Lean times necessitate creative approaches to financing and delivering health care. Leveraging existing local government spending on health care is a ripe opportunity for state and local officials to work together to stretch tax dollars as far as possible, manage health care spending, and expand coverage.

**Conclusion**

Lean times necessitate creative approaches to financing and delivering health care. Leveraging existing local government spending on health care is a ripe opportunity for state and local officials to work together to stretch tax dollars as far as possible, manage health care spending, and expand coverage.

**About the Author**

Caton Fenz is legislative coordinator for Harris County, Texas, the third largest county in the nation. Previously he served as legislative staff in the Texas Legislature, where he focused on health and human services policy and financing. He can be reached via e-mail at caton_fenz@co.harris.tx.us.

**Endnotes**


3. “Units of local government” include counties, cities, and special taxing districts whose primary responsibility is health care (e.g., hospital districts, emergency service districts, and combinations of these, consolidated city-county health services departments). In some cases, it could include school districts.


8. The effect on the bottom line will be negligible rather than zero because the state may incur some administrative costs. As with service costs, these administrative costs could be shared with or devolved entirely to the participating units of local government.


15. See “Coverage Matters: Insurance and Health Care,” Committee on the Consequences of Uninsurance, Board of Health Care Services, Institute of Medicine, 2003.


17. See “Coverage Matters: Insurance and Health Care,” Committee on the Consequences of Uninsurance, Board of Health Care Services, Institute of Medicine, 2003.


20. Note that local and state officials must work together on any proposal; local units of government have no mechanism to apply for waivers directly. In some cases, local officials must apply for waivers on the state’s behalf. In others, the state must devise a waiver application on behalf of local units of government.

21. External resources are available to assist states in developing coverage expansion models. The State Coverage Initiatives Program of AcademyHealth, for example, awards small and large policy planning grants for this purpose. See www.statecoverage.net.


cover all of the children the state proposed to cover with the original and revised waivers.

Another reason was the federal government’s concern about limiting enrollment options for the expansion populations. Texas proposed to mandate the expansion populations into local governmentsponsored health plans to ensure that the contributing state retained control over the funds they raised through local tax arrangements. The federal government at the time insisted that Texas offer the expansion populations a choice of at least two different plans. This issue was never formally resolved.

**Federal Perspective**

Recently announced federal policy initiatives provide new prospects for states that are interested in expanding coverage using local government dollars. The HIFA initiative, for example, with its emphasis on flexibility and maximizing existing resources, is an excellent opportunity for states to develop creative strategies to expand coverage, including leveraging local government funds.

Officials from the Centers for Medicare and Medicaid Services (CMS) confirmed that the federal government is willing to give states significant flexibility in program design and financing. This is primarily to allow states to experiment with the expansion populations that would be newly covered under the states’ waiver proposals. The HIFA initiative has very specific policy protections built in for mandatory populations such as pregnant women and children.

Past proposals that used local funds have generated federal concerns on two issues: limitation of enrollment options for expansion populations and potential variability in coverage levels across the states. CMS is willing to consider more flexibility on both issues.

**Limitation of Enrollment Options**

Historically CMS has expressed concern about the state waiver proposals not limiting the enrollment options of expansion populations. For example, CMS reacted coolly to a provision within Texas’s 1995 proposal that would have mandated enrollment of an expansion population in a particular region into a single local government-sponsored health plan. Recent experience with Michigan’s approved New Mexico HIFA waiver, which permitted the state to make its premium assistance model mandatory for its expansion population, this approach may signal a federal willingness to provide more flexibility with respect to enrollment options for expansion populations.

**State Efforts**

Several states have taken advantage of HIFA to expand coverage to parents and other groups. Six states have approved HFAs to expand coverage to childless adults with family incomes between 30 and 300 percent of Federal poverty level (FPL), all in counties that choose to offer a county-sponsored health plan and finance the non-federal share of that coverage.

Because Michigan’s HIFA proposal is currently classified as “inactive,” CMS has not issued a formal ruling. It is worth noting, however, that no other approved HIFA demonstrate allows for coverage levels and benefits to vary from county to county. If Michigan chooses to reactivate its proposal, the Bush administration will need to decide whether and what degree to allow such local variation in coverage.

The fact that CMS has not issued revised waivers has been noted that these have been in the context of long-term care demonstration projects (e.g., the Program of All Inclusive Care for the Elderly) or restructuring demonstration projects (e.g., in Los Angeles), and no coverage demonstration projects. CMS encourages states that want to pursue this approach to submit their proposals with their policy justifications and initiate the decision-making process. As with other areas that are not addressed in the HIFA guidance, this issue would be decided on a case-by-case basis.

A corollary issue is whether CMS will approve waivers that propose to expand coverage only within one geographic area. While CMS has approved geographically limited waivers in the past, officials note that these have been in the context of long-term care demonstration projects (e.g., the Program of All Inclusive Care for the Elderly) or restructuring demonstration projects (e.g., in Los Angeles), and no coverage demonstration projects. CMS encourages states that want to pursue this approach to submit their proposals with their policy justifications and initiate the decision-making process. As with other areas that are not addressed in the HIFA guidance, this issue would be decided on a case-by-case basis.

Michigan requested that CMS render its waiver application “inactive” because of the state’s tight budget situation. Even though unreported local funds are available, officials are concerned that the required state funds may not be. Adding to the uncertainty is a recent change in federal leadership; it is under what the new administration will do with the proposal.

Texas’s recent waiver proposals originated in 2002 when three local governments offered to finance the non-federal share of a coverage expansion to pregnant women and children in their areas. The proposals seek to cover, at a minimum, populations that the state could cover under a Medicaid section 1115 expansion; require cost-sharing on a sliding scale that places the benefits to mirror services provided by local governments; and limit enrollment options for the expansion population to local government-sponsored health plans. These proposals do not fit the HIFA template, so Texas is pursuing it through the traditional 1115 waiver process.

The Texas proposals would achieve budget neutrality by expanding coverage only to a population that the state could cover at its option—in this case, parents of Medicaid-eligible children since 1933. The state is not attempting to expand coverage to any other group, such as childless adults. This is an important distinction because the federal government gives states credit on the “without-waiver” portion of the budget neutrality calculation for populations that states could cover at state option. Because of this credit, the “without-waiver” calculation of federal expenditures for any project that proposes to cover these populations would automatically be equal to or less than the without-waiver calculation, assuming the state can keep expenditures within a growth rate that is agreed upon at the outset. The key question is whether the state can keep expenditures within CMS’s proposed growth rate, which is this point in the discussion is the Medicaid growth rate assumed in the Bush budget.

Texas officials are carefully evaluating the feasibility of this task because the growth rate is locked in at the beginning of the waiver, and the state is fully at risk if expenditures grow beyond the agreed-upon rate.

Intergovernmental Transfers

One unique way in which states use local government funds in their Medicaid programs is through intergovernmental transfers (IGTs). Several states (e.g., Iowa, Pennsylvania) use IGTs to maximize federal funding through their Medicaid Disproportionate Share Hospital (DSH) programs or Upper Payment Limit (UPL) arrangements.

In general, IGT arrangements work as follows: first, local governments transfer a sum of money to the state via an IGT. Next, the state returns those funds, usually less some portion retained by the state, to the local government. Finally, the state claims federal matching funds for the expenditure at the state’s standard federal matching assistance percentage, which ranges from 50 to 83 percent.

According to the U.S. General Accounting Office, in federal fiscal year 2000, states used IGTs to increase federal Medicaid reimbursement without additional state spending to the tune of $5 billion. The use of IGTs, especially for UPL arrangements, has likely skewed states’ Medicaid eligibility and enrollment decisions by making it less attractive to states to increase enrollment in new regulations that further restrict the use of IGTs by states.

The Texas proposals, which may be consolidated into a statewide initiative at some point, are in the conceptual phase, meaning that broad outlines of the three proposals have been submitted to CMS for their preliminary review. CMS suggested that additional research and discussion are necessary, primarily in the area of limitation of enrollment options.

**Pros and Cons**

For states, the benefits of leveraging local spending are increasing the number of people with health insurance, raising federal revenues flowing into the health care economy (resulting in increased economic activity and tax revenues), reducing health care spending through improved management, and encouraging a more efficient health care system—all with a negligible impact on the state’s bottom line. A drawback is that expanding Medicaid coverage may create an expectation that the state will continue to provide coverage if the local government withdraws from the arrangement.

For local governments, the benefits are similar except that they can also stretch local dollars further by leveraging federal funds. This may release upward pressure on local taxes. A drawback is that, once local governments opt to participate in financing an expansion, they may find it politically difficult to withdraw from if necessary. Local officials who participate in leveraging local government funds express frustration because the inflationary pressure of Medicaid comes from a program over which they have little administrative control.

**Next Steps**

State and local officials interested in leveraging local funds to expand coverage can:

- Quantify the amount spent on health care by various groups.
- Identify the potential for cost savings through increased efficiency.
- Develop innovative strategies to integrate local and federal funding streams.
- Collaborate with local and state officials to leverage Medicaid funding.
- Explore the potential for intergovernmental transfers.

These steps require a coordinated effort among all stakeholders to ensure a successful implementation of the proposed initiatives.
cover all of the children the state proposed to cover with the original and revised waivers.

Another reason was the federal government’s concern about limiting enrollment options for the expansion populations. Texas proposed to mandate the expansion populations into local government-sponsored health plans to ensure that the contributing entities kept more control over the funds they raised through local taxation. The federal government at the time insisted that Texas offer the expansion populations a choice of at least two different plans. This issue was never formally resolved.

Federal Perspective

Recently announced federal policy initiatives provide new prospects for states that are interested in expanding coverage for low-income local government dollars. The HIFA initiative, for example, with its emphasis on flexibility and maximizing existing resources, is an excellent opportunity for states to develop strategies to expand coverage, including leveraging local government funds.

Officials from the Centers for Medicare and Medicaid Services (CMS) confirmed that the federal government is willing to give states significant flexibility in program design and financing. This is particularly true of the expansion populations that would be newly covered under the states’ waiver proposals; the HIFA initiative has very specific protections built in for mandatory populations such as pregnant women and children.14

Past proposals that used local funds have generated federal concerns on two issues: limitation of enrollment options for expansion populations, and potential variability in coverage levies across states. CMS is willing to consider more flexibility in program design and financing.

Limitation of Enrollment Options

Historically CMS has expressed concern with state waiver plans that went beyond 100 percent of the enrollment options for expansion populations. For example, CMS reacted coolly to a provision within Texas’s 1995 proposal that would have mandated enrollment of an expansion population in a local government-sponsored health plan. Recent proposals, such as Michigan’s approved New Mexico HIFA waiver, which permitted the states to make their plans less self-assistance model mandatory for their expansion population. This approach may signal a federal willingness to provide more flexibility with respect to enrollment options for expansion populations.

Geographic Variations in Coverage

Another issue is potential variability in coverage levels from locality to locality. Michigan’s recent proposal requests permission to expand coverage to children and adults with family incomes between 36 and 100 percent of the Federal Poverty Level (FPL) only in counties that choose to offer a county-sponsored health plan and fund the non-federal share of that coverage. Because Michigan’s HIFA proposal is currently classified as “inactive,” CMS has not issued a formal ruling. It is worth noting, however, that no other approved HIFA demonstration allows for coverage levels and benefits to vary from county to county.

If Michigan chooses to reactivate its proposal, the Bush administration will need to decide whether, and to what degree, to allow such local variation in coverage.22 But the fact that CMS did not dismiss Michigan’s proposal outside the bounds well for states that want to try such an approach. Such states would have to present appropriate policy justification for the local variation and likely would have to build safety valves into their strategy (e.g., requiring a local maintenance of effort to prevent a “race to the bottom”).

A corollary issue is whether CMS will approve waivers that propose to expand coverage only within one geographic area. While CMS has approved geographically limited waivers in the past, official notice that these have been in the context of long-term care demonstration projects (e.g., the Program of All-Inclusive Care for the Elderly) or restructuring demonstration projects (e.g., in Los Angeles), and not coverage demonstration projects. CMS encourages states that want to pursue this approach to submit their proposals with their policy justifications and initiate the decision-making process. As with other areas that are not addressed in the HIFA guidance, this issue would be decided on a case-by-case basis.

For local governments, the benefits are similar except that they can also stretch local dollars farther by leveraging federal funds. This might release upward pressure on local taxes. A drawback is that, once local governments opt to participate in financing an expansion, they may find it politically difficult to withdraw from it if necessary. Local officials who participate in federal initiatives may find that state Medicaid programs express frustration because the inflationary pressure of Medicaid comes from a program over which they have little administrative control.

Next Steps

State and local officials interested in leveraging local funds to expand coverage can:

- Quantify the amount spent on health care for the uninsured by local governments.
- State policymakers can engage state-level associations that represent local governments and press for better data on enrollment options in their respective state Medicaid programs.
Develop a conceptual model of the expansion, including the target population, benefits packages, cost-sharing, delivery systems, and methods of achieving budget neutrality. Present the model to key state and local government officials. Use their comments to refine the conceptual model. Submit the concept paper to CMS for pre-review and comment.

Engage in a formal deliberative process to solicit public input. This could take the form of a series of legislative committees, an agency advisory committee, or a public-private task force. Assemble input and finalize the model.

Seek formal approval from the federal government, negotiate terms of approval, and begin implementation.

Conclusion
Lean times necessitate creative approaches to financing and delivering health care. Leveraging existing local government spending on health care is a ripe opportunity for state and local officials to work together to stretch tax dollars as far as possible, manage health care spending, and expand coverage.

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Endnotes
3 Units of local government include counties, cities, and special taxing districts with primary responsibility for health care (e.g., hospital districts), emergency service districts, and combinations of the three (e.g., consolidated city-county health services departments). In some cases, it could include school districts.
4 Staff of the National Association of Counties report that no national-level data exist on the amount spent by local government on health care for the uninsured. Some state data are available. See Fenz, "Providing Health Care to the Uninsured in Texas: A Guide for County Officials," The Acacia Project, September 2000, available at www.statecoverage.net/statements00/isdf.pdf.
6 Data compiled from the National Association of Counties Health and Human Services Survey, available at www.naco.org/health-humanservs/health/community/tx_CommunityHealth_5.pdf; "Local Health Contributions," U.S. General Accounting Office, Publication 2002/05/03, May 2002. State revenue estimates for fiscal year 2002 continue to be revised downward, and the outlook for fiscal year 2003 is generally pessimistic.* In these tight budgetary times, many states have made, or are considering making, cuts in state health care spending.* One way to reduce spending and the number of uninsured is to leverage local dollars.

Leveraging Local Funds to Expand Coverage in Lean Times

There are thousands of units of local government in the United States—such as counties, cities, hospital districts, and more—that spend billions of dollars annually on health care services for the uninsured.* Almost all of this spending is unmatched by the federal government, even though most of it is devoted to low-income, uninsured individuals. Some states have recognized this opportunity and are seeking approval from the federal government to leverage local dollars to pursue coverage expansions under Medicaid.

Local Governments and Medicaid
Since the inception of Medicaid in 1965, many states have required their local governments to participate in the administration and financing of the program. Currently, local governments help finance state programs in six states, help finance administrative costs and perform administrative functions in four states, and do both in 11 states (see Table 1).*

Federal law places few limitations on state government involvement in state Medicaid programs. The major statutory restrictions are: 1) a requirement that at least 40 percent of the non-federal share of Medicaid expenditures come from the states; 2) a prohibition against using federal dollars (e.g., federal grant dollars) to match local dollars; and 3) a limitation on the use of voluntary contributions and provider-specific taxes to finance the non-federal share.*

Since 1994, when the federal government issued policy guidance allowing states to demonstrate budget neutrality of Section 1115 Medicaid waivers over five-year periods, more than 25 states have submitted waiver proposals to expand coverage, some using a permutation of this model.* For example, in late 1995, Texas submitted a waiver proposal that included a coverage expansion to all children with family incomes up to 133 percent of the federal poverty level (FPL), and adults (with and without children) with incomes up to 45 percent FPL. The proposed financing method for the non-federal share of this new Medicaid coverage was voluntary intergovernmental transfers to the states from local governments. Budget neutrality would be achieved through reductions in Medicaid Disproportionate Share Hospital (DSH) funds and the savings that resulted from moving existing populations into capitated managed care.

After 12 months of negotiations between the state and the federal government, the waiver proposal was scaled back to include just the children's expansion. After another six months, the waiver was left pending. The primary reason was the prospect of passage of legislation in 1997 enacting the State Children's Health Insurance Program (SCHIP), which would...