligible for Medicaid;  <b>Benefits:</b> Full Medicaid benefits. Employer sponsored insurance program – enrollees whose employers offer an approved health plan are required to enroll in RiteShare, the State’s ESI program. The State subsidizes the enrollee’s portion of the premiums and copays. Enrollees may qualify for wrap-around services.</p> <p>(viii) Women up to 250% FPL who would otherwise lose Medicaid eligibility at the end of the 60-day post partum period, for up to 24 months.  <b>Benefits:</b> Family planning related services only.</p>
<b>State’s policy goals</b>	<p>(i) Statewide program to deliver primary and preventive health care services for all Family Independence Program Families (formerly known as AFDC families) and certain low-income women and children through a fully capitated managed care delivery system;</p> <p>(ii) Includes RiteShare, a premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI). RiteShare provides coverage for all Medicaid benefits as wrap-</p>

	around coverage to ESI as well as co-payments.
<b>Federal goals</b>	(i) Improve access and quality of care (larger specialty networks); (ii) Predictable and efficient payment system, care coordination, beneficiary protections; (iii) New coverage.
<b>Eligibility expansion</b>	(i) Pregnant women with incomes between 185% and 250% FPL. Family income is counted based on existing legal/financial responsibility; (ii) Women up to 250% FPL who would otherwise lose Medicaid eligibility at the end of the 60-day post partum period, for up to 24 months.
<b>Other items of spending for cost not otherwise matchable</b>	(i) Expenditures for payments to non-HMO MCOs; (ii) Expenditures related to eligibility expansions; (iii) Expenditures for family planning services; (iv) Expenditures for special programs or initiatives; (v) Expenditures for non-traditional Medicaid services.
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	Managed care savings.
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds.
<b>Current budget neutrality status</b>	Rhode Island was spending near its BN ceiling.
<b>Issues or problems</b>	Rhode Island did not cut back on coverage or expansion during the life of the waiver and therefore, used the majority of its savings.
<b>Likelihood of replication</b>	Potential replication.
Key similarities or differences compared to California (comparison of the state's situation)	The key difference is that Rhode Islands began the waiver at the same time it implemented mandatory Medicaid managed care, thus capturing savings over a several year period. This would be more challenging for California since the State already has extensive experience with managed care under the State plan; therefore, savings for families and children and in a number of counties are not available for this waiver. If California is able to get "credit" for historical savings achieved under its managed care program and generous trend rates, it is possible to have a high level of budget savings. Rhode Island used managed care savings to obtain the authority to claim costs not otherwise matchable. Per Kaiser Family Foundation, Rhode Island's Medicaid spending per enrollee is \$8,082 compared to \$2,740 in California

	<b>New York – Partnership Plan</b>
<b>Current approval period</b>	10/1/1997 - 9/30/2009
<b>Five year spending cap</b>	No. Per member per month x caseload; at risk for cost.
<b>Populations included</b>	<p>(i) TANF or TANF-related women, children and family currently enrolled in mandatory managed care and residing in the 5 boroughs of New York City as well as 23 counties; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(ii) Adults not otherwise eligible for TANF or Medicaid and previously covered under the State’s “Safety Net” program (a medical assistance program for General Assistance recipients); <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iii) Childless adults with income up to 100% FPL (FHPlus eligible) and resources below 150% of the medically needy income standard; <b>Benefits:</b> Based on Medicaid, but no long-term care for the chronically ill, non-emergency transportation, medical supplies, or non-prescription drugs (except smoking cessation). Limited home health and inpatient psychiatric. Dental benefits vary by plan.</p> <p>Employer sponsored insurance program – if ESI is available and cost-effective, eligible individuals must enroll. The State will provide wrap-around coverage to ensure availability of the full FHPlus benefits.</p> <p>(iv) Parents with income up to 150% FPL (FHPlus eligible) and resources below 150% of the medically needy income standard; <b>Benefits:</b> Based on Medicaid, but no long-term care for the chronically ill, non-emergency transportation, medical supplies, or non-prescription drugs (except smoking cessation). Limited home health and inpatient psychiatric. Dental benefits vary by plan.</p> <p>Employer sponsored insurance program – if ESI is available and cost-effective, eligible individuals must enroll. The State will provide wrap-around coverage to ensure availability of the full FHPlus benefits.</p> <p>(v) Women who would otherwise lose Medicaid eligibility after the 60-day post partum period, for up to 12 months; and men and women up to 200% of FPL who are not otherwise eligible for Medicaid or other health insurance coverage that provides family planning services. <b>Benefits:</b> Family planning related services only.</p>
<b>State’s policy goals</b>	<p>(i) To enroll most Medicaid beneficiaries into managed care – 1997;</p> <p>(ii) Family Health Plus program was implemented as an amendment to the demonstration providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards – 2001;</p> <p>(iii) To provide family planning services to women losing Medicaid eligibility and certain other adults of child bearing age (family planning expansion program).</p>
<b>Federal policy goals</b>	<p>(i) Improve access and quality of care (larger specialty networks);</p> <p>(ii) Predictable and efficient payment system, care coordination, beneficiary protections;</p> <p>(iii) New coverage.</p>
<b>Eligibility expansion</b>	<p>(i) Adults not otherwise eligible for TANF or Medicaid and previously covered under the State’s “Safety Net” program;</p> <p>(ii) Childless adults with income up to 100% FPL (FHPlus eligible) and resources below 150% of the medically needy income standard;</p> <p>(iii) Parents with income up to 150% FPL (FHPlus eligible) and resources below 150% of the medically needy income standard;</p> <p>(iv) Women who would otherwise lose Medicaid eligibility after the 60-day post partum period, for up to 12 months; and men and women up to 200% of FPL who are not otherwise eligible for Medicaid or other health insurance coverage that provides family planning services.</p>
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditures to provide health insurance coverage to Safety Net and Family Health Plus populations who are not otherwise eligible for Medicaid;</p> <p>(ii) Expenditures to provide family planning services only to men and women with no access to private insurance that offers family planning services and who have incomes below 200% FPL;</p>

	<p>(iii) Expenditures to provide family planning services to Partnership Plan enrollees who lose eligibility after 60-days post partum;</p> <p>(iv) Expenditures that would otherwise be disallowed under section 1903(u) of the Social Security Act. based on Medicaid Eligibility Quality Control findings;</p> <p>(v) Expenditures for services to Partnership Plan enrollees residing in an Institution for Mental Disease for the first 30 days of an inpatient episode with an annual limit of 60 days subject to the phase-down specified in the terms and conditions [Note: The phase-down period has expired and it is unlikely such expenditure authority would be approved by CMS.];</p> <p>(vi) Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of section 1903(b)(4) of the Act, as interpreted by section 438.810(b)(1) and (2).</p>
<b>Regional variation</b>	TANF or TANF-related women, children and family currently enrolled in mandatory managed care and residing in the 5 boroughs of New York City as well as 23 counties.
<b>Ways in which budget neutrality was achieved</b>	Managed care savings.
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds.
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	None.
<b>Likelihood of replication</b>	New York could serve as a good model for California to follow by requesting credit for prior “savings” achieved under the Medi-Cal program. Unknown whether the Obama Administration would support.
<b>Key similarities or differences compared to California (comparison of the state’s situation)</b>	The key difference is that New York began the waiver at the same time it implemented mandatory Medicaid managed care, thus capturing savings when they were presumable more plentiful. NY believes it also benefited from very good waiver trend rates. This would be more challenging for California since the State already has extensive experience with managed care under the State plan; therefore, savings for families and children and in a number of counties are not available for this waiver. If California is able to get “credit” for historical savings achieved under its managed care program and generous trend rates, it is possible to have a high level of budget savings like New York. Note that New York’s waiver is up for renewal now. It will be a waiver that should be closely followed to monitor any new federal policy. New York will likely seek to roll over prior waiver savings to the new waiver. California with a much lower per enrollee cost, with savings derived from state plan actions may consider asking that this concept be applied to California. Per Kaiser Family Foundation, New York’s Medicaid spending per enrollee is \$7,927 compared to \$2,740 in California. New York’s DSH allotment is \$1.6 billion compared to \$1.1 billion in California.

	<b>New York -- Federal-State Health Reform Partnership (FSHRP)</b>
<b>Current approval period</b>	10/1/2006 - 9/30/2011
<b>Five year spending cap</b>	Yes. \$3 billion total computable (Federal and State share)
<b>Populations included</b>	(i) TANF or TANF-related women, children and family in 14 upstate counties; <b>Benefits:</b> Full Medicaid benefits.  (ii) SSI-eligible individuals or those otherwise aged, blind or disabled under the State plan (Statewide voluntarily enrollment, mandatory phase-in in process). <b>Benefits:</b> Full Medicaid benefits.
<b>State's policy goals</b>	(i) Federal matching funds for designated state health programs; (ii) Implement reforms to promote efficient operation of the States health care system. (closing and reconfiguring hospitals, taking nursing home beds off line or converting to assisted living facilities, improving health IT, regional health information networks, pilots on EHR, rationalize payments – redirect hospital spending to primary care). Excess bed capacity, rationalizing distributions of beds - moving beds to area of need and away from low occupancy. (iii) Mandatory managed care enrollment for beneficiaries receiving SSI or who otherwise aged, blind, or disabled; (iv) Mandatory managed care enrollment for low-income families (AFDC-related) in 14 counties.
<b>Federal goals</b>	(i) Health Care Delivery System Reform - more efficient system results in savings for State and Federal government. (ii) Health IT Reform.
<b>Eligibility expansion</b>	None. These populations are State plan eligibles and are separate and distinct from the populations/counties included in the Partnership Plan.
<b>Other items of spending for cost not otherwise matchable</b>	(i) Expenditures for capitation payment provided to MCOs that use more restrictive grievance rules than Medicaid; (ii) Expenditures for otherwise covered services provided to Demonstration eligibles age 21-64 enrolled in MCOs who reside in IMD for the first 30 days of an inpatient episode; (iii) Expenditures that would have been disallowed based on Medicaid Eligibility Quality Control findings; (iv) Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of 1903(b)(4). (v) Expenditures for State designated health programs that provide services to low-income or uninsured New Yorkers.
<b>Regional variation</b>	Mandatory managed care in 14 counties.
<b>Ways in which budget neutrality was achieved</b>	Managed care for State plan eligibles. Accumulated significant savings under NY's 1115 Partnership Plan. NY is required to demonstrate savings and lower costs in facility settings (i.e., reduction of per patient per day inpatient hospital and long-term care costs). NY had benchmarks that must be met before Federal funds can be claimed.
<b>Financing-sources of non-federal share and types of reimbursement</b>	Appropriations and bond issuance (Dormitory Authority).
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	(i) Potential loss of Medicaid supplemental revenue for hospitals; (ii) Must meet benchmarks/milestones to generate Federal matching funds.
<b>Likelihood of replication</b>	Potential replication of certain health reform activities and Federal match of State/local designated health programs.
<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	New York's waiver enables service delivery change by allowing Federal funds for existing State expenditures, which frees up funding for other uses (California does this in its hospital waiver). New York was able to show significant savings from its Partnership Plan waiver to justify spending levels in this waiver. A number of milestones to generate savings in NY's waiver, supplemental rebates, and increased anti-fraud activities, are already features of the Medi-Cal program.

	<b>Tennessee – TennCare II</b>
<b>Current approval period</b>	7/1/2002 – 6/30/2010
<b>Five year spending cap</b>	No. Per member per month x caseload; only at risk for cost.
<b>Populations included</b>	<p>(i) Transition Group: Non-pregnant, non-postpartum adults 21 or older enrolled as medically needy as of July 1, 2007, who have not been assessed for transition to the Standard Spend down Demonstration population; (Closed to new enrollment)</p> <p>(ii) State plan eligible populations – all Medicaid populations except those whose Medicaid benefit consists only of Medicare premium payments; <b>Benefits:</b> Full Medicaid benefits – participants also receive expanded services, as well as services that managed care organizations may provide as cost-effective alternatives.</p> <p>(iii) Individuals under age 19 who are uninsured and meet the State-defined criteria as “Medically Eligible” (no income limit); (Enrollment closed except for Medicaid rollovers); <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – most Medicaid State plan services are provided, including EPSDT. Long-term care services are excluded. Participants also receive expanded services, as well as services that managed care organizations may provide as cost-effective alternatives.</p> <p>(iv) Individuals under age 19 who are uninsured with family incomes at or below 200% FPL (these are optional targeted low-income children); (Enrollment closed except for Medicaid rollovers); <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – most Medicaid State plan services are provided, including EPSDT. Long-term care services are excluded. Participants also receive expanded services, as well as services that managed care organizations may provide as cost-effective alternatives.</p> <p>(v) Discontinued Demonstration Group: Uninsured and/or medically eligible adults aged 19 and older who lost medical assistance eligibility as categorically needy and have not yet been either disenrolled or found eligible in an active Medicaid category; (Closed to new enrollment)</p> <p>(vi) Standard Spend Down Demonstration Population – non-pregnant/postpartum adults 21 or older who have been determined to meet the criteria patterned after the medically needy requirements. <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – most Medicaid State plan services are provided, except long-term care services. Participants also receive expanded services, as well as services that managed care organizations may provide as cost-effective alternatives.</p>
<b>State’s policy goals</b>	To restructure original TennCare Demonstration amidst budget constraints.
<b>Federal goals</b>	<p>(i) Improve access and quality of care (larger specialty networks);</p> <p>(ii) Predictable and efficient payment system, care coordination, beneficiary protections;</p> <p>(iii) New coverage.</p>
<b>Eligibility expansion</b>	Same as list in section titled “Populations Included.”
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditures for MCOs that use different enrollment and disenrollment than regular Medicaid;</p> <p>(ii) Expenditures related to expansion of existing eligibility groups;</p> <p>(iii) Expenditures for expanded benefits and coverage of cost effective alternative services;</p> <p>(iv) Expenditures for pool payments;</p> <p>(v) Expenditures related to eligibility expansion;</p> <p>(vi) Expenditures for SCHIP-related Medicaid demonstration population children.</p>
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	Medicaid managed care savings and redirection of DSH.
<b>Financing-sources of non-federal share and types of reimbursement</b>	State General Funds; certified public expenditures (CPEs).
<b>Current budget neutrality status</b>	On track.
<b>Issues or problems</b>	None at this time.
<b>Likelihood of replication</b>	Not likely given history of TennCare.
<b>Key similarities or differences</b>	The TennCare Demonstration was one of the most troubled 1115 waivers in the nation. Tennessee began

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<b>compared to California (comparison of the state's situation)</b>	the waiver with a high per member Medicaid expenditure level that they believed they could reduce through managed care and use that savings to fund additional populations. The State had numerous implementation problems and eventually found the program to be unaffordable given the state budget. Most of the expansion populations are now closed. Tennessee is now addressing how to move some DSH funding back from the waiver to hospitals to pay for uncompensated care costs.
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	<b>Vermont – Global Commitment to Health</b>
<b>Current approval period</b>	10/1/2005 - 9/30/2010
<b>Five year spending cap</b>	Yes. \$4.7 billion
<b>Populations included</b>	<p>(i) Underinsured children with income between 225% and 300% FPL, not otherwise eligible for Medicaid or SCHIP; <b>Benefits:</b> Full Medicaid benefits.</p> <p>(ii) Mandatory Medicaid State Plan children and adults. <b>Benefits:</b> Full Medicaid benefits.</p> <p>(iii) Pregnant women up to 185% FPL <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – Vermont Health Access Plan, Primary Care Plus (VHAP PC Plus). Excludes LTC, EPSDT, private duty nursing, eyeglasses, dental, prosthetic devices, IMD, ICF/MR, inpatient psychiatric, personal care, case management, respiratory care for ventilator dependent individuals, PACE, hospice, and transportation.</p> <p>(iv) Parents between 150% and 185% FPL <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – VHAP PC Plus. Excludes LTC, EPSDT, private duty nursing, eyeglasses, dental, prosthetic devices, IMD, ICF/MR, inpatient psychiatric, personal care, case management, respiratory care for ventilator dependent individuals, PACE, hospice, and transportation.</p> <p>(v) Childless adults up to 150% FPL; <b>Benefits:</b> Reduced Medicaid/SCHIP benefits – VHAP PC Plus. Excludes LTC, EPSDT, private duty nursing, eyeglasses, dental, prosthetic devices, IMD, ICF/MR, inpatient psychiatric, personal care, case management, respiratory care for ventilator dependent individuals, PACE, hospice, and transportation.</p> <p>(vi) Aged and disabled not eligible for Medicaid or VHAP up to 175% FPL; <b>Benefits:</b> Pharmacy only benefits.</p> <p>(vii) Childless adults with incomes 150% and 200% FPL; <b>Benefits:</b> Employer sponsored insurance program – premium assistance to purchase ESI or Catamount Health Plan coverage (if ESI not available). Benefits must be actuarially equivalent to a minimum benefit package defined in State law.</p> <p>(viii) Parents with incomes between 185% and 200% FPL; <b>Benefits:</b> Employer sponsored insurance program – premium assistance to purchase ESI or Catamount Health Plan coverage (if ESI not available). Benefits must be actuarially equivalent to a minimum benefit package defined in State law.</p> <p>(ix) Individuals with persistent mental illness, not eligible for Medicaid, with income up to 150% of the FPL; <b>Benefits:</b> Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services.</p>
<b>State's policy goals</b>	Increased flexibility.
<b>Federal goals</b>	<p>(i) Improve access and quality of care (larger specialty networks);</p> <p>(ii) Predictable and efficient payment system, care coordination, beneficiary protections;</p> <p>(iii) New coverage.</p>
<b>Eligibility expansion</b>	Same as list in section titled "Populations Included." The waiver does allow additional flexibility to provide services to uninsured populations.
<b>Other items of spending for cost not otherwise matchable</b>	<p>(i) Expenditures related to eligibility expansion for Demonstration population;</p> <p>(ii) Expenditures for additional health care-related services for the demonstration population;</p> <p>(iii) Expenditures for capitation payments provided to MCOs that restrict enrollees' rights to disenroll within 90-days of enrollment into a new MCO;</p> <p>(iv) Expenditures for capitation payments provided to MCOs, which do not meet contract requirements;</p> <p>(v) Expenditures to enable the State to adopt policies, procedures and rules that define "uninsured" for purposes of establishing eligibility criteria for the expansion groups, as well as other policies, procedures and rules intended to prevent crowd out of private coverage.</p>
<b>Regional variation</b>	No.
<b>Ways in which budget neutrality was achieved</b>	Aggregate cap calculated based on cost and enrollment projections going forward. State initially estimated \$4.2 billion over 5 years without the waiver but generous assumptions resulted in \$4.7 billion cap (high trend rates unlikely to be duplicated). On a year to year basis, the State is permitted to claim Federal match based on an actuarially sound PMPM for all eligibles; the difference between the PMPM and actual expenditures can be used for other purposes spelled out in the terms and conditions.
<b>Financing-sources of non-federal</b>	State General Funds.

<b>share and types of reimbursement</b>	
<b>Current budget neutrality status</b>	Increased cost and enrollment could be eating into savings. In 2007, Vermont added childless adults with incomes 150% and 200% FPL and parents with incomes between 185% and 200% FPL (Catamount Health Plan)).
<b>Issues or problems</b>	Office of Vermont Health Access operates as a public MCO. OVHA receives a monthly capitation payment from its parent agency (Vermont Agency of Human Services), and is at risk for all services (except long-term care) required by covered populations. Increased cost and/or enrollment could reduce budget neutrality room.
<b>Likelihood of replication</b>	Not likely to be approved again. State works with legislature to set rates and can use savings (profits) for non-Medicaid purposes.
<b>Key similarities or differences compared to California (comparison of the state's situation)</b>	Vermont and California are very dissimilar States but the Vermont model provides a model for waiver financing that is worth exploring. State projections showed that Vermont cannot come up with a non-Federal match for all the Federal money available with the waiver funded at 112% of the State's estimate. Further, the concept of a State being able to claim funding at an actuarially set rate offers financial possibilities if California is able to claim administration, excluding county administration, enrollment activities, and health plan enrollment at 8 or 9 percent and if the actuarially rate includes at 2 to 6 percent for risk. It is unclear if the rate markup would be applied to people enrolled in managed care, but even if it was applied to only the fee-for-service population in the waiver, it could net over \$200 million a year in expenditure authority just from a conservative differential on administration and a 2 percent risk factor. If the State was able to get in its actuarial rate a 9 percent rate for administration of the health plan component of the program and a 6 percent rate for risk, this would provide the State with significant spending room above its current expenditure trend. Per Kaiser Family Foundation, Vermont's Medicaid spending per enrollee is \$5,096 compared to \$2,740 in California.