

DEVORAH ADLER
Domestic Policy Council

Box 6 of 7

Binders:

CHIP Info
Medicare & States
Medicare
HCFA Medicare and Medicaid Guide
Chip Info
Summaries of States' Title XXI State Plan/Amendment
Plan to Strengthen and Modernize Medicare for the 21st Century
Medicaid Background

Enclosures filed in
Oversize Attachments # 20473
VARA # 17676

MEDICAID BACKGROUND

/ MEDICAID /

**PHOTOCOPY
PRESERVATION**

MEDICAID REFORM: RESTRUCTURING THE BOREN AMENDMENT

This paper lays out HHS staff recommendations for restructuring the requirements under the Boren Amendment for hospitals and nursing facilities.

RESTRUCTURING BOREN FOR HOSPITALS:

The application of the Boren amendment provisions to payment rates for hospitals should be repealed. The competition between hospitals and payers has increased over the years to the point where the Boren provisions are no longer necessary to ensure beneficiary access.

ISSUES:

Interaction with DSH policy. There is a concern that states may potentially use this increased flexibility in establishing hospital payment rates to offset any protection provided to public (or other) hospitals through DSH. The DSH policy should include a provision which protects hospitals from states using DSH to offset lowered hospitals base payments rates [Per BV].

Repeal §1902(a)(30). Section 1902(a)(30) of the Social Security Act requires that in general, states' payment rates must be "consistent with efficiency, quality and economy of care and are sufficient to assure sufficient access to services." This provision is extremely vague and would probably be the source of litigation if the Boren amendment is repealed. Further, repealing this section also affects all other Medicaid providers. On the other hand, repealing §1902(a)(30) would give states unfettered latitude in setting hospital payment rates. [BV wants to retain these provisions particularly for providers other than hospitals.]

RESTRUCTURING BOREN FOR NURSING FACILITIES:

The current Boren provisions should be restructured to indicate that the provisions only apply to payment rates for nursing facilities. In addition, states would be deemed to be meeting the requirements of the Boren amendment if they met any of the following "safe harbors."

- Nursing facilities payment rates equal to or greater than the 50th percentile of facility costs within the state. A time-limited (3 or 5 year) grandfather clause would be established for States below the 50th percentile standard to come into compliance.
- Nursing facility payment rates which increased during the current fiscal year at a rate equal to or greater than the increase in the Medicare Skilled Nursing Facility market basket index;
- A methodology for calculating nursing facility payment rates which is consistent with the Medicare calculation of payment rates for Skilled Nursing Facilities [per BV].

Table 11

**Percent Change in Four-Quarter Averages in the Skilled Nursing Facility Input Price Index,
by Expense Category: Calendar Years 1988-96**

Expense Category ¹	Base Year Weights 1977 ²	Calendar Year								
		1988	1989	1990	1991	1992	1993	1994	1995	1996
Total	100.000	5.1	6.6	6.3	4.4	3.9	3.7	3.4	3.3	3.9
Compensation	70.620	5.5	7.1	6.5	4.8	4.4	4.0	3.7	3.6	4.2
Wages and Salaries	63.020	5.4	7.4	6.5	4.4	3.9	3.9	3.7	3.5	4.1
Employee Benefits	7.600	5.9	4.7	6.0	7.7	7.7	4.9	4.1	4.0	4.6
Fuel and Other Energy	4.270	1.0	3.8	8.8	0.7	0.4	2.6	0.8	0.5	4.1
Fuel Oil and Coal	1.660	0.3	4.3	20.4	-3.8	-3.8	-0.2	-1.4	-0.5	5.2
Electricity	1.210	1.4	3.1	2.3	3.8	2.0	1.9	0.0	1.9	1.1
Natural Gas	0.910	-0.6	2.8	0.1	1.2	1.8	6.2	2.1	-2.4	4.8
Water and Sewerage										
Maintenance	0.490	5.5	6.1	8.7	7.3	6.8	5.4	5.0	4.5	5.9
Food	9.740	4.3	5.2	4.5	1.8	1.2	1.9	1.9	2.3	2.4
Direct Purchase	4.930	4.4	4.5	3.5	0.0	0.2	1.6	1.2	1.6	2.2
Contract Service	4.810	4.1	5.8	5.3	3.0	2.0	2.1	2.5	2.8	2.6
All Other	15.370	4.9	5.6	6.0	5.1	4.0	3.7	3.1	3.0	3.5
Pharmaceuticals	1.500	7.9	9.1	8.9	8.4	6.5	4.5	3.2	2.4	3.9
Supplies	3.280	4.1	4.8	5.4	4.2	3.0	3.0	2.6	2.9	3.1
Health Services	1.210	7.2	7.3	7.2	6.0	6.3	5.6	4.4	4.2	4.4
Other Business Services	4.590	4.5	4.9	5.3	4.8	3.8	3.8	3.3	3.2	3.5
Miscellaneous Costs	4.790	4.1	4.8	5.4	4.2	3.0	3.0	2.6	2.9	3.1

¹ For data sources used to estimate the input price index relative weights and choice of price proxies, see the *Federal Register* (1992c).

² Category weights may not sum to total because of rounding.

NOTES: Data through 1994 are historical. Data beginning with 1995, quarter 1 are forecasted.

SOURCES: Health Care Financing Administration, Office of the Actuary; Data from the Office of National Health Statistics, Division of Health Cost Analysis. First quarter 1995 forecasts were produced by Data Resources, Inc., McGraw-Hill.

March 5, 1997



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Please route to:

Nancy-Ann Min
Chris Jennings

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HOTBOX _____ *OVERNIGHT* _____ *Attached cc: Sarah Bianchi* _____

Subject: One-Page Description
of Medicaid Error -
CBO Scoring

With informational copies for:

HD Chron, HFB Chron, Medicaid Examiners,

From: Bonnie Washington

Phone: 202/395-4922
Fax: 202/395-3910
Room: NEOB #7025

Attached for your review is the final draft of the one-page description of the Medicaid error in CBO scoring. This version incorporates all comments received as of 11:30 am.

Please let us know if you have any additional comments on this document by 1:00 pm. Also, please let us know how you would like to distribute this document to interested parties. We recommend asking HCFA OLIGA to take the lead in distributing the document to Hill staff and other interested parties.

We will not distribute this document until we receive final clearance from you.

President's FY 1998 Budget Medicaid Proposal

The President's Policy. The President's Medicaid policy achieves modest savings through a reduction in disproportionate share hospital payments and a per capita cap. These savings are offset with new investments, including expanding coverage for eligible children. The savings come from two policies:

- **Reductions in disproportionate share hospital (DSH) payments:** Under this policy, Federal DSH payments will be frozen at 1995 levels for 1998 (about \$10 billion), and then reduced to an estimated \$9 billion in 1999 and \$8 billion in each subsequent year. Of the savings generated from the DSH reductions over the five-year period, about \$1.4 billion will fund temporary supplemental payments to Federally qualified health centers and rural health clinics. This will help these providers during the transition to a per capita cap, and will also compensate for our proposed repeal of cost-based reimbursement.
- **Per capita cap:** The growth in the Federal payments per beneficiary will be limited to a specified index. The index is equal to the growth in nominal gross domestic product per capita (based on a five-year rolling historical average) plus 2 percentage points in 1997 and 1998; and 1 percentage point in 1999 and each subsequent year. Of the savings generated from the per capita cap over the five-year period, about \$1 billion will fund a temporary transition pool to assist States and safety net providers who are disproportionately affected by this policy.

CBO Scored Policy in the March 4, 1997 Testimony

- In their testimony for the Senate Finance Committee on March 4, 1997, the Congressional Budget Office (CBO) reported their official estimates of the effects of the President's budget. They estimated net Medicaid savings of \$7.5 billion over five years.
- However, there were two errors in the specifications of the Medicaid policy that were sent to CBO for scoring. Specifically, CBO was given incorrect "additive factors" for the per capita cap index and incorrect amounts for the transition pool funding. These differences are small, and affect the scoring of the President's Medicaid proposal by only \$500 million over five years.
- CBO has been informed of the errors in the specifications but due to time constraints were unable to incorporate these technical corrections prior to the release of their analysis. Although they cannot change their official estimate of the President's Budget that was included in the testimony for the Senate Budget Committee, they have provided an unofficial estimate of the savings associated with the corrected Medicaid policy. This estimate is included in the attached table and reflects the correct growth index and transition pool payment amounts as described above. As shown on the attached table, CBO estimates that savings from the corrected version of the Medicaid policy are \$7.0 billion over five years.

Medicaid Summary Table President's 1998 Budget - Different Adjustment Factors and Pool Amounts

04-Mar-97

This is Not the Official CBO Estimate of the President's Budget

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998-2002
Baseline	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4
Savings											
Per Capita Cap	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-6.8	-8.7	-11.1	-13.8	-8.5
DSH	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-7.7	-8.9	-10.2	-11.6	-16.6
Pool Amounts											
Federally Qualified Health Centers	0.0	0.5	0.4	0.3	0.2	0.1	0.0	0.0	0.0	0.0	1.4
Transition Pool	0.0	0.4	0.3	0.2	0.1	0.1	0.0	0.0	0.0	0.0	1.0
Welfare											
Exempt SSI Disabled Aliens	0.8	0.8	0.7	0.7	0.7	0.6	0.6	0.6	0.5	0.4	3.7
Exempt Alien Disabled from 5 Yr Ban	0.1	0.1	0.3	0.5	0.8	1.2	1.6	2.1	2.6	3.2	1.8
Exempt Alien Kids from 5 Year Ban	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.4
Keep Medicaid for Disabled Kids	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	1.0
Kids Initiatives											
12 Month Eligibility	0.9	0.9	1.0	1.0	1.1	1.2	1.2	1.3	1.4	1.4	4.9
Outreach - Kids Health Demos	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8
Other											
Puerto Rico	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3
Extension of VA Sunset	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	1.1
Working Disabled*	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Raise DC FMAP to 70%	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9
Eliminate Excise Tax for Vaccines	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1
Interactions											
Part B Premium Interactions	0.0	0.1	0.2	0.2	0.4	0.6	0.8	1.1	1.3	1.6	0.9
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Change	1.8	1.1	-1.6	-3.3	-5.1	-7.0	-8.9	-11.2	-14.0	-17.1	-7.0
New Outlays	107.1	114.7	121.3	129.5	138.7	148.9	159.8	171.9	185.0	199.1	611.3

*Under \$50 million

Notes:

- 1) Assumes per capita growth rate equal to the growth in GDP per capita plus 2% in 1997 and 1998 and 1% thereafter.
- 2) Assumes DSH payments would be limited to \$10 billion in 1998, \$9 billion in 1999, and \$8 billion thereafter
- 3) Assumes supplemental payments for federally qualified health centers and rural health clinics to total \$1.4 billion
- 4) Assumes supplemental payments for other purposes to total \$1 billion

Totals may not add due to rounding

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reflects correct President's
Medicaid
Policy

THE PRESIDENT'S MEDICAID REFORM PROPOSAL

1. Overview

- Advantages of a Per Capita Cap

2. Financing

- Responsive and Responsible Federal Financing
- Per Capita Cap: What Is It
- Per Capita Cap: How Does It Work and Adapt to Enrollment Changes
- Per Capita Cap: Adapting to State Spending
- Disproportionate Share Hospital (DSH) Changes and Pool Payments

3. Flexibility

- Provider Payment Flexibility
- Managed Care Flexibility
- Eligibility and Benefits Flexibility
- Administrative Flexibility

1. OVERVIEW

The President's Medicaid proposal achieves significant reform and offers:

- **Responsive and responsible Federal funding:**
 - Federal funding is not fixed but responds to unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
 - Federal reductions are responsible, providing states with sufficient funds to maintain coverage for the millions of Americans who rely on Medicaid.
- **State flexibility:** The top concerns of the Governors have been addressed, including:
 - Repeal of the Boren Amendment regulating provider payments;
 - End to the burdensome waiver process for managed care and home and community-based waivers;
 - Eligibility simplification and expansions without waivers; and
 - Elimination of many unnecessary and duplicative administrative requirements.

Why The President's Medicaid Proposal is Better

[Melissa Skolfield's two-page summary is to be inserted here]

2. FINANCING

The President has proposed to reform Medicaid financing through a **Per Capita Cap** and **Disproportionate Share Hospital (DSH)** payment changes.

- **Responsiveness:** A per capita cap maintains the responsiveness of Federal funding to states' unexpected costs.
 - Under the President's proposal, the Federal government shares in the unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
- **Responsible:** The per capita cap and Disproportionate Share Hospital payment reductions achieve responsible levels of Federal savings.
 - The President's proposal provides states with sufficient Federal funds to maintain coverage for the millions of Americans who rely on Medicaid.

The following section reviews:

- Responsive and Responsible Federal Financing
- Per Capita Cap: What Is It
- Per Capita Cap: How Does It Work and Adapt to Enrollment Changes
- Per Capita Cap: Adapting to State Spending
- Disproportionate Share Hospital (DSH) Changes and Pool Payments

Responsive and Responsible Federal Financing

The President's proposal maintains the Federal commitment to share in states' Medicaid costs:

- Protection from recession. During a period of economic recession, enrollment will increase, causing state costs to rise. The Center on Budget and Policy Priorities estimates that Medicaid costs could increase between \$8 billion and \$29 billion over seven years depending on the intensity of the recession. Under a per capita cap, the Federal government shares in these unexpected costs.
- Protection from changes in Medicaid caseload. States may find themselves with greater proportions of costly persons such as seniors or people with disabilities. The per capita cap adapts to shifts in the types of beneficiaries covered by a state, increasing Federal payments to states if their patient population becomes sicker.

The President's proposal also takes a responsible and not a radical amount of savings from the Medicaid program.

- President's plan saves \$59 billion. CBO has certified that the President's proposal will save \$59 billion over seven years.
Republicans' plan saves \$85 billion. The Republicans claim \$85 billion in Federal Medicaid savings over seven years.
 - This is \$26 billion -- or 44 percent -- higher than the savings proposed by the President.
 - Under the Republican plan, the spending growth per beneficiary would average 2 percent -- less than inflation and significantly below private spending growth per person (7 percent). States probably cannot afford to maintain coverage at such low rates, and may be forced to deny coverage for millions of Americans by the year 2002.

Per Capita Cap: What Is It

- A “per capita cap” is a policy that limits Federal Medicaid spending growth per beneficiary. Under this policy, Federal payments automatically adjust to a state’s enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in these increased costs. In other words, Federal money will flow with the number of needy persons a state serves.

There are three components to the per capita limit on Federal funding:

- Base spending: Each state’s 1995 spending per beneficiary is calculated, excluding spending items such as payments for Medicare premiums and cost-sharing and Disproportionate Share Hospital payments. The spending per beneficiary is separated for the four major groups of Medicaid beneficiaries: seniors, people with disabilities, adults and children.
- Index: Future year spending limits will be calculated by growing the average 1995 spending per beneficiary by a pre-set “index”. The index updates the 1995 spending in proportion to the growth in the gross domestic product per person. In the President’s proposal, the index averages over 5 percent between 1996 and 2002.
- Actual enrollment: This indexed spending per beneficiary is then multiplied by the number of beneficiaries in each category in a given year. The category-specific limits are then added together to yields the maximum spending that the Federal government will match.

Each state will have a single total limit, so it can use savings from one group to support expenditures for other groups or to expand benefits or coverage.

Per Capita Cap: How Does It Work and Adapt to Enrollment Changes

- To give an example of how the formula works, take a hypothetical state:

	1995 Spending per Beneficiary	2000 Limit per Beneficiary *	Enrollment in 2000	Total Limit (Millions)	Federal Limit (Millions)**
Elderly	\$9,000	\$11,487	1,000	\$11.5	
Disabled	\$8,000	\$10,210	2,000	\$20.4	
Adults	\$2,000	\$2,553	3,000	\$7.7	
Children	\$1,000	\$1,276	6,000	\$7.7	
Total				\$47.2	\$23.6

* Index is 5% per year, or 28% growth between 1995 and 2000.

** Assumes that the Federal medical assistance rate is 50%.

- In the year 2000, the maximum Federal matching payments for this state would be \$23.6 million.

The cap adapts automatically to state enrollment changes

- If enrollment in these categories increases above the levels noted above, the total and Federal limit would increase automatically -- because the limit is calculated on a per person basis.
- If enrollment shifts to more expensive populations or enrollment grows faster than expected, then the total limit would increase automatically.
 - For example, if there are 500 more seniors than noted above, then the total limit would increase by \$5.7 million (500 seniors times \$11,487 limit per senior), and the Federal limit would increase by around \$2.85 million.

Per Capita Cap: Adapting to State Spending

- If the state keeps spending per beneficiary below the limit for one or more categories of beneficiary, it has a number of options. For example, assume that the state kept spending for the elderly to \$10,376 per elderly beneficiary (\$1,000 below the limit per beneficiary). With 1,000 senior enrollees, that would free up \$1 million within the state's aggregate limit (\$1,000 per enrollee times 1,000 seniors). The state could:
 - o Spend above its per beneficiary limit for another group. For example, the state could spend \$150 more per child -- a total of \$1,426 per child -- for a total cost of \$0.9 million (\$150 per child times 6,000 children) and still remain within its aggregate limit.
 - o Use the funds to expand eligibility to new groups whose income is within the 150 percent of poverty level (see Eligibility Flexibility).
 - o Save the state share of the funds.

Disproportionate Share Hospital (DSH) Changes and Pool Payments

Disproportionate Share Hospital Payments Changes:

- Disproportionate Share Hospital (DSH) payments would be reduced and retargeted.
 - Financing: The current (1995) Federal payments to states would be gradually phased out, and a new DSH payment method would be phased in. Funding from a fixed Federal pool would be allotted to states on the basis of their share of low-income days for eligible hospitals.
 - Program Design: States would use the funds for hospitals that serve a high number of uninsured and Medicaid patients, and would have the flexibility to cover additional hospitals that they deem needy.

Pool Payments:

- Three pools of grant funding would be created to ease the transition to the reformed Medicaid program.
 - **Undocumented Persons Pool**: A \$3.5 billion pool to help the 15 states with the largest numbers of undocumented persons would be created. This 100 percent Federal pool would be in effect from 1997 to 2001, and would be allocated to states in proportion to their share of the nation's undocumented persons. It would be used by states for emergency care for these persons.
 - **Federally Qualified Health Centers and Rural Health Clinics Pool**: As part of the proposed changes to promote state flexibility, the mandate for states to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) on a cost basis would be repealed. To ease the change in funding for these facilities, a program would be created with \$500 million in Federal funds in each year beginning in 1997.
 - **Transition Pool**: For 1997 through 1999, \$3.5 billion in Federal funds would be given to states to enable a smooth transition to the reformed Medicaid program.

3. FLEXIBILITY

The President's Medicaid proposal significantly increases states' flexibility to design and managed their own Medicaid programs.

The President's plan addresses the top concerns of the Governors:

- Repeal of the Boren Amendment regulating provider payments;
- End to the burdensome waiver process for managed care and home- and community-based waivers;
- Eligibility simplification and expansions without waivers; and
- Elimination of many unnecessary and duplicative administrative requirements.

The following section describes new state flexibility in the following areas:

- Provider Payment Flexibility
- Managed Care Flexibility
- Eligibility and Benefits Flexibility
- Administrative Flexibility

Provider Payment Flexibility

The President's plan gives states greater flexibility in setting provider payment rates:

- **Boren Amendment is Repealed:** The proposal repeals the Boren Amendment, allowing states greater discretion in establishing their provider payment rates. Under the Boren Amendment, states were required states to pay hospitals and nursing homes "adequate" and "reasonable" rates. Because of its ambiguity, this requirement led to many costly lawsuits for states.
- **Cost-Based Reimbursement for Clinics is Repealed:** States will no longer be required to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that are not Indian Health Service facilities on a cost basis beginning in FY 1999.
- **Burdensome Standards for Obstetrician and Pediatrician Payments are Eliminated:** States currently must file extensive documentation relating to their payments for these providers. Under the proposal, states could set their own payment standards for obstetricians and pediatricians and would be freed from the paperwork burden.
- **Obligation to Pay for Private Insurance When Cost Effective is Ended:** States will no longer be required to enroll individuals in private insurance in certain situations, and to pay the private insurance premiums and copayments. States will have the option to continue purchasing group insurance and negotiate their own rates.

Managed Care Flexibility

Under the President's proposal, states will have new flexibility to implement and operate Medicaid managed care programs.

- **Elimination of Need for a Waiver:** States will be able to implement managed care programs without the need for Federal waivers, so long as beneficiaries have a choice of plans, except in rural areas. States will be permitted to enroll Medicaid beneficiaries into their health plans for up to six months and to guarantee Medicaid eligibility during this enrollment period.

- **Outdated Quality Standards are Repealed:** The 75/25 enrollment composition rule will be eliminated.

Quality of care will be assured through state-designed quality improvement programs -- which follow Federal guidelines -- that ensure that managed care providers maintain reasonable access to quality health care.

- **Federal Contract Review is Eliminated:** The Federal government will no longer review states' contracts with managed care plans that exceed \$100,000.
- **HMO Copayments are Allowed:** States will be able to require some HMO enrollees to make nominal copayments.

Eligibility and Benefits Flexibility

The President's proposal maintains the Federal entitlement and keeps Medicaid basic benefits intact. It builds upon this base to offer states options for simplifying and expanding eligibility and designing community-based long-term care programs.

- **Eligibility Categories are Simplified:** Many of the outdated eligibility categories are consolidated and eliminated.
- **Eligibility Expansions are Allowed Without Waivers:** If states are able to manage costs below their per capita limits, they may add any new eligibility group at their discretion. The only limits on this flexibility are that the new beneficiaries' income is less than 150 percent of the poverty level, and the expansion does not result in spending above the per capita limit.
 - o In the example of the how a per capita cap would work, the state could, under one scenario, spend \$1,000 less than its limit per senior (\$10,476). With 1,000 senior enrollees, that would free up \$1 million within the state's aggregate limit (\$1,000 per enrollee times 1,000 senior enrollees).
 - o With this \$1 million, the state could choose to add 500 individuals with spending of \$2,000 per person and still be within their limit.
- **Home and Community-Based Care Programs are Allowed Without Waivers:** States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

Administrative Flexibility

The President's plan repeals and simplifies Federal administrative requirements for the Medicaid program.

- **Certain Personnel and Program Requirements are Repealed:** Federally-mandated administrative requirements for State personnel standards and cooperative agreements with other State programs will be repealed. States will be free to establish similar standards, if they choose.
- **Data Requirements are Streamlined:** Medicaid Management Information System (MMIS) requirements for the use of standardized claims formats and standardized HCFA reporting requirements will be simplified and reduced.
- **State Plan Process will be Simplified:** State plan submissions will be consolidated.
- **Nursing Home Resident Duplicative Reviews are Eliminated:** Required annual resident review in nursing homes will be repealed. States will conduct reviews when indicated.
- **Permissible Sites for Nurse-Aide Training are Broadened:** States will be able to conduct nurse-aide training in certain rural nursing homes, which currently are not considered permissible training sites.
- **Certain Federal Provider Qualifications Requirements are Repealed:** Special minimum qualifications for obstetricians and pediatricians will be repealed.

MEDICAID:
Comparison of Two Different Approaches
January 23, 1996

I. Cost Differences

	President	Republicans	Difference
Federal Spending Reductions (1996 - 2002)	-\$59 billion Federal	-\$85 billion Federal	Republican plan cuts Federal spending by \$26 billion (45%) more than the President's plan. Total Federal and state cuts would triple (\$285 billion) if states only spend the minimum required.
7-Year Growth Rates Per Person *	5%	2%	Republican plan slows spending per person to rates 33% below inflation -- making it a cut in real terms.
Estimated Number of People Losing Coverage in 2002	0	3 to 6 million	Even if states were to significantly slow spending growth, they could be forced to reduce coverage by 3 to 6 million in 2002 under the Republican plan.

* The Republicans' \$85 billion offer (January 8) was not accompanied by specific policies or CBO scoring so the policies associated with the \$117 billion proposal were used. Assumes baseline enrollment growth rates.

MEDICAID: Comparison of Two Different Approaches

II. Policy Differences

	President	Republicans*
Coverage Guarantee	Maintains individual entitlement to meaningful benefits.	Repeals Federal guarantee of coverage, and only requires immunization and limited family planning services.
Financial Protection for States	Shares unexpected costs of recession, inflation or demographic changes.	Fixes Federal funding -- leaving states responsible for 100% of unexpected costs.
Family Protections	Maintains protections against spousal and family impoverishment when the relative is in a nursing home.	Weakens asset and spousal protections, and repeals protections for adult children with incomes above the median state income.
Quality Protections	Maintains Federal nursing home quality standards and requires quality standards for Medicaid managed care plans.	Appears to retain nursing home quality protections, but in fact substantially weakens the protection because there is no Federal authority to enforce quality provisions either across states or within states. Repeals Federal managed care quality standards.
Medicare Protections	Maintains guarantee of coverage for low-income Medicare beneficiaries.	Eliminates guarantee; "set asides" do not cover cost sharing, and are not sufficient to cover premiums.

MEDICARE:
Comparison of Two Different Approaches
January 23, 1996

I. Cost Differences

	President	Republicans*	Difference
Spending Reductions	-\$124 Billion	-\$168 Billion	Republican plan cuts Medicare \$44 billion (35%) more - even though it is not needed to balance the budget or extend the Trust Fund for at least 10 years.
Federal Spending Per Person 2002	\$6,600	\$6,000	Republicans spend \$600 less per person while charging beneficiaries higher premiums.
Monthly Premiums 2002	Less than \$67.20**	\$84.60	Republican plan charges over \$17 more in monthly premiums.
Yearly Premiums Per Couple 2002	Less than \$1,612.80**	\$2,030.40	Republican plan charges couples over \$400 more in yearly premiums.

* The Republicans' \$168 billion offer (January 8) was not accompanied by specific policies or CBO scoring so the policies associated with the \$202 billion proposal were used.

** Premium estimates for the President's \$124 billion offer are not yet available. These figures are based on the President's \$102 billion offer and premiums will be lower for the \$124 billion offer because the President's proposal maintains premiums at 25% of Part B program costs, which are lower under the latest offer.

MEDICARE: Comparison of Two Different Approaches

II. Policy Differences

	<u>President</u>	<u>Republicans</u>
Arbitrary Cap	No arbitrary cap -- maintains link between Medicare financing and benefits.	Arbitrary budget cap means that for the first time in 30 years, Medicare is no longer linked to the cost of Medicare benefits.
Medical Savings Accounts and Fee-For-Service Plans	NONE	Draws the healthiest and wealthiest out of Medicare, leaving the sickest and most costly beneficiaries in a weakened program. Costs \$4 billion over 7 years (CBO est.)
Balance Billing	Extends current protections	Permits doctors to overcharge beneficiaries in private fee-for-service plans
Low-Income Protection	Maintains current Medicaid guarantee	Eliminates guarantee
Prevention	Coverage for critical preventive services, including: mammograms, sigmoidoscopies, and additional immunizations. New respite care benefits for families of beneficiaries with Alzheimer's disease.	Offers only 1 new benefit: oral nonsteroidal antiestrogen for treatment of breast cancer
Fraud and Abuse	New comprehensive policies to reduce waste, fraud, and abuse.	Reduces penalties for defrauding Medicare and puts new obstacles in the way of enforcing fraud and abuse laws.
Medigap	Introduces Medicare reforms to ensure that beneficiaries can choose any plan without fear of losing their Medigap protection.	No changes in Medigap rules that effectively lock beneficiaries into managed care plans.

Medicaid Policy

The President's plan achieves \$9 billion in net Medicaid savings over five years, \$22 billion in total savings. About one third of the savings come from a per capita cap, which reduces the growth in Medicaid spending per beneficiary. Another two-thirds is achieved by reducing payments to Disproportionate Share Hospitals. About \$13 billion is spent on Medicaid investments, including parts of the children's health and welfare initiatives.

Per Capita Cap (net savings of \$7 billion)

- The President's plan includes about \$8 billion in savings from a Medicaid per capita cap. A "per capita cap" is a policy that limits Federal Medicaid spending growth per beneficiary.
- The base year for the policy will be 1996. Each state will get a single limit for Federal matching based on the group-specific spending per beneficiary in the base year, growth by an "index".
- This index is the growth in nominal GDP per capita (5-year historical average), plus adjustment factors to both phase in the policy and account for Medicaid's high utilization and intensity. Over the budget window, the index averages 5 percent, and, by 2002, is nominal GDP plus 1 percent.
- Additionally, about \$1 billion will be made available in capped transition funds to help States who are disproportionately affected by the DSH reduction or the per capita cap.

Reduction in Payments to Disproportionate Share Hospitals (net savings of \$15 billion)

- The President's plan includes about \$16.5 billion in savings from Federal payments to Disproportionate Share Hospitals (DSH). Spending in 1998 will essentially be frozen at 1995 levels, with a gradual decline to \$8 billion in spending for 2000 and each subsequent year.
- These savings are achieved by taking an equal percentage reduction off of States' 1995 DSH spending up to a limit. If a State's DSH spending is greater than 12 percent of total spending, the equal percent reduction is taken off of this amount rather than the full DSH amount. This upper limit ensures that all of the savings is not coming from a few selected States with high DSH spending.
- The Administration believes that the DSH dollars should be better targeted to hospitals that disproportionately serve the uninsured, underinsured and high

volumes of Medicaid patients. This is a technically complex endeavor that requires broad input from interested parties; we look forward to working with the Congress, providers and advocates in the near future to develop an appropriate targeting mechanism.

- The President's plan also includes a temporary fund of \$1.4 billion to help pay for care in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). These facilities may require supplemental funding in the transition to both a per capita cap environment and when their current cost-based reimbursement is repealed in 1999.

MEDICAID POLICY: SPECIFICS OF PER CAPITA CAP & DSH REDUCTION

Q: What is the Administration's Medicaid policy? How will you achieve the \$22 billion in cuts without hurting States' Medicaid programs?

A: The Administration proposes to maintain and strengthen Medicaid. Our policy preserves the guarantee of coverage for the 37 million low-income children, pregnant women, disabled, and elderly people who depend on Medicaid for basic health coverage and long-term care. At the same time, we achieve modest savings in the program--about \$22 billion from FY 1998-FY 2002, not counting the investments in expanding coverage for eligible children (about \$5 billion over 5 years), restoring coverage for some groups who lost it as a result of last year's welfare reform law (also about \$5 billion over 5 years) and other investments (about \$3 billion over 5 years), including helping the District of Columbia and helping people with disabilities who earn above a certain income level retain their Medicaid coverage.

The President's plan recognizes the significant strides that have been made in reducing the growth of Medicaid spending.

The \$22 billion in savings comes from two sources: (1) two thirds of the savings, or roughly \$15 billion, comes from reducing the amount the Federal government spends on so-called "disproportionate share hospitals" (DSH); and (2) one third of the savings, or roughly \$7 billion, comes from a "per capita cap" policy that will limit Federal Medicaid spending growth on a per-beneficiary basis. This includes about \$2.5 billion for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and helps providers and states adjust to the new Medicaid policy.

Reduction in DSH Payments (about \$15 billion in net savings from FY 1998- FY 2002)

The Federal government spends about \$10 billion annually on DSH, which is an important source of support for many hospitals that serve a disproportionate number of Medicaid and low-income patients. In the late 1980's and early 1990's, DSH spending was growing at double-digit rates, and was the driving force in Medicaid's high growth rates. While DSH growth has moderated--partly because of changes made by the Congress and the Administration in 1991 and in OBRA 1993--both the HCFA actuaries and CBO's analysts believe that the growth will accelerate again.

The Administration's policy essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to \$8 billion in spending for FY 2000-2002. (Under the CBO baseline, DSH spending would have grown to about \$14 billion by 2002).

DSH savings are achieved by taking an equal percentage reduction off of States' 1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY 1995 is greater than 12 percent of total Medicaid spending in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy

balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional enactments, this "upper limit" policy ensures that the few States with high DSH spending are not bearing most of the impact of the savings policy.

The Administration has always said that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to take the position of supporting better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is a technically complex issue that could have potentially disruptive effects in some States, our policy does not yet prescribe a mechanism for targeting. We want to work with the Congress, the States, providers, and advocates to develop an appropriate targeting mechanism.

To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about \$1.4 billion over five years to help cover the costs of care delivered in FQHCs and RHCs. We believe this supplemental fund is necessary to help these providers during the transition to a per capita cap, particularly in view of our proposal to end, effective in FY 1999, the requirement that States reimburse them on a cost basis in 1999.

Per Capita Cap (about \$7 billion in net savings from FY 1998 to FY 2002)

Under the per capita cap policy, Federal Medicaid spending growth will be limited on a per beneficiary basis. The per capita cap will work as follows:

The base year for the policy will be 1996. Under the plan, the cap would be the product of three components: 1) total spending per beneficiary in the base year; 2) an index (for years between the base year and the current year); and 3) the number of beneficiaries in the current year. To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the elderly, individuals with disabilities, non-disabled adults, and non-disabled children. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum spending in each state.

The index we have used is the growth in nominal GDP per capita (based on a five-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period--1998-2002--the index would allow per capita spending to increase by an average of 5 percent per year. By 1999 and subsequent years, the index will be nominal GDP plus 1 percent. Our policy development to this point has focused on an index based on nominal GDP. There is a debate about which is the most appropriate index. The Blue Dogs use the CPI, and the Department is reviewing an index that could more precisely reflect growth in health care costs and in particular, the volume and intensity inherent in a program that serves many low-income people. When our work is complete, we will share that information with the Congress, the States, and other stakeholders, in order to facilitate the development of the best index possible.

What this means is that, after 2000, when both the HCFA actuaries and CBO's analysts have indicated that they expect Medicaid spending growth on a per capita basis to rise more rapidly again, the per capita cap would constrain Medicaid growth per person (for non-DSH benefits and administration) to about 5 percent per year. If we and the States are successful in holding spending growth per beneficiary to about 5 percent a year during this period--which is close to the annual growth rate CBO is projecting for private insurance on a per person basis--the per capita cap will produce little to no savings. But if the analysts are correct, and per capita spending growth rises again, our policy will prevent that increase from overtaking our balanced budget.

As you know, the President's plan includes a number of provisions to give States more flexibility in running their Medicaid programs; for example, by repealing the Boren Amendment and by allowing States to move to managed care without a waiver. We also include about \$1 billion in capped "transition pool" funding to assist states and safety net providers who are disproportionately affected by the Medicaid savings policies. We believe that we can work together with the States to ensure that Medicaid maintains its guarantee of coverage for the people who depend on it, while at the same time strengthening Medicaid's fiscal discipline and building on the success of the past few years in constraining unnecessary growth in spending.

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MEDICAID FACTS

THE KAISER COMMISSION ON THE FUTURE OF MEDICAID

November 1997

THE MEDICAID PROGRAM AT A GLANCE

What is Medicaid?

Medicaid is the nation's major public financing program for providing health and long-term care coverage to millions of low-income people. Initially designed to pay for the health care of recipients of welfare assistance and certain other needy people, by 1995, 35.2 million people—more than 1 in 10 Americans—were covered by Medicaid at a cost of \$152.4 billion.

Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by the state and federal governments and administered by the states. Federal financial assistance is provided to states for coverage of specific groups of people and benefits through federal matching payments based on the state's per capita income. The federal share ranges from 50 to 80 percent of Medicaid expenditures.

Who is Covered by Medicaid?

Being poor does not automatically qualify an individual for Medicaid. Only persons who fall into particular "categories" such as low-income children, pregnant women, the elderly and people with disabilities are eligible. Under the new welfare program, Temporary Aid to Needy Families (TANF), Medicaid eligibility is no longer automatic for families who receive cash assistance. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. As a result, there are large state variations in coverage. Although Medicaid has increasingly been used to expand coverage to the low-income population, it covers only half of poor Americans. While the new State Child Health Insurance Program will expand coverage to low-income uninsured children either through Medicaid or a separate program, millions of low-income people will remain uninsured.

The diverse Medicaid population is comprised of:

- 17.5 million children
- 8.0 million adults in families
- 3.9 million elderly persons
- 5.8 million blind and disabled persons

Although adults and children in low-income families make up nearly three-fourths of beneficiaries, they account for only 28 percent of Medicaid spending. The elderly and the disabled account for the majority (60 percent) of spending because of their intensive use of acute and long-term care services. Disproportionate share hospital (DSH) payments account for about 12.5 percent of Medicaid spending (Figure 1).

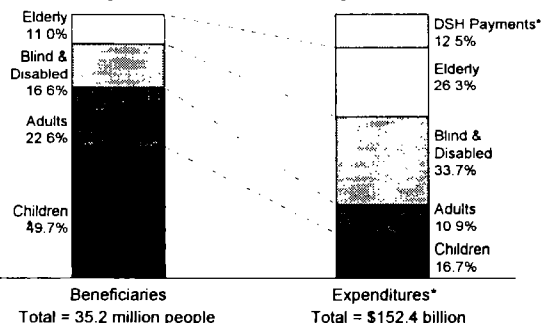
What Services are Covered Under Medicaid?

Medicaid covers a broad range of services to meet the complex needs of beneficiaries. Because of the limited financial resources of beneficiaries, cost-sharing requirements are nominal. Federally mandated services include:

- inpatient and outpatient hospital
- physician, midwife, and certified nurse practitioner
- laboratory and X-ray
- nursing home and home health care
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- family planning
- rural health clinics/federally qualified health centers

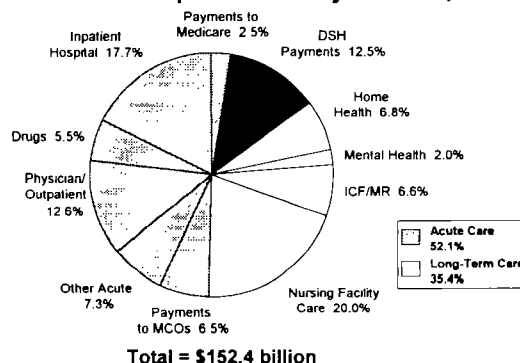
States have the option to cover additional services and still receive federal matching funds. Commonly offered services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care and intermediate care facilities for the mentally retarded (ICF/MR).

Figure 1
Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995



* Disproportionate share hospital payments.
Note: Total expenditures exclude administrative expenses, adjustments and the territories.
SOURCE: Urban Institute Estimates, 1997.

Figure 2
Medicaid Expenditures by Service, 1995



SOURCE: Urban Institute Estimates, 1997.

Of the \$152.4 billion Medicaid spent in 1995 (Figure 2):

- Acute care services comprised about half (52.1 percent) of spending. This includes 6.5 percent of spending on Managed Care Organization (MCO) premiums.
- Long-term care services accounted for 35.4 percent of expenditures. Medicaid pays for half of total nursing home care (47 percent) and 14 percent of all home health spending in the United States.
- Payments to Medicare accounted for 2.5 percent.
- Payments to hospitals with a disproportionately large population of indigent patients (DSH) comprised 12.5 percent of total expenditures.

How is Care Delivered Under Medicaid?

As states try to expand insurance coverage to low-income people, improve access, and contain costs, many are adopting new care delivery and financing arrangements under Medicaid. While traditional fee-for-service still predominates, an increasing number of states are enrolling their Medicaid populations in managed care.

As of June 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care, a fourfold increase from 2.7 million in 1991. Medicaid managed care models range from HMOs that use prepaid capitated care to loosely structured networks that contract with selected providers for discounted services and use gatekeeping to control utilization. States have initially targeted low-income families for managed care enrollment rather than aged or disabled beneficiaries.

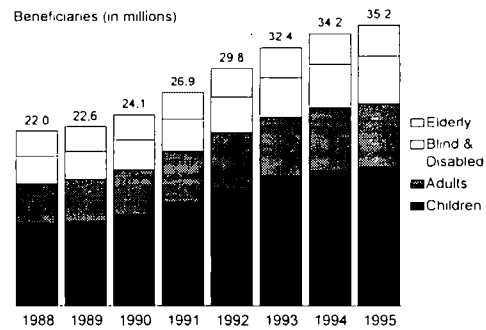
Until recently, states have used waivers of Section 1915(b) and Section 1115 of the Social Security Act to undertake mandatory managed care programs. However, the Balanced Budget Act (BBA) of 1997 permits states to mandate managed care enrollment for most Medicaid beneficiaries without a waiver (except special needs children, Medicare beneficiaries and Indians.) As a result, mandatory managed care enrollment is likely to rise.

Long-term care is a major component of Medicaid. While over three-fourths of Medicaid spending for long-term care is on institutional services, Home- and Community-Based Services (HCBS) waivers are often used by states to deliver community-based care. Although all states have HCBS waivers, the population served remains small. States also now have the option to provide dual eligibles (Medicaid/Medicare) with acute and community-based long-term care services under the Program for All-Inclusive Care for the Elderly (PACE).

Recent Beneficiary and Expenditure Growth

Medicaid enrollment rose dramatically in the early 1990's, reaching 35.2 million beneficiaries in 1995 (Figure 3). This growth is mostly attributable to expanded coverage of low-income pregnant women and young children and increases in blind and disabled beneficiaries. However, enrollment growth appears to have leveled somewhat, increasing by only 3 percent from 1994 to 1995.

Figure 3
Medicaid Beneficiary Growth by Enrollment Group, 1988-1995

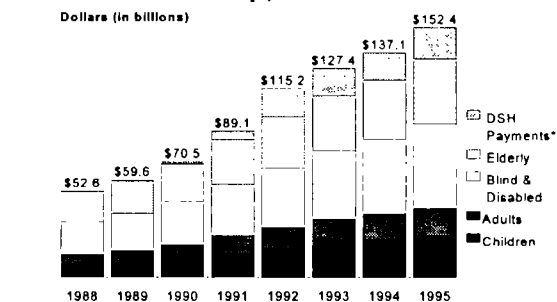


SOURCE: Urban Institute Estimates, 1997

Medicaid has become a major budgetary commitment for both the federal and state governments. Medicaid expenditures escalated rapidly between 1988 and 1992—more than doubling (Figure 4). The rise in spending in that period was attributable to a combination of health care inflation, state use of alternative financing mechanisms, and an increase in enrollment. Only a small fraction of spending growth was attributable to the expansions in coverage of low-income pregnant women and children.

The rate of growth in Medicaid spending has now returned to historic levels—rising 11.2 percent from 1994 to 1995. This suggests that legislation enacted to limit states' capacity to raise funds through provider taxes and DSH payments has played a role in slowing Medicaid spending growth. The BBA of 1997 further reduces the growth in DSH payments by \$10.4 billion over the next five years and lowers the state-specific ceilings on federal Medicaid DSH matching payments.

Figure 4
Medicaid Spending by Enrollment Group, 1988-1995



* Disproportionate Share Hospital payments
Note: Total expenditures exclude administrative expenses
SOURCE: Urban Institute Estimates, 1997

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Medicaid has been consistently shown to improve access to health care for the population it serves. Low-income people without insurance coverage use care at considerably lower levels than those with Medicaid coverage. As Medicaid struggles to meet multiple responsibilities under continued fiscal pressure, the program plays a critical role in providing acute and long-term care services to our nation's most vulnerable people.

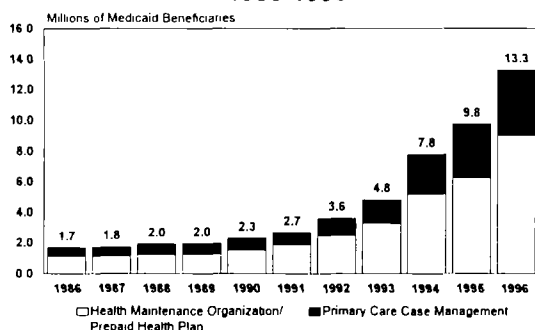
MEDICAID AND MANAGED CARE

Medicaid provided health and long-term care coverage to approximately 35 million low-income Americans at a cost of \$152 billion in 1995. In its role as a purchaser of health services for low-income families, Medicaid increasingly relies on managed care to deliver services. About 40% of Medicaid beneficiaries, predominately poor children and their parents, now receive health care services through a broad array of managed care arrangements.

MEDICAID MANAGED CARE ENROLLMENT

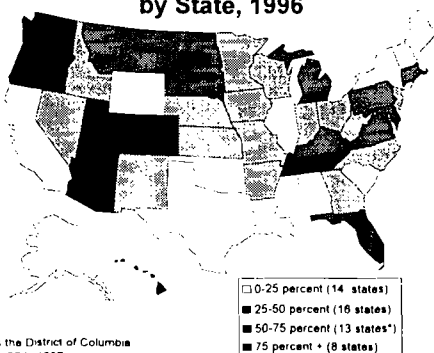
Medicaid's use of managed care has grown dramatically in recent years in response to pressure to contain the growth in Medicaid spending while maintaining access to care for low-income individuals. In 1996, 13.3 million Medicaid beneficiaries were enrolled in managed care, up from 2.7 million in 1991, a four-fold increase (Exhibit 1). Today, all states (except Alaska) are pursuing some

Exhibit 1
Growth in Medicaid Managed Care Enrollment,
1986-1996



managed care initiatives. As of June 1996, 36 states and the District of Columbia had more than one-quarter of their Medicaid population enrolled in managed care (Exhibit 2). Of these, 8 states have more than 75% of their Medicaid beneficiaries enrolled in managed care.

Exhibit 2
Medicaid Managed Care Enrollment,
by State, 1996



MODELS OF MEDICAID MANAGED CARE

Managed care includes a broad array of health financing and delivery arrangements designed to reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care. Managed care arrangements are characterized by formal enrollment of individuals in a managed care organization; contractual agreements between the provider and a payer; and some gatekeeping and utilization control.

The major Medicaid managed care models include:

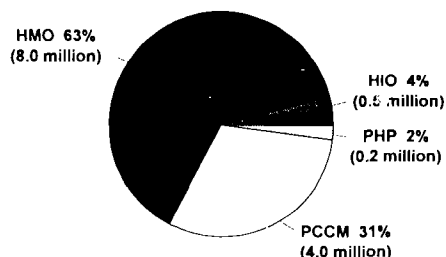
- **Full-Risk Plans (HMOs or HIOs):** Under a fully capitated plan, a health plan is paid a fixed monthly fee per enrollee and assumes full-risk for the delivery of a comprehensive range of services. The major types of full-risk plans are Health Maintenance Organizations (HMOs), in which the contracting entity and the providers are integrated into one plan, and Health Insuring Organizations (HIOs), which operate as fiscal intermediaries.
- **Limited-Risk Prepaid Health Plans (PHPs):** A PHP is an entity, usually a clinic or large group practice, that either contracts on a non-risk basis or a prepaid, capitated-risk basis to provide services that are not comprehensive (often ambulatory care only).
- **Fee-for-Service Primary Care Case Management (PCCM):** In a PCCM plan, a specific provider, usually the patient's primary care physician, is responsible for acting as a "gatekeeper" to approve and monitor the provision of covered services to beneficiaries. These gatekeepers contract directly with State Medicaid agencies, do not assume financial risk for the provision of services, and are paid a per-patient monthly case management fee, as well as fee-for-service payment for medical care.

As of June 1996, 511 Medicaid managed care plans, primarily full-risk HMOs, were in operation -- almost double the number of plans in 1993. The predominance of full-risk plans is reflected in the distribution of enrollees: 67% of all Medicaid managed care beneficiaries were enrolled in HMOs or HIOs, 2% in PHPs, and 31% in PCCMs and other managed care arrangements (Exhibit 3).

STATE MANAGED CARE OPTIONS

States have long had the option to voluntarily enroll Medicaid beneficiaries in managed care plans. Legislative authority to require mandatory enrollment has evolved over time. Until recently, states have used Section 1915(b) freedom-of-choice waivers or Section 1115 research and demonstration waivers to undertake mandatory managed care programs.

Exhibit 3
**Medicaid Managed Care Enrollment,
 by Type of Plan, 1996**



Note. Excludes enrollees in Behavioral and Dental Health Plans.
 Source: PPRC, 1997

Under 1915(b) waivers, in place in 42 states, mandatory managed care has been implemented in part of the state or for certain categories of beneficiaries. Section 1115 waivers have been used to implement statewide mandatory mandatory managed care enrollment, as well as to waive the requirement that 25% of a plan's enrollment be privately insured (the 75/25 rule). As of May 1997, 10 states have implemented Section 1115 waivers (AZ, DE, HI, MN, OH, OK, OR, RI, TN, VT).

The Balanced Budget Act (BBA) of 1997 gives states new authority to mandate enrollment in managed care organizations (MCOs) for Medicaid beneficiaries without obtaining a federal waiver (except for special needs children, Medicare beneficiaries and American Indians). Furthermore, the new law permits the establishment of Medicaid-only plans by eliminating the 75/25 rule. Finally, the law establishes certain new managed care consumer protections, but exempts Section 1915 and Section 1115 waivers from the new requirements (Exhibit 4).

ISSUES IN MEDICAID MANAGED CARE

Medicaid beneficiaries are economically disadvantaged, frequently reside in medically underserved areas, and often have more complex health and social needs than do higher-income Americans. The success of managed care depends, in large part, on the future adequacy of the capitation rates and the ability of states and the federal government to monitor access and quality.

As a public program, Medicaid has operated under tight budget constraints. This has resulted in provider payment rates that are often substantially below market rates, contributing to access problems. Capitation rates need to be sufficient to assure that plans are able to adequately serve Medicaid enrollees. Adequate payment levels are particularly important in the context of mandatory enrollment of beneficiaries in Medicaid-only MCOs because these plans are wholly dependent on Medicaid financing and do not have other payers to cover Medicaid shortfalls.

Broadened use of managed care for low-income children and families, the target of most managed care initiatives, is unlikely to accomplish large overall savings for Medicaid. Acute care services for low-income children and adults account for a quarter of program spending, whereas approximately 60% of spending is for the elderly and the disabled. Enrollment of elderly and disabled populations into

Medicaid Managed Care Selected Provisions in the Balanced Budget Act of 1997

Enrollment/Marketing: Allows states to mandate managed care enrollment, to guarantee managed care enrollment for 6 months for adults and 12 months for children, and to "lock-in" beneficiaries for up to 12 months; prohibits door to door marketing; and requires state default enrollment systems to consider existing beneficiary-provider relationships and traditional Medicaid providers.

Plan Choice: Permits states to limit Medicaid beneficiaries to a choice of two MCOs in urban areas and one MCO in rural areas. Plans may serve Medicaid beneficiaries exclusively.

Access: Requires MCOs to comply with a "prudent layperson" emergency care coverage standard and prohibits physician "gag rules."

Consumer Protections: Requires MCOs to provide information regarding participating providers, enrollee rights and responsibilities, information on covered services, and grievance and appeals procedures (an internal grievance process is required).

MCO Payment Rates: Requires state Medicaid agency capitation payment rates be made on an "actuarially sound basis", and requires DSH payments go directly to providers, not incorporated into capitation payments.

Plan Requirements: Requires plans to demonstrate adequate capacity, including an appropriate range of services and access to preventive and primary care services and a sufficient number, mix, and geographic distribution of providers.

Quality/Oversight: Increases the threshold for prior federal approval of managed care contracts to \$1 million; requires states to develop and implement a quality assessment and improvement strategy by 1999 consistent with standards to be established by the Secretary of HHS; and establishes external independent review of MCO performance.

managed care remains low and is complicated by difficulties in setting appropriate capitation rates, limited plan experience in providing specialized services, as well as lack of systems to coordinate Medicare and Medicaid benefits for "dual eligibles."

Changes in the delivery system can be made to accomplish savings, but in order to be effective and preserve access to needed services, these changes will require sufficient time to implement, the development of an adequate infrastructure to deliver care, oversight of program implementation, and more experience with enrolling the elderly and disabled.

The BBA provides new standards to assure plan capacity and enforce consumer protections. However, the development of access and quality performance standards for Medicaid MCOs, and the measurement of compliance with those standards, is evolving. Ensuring that plans have provider networks in place, educating both providers and beneficiaries about managed care, and responding to the unique needs of the Medicaid population are critical to assuring access and quality of care in a managed care environment.

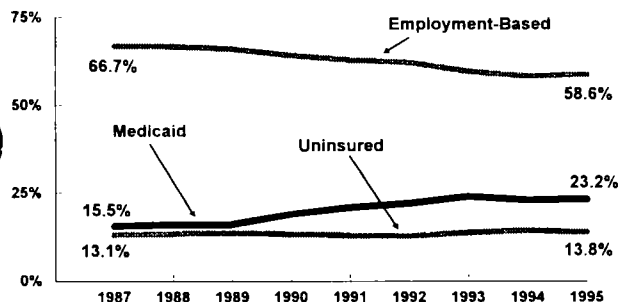
MEDICAID'S ROLE FOR CHILDREN

In 1995, 17.5 million children -- one-quarter of all children under age 18 -- had Medicaid coverage for health care services. Medicaid, the federal/state health program for the poor, pays for a broad range of services for children including well-child care, immunizations, prescription drugs, doctor visits, and hospitalization, and a range of long-term care services for children with disabilities.

Medicaid plays a particularly strong role for low-income children, covering two-thirds (64%) of all poor children and a quarter (27%) of children with incomes between 100% and 199% of the federal poverty level (FPL). While employer-based insurance coverage of children declined from 1987 to 1995, expansions in Medicaid have resulted in greater coverage of children in low-income families (Figure 1). During this same period, Medicaid enrollment grew from about 10 million -- 15.5% of all children -- to 17.5 million children (23.2%).

Figure 1

Trends in Coverage for Children, 1987-1995



Note: Children under age 18
SOURCE: Employee Benefit Research Institute, 1997.

Despite the importance of Medicaid today, about 10 million children are uninsured. Lack of insurance is particularly high among low-income children. Seventy percent of uninsured children are in families with incomes below 200% of poverty. The new State Child Health Insurance Program, enacted as part of the Balanced Budget Act of 1997, is intended to provide coverage to this group.

ELIGIBILITY

Being poor does not automatically qualify a child for Medicaid. In the past 15 years, Medicaid eligibility for children has been broadened considerably through federal legislation and state optional expansions. Prior to 1986, Medicaid primarily served children who received AFDC cash assistance. Today, children qualify for Medicaid based on their age and income.

Medicaid coverage is especially prominent among young children, covering 33% of infants and 29% of children ages 1 to 5. Because recent expansions focused on young

children, older children are less likely to qualify for Medicaid. Medicaid covers 22% of children between the ages of 6 to 12 years and 17% of teens between the ages of 13 to 18 years.

Medicaid Coverage of Children:

States are mandated to cover certain groups of children based on age and income criteria. By 2002, all states will be required to have phased-in coverage of children under age 19 with incomes below poverty. States can choose to expand Medicaid eligibility beyond federal minimum standards by raising age and income levels for children (Figure 2). They can also use Section 1115 research and demonstration waivers to broaden eligibility. In total, 41 states have expanded Medicaid coverage to children in one or more age or income levels. Federal coverage requirements for children are as follows:

Up to age 6 with family incomes up to 133% FPL. For infants, 35 states have chosen to expand coverage beyond 133% FPL and 13 have expanded for children age one to six.

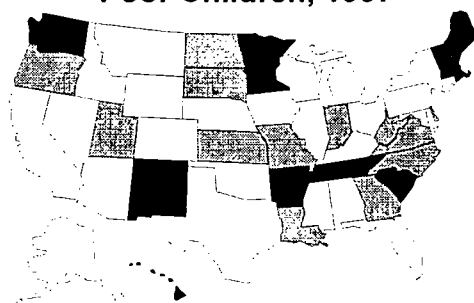
Age 6 to 14 with family incomes below 100% FPL. Fifteen states have opted to expand eligibility beyond 100% FPL.

Age 15 to 19 if family income meets the AFDC criteria of August 1996 (state average is 41% of FPL) with coverage phased-in for poor children born before 9/30/83. 25 states have opted to accelerate this phase-in to cover older children up to age 18 with income below 100% FPL (Figure 2).

Children with disabilities also qualify for Medicaid assistance on the basis of SSI eligibility. Medicaid covers about 1 million additional children with physical or mental disabilities.

Figure 2

States Opting to Accelerate Coverage of Poor Children, 1997



Accelerated phase-in to 18 years up to 100% FPL up to age 18 (13)
Accelerated phase-in up to age 18 above poverty (12)
No Accelerated phase-in (25)

SOURCE: National Governors' Association, 1997

Because states established varied Medicaid income eligibility levels for children, and because of state variations in per capita income there is considerable variation in Medicaid coverage, ranging from 13% of children in Colorado to 47% in West Virginia. Similarly, Medicaid pays for 39% of all births nationally, but coverage varies from 21% of births in Massachusetts to 61% in Georgia.

The Balanced Budget Act (BBA) of 1997 creates new options for states to strengthen and expand Medicaid coverage for children. The new State Children's Health Insurance Program (CHIP) was enacted as part of the Balanced Budget Act (BBA) of 1997. This new capped federal program allocates \$20.3 billion over five years in the form of a matched grant to states to expand coverage to uninsured low-income children through either a separate state program or by broadening Medicaid -- or both. The funds became available on October 1, 1997 and are targeted to uninsured children under 19 with income below 200% of poverty who are not eligible for Medicaid or not covered by private insurance.

Provisions of the Balance Budget Act also included some important changes to Medicaid. It clarifies the state Medicaid option to accelerate the phase-in for children born before September 30, 1983. In addition, the new law gives states the option to extend presumptive eligibility to children, meaning that services provided to low-income uninsured children will be covered by Medicaid before the Medicaid eligibility determination process is complete. States can also offer 12 month continuous eligibility to children, regardless of any changes in family income during that period.

SERVICES AND COSTS

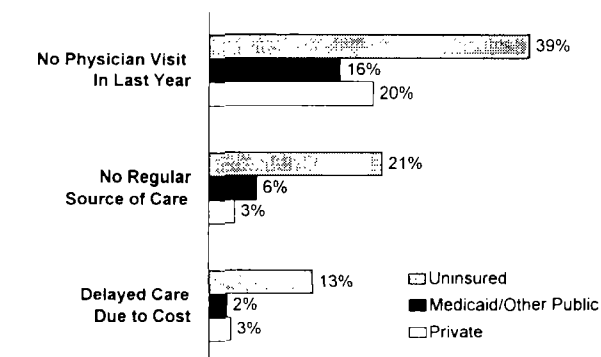
Federal guidelines require that Medicaid cover a comprehensive set of services with nominal or no cost-sharing for children. Access to these services is important because poor children experience more health problems than more affluent children. Children with Medicaid are eligible to receive physician and outpatient services, prescription drugs, inpatient hospital care, and long-term care services.

Medicaid coverage also entitles children to early and periodic screening, diagnostic, and treatment (EPSDT) services including a comprehensive health and developmental history and physical exam, immunizations, laboratory tests including blood lead levels, and health education. Children found to have conditions requiring further attention are covered for needed treatment.

The importance of health insurance in securing access to health care services is well documented. Despite their complex health and social needs, children with Medicaid coverage have access to care that is similar to higher income privately insured children (Figure 3).

Figure 3

Access to Care for Children by Insurance Status, 1993



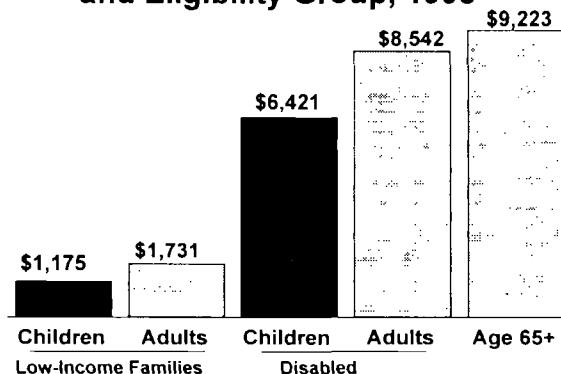
Source: National Center for Health Statistics, 1997, Kaiser/Commonwealth Survey, 1997.

In 1995, Medicaid spent \$25.4 billion on health care services for 17.5 million children in low-income families and about \$7.1 billion for one million disabled children. The majority (93%) of the expenditures for non-disabled children are for acute care services, with one third for inpatient hospital care.

While low-income children represent half of the 35 million Medicaid beneficiaries, they account for only 16.7% of overall Medicaid spending. In 1995, Medicaid spent an average of \$1,175 per low-income child enrolled in the program. On average, children cost less to care for than older Medicaid beneficiaries, but some disabled children have very costly health and long-term care needs. Medicaid spent an average of \$6,421 per year per child qualifying on the basis of disability (Figure 4).

Figure 4

Medicaid Spending Per Enrollee By Age and Eligibility Group, 1995



SOURCE: The Kaiser Commission on the Future of Medicaid, 1997.

ISSUES AND CHALLENGES

Expanding Coverage. To broaden coverage of low-income uninsured children, Congress enacted the new State Child Health Insurance Program and included provisions to allow states to facilitate enrollment and continuity of coverage under Medicaid. Key issues facing state Medicaid agencies include how the new children's program will be structured, financed, and implemented, as well as how it will be integrated with or build on the state's existing Medicaid program.

Participation. An estimated 3 million of the 9.8 million uninsured children are eligible for but not enrolled in Medicaid. This is largely due to enrollment barriers or lack of awareness of the program. States can streamline the eligibility process and facilitate enrollment. For example, 25 states allow mail-in eligibility applications and 29 states have dropped the asset test. Medicaid eligibility policy has also changed markedly as a result of the 1996 welfare law, which eliminated the automatic link between cash assistance and Medicaid. Ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible for assistance under Medicaid are enrolled.

Managed Care. In 1996, 40% of beneficiaries were enrolled in managed care, mostly low-income children and their parents. The BBA of 1997 expands state flexibility by allowing states to mandate Medicaid managed care enrollment without requiring states to obtain a Section 1115 or 1915(b) waiver. States will still need a waiver to mandatorily enroll special needs children, but will be able to enroll other non-disabled children. Managed care has the potential to improve access to preventive and primary care, but given the vulnerable nature of the Medicaid population, it requires careful implementation and monitoring to assure quality and access.

December 1997

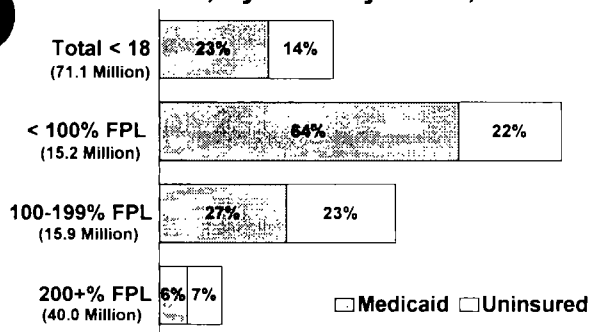
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Nearly 10 million children are uninsured, often resulting in difficulties in obtaining needed health care. To expand coverage to low-income uninsured children, Congress enacted the State Children's Health Insurance Program (CHIP) as part of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33). This new program allocates \$20.3 billion in federal matching funds over five years to states to expand insurance for children. States can use the federal funds to expand coverage either through a separate state program or by broadening their Medicaid programs -- or both.

ELIGIBILITY

The intent of CHIP is to expand health insurance coverage to uninsured children under age 19 in families with incomes below 200% of poverty (Figure 1). Children with private insurance or who are covered by or qualify for Medicaid are ineligible for CHIP, as are those who are residents of public institutions or whose families are eligible for state employee health benefits.

Figure 1
Health Insurance Coverage of Children, by Poverty Level, 1995



Note: Federal Poverty Level (FPL) is \$12,158 for a family of three.
Source: Employee Benefits Research Institute, 1996.

Undocumented children and legally resident children arriving in the U.S. after August 22, 1996 are ineligible for coverage but may qualify for emergency Medicaid assistance. States that implement their child health insurance programs through Medicaid may use federal funds to cover legally resident children in the country prior to August 22, 1996.

States that choose to operate a separate state child insurance program can establish eligibility based on geographic area, age, income and resources, residency, and disability status, as well as limit duration of coverage. States cannot exclude children based upon a preexisting condition or diagnosis, and cannot cover higher income children before lower income children.

If states use the Medicaid option, children become entitled to full Medicaid coverage. States that have already broadened Medicaid income eligibility levels above 150% of the federal poverty level (FPL) can expand coverage to children up to 50 percentage points above the current level. For example, a state with eligibility set at 175% FPL could expand to 225% FPL.

BENEFITS AND COST-SHARING

The benefit package options available to states fall into three general categories: Benchmark, benchmark-equivalent, or Medicaid.

- **Benchmark Packages:** States can offer one of three existing benefit packages: including the Federal Employees Blue Cross/Blue Shield PPO plan; coverage available to state employees; or coverage offered by the HMO with the state's largest commercially enrolled population.
- **Benchmark-Equivalent Coverage:** States can use a package with aggregate value greater than or equal to a benchmark plan. Hospital, physician, laboratory and x-ray, and well baby/child services must be included at a value at least actuarially equivalent to the benchmark benefit package. If prescription drugs, mental health, vision, and hearing services are included in the benchmark plan, then they must be part of the benchmark-equivalent coverage with a value of at least 75% of the benchmark plan's actuarial value.
- **Medicaid:** States that expand Medicaid must provide the complete benefit package, which includes well-child care, immunizations, prescription drugs, doctor visits, hospitalization, and EPSDT, as well as long-term care for disabled children. The Medicaid benefit package for children is broad and should satisfy the benchmark requirement in a state that administers a separate CHIP program.

The Secretary has the authority to approve a different benefit package that is determined to be appropriate for low-income children. The existing New York, Florida, and Pennsylvania child health programs are deemed to satisfy federal requirements for benefits.

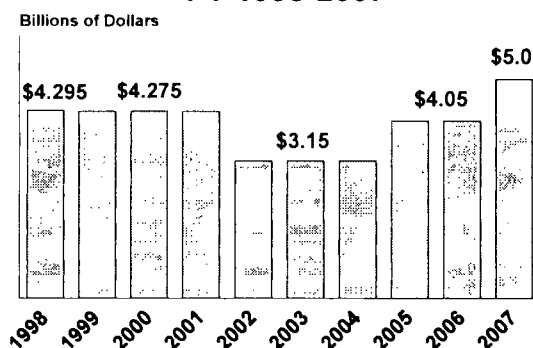
Under the new CHIP program, states cannot impose cost-sharing for preventive services including well-baby and well-child care and immunizations. For children with family incomes at or below 150% FPL, cost-sharing must be "nominal" as under the Medicaid statute. Medicaid currently permits premiums of \$15 to \$19 per month per family and co-payments of up to \$3 per service.

Cost-sharing for children with incomes above 150% FPL can be imposed based on an income-related sliding scale, but total cost sharing cannot exceed 5% of family income. Coverage can be provided directly by the state Medicaid program, an insurer, or any other entity qualified by the state.

FINANCING

The BBA authorizes \$20.3 billion in federal funds from FY 1998 through FY 2002 and \$19.4 billion over the second five years. Over the ten-year period, the funds are allocated as follows: \$4.295 billion in FY 1998, \$4.275 billion per year in FY 1999-2001, falling to \$3.15 billion annually in FY 2002 through 2004, and then rising to \$4.05 billion from FY 2005 through 2006, and reaching \$5 billion for 2007, for a total of \$40 billion.

Figure 2
**Federal Allocations for SCHIP,
FY 1998-2007**



Source: Federal Register, 1997.

Annual federal allocations to states are based on the states' share of low-income and uninsured children using estimates from the Current Population Survey, conducted by the U.S. Census Bureau. The allotment formula changes over time to adjust for reductions in the number of uninsured children.

States do not receive their allotments automatically. States must have their child health plan approved by HHS and are required to contribute state funds in order to draw down, or "match" their federal allotment. The state share cannot include beneficiary cost-sharing and is subject to the same provider tax and donation limitations specified in the Medicaid statute.

Under the new state program, states receive an "enhanced" federal matching rate based on their Medicaid matching rate. The CHIP enhanced rate essentially reduces by 30 percent the share states pay as compared to what they would contribute under their Medicaid match. For example, a state with a federal match of 60% under Medicaid would receive an "enhanced" rate of 72% under the new program. In essence, the state would pay 28 cents of every dollar spent under the new children's program. No state may receive a matching rate greater than 85% and the minimum annual payment for a state is \$2 million.

States can receive an enhanced matching rate for providing Medicaid coverage to an expanded group of children. All Medicaid rules, including the entitlement to coverage, would

apply to the newly covered group of children. States would continue to receive the regular Medicaid matching rate after their CHIP allotment was depleted.

While the states have considerable latitude in designing and structuring their CHIP programs, there are some limits on what federal CHIP payments can be used for:

- No more than 10 percent of federal and state spending can be used for outreach, administrative costs or direct service payments to clinics or hospitals. The Secretary can authorize waivers to allow states to create community-based programs or to purchase family coverage.
- If states create a new program, they cannot adopt Medicaid eligibility criteria that are more restrictive than those in effect as of June 1, 1997. If states expand coverage under Medicaid, they must maintain eligibility standards in effect as of March 31, 1997.
- Maintenance of effort is also required in state-only programs in New York, Pennsylvania, and Florida.
- Abortions cannot be covered by federal or state funds except to save the life of the mother or in the case of rape or incest.

CHILD-RELATED MEDICAID PROVISIONS

In addition to the creation of the new state child health insurance program, several changes to Medicaid were made to strengthen coverage for children under the Balanced Budget Act of 1997. States can now opt to:

- **Extend presumptive eligibility to children** -- This means that services provided to uninsured children will be covered by Medicaid before eligibility determination is complete. For children who are determined to be eligible for the new program, the costs will be paid through new program funds.
- **Offer 12 month continuous eligibility to children** -- States can choose to provide up to one year of continuous eligibility for children under Medicaid, regardless of any changes in family income during that period.
- **Accelerate the phase-in to cover poor children born before September 30, 1983.** In the past, states could cover these children under Section 1902(r)(2) at state option or through a Section 1115 waiver. The BBA of 1997 clarifies this option. Some 27 states have used these options to expand coverage to older children.

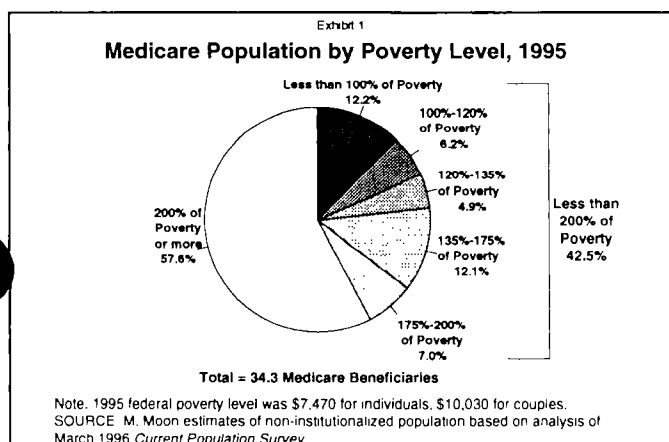
States must also restore Medicaid eligibility to disabled children who lost SSI under the 1996 welfare reform legislation. The Balanced Budget Act also includes numerous provisions that grant states increased flexibility over their Medicaid programs. These include the ability to mandate managed care enrollment without a waiver, greater control over provider payment through the repeal the Boren Amendment, and a phase-out of cost-based reimbursement for Federally Qualified Health Centers.

MEDICAID'S FINANCIAL PROTECTIONS FOR MEDICARE'S POOR AND NEAR-POOR

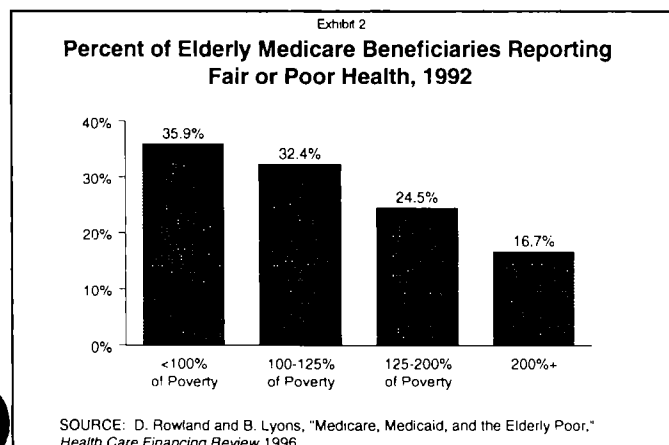
Medicare offers nearly universal coverage to the nation's elderly population and is an important source of coverage for persons with disabilities. Despite the significance of Medicare's protections, gaps in the scope of benefits and beneficiary financial obligations can result in significant out-of-pocket expenses for Medicare's poor and near poor. Medicaid helps to supplement Medicare by paying premiums and cost-sharing for some low-income beneficiaries, but participation is limited with less than half of the eligible population covered.

INCOME, HEALTH STATUS, AND HEALTH SPENDING

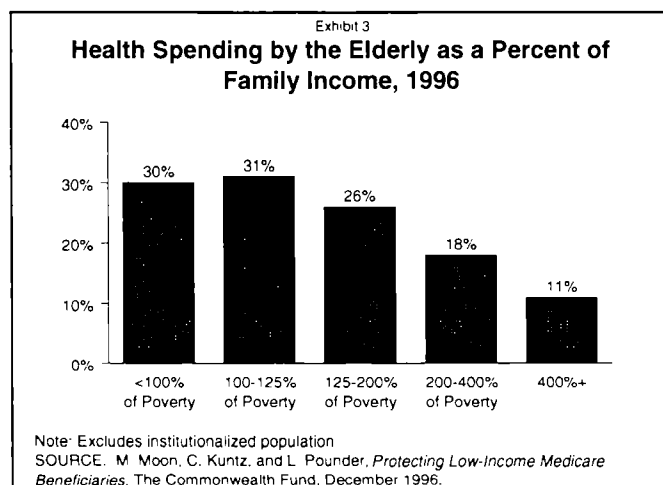
Nearly 15 million elderly and disabled Medicare beneficiaries (42.5%) are poor or near-poor with incomes below 200 percent of the federal poverty level (Exhibit 1). An even greater share of Medicare's beneficiaries who are women (48%), age 80 and older (52%), and African American (63%) have an income below twice the poverty level.



Low-income Medicare beneficiaries are more likely to be in poor health and have problems that require medical attention than their higher income counterparts (Exhibit 2). Because of their low-incomes, poor and near-poor beneficiaries are less able to afford basic medical services and prescription drugs.



Health expenses consume nearly one-third of the family income of Medicare's poor and near poor beneficiaries compared to about 21% of family income for all beneficiaries (Exhibit 3). High out-of-pocket costs are due to the financial requirements of the Medicare program, the limited coverage of



certain benefits, and lack of coverage for outpatient prescription drugs. The 1998 Medicare financial obligations for beneficiaries include a \$764 hospital deductible, a \$100 Part B deductible, 20% co-insurance for physician services, and Part B premium of \$43.80 per month (\$525.60 per year).

Although the majority of Medicare beneficiaries have Medigap or retiree health benefits to fill the gaps in the Medicare benefit package, lower income beneficiaries are much more likely than their higher income counterparts to rely solely on Medicare. Beneficiaries without any supplemental coverage experience the greatest access and financial barriers to care. Thus, Medicaid is an important source of supplemental health coverage for the low-income Medicare population.

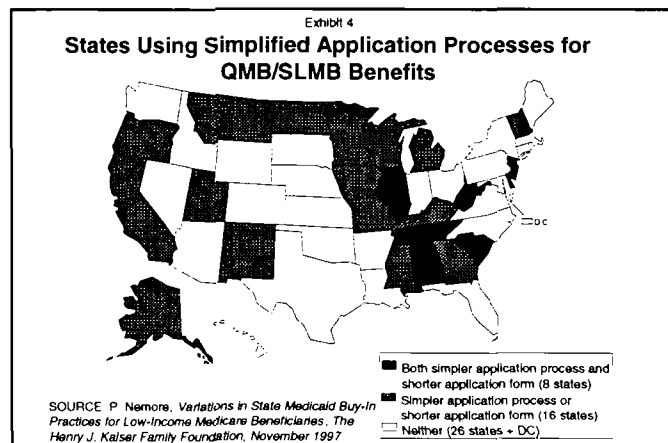
MEDICAID'S BUY-IN PROTECTIONS

Medicaid, the federal/state health financing program for the poor, provides benefits which vary based on income and assets for about 6 million Medicare beneficiaries.

- **Full Medicaid Benefits:** The majority of Medicare beneficiaries eligible for Medicaid qualify because they are entitled to SSI or have incurred large health expenses. These "dual eligibles" receive full Medicaid benefits (such as prescription drugs) as defined under each state's program. Medicaid also pays Medicare's premiums, deductibles, and cost-sharing requirements, known as QMB benefits (5.4 million beneficiaries in 1995).

- **Qualified Medicare Beneficiaries (QMBs):** For Medicare beneficiaries with incomes below 100% of the poverty level and limited assets (less than \$4,000 per individual), Medicaid pays Medicare's premiums, deductibles, and cost-sharing (367,000 QMB-only beneficiaries in 1995).
- **Specified Low-income Medicare Beneficiaries (SLMBs):** For Medicare beneficiaries with incomes between 100-120% of poverty and limited assets, Medicaid pays only the Medicare Part B premium (195,000 beneficiaries in 1995).

In 1996, only 63 percent of those eligible for QMB benefits and only 10 percent of those eligible for SLMB benefits received financial assistance under Medicaid (Moon, 1996). While some, but not most states, have taken steps to ease the QMB/SLMB enrollment process, requirements to apply in person at Medicaid and welfare offices, lengthy application forms, and the lack of effective outreach are barriers to Medicaid participation (Exhibit 4).



The emerging role of managed care under Medicare and Medicaid offers the promise of coordinated care for dual eligibles. However, few states have systems in place to coordinate Medicare and Medicaid benefits for beneficiaries enrolled in HMOs (Nemore, 1997). Lack of coordination limits the capacity of states to pay cost-sharing benefits for low-income beneficiaries in Medicare HMOs. Medicaid programs are often unable to determine if beneficiaries are enrolled in Medicare HMOs and may be paying for benefits already included in the Medicare capitation rate. Finally, for beneficiaries, enrollment in Medicaid managed care plans may limit access to Medicare-covered services outside the Medicaid HMO (Feder, 1997).

BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA 97) increases financial obligations for beneficiaries under Medicare by raising the monthly Part B premiums. The new law is expected to increase Medicare Part B premiums from \$43.80 per month in 1997 to \$67 in 2002 and to \$105.40 per month in 2007.

To help offset these costs for low-income beneficiaries, the BBA 97 established a new block grant to states (\$1.5 billion over 5 years) to cover the premium for those with incomes between 120 and 135% of poverty and a portion of the premium for those with incomes between 135 and 175% of

Exhibit 5 LEGISLATIVE HISTORY OF MEDICAID BUY-IN PROGRAMS

1965: (P.L. 89-97) Medicare and Medicaid enacted. States permitted to enroll certain eligible Medicaid recipients in Medicare Part B by paying their Part B premium.

1968: (P.L. 90-248) Federal payments prohibited for Medicaid services that could have been paid for by Medicare Part B if the recipient had been enrolled.

1986: (P.L. 99-509) States *permitted* to pay Medicare premiums and cost-sharing for Medicare beneficiaries with incomes up to 100% of poverty who are "not otherwise eligible" for Medicaid.

1988: (P.L. 100-360) States *required* to pay Medicare premiums and cost-sharing for Medicare beneficiaries up to 100% of poverty (QMB).

1989: (P.L. 101-239) States required to pay Medicare Part A premiums for certain qualified disabled working individuals (QDWI) with incomes up to 200% of poverty.

1990: (P.L. 101-508) States are required to pay the Part B premium for Medicare beneficiaries with incomes up to 120% of poverty (SLMB).

1997: (P.L. 105-33) States provided a \$1.5 billion block grant (100% federal dollars) to pay the Part B premium, beginning in 1998, for individuals with incomes to 135% of poverty and a portion of the Part B premium for those with incomes up to 175% of poverty. States permitted to pay cost-sharing based on the Medicaid payment rate instead of the Medicare rate.

Source: Adapted from P. Nemore, *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries*, The Henry J. Kaiser Family Foundation, November 1997.

poverty (Exhibit 5). In contrast to the QMB/SLMB programs, the block grant is not an individual entitlement and states are not required to contribute matching funds. Thus, the block grant is estimated to cover only one-third of those eligible (Moon, 1997).

The BBA 97 also permits states to limit their QMB cost-sharing contributions to providers if the Medicaid rates are lower than the Medicare rates. This provision may result in access problems because Medicaid reimbursement rates are generally lower than Medicare rates and may not be accepted by some providers.

ISSUES AND CHALLENGES

While federal policymakers have historically relied on Medicaid to provide financial protections for low-income Medicare beneficiaries, state Medicaid programs have multiple responsibilities and may lack the capacity to absorb rising premiums and cost-sharing expenses for Medicare's poor and near-poor. At the same time, a significant share of the Medicare population (more than 4 in 10) have incomes below 200% of poverty (\$15,780 in 1997) and already incur high financial burdens for their health expenses. The challenge facing policymakers is to make Medicaid work more effectively for low-income Medicare beneficiaries, minimize Medicare's financial burdens on the poor and near-poor, and preserve the Medicare program for future generations.

MEDICAID POLICY: SPECIFICS OF PER CAPITA CAP & DSH REDUCTION

Q: What is the Administration's Medicaid policy? How will you achieve the \$22 billion in cuts without hurting States' Medicaid programs?

A: The Administration proposes to maintain and strengthen Medicaid. Our policy preserves the guarantee of coverage for the 37 million low-income children, pregnant women, disabled, and elderly people who depend on Medicaid for basic health coverage and long-term care. At the same time, we achieve modest savings in the program--about \$22 billion from FY 1998-FY 2002, not counting the investments in expanding coverage for eligible children (about \$5 billion over 5 years), restoring coverage for some groups who lost it as a result of last year's welfare reform law (also about \$5 billion over 5 years) and other investments (about \$3 billion over 5 years), including helping the District of Columbia and helping people with disabilities who earn above a certain income level retain their Medicaid coverage.

The President's plan recognizes the significant strides that have been made in reducing the growth of Medicaid spending.

The \$22 billion in savings comes from two sources: (1) two thirds of the savings, or roughly \$15 billion, comes from reducing the amount the Federal government spends on so-called "disproportionate share hospitals" (DSH); and (2) one third of the savings, or roughly \$7 billion, comes from a "per capita cap" policy that will limit Federal Medicaid spending growth on a per-beneficiary basis. This includes about \$2.5 billion for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and helps providers and states adjust to the new Medicaid policy.

Reduction in DSH Payments (about \$15 billion in net savings from FY 1998- FY 2002)

The Federal government spends about \$10 billion annually on DSH, which is an important source of support for many hospitals that serve a disproportionate number of Medicaid and low-income patients. In the late 1980's and early 1990's, DSH spending was growing at double-digit rates, and was the driving force in Medicaid's high growth rates. While DSH growth has moderated--partly because of changes made by the Congress and the Administration in 1991 and in OBRA 1993--both the HCFA actuaries and CBO's analysts believe that the growth will accelerate again.

The Administration's policy essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to \$8 billion in spending for FY 2000-2002. (Under the CBO baseline, DSH spending would have grown to about \$14 billion by 2002).

DSH savings are achieved by taking an equal percentage reduction off of States' 1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY 1995 is greater than 12 percent of total Medicaid spending in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy

balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional enactments, this "upper limit" policy ensures that the few States with high DSH spending are not bearing most of the impact of the savings policy.

The Administration has always said that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to take the position of supporting better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is a technically complex issue that could have potentially disruptive effects in some States, our policy does not yet prescribe a mechanism for targeting. We want to work with the Congress, the States, providers, and advocates to develop an appropriate targeting mechanism.

To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about \$1.4 billion over five years to help cover the costs of care delivered in FQHCs and RHCs. We believe this supplemental fund is necessary to help these providers during the transition to a per capita cap, particularly in view of our proposal to end, effective in FY 1999, the requirement that States reimburse them on a cost basis in 1999.

Per Capita Cap (about \$7 billion in net savings from FY 1998 to FY 2002)

Under the per capita cap policy, Federal Medicaid spending growth will be limited on a per beneficiary basis. The per capita cap will work as follows:

The base year for the policy will be 1996. Under the plan, the cap would be the product of three components: 1) total spending per beneficiary in the base year; 2) an index (for years between the base year and the current year); and 3) the number of beneficiaries in the current year. To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the elderly, individuals with disabilities, non-disabled adults, and non-disabled children. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum spending in each state.

The index we have used is the growth in nominal GDP per capita (based on a five-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period--1998-2002--the index would allow per capita spending to increase by an average of 5 percent per year. By 1999 and subsequent years, the index will be nominal GDP plus 1 percent. Our policy development to this point has focused on an index based on nominal GDP. There is a debate about which is the most appropriate index. The Blue Dogs use the CPI, and the Department is reviewing an index that could more precisely reflect growth in health care costs and in particular, the volume and intensity inherent in a program that serves many low-income people. When our work is complete, we will share that information with the Congress, the States, and other stakeholders, in order to facilitate the development of the best index possible.

What this means is that, after 2000, when both the HCFA actuaries and CBO's analysts have indicated that they expect Medicaid spending growth on a per capita basis to rise more rapidly again, the per capita cap would constrain Medicaid growth per person (for non-DSH benefits and administration) to about 5 percent per year. If we and the States are successful in holding spending growth per beneficiary to about 5 percent a year during this period--which is close to the annual growth rate CBO is projecting for private insurance on a per person basis--the per capita cap will produce little to no savings. But if the analysts are correct, and per capita spending growth rises again, our policy will prevent that increase from overtaking our balanced budget.

As you know, the President's plan includes a number of provisions to give States more flexibility in running their Medicaid programs; for example, by repealing the Boren Amendment and by allowing States to move to managed care without a waiver. We also include about \$1 billion in capped "transition pool" funding to assist states and safety net providers who are disproportionately affected by the Medicaid savings policies. We believe that we can work together with the States to ensure that Medicaid maintains its guarantee of coverage for the people who depend on it, while at the same time strengthening Medicaid's fiscal discipline and building on the success of the past few years in constraining unnecessary growth in spending.

MEDICAID POLICY: SPECIFICS OF PER CAPITA CAP & DSH REDUCTION

Q: What is the Administration's Medicaid policy? How will you achieve the \$22 billion in cuts without hurting States' Medicaid programs?

A: The Administration proposes to maintain and strengthen Medicaid. Our policy preserves the guarantee of coverage for the 37 million low-income children, pregnant women, disabled, and elderly people who depend on Medicaid for basic health coverage and long-term care. At the same time, we achieve modest savings in the program--about \$22 billion from FY 1998-FY 2002, not counting the investments in expanding coverage for eligible children (about \$5 billion over 5 years), restoring coverage for some groups who lost it as a result of last year's welfare reform law (also about \$5 billion over 5 years) and other investments (about \$3 billion over 5 years), including helping the District of Columbia and helping people with disabilities who earn above a certain income level retain their Medicaid coverage.

The President's plan recognizes the significant strides that have been made in reducing the growth of Medicaid spending.

The \$22 billion in savings comes from two sources: (1) two thirds of the savings, or roughly \$15 billion, comes from reducing the amount the Federal government spends on so-called "disproportionate share hospitals" (DSH); and (2) one third of the savings, or roughly \$7 billion, comes from a "per capita cap" policy that will limit Federal Medicaid spending growth on a per-beneficiary basis. This includes about \$2.5 billion for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and helps providers and states adjust to the new Medicaid policy.

Reduction in DSH Payments (about \$15 billion in net savings from FY 1998- FY 2002)

The Federal government spends about \$10 billion annually on DSH, which is an important source of support for many hospitals that serve a disproportionate number of Medicaid and low-income patients. In the late 1980's and early 1990's, DSH spending was growing at double-digit rates, and was the driving force in Medicaid's high growth rates. While DSH growth has moderated--partly because of changes made by the Congress and the Administration in 1991 and in OBRA 1993--both the HCFA actuaries and CBO's analysts believe that the growth will accelerate again.

The Administration's policy essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to \$8 billion in spending for FY 2000-2002. (Under the CBO baseline, DSH spending would have grown to about \$14 billion by 2002).

DSH savings are achieved by taking an equal percentage reduction off of States' 1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY 1995 is greater than 12 percent of total Medicaid spending in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy

balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional enactments, this "upper limit" policy ensures that the few States with high DSH spending are not bearing most of the impact of the savings policy.

The Administration has always said that DSH dollars should be targeted to the providers that need them most: those hospitals and other providers that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to take the position of supporting better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is a technically complex issue that could have potentially disruptive effects in some States, our policy does not yet prescribe a mechanism for targeting. We want to work with the Congress, the States, providers, and advocates to develop an appropriate targeting mechanism.

To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about \$1.4 billion over five years to help cover the costs of care delivered in FQHCs and RHCs. We believe this supplemental fund is necessary to help these providers during the transition to a per capita cap, particularly in view of our proposal to end, effective in FY 1999, the requirement that States reimburse them on a cost basis in 1999.

Per Capita Cap (about \$7 billion in net savings from FY 1998 to FY 2002)

Under the per capita cap policy, Federal Medicaid spending growth will be limited on a per beneficiary basis. The per capita cap will work as follows:

The base year for the policy will be 1996. Under the plan, the cap would be the product of three components: 1) total spending per beneficiary in the base year; 2) an index (for years between the base year and the current year); and 3) the number of beneficiaries in the current year. To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the elderly, individuals with disabilities, non-disabled adults, and non-disabled children. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum spending in each state.

The index we have used is the growth in nominal GDP per capita (based on a five-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period--1998-2002--the index would allow per capita spending to increase by an average of 5 percent per year. By 1999 and subsequent years, the index will be nominal GDP plus 1 percent. Our policy development to this point has focused on an index based on nominal GDP. There is a debate about which is the most appropriate index. The Blue Dogs use the CPI, and the Department is reviewing an index that could more precisely reflect growth in health care costs and in particular, the volume and intensity inherent in a program that serves many low-income people. When our work is complete, we will share that information with the Congress, the States, and other stakeholders, in order to facilitate the development of the best index possible.

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As you know, the President's plan includes a number of provisions to give States more flexibility in running their Medicaid programs; for example, by repealing the Boren Amendment and by allowing States to move to managed care without a waiver. We also include about \$1 billion in capped "transition pool" funding to assist states and safety net providers who are disproportionately affected by the Medicaid savings policies. We believe that we can work together with the States to ensure that Medicaid maintains its guarantee of coverage for the people who depend on it, while at the same time strengthening Medicaid's fiscal discipline and building on the success of the past few years in constraining unnecessary growth in spending.

PER CAPITA CAP

MEMORANDUM

January 30, 1997

TO: Interested Parties

FROM: Chris Jennings

RE: Medicaid per capita cap

Attached are talking points in response to the Governors' strong opposition to the President's Medicaid per capita cap as reported in today's article in the *New York Times*. In short, our response should state that the Governors' opposition is neither surprising nor particularly newsworthy.

As usual, the Governors want maximum flexibility to administer their Medicaid programs with little or no fiscal constraints over their programs' growth. And, for the third straight year, the President will propose a per capita cap to guard against excessive program growth; at the same time, the President will also include a series of unprecedented Medicaid flexibility provisions that have been priorities of the Governors for years. The most newsworthy development is that the President's budget proposal will call for more modest Medicaid savings than in previous years.

I hope you find this information helpful. Please call me if you have any questions

**Talking Points/Q&A to Respond to Governors' Opposition to the
President's Medicaid Proposal**

Q: The Governors are joining advocates and providers in strongly opposing your per capita cap and significant savings in the Medicaid program. Aren't you concerned that support for your proposal seems to be waning?

A: There is no news here. Both sides are taking consistent and expected positions going into an important discussion about balancing the budget.

The Governors are once again taking the position that they would like maximum flexibility in administering their programs and would prefer not to have Federal budget constraints on the program if we are going to maintain the Medicaid's guarantee of coverage. This is not new.

The President, for the third year in a row, is proposing significant flexibility provisions for the States. In return, he is also proposing that the Federal Treasury be protected against excessive cost increases in the future. Again, this is not new.

The only thing that has changed is that the President's budget recognizes that growth in the Medicaid program has declined and as such will include much more modest savings than previous balanced budget initiatives.

We look forward to working with the Governors to craft appropriate and much overdue flexibility provisions to enable us to not only constrain costs but hopefully to expand health insurance coverage.

DSH

POOLS

MEMORANDUM

TO: Jack L.
FR: Chris J.
RE: Your concerns re pools
cc: Nancy-Ann

A quick response to address your concerns about the two pools that we put into the Medicaid policy: It is true that we run the risk of undermining the soundness of the policy by including "transition" pools. However, there are good reasons why I personally think that this risk is low and that the pools are justifiable and, in fact, (unfortunately) necessary.

The Transition Pool. First, as you know more than most, Medicaid is exceptional in its variation. Not only is no State like another in terms of its benefits and eligibility; the growth rates across States are extremely disparate. This means that having a single national policy that fits all States equally well is, by definition, an absolute impossibility.

The \$1 billion "transition" pool, which is at its maximum only \$500 million per year will likely meet real policy (and political) needs in converting to a different Medicaid payment structure. Clearly, this policy will help us respond to state-by-state variations that our DSH policy cannot and will not adequately address. Moreover, it gives us a potential mechanism to better target some limited dollars to vulnerable health care providers that States may ignore in their DSH allocation formulas. (This will be necessary because both Nancy-Ann and I believe that we probably will be unable to have a significantly prescriptive DSH targeting policy because of the demands by states and providers to avoid altering their current allocation formulas too much.) Lastly, I would argue that our policy is exactly comparable to the \$500 million in grants that were added to the welfare bill to help States adapt eligibility systems to TANF.

FQHC/RHC Pool. As for the FQHC pool, the \$1.4 billion in payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) is less than what HCFA estimates that these States would receive under Medicaid's current cost-based reimbursement requirement. This is significant because we are repealing this requirement in response to states' frustration with it. Moreover, like the transition pool, the funding is temporary and extremely small relative to Medicaid spending in general.

Pools have been moderated significantly. To put these numbers in context, they are significantly lower than the pools (one-eighth the size) that we put in last year's legislation. The bill that we sent to the Hill funded an \$11.2 billion transition pool, a \$3.5 pool for States with many illegal immigrants, and \$3.0 billion pool for FQHCs and RHCs over the 1997 to 2002 period. While it is true that most of the transition pool was created largely to compete with the Block Grant allocations, there always was and is legitimate policy reasons why this pool is needed. In addition, as outlined above, there are strong policy reasons for the retention of a FQHC/RHC pool. Having said this, both pools have been significantly reduced.

I hope this give you some comfort with this policy. Please call with any questions.

MEMORANDUM

TO: Jack L.
FR: Chris J.
RE: Your concerns re pools
cc: Nancy-Ann

February 12, 1997

A quick response to address your concerns about the two pools that we put into the Medicaid policy: It is true that we run the risk of undermining the soundness of the policy by including "transition" pools. However, there are good reasons why I personally think that this risk is low and that the pools are justifiable and, in fact, (unfortunately) necessary.

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GOVERNORS

THE WHITE HOUSE
WASHINGTON

January 30, 1997

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Governors and Medicaid

I. SUMMARY

Today, the *New York Times* reported on the Governors' expected opposition to our Medicaid policy, particularly focusing their attention on the per capita cap. Their rejection of our policy is not surprising since the Governors have always desired to have maximum administrative flexibility with minimum Federal financial constraints in the Medicaid program. However, their opposition is receiving a great deal of press coverage because the Governors are taking a unified position against our policy (even though they supported it last year) and because it teams up the Governors with the advocates against our Medicaid policy. The media will no doubt focus on this "conflict" as they cover the DGA and NGA conference meetings. Ironically and importantly, the fact that there is opposition to our position serves to validate that our balanced budget proposal is a legitimate, tough package.

II. DISCUSSION

The Governors have a long-standing policy of opposition to any cap (such as a per capita cap) on Medicaid expenditures in combination with the retention of a Federal entitlement. They believe that such an approach leaves them at risk for increased costs of the program's guaranteed benefits and coverage. (The Democratic Governors now take the position that they only supported a per capita cap when it was the only realistic alternative to a block grant; they now believe that this Congress will not come close to passing a block grant.)

The Governors are taking the position that the per capita cap will be a fait accompli if they do not actively reject our proposal. They know that the "Blue Dog" Democrats, the bipartisan Senate coalition, and the Republican Leadership are currently carrying a per capita cap mechanism in their internal budget tables. They believe that any acceptance on the part of the Governors will lead to an inevitable Medicaid per capita cap. But, even if they lose this debate, the Governors believe a strong and negative position on the per capita cap will give them leverage to achieve more flexibility concessions.

While some Governors will not oppose the concept of additional savings from disproportionate share spending (DSH), their support inevitably dwindles when they conclude that such proposals would have significant and "unfair" impacts on their state. Moreover, they strongly believe that the Medicaid program has made a major contribution to deficit reduction that mitigates any need for any significant savings from Medicaid in the upcoming budget debate.

We recognize that we start at different places in this debate. Our strategy is to ask the Governors, particularly the Democrats, to express their opposition without any excessively negative rhetoric against us. As they do criticize the proposal, we will use their opposition as validation that we do have a credible, thoughtful package.

In the upcoming weeks and months, we will talk with the Governors about developing an unprecedented package of flexibility provisions. However, their almost single-minded focus against the per capita cap creates a poor environment to discuss this issue at this time. This will almost inevitably change over time, but my recommendation is to defer serious flexibility discussions with the Governors to a time in which they are more likely to be more receptive and positive about such negotiations. In the meantime, we should reiterate our strong support for the general concept of more flexibility provisions, focusing on our acceptance of the priority items the Governors have always wanted -- e.g, the repeal of the Boren amendment, the repeal of cost-based reimbursement requirements to community health centers, and the elimination of managed care waiver requirements.

Finally, most of the public and the Governors are under the impression that your budget proposal will achieve over \$20 billion in savings. However, when the investments (welfare improvements, children's coverage, etc.) are netted against the savings, it totals to \$9 billion. This is significantly lower than last year's savings targets and appropriately reflects the change in projected Medicaid spending. While this news will be positively received by many, the Governors (and a number of advocate groups) will argue that such a low number raises the question why we are insisting on the controversial per capita cap. Our response will simply be that the program, the Treasury, and the taxpayers who support it must be protected against excessive cost growth in the out-years. We will also argue that this mechanism will protect the program against future attempts to block grant it in the context of future entitlement reform debates.

THE PRESIDENT'S MEDICAID REFORM PROPOSAL

1. Overview

2. Financing

- Responsive and Responsible Federal Financing
- Per Capita Cap: What Is It
- Per Capita Cap: How Does It Work and Adapt to Enrollment Changes
- Per Capita Cap: Adapting to State Spending
- Disproportionate Share Hospital (DSH) Changes and Pool Payments

3. Flexibility

- Provider Payment Flexibility
- Managed Care Flexibility
- Eligibility and Benefits Flexibility
- Administrative Flexibility

1. OVERVIEW

The President's Medicaid proposal achieves significant reform and offers:

- **Responsive and responsible Federal funding:**
 - Federal funding is not fixed but responds to unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
 - Federal reductions are responsible, providing states with sufficient funds to maintain coverage for the millions of Americans who rely on Medicaid.
- **State flexibility:** The top concerns of the Governors have been addressed, including:
 - Repeal of the Boren Amendment regulating provider payments;
 - End to the burdensome waiver process for managed care and home and community-based waivers;
 - Eligibility simplification and expansions without waivers; and
 - Elimination of many unnecessary and duplicative administrative requirements.

2. FINANCING

The President has proposed to reform Medicaid financing through a **Per Capita Cap** and **Disproportionate Share Hospital (DSH) payment changes**.

- Responsiveness: A per capita cap maintains the responsiveness of Federal funding to states' unexpected costs.
 - Under the President's proposal, the Federal government shares in the unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
- Responsible: The per capita cap and Disproportionate Share Hospital payment reductions achieve responsible levels of Federal savings.
 - The President's proposal provides states with sufficient Federal funds to maintain coverage for the millions of Americans who rely on Medicaid.

The following section reviews:

- Responsive and Responsible Federal Financing
- Per Capita Cap: What Is It
- Per Capita Cap: How Does It Work and Adapt to Enrollment Changes
- Per Capita Cap: Adapting to State Spending
- Disproportionate Share Hospital (DSH) Changes and Pool Payments

Responsive and Responsible Federal Financing

The President's proposal maintains the Federal commitment to share in states' Medicaid costs:

- Protection from recession. During a period of economic recession, enrollment will increase, causing state costs to rise. The Center on Budget and Policy Priorities estimates that Medicaid costs could increase by at least \$26 billion over seven years if there is a recession similar to the one experienced in the early 1980s. Under a per capita cap, the Federal government shares in these unexpected costs.
- Protection from changes in Medicaid caseload. States may find themselves with greater proportions of costly persons such as seniors or people with disabilities. The per capita cap adapts to shifts in the types of beneficiaries covered by a state, increasing Federal payments to states if their patient population becomes sicker.

The President's proposal also takes a responsible and not a radical amount of savings from the Medicaid program.

- President's plan saves the Federal government \$59 billion over seven years.
- Republicans' plan saves the Federal government \$85 billion over seven years.
 - This is \$26 billion -- or 44 percent -- higher than the savings proposed by the President.
 - Under the Republican plan, spending growth per beneficiary would be significantly below private spending growth per person (7 percent).
 - By 2002, Federal funding to states will be inadequate and states will be forced to reduce payments, benefits and deny coverage for millions of Americans.

Per Capita Cap: What Is It

- A “per capita cap” is a policy that limits Federal Medicaid spending growth per beneficiary. Under this policy, Federal payments automatically adjust to a state’s enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in these increased costs. In other words, Federal money will flow with the number of needy persons a state serves.

There are three components to the per capita limit on Federal funding:

- Base spending: Each state’s 1995 spending per beneficiary is calculated, excluding spending items such as payments for Medicare premiums and cost-sharing and Disproportionate Share Hospital payments. The spending per beneficiary is separated for the four major groups of Medicaid beneficiaries: seniors, people with disabilities, adults and children.
- Index: Future year spending limits will be calculated by growing the average 1995 spending per beneficiary by a pre-set “index”. The index updates the 1995 spending in proportion to the growth in the gross domestic product per person.
- Actual enrollment: This indexed spending per beneficiary is then multiplied by the number of beneficiaries in each category in a given year. The category-specific limits are then added together to yields the maximum spending that the Federal government will match.

Each state will have a single total limit, so it can use savings from one group to support expenditures for other groups or to expand benefits or coverage.

Per Capita Cap: How Does It Work and Adapt to Enrollment Changes

- To give an example of how the formula works, take a hypothetical state:

	1995 Spending per Beneficiary	2000 Limit per Beneficiary *	Enrollment in 2000	Total Limit (Millions)	Federal Limit (Millions)**
Elderly	\$9,000	\$11,487	1,000	\$11.5	
Disabled	\$8,000	\$10,210	2,000	\$20.4	
Adults	\$2,000	\$2,553	3,000	\$7.7	
Children	\$1,000	\$1,276	6,000	\$7.7	
Total				\$47.2	\$23.6

* Index is 5% per year, or 28% growth between 1995 and 2000.

** Assumes that the Federal medical assistance rate is 50%.

- In the year 2000, the maximum Federal matching payments for this state would be \$23.6 million.

The cap adapts automatically to state enrollment changes

- If enrollment in these categories increases above the levels noted above, the total and Federal limit would increase automatically -- because the limit is calculated on a per person basis.
- If enrollment shifts to more expensive populations or enrollment grows faster than expected, then the total limit would increase automatically.
 - For example, if there are 500 more seniors than noted above, then the total limit would increase by \$5.7 million (500 seniors times \$11,487 limit per senior), and the Federal limit would increase by around \$2.85 million.

Per Capita Cap: Adapting to State Spending

- If the state keeps spending per beneficiary below the limit for one or more categories of beneficiary, it has a number of options. For example, assume that the state kept spending for the elderly to \$10,376 per elderly beneficiary (\$1,000 below the limit per beneficiary). That would free up \$1 million within the state's aggregate limit (\$1,000 per enrollee times 1,000 seniors). The state could:
 - o Spend above its per beneficiary limit for another group. For example, the state could spend \$150 more per child -- a total of \$1,426 per child -- for a total cost of \$0.9 million (\$150 per child times 6,000 children) and still remain within its aggregate limit.
 - o Use the funds to expand eligibility to new groups whose income is within the 150 percent of poverty level (see Eligibility Flexibility).
 - o Save the state share of the funds.

Disproportionate Share Hospital (DSH) Changes and Pool Payments

Disproportionate Share Hospital Payments Changes:

- Disproportionate Share Hospital (DSH) payments would be reduced and retargeted.
 - Financing: The current (1995) Federal payments to states would be gradually phased out, and a new DSH payment method would be phased in. Funding from a fixed Federal pool would be allotted to states on the basis of their share of low-income days for eligible hospitals.
 - Program Design: States would use the funds for hospitals that serve a high number of uninsured and Medicaid patients, and would have the flexibility to cover additional hospitals that they deem needy.

Pool Payments:

- Special transition pools would be created to ease the transition to the reformed Medicaid program.
 - **Undocumented Persons Pool**: A special pool to help the 15 states with the largest numbers of undocumented persons would be created. This 100 percent Federal pool would be in effect from 1997 to 2001, and would be allocated to states in proportion to their share of the nation's undocumented persons. It would be used by states for emergency care for these persons.
 - **Federally Qualified Health Centers and Rural Health Clinics Pool**: As part of the proposed changes to promote state flexibility, the mandate for states to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) on a cost basis would be repealed. To ease the change in funding for these facilities, a program would be created with \$500 million in Federal funds in each year beginning in 1997.
 - **Transition Pools**: Additional federal funds would be allocated through special pools designed to ease the transition to the new program and allow states to plan now for program changes.

3. FLEXIBILITY

The President's Medicaid proposal significantly increases states' flexibility to design and managed their own Medicaid programs.

- The President's plan addresses the top concerns of the Governors:
 - Repeal of the Boren Amendment regulating provider payments;
 - End to the burdensome waiver process for managed care and home- and community-based waivers;
 - Eligibility simplification and expansions without waivers; and
 - Elimination of many unnecessary and duplicative administrative requirements.

The following section describes new state flexibility in the following areas:

- Provider Payment Flexibility
- Managed Care Flexibility
- Eligibility and Benefits Flexibility
- Administrative Flexibility

Provider Payment Flexibility

The President's plan gives states greater flexibility in setting provider payment rates:

- **Boren Amendment is Repealed:** (NGA Recommendation) The proposal repeals the Boren Amendment, allowing states greater discretion in establishing their provider payment rates. Under the Boren Amendment, states were required states to pay hospitals and nursing homes "adequate" and "reasonable" rates. Because of its ambiguity, this requirement led to many costly lawsuits for states.
- **Cost-Based Reimbursement for Clinics is Repealed:** (NGA Recommendation) States will no longer be required to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that are not Indian Health Service facilities on a cost basis beginning in FY 1999.
- **Burdensome Standards for Obstetrician and Pediatrician Payments are Eliminated:** (NGA Recommendation) States currently must file extensive documentation relating to their payments for these providers. Under the proposal, states could set their own payment standards for obstetricians and pediatricians and would be freed from the paperwork burden that can range from 30 pages to 300 pages.
- **Requirement to Pay for Private Insurance When Cost Effective is Repealed:** (NGA Recommendation) Under current law, states are required to enroll individuals in private insurance in certain situations, when private insurance is more cost effective. States will have the option to continue purchasing group insurance and negotiate their own rates.

Managed Care Flexibility

Under the President's proposal, states will have new flexibility to implement and operate Medicaid managed care programs.

- **Elimination of Need for a Waiver:** (NGA Recommendation) States will be able to implement managed care programs without the need for Federal waivers, so long as beneficiaries have a choice of plans, except in rural areas. States will be permitted to enroll Medicaid beneficiaries into their health plans for up to six months and to guarantee Medicaid eligibility during this enrollment period.

- **Outdated Quality Standards are Repealed:** (NGA Recommendation) The 75/25 enrollment composition rule will be eliminated.

Quality of care will be assured through state-designed quality improvement programs -- which follow Federal guidelines -- that ensure that managed care providers maintain reasonable access to quality health care.

- **Federal Contract Review is Eliminated:** The Federal government will no longer review states' contracts with managed care plans that exceed \$100,000.
- **HMO Copayments are Allowed:** (NGA Recommendation) States will be able to require HMO enrollees to make nominal copayments, consistent with their ability to require copayments in fee-for-service settings.

Eligibility and Benefits Flexibility

The President's proposal maintains the Federal entitlement and keeps Medicaid basic benefits intact. It builds upon this base to offer states options for simplifying and expanding eligibility and designing community-based long-term care programs.

- **Eligibility Expansions are Allowed Without Waivers:** If states are able to manage costs below their per capita limits, they may add any new eligibility group at their discretion. This means that if states want to expand coverage, they may do so without a waiver and to any group of low-income people. The only limits on this flexibility are that the new beneficiaries' income is less than 150 percent of the poverty level, and the expansion does not result in spending above the per capita limit.
 - o In the example of the how a per capita cap would work, the state could, under one scenario, spend \$1,000 less than its limit per senior (\$10,476). With 1,000 senior enrollees, that would free up \$1 million within the state's aggregate limit (\$1,000 per enrollee times 1,000 senior enrollees).
 - o With this \$1 million, the state could choose to add 500 individuals with spending of \$2,000 per person and still be within their limit.
- **Eligibility Expansions can be Scaled Back:** (NGA Recommendation) Under current law, a state that chooses to cover pregnant women and children above the mandatory levels cannot reverse that decision. This mandate is repealed, so states can return to the minimum level.
- **Home and Community-Based Care Programs are Allowed Without Waivers:** (NGA Recommendation) States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

Administrative Flexibility

The President's plan repeals and simplifies Federal administrative requirements for the Medicaid program.

- **Certain Personnel and Program Requirements are Repealed:** The current Federal mandates to document the establishment and maintenance of merit-based personnel standards, and to use professional medical personnel in administration and supervision, are duplicative and are repealed. Also repealed is the obligation to enter into cooperative agreements with other state agencies.
- **Data Requirements are Streamlined:** Medicaid Management Information System (MMIS) requirements for the use of standardized claims formats and standardized HCFA reporting requirements will be simplified and reduced. The Medicaid Eligibility Quality Control (MEQC) system will also be reformed. States will no longer have to go through the entire determination, adjudication, and cost accounting process every six months.
- **Nursing Home Resident Duplicative Reviews are Eliminated:** (NGA Recommendation) Required annual resident review in nursing homes will be repealed. States will conduct reviews when indicated.
- **Permissible Sites for Nurse-Aide Training are Broadened:** (NGA Recommendation) States will be able to conduct nurse-aide training in certain rural nursing homes, which currently are not considered permissible training sites.
- **Certain Federal Provider Qualifications Requirements are Repealed:** (NGA Recommendation) Special minimum qualifications for obstetricians and pediatricians will be repealed.

MEDICAID PER CAPITA CAP: STATE FLEXIBILITY

List 1: Included in Administration's 96 bill; HCFA recommendation to retain without modification.

Payment provisions:

- Repeal the Boren amendment for hospitals
- ~~Modify Boren amendment~~ for nursing homes to require public notice
- Eliminate OB/Peds physician qualification requirements
- Eliminate annual state reporting requirements on payments to certain providers (OB/Peds)
- Eliminate Cost-Based Reimbursement for FQHCs in 1998 (99)

Eligibility:

- Enable states to expand or simplify eligibility for individuals up to 150 percent of the federal poverty level through a simplified and expedited procedure. Current enrollees would not lose coverage if a state chose this option.

Managed care:

- Convert 1915(b) waivers to State Plan Amendments
- Eliminate 75/25 rule
- Nominal copayments for HMO enrollees

Long-term care:

- PACE Demonstrations -- Grant full permanent provider status for entities
- Nurse Aide Training Waivers
- Convert HCBS (1915(c)) waivers into State Plan option

American Indians/Alaska Natives:

- Guarantee qualified IHS, tribal, and urban Indian organization providers (ITUs) the right to participate in State managed care networks

Administrative:

- Simplify computer systems requirement
- Eliminate personnel requirements → merge system requirements
just the employees.

Contractors not affected.

- Modify and strengthen Medicaid Eligibility Quality Control system
- New reporting requirements to ensure program integrity
- Elimination of requirement for States to pay for private health insurance premiums where cost-effective.
- Establish commission on equity in Medicaid financing (FMAP).

List 2: Included in Administration's 96 bill; HCFA recommends to retain with modification.

Managed care

- the \$1 billion*
- check it out* →
- Modify Federal review of managed care contracts with higher threshold.
 - Modify upper payment limit for capitation rates, enhance actuarial review of rates
 - Develop quality review and monitoring procedures (Administrative)
- 1918 (B)*

Administrative

- Replace some current reporting requirements with the requirement that all states participate in person-based data system (MSIS)
- check out*

List 3: Included in Administration's 96 bill; HCFA recommendation to drop this year.

- Eligibility levels for pregnant women and children -- Permit all States to roll back higher, optional income levels for pregnant women and children to the Federally mandated level.
 - Repeal cooperative agreements requirements.
- Table*

List 4: Not in Last Year's Proposal; HCFA recommendation to add.

- Cap for other Territories -- Increase the Federal payment cap for other Territories (Virgin Islands N. Mariana Islands, America Samoa) -- budget includes an increase in Federal payment cap for Puerto Rico.
- Create process to permit permanent extension of 1115 demonstrations that meet Federal criteria, such as increased access and measurement of quality care. **Cost:** No cost.

Long Term Care

- ~~Repeal authority for criminal penalties for persons who transfer assets to qualify for Medicaid. Cost: No cost.~~
- Give States incentive to use alternative remedies to correct nursing home quality of care deficiencies. Cost: No cost
- Eliminate the duplicative inspection of care requirements in mental hospitals and ICFs/MR -- rely on survey and certification review process. Cost: No cost.
- Alternative Sanctions in ICFs/MR Cost: No cost.
- Survey and Certification. match from 75% to 85% Cost: Admin. Cost -- \$0.13 B. over 5 years

American Indians/Alaska Natives:

- Allow tribal/urban Indian providers to bill directly for Medicaid. Cost: No cost.
- Extend 100% Federal matching to urban Indian organizations Cost: \$40 million over 5 years
- Allow ITUs to be reimbursed for services they provide to eligible Indians enrolled in another provider (as in the OK waiver) and to participate in managed care systems as primary care case managers (PCCMs) Cost: No cost.

Grand

ADVANTAGES OF PROVIDING CONTINUOUS ELIGIBILITY FOR MEDICAID CHILDREN FOR 12 MONTH PERIODS

Children age one and older are eligible for Medicaid on a month-to-month basis. Federal Medicaid regulations require that agencies redetermine eligibility at least every 12 months. Families are instructed to immediately report changes in income or family circumstances in order for the eligibility agency to decide if the children are still eligible. The result is an unpredictable eligibility status for Medicaid children.

Often children lose and then regain Medicaid coverage as a result of the ups and downs of family income. The on-again/off-again pattern of Medicaid coverage has long frustrated health providers and parents. If the family becomes income ineligible, children can lose Medicaid coverage even if they are sick and in the course of medical treatment.

Providing continuous Medicaid coverage over a known time period on a guaranteed basis will create a more stable environment for the health care of Medicaid children. Continuous coverage has the following advantages:

- **Promotes Continuity of Health Care and Preventive Care for Children.** Providing Medicaid coverage for children over a sustained and predictable period of time such as a year promotes continuity of care which is an essential feature of establishing medical homes. Under continuous eligibility, the longevity of the relationship between the health provider and the family allows the time and the incentive to educate the family about the appropriate use of health services and the informed use of home care. Preventive care can be promoted when providers are able to see children on a regular age-appropriate schedule.
- **Encourages Provider Participation in the Medicaid Program.** Continuous eligibility for children can reduce the frustration voiced by physicians and other health care providers who find it difficult to deal with situations where children are Medicaid eligible today, but possibly not tomorrow. The certainty of Medicaid eligibility guided by a continuous eligibility policy also reduces the provider's administrative burden of participating in Medicaid.
- **Aids Managed Care Providers in Delivering Cost Effective Services.** Experts in Medicaid managed care advise states to utilize continuous eligibility as a method to promote prevention and achieve cost effective service delivery. Continuous eligibility encourages managed care plans to invest in primary and preventive services. Studies have shown that the marginal costs of continuous eligibility can be low.
- **Helps Families Move from Welfare to Work.** Providing continuous Medicaid eligibility to children can assist in efforts to move families from welfare to work. Research has documented that welfare families are insecure about giving up welfare and Medicaid for jobs without health benefits and uncertain futures. Families are concerned about losing Medicaid coverage for their children.
- **Reduces Administrative Costs.** Continuous eligibility provides the opportunity for states to obtain administrative savings by eliminating the need to produce and mail Medicaid cards to recipients each month.

Action Needed to Allow States the Option of Providing Continuous Eligibility for Medicaid Children

An amendment to the federal Medicaid statute is needed to specifically give states the option to provide children with continuous Medicaid coverage for renewable state designated periods without the need for a federal waiver. The amendment should provide permissive language to allow states to designate the period of continuous eligibility and should also allow for renewal of continuous eligibility at the end of the period, if the child is still eligible.

There is precedent for providing continuous eligibility. Section 1902(e) of the federal Medicaid law provides for specific extensions of Medicaid beyond the ordinary time frame. It provides continuous coverage for infants born to Medicaid mothers for a period of one year. Coverage is guaranteed regardless of changes in income as long as the infant continues to reside with the mother. Section 1902(e) also extends eligibility for Transitional Medicaid recipients, enrollees in *federally qualified* Health Maintenance Organizations and pregnant women.

For More Information:

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CBO January 1997 Baseline: MEDICAID

Federal Fiscal Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Rates of Growth 96-02	96-07
Federal Medicaid Outlays (billions of dollars)														
Benefits														
Acute care	48.9	52.2	55.8	60.6	65.7	71.1	76.8	83.0	89.5	96.8	104.7	113.3	7.6%	7.9%
Long term care	30.4	32.2	34.1	36.4	39.2	42.4	46.2	50.4	54.9	60.1	65.9	72.2	7.2%	8.2%
Subtotal, Benefits	79.3	84.4	89.9	97.0	104.9	113.5	123.0	133.4	144.5	156.9	170.6	185.5	7.6%	8.0%
Disproportionate share (DSH)	9.0	9.8	10.3	11.1	11.8	12.7	13.8	14.8	16.7	18.9	18.2	19.8	7.2%	7.4%
Administration	3.7	4.4	5.1	5.6	6.1	6.8	7.2	7.8	8.5	9.3	10.2	11.1	11.5%	10.4%
Total	92.0	98.6	105.3	113.8	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	7.7%	8.1%
Annual Percentage Change in Total	3.3%	7.2%	6.8%	7.9%	8.1%	8.1%	8.3%	8.4%	8.2%	8.6%	8.6%	8.7%		
State Share of Medicaid Payments	66.5	71.4	76.3	82.3	89.0	96.2	104.1	112.9	122.2	132.6	144.1	156.6	7.8%	8.1%
Total State and Federal Shares	158.5	170.0	181.6	195.9	211.8	229.0	247.9	268.7	290.8	315.7	343.0	372.8	7.7%	8.1%
Federal Outlays for Benefits by Eligibility Category														
Aged	24.6	26.1	27.3	29.0	31.1	33.6	36.2	39.2	42.2	46.7	49.6	53.8	6.7%	7.4%
Blind and Disabled	31.7	33.9	36.7	40.2	44.0	48.3	53.1	58.3	63.9	70.3	77.3	84.9	8.9%	9.4%
Children	13.8	14.5	15.7	17.0	18.2	19.5	20.8	22.2	23.7	25.3	27.0	28.9	7.3%	7.1%
Adults	9.4	9.8	10.2	10.9	11.5	12.2	12.9	13.8	14.8	15.8	16.7	17.8	5.4%	6.0%
Total	79.3	84.4	89.9	97.0	104.9	113.5	123.0	133.4	144.5	156.9	170.6	185.5	7.6%	8.0%
Enrollees by Eligibility Category (millions)														
Aged	4.2	4.3	4.3	4.4	4.4	4.5	4.6	4.7	4.8	4.8	4.9	5.0	1.8%	1.8%
Blind and Disabled	6.8	6.7	6.8	7.0	7.2	7.5	7.7	7.9	8.2	8.4	8.6	8.8	2.7%	2.8%
Children	21.0	21.4	21.7	22.1	22.4	22.6	22.7	22.9	23.0	23.2	23.3	23.4	1.3%	1.0%
Adults	10.0	10.1	10.1	10.2	10.2	10.3	10.3	10.4	10.4	10.4	10.5	10.5	0.5%	0.5%
Total	41.8	42.4	43.0	43.8	44.3	44.8	45.3	45.8	46.3	46.8	47.4	47.9	1.3%	1.2%
Federal Share of Payments Per Enrollee														
Aged	\$5,880	\$6,090	\$6,370	\$6,660	\$7,040	\$7,440	\$7,910	\$8,400	\$8,860	\$9,430	\$10,020	\$10,660	5.1%	5.6%
Blind and Disabled	4,640	5,050	5,370	5,730	6,080	6,480	6,890	7,350	7,840	8,360	8,980	9,600	6.1%	6.4%
Children	650	680	720	770	810	870	920	970	1,030	1,090	1,160	1,230	6.0%	6.0%
Adults	940	970	1,010	1,070	1,130	1,190	1,260	1,330	1,410	1,500	1,590	1,700	6.0%	6.5%
Average	1,800	1,990	2,090	2,220	2,370	2,530	2,720	2,910	3,120	3,350	3,600	3,880	6.2%	6.7%

Note: Payments per enrollee are projected based on reported enrollees and not recipients as in prior CBO Medicaid baseline fact sheets.

Recipients are beneficiaries who received a medical service paid for by Medicaid during the year

Enrollees are beneficiaries who have applied and are enrolled in the Medicaid program but may or may not have received a medical service paid for by Medicaid during the year.

CBO January 1997 Baseline: MEDICARE

Revised: 16-Jan-97 Printed: 16-Jan-97

By fiscal year 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007

MEDICARE TOTALS:

Mandatory Outlays (in billions of dollars) /1	\$191.3	\$208.8	\$227.0	\$248.2	\$273.0	\$285.6	\$313.7	\$339.4	\$368.2	\$409.8	\$437.6	\$464.1
Discretionary Outlays	3.0	3.2	3.1	3.2	3.4	3.6	3.7	3.8	4.0	4.2	4.4	4.6
Total Outlays	194.3	212.0	230.1	251.4	276.3	289.2	317.4	343.2	372.3	414.0	442.0	468.7
Total Premium Receipts	-20.0	-20.2	-21.4	-22.4	-23.4	-24.6	-26.6	-26.7	-28.0	-28.3	-30.7	-32.3
Net Outlays (Total Outlays - Receipts)	174.2	191.8	208.6	228.9	252.9	264.7	291.8	316.5	344.3	384.7	411.3	436.4
Net Outlays (Mandatory Outlays - Receipts) /2	171.3	188.6	205.5	226.7	249.5	261.1	288.1	312.6	340.3	380.5	407.0	431.8

COMPONENTS OF MANDATORY OUTLAYS:

Benefits

Payments to HMOs												
Risk HMOs	\$16.6	\$24.2	\$32.4	\$41.9	\$56.8	\$58.2	\$71.4	\$83.9	\$99.0	\$128.1	\$139.4	\$151.2
Cost HMOs and Demonstrations	0.5	0.7	0.6	0.7	0.8	0.7	0.9	1.0	1.1	1.2	1.3	1.3
Health Care Prepayment Plans /3	0.7	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.6	0.5
Subtotal	17.9	25.6	33.7	43.3	57.1	57.5	72.9	85.5	100.6	127.9	141.2	153.0
Payments to Fee-for-Service Providers												
Part A	113.8	120.5	128.8	133.5	140.4	148.3	156.4	164.8	173.0	181.4	189.9	198.5
Part B	59.3	61.7	65.5	70.2	74.3	78.6	83.1	87.8	93.2	99.0	105.1	111.2
Subtotal	173.1	182.3	192.3	203.8	214.7	226.8	239.5	252.4	266.2	280.4	295.0	309.7
Benefits Subtotal	191.0	207.9	226.0	247.1	271.8	284.4	312.4	337.9	366.8	408.4	436.2	462.6
Administration	0.3	0.9	1.0	1.1	1.2	1.3	1.4	1.4	1.4	1.4	1.6	1.6
Total Mandatory Outlays	191.3	208.8	227.0	248.2	273.0	285.6	313.7	339.4	368.2	409.8	437.6	464.1

Memorandum:

Number of Capitation Payments /4	11	12	12	12	13	11	12	12	12	13	12	11
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Notes:

- 1/ Average annual rate of growth of mandatory outlays from fiscal year 1996 through 2007 is 7.7 percent.
- 2/ Average annual rate of growth of net mandatory outlays from fiscal year 1996 through 2007 is 8.0 percent.
- 3/ Health Care Prepayment Plans provide Part B services only, and are paid on a cost basis.
- 4/ HMO capitation payments for the month of October are accelerated into the preceding fiscal year when October 1st falls on a weekend.

CBO January 1997 Baseline: MEDICARE

Revised: 18-Jan-97
Printed: 18-Jan-97

By fiscal year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
PART A: HOSPITAL INSURANCE (HI)												
TOTAL OUTLAYS (in billions of dollars) /1	\$125.3	\$137.4	\$148.6	\$161.1	\$176.5	\$184.5	\$201.7	\$217.5	\$234.7	\$259.4	\$275.1	\$289.7
MANDATORY OUTLAYS /2	124.1	130.1	147.3	159.8	175.1	183.1	200.2	215.9	233.0	257.7	273.3	287.9
BENEFITS	123.6	135.8	148.7	159.1	174.6	182.4	199.5	215.1	232.2	256.9	272.5	287.1
HMOs	10.0	15.1	19.9	25.6	34.1	34.1	43.1	50.5	59.2	75.5	82.6	88.8
Hospitals	84.1	86.7	89.3	92.6	95.9	100.2	104.6	108.9	113.2	117.2	121.1	124.6
Home Health	16.7	19.0	21.1	23.2	25.3	27.5	29.9	32.3	34.9	37.6	40.4	43.4
Skilled Nursing Facilities	11.1	12.8	14.1	15.4	16.7	17.9	19.2	20.5	21.8	23.3	24.9	26.6
Hospice	2.0	2.1	2.2	2.4	2.5	2.6	2.8	2.9	3.1	3.2	3.4	3.6
Annual Growth Rate:												
TOTAL OUTLAYS	9.1%	9.6%	8.1%	8.4%	9.0%	4.5%	9.3%	7.8%	7.9%	10.6%	6.1%	5.3%
BENEFITS	9.2%	9.5%	8.2%	8.5%	9.6%	4.5%	9.4%	7.8%	7.9%	10.8%	6.1%	5.3%
HMOs	30.2%	50.2%	32.4%	28.5%	33.2%	-0.1%	26.5%	17.2%	17.2%	27.4%	9.4%	7.3%
Hospitals	5.4%	3.1%	3.0%	3.6%	3.6%	4.5%	4.4%	4.1%	3.9%	3.6%	3.3%	3.0%
Home Health	11.5%	14.0%	11.1%	9.8%	9.3%	8.8%	8.5%	8.2%	8.0%	7.7%	7.5%	7.3%
Skilled Nursing Facilities	21.6%	15.2%	10.6%	9.1%	8.2%	7.5%	6.9%	6.8%	6.8%	6.8%	6.8%	6.9%
Hospice	6.2%	5.3%	6.8%	6.3%	5.9%	5.6%	5.4%	5.4%	5.4%	5.4%	5.6%	5.8%
PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)												
TOTAL OUTLAYS (in billions of dollars) /1	\$68.9	\$74.6	\$81.5	\$90.3	\$99.8	\$104.7	\$115.7	\$125.7	\$137.8	\$154.6	\$168.9	\$178.9
MANDATORY OUTLAYS /2	67.2	72.7	79.7	88.4	97.8	102.6	113.5	123.4	135.2	152.1	164.3	176.2
BENEFITS	67.2	72.3	79.3	87.9	97.3	102.0	112.9	122.8	134.6	151.5	163.7	175.5
HMOs	7.9	10.6	13.7	17.7	23.0	23.4	29.8	35.0	41.4	52.4	58.6	64.3
Physician Fee Schedule Payments	30.5	30.7	31.9	33.5	34.3	34.7	35.1	35.4	36.0	37.0	38.1	39.2
Benefits paid by Intermediaries /3	16.6	18.0	19.4	21.1	22.9	24.8	26.8	28.9	31.1	33.4	35.7	38.1
Non-Physician Benefits paid by Carriers /4	12.1	13.1	14.2	15.6	17.1	19.1	21.2	23.5	26.1	28.7	31.2	33.9
Annual Growth Rate:												
TOTAL OUTLAYS	5.7%	8.2%	9.3%	10.8%	10.6%	4.8%	10.5%	8.7%	9.5%	12.4%	8.0%	7.2%
BENEFITS	5.8%	7.7%	9.8%	10.9%	10.7%	4.8%	10.7%	8.8%	9.6%	12.5%	8.1%	7.2%
HMOs	20.9%	34.7%	29.8%	26.7%	30.0%	1.9%	27.1%	17.5%	18.4%	26.7%	11.8%	9.8%
Physician Fee Schedule Payments	1.6%	0.5%	4.0%	5.1%	2.3%	1.3%	1.1%	0.7%	1.8%	2.7%	3.1%	2.8%
Benefits paid by Intermediaries	8.1%	8.4%	7.6%	9.0%	8.3%	8.3%	8.1%	7.9%	7.6%	7.3%	7.0%	6.8%
Non-Physician Benefits paid by Carriers	5.4%	7.5%	8.8%	9.5%	10.1%	11.2%	11.2%	11.0%	10.8%	9.9%	8.9%	8.5%

1/ Includes mandatory outlays and discretionary administration outlays.

2/ Includes benefits outlays and mandatory administration outlays.

3/ Includes outpatient hospital services, laboratory services in hospital outpatient departments, and other services.

4/ Includes durable medical equipment, independent and physician in-office laboratory services, ambulance services paid by carriers, and other services.

CBO January 1997 Baseline: MEDICARE

Revised: 10-Jan-97
Printed: 10-Jan-97

By fiscal year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
STATUS OF HOSPITAL INSURANCE TRUST FUND: (billions of dollars)												
Income	\$121.1	\$127.7	\$131.0	\$135.8	\$140.2	\$143.6	\$147.3	\$150.7	\$153.6	\$156.3	\$158.4	\$160.0
Outlays	125.3	137.4	148.8	161.1	178.5	184.5	201.7	217.5	234.6	259.4	275.1	289.7
Surplus (Income - Outlays)	-4.2	-9.7	-17.8	-25.3	-38.3	-40.9	-54.4	-66.7	-81.1	-103.1	-116.6	-129.6
HI Trust Fund Balance (end of year)	125.3	115.6	98.0	72.8	38.5	-4.8	-58.9	-125.6	-206.7	-309.8	-426.5	-556.3
COMPONENTS OF HOSPITAL INPATIENT PAYMENTS: (billions of dollars)												
Non-PPS Hospitals and Units of Hospitals	\$11.4	\$12.3	\$13.3	\$14.4	\$15.6	\$17.0	\$18.5	\$20.1	\$21.8	\$23.6	\$25.7	\$27.1
PPS Hospitals	72.7	74.4	76.1	78.2	80.3	83.2	86.1	88.9	91.4	93.6	95.5	96.9
Inpatient Capital /1	8.6	8.9	9.0	9.2	9.3	9.4	9.6	9.8	10.0	10.1	10.3	10.4
Disproportionate Share /2	4.3	4.5	4.8	5.0	5.3	5.5	5.8	6.0	6.2	6.4	6.6	6.7
Indirect Medical Education /2	4.3	4.6	4.9	5.3	5.7	6.1	6.6	7.0	7.5	8.0	8.4	8.8
Graduate Medical Education	2.4	2.5	2.6	2.6	2.7	2.8	2.9	3.1	3.2	3.3	3.4	3.5
PAYMENT UPDATES AND RATES:												
Part A: (fiscal year)												
PPS Market Basket Increase	3.6%	2.5%	3.0%	3.5%	3.5%	3.5%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
PPS Update Factor (average)	1.5%	2.0%	3.0%	3.6%	3.5%	3.5%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
Part B: (calendar year)												
MEI percentage change	2.0%	2.0%	2.3%	2.4%	2.5%	2.3%	2.3%	2.4%	2.3%	2.3%	2.2%	2.2%
Part B Updates:												
Physicians (weighted average)	0.3%	-1.0%	3.8%	2.0%	-1.2%	-2.7%	-2.5%	-2.4%	-0.6%	0.7%	1.5%	1.3%
Primary Care	-2.7%	1.0%	8.2%	3.9%	1.5%	-2.7%	-2.1%	-2.6%	-1.6%	0.6%	1.0%	1.6%
Surgery and Anesthesia	3.4%	0.4%	3.4%	-1.2%	-2.5%	-2.7%	-2.7%	-1.8%	0.2%	1.1%	1.7%	1.1%
Other Physicians	0.0%	-2.3%	2.3%	2.7%	-1.7%	-2.7%	-2.7%	-2.6%	-0.5%	0.6%	1.6%	1.3%
Non-physician Updates:												
Laboratory	2.8%	2.7%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%
Durable Medical Equipment	2.9%	2.8%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%
Prosthetics and Orthotics	2.9%	2.8%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%
Ambulatory Surgical Centers	2.5%	2.5%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%
Physician Fee Schedule Conversion Factors:												
Physicians (weighted average)	\$36.27	\$35.95	\$37.36	\$38.02	\$37.60	\$36.58	\$35.66	\$34.81	\$34.60	\$34.86	\$35.36	\$35.81
Primary Care	35.42	35.77	38.71	40.21	40.81	39.71	38.88	37.85	37.24	37.46	37.83	38.41
Surgery	40.80	40.96	42.34	41.83	40.78	39.66	38.60	37.92	38.00	38.42	39.09	39.50
Anesthesia	15.28	16.68	17.24	17.03	16.60	16.15	15.72	15.44	15.47	15.66	15.92	16.05
Other Physicians	34.63	33.85	34.62	35.54	34.94	34.00	33.10	32.23	32.07	32.24	32.74	33.11

Notes

1/ Included in Payments to Non-PPS Hospitals and Units of Hospitals and in Payments to PPS Hospitals.

2/ Included in Payments to PPS Hospitals. These payments include adjustments to both operating and capital-related prospective payments.

CBO January 1997 Baseline: MEDICARE

By fiscal year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
BENEFICIARY COST SHARING:												
Deductible (calendar year, in dollars)												
Part A (per hospital admission)	\$736	\$756	\$784	\$816	\$852	\$888	\$924	\$964	\$1,004	\$1,048	\$1,092	\$1,140
Part B (per year)	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
Monthly Premium (calendar year, in dollars)												
Part A (for voluntary enrollees) /1	\$289	\$311	\$333	\$366	\$379	\$404	\$429	\$457	\$488	\$517	\$551	\$586
Part B	\$42.60	\$43.80	\$45.80	\$47.10	\$48.50	\$50.00	\$51.60	\$53.00	\$54.60	\$56.20	\$57.80	\$59.70
Part B Premium: Percent of Program Costs for Aged Enrollees (calendar year)	26.6%	26.1%	25.0%	23.4%	22.5%	21.7%	20.8%	19.9%	18.9%	17.9%	17.0%	16.1%
Premium Receipts (fiscal year, in billions of dollars)												
Part A	1.1	1.2	1.4	1.6	1.6	1.8	1.9	2.1	2.2	2.4	2.6	2.9
Part B	18.9	19.0	20.1	21.0	21.8	22.7	23.7	24.7	25.7	26.8	28.0	29.4
ENROLLMENT: (in millions)												
Part A	37.7	38.1	38.6	39.0	39.5	40.0	40.6	41.1	41.6	42.2	42.9	43.7
Part B	36.0	36.5	36.9	37.3	37.8	38.2	38.6	39.1	39.5	40.0	40.6	41.3
Fee-for-Service Enrollment (Part A)	34.1	33.5	32.8	32.2	31.6	31.4	31.0	30.6	30.2	29.7	29.1	28.5
HMO Enrollment:												
Risk HMOs	3.4	4.4	5.6	6.7	7.7	8.4	9.3	10.2	11.2	12.3	13.6	14.9
Cost HMOs and Demonstrations	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Health Care Prepayment Plans /2	0.5	0.4	0.4	0.4	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2
Share of Medicare Part A Enrollment:												
Fee-for-Service	90.4%	87.8%	85.1%	82.4%	80.1%	78.4%	76.6%	74.6%	72.6%	70.3%	67.8%	65.3%
Risk HMOs	9.1%	11.7%	14.4%	17.1%	19.4%	21.1%	22.9%	24.8%	27.0%	29.2%	31.7%	34.2%
Cost HMOs and Demonstrations	0.6%	0.6%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.5%	0.5%	0.6%
Growth in Enrollment:												
Total Medicare Enrollment (Part A)	2.0%	1.2%	1.2%	1.2%	1.3%	1.3%	1.3%	1.3%	1.4%	1.4%	1.6%	1.6%
Fee-for-Service (Part A)	-0.5%	-1.7%	-2.0%	-2.0%	-1.6%	-0.9%	-1.1%	-1.3%	-1.6%	-1.7%	-1.9%	-2.0%
Risk HMOs	36.0%	30.0%	25.0%	20.0%	15.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Cost HMOs and Demonstrations	0.0%	4.0%	-5.6%	2.7%	2.2%	1.7%	1.3%	0.8%	0.3%	-0.1%	-0.6%	-1.0%
Health Care Prepayment Plans	-14.6%	-11.4%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%

Notes:

- 1/ Persons 65 and older are entitled to Part A coverage (they do not pay a monthly Part A premium) if they are eligible for Social Security or Railroad Retirement monthly cash benefits. Persons 65 and older who are not entitled may obtain Part A coverage by paying a monthly premium equal to the full actuarial cost of that coverage.
- 2/ Health Care Prepayment Plans provide Part B services only, and are paid on a cost basis.

A DEMOCRAT'S INTRODUCTION TO MEDICAID

(DRAFT, 11/5/96)

This is a primer on the nation's second largest health care program. It is written by the staff of the House Democratic Policy Committee for Democratic Members and staff of the 105th Congress, who will be called upon to decide the future of program in the context of balancing the Federal budget.

During the 104th Congress, Republicans tried twice to repeal Medicaid altogether, eliminating its entitlement of basic health and long-term care coverage for over 36 million elderly, disabled, and women and children, and establishing a new block grant to the States. Under the Republican block grant, Federal spending would have been cut sharply, State spending would have declined precipitously, and State discretion over billions in Federal funds would have increased dramatically, with far-reaching implications for Democratic constituencies and Democratic officeholders at all levels. Fortunately, the Republicans accomplished almost none of their extreme Medicaid agenda during the 104th.

Whether the Republicans resume their efforts to repeal Medicaid in the 105th Congress remains to be seen. At a minimum, however, they will continue to push for maximum State control over the use of Federal Medicaid dollars, if only because nearly 80 percent of the nearly \$100 billion in Federal funds flow to States with Republican Governors. This "management flexibility" will have enormous consequences for the families and children and elderly and disabled that Medicaid now covers, as well as for the hospitals, nursing homes, health centers, and physicians that now serve them.

While the 104th Congress did not enact the Republican Medicaid repeal, it did enact two laws -- welfare (P.L. 104-193) and immigration (P.L. 104-208) -- that made significant changes in the program. For additional information about these, see the Democrat's Guide to Medicaid-related Legislation in the 104th Congress (November, 1996), available through the House Democratic Policy Committee.

Reforming a program as large and complex as Medicaid in a way that beneficiaries and other Democratic constituencies don't get hurt is a complicated business. More detail on 10 of the major issues that the 105th Congress is likely to face may be found in the Democrat's Briefing Book on Medicaid Issues in the 105th Congress (November, 1996), also available through the House Democratic Policy Committee.

**PHOTOCOPY
PRESERVATION**

Contents

Medicaid at a Glance

What Is Medicaid's Impact?

Who Gets Medicaid?

What Does Medicaid Cover?

What Does Medicaid Cost, and Why?

Who Runs Medicaid?

Who Pays for Medicaid?

Distribution of Federal Medicaid Funds Among States (FY 1995)

What Didn't Happen to Medicaid in the 104th Congress?

The Republican 1996 Medicaid Repeal and Block Grant

The President's 1996 Medicaid Proposal

The Coalition's 1995-6 Medicaid Proposal

MEDICAID AT A GLANCE

Medicaid is a Federal-State entitlement program. Enacted in 1965, at the same time as Medicare, in 1965, Medicaid makes Federal matching funds available to States for the costs of paying for covered services to eligible Americans. Those Americans who meet the program's eligibility standards are entitled to have payment made on their behalf for covered services. States that elect to participate are entitled to Federal matching funds for their costs of paying for covered services for eligible residents.

Medicaid covers basic health and long-term care services. Medicaid covers hospital, physician, clinic, nursing home, prescription drug, and other health and long-term care services. Nationally, about 63 percent of what Medicaid spends on services pays for hospital, physician, and other acute care; the remaining 37 percent of Medicaid service dollars is spent on nursing home and other long-term care.

Medicaid covers three main groups of low-income Americans: the elderly, the disabled, and women and children. In 1996, Medicaid covered nearly 37 million Americans. About 4 million of these were elderly, about 6 million were disabled, over 18 million were children, and roughly 8 million were low-income women.

Although half of all Medicaid eligibles are children, nearly 60 percent of all Medicaid funds are spent on the elderly and disabled. In 1996, 50 percent of all Medicaid eligibles were children, but payments for services to the elderly (27 percent) and the disabled (31 percent) accounted for about 58 percent of all Medicaid spending. Only 16 percent of all Medicaid spending that year paid for services to children.

Medicaid cost the Federal government \$92 billion in FY 1996, an increase of 3 percent. Federal Medicaid spending in the year ending September 30, 1996, was \$91.8 billion, or \$4 billion below the amount projected by the Congressional Budget Office (CBO) in April, 1996. This translates into an annual growth rate of 3 percent, by far the lowest the program has experienced in the 1990's. Federal Medicare spending in FY 1996 was \$124 billion for Part A (hospital benefits), an increase of 9.2 percent, and \$69 billion for Part B (physician services), an increase of 6.0 percent.

The Federal Government pays at least half of the cost of Medicaid in every State (57 percent on average). The Federal share of the cost of Medicaid is at least 50 percent in every State and can go as high as 83 percent, depending on a State's per capita income (relatively poorer States receive a higher matching rate). On average, the Federal government finances 57 percent of total program costs.

The States administer Medicaid within Federal guidelines. The program is administered on a day-to-day basis by State Medicaid agencies, subject to oversight of Federal funds by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services.

WHAT IS MEDICAID'S IMPACT?

Medicaid is America's 2nd largest health care program, covering almost as many Americans as Medicare. According to CBO, Medicaid covered about 36.8 million Americans in FY 1996 at a total cost of \$161 billion (\$91.8 billion Federal, \$69.2 billion State). By way of comparison, CBO estimates that Medicare covered 37.5 million Americans in FY 1996 at a total cost to the Federal government of \$192.7 billion. (About 4.9 million aged or disabled Medicare beneficiaries received assistance from Medicaid during FY 1996).

Medicaid is America's largest single purchaser of nursing home services and other long-term care. The Federal government, through Medicaid, spent an estimated \$30 billion on long-term care in FY 1996, the States another \$22.7 billion. These figures represent nearly 1/3 of all program spending. Most of the long-term care paid for by Medicaid is delivered in nursing homes; Medicaid pays for about half of all the nursing home care provided in this country. Of the 1.5 million nursing home residents nationwide, about two thirds, or 1.0 million, are covered by Medicaid.

Medicaid covers about one fourth of the children in America. Of the over 71 million children in America in 1996, an estimated 18.6 million are covered by Medicaid. Under current law, by the year 2001, all American children under 18 who live in families with incomes below the Federal poverty line will be eligible for Medicaid coverage.

Medicaid is America's largest single purchaser of maternity care. Medicaid pays for about one third of the births in the country (1.4 million deliveries in 1993), including prenatal care, delivery, and post-partum care.

Medicaid is the safety net for nearly 5 million Medicare beneficiaries. In FY 1996, Medicaid paid the monthly Medicare premiums, deductibles, and coinsurance for about 4.9 million poor and near-poor elderly and disabled Americans who are covered by Medicare. For roughly half of these, Medicaid will also pay for nursing home care, prescription drugs, and other needed services that Medicare does not cover.

Medicaid affects thousands of health care providers and hundreds of thousands of health care workers. According to HCFA, in 1996, Medicaid made payments to over 5,000 community hospitals, over 1,000 mental and rehabilitation hospitals, nearly 12,000 nursing homes, over 7,000 facilities for the mentally retarded, and over 400 managed care organizations.

For teaching hospitals, public hospitals, children's hospitals, and rural and urban health centers, Medicaid is a major source of revenue. On average, Medicaid accounts for about 15 percent of the net revenues of teaching hospitals (1994), 25 percent of the net revenues of public hospitals (1994), 45 percent of the gross revenues of children's hospitals (1994), and 36 percent of the revenues of community health centers (1995).

WHO GETS MEDICAID?

Three basic groups of people are eligible for Medicaid:

- **Elderly.** More than 4 million adults 65 and over were eligible for Medicaid in FY 1996. About one third of these were eligible because they were receiving cash assistance through the Supplemental Security Income (SSI) program. Others had too much income or resources to qualify for SSI, but "spent down" to Medicaid eligibility by incurring high medical or long-term care expenses. Finally, perhaps 2 million of these were eligible as "Qualified Medicare Beneficiaries," or QMBs: their incomes were below 100 percent of the poverty level and they received Medicaid assistance with their Medicare premiums, co-insurance, and deductibles (but not for nursing home care or prescription drugs).
- **Disabled.** About 6 million disabled individuals were eligible for Medicaid in FY 1996. Most of these were eligible because they received cash assistance through the SSI program. The remainder "spent down" to qualify by incurring large hospital, prescription drug, nursing home, or other medical bills.
- **Women and Children.** Over 18.6 million low-income children and about 7.8 million low-income women were eligible for Medicaid in FY 1996. The majority of these were eligible because they were receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program. (The new welfare law, P.L. 104-193, breaks the 30-year old link between receipt of cash assistance and automatic eligibility for Medicaid for poor families).

There are some eligibility groups that States choosing to participate in Medicaid must cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal poverty level. There are also 13 statutory categories of individuals that States may elect to cover with the assistance of Federal Medicaid matching funds.

All Medicaid eligibles must have incomes and resources (i.e., savings and other assets) below specified levels. These levels are determined by the States within Federal guidelines, and they vary from State to State.

Meeting State income and resource standards is not sufficient to qualify for Medicaid. An individual must also fit into a covered eligibility category. Millions of poor Americans, including childless couples and single adults who are not aged or disabled, cannot receive Medicaid unless their States have obtained Federal demonstration waivers.

To qualify for Medicaid, individuals must, in general, be American citizens. Illegal aliens cannot qualify for Medicaid coverage except with respect to emergency care (including emergency labor and delivery). Legal resident aliens who entered the country before August 22, 1996, may, at State option, qualify.

WHAT DOES MEDICAID COVER?

States that choose to participate in Medicaid must cover a minimum set of benefits for certain populations. However, benefit packages vary from State to State due to the different ways in which States exercise their discretion under current law.

Services that States must cover. Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary:

- hospital care (inpatient and outpatient)
- nursing home care
- physician services (including abortion, but only when necessary to save the life of the mother or in cases of rape or incest)
- laboratory and x-ray services
- immunizations and other early and periodic screening, diagnostic, and treatment (EPSDT) services for children
- family planning services
- health center and rural health clinic services
- nurse midwife and nurse practitioner services

Services that States may cover. States have the option of covering additional services and receiving Federal matching funds for those services, which include:

- prescription drugs
- institutional care and community care for individuals with mental retardation
- home- and community-based care for the frail elderly
- dental care and vision care for adults

Services must be adequate in amount, duration, and scope. States have discretion to vary the amount, duration, or scope of the services that they cover, but in all cases the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." For example, a State may not limit coverage for inpatient hospital care or nursing home care to 1 day per year.

Services must be comparable throughout the State. States may not vary the amount, duration, or scope of services based on the individual's residence. For example, a State may not offer coverage for 30 hospital days per year to residents of urban areas but only 20 hospital days per year to residents of rural counties.

States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, type of illness, or condition." For example, States may not exclude individuals with AIDS from coverage for hospital care, or individuals with Alzheimer's from coverage for nursing home or home health care.

States may impose nominal copayments on some services. States may impose nominal copayments on prescription drugs and certain other non-emergency services, except with respect to children, pregnant women, and nursing home residents.

THE COST OF THE MEDICAID PROGRAM

Federal Medicaid spending in FY 1996 was \$91.8 billion, about \$4 billion less than CBO had projected. In April, 1996, CBO projected Federal Medicaid spending at \$95.7 billion for FY 1996. Actual Federal spending for FY 1996 was \$91.8 billion, in part because the number of eligibles did not grow as fast as CBO had anticipated, perhaps because of the strong national economy.

Overall Federal Medicaid spending increased 3 percent. In April, 1996, CBO projected that Federal Medicaid spending would rise 7.5 percent between FY 1995 and FY 1996. The actual increase was 3 percent, from \$89.1 billion to \$91.8 billion.

The CBO Medicaid baseline for FY 1997 through FY 2002 will drop at least \$28 billion. CBO's current projection of Federal Medicaid spending under current law over the next 7 years was issued in April, 1996. CBO will not formally revise its Medicaid baseline until January, 1997. However, CBO analysts have indicated that the \$4 billion in Federal spending that the current CBO baseline overestimates for FY 1996 will be taken out of its January, 1997, baseline; as a result, CBO's projection of Federal Medicaid spending over the next 7 years will drop at least \$28 billion.

Most -- about 70 percent -- of the growth in Federal Medicaid spending is caused by an increase in the number of eligible Americans and inflation in the price of medical and long-term care services that Medicaid buys. According to CBO, in 1995 there were four causes for the increase in Federal Medicaid spending:

- an increase in the number of low-income Americans eligible for the program
- inflation in the price of the hospital, nursing home, physician, and other services that Medicaid buys
- State payments to disproportionate share (DSH) hospitals
- other factors, such as the use of covered services by eligible beneficiaries, and State decisions as to whether to cover optional benefits or services.

The first two causes, CBO estimated, explained about 41 and 31 percent, respectively, of the growth in Federal Medicaid spending in 1995. State payments to DSH hospitals accounted for only about 3.5 percent; all other factors explained the other 24 percent.

Double-digit Medicaid cost increases are a historical artifact. Republicans typically cite the experience between 1988 and 1993, when, according to CBO, Federal Medicaid spending grew at an average annual rate of 19.6 percent. Reforms enacted by Congress in 1991 and 1993 curbed the principal source of these increases: the exploitation, by some States, of Federal matching payments to "disproportionate share" (DSH) hospitals and provider-based financing schemes. Federal Medicaid spending increases are unlikely to stay as low as 3 percent each year, if only because the number of beneficiaries is likely to rise more rapidly than that during periods of economic downturn. However, persistent double digit increases are equally implausible.

WHO PAYS FOR MEDICAID?

Medicaid is paid for by Federal and State governments. Unlike Medicare, which is financed by the Federal government and Medicare beneficiaries (through premiums), Medicaid is paid for by Federal and State governments (some States require their localities to contribute toward the State share). The Federal government matches State Medicaid spending for covered services on behalf of eligible populations. Most Medicaid beneficiaries do not pay premiums because they are unable to afford them.

State participation in Medicaid is voluntary. Federal Medicaid law does not require any State to participate in the program. However, if a State chooses to participate, it is entitled to receive Federal matching payments for its spending on covered services for eligible populations. All States have chosen to participate (the last State to join the program, Arizona, did so in 1982).

On average, the Federal government pays 57 percent of the costs of the Medicaid program. The Federal share of the cost of Medicaid is at least 50 percent in every State and can reach 83 percent, depending on a State's per capita income (relatively poorer States receive a higher matching rate). On average, the Federal share is at least 57 percent (due to what GAO has called "illusory" financing arrangements in some States, the actual Federal share is higher).

Medicaid is far and away the single largest source of Federal funds to the States, and represents 40 percent of all Federal grants-in-aid to States. In FY 1996, the Federal Medicaid matching payments to States totalled \$92 billion, or nearly 40 percent of the \$238 billion in Federal grants-in-aid to the States. Federal Medicaid payments dwarfed those for highways and mass transit (\$25.2 billion), education (\$13.3 billion), housing (\$12.4 billion), and food stamps (\$29.8 billion) and welfare (\$16.9 billion).

About half of all Medicaid spending is for populations and services that are not mandatory. As a condition of participating in Medicaid, States are required to cover certain populations (e.g., pregnant women below 133 percent of poverty) and certain services (e.g., medically necessary physician care). However, States also have the option of covering populations and services that are not mandatory and receiving Federal matching funds to help pay for the cost of this coverage. About half of all Medicaid spending is for populations or services that States are not required to cover.

In FY 1995, States headed by Republican Governors received over three fourths of all Federal Medicaid dollars, and nearly four fifths of all Federal Medicaid DSH spending. The accompanying table shows the amount of Federal Medicaid matching payments each State received during FY 1995, as well as the amount of Federal Medicaid matching funds for payments to "disproportionate share" (DSH) hospitals. States with Republican Governors in 1995 received 76.6 percent of all Federal Medicaid matching funds and 79.7 percent of all Federal DSH matching payments.

DISTRIBUTION OF FEDERAL MEDICAID FUNDS FY 1995
(Dollars in thousands)

State	Total Federal Payments	Federal Payments as % of National Total	Federal DSH Payments	Federal DSH as % of Total DSH
Alabama	1,394,059	2%	294,099	3%
Alaska	177,091	less than 1%	10,059	less than 1%
Arizona	1,112,131	1%	81,268	1%
Arkansas	898,204	1%	2,391	less than 1%
California	8,603,803	10%	1,095,718	11%
Colorado	840,222	1%	92,571	1%
Connecticut	1,290,554	1%	204,467	2%
Delaware	178,557	less than 1%	3,535	less than 1%
District of Columbia	394,702	less than 1%	23,120	less than 1%
Florida	3,491,022	4%	188,078	2%
Georgia	2,244,233	3%	254,569	3%
Hawaii	337,807	less than 1%	unknown	unknown
Idaho	252,325	less than 1%	1,460	less than 1%
Illinois	3,132,830	4%	201,734	2%
Indiana	1,317,242	2%	124,284	1%
Iowa	744,861	1%	3,833	less than 1%
Kansas	572,952	1%	51,979	1%
Kentucky	1,509,374	2%	136,549	1%
Louisiana	3,037,495	3%	865,245	9%
Maine	605,919	1%	104,646	1%
Maryland	1,282,901	1%	71,550	1%
Massachusetts	2,501,409	3%	287,645	3%
Michigan	3,013,317	3%	248,972	3%
Minnesota	233,416	less than 1%	16,009	less than 1%
Mississippi	1,231,773	1%	143,493	1%
Missouri	1,697,659	2%	436,415	4%
Montana	262,959	less than 1%	168	less than 1%
Nebraska	408,115	less than 1%	4,000	less than 1%
Nevada	238,628	less than 1%	36,780	less than 1%
New Hampshire	382,680	less than 1%	52,350	1%
New Jersey	2,567,168	3%	547,057	5%
New Mexico	592,138	1%	4,944	less than 1%
New York	12,323,482	14%	1,511,935	15%
North Carolina	2,450,917	3%	277,784	3%
North Dakota	211,647	less than 1%	827	less than 1%
Ohio	3,862,723	4%	382,301	4%
Oklahoma	841,519	1%	16,317	less than 1%
Oregon	960,995	1%	19,566	less than 1%
Pennsylvania	4,197,870	5%	521,376	5%
Rhode Island	566,799	1%	61,539	1%
South Carolina	1,448,377	2%	310,952	3%
South Dakota	221,120	less than 1%	730	less than 1%
Tennessee	2,229,545	3%	unknown	unknown
Texas	5,716,963	7%	957,899	10%
Utah	427,232	less than 1%	3,324	less than 1%
Vermont	219,164	less than 1%	17,583	less than 1%
Virginia	1,071,279	1%	33,989	less than 1%
Washington	1,587,788	2%	174,392	2%
West Virginia	972,244	1%	64,044	1%
Wisconsin	1,540,917	2%	6,581	less than 1%
Wyoming	111,154	less than 1%	unknown	unknown
Total:	87,509,281	100%	9,950,127	100%

SOURCE: Data reported by the States to the Health Care Financing Administration.

WHAT DIDN'T HAPPEN TO MEDICAID DURING THE 104TH CONGRESS?

During the 104th Congress, three major proposals were advanced to cut Federal Medicaid spending: the Republican Medicaid block grant, the President's "per capita cap" proposal, and the Coalition's "per capita cap" proposal. None of these was enacted. However, the 104th did enact a welfare block grant (P.L. 104-193) and restrictions on benefits for legal immigrants (P.L. 104-208); the impact of these changes on Medicaid are discussed in a Democrat's Guide to Medicaid-related Legislation in the 104th Congress (November, 1996).

Although they were not enacted, the three major Medicaid proposals were "scored" by the Congressional Budget Office, which estimated that the 1996 version of the Republican block grant would cut Federal Medicaid spending over 6 years by \$72 billion, the President's plan by \$54 billion, and the Coalition's by \$67 billion. However, these differences in the level of cuts achieved are dwarfed by the differences in the structural changes they would make in Medicaid:

- **Entitlement.** The Republican proposal would repeal the individual Medicaid entitlement and replace it with a new block grant to the States; the President and the Coalition would retain the current individual entitlement.
- **Limits on Federal Matching Payments.** The Republican proposal would set a fixed annual limit on the amount of Federal Medicaid funds available nationally for distribution among the States in the form of block grants, supplemented with a small "umbrella" fund for States with high population growth. In contrast, the President's and the Coalition's plan, recognizing that people, not States, get sick, would limit the annual rates of increase in Federal Medicaid payments to each State on a "per capita" (i.e., per beneficiary) basis.
- **Disproportionate Share (DSH) Hospital Payments.** The Republican proposal would repeal the current law requirement that States make payment adjustments to hospitals serving a "disproportionate share" of Medicaid and other low-income patients. The President's and Coalition's plans would revise, but not repeal, the current law requirement so as to reduce and retarget Federal "DSH" payments.
- **Provider Reimbursement.** Both the Republican and the President's proposals would repeal the "Boren" amendment; the Coalition plan would retain it.
- **Managed Care.** The Republican bill would repeal all current policy with regard to Medicaid managed care; the President's and the Coalition's plans would revise current policy while giving States more (but not unlimited) flexibility.
- **State Share.** The Republican bill would raise the minimum Federal matching rate from 50 to 60 percent. The President's and Coalition's plans would retain the current Federal-State matching arrangements.

THE REPUBLICAN 1996 MEDICAID BLOCK GRANT: A BRIEF OVERVIEW

On May 22, 1996, Republicans in the House and Senate introduced bills (H.R. 3507, S. 1795) creating a welfare block grant and a Medicaid block grant. This is a summary of the major provisions of the Republican Medicaid block grant as reported by the House Budget Committee on June 13, 1996, as H.R. 3734 (H. Rept. 104-651).

CBO Estimates. According to CBO, the Republican bill would cut Federal Medicaid spending by \$71.7 billion over the six-year period FY 1997 - FY 2002. Nearly 70 percent of these cuts -- \$49.8 billion -- would occur in the last two years.

Entitlement Repeal. The Republican bill would repeal the current Medicaid individual entitlement effective October 1, 1996, and would instead entitle each State to a specified amount of Federal dollars each year. The bill specifies certain population groups and certain services which States receiving Federal block grant funds must "guarantee;" however, States have complete discretion with respect to the amount, duration, or scope of these "guaranteed" benefits offered to any particular individual, and the enforcement of these "guarantees" in Federal court is expressly prohibited.

Limit on Federal Matching (Per Capita Cap). The Republican bill would establish a block grant to the States for providing medical assistance to low-income individuals and families. The bill specifies, for each of the fiscal years 1997 through 2002, a precise amount of Federal dollars available nationally for the Medicaid block grant, as well as the formula for allocating these funds among the States. The bill also specifies the amount of supplemental funds to certain States for services provided to undocumented immigrants (\$3.5 billion over 5 years) and to Indians (\$500 million over 5 years). Finally, the bill provides a limited, one-time "supplemental umbrella allotment" to States with high population growth, estimated by CBO to cost about \$26 billion over 6 years, or 3 percent of the total Federal funding available to States under the bill.

"DSH" Payments. The Republican bill would repeal the current law requirement that States make payment adjustments to hospitals serving a "disproportionate share" of Medicaid and low-income patients. States would have complete discretion with respect to participation of these facilities in the program and levels of reimbursement, if any.

Provider Reimbursement. The Republican bill would repeal the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

Managed Care. The Republican bill would allow States to require eligible individuals to enroll in a managed care organization selected, regulated, and paid by the State.

State Share. The Republican bill raises the minimum Federal matching percentage to 60 percent and authorizes the Secretary to waive the current law limitations on State use of revenues from provider taxes and donations, effective FY 1998.

THE PRESIDENT'S 1996 MEDICAID PROPOSAL: A BRIEF OVERVIEW

On May 24, 1996, OMB transmitted to the Congress the text of the bill implementing the President's balanced budget plan. This is a summary of the major provisions of the Medicaid title of that bill, which was not introduced.

CBO Estimates. In its April, 1996, analysis of the President's FY 97 budget, CBO estimated \$54 billion in reduced Federal Medicaid spending over the 6-year period FY 1997 - FY 2002. About \$35 billion, or nearly two thirds of this amount, was attributable to the imposition of a "per capita cap" on increases in Federal Medicaid matching payments; the remaining \$19 billion reflected net reductions in Federal payments to States for "DSH" (disproportionate share) hospitals.

Entitlement. The President's plan retains the current Medicaid individual entitlement, including the current minimum eligibility requirements, the current basic benefits requirements, and the current administrative due process and judicial protections.

Limit on Federal Matching (Per Capita Cap). The President's plan would impose, effective FY 1997, a 5 percent annual limit on the rate of increase in Federal Medicaid matching payments, determined on a per beneficiary basis for each State. This limit on the increase in Federal payments would not apply to payments for "DSH" hospitals, for low-income Medicare beneficiaries (QMBs), or for certain other types of expenditures.

"DSH" Payments. The President's plan would phase-in a reduction in the total amount of Federal Medicaid matching payments to "disproportionate share" hospitals nationally from \$10.7 billion in FY 1996 to \$4.0 billion by FY 2002. A portion of the Federal savings attributable to this change would offset the cost of 3 new grant programs established by the bill: \$11 billion over the FY 1997 - FY 2000 period to assist States and hospitals with the transition away from the current "DSH" policy; \$3.5 billion over the FY 1997 - FY 2001 period for 15 States with large numbers of undocumented immigrants; and \$3 billion over the FY 1997 - FY 2002 period in grants to Federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

Provider Reimbursement. The President's plan would repeal the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

Managed Care. The President's plan would allow States to require beneficiaries to enroll in a managed care plan that serves only Medicaid eligibles, so long as the beneficiary has a choice between 2 plans (except in rural areas).

State Share. The President's plan maintains the current law Federal-State matching formula as well as the current law limitations on State use of revenues from provider taxes and donations.

THE COALITION'S 1995-6 MEDICAID PROPOSAL: A BRIEF OVERVIEW

During the budget process in both 1995 and 1996, the Coalition, a group of moderate and conservative Democrats in the House, offered an alternative to the Republican and the President's balanced budget proposals. This is a summary of the major provisions of the Medicaid portion of that balanced budget alternative.

CBO Estimates. In July, 1996, CBO estimated \$67.5 billion in net reductions in Federal Medicaid spending over the 6-year period FY 1997 - FY 2002. Of this amount, \$36.8 billion, about 55 percent, was attributable to the imposition of a per capita cap on increases in Federal Medicaid matching payments. The remaining \$30.7 billion reflected reductions in Federal payments to States for "DSH" (disproportionate share) hospitals, net of \$5 billion in direct payments to Federally qualified health centers (FQHCs) and rural health clinics (RHCs) for unfunded costs.

Entitlement. The Coalition's plan retains the current Medicaid individual entitlement, including the current minimum eligibility requirements, the current basic benefits requirements, and the current administrative due process and judicial protections.

Limit on Federal Matching (Per Capita Cap). The President's plan would impose, effective FY 1997, an annual limit (starting at 3.5 percent and declining to 1.0 percent) on the allowable rate of increase in Federal Medicaid matching payments, determined on a per beneficiary basis for each State. This limit on the increase in Federal payments would not apply to payments for "DSH" hospitals, for low-income Medicare beneficiaries (QMBs), or for certain other types of expenditures.

"DSH" Payments. The Coalition's plan would phase in a reduction in the total amount of Federal Medicaid matching payments to "disproportionate share" hospitals nationally from \$10.7 billion in FY 1996 to \$6.0 billion by FY 2002. A portion of the Federal savings attributable to this change would offset the \$5.0 cost of a new grant program to cover the unfunded costs of Federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

Provider Reimbursement. The Coalition's proposal would retain the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

Managed Care. The Coalition's plan would allow States to require most beneficiaries to enroll in a managed care plan that serves only Medicaid eligibles, so long as the beneficiary has a choice between 2 plans (except in rural areas).

State Share. The Coalition's plan maintains the current law Federal-State matching formula as well as the current law limitations on State use of revenues from provider taxes and donations.

MEDICAID-RELATED LEGISLATION IN THE 104TH CONGRESS: A DEMOCRAT'S GUIDE

(November, 1996)

The 104th Congress, which adjourned sine die on October 4, 1996, marked the failure of Republican efforts to repeal the Medicaid entitlement and replace it with a block grant to the States, and to cut Federal payments to the States by as much as \$182 billion over the next 7 years. The Republicans were, however, successful in enacting major changes in welfare and immigration policy that will have an impact on many Medicaid beneficiaries, on hospitals and clinics that serve low-income Americans, and on State Medicaid programs. In addition, the 104th Congress enacted a number of bills which include provisions affecting Medicaid, as well as a few minor Medicaid-specific bills.

This Guide reviews the Medicaid-related legislation enacted by the 104th Congress, as well as the significant legislation not enacted. It is designed to accompany the Democrat's Introduction to Medicaid and the Democrat's Briefing Book on Medicaid Issues for the 105th Congress, both of which are also available through the House Democratic Policy Committee.

Additional information on the major new enactments is available from the Congressional Research Service. Cost estimates and intergovernmental mandate estimates for these enactments are available directly from the Congressional Budget Office.

Table of Contents

Medicaid-related Legislation Not Enacted in the 104th Congress

Republican Medicaid Cuts: A Scorecard for the 104th Congress

Medicaid-related Legislation Enacted in the 104th Congress

Medicaid-related Provisions in the Republican Welfare Law (P.L. 104-193)

Medicaid-related Provisions in the Illegal Immigration Law (P.L. 104-208)

Section 1115 Medicaid Waivers Granted During the 104th Congress

MEDICAID-RELATED LEGISLATION NOT ENACTED BY THE 104TH CONGRESS

Despite their majority status in both the House and the Senate, the Republicans failed to enact their Medicaid repeal agenda in the 104th Congress.

1st Session (1995)

Budget Resolution. On June 29, 1995, the House and Senate adopted a budget resolution (H. Con. Res. 67) directing a cut in Federal Medicaid spending of \$182 billion over the 7-year period FY 1996 through FY 2002.

Reconciliation. On November 17, 1995, the House and the Senate adopted a budget reconciliation conference report (H.R. 2491, "The Balanced Budget Act of 1995") that, among other things, would have repealed the current Medicaid program and replaced it with a block grant to the States ("Medigrant") and cut Federal Medicaid spending by \$163.4 billion (under the March, 1995, CBO baseline) over the 7-year period FY 1996 through FY 2002. (Under the December, 1995, CBO baseline, the cut would have been \$133 billion). On December 6, 1995, the President vetoed H.R. 2491.

2nd Session (1996)

NGA Medicaid Proposal. On February 6, 1996, the National Governors' Association adopted a 6-page proposal entitled "Restructuring Medicaid." On May 22, 1996, Republicans introduced the "Personal Responsibility and Work Opportunity Act of 1996," (H.R. 3507, S. 1795), which contained a repeal of the Aid to Families with Dependent Children (AFDC) program as well as a repeal of the Medicaid program. The Medicaid repeal was titled the "Medicaid Restructuring Act of 1996." On May 29, 1996, Democratic Governors wrote to the Chairmen of the House and Senate committees of jurisdiction to inform them that "your Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year...."

Budget Resolution. On June 12 and 13, 1996, the House and Senate adopted a budget resolution for FY 1997 (H. Con. Res. 178) directing a cut in Federal Medicaid spending of \$72 billion over the 6-year period FY 1997 through FY 2002. In contrast to the FY 1996 resolution, this resolution called for the enactment of not one, but three separate reconciliation bills: one relating to welfare and Medicaid and tax relief; one relating to Medicare; and one relating to taxes and miscellaneous direct spending.

Reconciliation. On July 31 and August 1, 1996, the House and Senate adopted the conference report on the first reconciliation bill, H.R. 3734, from which the Republican "Medicaid Restructuring Act of 1996" was excluded. The legislation repeals the current AFDC program and replaces it with a block grant. The President signed H.R. 3734 on August 22, 1996 (P.L. 104-193).

REPUBLICAN MEDICAID CUTS: A SCORECARD FOR THE 104TH CONGRESS
(Totals in billions, 7-year period FY 1996 - FY 2002)

**Legislation Proposing Cuts in
Federal Medicaid Spending**

Amount of Cut Proposed

FY 1996 Budget Resolution (6/29/95)	- \$182.0
FY 1996 Budget Reconciliation Conference Report (vetoed 12/6/95)*	- \$163.4
FY 1996 Budget Reconciliation Conference Report (reestimated under new CBO baseline, 12/11/95)*	- \$133.0
FY 1997 Budget Resolution (6/13/96)	- \$ 72.0
FY 1997 Budget Reconciliation ("Welfare and Medicaid Reform Act") (6/27/96)*	- \$ 71.7

Medicaid Cuts Enacted

Amount

Termination of SSI Benefits and Medicaid Coverage for Individuals Disabled by Alcoholism or Drug Abuse (Section 105(b) of P.L. 104-121) (3/29/96)*	- \$ 0.6
Welfare Law (P.L. 104-193)(8/22/96)*	- \$ 4.1

*Final Congressional Budget Office estimates.

MEDICAID-RELATED LEGISLATION ENACTED BY THE 104TH CONGRESS

Abortion. Both the Omnibus FY 1996 Appropriations Act (P.L. 104-134), and the Omnibus Consolidated Appropriations Act for FY 1997 (P.L. 104-208) contain "Hyde Amendment" language that prohibits the use of Federal Medicaid matching funds for any abortion except when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

Administrative Simplification. Section 262 of the "Health Insurance Portability and Accountability Act of 1996" (P.L. 104-191)(Kennedy-Kassebaum) directs the Secretary of HHS to adopt standards and data elements for "transactions" (e.g., eligibility, enrollment, claims processing) that will enable information to be exchanged electronically among Medicare, Medicaid, HMOs, and insurers. Under these standards, every health care provider and plan will have a unique identifier that will apply to most public and private payors, including Medicaid, thereby facilitating the identification and exclusion of fraudulent or abusive providers.

Aliens. For an overview of the changes affecting Medicaid eligibility of both illegal and legal aliens, see the summaries of the welfare law (P.L. 104-193) and the illegal immigration law (enacted in the omnibus FY 1997 appropriations legislation, P.L. 104-208) elsewhere in this Guide.

California County Health Insuring Organizations. This amends demonstration authority enacted in 1985 to enable county-operated health insuring organizations (HIOs) to serve beneficiaries in more than one county. This change will permit the enrollment of about 12,000 Medicaid beneficiaries living in Napa County into the Solano County HIO (P.L. 104-240, signed into law on October 8, 1996).

Continuation of Medicaid Eligibility Standards for Families with Dependent Children. Since the enactment of Medicaid in 1965, States that elect to participate have been required to extend Medicaid coverage to members of families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. Of the 36.8 million Americans eligible for Medicaid in FY 1996, 8.8 million are children up to age 18, and 4.2 million are mothers or other adults in households receiving AFDC benefits. Under the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," H.R. 3734, the AFDC entitlement is repealed effective October 1, 1996, and is replaced with a block grant to the States for "Temporary Assistance for Needy Families." Recipients of aid or assistance under this new block grant are not eligible for Medicaid on the basis of their receipt of cash or other assistance (although they may be eligible on some other basis). Section 114 of H.R. 3734 provides that States must extend Medicaid coverage to individuals who, now or in the future, would be eligible for cash assistance under the AFDC program in effect in the State as of July 16, 1996, whether or not those individuals are receiving assistance under the new

block grant. (For purposes of Medicaid eligibility, States have the option of lowering their AFDC income standards to those in effect as of May 1, 1988). H.R. 3734 was signed into law on August 22, 1996 (P.L. 104-193). For additional information, see the summary of P.L. 104-193 elsewhere in this Guide.

FY 1996 and First Quarter FY 1997 Funding. Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to States for the last 3 quarters of FY 1996 was contained in the 7th continuing resolution for FY 1996, H.R. 1358, which was signed into law on January 6, 1996 (P.L. 104-91). Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to the States for the last quarter of FY 1996 for unanticipated costs incurred for FY 1996, and for matching payments for the first quarter of FY 1997, was contained in the Omnibus FY 1996 Appropriations bill, H.R. 3019, signed into law April 26, 1996 (P.L. 104-134).

FY 1997 and First Quarter FY 1998 Funding. Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to States for FY 1997 and the first quarter of FY 1998 is contained in the Omnibus Consolidated Appropriations Act for FY 1997, H.R. 4278, signed into law on September 30, 1996 (P.L. 104-208).

Fraud and Abuse. The "Health Insurance Portability and Accountability Act of 1996" (P.L. 104-191)(Kennedy-Kassebaum) contains a major expansion in Federal civil and criminal fraud and abuse authorities, several of which directly affect Medicaid. Section 201(a) authorizes and appropriates additional funding to the DHHS Inspector General for FY 1997 and each subsequent fiscal year in order to expand the enforcement of fraud and abuse laws with respect to Medicare and Medicaid. Section 221 directs the Secretary of HHS to establish, by January 1, 1997, a national health care fraud and abuse data bank which contains information on "adverse actions" (e.g., civil judgments, criminal convictions, exclusions) taken against health care providers by Medicaid, Medicare, other Federal health care programs, as well as private health plans. Section 231(h) creates a new civil monetary penalty for offering inducements to Medicaid beneficiaries to receive services from a particular provider or managed care plan. Section 231(d) increases the burden that prosecutors must meet in establishing the liability of providers for civil monetary penalties under Medicaid (and Medicare) by requiring a showing that an individual acted with "deliberate ignorance or reckless disregard" of the truth or falsity of the information provided.

Line-Item Veto (Enhanced Recission). S. 4, the Line-Item Veto Act, gives the President the authority to "cancel in whole... any item of new direct spending" (including Medicaid expansions). The President's cancellation is effective unless disapproved by the Congress in a disapproval bill signed by the President or enacted over his veto. This new Presidential authority is effective with respect to laws enacted on or after January 1, 1997. S. 4 was signed into law on April 9, 1996 (P.L. 104-130).

Louisiana Enhanced Federal Matching Rate. Section 519 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, raises the Federal Medicaid matching rate for the

State of Louisiana. If the State elects, it may receive an effective Federal matching rate higher than its current 71.9 percent: 84.3 percent for the 9-month period ending 6/30/96; 81.6 percent for the 12-month period 7/1/96 through 6/30/97; and, subject to subsequent appropriations acts, 78.2 percent for the 12-month period 7/1/97 through 6/30/98. In order to qualify for these higher matching rates, the State would have to agree to a specified limit on the amount of Federal Medicaid matching funds it could draw down during each of these periods. All existing Federal Medicaid requirements relating to eligibility, benefits, reimbursement, etc., would continue to apply; however, eligible individuals and providers would have an individual entitlement only against the State, not against the Federal government. The Omnibus Consolidated Appropriations Act for FY 1997, P.L. 104 - 208) did not authorize the election of the 78.2 percent matching rate for the 12-month period 7/1/97 through 6/30/98.

Managed Care "75-25" Rule Waivers. Five managed care plans have received statutory waivers of the current 75 percent/25 percent public/commercial enrollment mix requirement for Medicaid managed care contractors: the Dayton Area Health Plan (P.L. 104-87, signed on December 29, 1995); D.C. Chartered Health Plan, Inc. (Section 517 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134); and Fidelis Health Plan of New York, Managed Healthcare Systems of New York, and Health Partners of Philadelphia (P.L. 104-267, signed into law on October 9, 1996).

Medicare-Medicaid Coverage Data Bank Repeal. Under current law (section 1144 of the Social Security Act), the Secretary is required, effective January 1, 1994, to establish a data bank to collect information from employers regarding the employees covered under their group health plans; this information is to be used to identify third parties (e.g., insurers and managed care plans) responsible for payment for health care services received by Medicare and Medicaid beneficiaries. This legislation (H.R. 2685) repeals the current law requirement (P.L. 104-226, signed into law October 2, 1996).

New Hampshire (and certain other States). Section 214 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, directs the Secretary of HHS to pay Federal Medicaid matching funds to States, up to a limit of \$54 million, in connection with certain reimbursements to State-operated psychiatric hospitals and contracting providers with respect to which the Secretary had notified the State of an intent to defer matching payments. The largest of the claims at issue is that of New Hampshire (\$44.7 million).

Nursing Home Resident Review. This legislation (H.R. 3632) repeals the Medicaid requirement that nursing home residents with mental illness or mental retardation be reviewed annually by a State agency to determine whether continued nursing home placement is necessary. The legislation requires that nursing facilities participating in Medicaid promptly notify State officials of a significant change in the physical or mental condition of a resident with mental illness or mental retardation, and requires that, promptly after receiving such notification, the appropriate State agency review the need for continued placement of the resident in the nursing home (P.L. 104-315, signed into

law on October 19, 1996). (A companion bill, H.R. 3633, relating to nurse aide training programs, was not enacted).

Physician Quality Requirements: Technical Corrections. Under current law, in order to qualify for Medicaid reimbursement for physician services delivered to children or pregnant women, a physician must meet at least one of six different quality criteria other than licensure by the State. One of these criteria relates to certification by a medical specialty board; the legislation (H.R. 1791) clarifies that this includes certification by specialty boards recognized by the American Osteopathic Association. The legislation also adds a seventh qualifying criterion: delivery of services in the emergency department of a hospital participating in Medicaid. Finally, the legislation provides that physicians may qualify for Medicaid reimbursement if they are certified by the State in accordance with policies of the Secretary (P.L. 104-248, signed into law on October 9, 1996).

Termination of Medicaid Coverage for Certain Disabled Children. Section 211 of H.R. 3734 (the welfare bill, P.L. 104-193) narrows the current law definition of disability for purposes of establishing the eligibility of children for cash assistance under the Supplemental Security Income (SSI) program. Children could no longer establish eligibility for SSI disability benefits based on an individualized functional assessment, and maladaptive behavior would be removed from the regulatory medical listings used to establish whether a child has a medically determinable physical or mental impairment of sufficient severity to qualify. In some cases, children who now qualify for Medicaid based on their eligibility for SSI benefits, and who lose SSI as a result of the changes made by the bill, would not be able to reestablish their eligibility for Medicaid on some other basis (such as poverty status), and would therefore lose coverage.

Termination of Medicaid Coverage for Certain Legal Aliens. Section 403 of H.R. 3734, the welfare law (P.L. 104-193), bars most legal aliens who enter the country on or after August 22, 1996, from receiving Medicaid coverage (other than with respect to the treatment of emergency medical conditions) for 5 years from the date of entry. Section 402(b) of H.R. 3734 gives States the option of denying Medicaid coverage (other than with respect to the treatment of emergency medical conditions) to most legal aliens, including those now residing in the U.S. who are currently covered. The illegal immigration law, enacted as part of the Omnibus Consolidated Appropriations Act for FY 1997 (P.L. 104-208), contains additional provisions affecting the eligibility of legal aliens for Medicaid; see the summary of this bill elsewhere in this Guide.

Termination of Medicaid Coverage for SSI Recipients Due to Alcoholism or Drug Addiction. Section 105(b) of H.R. 3136 (P.L. 104-121) terminates Supplemental Security Income (SSI) benefits for individuals who are eligible on the basis of disability and for whom alcoholism or drug addiction is a "contributing factor" material to a determination of disability. For new applicants, this policy is effective on enactment (March 29, 1996); for current beneficiaries, it is effective 1/1/97. There is no provision for continued Medicaid coverage for individuals terminated from SSI on this basis.

CBO estimates that the Federal government will save \$650 million over the next 7 years in Federal Medicaid matching funds as a result of the loss of Medicaid coverage by some 40,000 to 50,000 individuals each year.

Transfer of Assets Criminalization. Section 217 of the "Health Insurance Portability and Accountability Act of 1996," H.R. 3103 (Kennedy-Kassebaum) makes it a crime, effective January 1, 1997, to "knowingly and willfully" dispose of assets in order to qualify for Medicaid if the disposal would result in the imposition of a period of ineligibility for Medicaid. Under prior law (which remains in effect), individuals who, within 3 years prior to application for benefits (5 years in the case of trusts), dispose of assets for less than fair market value in order to qualify for Medicaid nursing home coverage are subject to a period of ineligibility for Medicaid. The effect of section 217 is to subject these same individuals to the possibility of criminal prosecution in addition to the period of ineligibility for Medicaid. H.R. 3103 was signed into law (P.L. 104-191) on August 21, 1996.

"Unfunded Mandates." The Unfunded Mandates Reform Act of 1995, P.L. 104-4, signed into law on March 22, 1995, establishes points of order against in both the House and the Senate against legislation that would increase the direct costs of "Federal intergovernmental mandates" by an amount in excess of certain thresholds, unless the legislation provides full Federal funding for the excess costs. Although participation in the Medicaid program is voluntary with the States, and although the Federal government pays about 57 percent of the program costs, P.L. 104-4 defines as a "Federal intergovernmental mandate" any amendment to the Medicaid program that would either "increase the stringency of conditions of assistance to State governments" or "place caps upon or otherwise decrease" the Federal government's responsibility for funding the program, except where the States have the authority to "amend their financial or programmatic responsibilities to continue providing required services."

Welfare. For a summary of provisions affecting Medicaid eligibility of low-income mothers and children, legal aliens, and disabled children, see the discussion of the welfare law (P.L. 104-193) elsewhere in this Guide.

"Welfare to Work" Transitional Medicaid Coverage. Under current law, members of families that lose cash assistance under the AFDC program due to earnings are entitled to continued Medicaid coverage for up to 12 months after the loss of cash assistance, so long as the family continues to report earnings, and so long as the family's income does not exceed 185 percent of the poverty level. Section 114 of H.R. 3734, the welfare bill (P.L. 104-193), extends the sunset date for this 12-month transitional coverage, currently September 30, 1998, through September 30, 2001.

**SUMMARY OF MEDICAID-RELATED PROVISIONS IN
REPUBLICAN WELFARE CONFERENCE REPORT (H.R. 3734)
(P.L. 104-193, signed into law August 22, 1996)**

CBO Estimates. Over the 6-year period FY 1997 through FY 2002, CBO estimates that the conference report would reduce Federal Medicaid spending by a net of \$4.1 billion. This reflects total cuts of \$5.8 billion (\$5.3 billion attributable to the provisions relating to legal aliens and \$0.5 billion attributable to changes in the provisions relating to disabled children and child support enforcement), offset by new spending of \$1.7 billion (\$0.5 billion for State administrative costs relating to eligibility determinations and \$1.2 billion for the 3-year delay in the sunset of "welfare-to-work" transitional coverage).

Medicaid Coverage of Mothers and Children. In contrast to current law, under which mothers and children receiving cash assistance under the AFDC program are automatically eligible for Medicaid, receipt of cash or other assistance under the new welfare block grant would not be a basis for Medicaid eligibility. Instead, States would be required to extend Medicaid coverage to all mothers and children who meet the income and resource standards, and the family composition rules, in effect under the State's AFDC program as of July 16, 1996. As under current law, States would have the option of lowering their income standards to those in effect as of May 1, 1988. They could also use less restrictive methodologies in determining income and resources. State administrative costs attributable to these Medicaid eligibility determinations during the first 3 years of implementation of the welfare block grant would qualify for increased Federal matching funds as specified by the Secretary (subject to a limit of \$500 million over the period FY 1997 through FY 2000).

States would have the option of terminating Medicaid coverage for individuals (other than pregnant women and minor children who are not heads of households) receiving cash assistance under the new welfare block grant who lose their cash assistance because of refusing to work. The legislation's denial of benefits to individuals convicted of drug-related felonies is limited to the denial of welfare block grant and food stamp benefits, and would not extend to a denial of Medicaid coverage.

As under current law, mothers and children losing eligibility for Medicaid due to increased earnings from employment would be entitled to 12 months of transitional Medicaid coverage. Those losing eligibility for Medicaid due to collection of child support would be entitled to 4 months of transitional Medicaid coverage. The current law sunset of the 12-month "welfare to work" transitional Medicaid benefit would be extended from September 30, 1998, to September 30, 2001.

Termination of Medicaid Coverage for Certain Legal Aliens. (Note: some of these provisions were amended by the illegal immigration law (P.L. 104-208), described elsewhere in this Guide). The welfare legislation, P.L. 104-193, would bar Medicaid coverage (for all but the treatment of emergency medical conditions) to otherwise

eligible legal aliens who enter the U.S. on or after the date of enactment for a period of 5 years from the date of entry. This five-year bar would not apply to refugees, asylees, veterans, or active-duty members of the armed services.

In addition, States would have the option of denying Medicaid coverage (for all but the treatment of emergency medical conditions) to otherwise eligible legal aliens who entered the U.S. prior to enactment, or who entered on or after enactment but are no longer subject to the 5-year bar. This optional denial of Medicaid eligibility would not apply to permanent residents with a 10-year work history who did not receive public benefits during that time, to veterans or active duty members of the armed services, or, for 5 years after entry, to refugees or asylees. Current resident legal aliens now receiving Medicaid benefits could not be denied coverage until January 1, 1997.

The legislation would also bar legal aliens, whether currently in the U.S. or future entrants, from receipt of cash assistance under the Supplemental Security Income (SSI) program (subject to a transition period of up to one year for currently eligible aliens). Exempt from this prohibition are refugees and asylees (but only for 5 years), permanent residents with a 10-year work history who did not receive public benefits during that time, and veterans and active duty members of the armed services. Those legal aliens who are currently eligible for Medicaid based on their receipt of SSI benefits and who lose their SSI eligibility under this legislation may also lose their Medicaid coverage if they are unable to establish an alternative basis for eligibility.

For purposes of determining eligibility for Medicaid coverage (for all but the treatment of emergency medical conditions), the income and resources of all legal aliens entering the U.S. after enactment would be deemed to include the income and resources of sponsors and their spouses. (Sponsors of aliens entering after enactment would be required to sign legally enforceable affidavits of support obligating them to reimburse the State and Federal governments for Medicaid expenditures other than for treatment of emergency medical conditions on behalf of the aliens they are sponsoring).

Termination of Medicaid Coverage for Certain Disabled Children. The legislation would narrow the current law definition of disability for purposes of establishing the eligibility of children for cash assistance under the Supplemental Security Income (SSI) program. Under the legislation, children would be disabled for SSI purposes if they have a medically determinable physical or mental impairment which results in marked and severe functional limitations and has lasted (or can be expected to last) for 12 months or could result in death. Children could no longer establish eligibility for SSI disability benefits based on an individualized functional assessment, and maladaptive behavior would be removed from the regulatory medical listings used to establish whether a child has a medically determinable physical or mental impairment of sufficient severity to qualify. In some cases, children who now qualify for Medicaid based on their eligibility for SSI benefits, and who lose SSI as a result of the changes made by the bill, would not be able to reestablish their eligibility for Medicaid on some other basis (such as poverty status), and would therefore lose Medicaid coverage.

**SUMMARY OF MEDICAID-RELATED PROVISIONS OF THE
ILLEGAL IMMIGRATION REFORM AND IMMIGRANT RESPONSIBILITY ACT
(Enacted in P.L. 104-208, signed into law on September 30, 1996)**

The FY 1997 omnibus appropriations bill (P.L. 104-208) contains the "Illegal Immigration Reform and Immigrant Responsibility Act of 1996," which includes provisions that affect the Medicaid eligibility of both legal and illegal aliens. A number of these provisions amend similar provisions contained in the welfare law (P.L. 104-193) enacted one month earlier (August 22, 1996).

CBO Estimates. The Congressional Budget Office does not attribute any significant Federal savings or costs to the enactment of the public benefits provisions affecting aliens in P.L. 104-208. The previous CBO estimates with respect to the alien provisions in the welfare law (P.L. 104-193) remain unchanged (i.e., Federal Medicaid spending attributable to legal aliens would be reduced by \$5.3 billion over 6 years).

Denial of Medicaid to Illegal Aliens. Under the welfare law, P.L. 104-193, illegal aliens (generally, aliens who are not refugees, asylees, or lawfully admitted for permanent residence) are not eligible for Medicaid coverage except for services necessary for treatment of an emergency medical condition. (As under current law, States must provide coverage for treatment of emergency medical conditions for otherwise-eligible illegal aliens). The illegal immigration law in P.L. 104-208 amends the welfare law provisions to exempt from the general prohibition of Medicaid coverage illegal aliens who have been battered or subjected to extreme cruelty in the U.S. by a spouse or parent, so long as the individual responsible for the battery or cruelty does not reside in the same household.

"Deeming" of Sponsor's Income and Resources. The welfare law denies Medicaid coverage to most legal aliens who enter the U.S. on or after August 22, 1996, for a period of 5 years from the date they enter the country, except with respect to treatment of an emergency medical condition. The welfare law also requires that States, in determining the eligibility of a legal alien for non-emergency Medicaid services after the 5-year exclusion period, "deem" the income and resources of the alien to include the income and resources of a sponsor (and the sponsor's spouse) who has executed a affidavit of support meeting certain requirements.

The illegal immigration law replaces the welfare law's requirements relating to these affidavits of support with the following requirements. The affidavit must be a contract (1) in which the sponsor agrees to maintain the sponsored alien at an annual income of at least 125 percent of the Federal poverty level; (2) that is legally enforceable in Federal or State court against the sponsor by the Federal government, State Medicaid agencies, or health care providers that deliver Medicaid services to the sponsored alien; and (3) that is enforceable with respect to benefits provided to the sponsored alien until the date the alien is naturalized as a citizen, or, if earlier, until the alien has worked 40 qualifying calendar quarters for Social Security purposes.

In addition, the illegal immigration law also requires States to obtain from the sponsor reimbursement for the costs of providing any Medicaid benefits, including emergency care, to the sponsored alien. Finally, the illegal alien law also amends the welfare law's sponsor "deeming" requirements by carving out two limited exceptions: (1) in cases where the sponsored alien has been determined to be indigent due in part to lack of adequate support from the sponsor, and (2) in cases where the alien has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent, and the individual responsible for the battery or cruelty no longer resides in the same household.

"Public Charge." The welfare law does not speak to the issue of "public charge." The illegal immigration law provides that an alien who is seeking admission to the U.S. or is applying for permanent resident status is excludable from the U.S. if the individual "is likely at any time to become a public charge." This "public charge" test may, in the discretion of the Attorney General, be satisfied by the filing of an affidavit of support by a qualified sponsor. The legislation is silent as to whether receipt of emergency or non-emergency Medicaid benefits would trigger a finding that an individual is likely to become a "public charge." These new provisions do not apply to legal aliens residing in the U.S. before (at least) September 30, 1996.

Exemption of Nonprofit Charitable Organizations from Verification Requirements.

The welfare law directs the Attorney General to issue regulations requiring verification that individuals applying for non-emergency Medicaid services (and other "Federal public benefits") have legal immigration status. Within 2 years of issuance of these regulations, States administering Medicaid programs must comply. The illegal immigration law amends this provision by exempting any nonprofit charitable organization providing Medicaid benefits from a requirement to determine, verify, or otherwise require proof of eligibility of any applicant for Medicaid benefits.

Federal Reimbursement for Costs of Emergency Care to Illegal Aliens. Under current law, the Federal government matches, at the regular matching rates (57 percent on average), State Medicaid expenditures for emergency medical services for eligible illegal aliens. Under the illegal immigration law, States and localities are eligible for reimbursement by the Federal government for the costs of emergency care provided to illegal aliens through public hospitals and clinics after January 1, 1997, but only if: (1) the costs aren't otherwise reimbursed through Medicaid (including, presumably, Medicaid "disproportionate share" payment adjustments); (2) the hospital or clinic is unable to recover the costs from the alien or "another person;" (3) the immigration status of the alien has been verified (presumably by the hospital or clinic); and (4) the Federal funds are provided in advance through appropriations acts.

SECTION 1115 MEDICAID WAIVERS GRANTED DURING THE 104TH CONGRESS

(October 30, 1996)

With the exception of the welfare block grant, the 104th Congress enacted no significant structural changes in Medicaid. Nonetheless, structural changes did occur as a result of administrative rather than legislative action. During 1995 and the first 10 months of 1996, the Secretary of Health and Human Services granted 8 States (Delaware, Illinois, Maryland, Massachusetts, Minnesota, Ohio, Oklahoma, and Vermont) waivers of Federal Medicaid requirements which enable them to make major changes in the delivery of services under their programs while continuing to receive Federal matching funds.

These "demonstration" waivers are granted by the Secretary of HHS under section 1115 of the Social Security Act and are required to be budget neutral (from the Federal government's standpoint) over their 5-year terms. In general, they apply on a statewide basis. (The Medicaid statute also authorizes the Secretary of HHS to grant "section 1915(b)" waivers to enable States to increase managed care enrollment and "section 1915(c)" waivers to enable States to offer home-and community-based services to individuals at risk of nursing home care).

Republican efforts during the 104th Congress to enact legislation directing the Secretary of HHS to approve section 1115 Medicaid waiver applications from Michigan (H.R. 3562) and Wisconsin (H.R. 3507) were unsuccessful.

All of the section 1115 Medicaid demonstrations maintain the current individual entitlement, the currently required eligibility categories, and the current Federal-State matching arrangements. Most of them affect hospital, physician, and other acute care services, not nursing home and other long-term care. Almost all of them enable States to require beneficiaries to enroll in managed care organizations that serve primarily or exclusively Medicaid enrollees.

Operational States. The following 10 States are operating statewide Medicaid demonstrations under section 1115 waivers: Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. (Florida, Kentucky, Maryland, Massachusetts, and Illinois have also received section 1115 waivers but were not operational as of October 1, 1996). California received a section 1115 Medicaid waiver to enable Los Angeles County to restructure its hospital and clinic system. The 10 States operating section 1115 statewide Medicaid waivers as of October 1, 1996, covered about 3 million beneficiaries, or about 8 percent of the 36.8 million Medicaid beneficiaries nationwide. About 500,000 of these were individuals who would not be eligible for Medicaid under traditional eligibility rules, but who are receiving coverage under the terms of their State's waiver.

A more detailed discussion of section 1115 statewide Medicaid waivers is found in the Democrat's Briefing Book on Medicaid Issues for the 105th Congress.

A DEMOCRAT'S BRIEFING BOOK ON MEDICAID ISSUES FOR THE 105TH CONGRESS

(DRAFT, November 8, 1996)

During the 104th Congress, Congressional Republicans, urged on by the 32 Republican Governors, made repeated -- but unsuccessful -- efforts to repeal the Medicaid entitlement and replace it with a block grant. While the debate turned largely on whether the Republican Medicaid repeal would, as they asserted, have continued the "guarantee" of health care for the 36 million Americans now covered -- of course, it would not have -- their bill raised many other issues.

Whether the Republicans continue their efforts to repeal Medicaid in the 105th Congress remains to be seen. At a minimum, they can be expected to push for maximum control over Federal Medicaid funds, perhaps under the code of "entitlement reform" or "management flexibility." (Republicans control the Governorships in States that receive over 75 percent of all Federal Medicaid funds -- roughly \$70 billion in FY 1996).

The purpose of this Briefing Book is to help prepare Democratic Members and staff for the next Republican attack on Medicaid. Written by staff of the House Democratic Policy Committee, it summarizes 10 key Medicaid policy issues that arose during the 104th Congress and that are likely to resurface during the 105th.

This Briefing Book supplements A Democrat's Introduction to Medicaid and A Democrat's Guide to Medicaid-Related Legislation in the 104th Congress, both of which are also available through the House Democratic Policy Committee.

Obviously, there are far more than 10 important policy issues in a program that buys basic health and long-term care services for over 36 million Americans. Moreover, these 10 issue summaries are just that -- summaries. Additional information on these and other Medicaid issues can be obtained from:

- Center on Budget and Policy Priorities (202) 408-1080
- Congressional Budget Office (202) 226-2673
- Congressional Research Service (202) 707-5863
- Democratic Governors' Association (202) 479-5153
- General Accounting Office (202) 512-7114
- Health Care Financing Administration (202) 690-5960
- Kaiser Commission on the Future of Medicaid (202) 347-5270

Contents

Boren Amendment

Children's Coverage

Disproportionate Share Hospitals (DSH)

Federal Matching Rate Formula

Federally Qualified Health Centers (FQHCs)

Flexibility

Managed Care

Provider Taxes

Qualified Medicare Beneficiaries (QMBs)

Section 1115 Medicaid Waivers

BOREN AMENDMENT

Named after its principal author, former Senator David Boren (D-OK), this provision of Federal Medicaid law requires States that elect to participate in Medicaid to pay for inpatient hospital services and nursing home care using rates that are "reasonable and adequate." This requirement does not apply to any other Medicaid-covered services. For almost all other Medicaid-covered services, there is no Federal minimum payment standard; the Medicaid statute requires only that payments to providers be "consistent with efficiency, economy, and quality of care," and that they be "sufficient to enlist enough providers so that care and services are available under the [State's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area." (The principal exception is the requirement that States pay 100 percent of the costs of services provided by Federally-qualified health centers and rural health clinics to Medicaid beneficiaries).

Nationally, inpatient hospital services account for about 18 percent of all Medicaid spending on services (1995) (about 28 percent if additional payments to "disproportionate share" (DSH) hospitals that are not mental hospitals are included). Nursing home services account for another 26 percent of all Medicaid spending (1995). Since the reimbursement rate is one important factor in determining these expenditure levels, the Boren amendment and its implementation are a central concern for the States. The amendment is also important to the nursing home industry, which on average receives about 50 percent of its revenues from Medicaid. While the hospital industry overall receives a lower percentage of its revenues from Medicaid (about 13 percent in 1994), some types of hospitals are highly dependent on Medicaid, including children's hospitals (45 percent of gross revenues in 1994), public hospitals (25 percent of net revenues in 1994), and teaching hospitals (15 percent of net revenues in 1994).

The enforcement of the Boren amendment against States through the Federal courts (by both hospitals and nursing homes) has led to calls from Governors for its repeal. At the same time, increasing Medicaid beneficiary enrollment in managed care is gradually achieving a *de facto* repeal of the Boren amendment with respect to hospitals, because as interpreted by HCFA, the amendment does not apply to inpatient hospital services delivered through Medicaid managed care plans.

History. Ironically, in light of current calls from Governors for its repeal in the name of State flexibility, the Boren amendment was originally enacted to give the States greater flexibility. Congress first enacted the Boren amendment in the 1980 budget reconciliation bill (P.L. 96-499), and applied it to nursing homes. Prior to OBRA '80, States were required to pay nursing homes on a reasonable cost-related basis using cost-finding methods approved and verified by the Secretary of HHS (at that time, Medicare was reimbursing skilled nursing facilities (SNFs) on a reasonable cost basis). The thrust of the Boren amendment was to move away from payment of "reasonable

cost" to payment through "reasonable and adequate" rates that were determined using methods developed by the State. The Congress extended this same policy to payment for inpatient hospital services in OBRA '81 (P.L. 97-35); prior to this change, States had been required to pay for Medicaid hospital services on the same retrospective, reasonable cost basis that the Medicare program was using, unless they obtained a waiver from the Secretary.

In OBRA '87 (P.L. 100-203), Congress established new minimum Federal quality standards for nursing homes participating in Medicaid, effective October 1, 1990. In doing so, Congress modified the Boren amendment to require that States adjust their Medicaid payment rates to nursing homes to reflect the facilities' costs of complying with the new standards (nursing homes receiving waivers of minimum nurse staffing requirements might find their rates adjusted downward). In OBRA '90 (P.L. 101-508), Congress clarified that the nature of these compliance costs, as reflected in the statutory language set forth below.

In 1990, the Supreme Court ruled that hospitals have the right to seek judicial review in Federal court of State compliance with the requirements of the Boren amendment, Wilder v. Virginia Hospital Association, 110 S. Ct. 2510 (1990). As a result, both hospitals and nursing homes dissatisfied with State Medicaid payment rates have sought relief from the Federal courts, or have used the threat of litigation in negotiations over payment rates with their State Medicaid agencies. According to information supplied by HCFA, between 1991 and 1995 alone there have been 27 reported Federal court decisions involving the Boren Amendment; about half of these involve hospitals, the other half, nursing facilities.

Current Law. The Boren amendment appears at section 1902(a)(13)(A) of the Social Security Act. Implementing regulations are found at 42 C.F.R. 447.253 and 42 C.F.R. 447.272 (upper payment limit). The "DSH" hospital payment rules appear at section 1923 of the Act.

Hospitals. The Boren amendment requires that States pay for inpatient (but not outpatient) hospital services delivered to Medicaid patients "through the use of rates (determined in accordance with methods and standards developed by the State...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality."

"DSH" Hospital Payments. The Boren amendment also requires that, in setting rates for inpatient hospital services, States use methods and standards that "take into account the situation of hospitals which serve a disproportionate number of

low income patients with special needs." This element of the Boren amendment has evolved into the Medicaid "Disproportionate Share (DSH) Hospital" program, which is summarized elsewhere in this Briefing Book).

Nursing Homes. The Boren amendment requires that States pay for nursing facility services (and services in an intermediate care facility for the mentally retarded (ICF/MR)) provided to Medicaid beneficiaries "through the use of rates...which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards...."

The Boren amendment further provides that the rates must be "determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of complying with ["nursing home reform" requirements relating to provision of services, residents' rights, and administration and other matters]."

In addition, in the case of nursing facilities that have received waivers of the minimum nurse staffing requirements in the "nursing home reform" provisions of the Medicaid statute, the Boren amendment requires that, in setting rates, the States provide for "an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care."

Upper Payment Limit. The Boren amendment essentially sets a floor Medicaid under payment rates for inpatient hospital and nursing home services. By regulation, 42 C.F.R. 447.272, HCFA has established aggregate ceilings on payments to these providers. Aggregate Medicaid payments in any year for inpatient hospital services, nursing facility services, and ICF/MR services may not, under these regulations, exceed the amounts that would have been paid for each of these groups of services under Medicare payment principles. (Medicaid payment adjustments to DSH hospitals are not subject to these aggregate ceilings; as discussed elsewhere in this Briefing Book, they are subject to separate facility-specific and State-specific caps).

Managed Care. As interpreted by HCFA, the Boren amendment applies only when a State Medicaid program pays a hospital directly for inpatient care. When Medicaid beneficiaries enroll (or are required to enroll) in a managed care organization (MCO) that contracts with the State to provide hospital care and other Medicaid-covered services, the only Federal requirement is that the State's payments to the MCO be made on "an actuarially sound basis." What the MCO in turns pays to its affiliated hospitals for delivering inpatient care to its Medicaid enrollees is a matter of negotiation between the MCO and the hospital; it could be more or less than the rate that would apply under the Boren amendment.

CBO Estimates. In April, 1995 CBO staff estimated that repealing the Boren amendment with respect to hospitals would reduce Federal Medicaid spending by a total of \$1.1 billion over 7 years (FY 1997 - FY 2002). Although it is not possible to predict how CBO might score this proposed policy change for the budget debate in 1997, it is unlikely that the estimated Federal savings would be any greater than \$1.1 billion, since the number of Medicaid eligibles receiving hospital services through managed care plans rather than on a fee-for-service basis has increased rapidly.

The same April, 1995 CBO staff estimate found that repealing the Boren amendment with respect to nursing homes would reduce Federal Medicaid spending by a total of \$1.3 billion over 7 years (FY 1997 - FY 2002). It is unknown what the CBO estimate of this proposed policy change would be for purposes of the budget debate in 1997.

Most Recent Republican Proposal. Under both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795), the current Boren amendment, as it applies both to inpatient hospital and nursing home services, would have been repealed. States receiving block grant funds would have had complete discretion with respect to whether a particular hospital or nursing home could participate in the block grant program (either as a fee-for-service provider or as a subcontractor to a managed care plan) and with respect to the amount of reimbursement that the hospital or nursing home would receive for inpatient services provided to eligible individuals (whether directly from the State or from a managed care plan). Both versions of the Republican Medicaid block grant would also have barred private rights of action by providers or beneficiaries, effectively prohibiting any hospital or nursing home from bringing suit in Federal court to enforce compliance by a State with any requirements under the block grant. Finally, both versions would have made any existing Federal court orders entered against States to remedy violations of the Boren amendment inapplicable to the States under the block grant and would have authorized the States to return to court to seek the abrogation of those orders.

MEDICAID COVERAGE OF CHILDREN

Medicaid is a voluntary social contract. States can choose to participate or not. However, if States want Federal Medicaid matching dollars to help pay for nursing home and other long-term care expenses for their elderly and disabled residents, they must also extend basic health care coverage to certain categories of children (and pregnant women). Because all 50 States have opted to participate in this social contract, the Medicaid program is currently the health insurer for one fourth of all the children in America (18.6 million in FY 1996, according to CBO). Children represent about 50 percent of all Medicaid eligibles, but they account for less than 15 percent of all program spending. According to the Census Bureau, in 1995, about 10 million children under 18 -- nearly 14 percent of all children -- had no health insurance coverage whatsoever. In the absence of the Medicaid program, the number of uninsured children would be at least twice as high. None of these children -- whether insured or not -- is eligible to vote in State (or Federal) elections.

Of all the population groups that Medicaid covers, children are, on average, the least expensive. CBO estimates that, in FY 1996, the Federal government spent an average of \$820 per non-disabled child under Medicaid. This compares with an average of Federal Medicaid spending of \$2200 per beneficiary for all Medicaid eligibles that year, \$4850 per disabled individual, and \$5930 per elderly individual.

History. For most of the first 2 decades of Medicaid's existence (1965 - 1983), almost all children who qualified for Medicaid coverage were eligible because they were members of families receiving cash welfare under the Aid to Families with Dependent Children (AFDC) program. Beginning in the mid-1980's, and extending through 1990, the Congress enacted, over the objections of the Reagan and Bush Administrations, a series of incremental expansions in Medicaid coverage for children and pregnant women under which eligibility was based on Federally-determined minimum income standards, not on receipt of cash assistance (children in AFDC households continued to receive Medicaid coverage).

One of these incremental expansions is still being implemented. In OBRA '90 (P.L. 101-508), Congress extended Medicaid coverage to all children born after September 30, 1983, in families with incomes at or below the Federal poverty level (\$12,980 for a family of 3 in 1996). As of October 1, 1996, the oldest of these children turned 13; all poor children younger than 13 are covered. This mandatory coverage for children in poor families continues to be phased in for those older than 12, up to age 19, one year at a time. By the year 2002, Medicaid will cover all children under 19 living in families with incomes at or below the Federal poverty level. (According to CBO staff estimates, an additional 250,000 poor children per year are covered by Medicaid under this phase-in).

The welfare law (P.L. 104-193), signed on August 22, 1996, breaks the 30-year-

old linkage between receipt of AFDC cash assistance and eligibility for Medicaid. Whether a State, under its welfare block grant, decides to give cash assistance to a family will have no bearing on whether the children (or parents) in that family are eligible for Medicaid. Instead, the P.L. 104-193 requires States to provide Medicaid coverage to children (and parents) in families whose income and resources meet the State's AFDC income and resource standards as in effect on July 16, 1996, and who meet the AFDC family composition requirements in effect as of that date (i.e., a one-parent family with a minor child, or a two-parent family with a minor child in which the principal wage earner is unemployed). The purpose of this provision is to ensure that the loss of welfare benefits by a child under the new block grant does not result in the loss of Medicaid coverage if the child would have been eligible for AFDC prior to the enactment of the welfare law. Whether this objective is actually achieved as States implement their new welfare block grants remains to be seen.

Current Law. The current Medicaid coverage categories for children, both mandatory and optional, are set forth in section 1902(a)(10) of the Social Security Act; the "poverty-related" categories are found at section 1902(l). States are given the discretion to use more liberal methodologies for determining income and resource eligibility for certain categories of children in section 1902(r)(2). The new rules relating to Medicaid eligibility for children whose families would have qualified for AFDC cash assistance under previous law are found at section 1931.

States electing to participate in Medicaid must extend basic coverage to certain "mandatory" categories of children. They may also obtain Federal Medicaid matching funds to help pay for the cost of coverage of basic services for certain "optional" categories. From the child's (and parent's) point of view, there may be several pathways to eligibility for Medicaid coverage. In order to qualify, a child need only meet the requirements of one of the eligibility categories in effect in his or her State. Here are the major Medicaid eligibility categories for children:

"Mandatory" Eligibles:

- States must cover children up to age 6 with family incomes at or below 133 percent of the Federal poverty level (\$17,263 for a family of 3 in 1996). States are not required to apply a resource test to this population, and few do so.
- States must cover children up to age 19 born after September 30, 1983, with family incomes at or below 100 percent of the Federal poverty level (\$12,980 for a family of 3 in 1996). As of October 1, 1996, all of these children were at least 12 years old. States are not required to apply a resource test to this population, and few do so.
- States must cover children in families that meet the income and resource standards and family composition rules in effect under their State's AFDC plan as of July 16, 1996. Given that State AFDC payment standards averaged about

40 percent of poverty for a family of 3 in 1996, most of the children eligible for Medicaid under this category will also be eligible under one of the "poverty-related" categories described above. The practical effect of this particular requirement is to assure coverage for children aged 13 to 19 in families that meet their State's July 16, 1996, AFDC income and resource standards until the Medicaid coverage for all children in poverty has been completely phased in.

- States must either (1) cover disabled children receiving Supplemental Security Income (SSI) benefits or (2) cover disabled children who meet the Medicaid eligibility standards in effect in the State as of January 1, 1972. As of July 1, 1996, only 11 States had chosen not to extend Medicaid coverage automatically to children (and adults) receiving SSI benefits (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia).

"Optional" Eligibles:

- States have the option of receiving Federal Medicaid matching funds for covering "medically needy" children -- those with large, recurring medical expenses which, when applied against their family incomes, bring them below the "medically needy" income eligibility threshold set by the State. (In contrast, under the mandatory "poverty related" eligibility categories described above, children may not "spend down" into eligibility by incurring medical expenses; if a child's family countable income is \$1 above the relevant poverty level, the child is not eligible for Medicaid, no matter how high his or her medical care costs).
- States have the option of receiving Federal Medicaid matching funds for covering infants up to age 1 (and pregnant women) with family incomes above 133 percent of the Federal poverty level up to 185 percent of the poverty level (\$24,013 in 1996).
- States have the option of applying less restrictive "methodologies" for determining income (and resource) eligibility for "poverty-related" children. For example, in determining whether a family of 3 meets the income "standard" of poverty (\$1,082 per month), a State that wants to encourage work might choose to use a "methodology" which disregards the first \$541 per month of the family's earnings, allowing it to earn \$1,623 per month, or 150 percent of poverty, and still qualify). As of August, 1996, 13 States (Colorado, Connecticut, Delaware, Kansas, Maine, Minnesota, New Hampshire, New Mexico, North Carolina, North Dakota, Vermont, Washington, Wisconsin) had used this option to effectively raise their income eligibility standards for children (in varying age categories) to as high as 225 percent of poverty (Vermont).

"Waiver Eligibles:" Under section 1115 of the Social Security Act, the Secretary has the discretion to authorize States, as part of a demonstration project, to

receive Federal Medicaid matching funds for populations, including children, for which Federal matching is not available under current Medicaid law (Title XIX of the Act). As of October 1, 1996, the following States were operating section 1115 Medicaid waivers that extended Medicaid to some 564,000 "waiver eligibles," many of whom are children (Delaware, Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, and Vermont).

Basic Benefits. As the 1996 version of the Republican Medicaid block grant makes crystal clear, eligibility for coverage is meaningless unless the coverage itself has some content. Under current law, "mandatory" eligibles have an individual entitlement to have payment made on their behalf for the following services, when "medically necessary:" hospital care (inpatient and outpatient), physicians' services, laboratory and x-ray services, family planning services and supplies, Federally-qualified health center (FQHC) and rural health clinic (RHC) services, pediatric or family nurse practitioner services, and early and periodic screening, diagnostic, and treatment (EPSDT) services. In general, States may impose limits on the amount, duration, or scope of covered services, but the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." (42 C.F.R. 440.230(b)). However, States may not impose any amount, duration, or scope limitations on "Treatment" services for children to correct or ameliorate defects and physical and mental illnesses and conditions discovered by EPSDT screenings.

Cost-Sharing. Under current law, States may not impose deductibles, coinsurance, copayment, or similar cost-sharing requirements on any service with respect to Medicaid-eligible children under 18, whether the child qualifies under a "mandatory" or "optional" eligibility category, and whether or not the child is enrolled in a managed care organization (MCO). In addition, States may not impose any premiums with respect to coverage of children under 18 who qualify under a "mandatory" eligibility category; however, they may impose income-related premiums with respect to coverage of children who qualify for Medicaid under certain "optional" eligibility categories, such as the "medically needy."

Medicaid and Private Health Insurance. Some poor or near-poor children are covered as dependents under a health insurance policy offered through a parent's employer. This insurance coverage has no effect on the child's Medicaid eligibility, which depends solely on whether they meet the requirements of one of the above statutory requirements. However, the parent is required, as a condition of Medicaid eligibility for herself and the child, to assign to the State Medicaid agency any right to insurance payments under such a policy and to cooperate with the State in recovering payments from the health insurer.

Implementation. Medicaid does not cover all poor children in America; the Census Bureau reports that, in 1995, over 3 million poor children (about one fifth of all poor children) had no Medicaid coverage and no private health insurance coverage. There are two main reasons. First, a significant number of children who meet the Medicaid eligibility standards in effect in their States do not participate in the program. (GAO

recently reported that, in 1994, 2.9 million children -- about 30 percent of uninsured children that year -- were eligible for Medicaid but did not receive it). Secondly, while States can receive Federal matching funds for covering all poor children under 19, they are not currently required to do so, and many of them do not. (As discussed above, coverage for all poor American children under 19 is being phased in one year at a time; as of October 1, 1996, all poor children under 13 were covered).

The accompanying chart shows the August, 1996 income eligibility thresholds in each State for 4 groups: pregnant women and infants; children under 6; children age 6 through 12; and children age 13 through 18. Over half the States (26) have elected to cover infants (and pregnant women) with family incomes up to 185 percent of poverty or above. Ten States have chosen to raise their income standards for children under 6 above the 133 percent of poverty required under current law. Ten States have established income thresholds for children age 6 through 12 higher than the 100 percent of poverty required under current law. Finally, 21 States have opted to set Medicaid income standards for children age 13 through 18 at levels higher than those under their former AFDC programs. In all cases, States with higher than minimum eligibility standards receive Federal Medicaid matching funds for the costs of covering those children made eligible as a result.

Increasingly, Medicaid coverage for children equates to enrollment, often mandatory, in managed care organizations (MCOs), many of which serve only or primarily Medicaid patients. Concerns have been raised by journalists and child health advocates regarding the quality and accessibility of covered services, including EPSDT services, for Medicaid-eligible children in some MCOs.

Most Recent Republican Proposal. The two Republican efforts to repeal Medicaid during the 104th Congress and replace it with a block grant to the States would have left many, if not most of the 18 million children now covered by Medicaid uninsured.

Under the 1996 version of the Republican Medicaid block grant (H.R. 3507, S. 1795), the current Federal entitlement to coverage for basic health care benefits for all Medicaid-eligible children would have been repealed, effective October 1, 1996. States would have been required to provide coverage for a so-called "guaranteed benefits package" to certain categories of children (e.g, those under 6 with family incomes at or below 133 percent of the poverty level, those aged 6 to 12 (phased in to 19) with family incomes at or below 100 percent of the poverty level). The so-called "guaranteed benefit package" would have included inpatient and outpatient hospital services, physician care, and early and periodic screening and diagnostic (EPSD) services (without the current "Treatment" component). However, eligible children would not have been entitled under Federal law to coverage for any services. Moreover, States would not have been required to cover these so-called "guaranteed services" when medically necessary, and States would have had complete discretion in determining the amount, duration, and scope of any of the benefits in the so-called "guaranteed benefit package" (e.g., 2 days of hospital care per year, etc).

MEDICAID COVERAGE OF CHILDREN

(August 1996 Income Eligibility Thresholds as a percentage of the Federal Poverty Guideline)

State	Infants	Children to Age 6	Children 6 to 13	Children 13 to 19
Alabama	133%	133%	100%	15%
Alaska	133%	133%	100%	76%
Arizona	140%	133%	100%	32%
Arkansas	133%	133%	100%	19%
California	200%	133%	100%	100%
Colorado	133%	133%	100%	39%
Connecticut	185%	185%	185%	81%
Delaware	185%	133%	100%	100%
District of Columbia	185%	133%	100%	39%
Florida	185%	133%	100%	28%
Georgia	185%	133%	100%	100%
Hawaii	300%	300%	300%	300%
Idaho	133%	133%	100%	28%
Illinois	133%	133%	100%	35%
Indiana	150%	133%	100%	27%
Iowa	185%	133%	100%	39%
Kansas	150%	133%	100%	100%
Kentucky	185%	133%	100%	100%
Louisiana	133%	133%	100%	18%
Maine	185%	133%	125%	125%
Maryland	185%	185%	185%	35%
Massachusetts	185%	133%	100%	52%
Michigan	185%	150%	150%	45%
Minnesota	275%	133%	100%	48%
Mississippi	185%	133%	100%	34%
Missouri	185%	133%	100%	100%
Montana	133%	133%	100%	41%
Nebraska	133%	133%	100%	34%
Nevada	133%	133%	100%	32%
New Hampshire	185%	185%	185%	185%
New Jersey	185%	133%	100%	41%
New Mexico	185%	185%	185%	185%
New York	185%	133%	100%	61%
North Carolina	185%	133%	100%	100%
North Dakota	133%	133%	100%	100%
Ohio	133%	133%	100%	32%
Oklahoma	150%	133%	100%	28%
Oregon	133%	133%	100%	100%
Pennsylvania	185%	133%	100%	39%
Rhode Island	250%	250%	100%	51%
South Carolina	185%	133%	100%	19%
South Dakota	133%	133%	100%	100%
Tennessee	185%	133%	100%	54%
Texas	185%	133%	100%	17%
Utah	133%	133%	100%	100%
Vermont	225%	225%	225%	225%
Virginia	133%	133%	100%	100%
Washington	200%	200%	200%	200%
West Virginia	150%	133%	100%	100%
Wisconsin	185%	185%	100%	48%
Wyoming	133%	133%	100%	55%

NOTE: The 1996 Federal poverty guideline for a family of 3 is \$12,980; 133% of this income level is \$17,263; 185% of this income level is \$24,013. Data in column 4 for States below 100% poverty reflects AFDC payment standard for family of 3.

SOURCE: Data from National Governor's Association (August, 1996).

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Under current law, States electing to participate in Medicaid are required to make special Medicaid payments to hospitals serving a "disproportionate share" of low-income patients. These payments are in addition to the reimbursement these "DSH" hospitals receive from the Medicaid program for providing inpatient services to eligible individuals, and they are intended to help offset the costs these facilities incur in providing care to uninsured and under-insured low-income patients. Medicaid DSH payments can be particularly important to children's hospitals, public hospitals, and other hospitals with high volumes of Medicaid patients. However, a number of States (and localities) have also used the DSH payments, in combination with provider tax or intergovernmental transfer mechanisms, to increase the amount of Federal Medicaid matching funds flowing into the State (and locality) without a commensurate increase in State (or local) funding.

CBO estimates that, in FY 1996, Federal Medicaid matching funds for payments to DSH hospitals totalled \$10.7 billion, or 11.2 percent of total Federal Medicaid spending. Over the next 7 years, Federal Medicaid DSH spending is projected by CBO to rise at an average annual rate of 5 percent, to \$14.3 billion in FY 2002 (April, 1996 baseline). In the Medicaid proposals advanced by both the President and the Coalition in the House, reductions in Federal Medicaid DSH spending accounted for 35 percent and 45 percent, respectively, of the total reductions in Federal spending sought over 7 years.

History. Since 1981, Federal Medicaid law has required States to make payment adjustments to hospitals serving a disproportionate share of low-income patients. However, States did not begin to implement this requirement until the late 1980's, when a number of them seized on the "DSH" provisions, in combination with provider taxes or donations, as a mechanism for drawing down large amounts of Federal funds. Between 1988 and 1992, Medicaid DSH spending (Federal and State) climbed from \$449 million to \$17.5 billion, an average increase of 250 percent per year. Obviously, neither the number of true "disproportionate share" hospitals, nor the number of low-income patients they served, was increasing at that rate, so Congress intervened.

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), the Congress imposed State-specific caps on the total amount of Federal Medicaid matching funds a State could draw down for payments to DSH hospitals each year. In the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), the Congress imposed facility-specific caps on the amount of Medicaid DSH payments, set at the amount of costs a hospital incurs each year in serving Medicaid and uninsured patients that is not otherwise recovered from those patients. To ease the transition for certain "high disproportionate share" public hospitals, the Congress provided for a transition period to 1995 during which they could receive up to twice their uncompensated costs of operation in Medicaid DSH payments.

Current Law. The Federal DSH payment requirements are found at sections 1902(a)(13)(A) and 1923 of the Social Security Act. Implementing regulations have been issued, 42 C.F.R. 447.296 - 447.299.

Under the "Boren" amendment, States are required to reimburse hospitals for inpatient services at rates that are "reasonable and adequate," using methods and standards that "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." States have considerable discretion in determining which facilities qualify as DSH hospitals and what the amount of DSH payment adjustments to those hospitals should be. This discretion is not unlimited, however:

- States must, at a minimum, make Medicaid DSH payments to hospitals that either (1) have a high proportion of Medicaid inpatients (i.e., a Medicaid inpatient utilization rate that is at least one standard deviation above the mean for hospitals in the State), or (2) have a high proportion of Medicaid and charity care patients (i.e., a low-income utilization rate of at least 25 percent).
- States cannot treat a hospital as a Medicaid DSH hospital unless at least 1 percent of its inpatients are covered by Medicaid.
- A State may not receive more in Federal Medicaid matching funds for payment adjustments made to all DSH hospitals in the State in a year than a fixed dollar amount determined under a statutory formula. These State-specific dollar allotments are published annually in the Federal Register by HCFA.
- A State may not make Medicaid DSH payment adjustments to any specific DSH hospital in an amount greater than 100 percent of the cost incurred by that facility in providing inpatient or outpatient services to Medicaid beneficiaries or uninsured individuals, less the amount of Medicaid and other reimbursement the hospital recovers from those patients (other than Medicaid DSH payments).

Implementation. The accompanying table shows the distribution of Federal Medicaid DSH funds among the States in FY 1995 (information on the number and types of DSH hospitals by State, and the amount of Medicaid DSH payments these facilities receive, is unavailable):

- On average, Federal DSH payments represent about 11 percent of all Federal DSH spending; however, the variation from State to State is great. As a percent of total Federal matching payments, Federal DSH payments range from less than 1 percent in Arkansas, Montana, North Dakota, South Dakota, Wisconsin and Wyoming to 28 percent in Louisiana.
- Federal DSH spending is concentrated in certain States. The 10 States with the

largest amounts of Federal DSH payments (New York, California, Texas, Louisiana, New Jersey, Pennsylvania, Missouri, Ohio, South Carolina, and Alabama) account for about 75 percent of all Federal DSH spending.

Most Recent Republican Proposal. In the 1995 version of the Republican Medicaid block grant (contained in the budget reconciliation bill, H.R. 2491, vetoed by the President on December 6, 1995), all of the current Federal statutory provisions relating to DSH would simply have been repealed. States would have been required only to describe in their block grant plans what provisions, if any, were made for expenditures for hospitals with high low-income utilization rates; however, States would not have been required to allow these hospitals to participate in the program, to reimburse them at any particular level, or to make DSH payments to them or to any other facilities. In establishing the FY 1996 block grant allotments for each State, the Republican bill incorporated historical Federal DSH payments in each State's base funding level.

The 1996 version of the Republican Medicaid block grant, as reported out by the House Commerce and Senate Finance Committees (H.R. 3734, S. 1795) followed the same approach with respect to DSH as the 1995 version. This approach, which preserved for each State the historical Federal Medicaid DSH spending while at the same time repealing the requirement that these funds actually be spent on hospitals serving disproportionate numbers of low-income patients, was to the obvious benefit of the 10 States with 75 percent of all Federal Medicaid DSH payments. All but one of these States is headed by a Republican Governor.

FEDERAL MEDICAID DSH PAYMENTS FY 1995
(Dollars in thousands)

State	Federal DSH Payments	Total Federal Payments	Federal DSH as % of Total Payments
Alabama	294,099	1,394,059	21%
Alaska	10,059	177,091	6%
Arizona	81,268	1,112,131	7%
Arkansas	2,391	898,204	less than 1%
California	1,095,718	8,603,803	13%
Colorado	92,571	840,222	11%
Connecticut	204,467	1,290,554	16%
Delaware	3,535	178,557	2%
District of Columbia	23,120	394,702	6%
Florida	188,078	3,491,022	5%
Georgia	254,569	2,244,233	11%
Hawaii	unknown	337,807	unknown
Idaho	1,460	252,325	1%
Illinois	201,734	3,132,830	6%
Indiana	124,284	1,317,242	9%
Iowa	3,833	744,861	1%
Kansas	51,979	572,952	9%
Kentucky	136,549	1,509,374	9%
Louisiana	865,245	3,037,495	28%
Maine	104,646	605,918	17%
Maryland	71,550	1,282,901	6%
Massachusetts	287,645	2,501,409	11%
Michigan	248,972	3,013,317	8%
Minnesota	16,009	233,416	7%
Mississippi	143,493	1,231,773	12%
Missouri	436,415	1,697,659	26%
Montana	168	262,959	less than 1%
Nebraska	4,000	408,115	1%
Nevada	36,780	238,628	15%
New Hampshire	52,350	382,680	14%
New Jersey	547,057	2,567,168	21%
New Mexico	4,944	592,138	1%
New York	1,511,935	12,323,482	12%
North Carolina	277,784	2,450,917	11%
North Dakota	827	211,647	less than 1%
Ohio	382,301	3,862,724	10%
Oklahoma	16,317	841,519	2%
Oregon	19,566	960,995	2%
Pennsylvania	521,376	4,197,870	12%
Rhode Island	61,539	566,799	11%
South Carolina	310,952	1,448,377	21%
South Dakota	730	221,120	less than 1 %
Tennessee	unknown	2,229,545	unknown
Texas	957,899	5,716,963	17%
Utah	3,324	427,232	1%
Vermont	17,583	219,164	8%
Virginia	33,989	1,071,279	3%
Washington	174,392	1,587,788	11%
West Virginia	64,044	972,244	7%
Wisconsin	6,581	1,540,917	less than 1%
Wyoming	unknown	111,154	unknown
Total:	9,950,127	87,509,281	11%

SOURCE: Data reported by the States to the Health Care Financing Administration.

FEDERAL MEDICAID MATCHING FORMULA

Medicaid is financed through Federal dollars matching State expenditures. If a State chooses to participate in Medicaid, it is entitled to have the amount of State funds it spends on behalf of eligible populations for covered services matched by the Federal government at a specified rate. In the case of State spending for acute and long-term care services, this rate, which is determined under a statutory formula described below, varies from 50 to 83 percent, depending on a State's per capita income. In the case of State spending for administration, the Federal matching rate is set at 50 percent, with exceptions for certain functions (such as nursing home inspections) that are matched at higher rates. On average, the Federal government pays at least 57 percent of the cost of the program. In reality, the Federal share is higher because of techniques that some States have used to substitute Federal dollars for the State dollars that should be used to draw down Federal Medicaid matching funds.

History. The current Medicaid matching formula was first enacted in 1965, when the program was created. Despite criticism of the formula from GAO and others for its dependence on per capita income, the formula has not been significantly altered since that time. The same matching formula was also used in the Aid to Families with Dependent Children (AFDC) program, which the welfare law (P.L. 104-193) repealed.

Current Law. The current matching formula, known technically as the Federal Medical Assistance Percentage (FMAP), is found at section 1905(b) of the Social Security Act.

The statutory formula for calculating each State's Federal matching rate is:

$$[1 - (\text{State per capita income}^2 / \text{National per capita income}^2) * .45]$$

Under this formula, a State's Federal Medicaid matching rate is based on the ratio of its per capita income to the average per capita income of all States. States with per capita incomes above the national average receive a lower Federal matching percentage; States with per capita incomes below the national average receive higher percentages. The formula is constructed so that the Federal government will never match less than 50 percent or more than 83 percent of a State's spending. The percentages are recalculated each Federal fiscal year based on State and national income data from the most recent 3-year periods.

This formula applies to State spending on all covered services except family planning services and supplies, for which current law specifies a Federal matching rate of 90 percent in all States.

Here's how Federal-State matching works. Say that a State has a Federal matching rate of 57 percent. If it spends \$100 on Medicaid services for eligible

individuals, the State is entitled to receive \$57 from the Federal government in Medicaid matching payments. The remaining \$43 is the State's share. If the State's rate increases to 70 percent, it will receive \$70 from the Federal government, and its share will be \$30.

Implementation. The accompanying table shows each State's Federal matching rates under the statutory formula for both FY 1996 and FY 1997. Eleven States and the District of Columbia, the majority of which are from the Northeast or Mid-Atlantic region, have statutory matching rates of 50 percent in FY 1997 (Alaska, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, and New York). Nine States, all of which are in the South or the West, have statutory matching rates of more than 70 percent in FY 1997 (Arkansas, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Utah, West Virginia).

In a number of instances, the statutory formula understates the actual proportion of the cost of a State's Medicaid program that the Federal government is assuming.

In the case of Louisiana, the effective Federal matching rate for most of FY 1996 was not the statutory formula rate of 71.9 percent, but 84.3 percent. For most of FY 1997, Louisiana's effective matching rate will be 81.6 percent, not the statutory formula rate of 71.4 percent. This matching rate enhancement was authorized in section 519 of the Omnibus FY 1996 Appropriations Act (P.L. 104-134).

The more common reason that some States have actual Federal matching rates higher than those determined under the statutory formula is that they have used what GAO calls "creative financing mechanisms," including intergovernmental transfers, provider taxes, and disproportionate share (DSH) hospital payments, to effectively replace State share funds with Federal matching funds. The GAO describes how one State used intergovernmental transfers to raise its effective Federal matching rate in FY 1993 from the statutory rate of 56 percent to an actual rate of 68 percent:

- ...Michigan's 1994 DSH program included a single \$489 million payment to the University of Michigan Hospital... This single payment included \$276 million in Federal matching funds and \$213 million in State funds. On the same day that it received the payment, the hospital returned the entire amount to the State through an intergovernmental transfer. As a result, the State realized a net benefit of \$276 million from the federal share of the DSH payment that the State could use to fund \$633 million in additional Medicaid payments. (GAO/HEHS-96-76R State Medicaid Financing Practices).

Although the Congress in 1991 and 1993 enacted restrictions on provider taxes and DSH payments to limit their use as "creative financing mechanisms," there are no direct restrictions on the use of intergovernmental transfers. However, the facility-specific caps on DSH payments enacted in OBRA '93 (limiting the total amount of DSH payments to the facility's uncompensated costs of serving Medicaid and uninsured

patients) has had the effect of limiting the use of intergovernmental transfers by some State and county hospitals.

Most Recent Republican Proposal. In the 1996 version of the Republican Medicaid block grant, H.R. 3507/S. 1795, States would be given three options for a Federal Medicaid matching rate (FMAP): (1) the current law FMAP; (2) a minimum FMAP of 60 percent; or (3) the lesser of (a) a new FMAP or (b) the current law FMAP plus 10 percentage points. The new FMAP would use a State's total taxable resources (TTR) rather than per capita income as a measure of State fiscal capacity, and would also include a measure of relative need for Medicaid spending.

The accompanying table shows estimates by the Congressional Research Service of the Federal matching rates that would apply in each State in FY 1996 under the Republican proposal, assuming each State chose the option most favorable to it. On average, the Federal share rises from 57 to 63 percent. Twenty two States (and the District of Columbia) benefit from the option allowing them to increase in the minimum Federal share to 60 percent.

Of course, the Republicans proposed this change in the Federal matching formula in the context of a repeal of the current Medicaid entitlement and the enactment of a new block grant to the States. In the context of a block grant, raising the average Federal share from 57 to 63 percent of program costs does not result in increased Federal outlays, since the block grant itself puts an absolute limit on how much each State will receive in Federal matching payments each year. If this change in the Federal matching formula were proposed in the context of the current open-ended matching program, it could cost the Federal government tens of billions of dollars.

Raising the average Federal matching rate as the Republicans proposed in their block grant could drastically reduce the total State and Federal funds going to health and long-term care for the poor. This is because under a block grant, with its limit on the total Federal matching funds available, a higher Federal matching rate means that a State will be able to receive the same amount of Federal funds for a smaller State expenditure. Moreover, once the State hits its limit on available Federal block grant funds, every additional dollar it spends on Medicaid will bring in no new Federal funds. In short, the State has strong incentives to withdraw some of its current State funding.

For example, assume Federal matching payments under the Republican block grant are capped at \$100. If a State has a Federal matching rate of 50 percent, it can spend \$200 on Medicaid, with \$100 coming back from the Federal government in the form of matching payments. However, if, as the Republicans have proposed, the State's Federal matching rate is increased from 50 to 60 percent, then the State only has to spend \$66.67 in order to receive \$100 in Federal matching funds (the State spends \$166.67, of which 60 percent, or \$100, is matched by the Federal government). The change in the matching rate alone has reduced total Federal and State spending on Medicaid services for the poor by almost 17 percent: from \$200 to \$166.67.

FEDERAL MEDICAID MATCHING RATES

State	Current FMAP FY 1996	Current FMAP FY 1997	Republican Block Grant FMAP FY 1996
Alabama	70%	70%	70%
Alaska	50%	50%	60%
Arizona	66%	66%	66%
Arkansas	74%	73%	74%
California	50%	50%	60%
Colorado	52%	52%	60%
Connecticut	50%	50%	60%
Delaware	50%	50%	60%
District of Columbia	50%	50%	60%
Florida	56%	56%	66%
Georgia	62%	62%	62%
Hawaii	50%	50%	60%
Idaho	69%	68%	69%
Illinois	50%	50%	60%
Indiana	63%	62%	63%
Iowa	64%	63%	64%
Kansas	59%	59%	60%
Kentucky	70%	70%	73%
Louisiana	72%	71%	78%
Maine	63%	64%	63%
Maryland	50%	50%	60%
Massachusetts	50%	50%	60%
Michigan	57%	55%	62%
Minnesota	54%	54%	60%
Mississippi	78%	77%	79%
Missouri	60%	60%	62%
Montana	69%	69%	69%
Nebraska	60%	59%	60%
Nevada	50%	50%	60%
New Hampshire	50%	50%	60%
New Jersey	50%	50%	60%
New Mexico	73%	73%	73%
New York	50%	50%	60%
North Carolina	65%	64%	65%
North Dakota	69%	68%	69%
Ohio	60%	59%	60%
Oklahoma	70%	70%	70%
Oregon	61%	61%	61%
Pennsylvania	53%	53%	60%
Rhode Island	54%	54%	60%
South Carolina	71%	70%	71%
South Dakota	67%	65%	67%
Tennessee	66%	65%	68%
Texas	62%	63%	67%
Utah	73%	72%	73%
Vermont	61%	61%	61%
Virginia	51%	52%	60%
Washington	50%	51%	60%
West Virginia	73%	73%	78%
Wisconsin	60%	59%	60%
Wyoming	60%	60%	60%
United States:	57%	57%	63%

SOURCE: Congressional Research Service, "Medicaid Reform: Estimates of the Distribution of Federal Funds Under H.R. 3507/S.1795," 96-704 EPW (July 24, 1996).

FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Clinics have long been an important source of outpatient care in rural and urban areas -- not just for Medicaid beneficiaries, but also for families with private health insurance and for the uninsured. The Federal Medicaid statute gives special coverage and reimbursement status to two types of free-standing (i.e., not part of a hospital) clinics: Federally-qualified health centers (FQHCs), and rural health clinics (RHCs). The services delivered by these clinics must be included in each State's basic Medicaid benefits package, and each State's Medicaid payment rates must cover the costs incurred by these clinics in providing those services.

Nationwide, about 1800 FQHCs and 2500 RHCs benefit from these statutory protections, which are intended to help make these clinics financially stable -- and therefore available as a source of outpatient care to underserved residents of the rural and urban areas in which they are located. The recent trend toward enrollment of Medicaid beneficiaries in managed care organizations (MCOs) has major implications for the continued financial viability of many FQHCs and RHCs.

History. Since the enactment of the Medicaid program in 1965, States have had the option of covering clinic services as part of their Medicaid benefits package and receiving Federal Medicaid matching funds for the cost of those services. States have broad discretion in defining clinic services (they include "any preventive, diagnostic, therapeutic, or rehabilitative services furnished at the clinic by or under the direction of a physician"). States also have broad discretion in setting payment rates for these services (there is no statutory floor under these payment levels).

In the Rural Health Clinic Amendments of 1977, P.L. 95-210, the Congress made rural health clinic (RHC) services one of the benefit categories that States are required to cover under Medicaid for the mandatory eligibles. Congress also required that States pay for RHC services at rates equal to 100 percent of the reasonable costs of providing these services (P.L. 95-210 also made RHC services a benefit under Medicare). State payments for RHC services are matched with Federal Medicaid funds at each State's regular matching rate. The purpose of the legislation was to increase access to health care for residents of rural medically underserved areas by assuring that physicians, as well as other practitioners such as physician assistants and nurse practitioners, would be adequately paid for the services they delivered to Medicare and Medicaid patients.

In OBRA '89 (P.L. 101-239), the Congress applied the coverage and reimbursement strategy of the 1977 RHC legislation to another category of clinics: Federally-qualified health centers, or FQHCs. Again, the Congress required that States include the ambulatory services delivered by FQHCs as a covered Medicaid benefit for the mandatory eligibles. The Congress also specified that States pay the FQHCs at rates equal to 100 percent of the reasonable cost of delivering these services. (In OBRA '90, P.L. 101-508, Congress made FQHC services a Medicare benefit). The purpose of the