Democratic Caucus Meeting

12/18

MEDICAID - Follow-up to Sunday meeting

1. Numbers - retain $54 billion - but with $20 billion in 2002 (current model achieves $18 billion).

2. DSH - phase-in Sabo-Stenholm DSH targetting approach.

   a. Pools - open. Consider FQHC/RHC pool based on earlier conversations with Cong. staff.

3. Cap - maintain per capita cap (higher in earlier years than in out-years, as in current policy).

   a. Attendees want us to consider "differential" growth cap in which states with some measure of a low cost base get a higher growth cap than states with a high cost base. Some would even move over a period of years to a nationally normalized policy.

   b. Data being developed.

   c. Options:

      (1) Keep as flat cap
      (2) Differential cap
      (3) Flat cap, with some combination of Secretary, commission to develop differential indices.

4. Flexibility

   a. Boren - repeal

   b. Cost sharing - consider extending current-law cost sharing with HMOs

November 19, 1995

To: Medicaid, Medicare drafters

From: Jack Ebeler

cc: Bruce Vladeck

Subj: Follow-up on our call with Chris Jennings and Nancy-Ann Min

Attached are my notes from our call Sunday on the Medicaid and Medicare restructuring passbacks.

Attachments

Medicare Restructuring - follow-up/changes in HHS position based on conference call at 5:00
Chris Jennings, Nancy-Ann Min, Bruce Vladeck, Jack Ebeler

1. Partial risk option - we will keep in the draft the partial risk option pending HCFA actuary review of whether it has cost (due Monday)

2. Enrollment - lock-in - OMB agreed to no annual lock-in.

3. Quality - 50/50 - as discussed at 1:00, keep 50/50 until date certain when quality standards are effective (note - this is a fairly fuzzy agreement - may be more feedback on it)

4. PSOs - OMB agreed with HHS positions that physician-only groups should not be allowed, and that POS options should not be allowed.

5. External quality review - HHS/OMB tentatively agreed to allow deemed status for internal quality review, but not for external review (Nancy-Ann will discuss with staff) - so there should be a follow-up staff discussion on this.

6. Case management - we explained "case management" position" - Nancy Ann will discuss with staff - so there should be a follow-up staff discussion on this.

7. Medigap - LTC insurance anti-duplication - OMB agreed to include.

Medicare savers

1. HH issue - resolution not clear - HCFA staff should check with Bruce, and have follow-up discussion with OMB staff.

2. Recalibration - OMB tentatively agreed so long as the language includes budget-neutrality provision

Additional item (not for Monday)

1. Chris Jennings wants us to include private LTC standards that were previously developed (because of the LTC tax changes in the Republican plan).

Medicaid - follow-up/changes in HHS position based on conference call at 5:00
Chris Jennings, Nancy-Ann Min, Bruce Vladeck, Jack Ebeler

1. Encounter data - we agreed to drop "encounter"

2. HCB services - keep in draft pending John Klem memo on cost (due Monday) - OMB agreed pending memo.

3. MEQC - as discussed at 1:00, OMB prevails

4. MMIS changes - Don J., other staff, should talk with Mark Miller to clarify issues - nobody on the phone call knew what was being kept, what we were proposing to drop.

5. IHS and managed care - as discussed at 1:00, OMB prevails - we should add in language

6. State plan amendments - we raised question - their only desire is to allow (permissive) states to submit one combined amendment -- we agreed so long as permissive.

7. DSH - as discussed at 1:00, we need to draft state plan approach that we developed.

   In addition, we agreed to add language under which the Secretary, in consultation with appropriate parties, would develop standards for an allocation formula.

8. Boren - as discussed at 1:00, move to process standard.

9. REGO II changes - OMB agreed to keep these in.

442E
Enclos

Debbie/Don T
Julia/Rob/Jeanne Christy S.
Karen P.

FYI
Gail E

A note to my friends Chris Jennings, Emily Bromberg, John Monahan, Bridgett Taylor, Bruce Lesley:

I am pleased to be back in Colorado, despite the snow this morning. Since I am not there to bother you, I thought I would share these thoughts.

Attached you will find a list of flexibility and related issues that I have compiled from my work with Democratic Governors' staffs over the last few months. I can't say it is complete, but I think it does justice to the major issues raised. I need to say as strongly as possible that I believe almost every single one of those items should appear in the unified proposal. I do not mean that Democratic Governors will leave the coalition if they are not included (although some may), but that the inclusion of these items is critical.

We are about to enter a major battle over the future of Medicaid. The recurring theme from our side to Republican Governors has been: tell us what flexibility you need to run your programs--we'll give it to you--but you must retain the guarantee of meaningful coverage. It is time to show that we are serious when we make that offer. Include every bit of flexibility and challenge the Republicans to state what else they need. I think they will have a hard time doing it.

Similarly, let's get the equity argument right. Come up with a good formula and defend it. Let the states that can negotiate a better deal do so. But the core formula needs to be principled. This will put us on a higher ground than the Republicans. High ground is going to become more important as this goes forward.

The intra-party debates I heard over the past few days were a bit surreal. I understand that, historically, the question was what policy is best for health care. With the attack we face, we need to ask the question: what policy can we put on the table that best prepares us to defend what we most care about. To me the answer is easy. It is a clearly defined individual entitlement with reliable funding and maximum flexibility.

I have to believe the Administration proposal is not something that will form the basis of negotiation. Therefore, it would be a mistake to treat increases in flexibility as a chit we can negotiate away. The people across the table from us are so dug in that they are going to reject this proposal. If they come to our side, it will not be through negotiation, but through desperation to make a deal. We need to make our offer so good that we can defend it to the end if they choose to walk away.

I am available to offer whatever assistance would be helpful as you attempt to pull this all together. Thank you for including me in this process. I'm sure I'll see you all soon.

Alan

Consolidated Document on Changes/Flexibility in Medicaid

Eligibility

Democratic governors have no difficulty accepting the retention of the entitlement for all current mandatory populations.

Within that context, states have the following concerns:

We need to break the link between cash assistance and medical assistance. Medical assistance eligibility should be based upon simple income and asset tests without regard to family structure.

The number of eligibility categories should be reduced and the determination of eligibility should be simplified.

Optional eligibility categories must be truly optional, meaning that states that have elected the option can roll back to the mandatory categories at any time.

There is a concern that, for scoring purposes, all avenues for expansion will be eliminated. This would mean that federal financial participation was being used to share the cost of serving a population in one state, but another state could not receive federal funds for covering that same population if they had not elected to cover that group prior to enactment of this law.

Federal trust and asset transfer provisions should be reexamined.

Benefits

States need significantly greater flexibility in designing their benefit packages.

States should be permitted to establish benefit comparability within an eligibility grouping rather than being required to have comparability across all Medicaid recipients. Optional services should be comparable within a class of beneficiaries, but need not be comparable for all beneficiaries.

Benefits should be defined by service; mandatory benefits defined by provider (such as FQHC/RHC) should be redefined to reflect the services those providers deliver.

The treatment component of EPSDT should be limited to those items in a state plan or a defined list of enhanced services, as opposed to being completely open-ended.

The exclusion of IMDs for adults should be repealed because the necessary cost-containment occurs by using the per capita cap.

Delivery System

States must be permitted to use managed care delivery systems without requiring a waiver.

States must be permitted to develop HCBS programs without a waiver.

State Medicaid programs should be permitted to require dual-eligible enrollees in managed care to receive their Medicare services through the same managed care entity. The Medicare/Medicaid integration language in the reconciliation bill is a good start, but does not go far enough. NASHP has developed alternative legislative language.

The requirements for states using managed care must be narrowly tailored along the lines in the Administration's bill, not like the Chafee language which appears in the coalition bill. Some states feel that even the Administration language is too restrictive in requiring plan choice and limiting plan lock-in to 6 months. There must be no Boren-like provisions for capitation payment rates.

States must have greater flexibility in the area of copayments and premiums. Copayments should be permitted in managed care plans. States should be permitted to define a higher level for nominal copayments in fee-for-service settings.

Financial Structure

States must not have a cap applied to federal FY96.

The general structure of the per capita cap as it appears in the Administration proposal is a workable one for states.

The Boren Amendment must be repealed in full.

States are very interested in having the QMB and SLMB programs incorporated into Medicare and having them administered (and financed) entirely by the federal government.

There is great interest in an effort to create more equity among states. This interest applies to the per capita values as well as the DSH program. There have been some preliminary staff discussions on this topic that could be pursued. It is difficult to take this discussion very far until a more concrete overall structure emerges.

States with approved but not implemented 1115 waivers are concerned that the federal funds they are anticipating for their expansions continue to be made available.

IHS should continue as a separate funding stream.

Other Provisions of Title XIX with major cost implications

These items must be changed in order to make it possible for states to operate within the fiscal constraints of a per capita cap.

The Boren Amendment must be repealed. There must be a close look at all of Title XIX to make sure that no similar basis for provider-initiated legal challenges will remain.

FQHC 100% cost reimbursement and mandatory coverage provisions should be removed, although we would consider a targeted, federally administered set-aside to ensure that these safety-net providers continue to operate.

We need to review the structure of the current survey and certification process.

Limitations on using a drug formulary should be removed.

Veteran's Administration prices should not be excluded from best pharmacy price.

The annual review portion of PASARR (pre-admission screening and annual resident review) should be eliminated.

Administrative Provisions of Title XIX with lesser cost implications

Many features of Title XIX place administrative burdens on states that do not drive program costs, but that do consume limited administrative resources. These are headache provisions that could be changed with no real effect on recipients.

Federal nursing home quality standards should remain in place, but states that can demonstrate that they have implemented and will enforce equally effective standards should be permitted to use those instead.

EPSDT participation and reporting requirements should be lifted.

The detailed federal standards relating to claims processing systems, fraud-detection programs and estate recovery systems are not needed.

As in the Administration proposal, we should eliminate HCFA contract approval, upper payment limits, 75/25 rule and mandated insurance purchase.

Broad administrative waivers should be available to states that adopt performance standards as an alternative to the many process standards in current law and rule.

MEDICAID PASS-BACK ISSUES

POLICY ISSUE	TECHNICAL ISSUES
Encounter data: OMB struck the work "encounter" between "patient" and "data" requirement for managed care	**Making index control to $54 billion** OMB recommends that rather than fix the index in legislation, put in language that says that the index will be whatever sums to $54 billion in savings (when combined with DSH savings); we agree
Home & community based waiver as state plan amendment: OMB wants this repealed unless we have a cost estimate that says its costs are negligible. John Klemm told Don Johnson it is negligible	**Subsequent disallowances in the per capita cap base year** OMB wants to make sure that they are not allowed; this is done
MEQC changes: We had made changes to simply; OMB wants the old system	**Publication of annual per capita cap limits** OMB has added this; we agree
MMIS changes: We had made changes to simply; OMB wants the old system plus new data for enforcement of the per capita cap	**Rural choice of providers:** OMB wants to require states to have at least two choices of providers for residents in rural areas; we agree
IHS & managed care: We had chosen to deal with this later; OMB wants us to deal with this now	**FQHC, RHC cost-based reimbursement repeal** OMB says that is isn't in the draft; they are right; it will be rep
State plan amendment: OMB wants us to add a provision that requires the Secretary to review and respond to SPAs within 90 days or else default	**Delete using Medicare conditions & standards for home health and hospices** We agree
DSH: OMB wants to see our policy [it wasn't drafted]; we need to make sure that we are all comfortable with it	
Boren: OMB verbally conveyed that we move from safe harbors for nursing homes with substantive standards to a process standard for both hospitals and nursing homes	
REGO nursing home changes: We had put in REGO II PASSAR and survey and cert. simplifications; OMB expressed concerns verbally about the inconsistency of this provision with the attacks on the Republicans on nursing home quality	

Other issues not in the pass-back:

EPSDT: NOTE: EPSDT is current law.

Medicaid Issues

1- Provider Payment

CURRENT PROPOSAL

- Repeal Boren Amendment for hospitals. Establish provider reimbursement provisions with pre-approved methods for states' payment rates for nursing homes. These safe harbors would include rates that use the Medicare nursing home rate methodology, rates equal to or greater than the median of nursing homes costs within a state, and rates that include an increase equal to or greater than the increase in the Medicare nursing home market basket. HHS would conduct a study to investigate the relationship between quality, access and provider payment to address the need for adequate access of Medicaid beneficiaries.

PROPOSED

- Establish process only standards

2- Index

CURRENT PROPOSAL

- Growth in spending per beneficiary would be indexed using an inflation-based index -- the GDP -- adjusted with a plus or minus factor to meet budgetary targets.

- The same index would be used for each eligibility category.

PROPOSED

- No specific index, rather a index that combined with DSH reduction would save $54 billion over 7 years.

3- DSH

CURRENT PROPOSAL

- <u>Reducing payments</u>:

  -- The reduction would be 33 percent of each state's federal DSH payments in 1995.

  -- Each state would receive the same proportional reduction from its current DSH spending regardless of whether or not the state was actually spending up to it full allotment under the current DSH program. Those states which do not currently have any DSH spending (i.e. Tennessee) would not have a DSH allotment.

-- For subsequent years, the maximum amount of federal DSH payments to all states would be increase by an inflation- based index -- GDP -- from the FY 1996 amount. **[interaction WITH INDEX ISSUE]**

o State plan: The States would submit a State plan that would:

-- Describe how providers would be targeted. The proposal would expand the states' options by also allowing states to spend the DSH funds on FQHC and RHC clinics.

-- Describe how these providers would be paid under the DSH program.

o Annual State report: The State would be required to submit an annual report to the Secretary and make it available to the general public that would include:

-- a list of DSH providers and their uncompensated care amount,

-- the amount of DSH payments to each provider, and

-- explanation of how the State's payments related to the State's plan.

ALTERNATIVE

o The current DSH program should be phased-out over the next four years while simultaneously, a new Federal DSH program would be phased-in. The provisions of the new program include:

- Each State would receive an initial allotment equal to 4 percent of their current benefit baselines;

- A national limit of 4 percent would also be established;

- For each year that the sum of states actual spending for DSH is below the national limit, the amount which was not spent will be proportionately distributed among those states which were designated as high-DSH states in 1995. In essence, high-DSH states could have a slightly higher than 4 percent allotment in a given year;

- States would continue to be required to provide their share of funding in order to receive Federal matching payments;

- Those hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the mean rate for hospital in the state or a low-income utilization rate which exceeds 25 percent (current law standards) would be eligible to receive Medicaid DSH payments. This provision only identifies those groups of hospitals which must be deemed eligible to receive DSH payments. This does not require

states to make DSH payments to the hospitals which meet these standards;

- States would be permitted to make DSH payments for outpatient services, clinic services, and services provided at FQHC/RHCs in addition to inpatient services.

4- LTC Services

CURRENT PROPOSAL

Include REGO II proposals:

o Repeal the duplicative annual resident review in nursing homes under PASARR.

o Allow nurse-aide training to be conducted in certain rural nursing homes even if the facility has been subject to an extended survey.

ALTERNATIVE

o make no changes

5-EPSDT Service

CURRENT PROPOSAL

o no change to EPSDT policy

ALTERNATIVE

o Optional rather than mandatory treatment proposal.

ADDITIONAL ISSUES

Administration

o Retain quality of care provisions, such as OBRA-87 nursing home reform provisions, an uncapped funding for the State survey and certification activities, and PRO utilization review provisions. **[Add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.--- This was never added into the draft legislation because we never had a clue how to really do this.]**

o MEQC

o IHS IN MANAGED ARE

- HCBW
- MMIS restructure
- encounter data

11/19

Changes In OMB Passback on Medicare Restructuring

Partial Risk Option

HHS Draft - Phases out the current cost options for managed care plans. Provides for a new partial risk option under which plans would be paid on a fee-for-service basis.

- o If expenditures for the year were below 95% of the AAPCC, plans would receive half the savings.

- o If expenditures were between 95% and 105% of the AAPCC, plans would receive 95% plus half of the amount over 95%.

- o If expenditures were above 105%, plans would receive only 100% of the AAPCC.

OMB Passback - Deletes the partial risk option.

Issues - OMB staff indicated that the passback eliminated the partial risk option because (1) it was not clear to them that anyone wanted such an option (2) they were concerned that it could have a cost (plans could be paid more than 95%).

- o The partial risk option is a bridge to full risk contracting. It allows entities that are used to working in a fee-for-service environment to contract with Medicare and receive additional payment if costs are below 95% of the AAPCC. Although most plans would probably continue to opt for full risk, why not make this option available as an alternative to the current cost option?

- o The potential budget impact of the partial risk option is difficult to gauge.

    - + Relative to the current risk methodology, Medicare would pay less if the interim payments to the plan totaled less than 95% of the AAPCC. There is the possibility that interim payments could exceed 95% of the AAPCC, but in no case would Medicare pay more than 100% which is what payments would have been on average under fee-for-service.

    - + Relative to Fee-for-service, Medicare would pay more under the partial risk option if interim payments were less than 95% of the AAPCC, but would pay less if interim payments were more than 95%..

PSOs

Modification #1

HHS Draft - PSO is "a hospital, a group of affiliated hospitals, or an affiliated group consisting of a hospital or hospitals and physicians".

OMB Passback - PSO is "established or organized by a health care provider or group of affiliated health care providers".

Issues - OMB staff indicate that they did not want to preclude a PSO consisting only of a group of affiliated physicians. (OMB did not, however, change the requirement that the PSO directly provide a substantial proportion of services . This requirement would appear to preclude a physician-only PSO.)

- Would a group of physicians have the assets required to meet fiscal soundness standards? Would we want to weaken the "substantial" requirement?

- Technical Issue -- just because an entity was "established" in one manner doesn't mean that it still is structured the way it was established.

Modification #2

HHS Draft - "The entity meets the requirements of subsection (c)(1)(E) (which may vary from the manner in which eligible organizations contracting under the previous paragraphs meet that requirement)."

OMB Passback - "The entity meets the requirements of subsection (c)(1)(E) **as implemented in accordance with Section 11203(a)**."

Issues - OMB staff indicate that they wanted to show the linkage to the Secretary's process for developing standards. In the latest HHS draft, we revised our language to make it clearer that we were talking about a different set of financial standards for PSOs that would be developed by the Secretary. We believe that our new language would be acceptable to OMB.

Modification #3

HHS Draft - PSO would be prohibited from offering a point-of-service option.

OMB Passback - deletes this prohibition.

Issues -

- OMB does not want to deny PSOs the POS option.

- The newspaper ads of the hospital organizations pushing for the PSO provision contrast PSOs with "Big Insurance Companies". The bill proposes that PSOs be subject to different fiscal soundness standards precisely for this reason. If you start with the premise that PSOs are not "big insurers", it follows that PSOs should not be allowed to offer an insurance product (POS) unless they are willing to meet the standards for insurers.

Enrollment in Plans APPEALING

HHS Draft - Provides for a 30 day period during which all managed care and Medigap plans would be open, also provides for an open enrollment when a beneficiary first enrolls in Part B or moves from one part of the country to another. Beneficiaries would still be allowed to disenroll from plans on a month to month basis.

OMB Passback - Requires lock-in for one year.

Issues

- The initial version of the restructuring proposal back in January contained a provision for annual lock-in with a free-look period and an option to leave the plan if the enrollee's primary care physician or specialist left the plan. Lock-in was proposed as one means of addressing favorable selection and to enhance continuity of care.

- Although HCFA is still considering requiring one-year lock-in in the context of the competitive pricing demonstrations such a provision was not included in the revised package because of the belief that given the state of knowledge about quality measurement, it was important to still allow enrollees to be able to vote with their feet against a plan. HCFA tracks disenrollment rates among plans and increases in disenrollment rates usually trigger a review of the plan by HCFA staff.

- The Conference agreement provides for one-year lock-in after a free-look period.

Quality

Modification #1 - 50/50

HHS Draft - Deletes reference to Medicaid in the 50/50 requirement (a plan's commercial enrollment would have to at least equal its Medicare enrollment).. Provides for additional exceptions for plans in underserved rural areas and for plans with good track records. 50/50 would be replaced with a requirement for a quality measurement system once the Secretary determined that such a system was feasible. Provides that the Secretary, by August 1986, will consult with plans, other purchasers and consumers concerning "the collection, analysis and reporting of managed care data that may be of use to purchasers and consumers in comparing performance and value of managed care plans".

Tie into quality

OMB Passback - Immediately replaces 50/50 with a requirement for a quality measurement system . Provides that by August 1997, the Secretary would **adopt** standards governing the collection, analysis and reporting of managed care data.

Requirement : NOT OPTIONAL

Issues It has been HCFA's position that an adequate system of quality measurement is years away and that 50/50 is necessary in the interim. The provision regarding consultation with the industry, other purchasers and consumers is deliberately vague because of the belief that mandating anything would damage the likely possibility of consensus emerging in the next year.

Issue - MCR, MCD

Modification #2 - External Quality Review

HHS Draft - Restates current law. Plans must have an internal quality assurance programs and a contract with a PRO or QRO for external review..

... allow plans to contract with entities other than PROs and QROs for ... ved by the Secretary. Plans with private accreditation ... the Secretary's would be deemed to meet the ... urance programs and external quality review.

... ors for external quality review is acceptable.

... y be an alternative for certifying internal quality assurance ... s desirable to have the same entity responsible for external

... ent that plans ensure that enrollees with chronic illnesses or ... y appropriate specialty care and case management.

... e requirements but deletes the case management requirement.

... to impose an additional requirement on plans.

... t of the definition of managed care. This is a new requirement ... that plans focus resources on enrollees with special needs.

Jeanne, I got a request from OS for the conf. Medicaid cut 96-02 for Louisiana + the Medicare cut for 96-02 also. Can you tell me? Thanks. Jeff

FN = 0

Care

Extent where Redundancy. Deem, Otherwise

New Ideas and Unresolved Issues
Medicaid Per Capita Cap Bill
November 9, 1995

Add Risk Adjustm
Managed Care
Expans. may

General Drafting Questions

Data Collection Incentives (Penalty)

Collecting timely and accurate enrollment and expenditure data is critical to enforcing the per capita cap. HCFA would defer paying one percent of the State's total grant until HHS has received complete and accurate date.

Enforcement Provisions "withhold" 1903(d)

HCFA could withhold some percentage (two to ten percent) of each State's grant award until final reconciliation with the annual limit on Federal spending. States that spend under their cap would receive all remaining matching funds, while States that spend above the cap would receive matching only up to the cap.

Budget Fail-Safe Provision

Overall budget projections would be strengthened through a behavioral offset similar to the volume performance standard for the Medicare fee schedule. Growth factors for per capita amounts -- currently linked to GDP -- would be increased or decreased (i.e., GDP plus one or GDP minus one), depending on whether leakage is low or high.

Provider Reimbursement

We are continuing discussions on Boren amendment issues and other provider reimbursement provisions. Changes to the per capita draft bill are likely. These changes would have implications for managed care upper payment limit requirements (see "B" list).

Base Year line 11 No

- Should base year calculations be adjusted for results of court suits, such as a court-ordered payments to hospitals, if these payments reflect litigation based on 1995 rates?

- Should 1115 demonstration States be able to choose between the alternative base methodologies only once? If yes, is the current deadline for the State's choice, July 31, 1996, appropriate?

- Should the alternative methodology for 1115 demonstration States be changed? If so, how?

Administrative Cap

Instead of including administrative spending in the base per capita rate, administrative spending could be limited by an overall cap, based on some percent of medical assistance expenditures. Administrative spending underneath this cap would not be audited and spending above the cap would not be matched. All administrative spending would be captured within the cap.

FQHCs and RHCs

- Transition from Cost-Based Reimbursement

  The bill includes a two-year extension of cost-based reimbursement for FQHCs and RHCs. An alternative method for transitioning FQHCs and RHCs from cost-based reimbursement could be:

  -- The State would be required to establish a new rate for FQHCs and RHCs;
  -- In year 1, payment rates would be a combination of 1/3 of the new rate and 2/3 of the previous cost-based payment;
  -- In year 2, payment rates would be a combination of 2/3 of the new rate and 1/3 of the cost-based payment;
  -- In year 3, the new rate would apply.

  However, States may game this method by annually updating the "real" rate for FQHCs and RHCs.

- Cost-Based Reimbursement and Managed Care

  -- Should the transition period for cost-based reimbursement apply to fee-for-service payments, but not to managed care subcontracts?

  -- Should States be required to make "wraparound" payments to FQHCs? These wraparound payments would provide for annual reconciliation between managed care subcontracting payments and cost-based reimbursement. (NACHC issue)

State Share

We do not make changes to D&T or other provisions on State share. One suggestion is to match only State funds that are appropriated expressly for Medicaid spending.

Quality Assurance

Should States be required to meet Federal standards for quality assurance programs? Should these programs be approved by the Secretary?

Indian Health Providers

- Should we extend 100 percent FMAP to tribal and urban Indian health providers?
- Should we require States to consult with Tribes as they develop State plan amendments?
- Should we establish an essential community provider protection for IHS and tribal and urban facilities under mandatory enrollment in managed care?
- Should Indian health providers (that do not qualify as DSH hospitals, FQHCs or RHCs) be eligible for DSH payments?
- In a mandatory managed care environment, should IHS beneficiaries be automatically assigned, or automatically defaulted if they do not choose an alternative provider, to IHS-funded health programs?
- Should we require States and/or HMOs to reimburse Indian health programs for services they provide on an out-of-plan basis to Indian Health Service beneficiaries?

Territories

Post-panel

Should the territories be given a choice between (1) participating on equal footing (with verified eligibility counts) in a per capita cap; and (2) retaining current caps on Federal matching?

Definition of Primary Care

For primary care case management programs, the draft defines primary care as services typically provided by, or under the supervision of, general practitioners, family practitioners, internists, OB/GYNs and pediatricians. Because we are seeking to turn current waiver programs into State plan options, this definition mirrors current PCCM programs authorized by 1915(b) waivers. Is this too physician-oriented? Would services provided by other health professionals -- such as speech and language therapists or psychiatrists/psychologists -- fall under this definition? Does this definition encapsulate all services delivered by nurse-practitioners? Should the definition of primary care services in section 330 of the Public Health Service Act be used instead?

Mental Health

Should there be greater Federal oversight -- or more prescriptive quality requirements -- for managed care programs that capitate mental health and substance abuse services?

Consumer Participation

Should States be required to consult with beneficiaries and other affected communities as they develop changes to their Medicaid programs?

Coordination for Immunizations

Should we retain the requirement that State plans provide for coordination of information and education on pediatric vaccinations and immunization services? This is included among statutory requirements for cooperative agreements, which have been deleted in the current draft.

Cooperative Agreements

Should requirements for cooperative requirements -- i.e., WIC, maternal and child health, vocational rehabilitation services -- be retained?

NO

Department "B" List Issues

Convert certain mandatory eligibility groups to optional.

Some groups could be changed from "mandatory" to "optional." The groups include:

-- Social Security beneficiaries who were eligible for AFDC or SSI at one time (or who would have been eligible if they were not in an institution) and who would continue to be eligible if the part of their Social security benefit attributable to COLAs were disregarded.

-- Categories of persons who lost cash assistance in 1973 when SSI replaced predecessor State cash assistance programs. (Categories are: recipients of mandatory state supplemental payments, "essential" spouses, certain persons in institutions.)

-- Categories of persons who lose SSI because of an increase in Social Security benefit other than COLAs. Categories include: disabled widow/ers affected by the 1983 changes in computation of their benefit or whose benefits increase when they attain age 60, and disabled adult who lose SSI due to Social Security increases based on a parent's entitlement

Allow States to use more restrictive eligibility methods under section 1902(r)(2).

States could use 1902(r) to be somewhat more restrictive than current law. Under current law, section 1902(r)(2) provides some relief to States, but only if they chose to liberalize an AFDC or SSI method.

Parameters could be developed to avoid undesirable excesses. For example, the "no limits on home equity value" rule could be put out of bounds.

Remove detailed federal rules governing certain optional program features

Detailed federal rules govern State implementation processes for certain optional provisions, such as medically needy spend down, determining the amount that institutional residents contribute to cost of care, presumptive eligibility for pregnant women, coverage of TB-related services for TB-infected individuals. States argue that, since these program elements are optional in the first place, detailed federal rules are inappropriate.

Managed Care

- Quality of Care and Accountability

These requirements are relatively minimalistic compared to the reporting and process requirements in other proposals. However, States may be particularly disturbed by the encounter data element in the monitoring requirement. Should this be retained?

- Greater Flexibility in Payments to Managed Care Plans

  -- Upper payment limit

  States are prohibited from setting rates that are higher than what they would have spent on the same enrollees, for the same services, if they retained a fee-for-service system. States may choose to develop bonus payments, quality incentives, or other methodologies that exceed what they would have spent in fee-for-service. In addition, the calculating UPL can be a cumbersome administrative requirement, particularly as a State's fee-for-service base is eroded by increased enrollment in managed care.

  However, some States may be dismayed by a repeal of the UPL, since this Federal requirement gives them additional negotiating leverage with health plans.

  Other per capita cap proposals repeal the section of 1902(a)(30) that includes the upper payment limit requirement. We could similarly repeal this language, which includes general language on access and payment for all services, or permit States to opt out of complying with the UPL.

  -- Actuarial soundness

  Under current law, States must establish capitation rates that are actuarially sound. This requirement prohibits States from driving their capitation rates to very low levels and protects enrollees from plan insolvencies. However, this rule also constricts State flexibility and, because Medicaid fee-for-service rates are often extremely low, this requirement may conflict with the upper payment limit. One per capita proposal repeals the actuarial soundness requirement, although others retain it.

Medicare Cost Sharing -- QMBs, SLMBs, QDWIs

- FMAP Changes for Dual Eligibles

  Provide 100 percent FMAP for prescription drugs provided to Medicare beneficiaries.

Cost Sharing

Several options could be developed to allow States to impose cost-sharing requirements that exceed the current restrictions on "nominal" cost-sharing.

- Cost-sharing above a designated income level;
- Cost-sharing for beneficiaries who qualify for medical assistance through optional eligibility categories;
- Cost-sharing for certain services (e.g., inappropriate emergency room utilization).

Data Collection Requirements

Current data collection requirements could be streamlined or simplified as new requirements are developed for enforcing the per capita cap. These requirements would need to be identified.

NGA Medicaid Policy Proposals

Included in Per Capita Cap Proposal

1. Impose no unilateral caps for federal spending on Medicaid entitlements. **(Addressed in general in Draft language)**

2. Allow states greater flexibility to establish managed care networks:

- States should be able to establish networks through the state plan process. (NGA '93, NGA '95) **(In Draft language)**

- Permit states to operate PCCM programs through state plan amendments rather than through freedom of choice waivers. (APWA) **(In Draft language)**

- Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95, APWA) **(In Draft language)**

- Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93, APWA) **(To be Included in Draft language)**

3.Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95, APWA) **(In Draft language)**

4. Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95) **(In Draft language)**

5. EPSDT

- Allow States to manage costs in the EPSDT program by providing services within their state Medicaid plan and selecting less costly alternatives for diagnosis and treatment without risking quality. (NGA '93, NGA '95, APWA) **(To be Included in Draft language)**

- Repeal the requirement that states cover treatment for children determined necessary by an EPSDT screen - or allow states to specify in the state plan the extent to which the state will cover such treatment if it is not a regular service. (NGA '93, APWA) **(To be Included in Draft language)**

6. OBRA '87 Nursing home reform modifications:

- Eliminate restrictions on training sites for nurse aides. (NGA '93, APWA) **(To be Included in Draft language)**

- Eliminate PASARR. (NGA '93, NGA '95, APWA) **(To be Included in Draft language)**

7. States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95, APWA) **(In Draft language)**

8. Provider Qualifications

- Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93, APWA) **(In Draft language)**

- Repeal the annual reporting requirements for OB and pediatric care. (NGA '93, APWA) **(In Draft language)**

9. Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93, APWA) **(Addressed in general in Draft language)**

10. Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93) **(Addressed in general in Draft language)**

11. Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93) **(Addressed in general in Draft language)**

12. Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93) **(In current law)**

13. OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93) **(In current law)**

Medicaid Meeting
(October 5, 1995 - 10:00 am)

1. Overview - where we have been/are

2. Major issues for review/decision (within HHS/ and HHS/OMB)

   a. Overall allocation of $54 billion savings - DSH v. Cap (1/3; $20 billion v. $30 billion)

   b. Per capita cap:

      (1) weighted average aggregate cap (current draft) v. separate caps (original position) - OMB/scoring issue

      (2) administration in or out (OMB)

   c. DSH:

      (1) How capture savings? Phase-down high-DSH states v. 1/3 from everyone

      (2) How spend remaining dollars?

         (a) State flexibility (high DSH hospital v. all hospital v. clinics)

         (b) Target - only for high DSH hospitals (OMB)

3. Analyses

4. Next steps

   a. Revised write-up

   b. Urban Institute analyses

   c. Meeting w/OMB/WH to finalize admin. policy

MEDICAID - OVERVIEW

Overview

The Medicaid proposal includes:

- o A per capita cap that limits the growth in Federal Medicaid matching per beneficiary;
- o Increased state flexibility in how to operate their programs; and
- o Limits on and re-targeting of disproportionate share payments.

Per capita cap

A per capita cap would be set to limit the annual growth in Federal Medicaid matching per beneficiary. Spending per beneficiary up to a set level would be matched under the current formula, but spending beyond that cap would not be matched. The cap would be set using spending per beneficiary in a base year and increased by an annual growth limit.

- o Each state would receive an aggregate cap that reflects the weighted average of these four categories: aged, disabled, adults in families with children, and children.
- o Expenditures for disproportionate share hospitals, Medicare premiums and cost sharing, Indian Health Service, administration, and Vaccines for Children would be excluded from the cap.
- o The annual growth limit would be an inflation-related factor, adjusted to meet the budgetary target. The same index would be used for all groups. An estimate of the range of possible caps is attached.
- o Current data systems and mechanisms for grants to states and enforcement would be modified to ensure that the per capita cap would be effective.

State flexibility

States would be given increased flexibility in how to manage their Medicaid programs.

The areas of increased flexibility would include:

- o Services: within the cap, states could provide optional

coverage of IMD services, nurse supervised clinics, vocational training for the severely disabled.

- o Payment: the Boren amendment would be modified and a limited set of safe harbors for the States would be created, including Medicare rates and rates created by competitive bidding. Links between quality, access, and payment rates would be studied.

- o Delivery systems:

-- States could mandate enrollment in managed care plans as a state plan option (without seeking a waiver), so long as enrollees have a choice of plans or delivery systems. Managed care contracting requirements would also be modified to be more flexible while enhancing quality protocols.

-- States could also provide home and community-based services as a state plan option.

- o Administration: Replace separate Medicaid standards on conditions of participation with Medicare conditions, except in the case of entities that serve only Medicaid enrollees (ICFs/MR). A number of Federally-mandated administrative requirements would be repealed, and the physician qualification requirements would be repealed.

At the same time, a number of core Federal requirements would remain.

- o Eligibility: Maintain current mandatory and optional eligibility groups.

- o Services: Maintain current Medicaid mandatory services.

- o Payment: Maintain cost sharing limits, the Federal matching structure of the program, as well as DSH payment requirements and limits (subject to new DSH policy), and taxes and donation policy.

- o Administration: expand Medicaid eligibility quality control (MEQC) system to monitor the per capita cap calculation; retain data and reporting authority, and refine it to enforce per capita cap; retain nursing home reforms, beneficiary protections, and fraud and abuse provisions.

Disproportionate share payments (DSH)

DSH payments would be limited in size and re-targeted. The design is still under discussion. issues remain with the magnitude of the reduction, the allocation among States of the reduction, and the definition of which providers would be eligible for the payment.

Magnitude: The reduction in Federal spending could range from $20 billion (approximately a 33 percent reduction) to $30 billion (a 50 percent reduction) over the 7-year period. This reduction would be combined with the savings from the per capita cap to equal the $54 billion target established by the President.

State Allocation: The reduction could be allocated proportionately to all States, or targeted to the high DSH States.

Targeted Providers: The proposal could limit the payment to hospitals as currently defined, or allow states to spend the DSH funds on hospitals, FQHCs/RHCs, and outpatient departments.

REDUCING AND RE-TARGETING MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The policy objective is to reduce and re-target the amount of Federal Medicaid Disproportionate Share Hospital (DSH) payments made by states to hospitals serving large low-income and uninsured populations to be consistent with the President's balanced budget plan.

The design is still under discussion. Issues remain with the magnitude of the reduction, the allocation among States of the reduction, and the definition of which providers would be eligible for the payment.

Magnitude: This reduction would be combined with the savings from the per capita cap to equal the $54 billion target established by the President.

OPTIONS:

1 - $30 billion or approximately 50 percent of the current spending over the 7-year period.

2 - $20 billion or approximately 33 percent of current spending.

State Allocation: The reduction could be allocated proportionately to all States, or targeted to the high DSH States.

OPTIONS:

1 - PROPORTIONAL

New DSH allotments would be established for each state. The new allotments would represent an amount equal to a proportional reduction from each states current DSH spending (e.g. one-third reduction). Each state would receive the same proportional reduction from its current DSH spending regardless of whether or not the state was actually spending up to it full allotment under the current DSH program. Those states which do not currently have any DSH spending (i.e. Tennessee) would not have a DSH allotment.

2 - TARGETED

The provisions of a targeted program include:

- Each State would receive an initial allotment equal to a set percentage of their current benefit baselines (we will model allotments set at 10 percent);

- Those state which have current DSH allotments greater than the set percentage would have their new allotments proportionately phased down over the next three years. Beginning FY 1999, no state would have an allotment greater than the set percentage;

- States would continue to be required to provide their share of funding in order to receive Federal matching payments;

Targeted Providers: The proposal could limit the payment to hospitals as currently defined, or allow states to spend the DSH funds on hospitals, clinics, outpatient departments.

OPTIONS:

1 - Hospitals Only:

Those hospitals whose Medicaid inpatient utilization rate would be at least one standard deviation above the mean rate for hospitals in the state or a low-income utilization rate which exceeds 25 percent (current law standards) would be eligible to receive Medicaid DSH payments. This provision only identifies those groups of hospitals which must be deemed eligible to receive DSH payments. States would be able to identify other hospitals which are eligible for DSH payments.

Another options would provide that only those hospitals which meet the standards above are eligible to receive DSH payments.

2 - Hospitals plus clinics - States would be permitted to make DSH payments to the hospitals identified in option 1 plus additional providers of outpatient services, clinic services, and services provided at FQHC/RHCs.

UNDISCUSSED ISSUE:

During the flexibility discussions, there was no discussion of making changes to the statutory requirement that states make DSH payments. Section 1902(a)(13)(A) provides that state have to provide rates which take into account those hospitals which serve a disproportionate number of low-income patients. Any options to target DSH payments should be balanced with the degree of statutory flexibility available to states.

PER CAPITA GROWTH LIMITS POLICY

Per Capita Cap: Summary

- A "per capita cap" would lower Federal Medicaid spending by limiting the amount of growth in *spending per beneficiary* that the Federal government will match.
  - States with spending below the cap, which is derived by applying a specified growth rate to spending per beneficiary, would receive full Federal matching payments, as under current law.
  - States with spending above the cap would receive Federal matching only up to the cap.
- The "cap" is the estimate of what the spending for a group of beneficiaries would have been had spending growth per beneficiary been limited to a specified index, such as the medical consumer price index or growth in the nominal gross domestic product per capita. If a state's actual spending for a group exceeds the cap, then the Federal government will match up to the cap using the FMAP.
- The limit on the Federal payments is based on three components: spending per beneficiary in a base year, an index, and the number of beneficiaries covered in a particular year. Key features of this policy include:
  - The per capita cap will become effective in FY 1997.
  - The base year for the calculation of the caps is FY 1995.
  - The caps are calculated separately for subgroups of Medicaid beneficiaries:
    Aged
    Disabled
    Adults in families with children
    Children
  - Based on these separate caps, an weighted average aggregate cap would be computed for each state.
  - Spending for disproportionate share hospitals, Medicare cost sharing, Indian Health Service, and Vaccines for Children are excluded from the cap.
  - The index will be an inflation-related factor, adjusted to meet the budgetary target. The same index will be used for all groups.
  - The current data systems and mechanisms for grant awards and enforcement will be modified to ensure that the per capita caps will be effective.

PER CAPITA GROWTH LIMITS POLICY SPECIFICATIONS

Definition of terms:

Cap: The total spending amount in a year that the Federal government will match.

Index: A rate of growth that will be used in the place of actual spending growth per beneficiary in order to calculate the cap.

Beneficiary: Enrollee on a person-year equivalent basis.

TRANSITION

When is the cap implemented?

FY 1997

Rationale: There is not enough time for states to change their programs to conform with a cap beginning in FY 1996. ~~An implementation date beyond FY 1997 would result in lower Federal savings.~~ than what?

Any transition period or phase-in?

No.

~~While the cap will be calculated for FY 96, it was~~ Jack?

Rationale: Not discussed; this could be changed.

CALCULATION OF THE CAP

Overall

Maximum Federal expenditures in a state in a particular year equal the product of:

a. Total state and Federal spending per beneficiary in a base year ;
b. An index (for years between the base year and the particular year);
c. The number of beneficiaries; and
d. The FMAP for the particular year.

Fixed or rolling base year: Is there a single, fixed base year or is the index applied in each year to the previous year's actual expenditures (i.e., rebased annually)?

Fixed base year

Rationale: Under a fixed base year (i.e., no rebasing), the growth index for a given year would be applied to the cap from the year before -- even if a state's actual spending in the previous year stayed below the cap. This allows a state that maintain spending below the annual index in one year to have more leeway the next year.

Under rebasing, the current year's cap would build off the previous year's actual spending rather than the cap for that year. This would offer greater potential for Federal savings, since the cap would be lower when states' expenditure growth is low. In this way, rebasing obviates the problem of the base year becoming disconnected from states' experience as time goes on. On the other hand, rebasing would penalize states that achieve spending growth below the index; it would also be more difficult to administer. Rebasing on a periodic basis (e.g., every five years) would align the caps with the actual experience of the states, but would (a) offer a possibility that states could alter their spending patterns in anticipation of the rebasing, to maximize the Federal share of their spending, and (b) introduce uncertainty into the Federal savings.

What is the base year?

FY 1995

Rationale: Choosing a year close to the actual implementation year will require fewer "updating" factors and will mitigate states' criticism that the base year does not accurately reflect state experience. Using the current year (FY 1995) as a base year may provide states an opportunity to increase their base spending amount in anticipation of this capping formula. However, the limited time left to affect spending levels combined with several states' constrained or reduced SFY 1995-1996 budgets would minimize these effects. FY 1995 may not completely reflect the effects of recently-enacted DSH limits, but probably reflects these effects better than FY 1994 spending. NOTE: Given the large amount of time required to set a base year and the delays in receiving final fiscal year data from the state, we may reconsider using FY 1994.

What expenditures are included?

Disproportionate Share payments?

Excluded. The proposal would reduce the federal share by $30 billion over the 7 years. In addition, the proposal would ~~re-target the Federal Medicaid Disproportionate Share Hospital (DSH) payments to each State and~~ allow states to re-target their payments to hospitals and clinics serving large low-income and uninsured populations. (Additional details in DSH paper - ASMB issue)

Rationale: Payments are not related to spending per beneficiary. Excluding DSH allows for a separate DSH policy.

Administrative costs?

Excluded. The proposal would establish a separate cap for administrative expenses and

continue the enhanced match rates for the current set of activities that draw enhanced matching. The cap would allow states a one-year rollover of unused portions of a cap from the previous year. The one-year rollover will limit the risk of payment lags causing States to breech the cap in a given fiscal year. Administrative spending would be limited to a specified percentage of spending on services, which would be higher than the current proportion of administrative spending to service expenditures, since States will be required to make new investments in information systems in a per capita environment.

The administrative cap will grow at the same rate as benefit spending -- and therefore growth will be constrained by the per capita growth rates for services. NOTE: Additional details in Flexibility paper.

Rationale: Treating administrative costs as a separate category increases the Federal flexibility to provide incentives to states to carry out the administrative requirements, such as data collection, that this proposal would require.

Medicare premiums and cost sharing?

Excluded.

Rationale: Excluded since they may rise for reasons beyond the states' control (e.g., changes in Federal policy).

Indian Health Service and Vaccines for Children?

Excluded.

Rationale: Medicaid is a pass-through for this spending.

Disallowances, prior period adjustments?

Included. All expenditures are included in base year.

1115 demonstration expenditures included or excluded?

Included.

Rationale: These expenditures are included since the terms and conditions say that states would be subject to changes in current law. Also, there would be less savings if the demonstration expenditures were excluded from the cap. NOTE: Additional details in Flexibility paper.

Should there be a single, aggregate cap in each state, or should there be separate caps for particular subgroups of beneficiaries?

Aggregate limit, based on weighted average of caps for each of the beneficiary subgroups for that state.

Rationale: Separate category limits would limit States' ability to balance savings and increased spending across categories, therefore greatly reducing States' flexibility to manage their Medicaid programs as a whole.

Which groups?

Aged (disabled and nondisabled);
Disabled (non-elderly);
Adults in families with children (non-disabled);
Children (non-disabled).

Rationale: The most likely groups would be the aged, disabled, adults, and children, since there is little room for misclassification across these groups. However, two alternatives should be considered. One would allow for all children -- disabled and non-disabled -- to be within the same cap, since the boundary between these groups is not necessarily clear. A second alternative would cap expenditures for institutionalized people separately. The cost experience for these beneficiaries is much higher than for non-institutionalized beneficiaries, and it is possible that the inclusion of these people skews the average costs in each of the four recommended groups.

How are base year expenditures per beneficiary group calculated when the audited financial data (HCFA 64 form data) are not reported by beneficiary group?

A merge of the 2082 and 64 form data could divide the historical expenditures by beneficiary group. Additionally, special reviews of the state-submitted data and MSIS data could be conducted.

How are "beneficiaries" defined?

Enrollees

Rationale: "Beneficiaries" can mean one of two things: all people enrolled in Medicaid, or the subset of enrollees who use at least one service in a specified time period. The use of all enrollees has the advantage of reflecting who is literally covered by Medicaid, and captures the movement toward managed care. However, some enrollees have no health care expenditures, and including them in the denominator of the average spending per beneficiary could lower the average. For planning purposes, the projected, estimated number of enrollees will be used to set preliminary caps. At the end of the fiscal year, the reported actual number of enrollees on a person-year basis, will be used for the final reconciliation of the Federal payments and the Federal cap.

INDEX

What type of index should be used?

Inflation-based index.

Rationale: Inflation-based indices allow for unexpected changes in the economy, and thus would adjust the per capita cap to reflect the underlying economic conditions. If a fixed index were chosen, and an unexpected period of inflation occurred, then the per capita cap would be more restrictive than planned and would put states at risk for the inflation.

Should one or multiple indices be used to develop caps for the different subgroup?

One index.

Rationale: If different indices were used for different groups, there would be a greater incentive for states to categorize their beneficiaries in the groups with the higher index.

FMAP

Is the cap based on the Federal share of spending in the base year, trended forward, or on the total spending in the base year, with the FMAP applied after the spending cap has been calculated?

Based on total spending in the base year, with the current year's FMAP applied to the total spending cap.

Rationale: The growth cap is intended to constrain Federal spending. However, applying a growth rate index to a Federal-only base amount does not adjust for FMAP changes over time. That is, this approach would "lock in" the FMAP percentages that were applied in the base year. Applying the growth rate index to the total state and Federal spending per beneficiary in the base year, and then multiplying by the FMAP for subsequent years allows the FMAP to change, as under current law.

ENFORCEMENT

How would the current reporting requirements change in order to implement a per capita cap?

HCFA 37 form:

Spending projections for the upcoming quarter would need to be disaggregated by

beneficiary subgroup. All categories would need to be made comparable to those on the modified HCFA 64 form.

Rationale: If the quarterly grant is modified to account for the cap, then it is necessary for the HCFA 37 form, which is the basis of these grants, to be specific enough to determine whether the state is above or below the cap.

HCFA 64 form:
This form would be changed to include beneficiary data and to cross-walk expenditure and beneficiary categories. States would submit beneficiary per month data on a quarterly basis. These beneficiary figures would be used to determine final aggregate spending limits for states.

Rationale: Actual data comparable to the projected data on the HCFA 37 form would be needed to determine retrospectively whether the Federal expenditures are capped.

HCFA 2082 form:

No need to modify.

Will there be a need to modify the auditing and Medicaid Eligibility Quality Control (MEQC) systems?

The financial data on the HCFA 64 reports are currently audited and would continue to be audited. This audit would be expanded to examine spending by beneficiary group. The enrollment information is currently subject to review based primarily on a trend/outlier analysis. This system would need to be expanded so that adequate samples could be taken at the subgroup level.

The MEQC system, which assure accuracy in a State's eligibility determinations, will be enhanced and tightened up.

Rationale: Ensuring that persons enrolled in Medicaid are actually eligible for it and that spending has actually occurred is essential to the integrity and effectiveness of the growth caps in restraining spending and preventing State gaming.

Will the quarterly grants to states be modified to account for the cap, or will there only be annual reconciliation process?

Quarterly grants will be modified, but the final reconciliation would occur after the actual data from the full fiscal year are reported. The cap would be enforced on an annual basis, so that quarterly grant adjustments are only interim steps.

Rationale: For states with high per capita growth, it would be less difficult to adjust to a quarterly modification of their grants than to an annual, lump-sum modification. Similarly, it

will be easier for the Federal government to enforce the policy prospectively than retrospectively.

How will it be determined that the states' quarterly grants are modified?

A process similar to that used to announce DSH allotments could be used. Under this system, HCFA uses a specified set of information and a formula to set preliminary and final allotments for states. These allotments are published in the Federal Register, and under a per capita cap, could be used to adjust the quarterly grant awards.

How will the annual reconciliation process work?

The current system for reconciling actual and allowed spending could be used.

Rationale: Currently, HCFA recoups Federal over-payments by giving states the option of repaying them directly or having a future grant award reduced by the appropriate amount. Disallowances mean that the final Federal match for spending in a quarter is less than the original grant award for that quarter. As an alternative or a substitute for disallowances, the per capita cap could incorporate a penalty provision authorizing the Secretary to levy a penalty for a state.

Would there be changes in eligibility requirements and options to conform to the policy?

A gross income test as an upper income eligibility limit for 1902(r)(2) would be added.

Rationale: This would limit states' ability to add low-cost, higher-income enrollees as a means of lowering their average spending per beneficiary and thus making the cap less binding. [SEE FLEXIBILITY PAPER]

MEDICAID FLEXIBILITY OPTIONS

DECISION PARAMETERS

- Federal Medicaid rules governing States can and should be made more flexible under per capita cap proposals.
    - By definition, a per capita cap would limit the Federal government's financial risk, thus creating different spending dynamics than the current unfettered matching structure. Rules designed mainly to control spending could be re-examined against other goals.
    - However, the Federal government is committed to protecting eligibility and to limiting cuts in mandatory services.
- Recommendations (below) on what kind and how much flexibility to give to States under Federal limits on per capita Medicaid spending aim to balance these goals:
    - Enabling States to manage their programs with reduced Federal resources, and
    - Need for Federal assurances of beneficiaries' rights, access to affordable, quality health care, and appropriate use and distribution of Federal resources.

MAJOR RECOMMENDED POSITIONS

The three sections below outline:

- Provisions affecting States' ability to design their Medicaid programs,
- Provisions affecting Federal oversight of States,
- Unresolved issues requiring additional analysis and next-level decisions.

Any Federal requirement that would be deleted would continue as a State option.

In addition to current requirements that should be deleted, modified or retained, we note new requirements that would be necessary for two purposes: first, to assure that States maintain what we have defined as a minimum program in a per capita environment, and second, to protect the Federal budget against excessive State eligibility expansions.

STATE FLEXIBILITY PROVISIONS:

- **Services**
  - Increase State flexibility to decide what services can be offered under the per capita spending cap. Examples:
    - Repeal the IMD exclusion and permit optional coverage of IMD services;
    - Add optional coverage of nurse-supervised clinics;
    - Expand optional coverage of vocational training for severely disabled.
- **Payment**
  - Restructure Boren Amendment regarding provider reimbursement by establishing safe harbors, including competitive bidding. HHS will investigate the relationship between quality, access and provider payment to address the need for adequate access of Medicaid beneficiaries.
  - Repeal Ob/Peds and other payment requirements.
  - Repeal requirement for States to pay for private insurance when cost-effective.
- **Delivery systems**
  - Authorize States to mandate enrollment in managed care delivery systems and to provide home and community based services as State plan options, without the need for Federal waivers. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.
  - Modify the managed care contracting requirements such as the 75/25 provision, disenrollment requirements, the upper payment limit for managed care contracts, the Federal prior approval of HMO contracts over $100,000, and Statewideness requirement.
- **Administration**
  - Replace separate Medicaid standards on conditions of participation with Medicare conditions of participation and private accreditation for hospitals, nursing facilities, hospices, and home health agencies, except for entities that only serve Medicaid enrollees (ICFs/MR).
  - Repeal physician qualification requirements.
  - Repeal Federally-mandated administrative requirements, but retain States' authority to establish similar requirements:

- TPL process requirements (e.g. cost avoidance vs. pay and chase);
- Transfer of asset and estate recovery requirements;
- MMIS Subsystem design requirements -- except where they affect the use of standardized claims formats, and standardized HCFA reporting requirements;
- Personnel-related requirements (e.g., merit personnel standards, training of sub-professional staff);
- Cooperative agreement requirements.

- Re-engineer the MMIS systems requirements to retain the required use of standardized claims formats, standardized HCFA reporting requirements, but retain the 90 and 75 percent incentive match rate.

Demonstration Waivers

- New Waivers

  The proposal would allow States to expand or simplify eligibility through two mechanisms. First, States could make modest eligibility changes within a certain threshold with limited Federal involvement. Federal matching would remain limited by the aggregated limit, which is based on current law eligibility. Second, States could pursue more significant changes in a budget-neutral manner under waiver authority.

FEDERAL OVERSIGHT PROVISIONS:

- **Eligibility**

  - All current mandatory and optional eligibility groups, including AFDC and SSI cash and non-cash groups, poverty level children and pregnant women, medically needy, and QMB/SLMB would be retained. However, eligibility expansions and simplifications would be permitted. The proposal would allow States to expand or simplify eligibility through two mechanisms. (see waiver section below.)

  - Add a gross income test as an upper income eligibility limit for 1902(r)(2) to limit States' ability to add low-cost new eligibles and "game" the per capita cap.

- **Services**

  - Retain the requirement that states continue to offer <u>all</u> Medicaid mandatory services, including EPSDT.

- **Payment**

- Retain the prohibition on States from imposing more than nominal copayments or other cost-sharing burdens on recipients unless they are reasonably related to income.

- Retain requirement for Federal matching as well as DSH payment requirements both from the 1991 law, and per hospital limits included in OBRA 93. Retain taxes and donations provisions. [See DSH paper for options to reduce and re-target DSH.]

- **Administration**

  - Expand eligibility quality control system (MEQC) to better ensure that only individuals eligible and enrolled in the program are included in the per capita limit calculation.

  - Retain Federal data and reporting authority. Refine current reporting requirements to develop an enforcement mechanism for per capita limits.

  - Retain quality of care provisions such as OBRA-87 nursing home reform provisions and PRO utilization review provisions. Add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.

  - Continue requirements for beneficiary protections.

  - Retain current fraud and abuse provisions.

- **Demonstration Waivers**

  All States would be subject to the per capita limits, including those with Statewide demonstration programs. The same per capita growth rates would apply to all States.

  - Enrollment Base

    The proposal would permit implemented demonstration States to choose between two approaches for maintaining their eligibility expansion: (1) Including demonstration eligibles in their enrollment base for calculating their aggregate limit; or (2) Calculating their aggregate limit off of current law eligibles, and expanding enrollment in a budget-neutral manner within this cap.

  - Covered Services and Growth Rates

    For States that choose Option 1, the proposal would establish separate "rate cells" for expansion eligibles within adult and children categories to reflect smaller benefit packages. The same growth rate would apply to these cells as to the rest

of the State program.

- Interaction with DSH Changes

  The proposal would retain DSH expenditures within per capita base if States choose to build their aggregate cap off of current law and demonstration eligibles. Reconstructing DSH spending for these States would be difficult, and may force these States to reduce coverage.

MEDICAID FLEXIBILITY OPTIONS
PROGRAM SPECIFICATIONS

How much State flexibility can be provided in eligibility determination?

Increases in Medicaid enrollees/eligibles would have a significant budget impact. Therefore, State flexibility in eligibility has been approached with caution. (In fact, additional provisions may be needed to limit the States' ability to add "low-cost" eligibles.)

- All current mandatory and optional eligibility groups, including AFDC and SSI cash and non-cash groups, poverty level children and pregnant women, medically needy, and QMB/SLMB would be retained. However, eligibility expansions and simplifications could be permitted through an exception or 1115 process.

- Add a gross income test as an upper income eligibility limit for 1902(r)(2) to limit States' ability to add low-cost new eligibles and "game" the per capita cap.

- Expand eligibility quality control system (MEQC) to better insure that only individuals eligible and enrolled in the program are included in the per capita limit calculation.

How would the eligibility expansions be administered?

The proposal would allow States to expand or simplify eligibility through two mechanisms. First, States could make modest eligibility changes within a certain threshold with limited Federal involvement. Second, States could pursue more significant changes under waiver authority.

- States could make modest eligibility changes as long as State spending remains budget-neutral -- constrained to the lower of the aggregate cap for current eligibles or projected State spending below the cap. These changes could be approved through a simple process that resembles either current streamlined program waiver processes, or State plan amendments. Parameters for these simplified eligibility changes could be specified as either within a certain percentage of the Federal poverty level (e.g., in the 100 to 150 percent range), or within a certain threshold level of enrollee expansion (e.g., 30 percent).

- If States wish to pursue more substantial eligibility changes they could do so through the current waiver process. These expansions would require greater Federal oversight because their larger scope would place current eligibles at greater risk for service reductions. States would also need to demonstrate budget neutrality in this context.

How much State flexibility can be provided in covered services?

Mandatory services should be maintained. As a fall-back mandatory services could be reduced. Optional services could be expanded. Program waivers would become State plan amendments.

- Retain the requirement that states continue to offer all Medicaid mandatory services.

- Retain EPSDT requirements.

- Increase State flexibility in the area of the services that can be offered under the per capita spending cap.
  - Repeal the IMD exclusion and permit optional coverage of IMD services;
  - Add optional coverage of nurse supervised clinics; and
  - Add optional coverage of vocational training in a HCB setting regardless of prior institutionalization.

- Enable States to adopt mandatory enrollment in managed care delivery systems and to provide home and community based services as State plan options, without Federal waivers. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.

How much State flexibility can be provided in provider payments?

Considerably more under a per capita limit.

- Restructure Boren Amendment -- Establish safe harbors, including competitive bidding. HHS will investigate the relationship between quality, access and provider payment to address the need for adequate access of Medicaid beneficiaries.

- Repeal Ob/Peds and other payment requirements.

How much State flexibility can be allowed in beneficiary copayments?

Low-income individuals are at equal risk of not receiving appropriate services and receiving inappropriate services. Therefore copayments are unwise.

- Retain the prohibition on States from imposing more than nominal copayments or other cost-sharing burdens on recipients unless they are reasonably related to income.

How much State flexibility can be provided in managed care?

Considerably more, with or without a per capita limit.

- Modify the managed care contracting requirements such as the 75/25 provision, disenrollment requirements, the upper payment limit for managed care contracts, the Federal prior approval of HMO contracts over $100,000, and Statewideness requirement.

  - Repeal the upper payment limit for managed care contracts (i.e., 100 percent of FFS) because payments to managed care plans would now be controlled by the per capita limit.

  - Repeal 75/25 provision because this is a process-related, ineffective proxy for quality of care.

  - Repeal freedom of choice requirement in all "managed care" situations -- HMO, PCCM, HIO, case management, home-community based services, etc -- to enable States to require enrollment in managed care. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.

  - Modify current disenrollment requirements to allow States to lock enrollees into a health plan for up to six months, but retain enrollees' right to disenroll for cause. Modifying these requirements will give States greater ability to contract with managed care plans.

  - Repeal Federal prior approval of HMO contracts over $100,000. This type of financial and administrative oversight is unnecessary in a per capita cap environment.

  - Repeal Statewideness requirement for managed care to enable States to operate managed care programs in limited geographic areas without needing Federal waivers.

How much State flexibility can be provided in program administration?

Process requirements can be eliminated, but quality of care and beneficiary protections would need to be retained.

- Repeal requirement for States to pay for private insurance when cost effective.

- Repeal separate Medicaid standards on conditions of participation and rely on Medicare conditions of participation and private accreditation for hospitals, nursing facilities, hospices, and home health agencies, except for entities that only

service Medicaid enrollees (ICFs/MR).

- Repeal physician qualification requirements.

- Repeal Federally-mandated administrative requirements, but retain States' authority to establish similar requirements:

  - TPL process requirements (e.g., cost avoidance vs. pay and chase).

  - Transfer of asset and estate recovery requirements.

  - MMIS Subsystem design requirements -- except where they affect the use of standardized claims formats, and standardized HCFA reporting requirements.

  - Personnel-related requirements (e.g., merit personnel standards, training of sub-professional staff).

  - Cooperative agreement requirements.

- Re-engineer the MMIS systems requirements to eliminate process-oriented requirements but retain the required use of standardized claims formats, standardized HCFA reporting requirements, and retain the 90 and 75 percent incentive match rate.

- Retain quality of care provisions such as OBRA-87 nursing home reform provisions and PRO utilization review provisions. Add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.

- Retain the administrative provisions that require States to ensure quality of care:

  - Use a single State agency to administer or supervise the administration of the plan;

  - Provide reasonable opportunities for all citizens to appeal and obtain a hearing on State actions;

  - Submit proposed program changes to public review and comment;

  - Make post-decisional records publicly available (e.g., policy guidelines, correspondence, court filings);

  - Consult with medical experts and establish procedures regarding medical appropriateness and standards of care paid for under Medicaid;

- Safeguard information about recipients.

- Retain current fraud and abuse provisions to ensure proper use of Federal funds.

- Retain spousal impoverishment provisions to protect this extremely vulnerable population.

- Retain Federal data and reporting authority to allow for proper administration of per capita caps and ensure Federal oversight.

  -- Refine current reporting requirements to develop an enforcement mechanism for per capita limits. Changes would include linking enrollment and expenditure data on HCFA-37 and HCFA-64 forms.

Is Federal oversight of State matching payments necessary under a per capita limit?

State matching would remain as it is under current law up to the per capita limit, so Federal rules on what constitutes State matching would be necessary.

- Retain requirements for Federal matching as well as DSH requirements from the 1991 law and DSH per hospital limits from OBRA 93. Retain taxes and donations provisions. [See DSH paper for options to reduce and re-target DSH.]

Does a single aggregate limit give more flexibility than separate eligibility group per capita limits?

The proposal would establish an aggregate limit. Separate category limits would limit States' ability to balance savings and increased spending across categories, therefore greatly reducing States' flexibility to manage their Medicaid programs as a whole.

Would the elimination of the IMD exclusion as part of State service flexibility increase eligibility?

Persons residing in IMDs remain eligible for medical assistance but do not receive any covered services for the duration of their stay. The length of stay for those eligible persons between 21 and 64 years of age in an IMD averages less than 30 days and they are enrolled and receive services before and after admission.**What is our Boren amendment policy?**

In order to restructure the Boren Amendment in a fashion which is acceptable to states and providers, and protects beneficiary access, pre-approved methods for states' payment rate calculations -- or "safe harbors" -- should be developed. Competitive bidding is an example of a methodology which would serve as an appropriate safe harbor. In restructuring the Boren Amendment, the primary concern is to ensure adequate provider payments and beneficiary access. The Department of HHS will therefore take a long-term look at outcomes, quality, and access and their relationship to changes in payment rates.

What is the level of and need for an appropriate level of oversight on managed care (both state and federal)?

- Modify requirements related to State contracts with health plans to maintain an appropriate level of State and Federal oversight on managed care as follows:
  - states must collect and analyze encounter data from contracting health plans [or States may require plans to report certain information from the plan's encounter data];
  - health plans must demonstrate capacity to deliver all contracted services for all populations; and
  - health plans must maintain an internal quality assurance program and a grievance process.
- Possibly add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.

What is the degree of administrative flexibility and the role of enhanced matching rates (i.e., MMIS, family planning, etc.)?

The proposal would establish a separate cap for administrative expenses and continue the enhanced match rates for the current set of activities that draw enhanced matching. The cap would allow states a one-year rollover of unused portions of a cap from the previous year. The one-year rollover will limit the risk of payment lags causing States to breech the cap in a given fiscal year. Administrative spending would be limited to a specified

percentage of spending on services, which would be higher than the current proportion of administrative spending to service expenditures, since States will be required to make new investments in information systems in a per capita environment.

The administrative cap will grow at the same rate as benefit spending -- and therefore growth will be constrained by the per capita growth rates for services.

Enhanced Match Rates. Currently, 11 activities receive an enhanced Federal match rate:

Family Planning - 90%
Survey & Certification - 75%
MMIS development - 90%
Preadmission Screening - 75%
Resident Review - 75%
Immigration Verification - 100%
Peer Review Organizations - 75%
Fraud Control Units - 75%
MMIS operation - 75%
Skilled Medical Professionals - 75%
Drug Use Review - 75%

This enhanced match rate is provided to encourage states to perform these activities. Enhanced match for administrative activities would continue under the administrative cap.

REDUCING AND RE-TARGETING MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

- The policy objective is to reduce and re-target the amount of Federal Medicaid Disproportionate Share Hospital (DSH) payments made by states to hospitals serving large low-income and uninsured populations to be consistent with the President's balanced budget plan.

RECOMMENDATIONS:

Given the rapid inflation in Medicaid DSH payments during the early 1990s, a greater portion of the President's proposed Medicaid reduction of $54 billion is recommended to come from the DSH program than from placing a limit of growth per recipient. **DSH reductions on the order of $30 billion from the CBO baseline over seven years** are recommended.

In addition, the current DSH program rules should be phased-out and a new program phased-in over the next four years. The provisions of the new program include:

- Each State would receive an initial allotment equal to 4 percent of their current benefit baselines;

- A national limit of 4 percent would also be established;

- For each year that the sum of states actual spending for DSH is below the national limit, the amount which was not spent will be proportionately distributed among those states which were designated as high-DSH states in 1995. In essence, high-DSH states could have a slightly higher than 4 percent allotment in a given year;

- States would continue to be required to provide their share of funding in order to receive Federal matching payments;

- Those hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the mean rate for hospital in the state or a low-income utilization rate which exceeds 25 percent (current law standards) would be eligible to receive Medicaid DSH payments. This provision only identifies those groups of hospitals which must be deemed eligible to receive DSH payments. This does not require states to make DSH payments only to the hospitals which meet these standards; [ASMB has a concern about this provision.]

- States would be permitted to make DSH payments for outpatient services, clinic services, and services provided at FQHC/RHCs in addition to inpatient services.

DRAFT PREPARATION FOR WH MEETING

Subject of meeting

1. Review Medicare - our proposals, Capitol Hill -- potential endgame?

2. Review Medicaid

    a. Our proposal

    b. Baseline issues

    c. Potential endgame

DRAFT

I. What is acceptable endgame?

A. Driven by overall decisions on:

1. Deficit glidepath -- 7 years v. 10 years v. something inbetween
2. Level of tax cut
3. What baseline is used - Admin v. CBO v. compromise

B. Those decisions yield overall budget cut targets; within this context, the Medicare and Medicaid budget numbers and structure will be decided.

II. Medicare and Medicaid

A. Medicare and Medicaid budget plans will depend, in part, on decisions about what baseline to use -- because the Administration baseline is lower than the CBO baseline for both Medicare and Medicaid.

B. Overview of baselines

1. Baseline overview - the CBO baseline is higher than the administration baseline.

Baseline - 1996-2002 (In billions)

	CBO	Admin.	CBO - Admin.
Medicare	$1871	$1799	$ 72
Medicaid	$ 955	$ 890	$ 65

2. See attached baseline review

III. What is acceptable at end - and what is not acceptable?

(See attached charts)

A. Key Medicare issues

1. Hard cap w/ lookback: alternative - "soft" cap and lookback

   a. Set target for program spending, and include some unspecified savings level ($20 b) to be guaranteed by lookback

   b. Lookback is triggered is spending over cap -- but amount to be sequestered is limited by amount of unspecified savings target for that year.

2. Total level of savings - can we get to $170 -$200 billion? Baseline differences?

3. Choice structure: issues

   a. Exclude MSAs and private FFS plans
   b. Standards for all plans (including such things as balance billing protections); adapt how to meet financial standards for provider network)
   c. Include Medigap in market choice/level playing field

4. Issues related to specific savers - for example, concerns about upper income elderly paying more than 50-75 percent of premium?

B. Medicaid

1. Overall target - very connected to which baseline to use: if use Administration baseline, need to keep overall target as close to $54 billion as possible (can get more from DSH, but less from per capita cap)

2. Structure - oppose block grant

3. Eligibility - maintain guaranteed coverage (entitlement)

4. Services - maintain benefit minimums (consider moving from current mandates to alternative package?)

5. Flexibility - in administration, managed care, payment (revised Boren)

Medicaid summary
1996 - 2002 total

	Total	Cap	DSH
Administration			
Baseline	$890	$794.2	$95.8
DSH savings (33%, indexed)			$38.8
4 %Cap	$56.4	$ 17.6	
5% Cap	$46.4	$ 7.6	
CBO			
Baseline	$955	$884.3	$70.7
DSH savings (33%, indexed)			$24.1
4 %Cap	$77.3	$ 53.2	
5 %Cap	$57.1	$ 33.0	

Alternative Capped Payments for Medicaid: Administration Baseline
(Dollars in billions, Fiscal Years)

17-Oct-95

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02	96-05
BASELINE EXPENDITURES														
MEDICAID														
Administration Baseline Expenditures														
Total	88.4	96.0	104.6	114.5	124.5	136.3	149.9	163.8	179.0	195.3	213.0			
		8.5%	9.0%	9.4%	8.7%	9.5%	9.9%	9.3%	9.2%	9.1%	9.1%	9.2%	9.3%	9.3%
DSH	10.4	11.1	11.9	12.7	13.6	14.5	15.5	16.5	17.5	18.6	19.7			
		7.2%	6.8%	6.9%	6.8%	6.9%	6.7%	6.5%	6.3%	6.1%	6.0%	6.9%	6.8%	6.6%
Enrollment Plus 0%														
Expenditures	78.1	81.6	85.1	88.7	92.5	96.4	100.7	105.2	110.1	115.2	120.7			
Aggregate growth		4.5%	4.3%	4.3%	4.2%	4.3%	4.4%	4.5%	4.6%	4.7%	4.8%	4.3%	4.3%	4.5%
Per capita cap growth		0.3%	0.4%	0.5%	0.5%	0.5%	0.6%	0.7%	0.7%	0.8%	0.8%	0.5%	0.5%	0.6%
Savings		-3.3	-7.7	-13.1	-18.5	-25.4	-33.7	-42.1	-51.4	-61.5	-72.6	-68.0	-143.8	-329.3
Savings w/ Offset		-2.0	-4.6	-7.9	-11.1	-15.2	-20.2	-25.3	-30.8	-36.9	-43.6	-40.8	-86.3	-197.6
Enrollment Plus 1%														
Expenditures	78.1	82.4	86.8	91.4	96.2	101.4	106.9	112.8	119.2	126.0	133.4			
Aggregate growth		5.5%	5.3%	5.3%	5.3%	5.4%	5.5%	5.5%	5.6%	5.7%	5.8%	5.3%	5.4%	5.5%
Per capita cap growth		1.7%	1.2%	0.8%	0.5%	0.2%	-0.1%	-0.4%	-0.7%	-0.9%	-1.1%	0.7%	0.4%	-0.1%
Savings		-2.5	-6.0	-10.4	-14.8	-20.5	-27.5	-34.5	-42.3	-50.7	-60.0	-54.1	-116.1	-269.1
Savings w/ Offset		-1.5	-3.6	-6.3	-8.9	-12.3	-16.5	-20.7	-25.4	-30.4	-36.0	-32.5	-69.7	-161.5
Enrollment Plus 2%														
Expenditures	78.1	83.2	88.5	94.1	100.1	106.5	113.4	120.9	128.9	137.7	147.2			
Aggregate growth		6.6%	6.3%	6.4%	6.3%	6.4%	6.5%	6.6%	6.7%	6.8%	6.9%	6.4%	6.4%	6.5%
Per capita cap growth		2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Savings		-1.7	-4.3	-7.7	-10.9	-15.3	-21.0	-26.5	-32.5	-39.1	-46.2	-39.9	-87.3	-205.0
Savings w/ Offset		-1.0	-2.6	-4.6	-6.5	-9.2	-12.6	-15.9	-19.5	-23.4	-27.7	-23.9	-52.4	-123.0
Enrollment Plus 3%														
Expenditures	78.1	84.0	90.2	96.9	104.1	111.8	120.2	129.4	139.4	150.3	162.2			
Aggregate growth		7.6%	7.4%	7.4%	7.4%	7.5%	7.5%	7.6%	7.7%	7.8%	7.9%	7.4%	7.5%	7.6%
Per capita cap growth		2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Savings		-0.8	-2.5	-4.9	-6.9	-10.0	-14.1	-17.9	-22.0	-26.4	-31.1	-25.2	-57.3	-136.8
Savings w/ Offset		-0.5	-1.5	-2.9	-4.1	-6.0	-8.5	-10.8	-13.2	-15.9	-18.7	-15.1	-34.4	-82.1
Enrollment Plus 4%														
Expenditures	78.1	84.5	91.6	99.4	107.7	116.9	126.9	137.7	149.3	161.8	175.3			
Aggregate growth		8.2%	8.4%	8.4%	8.4%	8.5%	8.6%	8.5%	8.4%	8.4%	8.3%	8.4%	8.5%	8.4%
Per capita cap growth		1.6%	2.0%	2.0%	2.0%	2.0%	2.0%	1.8%	1.6%	1.5%	1.4%	2.0%	1.9%	1.8%
Savings		-0.4	-1.1	-2.5	-3.3	-5.0	-7.5	-9.6	-12.1	-14.9	-18.0	-12.2	-29.3	-74.4
Savings w/ Offset		-0.2	-0.7	-1.5	-2.0	-3.0	-4.5	-5.8	-7.3	-9.0	-10.8	-7.3	-17.6	-44.6
Enrollment Plus 5%														
Expenditures	78.1	84.8	92.3	100.8	109.6	119.8	131.0	143.0	156.0	170.2	185.6			
Aggregate growth		8.6%	8.9%	9.2%	8.7%	9.2%	9.4%	9.2%	9.1%	9.1%	9.0%	9.0%	9.1%	9.1%
Per capita cap growth		0.9%	1.4%	1.7%	1.3%	1.7%	1.7%	1.4%	1.3%	1.2%	1.0%	1.5%	1.5%	1.4%
Savings		-0.1	-0.5	-1.0	-1.3	-2.1	-3.4	-4.4	-5.4	-6.5	-7.7	-5.0	-12.7	-32.4
Savings w/ Offset		-0.1	-0.3	-0.6	-0.8	-1.2	-2.0	-2.6	-3.3	-3.9	-4.6	-3.0	-7.6	-19.5

Alternative Capped Payments for Medicaid: CBO Baseline
(Dollars in billions, Fiscal Years)

17-Oct-95

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02	96-05
BASELINE EXPENDITURES														
MEDICAID														
CBO Baseline Expenditures														
Total	89.2	99.3	110	122.1	134.8	148.1	162.6	177.8	194.5	212.2	231.9			
		11.3%	10.8%	11.0%	10.4%	9.9%	9.8%	9.3%	9.4%	9.1%	9.3%	10.5%	10.2%	9.9%
DSH	8.5	8.9	9.4	9.8	10.3	10.5	10.8	11	11.2	11.4	11.6			
		4.7%	5.6%	4.3%	5.1%	1.9%	2.9%	1.9%	1.8%	1.8%	1.8%	4.2%	3.6%	3.0%
Enrollment Plus 0%														
Expenditures	80.7	84.8	89.0	92.8	96.6	100.4	103.7	106.6	109.5	112.4	115.3			
Aggregate growth		5.0%	5.0%	4.3%	4.0%	3.9%	3.3%	2.8%	2.7%	2.6%	2.6%	4.3%	3.9%	3.5%
Per capita cap growth		0.8%	0.8%	1.2%	1.0%	0.9%	0.6%	0.4%	0.4%	0.4%	0.4%	1.0%	0.8%	0.7%
Savings		-5.6	-11.6	-19.5	-27.9	-37.2	-48.1	-60.2	-73.8	-88.4	-105.0	-101.9	-210.2	-477.5
Savings w/ Offset		-3.4	-7.0	-11.7	-16.8	-22.3	-28.9	-36.1	-44.3	-53.0	-63.0	-61.1	-126.1	-286.5
Enrollment Plus 1%														
Expenditures	80.7	85.6	90.8	95.6	100.5	105.5	110.1	114.3	118.6	122.9	127.3			
Aggregate growth		6.1%	6.0%	5.3%	5.1%	5.0%	4.4%	3.8%	3.7%	3.7%	3.6%	5.4%	4.9%	4.5%
Per capita cap growth		1.8%	1.8%	2.2%	2.1%	1.9%	1.6%	1.4%	1.4%	1.4%	1.4%	2.0%	1.8%	1.7%
Savings		-4.8	-9.8	-16.7	-24.0	-32.1	-41.7	-52.5	-64.7	-77.9	-93.0	-87.4	-181.6	-417.3
Savings w/ Offset		-2.9	-5.9	-10.0	-14.4	-19.3	-25.0	-31.5	-38.8	-46.7	-55.8	-52.4	-109.0	-250.4
Enrollment Plus 2%														
Expenditures	80.7	86.5	92.6	98.5	104.5	110.8	116.8	122.4	128.3	134.3	140.5			
Aggregate growth		7.2%	7.1%	6.4%	6.1%	6.0%	5.4%	4.9%	4.8%	4.7%	4.6%	6.4%	6.0%	5.5%
Per capita cap growth		2.8%	2.9%	3.2%	3.1%	2.9%	2.6%	2.4%	2.4%	2.4%	2.4%	3.0%	2.8%	2.7%
Savings		-3.9	-8.0	-13.8	-20.0	-26.8	-35.0	-44.4	-55.0	-66.5	-79.8	-72.5	-151.9	-353.2
Savings w/ Offset		-2.4	-4.8	-8.3	-12.0	-16.1	-21.0	-26.6	-33.0	-39.9	-47.9	-43.5	-91.1	-211.9
Enrollment Plus 3%														
Expenditures	80.7	87.3	94.4	101.4	108.7	116.3	123.8	131.1	138.7	146.6	154.9			
Aggregate growth		8.2%	8.1%	7.4%	7.1%	7.1%	6.4%	5.9%	5.8%	5.7%	5.6%	7.4%	7.0%	6.6%
Per capita cap growth		3.8%	3.9%	4.2%	4.1%	3.9%	3.6%	3.4%	3.4%	3.4%	3.4%	4.0%	3.9%	3.7%
Savings		-3.1	-6.2	-10.9	-15.8	-21.3	-28.0	-35.7	-44.6	-54.2	-65.4	-57.2	-120.9	-285.1
Savings w/ Offset		-1.8	-3.7	-6.5	-9.5	-12.8	-16.8	-21.4	-26.8	-32.5	-39.2	-34.3	-72.5	-171.0
Enrollment Plus 4%														
Expenditures	80.7	88.2	96.3	104.4	113.0	122.1	131.2	140.3	149.8	160.0	170.6			
Aggregate growth		9.3%	9.2%	8.5%	8.2%	8.1%	7.5%	6.9%	6.8%	6.7%	6.7%	8.5%	8.0%	7.6%
Per capita cap growth		4.8%	4.9%	5.2%	5.1%	5.0%	4.6%	4.4%	4.4%	4.4%	4.4%	5.0%	4.9%	4.7%
Savings		-2.2	-4.3	-7.9	-11.5	-15.5	-20.6	-26.5	-33.5	-40.8	-49.7	-41.5	-88.6	-212.6
Savings w/ Offset		-1.3	-2.6	-4.7	-6.9	-9.3	-12.4	-15.9	-20.1	-24.5	-29.8	-24.9	-53.2	-127.6
Enrollment Plus 5%														
Expenditures	80.7	89.0	98.1	107.4	117.4	128.1	139.0	150.0	161.8	174.3	187.7			
Aggregate growth		10.3%	10.2%	9.5%	9.2%	9.1%	8.5%	7.9%	7.9%	7.8%	7.7%	9.5%	9.1%	8.6%
Per capita cap growth		5.8%	5.9%	6.2%	6.1%	6.0%	5.6%	5.4%	5.4%	5.4%	5.4%	6.0%	5.9%	5.7%
Savings		-1.4	-2.5	-4.9	-7.1	-9.5	-12.8	-16.8	-21.5	-26.5	-32.6	-25.4	-55.0	-135.6
Savings w/ Offset		-0.8	-1.5	-2.9	-4.3	-5.7	-7.7	-10.1	-12.9	-15.9	-19.5	-15.2	-33.0	-81.3

DSH Options: Percent Reductions
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-00	96-02	96-05
Admin Federal DSH Baseline	10.4	11.1	11.9	12.7	13.6	14.5	15.5	16.5	17.5	18.6	19.7			
CBO Federal DSH Baseline	8.5	8.9	9.4	9.8	10.3	10.5	10.8	11	11.2	11.4	11.6			
DSH - 33% (Admin Baseline)														
Growth at Nominal GDP		6.9	7.3	7.7	8.1	8.5	8.9	9.4	9.9	10.4	10.9			
Savings		(4.2)	(4.6)	(5.0)	(5.5)	(6.0)	(6.5)	(7.1)	(7.7)	(8.2)	(8.8)	(25.2)	(38.8)	(63.5)
No Growth		6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9			
Savings		(4.2)	(4.9)	(5.7)	(6.6)	(7.6)	(8.5)	(9.5)	(10.6)	(11.7)	(12.8)	(29.0)	(47.1)	(82.1)
DSH - 33% (CBO Baseline)														
Growth at Nominal GDP		5.7	6.0	6.3	6.6	7.0	7.3	7.7	8.1	8.5	9.0			
Savings		(3.2)	(3.4)	(3.5)	(3.7)	(3.5)	(3.5)	(3.3)	(3.1)	(2.9)	(2.6)	(17.3)	(24.1)	(32.7)
No Growth		5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7			
Savings		(3.2)	(3.7)	(4.1)	(4.6)	(4.8)	(5.1)	(5.3)	(5.5)	(5.7)	(5.9)	(20.4)	(30.8)	(48.0)

NOTE: Nominal GDP is based on the CBO baseline projections.

COMPARISON OF CBO AND ADMINISTRATION BASELINE: MEDICARE
(Dollars in billions, fiscal years)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	96-02	96-05
Administration Medicare Baseline	174.5	195.0	213.5	232.7	253.7	276.1	300.7	327.5	356.9	389.2	425.0	1799.0	2970.2
CBO Medicare Baseline	178.1	199	219.4	240.1	263.4	288.1	315.2	345.3	378.9	416.4	458.3	1870.5	3124.1
Difference (Administration -CBO)	-3.6	-4.0	-5.9	-7.4	-9.7	-12.0	-14.5	-17.8	-22.0	-27.2	-33.3	-71.5	-153.9

MEDICARE	What include	Oppose/eliminate
Overall Target	Can we get to $170-$200	$270
Budget cap	"Soft" target/lookback	Rigid budget cap
New health plans	New delivery options Standards Phase to level market for Medicare/Medigap	MSAs Indemnity FFS plans Differential standards/benefits
Savers	Can we develop list for $170-$200 (with and without a soft look-back provision)	Oppose specific savers? In case of higher premium for upper income, oppose premium payment of >50% actuarial value (participation issue?)

MEDICAID	What include	Have to oppose/eliminate
Overall target	Depends on baseline $54 billion off admin. $65 billion off CBO	$182 -- and even lower numbers
Structure	Continued federal guarantees of coverage, funding for growth, subject to caps/person Per capita cap or % matching rate reduction	Block grant
Eligibility	Guaranteed coverage of certain groups w/income below ___ % of poverty pregnant women infants, children disabled elderly What link to remaining welfare programs?	No guaranteed eligibility, services
Services	Minimum benefit package acute LTC	No benefit minimums
Flexibility	Flexibility managed care (with choice of plans) Flexibility administrative provisions (currently mandatory provisions to be made optional) Flexibility payment (revised Boren)	
DSH	DSH - whatever reductions politically acceptable	

IV. What do we do now?

A. Focus attacks on key policy areas

1. Medicare
   - Hard cap
   - Standards
   - MSAs
   - FFS plans
   - Medigap - lack of choice to return

2. Medicaid
   - Dollar level
   - Cap/block grant impact on states
   - Eligibility for key groups

B. Continue to develop back-pocket

C. Continue to work w/ Dems on hill, governors to advance // agendas

1. Revised Medicare target
2. Medicare structure

MEDICAID REFORM TASKS September 12, 1995

	Status	Staff	Date
POLICY DEVELOPMENT			
Per Capita Cap			
o Framework Paper -- Expand and clarify:	**Draft circulated** Sept. 8	Jeanne	9/15
o Growth Index Paper:	**Completed**	Parashar/Holly	9/5
o Medically Needy as separate class	**Draft in circulation**	Kristen	9/5
o MR / DD and ICFs MR treatment		Christie, Ruth	9/14
o 1115			
- Data Analysis	**Draft in circulation**	Meg	9/1
- Policy Implications/Rationale	**Draft in HCFA circulation**	Karen	9/11
o QMB			
- Description/data		Don; Robyn	9/14
- Policy Implications/Rationale		Don	9/14
o Enforcement			
- State gaming	**Draft in circulation**	Jeanne	9/5
- Administrative Process	**Draft in circulation**	Karen/Miles	9/5
- Enforcement / Scoring		Mark Miller	?
Flexibility			
Flexibility paper	**Draft in circulation**	Don/Bill H.	9/8
-Additional issues papers			
Eligibility simplification		Letty/Bill H.	
New 1115 waiver process		Karen/Meg	
Mandatory to option/EPSDT		Kristen/Christie	
IMD expansion		Sharman	
Managed Care oversight/quality		Karen	
Boren Revision		Bill H.	
Admin. flex/enhanced match		BillH.	
HCB waiver details		Mary H./Bill H.	
Welfare reform Elig.		Letty/Christie	
DSH			
o Reduce and Re-Target	**HHS draft in circualtion**	Jake	9/14
		Bonnie	9/8
Medicare Interaction			
o Medicare interaction	**Draft in circualtion**	Letty	9/14

RESPONSE / IMPACT ANALYSES

Block Grant

- o State by States
  - Impact of Hospital/workers — Canceled
  - Impact of Nursing Home Residents: Draft — Jeanne/Urban 9/12
  - Impact of Recession — Jeanne/Urban 9/15
  - Impact on the mentally ill — Jeanne/Urban ??
  - Impact of welfare match rate — Waiting for Sen. action
  - Other Long-Term Care — Jeanne, John Drabek / Lewin 9/30

- o Medicaid Briefing Document: Completed