

OBRA '89 policy was to assure that FQHCs, whether in urban or rural areas, would not have to cross-subsidize part or all of the cost of caring for Medicaid beneficiaries due to low Medicaid payment rates or restrictive Medicaid coverage.

Current Law. FQHC services are defined at section 1905(l)(1) of the Social Security Act, RHC services at section 1905(l)(2). FQHC and RHC services are set forth as part of the basic Medicaid benefit package at section 1905(a)(2)(B) and (C), respectively. The requirement that States reimburse on a cost basis is found at section 1902(a)(13)(E).

FQHCs. The FQHC provider category includes 3 main types of clinics:

- community health centers, migrant health centers, health care for the homeless programs, and public housing clinics that receive Federal grant funds under section 330 of the Public Health Service (PHS) Act to deliver primary care to medically underserved populations; in 1995, according to the National Association of Community Health Centers, there were 635 such centers delivering care through some 2400 sites.
- "look-alike" clinics that do not actually receive Federal grant funds under section 330 of the PHS Act but which the Secretary of HHS, through the Public Health Service, certifies as meeting the requirements for receiving such funds; according to HCFA, there were 214 "look-alike" clinics in FY 1995.
- outpatient health programs or facilities operated by Indian tribes or by urban Indian health organizations; according to HCFA, there were 42 such clinics in FY 1995.

Clinics certified by the Secretary of HHS as FQHCs for purposes of the Medicare program, which also covers the services of these providers, are automatically qualified as FQHCs for purposes of Medicaid.

With respect to fee-for-service Medicaid patients, FQHCs are entitled to payment from the Medicaid program for "100 percent of costs which are reasonable and related to the costs of furnishing [FQHC] services." By regulation, 42 C.F.R. 447.371, the Secretary of HHS has imposed a national cap on Medicaid (and Medicare) payments for a patient visit, which is updated annually. The 1995 cap levels for FQHC payments were \$84.47 per visit in an urban area and \$72.63 in a rural area.

RHCs. To be certified as an RHC, a clinic must, among other things: (1) provide both physician and physician assistant or nurse practitioner services primarily on an outpatient basis; (2) have a nurse practitioner, physician assistant, or certified nurse midwife available at least 50 percent of the time the clinic operates; and (3) be located in a non-urbanized area that has been designated by the Secretary of HHS as an area with a shortage of primary health care practitioners.

RHCs, like FQHCs, are entitled to payment under the Medicaid program for "100 percent of costs which are reasonable and related to the costs of furnishing [RHC] services." By regulation, the Secretary has imposed a cap on the Medicaid (and Medicare) payment per visit, which is updated annually. In 1995 the RHC cap was set at \$55.53 per visit.

Clinics certified by the Secretary as RHCs for purposes of the Medicare program are automatically qualified as RHCs for purposes of Medicaid.

FQHCs and RHCs. Although the majority of FQHCs are rural (398 out of 635 in 1995), FQHCs and RHCs are different. The 3 main differences stem from requirements in the PHS Act to which FQHCs are subject (and RHCs are not): (1) FQHCs typically offer a broader range of services than do RHCs, including pharmacy services, dental care, and "enabling" services such as outreach, transportation, and health education; (2) FQHCs must be either private non-profit or public, while RHCs may be for-profit, non-profit, or public; and (3) FQHCs are required to serve all residents of their service areas, regardless of ability to pay, while RHCs are not obligated to serve the uninsured.

Managed Care. As discussed elsewhere in this Briefing Book, States have the option of entering into contracts with managed care organizations (MCOs) to provide covered services specified by the State to Medicaid eligibles on a risk basis. States may continue to pay for RHC or FQHC services for managed care enrollees directly on a fee-for-service basis ("carving" these services out of the contract with the MCO), or, as is more commonly the case, they may include these services within their contract with the MCO. In this circumstance, the capitation rate paid by the State to the MCO must "reflect fully" the 100 percent of reasonable cost rate to which FQHCs are entitled. The FQHC, in turn, has the right to payment from the MCO at 100 percent of reasonable cost, or it can elect to negotiate a different rate in connection with negotiations on patient referrals, risk, and other issues. There is no similar statutory requirement with respect to RHCs, although States must still cover the RHC benefit.

CBO Estimates. In April, 1995, CBO staff estimated that repealing the requirement that FQHCs be reimbursed on a reasonable cost basis would reduce Federal Medicaid spending by \$50 to \$60 million per year. Thus, over 6 years, the maximum savings that CBO would have attributed to this policy change in 1995 would be about \$360 million. Although it is not possible to predict how CBO would estimate this change in 1997, it is unlikely that the Federal savings would be any greater, since the number of FQHCs receiving payments from managed care plans rather than on a fee-for-service, reasonable cost basis has increased.

Implementation. The accompanying table shows the number of RHCs in each State, as well as the amount of Federal Medicaid matching funds flowing to these providers in the States for which information was available. According to a July, 1996, report by the HHS Inspector General, the number of RHCs has been growing rapidly in recent years;

nearly 90 percent of the 2,530 RHCs as of October, 1995, were certified since 1991 ("Rural Health Clinics: Growth, Access, and Payment," OEI-05-94-00040). As of October, 1995, about 60 percent of all the RHCs were concentrated in 11 States (California, Florida, Arkansas, Georgia, Illinois, Iowa, Kansas, Missouri, Mississippi, North Carolina, and Texas).

The table contains data (supplied by the National Association of Community Health Centers) on the number of FQHCs participating in Medicaid in each State during 1995 and the amount of Federal Medicaid funds received by those FQHCs in that year, based on revenue data supplied by the FQHCs. During 1995, Medicaid accounted for about 36 percent of the revenues, on average, of community health centers, migrant health centers, and other FQHCs receiving Federal grants, according to the National Association.

Most Recent Republican Proposal. The 1996 version of the Republican Medicaid block grant (H.R. 3507, S. 1795) would have repealed not only the current entitlement of Medicaid eligibles to coverage for services delivered by FQHCs or RHCs, but also the requirement that States pay for those services on a reasonable cost basis. Instead, the 1996 version of the Republican Medicaid block grant would have required that States to spend a minimum amount under their block grants on FQHC and RHC services, set at 85 percent of what the State paid for these services in FY 1995; States could lower this "set aside" amount beginning in FY 2001. The legislation also required States to pay for FQHC and RHC services on a reasonable cost basis for the first 2 years of implementation of the block grant; thereafter, they would have had complete discretion with respect payment levels.

While the Republicans were unsuccessful in repealing the current Medicaid statutory protections for FQHCs and RHCs, the 104th Congress did enact a change in the Public Health Service Act authorizations for the FQHCs. P.L. 104-[] consolidates the separate authorizations for community health centers, migrant health centers, health care for the homeless programs, and public housing clinics, into one authorization (section 330 of the PHS Act). The new law continues to authorize the Secretary of HHS to make grants for the operation of health centers delivering primary health services to medically underserved populations, subject to the appropriation of such sums as may be necessary for each fiscal year through FY 2000. Clinics receiving these grant funds will continue to qualify as Medicaid (and Medicare) FQHCs.

MEDICAID FQHCS AND RHCS
(Dollars in Thousands)

State	FQHCS (as of 1995)	RHCS (as of 10/95)	Federal Matching Funds for FQHC Services (FY 1995)	Federal Matching Funds for RHC Services (FY 1995)
Alabama	17	61	14,306	2,146
Alaska	15	9	1,801	47
Arizona	17	7	12,783	0
Arkansas	9	95	3,567	2,094
California	99	146	63,391	77,633
Colorado	18	26	11,882	268
Connecticut	12	0	8,880	0
Delaware	4	0	785	0
District of Columbia	4	0	733	0
Florida	35	98	20,500	17,472
Georgia	21	90	8,991	4,523
Hawaii	13	2	3,226	0
Idaho	8	22	2,380	760
Illinois	35	113	13,222	5,793
Indiana	7	12	3,132	196
Iowa	6	98	2,454	1,655
Kansas	8	133	2,434	1,902
Kentucky	12	34	9,388	3,637
Louisiana	12	49	5,991	2,300
Maine	14	26	3,807	300
Maryland	12	0	32,727	0
Massachusetts	27	0	12,355	0
Michigan	33	82	13,593	1,671
Minnesota	15	36	3,971	unknown
Mississippi	22	139	14,262	10,113
Missouri	14	115	10,630	5,027
Montana	10	24	1,891	703
Nebraska	4	57	1,174	161
Nevada	9	1	1,324	257
New Hampshire	6	14	1,342	680
New Jersey	12	0	11,059	0
New Mexico	19	10	7,144	1,908
New York	47	11	64,130	unknown
North Carolina	21	105	6,747	5,870
North Dakota	4	69	833	1,543
Ohio	18	4	14,338	720
Oklahoma	22	78	3,847	2,157
Oregon	14	21	8,435	unknown
Pennsylvania	32	33	16,023	5,174
Rhode Island	11	1	5,749	55
South Carolina	21	52	8,886	3,465
South Dakota	10	44	1,208	899
Tennessee	20	70	9,856	256
Texas	42	367	18,618	unknown
Utah	7	14	2,243	143
Vermont	2	16	555	1,287
Virginia	22	27	3,632	864
Washington	23	32	16,219	876
West Virginia	28	41	11,530	12,615
Wisconsin	16	33	16,929	696
Wyoming	4	13	712	138
Total:	913	2,530	515,615	178,004

SOURCE: FQHC data (columns 1 and 3) from National Association of Community Health Centers.

RHC data (columns 2 and 4) from Office of Inspector General, DHHS, "Rural Health Clinics: Growth, Access, and Payments," (July, 1996).

FLEXIBILITY

The financing and the administration of Medicaid are shared by the Federal and State governments. Inherent in such a program structure is a tension over the amount of managerial and fiscal discretion available to the States, which run the program on a day-to-day basis. Because the Federal government pays, on average, at least 57 percent of the program's cost, and because the Federal investment is close to \$100 billion per year, there is a strong Federal interest in assuring State accountability for the efficient and effective expenditure of these Federal funds. States, on the other hand, implement and managed the Medicaid program. They have a natural interest in maximizing the amount of Federal Medicaid funds they receive and determining – in their sole discretion – the purposes to which those funds will be applied. This tension between these State and Federal interests defines the issue of "State flexibility."

From the standpoint of the Republican Governors, States have little flexibility under the current Medicaid program. In testimony before the Congress in April, 1996, Governor Engler of Michigan denounced what he described as "micromanagement" of Medicaid by Washington bureaucrats," which he contended was adding "billions of dollars" to health care costs in this country. (The purest legislative statement of the Republican Governors' view of "flexibility" was the Medicaid block grant proposal reported by the House Commerce Committee on September 22, 1995, and incorporated into the 1995 Budget Reconciliation bill (H.R. 2491)).

The Congressional Budget Office does not share Governor Engler's view. To the contrary, it believes that States have "significant flexibility" under the current Medicaid program. In a June 10, 1996, letter to Representative Thomas J. Bliley (R-VA.), June O'Neill, the Director of CBO, explained that capping Federal Medicaid spending on a per capita basis would not constitute an unfunded mandate because "states would have significant flexibility to offset reductions in federal funding with reductions in optional services and beneficiaries.... Courses of action available to states include eliminating or reducing some optional services, such as prescription drugs or dental services, and not serving some optional beneficiaries, such as the medically needy or pregnant women and children whose family income is between 133 percent and 185 percent of poverty. These options provide substantial flexibility to states. A frequently cited figure is that 60 percent of Medicaid spending is optional. Even though this flexibility varies dramatically between states, all states have significant flexibility."

The "significant flexibility" that States currently enjoy under Medicaid with respect to eligibility, benefits, provider payment, and other elements of the program has produced a startling variation in Medicaid spending from State to State. For example, in 1995, total Medicaid spending (Federal and State) varied from \$7,750 per beneficiary in New York to \$3,857 in Illinois to \$3,013 in California. (The Federal Medicaid matching rate in each of these States is 50 percent).

Current Law: Flexibility States Have. State participation in Medicaid is entirely voluntary; there is no statutory or constitutional requirement that States use Federal Medicaid funds to help pay for health and long-term care services for the poor. Moreover, those States that choose to participate have what CBO describes as "significant flexibility" in administering their programs. For example:

Eligibility. While there are certain categories of individuals that States must cover -- the "mandatory" eligibles -- there are at least 12 statutory categories of individuals that the States may cover with the assistance of Federal Medicaid matching funds. These "optional" eligibles range from aged or disabled individuals with high nursing home, prescription drug, or other medical expenses (the "medically needy") to pregnant women and infants with incomes between 133 and 185 percent of poverty.

Benefits. In order to receive Federal Medicaid matching funds, States must cover a specified set of services for the "mandatory" eligibles (although they have some discretion in limiting the amount, duration, or scope of those services). However, there are at least 15 types of services that States may cover and for which they may obtain Federal Medicaid matching funds. These "optional" services range from prescription drugs to clinic services to case management services to hospice care. States may also cover home and community-based services under "section 1915(c)" waivers.

Provider Payment. For most types of practitioners, including physicians, as well as many other provider categories, such as clinical labs, States have essentially complete discretion in determining Medicaid payment rates. One exception is the physicians serving children or pregnant women; States must show that their rates are sufficient to enlist enough of these providers so that care and services are available to Medicaid beneficiaries at least to the extent that they are available to the general population in the area. (Other exceptions on payment discretion are described below).

Managed Care. States have the option of offering Medicaid beneficiaries the choice of enrolling in managed care organizations (MCOs) rather than receiving care on a fee-for-service basis; however, in order to receive Federal matching funds, States may only contract with MCOs that also serve some privately-sponsored enrollees. In addition, States have the option, under a "section 1915(b)" waiver, of restricting Medicaid beneficiaries to a choice among primary care case management (PCCM) programs, if the restriction does not substantially impair access to services of adequate quality where medically necessary (as of June 30, 1995, according to HCFA, States had enrolled over 3.6 million Medicaid beneficiaries in PCCMs under these waivers).

Waivers. States have the option of using Federal Medicaid funds to cover acute care benefits exclusively through managed care organizations. However, States need waivers of certain Federal requirements in order to do so. The Secretary of HHS has exercised her authority under section 1115 of the Social Security Act to grant such "statewide Medicaid demonstration" waivers to 15 States. (See discussion of section 1115 Medicaid waivers elsewhere in this Briefing Book).

Current Law: Flexibility States Do Not Have. While States have what CBO has described as “significant flexibility” under Medicaid, they do not have unlimited flexibility. There are a number of areas in which the States do not have as much managerial discretion as many of them would like. Among the most contentious are:

Boren Amendment. This requires States to pay hospitals and nursing homes for inpatient services delivered to Medicaid beneficiaries using rates that are “reasonable and adequate.” (See separate discussion elsewhere in this Briefing Book).

FQHCs/RHCs. Under current law, State Medicaid programs must cover services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), and they must pay those entities 100 percent of their reasonable cost of delivering these services to Medicaid patients. This payment floor has been waived under the terms of some section 1115 Medicaid waivers. (See separate discussions of FQHCs and RHCs, and section 1115 waivers, elsewhere in this Briefing Book).

EPSDT. All children eligible for Medicaid are entitled to have payment made on their behalf for early and periodic screening, diagnostic, and treatment (EPSDT) services. The “T” or “treatment” element of the EPSDT benefit includes all necessary health care services to correct physical or mental illnesses or conditions discovered during an EPSDT screening, whether those services are otherwise covered under the State’s Medicaid program for other populations. (See discussion of Medicaid coverage of children elsewhere in this Briefing Book).

Managed Care. Except in the case of a section 1115 Medicaid demonstration waiver, States may not require Medicaid beneficiaries to enroll in managed care organizations that serve only Medicaid patients. States are also required to reimburse all managed care organizations with which they contract to enroll Medicaid beneficiaries using capitation rates that are set on an “actuarially sound basis.” (See discussions of Managed Care and of section 1115 Waivers elsewhere in this Briefing Book).

QMBs and Dual Eligibles. Under current law, States cannot require Medicare beneficiaries for whom Medicaid pays premiums and deductibles and coinsurance (known as QMBs), or Medicare beneficiaries for whom Medicaid also pays for prescription drugs and nursing home care (known Dual Eligibles), to enroll in managed care organizations (MCOs) to receive hospital, physician, and other services covered by Medicare. (See discussion elsewhere in this Briefing Book).

Most Recent Republican Proposal. Under both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1791), the States would have received virtually unlimited flexibility in designing and administering their block grant programs (including all 5 issues above) in exchange for a State-specific cap on the Federal government’s financial exposure for the costs of health and long-term care services for low-income Americans.

MANAGED CARE

A sea change is taking place in the way in which Medicaid pays for physician, hospital, and other acute care. Historically, Medicaid, like Medicare and private employer health plans, paid for such care largely on a fee-for-service basis. Medicaid is now in transition toward paying for acute care largely through managed care organizations (MCOs), reimbursing them on a prepaid, capitated basis (a fixed amount per enrollee per month). As of July 1, 1995, 3.3 million Medicaid beneficiaries were enrolled in 158 health maintenance organizations (a type of MCO that assumes full financial risk for the services contracted); this represented an increase of 630,000, or 23 percent, in the number of Medicaid enrollees in just one year. Medicaid beneficiary enrollment in MCOs will continue to increase over the next few years as States seek cost savings (through reductions in use of emergency rooms and hospital care) and, in the view of the States and managed care advocates, improved access and quality for beneficiaries.

The implications of this sea change are profound. MCOs face dramatically different financial incentives than do fee-for-service providers. In fee-for-service, hospitals and physicians can maximize net revenue by increasing the number of services delivered; under prepayment, providers can maximize net revenue by reducing the amount of care delivered. Medicaid beneficiaries who are required to enroll in MCOs are at risk for restricted access and lower quality care if the primary objective of the MCOs, knowing that their enrollees are "locked in," is to maximize net revenue by withholding the delivery of services, especially costly ones. In the absence of effective oversight, MCOs will continue to receive a monthly capitation payment from the State for each Medicaid enrollee regardless of the level of services actually provided.

From the Federal government's standpoint, the transition to managed care raises a host of fiscal integrity issues. In a largely fee-for-service system, Medicaid payments are disbursed by the States among a relatively large number of participating hospitals and physicians and other providers. In a largely managed care environment, Medicaid payments are channelled through a relatively small number of plans under what are often multi-year, multi-million dollar contracts with the States. The Federal government, which finances on average 57 percent of the cost of Medicaid, has the majority financial stake in these contracts. (No information is available as to how many Federal Medicaid matching dollars are paying for managed care).

Unquestionably, the shift from fee-for-service to managed care does provide States with more predictability as to their Medicaid expenditures. However, whether there are significant long-term savings to be had for either the States or the Federal government is still at issue. In April, 1995, CBO staff estimated that Federal savings from requiring the enrollment of all Medicaid beneficiaries in managed care would be only \$2.5 billion over a 7-year period. Whether CBO would provide a comparable estimate for this policy in 1997 is uncertain.

History. States have been contracting with managed care plans to deliver services to Medicaid beneficiaries since 1967, shortly after Medicaid was enacted. The first State to attempt to expand managed care enrollment on a systematic basis was California. In the early 1970's, during Governor Ronald Reagan's administration, the State entered into numerous contracts with MCOs (then called prepaid health plans, or PHPs), many of which were formed solely for the purpose of marketing to Medicaid beneficiaries. The General Accounting Office and other investigators documented marketing abuses, instances of underservicing and poor quality care, and profiteering and diversion of Federal health care funds.

These abuses prompted the Congress, in 1976, to enact minimum Federal requirements for State Medicaid contracts with managed care plans (P.L. 94-460). Among other things, these requirements specified that no more than 50 percent of a plan's enrollees could be Medicaid or Medicare-eligible (new plans were given 3 years to enroll sufficient commercial patients to meet this requirement). The purpose of this requirement was to stop the flow of Federal Medicaid funds to plans serving exclusively Medicaid eligibles, several of which had been closely associated with the most serious abuses. In addition, Federal Medicaid matching funds could generally only be paid to those managed care plans that were Federally qualified HMOs under Title XIII of the Public Health Service Act.

In 1981, at the urging of the Reagan Administration, the Congress relaxed these minimum Federal requirements (OBRA '81, P.L. 97-35). States were allowed to use Federal Medicaid funds to contract with managed care plans other than Federally-qualified HMOs, if the State determined the plan had the capacity to provide covered services. The 50 percent Medicare/Medicaid enrollment limitation was raised to 75 percent (the 3-year grace period continued to apply to all new plans); this requirement is now known as the "75-25 rule." Medicaid beneficiaries were given the right to disenroll from a managed care plan without cause upon one month's notice, enabling them to protect themselves against underservicing or poor quality care. Finally, the Secretary was given authority to grant "section 1915(b)" waivers to States to allow them to require beneficiaries to enroll in primary care case management (PCCM) plans.

Current Law. The current Federal minimum requirements governing the use of Federal matching funds by States in contracting with managed care plans are found at section 1903(m) of the Social Security Act. Implementing regulations are found at 42 C.F.R. 434.20 - 434.80 and 447.361 (upper limit on capitation rate).

The current law right of Medicaid beneficiaries to obtain covered services from any provider that elects (and is qualified to) to participate in the program -- the so-called "freedom of choice" of provider -- is set forth at section 1902(a)(23) of the Social Security Act. Implementing regulations are at 42 C.F.R. 431.51.

The Secretary has two separate authorities for waiving some or all of these requirements:

- Section 1915(b) of the Act (42 C.F.R. 430.25, 431.55) authorizes the Secretary to enable States to restrict beneficiary freedom of choice by limiting them to enrollment in managed care plans; however, these plans must meet the 1903(m) requirements, including the "75-25 rule."
- Section 1115 of the Act authorizes the Secretary to grant waivers to enable States to carry out broad Medicaid "demonstrations;" these include waivers of the "75-25 rule," the voluntary one-month disenrollment requirement, and the beneficiary "freedom of choice" provision. Under these waivers, States are mandating enrollment into managed care plans serving only Medicaid eligibles.

Implementation. While virtually all States are moving to increase Medicaid beneficiary enrollment in managed care, some States are much farther along than others. The accompanying table shows total Medicaid beneficiary enrollment by State, as of July 30, 1995, in MCOs that assume full financial risk for all covered acute care services. These figures do not include beneficiaries enrolled in mental health or dental managed care plans, or beneficiaries enrolled in primary care case management plans and other MCOs that assume financial risk only for some acute care services. Medicaid enrollment in these MCOs in 1995 varied widely as a percentage of total Medicaid recipients that year, from as low as 0 percent in Alabama to as high as 77 percent in Hawaii.

The recent rapid expansion of Medicaid beneficiary enrollment in managed care has not been without its problems. Over the past five years, the press has reported instances of marketing fraud (Illinois, Maryland, New York, Tennessee, Virginia); denial of covered, medically necessary services for which States contracted (Florida, New York, Ohio); failure to reimburse non-plan hospitals (and their ER physicians) for emergency care provided to plan enrollees (Florida, Ohio); and profiteering or excessive administrative costs (Florida, Ohio, Pennsylvania) on the part of MCOs serving exclusively Medicaid patients.

Most Recent Republican Proposal. In both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507/S. 1795), the current Federal statutory rules relating to Medicaid managed care contracting and enrollment would be repealed. Under the Republican block grant, States would have virtually unlimited discretion in contracting with MCOs and enrolling beneficiaries in them. The States would be subject to only two requirements in buying managed care with Federal block grant funds: (1) managed care plans at full financial risk would have to meet State solvency standards applicable to private HMOs, and (2) States would have to disclose to the public the amounts of capitation payments made to MCOs (unless State law treats this information as proprietary). All other issues, ranging from plan qualifications to capitation rates to marketing and enrollment practices, would be left to the sole discretion of the States.

MEDICAID MANAGED CARE
(FY 1995)

State	Medicaid Enrollees		Total Medicaid Eligible	Acute Care Full Risk Managed Care Enrollees as % of Total Medicaid Eligibles
	Managed Care Plans	In Full Risk Acute Care Managed Care Plans		
Alabama	1	0	539,251	0%
Alaska	none reported	none reported	68,117	0%
Arizona	15	337,213	493,893	68%
Arkansas	1	0	353,370	0%
California	48	704,568	5,016,645	14%
Colorado	7	40,175	293,723	14%
Connecticut	none reported	none reported	380,327	0%
Delaware	1	6,593	78,555	8%
District of Columbia	5	2,661	138,444	2%
Florida	27	432,754	1,735,141	25%
Georgia	3	0	1,147,443	0%
Hawaii	7	153,879	200,000	77%
Idaho	1	0	115,014	0%
Illinois	5	142,268	1,551,948	9%
Indiana	2	35,000	558,020	6%
Iowa	6	25,150	304,304	8%
Kansas	1	0	255,702	0%
Kentucky	1	0	640,930	0%
Louisiana	1	0	785,388	0%
Maine	1	0	153,180	0%
Maryland	7	119,691	414,261	29%
Massachusetts	17	73,930	727,506	10%
Michigan	18	265,300	1,168,435	23%
Minnesota	11	140,527	473,420	30%
Mississippi	1	0	519,697	0%
Missouri	5	31,713	695,458	5%
Montana	1	0	98,708	0%
Nebraska	none reported	none reported	168,383	0%
Nevada	5	0	105,233	0%
New Hampshire	2	10,985	96,954	11%
New Jersey	9	93,893	789,666	12%
New Mexico	1	0	286,763	0%
New York	48	583,914	3,035,477	19%
North Carolina	3	132,419	1,084,337	12%
North Dakota	1	0	61,383	0%
Ohio	14	211,680	1,532,547	14%
Oklahoma	none reported	none reported	393,613	0%
Oregon	36	246,877	451,959	55%
Pennsylvania	9	461,542	1,230,193	38%
Rhode Island	5	60,479	135,230	45%
South Carolina	3	29	495,500	less than 1%
South Dakota	1	0	74,077	0%
Tennessee	12	803,265	1,466,194	55%
Texas	2	0	2,561,957	0%
Utah	7	39,664	160,408	25%
Vermont	none reported	none reported	99,693	0%
Virginia	5	54,202	681,313	8%
Washington	30	361,463	639,256	57%
West Virginia	1	0	388,667	0%
Wisconsin	15	141,272	460,016	31%
Wyoming	none reported	none reported	51,374	0%
Total:	402	5,713,106	35,357,073	16%

SOURCE: "Medicaid Managed Care Enrollment Report," Office of Managed Care, HCFA, (July 30, 1995).
Data on Medicaid recipients for FY 1995 as reported by States to HCFA.

PROVIDER TAXES

This issue goes to the basic financing structure of the Medicaid program. States that elect to participate in Medicaid are entitled to receive Federal matching funds for State (or local) dollars spent on covered populations and services. In counting State dollars for purposes of qualifying for Federal matching, may the States use revenues received from taxes (or assessments or fees) imposed on hospitals, nursing homes, physicians, or other providers? The answer in Federal Medicaid law is yes, but only if the taxes meet certain minimum Federal standards designed to assure that the taxes are not subterfuges to draw down Federal dollars without any real State (or local) fiscal effort.

History. Until January 1, 1992, the date on which Federal minimum standards enacted in 1991 began to take effect in any State, there were no restrictions on the use of revenues from provider taxes (or donations) by States to claim Federal Medicaid matching funds. In the late 1980's, many States began to use revenues from provider taxes (or donations) as a bootstrap financing technique to generate Federal Medicaid matching payments to help balance their budgets. Between fiscal year 1990 and fiscal year 1993, the percentage of State Medicaid spending coming from provider taxes (or donations) rose from 5.8 percent to 21.1 percent.

Although the details of these provider tax (and donation) schemes varied from State to State, they shared a common dynamic. Hospitals, nursing homes, or other providers either "donated" funds to State Medicaid programs or agreed to be taxed or subjected to fees or assessments, with the revenues earmarked for Medicaid. The States would use these revenues to make expenditures that would qualify for Federal Medicaid matching funds. The States would then use the Federal matching funds to make payments to the providers to hold them harmless for the costs of their "donations" or taxes or fees or assessments (in the case of hospitals, this was commonly done using "disproportionate share" or "DSH" hospital payment adjustments). Both the States and the providers were better off — at the Federal government's expense.

Consider the following example. A State with a Federal Medicaid matching rate of 57 percent (the national average) imposes a \$43 licensing fee on a hospital, with the revenues earmarked for Medicaid. It then pays that hospital an additional \$100 in "disproportionate share" (DSH) payment adjustments. The State claims, and the Federal government makes a matching payment of, \$57 in connection with this \$100 expenditure. The State has incurred no net cost (it received \$43 from the hospital and \$57 from the Federal government). The hospital has gained \$57. And the Federal government has paid out \$57. If the hospital is a State-owned or -operated hospital, the \$57 can then be folded into the State general budget and used, among other things, for other State Medicaid spending that would in turn qualify for additional Federal matching payments.

Current Law. The Federal provider tax requirements are found at section 1903(w) of the Social Security Act. They were enacted in the the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). Detailed implementing regulations have been issued, 42 C.F.R. 433.50 - 433.74.

The basic thrust of the current Federal statute is to reduce, on a dollar for dollar basis, the amount of Federal Medicaid matching funds paid out to a State by the amount of revenues received by a State (or locality) from provider taxes (or donations) that do not meet certain minimum requirements. In the case of provider taxes, which the statute defines as a tax (or licensing fee, assessment, or other mandatory payment) 85 percent or more of the burden of which falls on health care providers, those requirements are:

(1) the tax must be "broad-based" (generally, it must cover at least all non-Federal, non-public providers in a class, such as hospitals, nursing homes, etc., and it must be imposed uniformly on every provider in the class); and

(2) the State must not have in effect a "hold harmless" provision with respect to the tax (generally, the State or locality provides, directly or indirectly, a payment or offset that holds the provider harmless for any portion of the cost of the tax).

The statute gives the Secretary the authority to waive the "broad-based" requirement if the State can show that the net impact of the tax and related Medicaid spending is "generally redistributive."

There is no limit on the amount of revenues a State may receive from legitimate provider taxes in order to finance its share of Medicaid (such a limit was enacted in 1991 and was effective January 1, 1992, but expired effective October 1, 1995).

Implementation. As the accompanying table indicates, during FY 1995, 34 States and the District of Columbia reported receiving revenues from provider taxes or donations (no information was available with respect to 5 States). On average, about 8 percent of all State Medicaid spending was raised from provider taxes or donations, according to reports by the States. However, there is considerable variation among the States in the degree of reliance on this revenue source. In 6 States (Colorado, Georgia, Kentucky, Missouri, Ohio, and West Virginia), revenues from provider taxes and donations accounted for more than 20 percent of all State Medicaid spending; 11 States (Alaska, Arizona, California, Delaware, Idaho, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, and Wyoming) reported no revenues from these sources at all.

As of September, 1996, HCFA had approved 6 different provider taxes in 5 States (Minnesota, Louisiana, Montana, Ohio, and Virginia); these affected hospitals(2), nursing homes (2), physicians (1), and intermediate care facilities for the mentally retarded (ICFs/MR)(1). As of that date, HCFA was reviewing requests for waivers of the Federal requirements with respect to 38 different provider taxes from 18

States. In addition, 6 States had received notices from HCFA that their provider taxes clearly violated the Federal statute (Hawaii, Illinois, Louisiana, Maine, New York, and Tennessee).

Most Recent Republican Legislative Proposal. Under the Republican Medicaid block grant contained in the budget reconciliation bill (H.R. 2491) vetoed by the President on December 6, 1995, the current Federal provider tax rules would simply have been repealed. 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), would have authorized the Secretary of HHS, effective 2 years after enactment, to waive the current Federal provider tax and donation standards for tax or donation schemes used by any State "if the Secretary determines that the waiver would not financially undermine the program under this title and would not otherwise be abusive" (sec. 1512(i)) of block grant authorization). The fiscal and political pressures on the Secretary in the exercise of such waiver authority are likely to be enormous.

MEDICAID PROVIDER TAXES FY 1995
(Dollars in thousands)

State	Total Provider Tax Revenues	Total State Expenditures	Tax Revenues as % State Expenditures
Alabama	27,148	589,382	5%
Alaska	0	157,366	0%
Arizona	0	559,794	0%
Arkansas	20,452	330,206	6%
California	0	8,982,938	0%
Colorado	259,861	728,519	36%
Connecticut	225,168	1,276,020	18%
Delaware	0	173,207	0%
District of Columbia	3,011	407,360	1%
Florida	206,096	2,711,912	8%
Georgia	494,942	1,368,196	36%
Hawaii	127	380,117	less than 1%
Idaho	0	112,442	0%
Illinois	564,729	3,122,606	18%
Indiana	unknown	793,427	unknown
Iowa	2,270	449,883	1%
Kansas	2,542	597,254	less than 1%
Kentucky	173,095	667,652	26%
Louisiana	72,570	1,162,269	6%
Maine	unknown	355,406	unknown
Maryland	504	126,011	less than 1%
Massachusetts	318,393	2,547,117	13%
Michigan	5,847	2,325,517	less than 1%
Minnesota	257,733	1,331,223	19%
Mississippi	12,294	342,819	4%
Missouri	373,265	1,140,761	33%
Montana	12,831	109,994	12%
Nebraska	8,212	269,057	3%
Nevada	23,744	233,681	10%
New Hampshire	unknown	426,317	unknown
New Jersey	0	2,771,366	0%
New Mexico	0	216,526	0%
New York	1,201,820	12,428,580	10%
North Carolina	0	1,422,710	0%
North Dakota	0	97,456	0%
Ohio	576,192	2,546,968	23%
Oklahoma	5,504	372,484	1%
Oregon	379	589,413	less than 1%
Pennsylvania	5,560	3,518,128	less than 1%
Rhode Island	16,157	455,106	4%
South Carolina	29,947	611,619	5%
South Dakota	0	100,420	0%
Tennessee	130,028	1,166,372	11%
Texas	2,223	3,356,264	less than 1%
Utah	unknown	162,927	unknown
Vermont	27,163	138,856	20%
Virginia	unknown	1,050,218	unknown
Washington	30,586	1,451,836	2%
West Virginia	115,823	338,991	34%
Wisconsin	18,205	1,032,475	2%
Wyoming	0	63,704	0%
Total:	5,224,421	67,670,872	8%

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

QUALIFIED MEDICARE BENEFICIARIES (QMBs) AND "DUAL ELIGIBLES"

Of the estimated 37 million Medicaid beneficiaries in 1996, about 5 million were also eligible for Medicare. For these low-income aged or disabled Americans, Medicaid makes their Medicare coverage effective, in one of two ways. For roughly 2.5 million of them -- known as "Qualified Medicare Beneficiaries," or QMBs -- Medicaid pays the monthly Medicare premiums, as well as the Medicare deductibles and coinsurance. For the remaining 2.4 million or so -- known as "Dual Eligibles" -- Medicaid not only pays their Medicare premiums and deductibles and coinsurance requirements, but it also "wraps around" their Medicare benefit by covering outpatient prescription drugs, nursing home care, and other services that Medicare does not cover. According to CBO, the Federal Government in 1995 spent about \$1.9 billion in Medicaid matching funds for Medicare Part B premiums alone for QMBs and Dual Eligibles (there is no information on total Federal Medicaid spending for either of these populations).

Because these aged and disabled Americans are entitled to coverage under both Medicare and Medicaid, changes in Medicare will affect State Medicaid programs. For example, if the Federal government, for budgetary reasons, increases the Medicare Part B premium, then the amount which States must spend for premium subsidies for both QMBs and Dual Eligibles will increase (of course, Federal Medicaid matching funds for these premium costs will rise correspondingly, offsetting the Federal Medicare Part B savings to some extent). Similarly, changes in State Medicaid policies will affect the viability of these beneficiaries' Medicare coverage. For example, States may wish to require aged and disabled residents, including Medicare beneficiaries, to enroll in managed care organizations (MCOs) for Medicaid-covered services. However, under Medicare law, these aged and disabled beneficiaries are entitled to freedom of choice of provider and may not be forced to enroll in an MCO to receive any Medicare-covered services. One State -- Minnesota -- has received a waiver of current law under section 1115 of the Social Security Act to require Dual Eligibles to enroll in MCOs that are responsible for delivering both acute and long-term care services to this population.

History. There have been Dual Eligibles since the enactment of both the Medicare and Medicaid programs in 1965 (P.L. 89-97). In that original enactment, States electing to participate in Medicaid were required to pay the costs of Dual Eligibles' Medicare Part A deductibles and, on an income-related basis, the costs of Medicare Part B deductibles and cost-sharing. These State expenditures, known as the Medicare "buy-in," were eligible for Federal matching funds at the State's normal matching rate. (From the standpoint of the States, it made fiscal sense to "buy in," i.e., help low-income elderly enroll in Medicare Part B by paying their monthly premium, because the States' Medicaid programs would then not have to pay for physician or other services covered by Medicare. Effective in 1970, costs of services for which Medicare would have paid did not because the Medicaid beneficiary was not enrolled in Medicare Part B were no longer eligible for Federal Medicaid matching funds).

In the mid-1980's, as Medicare premiums and other cost-sharing requirements were raised for budgetary reasons, the Congress took steps to protect low-income Medicare beneficiaries from the financial burden of increasing premiums, deductibles, and coinsurance. In many States, Medicaid eligibility standards for the elderly and disabled were so low that they excluded many individuals with incomes below the Federal poverty level. In OBRA '86 (P.L. 99-509), Congress gave States the option of using Federal Medicaid matching funds to provide Medicaid coverage (either full benefits or just assistance with Medicare premiums and cost-sharing) to low-income elderly or disabled individuals with incomes up to the Federal poverty level and resources up to twice the level permitted under the Supplemental Security Income (SSI) program. In the Medicare Catastrophic Act of 1988 (P.L. 100-360), the Congress required States to cover Medicare premiums and cost-sharing for QMBs with incomes up to 100 percent of poverty and resources no greater than 200 percent of the SSI level; this coverage requirement, which was phased in from 85 percent of poverty to 100 percent over 4 years, survived the repeal of the Medicare catastrophic coverage program in 1989 (P.L. 101-234).

Finally, in OBRA '90 (P.L. 101-508), Congress raised the Medicare Part B premium and accelerated the phase-in of coverage for QMBs by one year, to January 1, 1991. In that same legislation, Congress also required States to pay the Part B premiums (but not deductibles or coinsurance) for Medicare beneficiaries with incomes between 100 and 120 percent of the Federal poverty level, and resources at or below twice the SSI level; this requirement was fully phased in as of January 1, 1995.

Current Law. QMBs are defined in section 1905(p) of the Social Security Act. The requirement that States cover their Medicare premiums and cost-sharing expenses is set forth at section 1902(a)(10)(E).

Medicare Premium and Cost-Sharing Requirements. Premiums for Medicare Part B, which covers physician and other medical services, are \$42.50 per month in 1996. (Most elderly automatically qualify for Medicare Part A, which covers hospital care; the small number who do not must pay a monthly premium of \$289 in 1996 to enroll). The Medicare hospital deductible under Part A is \$736 in 1996; the Part B deductible is \$100. The Part B coinsurance requirement is 20 percent of Medicare's approved payment for the physician or other covered medical service.

QMBs. QMBs are elderly or disabled individuals who are entitled to Medicare Part A coverage, whose family income is at or below 100 percent of the Federal poverty line (\$7,740 for a single individual and \$10,360 for a couple in 1996), and whose resources (other than a home and certain other items) do not exceed 200 percent of the SSI resource standard (\$4,000 for an individual and \$6,000 for a couple in 1996).

QMBs are entitled to Medicaid payment for their Medicare premiums and cost-sharing, including Part B monthly premiums (and in a limited number of cases, Part A premiums), deductibles under both Part A and Part B, and coinsurance under Part A

and Part B, and coinsurance and deductibles charged by Medicare Health Maintenance Organizations and Competitive Medical Plans (States have the option of paying the Medicare HMO or CMP enrollment premiums).

Specified Low-income Medicare Beneficiaries (SLIMBs) must meet the same requirements as QMBs except that their incomes may range up to 120 percent of poverty (\$9,288 for a single individual and \$12,432 for a couple in 1996). SLIMBs are entitled only to Medicaid payment of their Medicare Part B premiums.

Dual Eligibles. These are aged and disabled Americans eligible for both Medicare and Medicaid, commonly because they qualify for Medicaid coverage due to the receipt of cash assistance under the SSI program in most States. (Some Medicare beneficiaries may also qualify for Medicaid as "medically needy" by incurring large medical costs for services not covered by Medicare). The Dual Eligibles are entitled to coverage not just for Medicare premiums and cost-sharing, as in the case of QMBs, but also for the other benefits covered under the State's Medicaid program, including nursing home care and prescription drugs.

Coverage of Coinsurance and Deductibles. Because State Medicaid programs commonly pay less than Medicare does for physician and other services that both Medicare and Medicaid cover, there is an issue as to how much assistance QMBs are entitled to receive with respect to coinsurance and deductibles. For example, if Medicare recognizes \$50 as the appropriate payment for a physician visit, and if the beneficiary has met her \$100 deductible, Medicare will pay 80 percent, or \$40, and the beneficiary must pay the 20 percent coinsurance, or \$10. Under HCFA's interpretation of current law, if the State only pays \$30 for the physician visit under Medicaid, then the QMB is entitled to no assistance with the \$10 coinsurance charge, because the actual Medicare payment (\$40) exceeds the Medicaid payment rate (\$30). However, Federal courts have disagreed with HCFA and the States. As of July, 1995, 4 circuit courts of appeals had ruled that States must pay the full Medicare cost-sharing expenses of QMBs, regardless of the State's Medicaid payment rate for the service in question; in this example, the State would have to pay the \$10 co-insurance requirement.

Managed Care. While States may, under waivers from the Secretary, require Medicaid eligibles to enroll in managed care organizations (MCOs), neither the States nor the Secretary have any legal authority to require Medicare beneficiaries to enroll in a Medicaid MCO in order to receive hospital, physician, or other services covered by Medicare. Medicare beneficiaries are free to choose whether to enroll in an MCO or not; if they choose to do so, Medicare will make capitation payments on the beneficiary's behalf to that MCO only if it meets Medicare standards. The potential for conflict between the beneficiary's Medicare rights and the State's Medicaid policy interest is obvious. For example, at least one State now pays for Medicaid-covered services for this population (including Medicare premiums and cost-sharing) only through Medicaid MCOs, effectively forcing Medicare beneficiaries to enroll in Medicaid MCOs if they want Medicaid assistance with their monthly Medicare premiums.

Implementation. The accompanying table provides the numbers of Medicare beneficiaries (both QMBs and Dual Eligibles) on whose behalf each State reported paying Medicare premiums (both Part B and Part A) in July, 1996, as well as the amount of Federal Medicaid matching funds paid to each State during FY 1995 in connection with the costs of the monthly Medicare premiums (both Part B and Part A). Data regarding the number of QMBs (or the number of Dual Eligibles) on a State-by-State basis is unavailable.

Most Recent Republican Proposal. Both the 1995 and the 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795) would have repealed the individual entitlement to coverage for both QMBs and Dual Eligibles (the Medicare entitlement of these individuals would not have been affected by the block grant, although the Republican Medicare proposals would have raised premiums and cost-sharing obligations).

With respect to QMBs, the 1996 version claimed to "guarantee" coverage of Medicare premiums and cost-sharing by requiring States to make payment for these costs. However, no individual Medicare beneficiary was given a right to this coverage, and all Medicare beneficiaries were expressly prohibited from enforcing this "guarantee" in Federal court. In addition, the Republican bill would have allowed States to make no payments toward the coinsurance requirements of a QMB, leaving the QMB to pay the entire coinsurance amount, if the State's payment rate for the service is less than the Medicare payment rate.

With respect to Dual Eligibles, the 1996 version purported to "guarantee" coverage for a so-called "guaranteed benefit package" to elderly individuals meeting SSI income and resource standards. However, no Medicare beneficiary had an individual entitlement to Medicaid coverage; States were given complete discretion in limiting the amount, duration, or scope of any of these "guaranteed benefits" (i.e., 1 month of nursing home care per year); and Medicare beneficiaries were expressly prohibited from enforcing any of these "guarantees" in Federal court.

The 1996 version also included a free-standing authority for a so-called "Integration Demonstration Project" which would have authorized the Secretary of HHS to waive any requirements of Medicare as well as the new Medicaid block grant in order to enable up to 10 States to implement "innovative programs" for individuals dually eligible for benefits under both programs. To obtain a waiver, a State would have had to demonstrate budget neutrality with respect to Federal Medicare and block grant funds. States would not have been authorized to require beneficiaries to participate.

QMBS AND DUAL ELIGIBLES

(Dollars in thousands)

State	Dual Eligibles and QMBs (July, 1996)	Federal Medicaid Matching Funds for Medicare Premiums (FY 1995)
Alabama	120,399	\$53,171
Alaska	6,659	\$2,413
Arizona	47,393	\$16,915
Arkansas	79,549	\$39,337
California	768,907	\$264,880
Colorado	49,651	\$12,325
Connecticut	50,226	\$18,817
Delaware	7,735	\$2,739
District of Columbia	14,195	\$8,398
Florida	290,838	\$150,981
Georgia	165,210	\$66,380
Hawaii	17,905	\$9,768
Idaho	13,835	\$5,121
Illinois	144,330	\$45,140
Indiana	75,930	\$21,528
Iowa	50,031	\$17,849
Kansas	37,064	\$12,153
Kentucky	103,705	\$44,607
Louisiana	114,917	\$57,998
Maine	31,063	\$594
Maryland	59,882	\$27,454
Massachusetts	132,575	\$48,826
Michigan	131,263	\$45,789
Minnesota	55,989	\$9,826
Mississippi	104,036	\$65,641
Missouri	76,883	\$25,157
Montana	11,638	\$5,428
Nebraska	16,986	\$5,446
Nevada	15,711	\$4,885
New Hampshire	5,878	\$1,576
New Jersey	131,292	\$41,393
New Mexico	32,346	\$13,787
New York	342,539	\$90,068
North Carolina	197,039	\$83,784
North Dakota	5,751	\$2,177
Ohio	172,316	\$54,171
Oklahoma	61,723	\$34,600
Oregon	47,600	\$12,926
Pennsylvania	170,790	\$68,149
Rhode Island	16,780	\$6,411
South Carolina	98,817	\$39,905
South Dakota	12,661	\$6,321
Tennessee	157,602	\$72,992
Texas	327,827	\$186,254
Utah	14,387	\$5,386
Vermont	12,863	\$4,666
Virginia	107,457	\$30,964
Washington	76,885	\$21,473
West Virginia	42,377	\$23,536
Wisconsin	78,661	\$32,185
Wyoming	5,548	\$1,862
Total:	4,913,644	\$1,870,981

SOURCE: Information reported by the States to the Health Care Financing Administration

SECTION 1115 MEDICAID WAIVERS

As of October 30, 1996, one fifth of the States were operating part or all of their Medicaid programs under so-called "section 1115 waivers." Granted by the Secretary of HHS, these "demonstration" waivers excuse States from compliance with specified requirements in the Federal Medicaid statute in order to enable the States to change the delivery of services under their Medicaid programs while continuing to receive Federal matching funds. More specifically, nearly all of the recently-granted section 1115 Medicaid waivers allow States to require beneficiaries to enroll in managed care organizations (MCOs) that serve only Medicaid eligibles. Several of these waivers have also resulted in expansion of health care coverage (paid for in part with Federal Medicaid matching funds) to populations not covered under current Medicaid law.

History. The "section 1115" waiver authority with respect to Medicaid has been in place since the enactment of the Medicaid program in 1965. However, this authority was not used to implement comprehensive, Statewide changes in Medicaid programs until 1982, when Arizona, which had not participated in the Medicaid program up to that point, received a section 1115 waiver to enable it to receive Federal Medicaid matching funds to implement a program of acute care coverage with no significant fee-for-service component. (Arizona continues to operate its Medicaid program under this 1115 waiver, which was subsequently extended to bring in Federal matching funds for long-term care services). Beginning with the approval of the Oregon "rationing" demonstration in 1993, the section 1115 waiver authority has been used to enable an additional 14 States to make comprehensive, Statewide changes in the delivery of services and eligibility under their programs.

Current Law. Section 1115(a) of the Social Security Act gives the Secretary of HHS authority to waive compliance with certain sections of the Medicaid statute to enable States to carry out demonstration projects if the project is "likely to assist in promoting the objectives of" the Medicaid statute. These "demonstration" waivers are required to be budget neutral (from the Federal government's standpoint) over their 5-year terms and generally are subject to a formal, independent evaluation.

In addition to section 1115, the Secretary of HHS has two other significant Medicaid waiver authorities: "section 1915(b)" waivers enable States to require beneficiaries to enroll in managed care plans, and "section 1915(c)" waivers enable States to offer home-and community-based services to individuals at risk of nursing home care. Under "section 1915(b)" waivers, States cannot require beneficiaries to enroll in managed care plans that serve only Medicaid eligibles, and they cannot expand eligibility beyond the categories allowed under current law; under section 1115 waivers, they can do so.

Implementation. Overall, the 10 States operating section 1115 statewide Medicaid waivers as of September 1, 1996, covered about 2.9 million beneficiaries, or about 8%

of the estimated 36.8 million Medicaid beneficiaries that fiscal year. In FY 1995, Federal Medicaid payments for these demonstrations (which were operational in only 6 of these States that year) totalled \$4.4 billion, or just under 5 percent of the \$89.1 billion in Federal Medicaid outlays nationwide in FY 1995. The accompanying table shows the numbers of individuals covered and the amounts of Federal funds received, by State, during FY 1995.

Operational States. The following 10 States were, as of October 30, 1996, operating statewide Medicaid demonstrations under section 1115 waivers: Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. (California received a section 1115 Medicaid waiver to enable Los Angeles County to restructure its hospital and clinic system).

Approved but Not Operational States. Florida, Illinois, Kentucky, Maryland, Massachusetts, and Illinois had received section 1115 waivers as of October 30, 1996, but were not operational as of that date.

Waiver Applications Under Review. As of October 30, 1996, the Secretary of HHS was reviewing applications for section 1115 Medicaid demonstration waivers from the following States: Alabama, Georgia, Kansas, Louisiana, Missouri, New Hampshire, New York, Texas, and Utah.

Main Features of Approved Waivers. While each section 1115 waiver has its own set of terms and conditions negotiated by the State with the Department of HHS, the Office of Management and Budget, and the White House, the operational (as of 10/1/96) waivers have certain features in common:

- They all maintain the current individual entitlement, the currently required eligibility categories, and the current Federal-State matching arrangements.
- Most of these waivers affect only acute care services, not nursing home or other long-term care services (the two exceptions are Arizona, which receives Federal long-term care matching funds under its 1115 waiver, and Minnesota waiver, which involves the integration of acute and long-term care services for individuals dually eligible for Medicare and Medicaid).
- Almost all of these waivers retain the current law minimum benefits package for current Medicaid eligibles (the major exception is the Oregon waiver, which is testing the denial of coverage of medical treatments for conditions with a "prioritization" ranking below a State-specified "line"). However, some of these waivers provide for a narrower benefit package or increased cost-sharing for those newly eligible under the waiver (so-called "expansion" eligibles).
- These waivers all allow States to require enrollment in managed care plans that serve primarily or exclusively Medicaid enrollees.

- The majority of these waivers allow States to use Federal Medicaid funds to purchase care for individuals not eligible under the current Medicaid statute (Delaware, Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, Vermont). As of September 1, 1996, health care coverage was extended through these waivers to about 564,000 individuals not otherwise eligible for Medicaid.
- Several of these waivers allow States to maintain current and/or projected levels of Federal matching funds for payments to "disproportionate share" (DSH) hospitals while at the same time allowing them to redirect these payments.

Most Recent Republican Proposal. Both the 1995 and the 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795) would have repealed the current Federal Medicaid statute, Title XIX of the Social Security Act, in its entirety. Although the Republican proposal technically did not amend section 1115, the Secretary's waiver authority under that section would have been rendered moot, since there would be no more requirements under Title XIX to waive. All States, whether operating under section 1115 or not, would have been entitled to Federal block grant funds. In theory, they could choose to keep operating their section 1115 demonstration within the confines of the block grant, but the amount of Federal funds available to them would have been determined by the statutory block grant formula, not by the current terms of their waivers.

After it became clear that Republicans would not succeed in their efforts to repeal Medicaid during the 104th Congress, individual Republicans made efforts to enact legislation requiring the Secretary of HHS to approve State-specific section 1115 Medicaid waiver applications from Michigan (H.R. 3507) and Wisconsin (H.R. 3562). Although H.R. 3562 did pass the House, neither bill was enacted.

Section 1115 Welfare Waivers. Section 1115 of the Social Security also authorizes the Secretary of HHS to waive provisions of the Aid to Families with Dependent Children (AFDC) program to enable States to carry out demonstrations. As of September 26, 1996, 43 States had received one or more section 1115 welfare waivers, including each of the 10 operational section 1115 Medicaid waiver States other than Rhode Island.

In some of the States with section 1115 welfare waivers, additional Medicaid-specific policy changes have been incorporated into the waivers. The most significant of these is the expansion of transitional Medicaid coverage for families losing cash assistance due to earnings; the section 1115 welfare waivers of 15 States include expansions in this "welfare to work" transitional Medicaid benefit, usually by extending the duration of coverage from the current 12 months to 18 or 24 months (Arizona, California, Connecticut, Delaware, Florida, Maine, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, Pennsylvania, South Carolina, Tennessee, and Virginia).

OPERATIONAL SECTION 1115 MEDICAID DEMONSTRATION WAIVERS
(September 1, 1996)

State	Traditional Eligibles (as of 9/1/96)	Expansion Eligibles (as of 9/1/96)	Federal Waiver Matching Payments (FY 1995) (millions of dollars)	Federal Waiver Payments as Percent of Total Federal Matching (FY 1995)
Arizona	480,024		\$ 1,080.8	97%
Delaware	54,990	4,000		
Hawaii	90,000	45,000	\$ 162.9	48%
Minnesota	142,200	86,000	\$ 7.5	3%
Ohio	295,861			
Oklahoma	125,133			
Oregon	255,742	108,207	\$ 904.0	94%
Rhode Island	68,943	2,424	\$ 39.9	7%
Tennessee	849,933	315,099	\$ 2,220.1	99%
Vermont		3,088		
Total	2,362,826	563,818	\$ 4,414.9	

*Jack/Mary Ann: Have you seen this?**Oh*

TO: Bridgett, Karen

FROM: Andy *K*

RE: Administration's Medicaid Proposal (transmitted May 24, 1996)

DATE: November 13, 1996

OVERVIEW

The May, 1996, version of the Medicaid title of the Administration's FY 1997 balanced budget proposal was scored by CBO (on 2/26/96) at \$55.1 billion over the 7 years FY 1997 - FY 2002:

- \$35 billion from the per capita cap, and
- a net of \$20 billion from DSH (\$39 billion in cuts — a 51 percent reduction — less \$11 billion for transition grants, \$3.5 for illegal aliens, and \$3 for FQHCs and RHCs).

The dramatic decline in the Medicaid growth rate to 3 percent in FY 1996 presents a political opportunity to lower these proposed cuts dramatically. Even Martha Phillips of the Concord Coalition concedes that "Medicaid, for the time being, seems to be under control." (National Journal, 11/9/96 at p. 2395). Whatever the target number for cuts, the Administration will clearly propose some Medicaid legislation in the 105th. Here are some suggestions for revising their 1996 version:

ELEMENTS THAT SHOULD BE DROPPED

- **Per capita cap (sec. 11301) and DSH reductions (sec. 11302).** Based on CBO's spring, 1995, estimates, any "flexibility" changes, like repeal of Boren and expanded managed care, are not likely to score more than \$5 billion or so in savings, if that, over 7 years. If larger cuts must be made, there are only two places to go for scorable savings: DSH and the per capita cap. Depending on CBO's new DSH baseline, I would go there first, recognizing that, even with the ploughbacks, the Administration's proposed 51 percent cut is neither desirable nor, given the skewed distribution of DSH funds, politically sustainable.

My information is that about 20 percent of DSH funds are spent on State mental hospitals, essentially gutting the IMD exclusion and refinancing State mental health spending. What about reducing some of that portion of Federal DSH spending by lowering the OBRA '93 facility specific caps for those institutions to, say, 50 percent of operating costs?

- **Capped optional eligibility (sec. 11311).** This would allow the States to cover anyone up to 150 percent of poverty, but exclude these new eligibles from enrollee counts for purposes of the per capita cap. Any new optional groups — whether children or any other categories — should be accompanied by Federal matching funds on the same basis as current eligibles. One place to start might be expanding the welfare-to-work transitional benefit (see below).
- **Closing off existing eligibility options (sec. 11312 - 11313).** The bill would amend section 1115 to prohibit any new waivers from allowing eligibility expansions (waivers as of 10/1/96 would be unaffected), and limiting new 1902(r)(2) expansions to 150 percent of poverty. Unless a per capita cap is absolutely necessary and these changes are needed for the cap to score, there is no reason to close off current law options, particularly in a way that discriminates against States that haven't used them yet.
- **Allowing States to reduce eligibility levels for pregnant women and infants (sec. 11314).** This would repeal the current law provision that once a State opts to raise the income threshold for pregnant women and infants above 133 percent, it must stay at that new, higher level.
- **Allowing MCOs to impose deductibles, copayments, or other cost-sharing (sec. 11334).** This would repeal the current protection for MCO enrollees and allow MCOs to impose "nominal" deductibles or copayments or other cost-sharing on categorically needy enrollees (they can already do so with respect to medically needy, at State option). It is not clear whether this overrides the current law protections against the imposition of cost-sharing on pregnant women and children, but if it does, just imagine the possibilities for underservicing as MCOs use cost-sharing to further reduce payments to subcontracting physicians and hospitals.
- **Repeal of Boren amendment for both hospitals and nursing homes (sec. 11341).** The bill would replace the Boren requirements, including the requirement that States make DSH payments, with a public process requirement for review and comment on hospital and nursing home payment rates. Given the shift toward managed care, this may soon be a moot point for most urban hospitals. But it would be prove very damaging for the enforcement of quality standards in the nursing home context. *disagree*
- **Repeal of FQHC and RHC cost reimbursement (sec. 11341).** The bill repeals the requirement that States pay FQHCs and RHCs 100 percent of their costs, effective October 1, 1998, at which point a new grant program is to be in place. Funded at \$500 million per year in entitlement spending, this program would be administered by the Secretary directly to FQHCs and RHCs. Could \$500 million per year possibly make up for the loss of cost-based reimbursement and underpayment by managed care plans? Even if it was sufficient, doesn't the bill, *disagree*

which is drafted without a linkage between these two policies, in effect ask for the Congress to repeal the current "mandate" without enacting the new "entitlement?"

- **Minimum qualifications for physicians serving children and pregnant women (sec. 11342).** The bill would repeal the provision in current law denying Federal matching funds for payments to physicians treating Medicaid-eligible children or pregnant women unless the physician meets just 1 of 6 different qualifying criteria. Not only should this provision be retained (it was enacted to shut down substandard Medicaid "mills," but it should be clarified to extend to managed care plans as well. *dr*
- **Repeal of obstetrical and pediatric payment rate requirements (sec. 11343).** The bill would repeal the requirement that States annually specify their payment rates for pediatric and obstetrical services to assure that these reimbursement levels are sufficient to attract the participation of enough physicians and nurse midwives and nurse practitioners to give Medicaid beneficiaries adequate access. The bill would also repeal the requirement that States document how their capitation rates to MCOs reflect these payment rates. With the landscape changing to managed care, it is worth rethinking how to assure adequate access to pediatricians and obstetricians in a managed care context. But wholesale repeal seems like overkill. *J. S. Jones*

ELEMENTS THAT SHOULD BE RETAINED OR MODIFIED

- **Home- and community-based services option (sec. 11331).** This would convert the 1915(c) waivers into a State option and repeal the frail elderly (Rockefeller) and community-supported living arrangements services (Chafee) capped entitlements, both of which expired in FY 1995. The Administration bill should be modified to include minimum protections against neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and provision of services by unqualified personnel, with enforcement by the State Medicaid Fraud Control Units (which already prosecute abuse and neglect of nursing home residents).
- **Managed care (secs. 11321 - 11325).** The bill would repeal the 75/25 rule, the one-month disenrollment protection, and would allow States to restrict beneficiary choice to one of two MCOs, except in rural areas, replacing the 1915(b) waiver with a State option. This is a political inevitability. And, to its credit, the Administration would provide 6-month guaranteed eligibility for MCO enrollees, and would retain some of the important quality and access protections in 1903(m), such as the requirement that capitation rates have an "actuarially sound basis." However, the bill does nothing to address problems with Medicaid managed care repeatedly documented by the media, including marketing abuse,

non-provision of EPSDT and other contracted services, profiteering and excessive administrative costs, auto-enrollment abuses, and nonpayment of emergency room providers. These provisions need much work if beneficiaries and Federal taxpayers are to be adequately protected.

- **Welfare-to-work transitional coverage (sec. 11333).** In the welfare bill, the Republicans extended the sunset on current law 12-month transitional coverage for working welfare families from September 30, 1998, to September 30, 2001. The Administration bill would have made some dubious changes in the current law provision, including (1) allowing States to gut the alternative coverage option by limiting deductible and copayment subsidies to Medicaid fee-for-service rates, (2) repealing the limit on the amount of premiums that States may impose on such families (currently set at 3 percent of average gross monthly earnings), and (3) allowing the States to require reporting of earnings and child care costs more frequently than quarterly. Surely we can do better with this issue, particularly since 15 States, as part of their section 1115 welfare waivers, have increased these transitional benefits. Among the changes to consider, depending on cost, are: repealing the sunset altogether; giving the States the option to cover up to an additional 24 months (for a maximum of 36 months); reducing the frequency of reporting to once every 6 months; and eliminating the requirement that an individual receive cash assistance in 3 of the 6 months before becoming ineligible for cash assistance and therefore eligible for transitional coverage.
- **Repeal of requirement that States buy beneficiaries into group health plans (sec. 11332).** This repeals the OBRA 90 provision (estimated 5-year savings of \$1 billion) requiring States, when "cost-effective," to pay premiums, deductibles, and coinsurance for beneficiaries who are eligible to enroll in their employers' group health plans, and makes purchase of such coverage optional.
- **MMIS (sec. 11351).** This revises the current MMIS requirements to make them more appropriate to a managed care, per capita cap world. This seems useful, and presents an opportunity to add in language to improve the quality and relevance of the information the States collect and report to the Federal government (for example, we don't know the number of QMBs by State or the amount of Federal Medicaid funds spent on managed care by State).
- **Personnel requirements (sec. 11352).** This repeals the requirement that Medicaid agency personnel be selected on a merit (rather than patronage) basis, and the requirement that States employ beneficiaries and other low-income consumers as "community service aides." The amendment retains the current law prohibition against conflicts of interest by State Medicaid agency personnel, which should be expanded to address the issues raised by managed care contracting.
- **Cooperative agreements (sec. 11353).** This repeals the requirement that

State Medicaid agencies coordinate with State Title V MCH Block Grant agencies, especially with regard to immunizations, and that they coordinate with WIC programs.

- **Nurse Aide Training (sec. 11355).** This would allow certain nursing facilities to continue conducting nurse aide training despite having been sanctioned or found to have provided substandard care during a survey. The language, similar to that in H.R. 3633, ought to be clarified to limit the exemption to facilities located in rural areas.
- **Public process for State plan amendments (sec. 11357).** It ought to be modified to prohibit approval of a plan amendment until the review and comment requirements have been satisfied, and it should be extended to any remaining waiver authorities (such as 1115).
- **PACE (sec. 11358).** This would give the On Lok demonstration projects (and similar public and nonprofit organizations providing health and long-term care services to the frail elderly on a risk basis) provider status for purposes of Medicaid and Medicare, and would eliminate the 15-site cap on such entities.

ELEMENTS THAT SHOULD BE ADDED

- **Repeal gutting of civil money penalty authority.** Section 231(d) of the Kennedy-Kassebaum legislation (P.L. 104-191) increases the burden that prosecutors must meet in establishing the liability of providers for civil monetary penalties under Medicaid (and Medicare). It should be repealed, and the previous law standard of "knows or should know" is fraudulent should be reinstated. This intermediate sanction is a critical enforcement tool, and the Kennedy-Kassebaum change makes it much hard to use effectively. ok if
can
- **Repeal criminalization of transfers of assets.** Section 217 of Kennedy-Kassebaum makes it a crime to dispose of assets in order to qualify for Medicaid if the disposal would result in a period of ineligibility for Medicaid. This is overkill. If the Members want to tighten the current law prohibitions on transfers of assets, they can lengthen the "look back" period and increase the period of ineligibility. ok
- **Prohibit States from requiring Medicare beneficiaries (QMBs or Dual Eligibles) to enroll in Medicaid managed care plans.** Evidently some States are taking the position that they can condition receipt of premium or cost-sharing assistance, or prescription drugs or other Medicaid benefits, on enrollment in a managed care plan, even if that plan does not meet Medicare standards. This should be prohibited, since it clearly undercuts the Medicare beneficiary's freedom of choice of provider. If States want to do this, they should get an 1115 waiver, like Minnesota did. ok

PHOTOCOPY
PRESERVATION

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Medicaid Financing Proposal

The Medicaid financing proposal has two components:

- A limit on Federal Medicaid spending on medical assistance (health benefits) and
- A reduction and retargeting of the Medicaid spending on disproportionate share hospitals (DSH).

MEDICAL ASSISTANCE LIMIT:

The total amount of state medical assistance expenditures that the Federal government will match will be limited. States will know in advance the preliminary Federal limit or "allotment". The allotment will be revised when data on enrollment for the year become available. The quarterly grants to states will be consistent with the limits. Each state's allotment will be the greater of:

- (A) the base amount or
- (B) the growth amount plus the umbrella adjustments.

The **base amount** for each state includes the expenditures subject to the limit for 1993, 1994 or 1995 (the year chosen by each state).

The **growth amount** for each state is the product of three numbers:

- (A) Previous year's allotment (the base amount for 1997) plus the umbrella adjustments,
- (B) the inflation adjuster, and
- (C) the estimated weighted average enrollment growth rate.

The ***inflation adjuster*** is a growth-rate limit on the Medicaid spending growth due to health care inflation, utilization and quality changes. It is set in legislation as the sum of the consumer price index (CPI) for previous 12 months and a specified adjustment factor.

The ***estimated weighted average enrollment growth rate*** is used to adjust base year spending and subsequent year allotments for enrollment changes. It is one rate that is composed of the specific enrollment growth for four groups of Medicaid enrollees: aged, disabled, adults and children. It is estimated in advance of each fiscal year by the Secretary. As the actual enrollment information becomes available, it is folded into the formula through the umbrella adjustment.

The **umbrella adjustment** is the mechanism for adjusting the preliminary allotments to account for the actual enrollment trends. Umbrella adjustments occur midway through the fiscal year, and at the end of the fiscal year when the actual enrollment growth is known.

Process for Determining Medical Assistance Limits:

The Secretary of Health and Human Services is primarily responsible for determining the medical assistance limits. The Secretary will produce: (a) a preliminary allotment for each state, prior to the start of the fiscal year, (b) an interim allotment halfway through the fiscal year to account for more recent enrollment trends, and (c) a final allotment at the close of the fiscal year which incorporates actual enrollment growth. The preliminary allotment will be updated through the "umbrella adjustment" which reconciles the estimated enrollment growth with more recent trends (interim allotment) and the actual enrollment growth in the state (final allotment). The Secretary will make the growth estimate based on (a) state estimates of enrollment growth; (b) Medicaid eligibility criteria and standards in each state; (c) legislation enacted or pending in each state; (d) historical trends; and (e) general economic trends.

DISPROPORTIONATE SHARE HOSPITAL (DSH) LIMITS:

The baseline Disproportionate Share Hospital (DSH) funding is divided into three different uses:

- (A) Deficit reduction,
- (B) A targeted DSH program, and
- (C) General medical assistance.

Deficit reduction will account for about one third of current DSH payments.

The targeted DSH program will allocate a share of a fixed Federal funding pool to states based on their share of low-income utilization days in eligible hospitals. The share is determined by the state's percent of the nation's inpatient days and outpatient visits for uninsured and Medicaid patients. States will still contribute to the program through matching payments (using the current matching rates). Funding begins in 1997 and is fully phased in by 2000.

There would also separate streams of funding within the DSH program for (a) states with high numbers of undocumented persons and (b) Federally-qualified health centers and rural health clinics. The 15 states with the highest number of undocumented persons would get a proportionate share of a \$3 billion pool over a five-year period for payments for emergency care for this population. Additionally, a \$3.5 billion pool (\$500 million per year) would be established to supplement payments to Federally-qualified health centers and rural health clinics. Both pools are 100 percent Federally funded.

The amount of DSH for general medical assistance is calculated as a percentage of the 1995 Federal payments to states. It is considered as an add-on to the limits described earlier. It is included in neither the base nor the growth amounts for the purpose of the allotment calculation. States will still contribute matching payments for this amount.

MEDICAID REVISIONS

Add a short title of the "Medicaid State Flexibility Act of 1996".

Amend subtitle A to read as follows:

Subtitle A—Spending Limitations

**SEC. 7001. LIMITATION ON EXPENDITURES RECOGNIZED
FOR PURPOSES OF FEDERAL FINANCIAL
PARTICIPATION.**

(a) LIMITATION.—

(1) IN GENERAL.—Title XIX of the Social Security Act is amended—

(A) in section 1903(a), by striking "From" and inserting "Subject to section 1931, from";

(B) by redesignating section 1931 as section 1932;

and

(C) by inserting after section 1930 the following

new section:

"LIMITATION ON FEDERAL FINANCIAL PARTICIPATION

"SEC. 1931. (a) LIMITATION.—

“(1) IN GENERAL.—Subject to subsection (c), the total amount of State expenditures for medical assistance for which Federal financial participation may be made under section 1903(a) for quarters in a fiscal year (beginning with fiscal year 1997) may not exceed the greater of—

“(A) the base amount specified in paragraph (2),

or

“(B) growth-adjusted amount specified in paragraph (3), which is subject to an umbrella adjustment under subsection (d)(5)).

“(2) **BASE AMOUNT.**—The base amount specified in this paragraph is (subject to subsection (c)) the total amount of State expenditures for medical assistance for which Federal financial participation was made under section 1903(a) for quarters in any of the following base years

1 (as selected by the State and in this section referred to as
2 the 'base fiscal year' for that State):

3 "(A) Fiscal year 1993.

4 "(B) Fiscal year 1994.

5 "(C) Fiscal year 1995.

6 "(3) GROWTH-ADJUSTED AMOUNT.—

7 "(A) FISCAL YEAR 1997.—The growth-adjusted
8 amount specified in this paragraph for a State for fis-
9 cal year 1997 is equal to the product of—

10 "(i) the base amount specified in paragraph
11 (2) for the State,

12 "(ii) a factor equal to 1 plus the weighted av-
13 erage enrollment growth rate (specified in para-
14 graph (4)) for the State for fiscal year 1996,

15 "(iii) a factor equal to 1 plus the weighted av-
16 erage enrollment growth rate (specified in para-
17 graph (4)) for the State for fiscal year 1997,

18 "(iv) a factor equal to 1 plus the inflation ad-
19 juster (specified in paragraph (5)) for fiscal year
20 1996, and

21 "(v) a factor equal to 1 plus the inflation ad-
22 juster for fiscal year 1997.

23 "(B) SUBSEQUENT FISCAL YEAR.—The growth-
24 adjusted amount specified in this paragraph for a State
25 for a subsequent fiscal year is equal to the product
26 of—

27 "(i) the growth-adjusted amount under this
28 paragraph for the State for the previous fiscal year,

29 "(ii) a factor equal to 1 plus the weighted av-
30 erage enrollment growth rate (specified in para-
31 graph (4)) for the State for the fiscal year, and

32 "(iii) a factor equal to 1 plus the inflation ad-
33 juster (specified in paragraph (5)) for the fiscal
34 year.

35 The growth-adjusted amount under clause (i) is subject
36 to an umbrella adjustment under subsection (d)(5).

3

1 “(4) WEIGHTED AVERAGE ENROLLMENT GROWTH
2 RATE.—For purposes of this subsection, the ‘weighted aver-
3 age enrollment growth rate’ for a State for a fiscal year is
4 the sum of the following:

5 “(A) The sum of the products, for each of the 4
6 categories of medicaid beneficiary (as defined in sub-
7 section (b)(7)), of (i) the percentage change in the
8 number of full-year equivalent individuals in such cat-
9 egory in the State in the fiscal year (compared to such
10 number in the previous fiscal year, or, for fiscal year
11 1996, in the base fiscal year for the State), and (ii) the
12 proportion, of the State medical assistance expenditures
13 (other than expenditures excluded under subsection (c))
14 for which Federal financial participation was provided
15 to the State in the previous fiscal year, which is attrib-
16 utable to expenditures under paragraphs (1) and (5) of
17 section 1903(a) with respect to medical assistance fur-
18 nished for individuals in such category.

19 “(B) The product of (i) the percentage change in
20 the number of full-year equivalent individuals in any of
21 the separate categories of medicaid beneficiary in the
22 State in the fiscal year (compared to such number in
23 the previous fiscal year, or, for fiscal year 1996, in the
24 base fiscal year for the State), and (ii) 100 percent
25 minus the sum of the proportions specified under
26 clause (ii) of subparagraph (A).

27 “(5) INFLATION ADJUSTER.—In this subsection, the
28 ‘inflation adjuster’ for a fiscal year is—

29 “(A) the percentage by which—

30 “(i) the Secretary’s estimate (before the begin-
31 ning of the fiscal year) of the average value of the
32 consumer price index for all urban consumers (all
33 items, U.S. city average) for months in the particu-
34 lar fiscal year, exceeds

35 “(ii) the average value of such index for
36 months in the previous fiscal year; increased by

37 “(B)(i) 4.0 percentage points for fiscal year 1996;

1 “(ii) 3.0 percentage points for fiscal year 1997:

2 “(iii) 2.0 percentage points for each of fiscal years
3 1998, 1999, and 2000; and

4 “(iv) 1.0 percentage points for each [of fiscal
5 years 2001 and 2002]/[subsequent fiscal year].

6 The Secretary shall not reestimate or recompute the infla-
7 tion adjuster for a fiscal year after the beginning of a fiscal
8 year.

9 “(6) LIMITATION ONLY ON EXPENDITURES FOR
10 WHICH FFP AVAILABLE.—This section does not apply to ex-
11 penditures for which no Federal financial participation is
12 available under this title.

13 “(b) DEFINITIONS RELATING TO CATEGORIES OF INDI-
14 VIDUALS AND MEDICAID BENEFICIARIES.—In this section:

15 “(1) NONDISABLED MEDICAID CHILD.—The term
16 ‘nondisabled medicaid child’ means an individual entitled to
17 medical assistance under the State plan under this title
18 who is not disabled (as such term is used under paragraph
19 (4)), not a QMB-related individual (as defined in para-
20 graph (5)), and is under 21 years of age.

21 “(2) NONDISABLED MEDICAID ADULTS.—The term
22 ‘nondisabled medicaid adult’ means an individual entitled
23 to medical assistance under the State plan under this title
24 who is not disabled (as such term is used under paragraph
25 (4)), not a QMB-related individual (as defined in para-
26 graph (5)), and is at least 21 years of age but under 65
27 years of age.

28 “(3) ELDERLY MEDICAID BENEFICIARY.—The term
29 ‘elderly medicaid beneficiary’ means an individual entitled
30 to medical assistance under the State plan under this title
31 who at least 65 years of age and is not a QMB-related indi-
32 vidual (as defined in paragraph (5)).

33 “(4) DISABLED MEDICAID BENEFICIARIES.—The term
34 ‘disabled medicaid beneficiary’ means an individual entitled
35 to medical assistance under the State plan under this title
36 who is entitled to such assistance on the basis of blindness

1 or disability and is not a QMB-related individual (as de-
2 fined in paragraph (5)).

3 “(5) QMB-RELATED INDIVIDUAL.—The term ‘QMB-
4 related individual’ means an individual who is eligible only
5 for benefits described in section 1902(a)(10)(E) under this
6 title as—

7 “(A) a qualified medicare beneficiary (as defined
8 in section 1905(p)(1)),

9 “(B) a qualified disabled and working individual
10 (as defined in section 1905(s)), or

11 “(C) an individual described in section
12 1902(a)(10)(E)(iii).

13 “(6) MEDICAID BENEFICIARY.—The term ‘medicaid
14 beneficiary’ means an individual enrolled in the State pro-
15 gram under this title, other than an individual described in
16 section 1902(a)(10)(G).

17 “(7) CATEGORY.—Nondisabled medicaid children, non-
18 disabled medicaid adults, elderly medicaid beneficiaries, and
19 disabled medicaid beneficiaries each constitute a separate ‘cat-
20 egory’ of medicaid beneficiaries.

21 “(c). SPECIAL RULES AND EXCEPTIONS.—For purposes of
22 this section, expenditures attributable to any of the following
23 shall not be subject to the limits established under this section
24 and shall not be taken into account in computing base amounts
25 under subsection (a)(2):

26 “(1) DSH.—Payment adjustments under section
27 1923.

28 “(2) MEDICARE COST-SHARING.—Payments for medi-
29 cal assistance described in section 1902(a)(10)(E).

30 “(3) INDIAN HEALTH PROGRAMS.—Amounts for medi-
31 cal assistance for services provided by—

32 “(A) the Indian Health Service;

33 “(B) Indian health programs operated by an In-
34 dian tribe or tribal organization pursuant to a contract,
35 grant, cooperative agreement, or compact with the In-
36 dian Health Service pursuant to the Indian Self-Deter-
37 mination Act (25 U.S.C. 450 et seq.); and

6

1 “(C) urban Indian health programs operated by an
2 urban Indian organization pursuant to a grant or con-
3 tract with the Indian Health Service pursuant to title
4 V of the Indian Health Care Improvement Act (25
5 U.S.C. 1601 et seq.).

6 “(4) FRAUD AND ABUSE ACTIVITIES.—Amounts paid
7 for activities of State medicaid fraud control units pursuant
8 to section 1903(a)(6).

9 “(5) SAVE.—Amounts for expenditures attributable to
10 implementation of the immigration status verification sys-
11 tem described in section 1137(d).

12 “(6) NURSING FACILITY SURVEY AND CERTIFI-
13 CATION.—Amounts paid pursuant to section 1903(a)(2)(D)
14 for State survey and certification activities pursuant to sec-
15 tion 1919(g).

16 “(7) PAYMENTS FOR GRANTS FOR UNFUNDED COSTS
17 OF RURAL HEALTH CLINICS AND FEDERALLY-QUALIFIED
18 HEALTH CENTERS.—Amounts paid pursuant to a grant
19 under section 1933.

20 “(8) CERTAIN EXPENDITURES FOR UNDOCUMENTED
21 ALIENS.—Payments for medical assistance described in sec-
22 tion 1932.

23 Nothing in this section shall be construed as applying any limi-
24 tation to expenditures for the purchase and delivery of qualified
25 pediatric vaccines under section 1928.

26 “(d) ESTIMATIONS AND NOTICE; UMBRELLA INSURANCE
27 ADJUSTMENT FOR UNDERESTIMATES AND OVERESTIMATES IN
28 CASELOAD.—

29 “(1) IN GENERAL.—The Secretary shall—

30 “(A) establish a process for estimating the limits
31 established under subsection (a) for each State before
32 the beginning of each fiscal year and adjusting such es-
33 timates during such year; and

34 “(B) notifying each State of the estimates and ad-
35 justments referred to in subparagraph (A).

36 “(2) REPORTS.—

1 “(A) IN GENERAL.—The Secretary shall produce,
2 for each fiscal year (beginning with fiscal year 1997)
3 the following reports that specify the growth-adjusted
4 amount under subsection (a)(3) for each State for the
5 fiscal year (taking into account any umbrella adjust-
6 ment under paragraph (5)):

7 “(i) PRELIMINARY REPORT.—A preliminary
8 report in July before the beginning of the fiscal
9 year.

10 “(ii) INTERIM REPORT.—An interim report at
11 such time during the fiscal year as permits a semi-
12 annual umbrella adjustment under paragraph (5).

13 “(iii) FINAL REPORT.—A final report not later
14 than 6 months after the end of the fiscal year.

15 “(B) CONTENTS OF REPORT.—Each such report
16 for a fiscal year shall include for each State for the fis-
17 cal year an estimate or statement of—

18 “(i) the weighted average enrollment growth
19 rate;

20 “(ii) the number of full-year equivalent indi-
21 viduals in each category of medicaid beneficiary;

22 “(iii) the growth-adjusted amount under sub-
23 section (a)(3); and

24 “(iv) the amount of any umbrella adjustment
25 under paragraph (5).

26 “(3) DETERMINATION OF NUMBER OF FULL-YEAR
27 EQUIVALENT INDIVIDUALS.—

28 “(A) STANDARD FORMULA.—

29 “(i) IN GENERAL.—For purposes of this sec-
30 tion, the number of full-year equivalent individuals
31 in each category described in subsection (b) for a
32 State for a year shall be determined, subject to
33 subparagraph (B), based on actual reports submit-
34 ted by the State to the Secretary.

35 “(ii) PART-YEAR ENROLLEES.—In the case of
36 individuals who were not enrolled under the State
37 program under this title for the entire fiscal year

(or are within a group of individuals for only part of a fiscal year), the number shall take into account only the portion of the year in which they were so enrolled or within such group.

“(B) ALTERNATIVE FORMULA FOR STATES OPERATING UNDER WAIVERS IN BASE YEAR.—

“(i) IN GENERAL.—A State that, during fiscal year 1995, had in effect a program under this title under which individuals not otherwise eligible were enrolled pursuant to waivers under section 1115 may elect to make the calculations required by this paragraph for fiscal year 1995 in the manner specified in clause (ii).

“(ii) ASSUMPTIONS FOR PURPOSES OF ALTERNATIVE CALCULATION.—For purposes of the calculation under this subparagraph it shall be assumed—

“(I) that only individuals eligible for medical assistance (or who would have been eligible if the State had exercised the option under section 1902(r)(2)) without regard to such waivers received such assistance; and

“(II) that notwithstanding subclause (I), State expenditures for individuals eligible for medical assistance only through such waivers shall be taken into account for purposes of determining what percentage of State expenditures for each group of individuals defined in subsection (b) bears to total State expenditures for medical assistance in such State.

“(iii) DEADLINE FOR ELECTION OF OPTION.—Election by a State of the option under this subparagraph must be made not later than September 1996.

“(C) SECRETARIAL OVERSIGHT.—In order to ensure the accuracy of the numbers reported by States pursuant to subparagraph (A), the Secretary may—

1 “(i) require documentation, whether on a sam-
2 ple or other basis;

3 “(ii) audit such reports (or require the per-
4 formance of independent audits); and

5 “(iii) revise the numbers so reported.

6 “(4) BASIS FOR ESTIMATIONS.—The Secretary shall
7 estimate the number of full-year equivalents before a fiscal
8 year taking into account—

9 “(A) estimates provided by the State,

10 “(B) the medicaid eligibility criteria and standards
11 under each State plan,

12 “(C) legislation enacted or pending in each State,

13 “(D) historical trends in medicaid enrollment in
14 the State, and

15 “(E) economic conditions in the State.

16 “(5) UMBRELLA ADJUSTMENT.—

17 “(A) IN GENERAL.—Based on reports provided
18 under paragraph (2), the Secretary shall provide for a
19 process for adjustment of estimated limits under this
20 section on a semi-annual basis in order to take into ac-
21 count the most current data available on actual medic-
22 aid beneficiary enrollments in the different categories
23 in each State.

24 “(B) ADJUSTMENTS.—If the actual number of
25 full-year equivalent individuals for a category in a State
26 is—

27 “(i) greater than the number of such equiva-
28 lents previously estimated, then the Secretary shall
29 increase the growth-adjusted amount under this
30 section in order to take into account the actual
31 number of full-year equivalents in that category in
32 that State (as well as the actual number of such
33 equivalents in other categories), or

34 “(ii) less than the number of such equivalents
35 previously estimated, then the Secretary shall de-
36 crease the growth-adjusted amount under this sec-
37 tion in order to take into account the actual num-

10

1 ber of full-year equivalents in that category in that
2 State (as well as the actual number of such equiva-
3 lents in other categories).

4 Adjustments under this subparagraph shall apply to
5 the fiscal year involved and (under the formulas pro-
6 vided under subsection (a)) for subsequent fiscal years.

7 (2) LIMITATION ON FEDERAL FINANCIAL PARTICIPA-
8 TION.—Section 1903 (42 U.S.C. 1396b) is amended by
9 adding at the end the following new subsection:

10 “(x)(1) Notwithstanding the previous provisions of this
11 section but subject to paragraph (3), the Secretary shall incur
12 no obligation after September 30, 1996, to make payments to
13 a State for State expenditures that exceed the limitation on
14 Federal financial participation specified in section 1931.

15 “(2) No payment shall be made to a State with respect
16 to an obligation incurred before October 1, 1996, unless the
17 State has submitted to the Secretary by not later than June
18 30, 1997, a claim for Federal financial participation for ex-
19 penses paid by the State with respect to such obligation.

20 “(3) Nothing in paragraph (1) shall be construed as af-
21 fecting the obligation of the Federal Government to pay claims
22 described in paragraph (2).

23 “(4) Nothing in this subsection or section 1931 shall be
24 construed as affecting the entitlement of eligible individuals to
25 medical assistance under this title.”.

26 (b) ENFORCEMENT-RELATED PROVISIONS.—

27 (1) ASSURING ACTUAL PAYMENTS TO STATES CON-
28 SISTENT WITH LIMITATION.—Section 1903(d) (42 U.S.C.
29 1396b(d)) is amended—

30 (A) in paragraph (2)(A), by striking “The Sec-
31 retary” and inserting “Subject to paragraph (7), the
32 Secretary”, and

33 (B) by adding at the end the following new para-
34 graph:

35 “(7)(A) The Secretary shall take such steps as are nec-
36 essary to assure that payments under this subsection for quar-
37 ters in a fiscal year are consistent with the payment limits es-

11

1 tablished under section 1931 for the fiscal year. Such steps
2 may include limiting such payments for one or more quarters
3 in a fiscal year based on—

4 “(i) an appropriate proportion of the payment limits
5 for the fiscal year involved, and

6 “(ii) numbers of individuals within each category, as
7 reported under subparagraph (B) for a recent previous
8 quarter.

9 “(B) Each State shall include, in its report filed under
10 paragraph (1)(A) for a calendar quarter—

11 “(i) the actual number of individuals within each cat-
12 egory described in section 1931(b) for the second previous
13 calendar quarter and (based on the data available) for the
14 previous calendar quarter, and

15 “(ii) an estimate of such numbers for the calendar
16 quarter involved.”

17 (2) RESTRICTION ON AUTHORITY OF STATES TO
18 APPLY LESS RESTRICTIVE INCOME AND RESOURCE METH-
19 ODOLOGIES.—Section 1902(r)(2) (42 U.S.C. 1396a(r)(2))
20 is amended by adding at the end the following new sub-
21 paragraph:

22 “(C) Subparagraph (A) shall not apply to plan amend-
23 ments made on or after October 15, 1995.”

24 (c) CONFORMING AMENDMENT.—Section 1903(i) (42
25 U.S.C. 1396b(i)) is amended—

26 (1) by striking “or” at the end of paragraph (14),

27 (2) by striking the period at the end of paragraph (15)
28 and inserting “; or”, and

29 (3) by inserting after paragraph (15) the following:

30 “(16) in accordance with section 1931, with respect to
31 amounts expended to the extent they exceed applicable lim-
32 its established under section 1931(a).”

33 (d) EFFECTIVE DATE.—The amendments made by this
34 section shall apply to payments for calendar quarters beginning
35 on or after October 1, 1996.

12

1 **SEC. 7002. ADDITIONAL FUNDING FOR ILLEGAL ALIENS.**

2 Title XIX of the Social Security Act, as previously amend-
3 ed, is amended—

4 (2) by redesignating section 1932 as section 1933; and

5 (3) by inserting after section 1931 the following new
6 section:

7 "FEDERAL FUNDING FOR ILLEGAL ALIENS

8 "SEC. 1932. (a) IN GENERAL.—Subject to the limitation
9 specified under subsection (b), for each of fiscal years 1997
10 through 2001 for each of the 15 States with the largest num-
11 ber of illegal immigrants, the Federal medical assistance per-
12 centage shall be 100 percent for expenditures described in sec-
13 tion 1903(v).

14 "(b) LIMITATION.—The limitation under this subsection
15 for a fiscal year for a State bears the same ratio to
16 \$700,000,000 as the ratio of the number of illegal immigrants
17 in the State bears to the total of such numbers for all 15
18 States described in subsection (a).

19 "(c) DETERMINATION OF NUMBER OF ILLEGAL IMMI-
20 GRANTS.—For purposes of this section, the number of illegal
21 immigrants in a State shall be based on estimated of the Sta-
22 tistics Division of the Immigration and Naturalization Service
23 as of October 1992."

Amend section 7203 to read as follows:

24 **SEC. 7203. REVISIONS TO BOREN AMENDMENT.**

25 (a) IN GENERAL.—Amend subparagraph (A) of section
26 1902(a)(13) (42 U.S.C. 1396a(a)(13)) to read as follows:

27 "(A)(i) for a public process for determination of
28 rates of payment under the plan (including payment
29 adjustments under section 1923) for hospital services,
30 nursing facility services, and services of intermediate
31 care facilities for the mentally retarded under which—

32 "(I) proposed rates and the methodology used
33 to achieve such rates are published, and providers,
34 beneficiaries and their representatives, and other

1 concerned State residents are given a reasonable
2 opportunity for review and comment thereon; and
3 “(II) final rates and the methodology used to
4 achieve such rates are published, together with jus-
5 tifications taking into account review and com-
6 mends thereon; and

7 “(ii) payment of hospital services provided under
8 the plan through the use of rates that take into ac-
9 count the situation of hospitals which serve a dis-
10 proportionate number of low income patients with spe-
11 cial needs and that provide, in the case of hospital pa-
12 tients receiving services at an inappropriate level of
13 care (under conditions similar to those described in sec-
14 tion 1861(v)(1)(G), for lower reimbursement rates re-
15 flecting the level of care actually received (in a manner
16 consistent with section 1861(v)(1)(G));”.

17 (b) **EFFECTIVE DATE.**—The amendment made by sub-
18 section (a) shall apply to quarters beginning on or after Octo-
19 ber 1, 1996. Nothing in such amendment shall be construed as
20 affecting the authority of the Secretary of Health and Human
21 Services (currently in regulations under section 447.272 of title
22 42, Code of Federal Regulations) to limit the payment amounts
23 that the Secretary may recognize for purposes of providing
24 Federal financial participation.

After section 7203, insert the following new section
(and redesignate the succeeding sections and conform the
table of contents accordingly):

25 **SEC. 7204. REVISION OF REQUIREMENTS RELATING TO**
26 **FEDERALLY QUALIFIED HEALTH CENTERS**
27 **AND RURAL HEALTH CLINICS; ESTABLISH-**
28 **MENT OF SEPARATE DIRECT PAYMENT PRO-**
29 **GRAM.**

30 (a) **LIMITATION OF CURRENT REQUIREMENTS TO FACILI-**
31 **TIES OF INDIAN TRIBES.**—

32 (1) **PAYMENT RULES.**—Section 1902(a)(13) (42
33 U.S.C. 1396a(a)(13)) is amended by inserting “furnished

1 by an Indian tribe or tribal organization described in the
2 last sentence of section 1905(b)" after "under the plan".

3 (2) COVERAGE REQUIREMENT.—Section 1905(a) (42
4 U.S.C. 1396d(a)) is amended—

5 (A) in paragraph (2)(B), by inserting "if furnished
6 in a facility of an Indian tribe or tribal organization de-
7 scribed in the last sentence of section 1905(b)" after
8 "included in the plan";

9 (B) in paragraph (2)(C), by inserting "if furnished
10 in a facility of such an Indian tribe or tribal organiza-
11 tion" after "included in the plan"; and

12 (C) in paragraph (9)—

13 (i) by inserting "(A)" after "(9)", and

14 (ii) by inserting before the semicolon at the
15 end the following: "(B) consistent with State law
16 permitting such services, rural health clinic services
17 (as defined in subsection (1)(1)) and any other am-
18 bulatory services which are offered by a rural
19 health clinic (as defined in subsection (1)(1)) and
20 which are otherwise included in the plan and which
21 are not described in paragraph (3)(B), and (C)
22 Federally-qualified health center services (as de-
23 fined in subsection (1)(2)) and any other ambula-
24 tory services offered by a Federally-qualified health
25 center and which are otherwise included in the plan
26 and which are not described in paragraph (3)(C)".

27 (3) EFFECTIVE DATE.—The amendments made by
28 this subsection shall apply to services furnished on or after
29 October 1, 1996.

30 (b) GRANT PROGRAM FOR UNFUNDED COSTS OF RURAL
31 HEALTH CLINICS AND FEDERALLY-QUALIFIED HEALTH CEN-
32 TERS.—Title XIX, as previously amended, is further amended
33 by redesignating section 1933 as section 1934 and by inserting
34 after section 1932 the following new section:

15

1 "GRANTS FOR UNFUNDED COSTS OF RURAL HEALTH CLINICS
2 AND FEDERALLY-QUALIFIED HEALTH CENTERS

3 "SEC. 1933. (a) GRANT PROGRAM FOR UNFUNDED POR-
4 TION OF REASONABLE COSTS INCURRED UNDER STATE
5 PLANS.—The Secretary shall make a grant under this section
6 to each public or private nonprofit rural health clinic and public
7 or private nonprofit Federally-qualified health center for fiscal
8 year 1997 and each subsequent fiscal year. The Secretary shall
9 make payments for such grants in advance, in such install-
10 ments as the Secretary finds appropriate and adjusted to take
11 into account any overpayments or underpayments in grants
12 previously made under this section.

13 "(b) AMOUNT OF GRANT.—Subject to subsection (d), the
14 amount of the grant made under this section to a Federally-
15 qualified health center or rural health clinic for a year is equal
16 to the Secretary's estimate of the difference between—

17 "(1) the total amount of costs projected to be incurred
18 by the center or clinic for the year in providing health care
19 and related services; and

20 "(2) the total amount (exclusive of the grant under
21 this section) projected to be received by the center or clinic
22 for the year as payment for providing health care and relat-
23 ed services.

24 "(c) DIRECT SPENDING.—

25 "(1) IN GENERAL.—For carrying out this section
26 there are hereby appropriated, out of any money in the
27 Treasury not otherwise appropriated, the following amounts
28 (as applicable to the fiscal year involved):

29 "(A) For fiscal year 1997—\$500,000,000.

30 "(B) For fiscal years 1998 and each subsequent
31 fiscal year, the amount determined under this sub-
32 section for the previous fiscal year multiplied by the na-
33 tional medicaid rural health clinic and Federally-quali-
34 fied health center rate of growth, as determined under
35 paragraph (2), for such fiscal year.

36 "(2) NATIONAL MEDICAID RURAL HEALTH CLINIC AND
37 FEDERALLY-QUALIFIED HEALTH CENTER RATE OF

16

1 GROWTH.—At the beginning of each fiscal year, the Sec-
2 retary shall determine for the preceding fiscal year a na-
3 tional medicaid rural health clinic and Federally-qualified
4 health center rate of growth for Federal payments made
5 under this title to all States with a State plan approved
6 under this title (or operating a medicaid program under a
7 waiver of the requirements of this title) based on—

8 “(A) the percentage increase in payments made
9 under this title that occurred during such fiscal year;
10 and

11 “(B) the annual percentage increase that occurred
12 during such year in the populations served by Federally
13 qualified health centers and rural health clinics eligible
14 for a grant under this section.

15 “(d) ENTITLEMENT STATUS OF GRANTS.—

16 “(1) IN GENERAL.—Effective on and after October 1,
17 1996, the requirement established in subsection (a) for the
18 Secretary (relating to making a grant)—

19 “(A) is an entitlement in a public or private non-
20 profit Federally qualified health center and a public or
21 private nonprofit rural health clinic on behalf of indi-
22 viduals served by the center or clinic (but is not an en-
23 titlement in any such individual); and

24 “(B) represents the obligation of the Federal Gov-
25 ernment, subject to paragraph (2), to make a grant
26 under subsection (a) to the center or clinic in the
27 amount determined for the clinic or center under sub-
28 section (b).

29 “(2) CAPPED ENTITLEMENT.—The entitlement estab-
30 lished in paragraph (1) is subject to the extent of the
31 amount appropriated in subsection (c) for the fiscal year.

32 “(3) PRO RATA REDUCTIONS UNDER CAP AMOUNT.—
33 If the Secretary determines that the budget authority pro-
34 vided in subsection (c) for a fiscal year is insufficient to
35 provide the total of all amounts under subsection (b) for
36 the year, the Secretary shall reduce each amount deter-
37 mined under subsection (b) for the year on a pro rata basis

1 to the extent necessary for the grants under this section to
2 be provided in an aggregate amount equal to the budget
3 authority available under subsection (c) for the year.

[AFDC eligibility] Add to subtitle C the following

new section:

4 **SEC. 720 ____ FLEXIBILITY IN ELIGIBILITY FOR AFDC-RE-**
5 **LATED POPULATIONS AND REVISIONS IN**
6 **TRANSITIONAL WORK PROVISIONS.**

7 (a) PERMITTING CATEGORICAL ELIGIBILITY TO BE
8 BASED ON CURRENT AFDC PLAN.—

9 (1) IN GENERAL.—Section 1902(a)(10)(A)(i)(I) (42
10 U.S.C. 1396a(a)(10)(A)(i)(I)) is amended by inserting “,
11 except that a State plan may elect to apply this subclause
12 based on its State plan under title IV as in effect on the
13 date of the enactment of the Medicaid State Flexibility Act
14 of 1996” before the comma at the end.

15 (2) CONFORMING AMENDMENT TO TRANSITIONAL
16 WORK PROVISIONS.—Section 1925(a) (42 U.S.C. 1396r-
17 6(a)) is amended by adding at the end the following new
18 paragraph:

19 “(4) USE OF HISTORICAL ELIGIBILITY STANDARD.—In
20 the case of a State that elects, under section
21 1902(a)(10)(A)(i)(I), to apply such section based on its
22 State plan under title IV as in effect on the date before the
23 date of the enactment of the Medicaid State Flexibility Act
24 of 1996, this section shall be applied as if any reference to
25 a provision of title IV is a reference to such provision as
26 in effect on the date before such date of enactment.”.

27 (b) REPEAL OF SUNSET ON TRANSITIONAL WORK PROVI-
28 SIONS.—Subsection (f) of section 1925 (42 U.S.C. 1396r-6(f))
29 is repealed.

30 (c) PAYMENT OF GROUP HEALTH COINSURANCE AT MED-
31ICAID RATES UNDER TRANSITIONAL WORK PROVISIONS.—

32 (1) IN GENERAL.—Section 1925(a)(4)(B) (42 U.S.C.
33 1396r-6(a)(4)(B)) is amended—

34 (A) by striking “and” at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting “; and”; and

(C) by adding at the end the following new clause:

“(iii) the State may limit the amount of any deductible or copayment for any health care item or service to the applicable portion of the amount the State would pay if such item or service had been furnished by a provider participating in the program under the State plan.”.

(2) LIMIT ON PAYMENTS FOR ADDITIONAL EXTENSION.—Section 1925(b)(4)(D) (42 U.S.C. 1396r-6(b)(4)(D)) is amended by adding at the end the following new sentence: “If the State elects to pay such deductibles and coinsurance, the State may limit the amount of such payments as provided in subsection (a)(4)(C)(iii).”.

(d) STATE FLEXIBILITY IN REPORTING REQUIREMENTS UNDER TRANSITIONAL WORK PROVISIONS.—Section 1925(b) (42 U.S.C. 1396r-6(b)) is amended—

(1) in paragraph (2)(B), by adding at the end the following new clause:

“(iv) STATE FLEXIBILITY.—Notwithstanding the previous provisions of this subparagraph, a State may delay or defer the deadlines for any reporting requirement established under this subparagraph.”; and

(2) in paragraph (3)(A)(iii)(I), by inserting “or unless the State has waived or modified such reporting requirement under paragraph (2)(B)” before the semicolon at the end.

[New Optional Eligibles] In subtitle C, insert the following new section (and conform the table of contents accordingly):

SEC. 720. STATE FLEXIBILITY IN COVERING ADDITIONAL POPULATIONS.

(a) EXPANDED ELIGIBILITY.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

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19

1 (1) by striking "and" at the end of subparagraph (E).

2 (2) by adding "and" at the end of subparagraph (F).

3 and

4 (3) by inserting after subparagraph (F) the following
5 new subparagraph:

6 "(G) at the option of a State, for making medical
7 assistance available to one of the following groups of
8 individuals who would otherwise be ineligible for such
9 assistance:

10 "(i) Individuals (including any reasonable clas-
11 sification of such individuals) whose income does
12 not exceed 100 percent of the poverty line (as de-
13 fined in section 673(2) of the Community Services
14 Block Grant Act (42 U.S.C. 9902(2))).

15 "(ii) Individuals (including any reasonable
16 classification of such individuals) whose income
17 does not exceed a higher percentage of such poverty
18 line, but only if the State establishes (to the satis-
19 faction of the Secretary) that coverage of such indi-
20 viduals under this clause will not result in Federal
21 payments to the State that exceed the payment
22 amounts that would have applied if clause (i) had
23 been applied instead of this clause;"

24 (b) CONFORMING AMENDMENT.—Section 1905(a) (42
25 U.S.C. 1396d(a)) is amended, in the matter before paragraph
26 (1)—

27 (1) by striking "or" at the end of clause (x),

28 (2) by inserting "or" at the end of clause (xi), and

29 (3) by inserting after clause (xi) the following new
30 clause:

31 "(xii) individuals described in section
32 1902(a)(10)(G)."

33 (c) DISREGARD OF ADDITIONAL ENROLLEES IN CALCULA-
34 TION OF FEDERAL PAYMENT LIMIT.—Section 1903(d)(7)(B),
35 as added by section 7001(b)(1)(B) of this Act, is amended by
36 adding at the end the following: "The numbers reported by the
37 State under this paragraph shall not include any individuals



GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

TO: Richard Kogan & Interested people
FROM: Jeanne Lambrew *Jeanne*
RE: CONCERNS ABOUT THE ALTERNATIVE TO THE PER CAPITA CAP
DATE: December 30, 1996

Thank you for sending me your paper. I am not sure whether this is a final copy or one for review, but here are my comments on it regardless.

There are two general sets of comments: about your alternative and about your criticism of the per capita cap.

Concerns about the Alternative:

The alternative proposal is essentially an across-the-board FMAP reduction, with a partial "performance rebates" to low-cost and / or low-growth states. To the extent that budget savings from Medicaid are not achieved from states' behavioral responses to these rebates, a "backstop" causes the FMAP reduction to exceed the total amount of the rebate. This alternative will likely produce budget savings and begins to address cross-state equity issues. However, the policy also:

- **Does not protect coverage.** One of the biggest advantages of the per capita cap is that it does not create an incentive to reduce the number of people enrolled in Medicaid (since the Federal matching limit is linked to enrollment). Under the alternative, there is no such protection. All states have their FMAP reduced irrespective of the number of people covered. The FMAP reduction means that for every Federal dollar saved, state spending increases by a dollar if total spending remains constant. For states that cannot put up additional funds to cover the same services and beneficiaries, this shift of costs to states may create an incentive to reduce total spending. Since reducing coverage of high-cost beneficiaries usually produces greater savings than reducing optional benefits, states may choose the former. In fact, the "performance rebate" may encourage this since eliminating coverage for high-cost beneficiaries lowers states' average per capita cost and possibly their per capita cost growth, making them more likely to receive a rebate.¹

¹While there is component of the performance rebate that is based on enrollment, it is less important than the ratio of the states per capita costs or growth to the national average.

• **"Performance rebates" could cause a race to the bottom.** The alternative bases the net FMAP reduction on a state's spending patterns relative to the national norm. States with per capita spending or growth that is lower than the national average get a lower FMAP reduction (or possibly an increase in their matching rates). As a consequence, states are rewarded for being lower than each other, not lower than some external standard. As more states cut their programs to receive the rebate, the average moves down, and states have to cut even more to become the lowest and get the maximum rebate. While this may produce Federal savings, it may result in the highest FMAP for states that have reduced most of their optional benefits and coverage. In contrast, the per capita cap's Federal spending limit for each state is independent of those for other states and encourages states to maintain per capita cost growth at or just below a normative index (growth in nominal GDP plus some factor). It penalizes states that lower the number of mandatory or optional enrollees.

• **"Performance rebates" assume that the national averages are "right".** One of my greatest concerns about last year's block grant proposal was the assumption that some states don't spend enough on Medicaid and should increase their spending, that other states spend too much and should be punished, and that the national average is the "right" amount of Medicaid spending. This ignores one of the fundamental features of Medicaid: It is really fifty different programs and the national average is consequently meaningless.

◦ **Ignores differences in benefits.** States vary in the number of optional benefits offered and the amount, duration and scope of those benefits. Consequently, valid differences in what is covered play a major role in the variation in spending across states. For instance, most states with higher-than-average per capita costs have higher long-term care costs. While adjusting for the number of elderly and disabled in a state addresses some of this variation, it does not account for the existence of a more generous medically needy program, fewer community-based options for people with long-term care needs, or a greater number of people older than 85 years requiring institutionalization.

◦ **Ignores differences in costs across states.** In order to assure access to providers, some states (like New York or Massachusetts) have to pay providers more than others. Other states (like Missouri or California) are able to cover the same services at lower rates. Does it make sense to reduce Federal matching for states whose environment is more costly, or to give extra matching to states that might be able to efficiently provide care at lower-than-average rates?

- Assumes national average is right.** In the same way that the average per capita spending in Medicaid represents no single person's experience², the national average Medicaid per capita represents no single state's experience. Furthermore, under the alternative, the national average is endogenous to the policy, so that the more states try to be below average, the lower the average, the harder it is to get "rebates" without cutting benefits or coverage.
- Would likely have its own "leakage" factor.** In its August 1996 Deficit Reduction book, the CBO discusses the implications of an FMAP reduction. One of the major questions posed is whether states will increase total spending to draw down the Federal funds that they would otherwise have received. For instance, a state that relies on a certain amount of Federal Medicaid dollars may add qualifying state-only spending to its Medicaid program in order to increase total expenditures and thus Federal matching payments. In fact, under this policy, a state could double its total spending and receive more matching than under current law, albeit at a lower matching rate. Under the per capita cap, the only way to get more Federal matching than under current law is to increase enrollment; otherwise, cost increases are not matched.

Criticisms of the Per Capita Cap:

From our previous discussions, you know that I agree that the per capita cap presents technical as well as political challenges. However, I think that your explicit concerns are to some extent addressed in the Administration's proposal. The following lists your concerns (in bold) and my responses.

- Locks in the base-year spending per capita.** This is not exactly true of the Administration's proposal. There was a commission which would assume the responsibility of determining how to increase equity across states. The commission approach is probably preferable to the legislative approach since it is more immune from the political vicissitudes that have plagued other statutorily mandated state formulae. It will also allow for greater sophistication in defining what is equity, what is valid variation, and how this can be achieved over time.
- Does not accurately adjust for valid health cost increases.** Couldn't the use of private spending growth per capita, suggested for a different use in your alternative, solve this problem within a per capita cap? We actually looked at this last year, but had concerns about the validity of the available measures of health spending growth — similar to those that you expressed in your December

² Since aged and disabled beneficiaries' per capita costs are more than 3 times higher than those of adults and children, the combined average per capita costs represents no groups' experience.

1995 memo on appropriate index factors.

- **Risk substitution of low-cost for high-cost beneficiaries.** To mitigate against this effect, the matchable spending limit was calculated by group. This means that the substitution of low-cost kids and adults for high-cost aged and disabled would actually lower the Federal matching limit, reducing the incentive. Within the four groups of people, this risk of substitution remains. However, very little savings could accrue from substituting low-cost for high-cost adults and kids, since these groups are inexpensive to begin with. And, it would probably be difficult for states to substitute low-cost for high-cost disabled and elderly, since the latter are mostly institutional residents. Research has shown that states have not had much success in using home and community-based care services as a substitute for nursing homes, since people who go into nursing homes often are there as a last resort anyway.
- **Would override waivers.** The Administration's policy explicitly preempted 1115 waivers. There was an option as to how DSH would be determined in states that had used it in their implemented demonstrations, but we only offered that option to the five states that had begun their demonstrations (not all approved waivers).

Your additional concern about the consequences of the per capita cap being too tight is, I think, a more general concern about too deep a reduction in Federal Medicaid spending. The alternative policy could have equally severe consequences if its savings target is too high. I, too, am concerned about excessive Medicaid reductions and am hoping that analysts can inform this question.

As a reminder, the per capita cap is also an FMAP reduction. States with per capita cost growth at or below the index value get the current FMAP; states with per capita cost growth above the index get reduced Federal matching payments in proportion to the excess growth. Thus, it is similar to the per capita growth component of the performance rebate, except that it sets up a normative standard for per capita cost growth that is linked to the general economy, not the average of all states' spending growth.

The crucial difference in the policies is the safeguard against coverage loss: the per capita cap has one, the alternative does not. Protecting coverage may be especially important in the coming years given welfare reform. Thus, assuming that both policies can produce equal Federal savings, the question becomes: do the advantages of the equal FMAP reduction plus performance rebates in the alternative outweigh the incentives for states to reduce coverage? In fairness, you should address this in your paper.

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NEM -

Jack Lew would like
to discuss this w/you.

JR

Comments:

The e... cap in last
year's Administration Budget. The alternative produces savings and, if desired, can be
designed to place a national per-capita cap on federal Medicaid expenditures to limit
fiscal exposure. We think this approach offers significant substantive and political
advantages over last year's per-capita cap. I hope you'll give this a serious look.

December 27, 1996

CONTROLLING FEDERAL MEDICAID COSTS: Beyond the Block Grant and the Per-Capita Cap

by Richard Kogan

Last year the Administration proposed a per-capita cap on federal Medicaid costs to supplement other sources of Medicaid savings.¹ While a per-capita cap is substantively greatly preferable to a block grant, it still has serious substantive and political drawbacks. If the Administration proposes a per-capita cap in February, those drawbacks will be put under a spotlight. Some have recommended that the Administration not include a per-capita cap in the budget now, but accede to a per-capita cap later, if necessary, as part of a grand budget compromise.

This paper suggests an alternative to a per-capita cap that would produce additional savings by creating significant new incentives for states to restrain Medicaid's per-capita cost growth. It also sets forth a different method of enforcing a national ceiling on Medicaid's per-capita cost growth if the Administration also considers it essential to include in its budget a backstop mechanism to protect the federal Treasury against any greater-than-expected growth in Medicaid costs. The mechanism outlined here would impose across-the-board reductions in federal Medicaid payments to all states if Medicaid costs exceed a national per-capita cost ceiling. *This alternative itself could be described as a per-capita cap, although it differs significantly from previous per-capita cap proposals.*

Drawbacks of a per-capita cap page 2

Reducing Medicaid costs by changing state incentives page 4

A Medicaid backstop mechanism to limit fiscal exposure page 6

Attachment: Calculating the rebate to states page 9

¹ The Administration also proposed: a) reforming and limiting "Disproportionate Share Hospital" (DSH) payments; b) repealing the Boren amendment's legal prop under the level of payments to nursing homes and hospitals; and c) allowing states to use managed care organizations such as HMOs without obtaining a waiver from the Department of Health and Human Services. Only the DSH proposal was estimated by CBO to produce substantial savings. In the context of a per-capita cap, the Boren repeal and managed care proposals were viewed merely as tools by which states could limit costs to the level of the cap. Absent a cap, CBO would credit Boren repeal and managed care with producing a relatively modest amount of savings. The low estimate of savings resulting from Boren repeal and managed care implies that any type of artificial cap on Medicaid costs — such as a block grant, a per-capita cap, or the national cap described in this paper — cannot generate substantial extra Medicaid savings without causing beneficiaries (or state treasuries) to suffer.

Drawbacks of a Per-Capita Cap

A per-capita cap is a better financing mechanism than a block grant. Unlike a block grant, a per-capita cap responds to variations in the growth of the Medicaid population from state to state, whether caused by variations in economic or demographic factors. In addition, a per-capita cap does not create an incentive to disenroll beneficiaries or deny enrollment to them, as a block grant does. Finally, a per-capita cap does not carry with it the implication inherent in a block grant that the federal guarantee of eligibility and benefits ought to be removed. Nonetheless, a per-capita cap has drawbacks that should not be ignored.

- Most per-capita cap proposals lock in existing state-by-state variations in the per-capita costs of medical care, providing much more generous per-capita payments, for example, to New York than California. Under current law, the justification for this outcome is that those two states have chosen to be, respectively, more and less generous with their own (state funded) payments on behalf of beneficiaries. Under a per-capita cap, the federal distribution of funds (per beneficiary) is locked in even if New York becomes less generous with its own Medicaid contributions or more efficient in delivering benefits, and even if California becomes more generous or less efficient. *locks in state variation*
- A per-capita cap is unresponsive to legitimate changes in the cost of health care. A flu epidemic, for example, can cause a much larger portion of the beneficiary population to require medical treatment in one part of the country than another.
- Per-capita caps establish incentives for states to sign up low-cost beneficiaries and provide them minimal service; CBO cost estimates estimate that one-third of potential savings will "leak away" for this reason, forcing the cap to be tighter than otherwise. Additionally, per-capita caps establish incentives for states to discriminate much more than they now do against high-cost beneficiaries. Yet rules to minimize "leakage" or counter discrimination will necessarily be complex; states will find them objectionable. *low cost beneficiaries minimalist*
- The design of a per-capita cap grows much more complicated as states such as Tennessee begin to operate under major waivers; a per-capita cap may require renegeing on some waiver agreements. *why?*

A per-capita cap also includes serious political risks — enough so that, even if the decision is made that a per-capita cap adequately balances the need for savings

against the needs of beneficiaries, it may be unwise to offer a per-capita cap as a starting point for negotiation.

- The first point above — that a per-capita cap locks in an inequitable level of payments from state to state — cannot easily be attacked by those advocating a block grant with the same flaws. However, if a per-capita cap is the first proposal made, it can be dissected at great length before an alternative must be created. The risk is that governors and Congress will conclude a per-capita cap constitutes an inequitable distribution of funds. In addition to historical inequities in state-to-state Medicaid payments per capita, it should be noted that a number of states, in anticipation of a block grant, artificially transferred costs from 1996 to 1995 in order to increase their block grant base. Such actions could also increase the inequitable base of a per-capita cap.²
- Governors will also note that a per-capita cap contains increased federal regulations and record-keeping requirements to minimize ("leakage") of savings and prevent discrimination against high-cost patients (see the third point above). A block grant may seem to governors to have only slightly more financial risk while promising much greater flexibility with respect to benefits. If the governors believe they'll be stuck with unfair financing in any case, some of them might feel the need to demand the repeal of the federal guarantee of coverage and benefits or the repeal of other important federal guarantees the Administration wishes to defend. If the per-capita cap is in the Administration's budget, a spirited debate on it — and potentially a vigorous attack on it — can be expected at the next National Governors' Association meeting.
- Even if the Administration proposes a per-capita cap that does not squeeze too hard, during negotiations with Congress the cap could be tightened so much that it would squeeze too hard within a few years. Under a per-capita cap, as under a block grant, states bear 100 percent of the cost increases in the price of medical care per capita — once the cap on federal payments is reached for a state, the Treasury of that state will have to cover all additional Medicaid costs with no additional federal "matching" payments. Thus, a per-capita cap that squeezes too hard

² It is also possible that the Medicaid eligibility provisions of the welfare bill — especially the denial of many benefits to legal immigrants — may alter the average per-capita cost of care for an eligibility group such as the elderly. This could affect some states to a significant extent but others only slightly. A per-capita cap would not capture these effects in the base-year level of per-capita payments (from which future state caps are calculated); thus, the welfare bill potentially creates another source of inequitable payments to states under a per-capita cap.

could, within a few years, lead a larger and more bipartisan contingent of governors than in 1995 to call for a block grant and a repeal of federal guarantees in order to give them more tools to deal with federal cost constraints.

If the initial budget proposal does not contain a per-capita cap, one criticism could be that the Medicaid savings are too small, forcing too deep cuts elsewhere (or allowing too little room for tax cuts!) This criticism is not likely to persuade the public at large. Further, the Administration can compromise on a per-capita cap later if there is a grand compromise. With the per-capita cap a compromise product, its inevitable anti-leakage and anti-discrimination rules (which may annoy governors) would be a bipartisan construct, not the Administration's proposal.

Reducing Medicaid Costs by Changing State Incentives

This paper proposes an alternative way to create federal Medicaid savings, beyond those flowing from DSH and other reforms: redistribute existing federal Medicaid payments by making "performance rebates" to those states that achieve, on a per-capita basis, either low costs or low growth rates. While this would purport to redistribute federal payments rather than reduce them, to the extent that states respond to the incentives by achieving greater savings, federal cost will be reduced.

Here is the recipe for the "performance rebate" plan.

- 1) Make an up-front estimate of the total — federal and state — level of "baseline" Medicaid outlays through 2002, less the savings from DSH and other reforms.
- 2) Reduce the Medicaid payment the federal government would otherwise make to each state by some percentage across the board (say four percent), to create federal savings that would be placed in a "rebate pool."³

³ This is achieved by reducing the federal match rate for each state — the FMAP — by an equal percentage. Thus, a four percent reduction means that the FMAP for a "50% state" would be reduced to 48 percent. The FMAP for a "30% state" would be reduced to 28.8 percent. If this were the totality of the proposal (which it is not), each state would have its federal dollar payment reduced by the same percentage, and would have to make up the lost federal cash from its own Treasury. As opposed to a per-capita cap or a block grant, an FMAP reduction does not create a strong incentive for states to jettison the very sick since states still share all health/cost risks with the federal government. Unlike a per-capita cap,

nly slightly. A per-
ents (from which future

such as the elderly. This would affect public aid to a significant extent but others
capita cap would not capture these effects in the base-year level of per-capita pay
state costs are calculated. Thus, the uniform FMAP

3) Calculate the size of the rebate pool generated by step 2 — the federal four percent reduction⁴ — and distribute *all* of the rebate pool to states as performance bonuses for cost-conscious behavior.

- Rebate half of the savings to states with below-average *costs* per capita.⁵
- Rebate the other half of the savings to states with below-average *growth* in per-capita costs.⁶

Most states can reasonably hope to get a performance rebate based on being low cost, low growth, or both. Only states that have both high costs *and* high growth rates will get nothing back. (The attachment describes the formula for distributing performance rebates to states. The principle is that the better a state does, the larger the per-capita rebate it will get.)

Even though all the savings from the 4 percent reduction will be rebated, the actions that states take to attempt to be "low cost" or "low growth" (or both) will reduce actual federal and state Medicaid costs by a noticeable amount. A four percent reduction/rebate creates a fairly robust incentive because some states can end up with more federal dollars than they lose through from the percentage reduction.⁷ The

⁴ This calculation measures the amount of savings that would be achieved by a four percent cut *if total Medicaid spending were at the "baseline" in step 1*. In practice, Medicaid spending before this cut will likely be below that baseline. Thus, the purpose of this calculation is really just to determine the size of the rebate pool in step 2.

⁵ Costs includes both state and federal costs, except for DSH payments. In this and all subsequent references to per-capita costs, the term should mean "per-capita costs adjusted to reflect differences among states in the composition of the caseload." For this purpose, the per-capita Medicaid costs in a state (combining federal and state payments) would be the actual costs in the state *if* the state had the same proportion of elderly, disabled, and other beneficiaries as the nation as a whole.

⁶ Growth is measured by comparing costs in one year with those in the prior year.

⁷ Since the amount of incentive rebates in a given year to each state depends on the final Medicaid expenditures in all the states, the amount for each state cannot be calculated with certainty until the year is over. The government could make the four percent reductions during the fiscal year but not pay rebates until the year is over and final numbers are in, but such an approach is not recommended; it is not the intent to gain a timing advantage for the federal government. One solution is to make estimated rebates during the year in question, with a final reconciliation after the year was over. Another is to defer both the reductions and the rebates until the final amounts are known; in essence, they would both be applied to the subsequent year's budget. In fact, both the reductions and rebates for a fiscal year could be applied in the year starting *after* the final figures are known (e.g. the 1998 reductions and rebates would be applied in 2000). This would maximize the states' ability to plan their budgets, although it might diminish the incentive to be cost conscious.

incentive can be made still more robust by increasing the reduction/rebate to five percent or even six percent.

A Medicaid Backstop Mechanism

The concept of Medicaid as an insurance program is that the risk of an unexpected increase in costs — whether from an epidemic or a new but expensive technological breakthrough — should be shared between the federal and state governments. A cap, in contrast, immunizes the federal government from financial risk, passing it on to state governments and providers. And as noted in footnote 1, any exogenous cap runs the risk of being too tight. No one knows how hard one can squeeze providers, for example, before the quality of care begins to deteriorate significantly. For these reasons, a Medicaid cap is not recommended policy.

If, nonetheless, it is considered essential to protect the federal Treasury against any greater-than-expected growth in Medicaid costs, the following method of enforcing a national ceiling on Medicaid's per-capita costs is superior to a per-capita cap.

- 1) Establish a ceiling for the growth of per-capita *national* Medicaid costs (the combined federal and state costs in all 50 states and the District of Columbia).⁸ This ceiling should equal the expected costs of Medicaid given DSH and other reforms plus the savings generated by the rebate plan described above; therefore, this ceiling would not be expected to produce additional savings — it exists as a backstop, to protect the federal Treasury in the event that costs rise faster than expected.
- 2) The ceiling should limit the cumulative percentage growth of per-capita Medicaid costs relative to costs in a base year (e.g. 1997).⁹ The ceiling should be set *relative to the growth of private-sector per-capita health care spending*.¹⁰ Suppose that

⁸ Note that this ceiling is not the "baseline" described on page 4.

⁹ Since the ceiling is national, the problem of states' deliberately distorting their Medicaid behavior in the base year to achieve a higher cap is eliminated. This also means that the base year could be *after* the proposal is enacted, e.g. 1998, which allows HCFA more time to establish definitions of beneficiary categories (e.g. disabled children vs. poor children) and insure more accurate data.

¹⁰ Establishing the ceiling by reference to per-capita national health care costs is the preferred method, since national health care costs take into account nationwide inflation, changes in medical technology and practice, etc. This type of ceiling would prevent Medicaid per-capita costs from growing unexpectedly faster than per-capita national health care costs (or more technically, from deviating from national health care costs by more than initially expected when the proposal is enacted). Other potential backstop ceilings are workable, as long as they respond to unexpected changes in the rate of inflation and in caseload. For

(continued...)

Medicaid per-capita costs were expected to rise at exactly the same rate as national health care per-capita costs, after the reforms proposed in the budget were taken into account: the ceiling would then say, "Medicaid costs per capita must not grow faster than private-sector health care costs per capita." If private-sector per-capita costs actually grew by a cumulative total of 10 percent from 1997 to 2000, then Medicaid per-capita costs could not grow by more than 10 percent. Or the Medicaid ceiling could be, for instance, "private-sector growth plus one percent per year" or "private-sector growth minus one percent per year," as necessary to track the estimated cost of Medicaid given DSH reform, other reforms, and the rebate plan.¹¹

This type of ceiling can be billed as a "per-capita cap," although it differs significantly from per-capita cap proposals made in prior years.

3) If the ceiling is breached in any year, there would be an automatic mechanism to achieve offsetting savings. That mechanism would be attached to the performance rebate mechanism previously described: the across-the-board reduction that generated the rebate pool would be increased but *the rebate to states would not*. For example, instead of a four percent reduction with all the savings being rebated, the reduction could grow to five percent but with only four-fifths of the savings rebated.

Is this backstop mechanism equitable? In many respects, yes. If the cause of an above-ceiling growth rate of per-capita costs in one year is a massive epidemic in the southeast (for instance), it makes sense that federal Medicaid payments be reduced for all states — this shares risk broadly among states, which is the purpose and strength of insurance. In the words of Sen. Bob Graham, such an approach would "thin the soup for everyone."

It is possible that a single state, or a few of them, could be so imprudent in their approach to Medicaid in some year that national per-capita costs would rise above the ceiling. Arguably, those states should bear a special burden. In fact, under this approach, they would. If their imprudence caused them to lose one or both of their incentive rebates, they would bear a burden, and the incentive rebates they otherwise

¹⁰ (...continued)

example, the ceiling could directly set forth the constant-dollar (inflation adjusted) level of estimated per-capita Medicaid expenditures through 2002. Or it could be linked to the growth of nominal per-capita GDP plus or minus the amount needed to track the estimated growth of nominal per-capita Medicaid costs. If some benchmark other than per-capita health care expenditures is used, it is desirable to include a margin of error cumulating to, for example, five percent to cover relatively small fluctuations in the costs of medical technology and practice.

¹¹ As a matter of policy, this national ceiling should expire after 2002 so that it can be re-evaluated. If the cap is permanent, it should not constrain Medicaid to grow more slowly than private-sector per-capita costs after 2002.

would have received would be redistributed to other states, mitigating for them the effect of the greater across-the-board reduction.

Ultimately, however, it is beyond the ability of any formula to decide which unexpectedly large cost increases are within a state's control and which are beyond its control. The performance rebates and backstop mechanism outlined above provide a mixture of features. They provide incentives for tight cost management without the inequities, special rules, and other drawbacks of a per-capita cap. At the same time, they provide the ability to constrain overall federal costs and prevent large, unintended increases in federal Medicaid expenditures.

Attachment: Calculating the Rebates to States

The first step is to calculate the dollar amount of each type of rebate. This is accomplished by multiplying a) the level of combined federal and state Medicaid outlays in the year in question in the statutory "baseline" described on page 4, by b) the national average FMAP before the across-the-board reduction, by c) the across-the-board reduction percentage. Thus, the amount might be \$175 billion * 57% * 4% = \$4 billion. This is the size of the rebates to states.

Then divide the \$4 billion rebate amount in half. One half will go to low-cost states, the other to low-growth states.

A. Distribute the \$2 billion for low-cost states as follows:

- 1) For each state, calculate the ratio of combined federal and state per-capita costs in that state (adjusted for case mix; see footnote 5) to the national average per-capita costs. This will give a ratio higher than 1.000 for high-cost states and lower than 1.000 for low-cost states.
- 2) Subtract that ratio from one, and discard all the negative results. This will give a list of 25 or so states with figures such as 0.034 or 0.127 associated with each; the higher the figure, the lower the state's per-capita costs relative to the national average.
- 3) For each of the 25 or so states on the list, multiply the figure from step 2 by the caseload for the state, adjusted to reflect the extent by which the state's case mix differed from the average case mix.
- 4) Divide the \$2 billion rebate in strict proportion to the figure for each state calculated in step 3.

B. Distribute the \$2 billion for low-growth states as follows:

- 1) For each state, calculate the percentage increase in combined federal and state per-capita costs in that state (adjusted for case mix) from the prior year to the year in question. This will produce figures such as 2.5%, 4.7%, and -0.3%. Make the same calculation for the nation as a whole.
- 2) For each state, calculate the ratio of the growth rate just calculated in step 1 for that state to the national average growth rate of per-capita costs. This will give a ratio higher than 1.000 for high-growth states and lower than 1.000 for low-growth states. THIS IS EQUIVALENT TO STEP A1 ABOVE.
- 3) Using the ratios just calculated in step B2, mirror steps A2, A3, and A4. This will distribute the other \$2 billion.



Bob Graham
Florida

FAX TRANSMITTAL SHEET

TO: CHRIS JENNINGS DEBBIE CHANG CHARLIE SALEM	NANCY ANN MEN	PHONE:
FROM: BRUCE LEDLEY		PHONE:
DATE: 1/8/97		TIME:
NUMBER OF PAGES (including cover): 3		524 Hart Senate Office Building, Washington D.C. 20510

COMMENTS:

FYI -- Senator Graham asked me to put these together for his meeting with Erskine Bowles. I wanted to give you all a heads up. We are deeply concerned about equity attacks from Florida GOP &

MEDICAID POINTS FOR MEETING WITH ERSKINE BOWLES January 8, 1997

President Largely Responsible for Protecting Medicaid Last Year

- ◆ President Should Be Commended: The President saved Medicaid from block grants.

Per Capita Cap Proposal Should Be Dropped in 105th Congress

- ◆ Policy Conflict Prevents Consensus: The policy conflict over Medicaid financing -- per capita caps versus block grants -- was the major impediment to enacting any Medicaid reform last year. We should not reengage in that futile discussion in the 105th Congress unless Medicaid program growth demonstrates the immediate need for some overall cap. That is not the case.
- ◆ Medicaid Has Already Disproportionately Contributed to Deficit Reduction: Spending growth in Medicaid fell to just 3.2 percent last year. The policy changes in immigration, welfare and SSI made last year also will contribute greatly to additional Medicaid savings in the future. In fact, according to the Urban Institute, the Medicaid projected baseline has dropped by \$94.1 billion through 2002. Medicaid has already disproportionately contributed to deficit reduction.
- ◆ Fix What is Broken -- Don't Impose Arbitrary Caps: As the low growth in 1996 indicates, the Medicaid program's growth can be controlled without arbitrary caps through the use by states of managed care, home- and community-based care, the disproportionate share hospital (DSH) program controls put in place by the Administration and Congress, and greater efforts at reducing waste, fraud, and abuse. As a result, states should be allowed to pursue cost effective approaches such as managed care and home- and community-based care without the need for a cumbersome federal waiver. Also, the federal government should take additional steps to clamp down on abusive DSH payments.
- ◆ Harms Low-Spending States Permanently: By establishing a "base" and imposing fixed growth limits in the out-years, a per capita cap harms those states that have been frugal and efficient with their Medicaid programs. past efficiency should not be penalized but a per capita cap without provision for differential growth rates for low-spending states would be that.

States harmed by such a proposal include: Florida, California, Illinois, Texas, New Mexico, Vermont, Georgia, North Carolina, South Carolina, Virginia, West Virginia, Alabama, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Oklahoma, Ohio, Iowa, Kansas, Missouri, Arizona, Colorado, Idaho, Montana, Utah, Wyoming, Hawaii, Oregon, Washington and Nebraska.

For example, Connecticut's per beneficiary spending on Medicaid is twice that of Florida's. That disparity would be permanently locked into place well into the future by a per capita cap whether justified or not.

Administration's Commission Language Does Nothing for Low-Spending States: As drafted last year, the Administration created a Commission to tackle the issue of disparate funding between the states locked in by the per capita cap approach. Without a "base closure commission" type legislative process such as that contained in the Chafee/Breaux proposal last year, such a Commission would be useless.

- ◆ Lose Support of Our Partners -- The States: The state flexibility package proposed by the Administration during the last session of Congress has the potential of receiving strong support by our nation's governors and state legislators. As partners in the Medicaid program, it makes little sense to destroy that goodwill with an arbitrary per capita cap that the National Governors' Association (NGA) will undoubtedly oppose. Rather, we should allow states the opportunity to be more efficient first with the state flexibility provisions that they have been asking for and that were included in last year's consensus Medicaid reform package.
- ◆ With Welfare, SSI and Immigration Changes, Now May Be the Worst Time to Impose Per Capita Caps: With the passage of SSI and immigration eligibility changes and the de-linkage of Medicaid eligibility from AFDC last year, per capita spending on Medicaid beneficiaries in states may actually increase although overall spending could very well decline by virtue of the fact that beneficiaries will likely not be eligible for Medicaid coverage for the same periods of time as in the past. Until we know the full implications and impact of this legislation, now may be the worst time to establish a baseline for a per capita cap -- particularly from a state perspective.
- ◆ Little Savings Would Be Achieved: If the Medicaid baseline drops by \$94.1 billion through FY 2002 as the Urban Institute estimates, the imposition of a per capita cap will result in very little savings. It also has the effect of precluding any "scored" savings by the CBO for the state flexibility provisions included in the same package.
- ◆ Negatives and Problems Outweigh Any Possible Positives: The problems associated with imposing a per capita cap, including whether it will even work or whether it will be administratively feasible, seem to outweigh any positives associated with reintroduction -- including arguments about the need to be consistent and protecting the federal budget in the out-years from state "revenue maximization" efforts. Again, let's fix what is broken with the program now such as the need for further DSH reform. These reforms will be difficult enough to pass without the added baggage of a per capita cap.

January 21, 1997



Health Division



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

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Through:

Barry Clendenin

Mark Miller

BC 1/22/97

TYPE OF DELIVERY:HOTBOX ☒

OVERNIGHT _____

Attached cc: Sarah Bianchi _____

Subject: CBO January 1997
Medicaid Baseline

With informational copies for:

HFB Chron, Medicaid Examiners

From: Bonnie Washington *BW*
Anne Tumlinson *A.T.*

Phone: 202/395-4930
Fax: 202/395-3910
Room: NEOB #7001

The purpose of this memo is to compare the CBO January 1997 Medicaid baseline to the FY 1998 President's Budget baseline (see Tab A table) and to the April 1996 CBO Medicaid baseline (see Tab B table). We also explain an important change in how CBO projects Medicaid enrollment.

closer to OMB

Summary: The CBO Medicaid baseline has dropped by \$79.5 billion (11%) from FY 1998 to 2002 from their April 1996 baseline, bringing it down to only \$15.7 billion higher than the FY 1998 President's Budget Medicaid baseline. The CBO average annual growth rate from FY 1997 to 2002 is 7.8% compared to the President's Budget baseline growth rate of 7.2%.

Change in CBO Enrollment Projection Methodology

- In the past, both OACT and CBO have projected the Medicaid beneficiaries and calculated the per capita spending projections using, as a count of people, those individuals who have received services (recipients). Recipients are those people who have made at least one Medicaid fee-for-service claim in a year. The problem with this method is that it does not necessarily capture the people enrolled in managed care organizations who may not have had a fee-for-service claim.

For this reason, CBO has decided to begin calculating the per capita spending estimates using enrollees instead of recipients.

-- *HD Analysis.* In order to accurately compare CBO's new baseline estimates of per capita spending to the President's Budget estimates, our table includes OACT projections of Medicaid enrollees instead of recipients. However, you should be aware that April 1996 CBO baseline estimates of enrollment are not comparable to the new CBO baseline estimates because the April baseline uses recipients instead of enrollees.

-- *Future Concern About Enrollee Estimates.* We are concerned about using enrollment projections because they are a measure of the number of people who have ever been enrolled in Medicaid regardless of how long each person has been enrolled. Because the enrollee estimates give equal weight to short-term and long-term enrollees, the number is inflated. OACT advises us that using an inflated enrollment estimate may give the public a false impression of the number of people who are covered by Medicaid and the overall number of people with health care coverage. OACT suggests using an average of the number of months each person is enrolled ("person-years"). For example, two people who are enrolled for six months each would represent one person-year. We agree with OACT and will discuss this issue with CBO in the near future.

Total Outlays

-- *CBO 1/97 vs. FY 1998 PB.* Overall, the FY 1998 President's Budget Medicaid baseline is about \$15.7 billion (2.5%) lower than the CBO January 1997 baseline for the FY 1998 - 2002 period. The average annual baseline growth for FY 1997 - 2002 is 7.2% under Administration assumptions, compared to 7.8% under CBO assumptions.

-- *CBO 1/97 vs. CBO 4/96.* The CBO January 1997 baseline is about \$79.5 billion (11.4%) lower than the CBO April 1996 baseline for the FY 1998 - 2002 period. The average annual baseline growth for FY 1997 - 2002 is 7.8% under the new January 1997 CBO assumptions, compared to 9.6% under the old April 1996 CBO assumptions.

Enrollment

-- *CBO 1/97 vs. FY 1998 PB.* The FY 1998 President's Budget projection of Medicaid enrollees in FY 2002 is close to 2 million (4.2%) higher than the CBO January 1997 projection. The average annual growth in enrollment from FY 1997 - 2002 is 1.5% under Administration assumptions, compared to 1.3% under CBO assumptions.

-- *CBO 1/97 vs. CBO 4/96.* As we mention above, the January 1997 CBO baseline projections of enrollment are not comparable to the April 1996 CBO baseline projections because the April baseline uses "recipients" and the January baseline uses "enrollees." In any given year, there will be more "enrollees" in Medicaid than "recipients." For example, in FY 1996, there were 5 million more enrollees than recipients. If you use comparable measures of people, you would

find that CBO's projection of the number of people receiving Medicaid has decreased since April 1996. Therefore, CBO's January 1997 baseline projection of the number of enrollees in FY 2002 is only 2.2 million higher than the April 1996 baseline projection of the number of recipients in FY 2002. Even though CBO's January 1997 projected enrollment in 2002 is still higher than the CBO April 1996 projection, the difference between the two has decreased. This decrease in the difference is due to lower projections of both SSI and welfare caseload.

Per Capita Spending

- *CBO 1/97 vs. FY 1998 PB.* The FY 1998 President's Budget projections of total Medicaid spending per enrollee (per capita) in FY 2002 is approximately \$229 lower (7.2%) than the CBO January 1997 estimate. The average annual growth in per capita spending from FY 1997 - 2002 is 5.5% under Administration assumptions, compared to 6.5% under CBO assumptions. The reason for this difference is CBO's projections of higher spending growth combined with lower enrollment growth than OACT's projections. These per capita amounts (both OACT and CBO) are artificially low because they are calculated using "enrollees" not "recipients." This methodology does not affect the per capita growth rate.
- *CBO 1/97 vs. CBO 4/96.* Because the January 1997 baseline uses "enrollees" and the April 1996 baseline uses "recipients," the per capita spending projections are not comparable.
- *CBO 1/97 vs. FY 1998 PB.* The projection of Federal spending for non-DSH benefits in the FY 1998 President's Budget is approximately \$9.3 billion (1.8%) lower than the CBO January 1997 projection for FY 1998 - 2002. The average annual growth in non-DSH benefits for FY 1997 - 2002 is 7.5% under Administration assumptions, compared to 7.8% under CBO assumptions. CBO's large downward reestimate of benefit spending from April 1996 to January 1997 (discussed below) is the main reason why the difference between the FY 1998 President's Budget baseline and the January 1997 CBO baseline is small.
- *CBO 1/97 vs. CBO 4/96.* The CBO January 1997 projection of spending for non-DSH benefits is significantly lower --- \$72.7 billion (12.1%) --- than the CBO April 1996 projection for FY 1998 - 2002. The average annual growth in non-DSH benefits for FY 1997 - 2002 is 7.8% under the new January 1997 CBO baseline assumptions, compared to 10.1% under the old April 1996 CBO baseline assumptions.

Disproportionate Share Hospital Payments

- *CBO 1/97 vs. FY 1998 PB.* The projection of Federal spending for disproportionate share hospital (DSH) payments in the FY 1998 President's Budget is approximately \$2.3 billion (3.8%) lower than the CBO January 1997 projection for FY 1998 - 2002. The average annual growth in DSH spending for FY 1997 - 2002 is 5.1% under the Administration's

assumptions, compared to 6.8% under CBO assumptions. The President's Budget baseline essentially stays constant from FY 1997 to FY 1998, while CBO projects that DSH spending growth will increase 5.1% from FY 1997 to FY 1998. From FY 2000 to FY 2001 and from FY 2001 to FY 2002, the President's Budget baseline projects that DSH spending will grow 5.9% and 5.6% respectively, while CBO projects DSH spending growth will be 7.6% and 7.1% for the same years.

-- *CBO 1/97 vs. CBO 4/96.* The CBO January 1997 projection of Federal spending for DSH payments is approximately \$5.7 billion (8.7%) lower than the CBO April 1996 projection for FY 1998 - 2002. The average annual growth in DSH spending for FY 1997 - 2002 is 6.8% under the new January 1997 CBO baseline assumptions, compared to 5.0% under the old April 1996 CBO baseline assumptions.

State and Local Administration

-- *CBO 1/97 vs. FY 1998 PB.* The projection of Federal spending for state and local administration in the FY 1998 President's Budget is \$3.4 billion (11%) lower than the CBO January 1997 baseline projection for FY 1998 - 2002. The average annual growth in administration baseline projection for this period is 5.7% under Administration assumptions, compared to 10.4% under CBO assumptions. The big difference in the growth rates may be due to CBO assumptions of increased administration spending growth as a result of the enactment of welfare reform legislation.

-- *CBO 1/97 vs. CBO 4/96.* The projection of Federal spending for state and local administration in the CBO January 1997 baseline is \$1.1 billion (3.4%) lower than the CBO April 1996 baseline for FY 1998 - 2002. The average annual growth in administration costs for this period is 10.4% under the new January 1997 CBO baseline assumptions, compared to 10.2% under old April 1996 CBO baseline assumptions.

Tab A

Federal Medicaid Spending
Comparison of FY 1998 President's Budget and CBO January 1997 Baselines
(Dollars in Billions)

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>Outlays 98-02</u>	<u>Growth 97-02</u>	<u>Outlays 98-03</u>	<u>Growth 97-03</u>
Total Medicaid Spending												
FY 1998 President's Budget	92.0	98.5	104.4	111.2	119.6	129.1	139.2	150.8	603.4		754.2	
Growth Rate	3.2%	7.1%	6.0%	6.5%	7.5%	8.0%	7.8%	8.4%		7.2%		7.4%
CBO 1/97 Baseline	92.1	98.8	105.4	113.8	122.9	133.1	144.0	155.8	619.1		774.9	
Growth Rate	3.4%	7.2%	6.7%	7.9%	8.1%	8.2%	8.2%	8.2%		7.8%		7.9%
Outlay Difference: PB to CBO	0.1	0.3	1.0	2.6	3.4	4.0	4.8	5.0	15.7		20.7	
Percent Difference	0.1%	0.3%	1.0%	2.2%	2.7%	3.0%	3.3%	3.2%	2.5%		2.7%	
Growth Rate Difference (pct. points)	0.1%	0.1%	0.8%	1.4%	0.5%	0.3%	0.4%	-0.1%		0.7%		0.5%
Enrollment (millions) *												
FY 1998 President's Budget	43.3	43.7	44.4	45.1	45.8	46.5	47.2	47.8				
Growth Rate	19.8%	1.0%	1.5%	1.6%	1.6%	1.5%	1.6%	1.4%		1.5%		1.5%
CBO 1/97 Baseline	41.8	42.5	42.9	43.7	44.2	44.8	45.3	45.9				
Growth Rate	16.1%	1.7%	0.9%	1.9%	1.1%	1.4%	1.1%	1.4%		1.3%		1.3%
Enrollment Difference: PB to CBO	-1.5	-1.2	-1.5	-1.4	-1.6	-1.7	-1.9	-1.9				
Percent Difference	-3.6%	-2.9%	-3.4%	-3.1%	-3.6%	-3.7%	-4.1%	-4.2%				
Growth Rate Difference (pct. points)	-3.7%	0.7%	-0.5%	0.3%	-0.4%	-0.1%	-0.4%	0.0%		-0.2%		-0.2%
Per Capita Spending												
FY 1998 President's Budget	2,123	2,252	2,352	2,467	2,612	2,779	2,950	3,152				
Growth Rate	-13.8%	6.1%	4.4%	4.9%	5.9%	6.4%	6.1%	6.8%		5.5%		5.8%
CBO 1/97 Baseline	2,203	2,324	2,457	2,603	2,782	2,970	3,178	3,392				
Growth Rate	-11.0%	5.5%	5.8%	5.9%	6.9%	6.8%	7.0%	6.8%		6.5%		6.5%
Per Capita Difference: PB to CBO	80	71	105	136	169	191	228	240				
Percent Difference	3.6%	3.1%	4.3%	5.2%	6.1%	6.4%	7.2%	7.1%				
Growth Rate Difference (pct. points)	2.8%	-0.6%	1.3%	1.1%	1.0%	0.4%	0.8%	-0.1%		0.9%		0.7%

* CBO and President's Budget projections of enrollment are of "enrollees" not "recipients."

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Federal Medicaid Spending
Comparison of FY 1998 President's Budget and CBO January 1997 Baselines
(Dollars in Billions)

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>Outlays</u> <u>98-02</u>	<u>Growth</u> <u>97-02</u>	<u>Outlays</u> <u>98-03</u>	<u>Growth</u> <u>97-03</u>
<u>Benefits (includes VFC)</u>												
FY 1998 President's Budget	79.6	83.9	89.5	95.3	102.8	111.3	120.2	130.8	519.1		649.9	
Growth Rate	7.4%	5.4%	6.7%	6.4%	7.9%	8.2%	8.1%	8.8%		7.5%		7.7%
CBO 1/97 Baseline	79.3	84.4	89.9	97.0	104.9	113.6	123.0	133.4	528.4		661.8	
Growth Rate	6.4%	6.4%	6.5%	7.9%	8.1%	8.3%	8.3%	8.5%		7.8%		7.9%
Outlay Difference: PB to CBO	-0.3	0.5	0.4	1.7	2.1	2.3	2.8	2.6	9.3		11.9	
Percent Difference	-0.4%	0.6%	0.4%	1.8%	2.0%	2.1%	2.2%	2.0%	1.8%		1.8%	
Growth Rate Difference (pct. points)	-0.9%	1.1%	-0.2%	1.5%	0.3%	0.1%	0.2%	-0.3%		0.4%		0.2%
<u>DSH</u>												
FY 1998 President's Budget	8.6	10.0	10.0	10.8	11.5	12.1	12.8	13.5	57.2		70.7	
Growth Rate	-21.8%	15.7%	-0.1%	8.0%	6.2%	5.9%	5.6%	5.0%		5.1%		5.1%
CBO 1/97 Baseline	9.0	9.8	10.3	11.1	11.8	12.7	13.6	14.6	59.5		74.1	
Growth Rate	-15.9%	8.9%	5.1%	7.8%	6.3%	7.6%	7.1%	7.4%		6.8%		6.9%
Outlay Difference: PB to CBO	0.4	-0.2	0.3	0.3	0.3	0.6	0.8	1.1	2.3		3.4	
Percent Difference	4.0%	-2.0%	3.0%	2.7%	2.8%	4.4%	5.7%	7.8%	3.8%		4.6%	
Growth Rate Difference (pct. points)	5.9%	-6.8%	5.2%	-0.3%	0.1%	1.7%	1.5%	2.4%		1.7%		1.8%
<u>Administration</u>												
FY 1998 President's Budget	3.8	4.6	4.9	5.1	5.3	5.7	6.1	6.5	27.1		33.7	
Growth Rate	-2.1%	23.5%	5.2%	5.3%	3.6%	7.2%	7.2%	7.2%		5.7%		5.9%
CBO 1/97 Baseline	3.8	4.4	5.1	5.5	6.1	6.8	7.2	7.8	30.5		38.3	
Growth Rate	-2.6%	15.8%	15.9%	7.8%	10.9%	8.2%	9.1%	8.3%		10.4%		10.0%
Outlay Difference: PB to CBO	0.0	-0.2	0.2	0.4	0.8	0.9	1.1	1.3	3.4		4.6	
Percent Difference	1.3%	-5.3%	4.4%	6.7%	12.8%	13.6%	15.2%	16.1%	11.0%		12.0%	
Growth Rate Difference (pct. points)	-0.4%	-7.7%	10.7%	2.5%	7.3%	1.0%	1.9%	1.2%		4.7%		4.1%

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Tab B

Federal Medicaid Spending
Comparison of CBO April 1996 and CBO January 1997 Baselines
(Dollars in Billions)

		<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>Outlays</u> <u>98-02</u>	<u>Growth</u> <u>97-02</u>	<u>Outlays</u> <u>88-03</u>	<u>Growth</u> <u>97-03</u>
<u>Total Medicaid Spending</u>													
CBO 4/96 Baseline		85.9	105.2	115.6	126.5	138.3	151.7	166.6	183.0	698.7		881.6	
	Growth Rate	7.6%	9.8%	9.8%	9.4%	9.3%	9.7%	9.8%	9.8%		9.6%		9.7%
CBO 1/97 Baseline		92.1	98.8	105.4	113.8	122.9	133.1	144.0	155.8	619.1		774.9	
	Growth Rate	3.4%	7.2%	6.7%	7.9%	8.1%	8.2%	8.2%	8.2%		7.8%		7.9%
Change: April to January		-3.8	-6.5	-10.2	-12.8	-15.4	-18.6	-22.6	-27.2	-79.5		-106.7	
	Percent Change	3.9%	6.2%	8.8%	10.1%	11.1%	12.3%	13.6%	14.8%	11.4%		-13.8%	
Growth Rate Change (pct. points)		-4.3%	-2.5%	-3.1%	-1.5%	-1.2%	-1.4%	-1.7%	-1.6%		-1.8%		-1.8%
<u>Enrollment (millions) *</u>													
CBO 4/96 Baseline		36.8	38.1	39.0	40.0	41.1	42.1	43.1	44.1				
	Growth Rate	3.9%	3.6%	2.5%	2.5%	2.6%	2.5%	2.4%	2.4%		2.5%		2.5%
CBO 1/97 Baseline		41.8	42.5	42.9	43.7	44.2	44.8	45.3	45.9				
	Growth Rate	16.1%	1.7%	0.9%	1.9%	1.1%	1.4%	1.1%	1.4%		1.3%		1.3%
Change: April to January		5.0	4.4	3.9	3.7	3.1	2.7	2.2	1.8				
	Percent Change	-13.6%	-11.6%	-9.9%	-9.1%	-7.6%	-6.5%	-5.1%	-4.1%				
Growth Rate Change (pct. points)		12.2%	-1.9%	-1.6%	-0.7%	-1.4%	-1.1%	-1.3%	-1.0%		-1.2%		-1.2%
<u>Per Capita Spending</u>													
CBO 4/96 Baseline		2,606	2,763	2,960	3,160	3,368	3,604	3,867	4,146				
	Growth Rate	3.6%	6.0%	7.1%	6.7%	6.6%	7.0%	7.3%	7.2%		7.0%		7.0%
CBO 1/97 Baseline		2,203	2,324	2,457	2,603	2,782	2,970	3,178	3,392				
	Growth Rate	-11.0%	5.5%	5.8%	5.9%	6.9%	6.8%	7.0%	6.8%		6.5%		6.5%
Change: April to January		(403)	(439)	(503)	(557)	(587)	(634)	(689)	(753)				
	Percent Change	15.5%	15.9%	17.0%	17.6%	17.4%	17.6%	17.8%	18.2%				
Growth Rate Change (pct. points)		-14.6%	-0.5%	-1.4%	-0.8%	0.3%	-0.2%	-0.3%	-0.5%		-0.5%		-0.5%

* CBO April enrollment projections are of "recipients." CBO January enrollment projections are of "enrollees."

Federal Medicaid Spending
Comparison of CBO April 1996 and CBO January 1997 Baselines
(Dollars in Billions)

		<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>Outlays</u> <u>96-02</u>	<u>Growth</u> <u>97-02</u>	<u>Outlays</u> <u>98-03</u>	<u>Growth</u> <u>97-03</u>
Benefits (includes VFC)													
	CBO 4/96 Baseline	80.8	89.2	98.5	108.3	118.9	131.0	144.5	159.5	601.1		760.7	
	Growth Rate	8.6%	10.3%	10.5%	9.9%	9.8%	10.2%	10.3%	10.4%		10.1%		10.2%
	CBO 1/97 Baseline	79.3	84.4	89.9	97.0	104.9	113.6	123.0	133.4	528.4		661.8	
	Growth Rate	6.4%	6.4%	6.5%	7.9%	8.1%	8.3%	8.3%	8.5%		7.8%		7.9%
	Change: April to January	-1.5	-4.8	-8.6	-11.3	-14.0	-17.4	-21.5	-26.1	-72.7		-98.9	
	Percent Change	1.9%	5.4%	8.7%	10.4%	11.8%	13.3%	14.9%	16.4%	12.1%		-14.9%	
	Growth Rate Change (pct. points)	-2.2%	-3.9%	-3.9%	-2.0%	-1.7%	-1.9%	-2.1%	-1.9%		-2.3%		-2.3%
DSH													
	CBO 4/96 Baseline	10.7	11.2	11.8	12.4	13.0	13.7	14.3	15.1	65.2		80.2	
	Growth Rate	0.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%		5.0%		5.0%
	CBO 1/97 Baseline	9.0	9.8	10.3	11.1	11.8	12.7	13.6	14.6	59.5		74.1	
	Growth Rate	-15.9%	8.9%	5.1%	7.8%	6.3%	7.6%	7.1%	7.4%		6.8%		6.9%
	Change: April to January	-1.7	-1.4	-1.5	-1.3	-1.2	-1.0	-0.7	-0.5	-5.7		-6.1	
	Percent Change	15.9%	12.8%	12.7%	10.4%	9.3%	7.0%	5.2%	3.0%	8.7%		-8.3%	
	Growth Rate Change (pct. points)	-15.9%	3.9%	0.1%	2.8%	1.3%	2.6%	2.1%	2.4%		1.8%		1.9%
Administration													
	CBO 4/96 Baseline	4.3	4.67	5.1	5.7	6.3	6.9	7.6	8.4	31.6		40.0	
	Growth Rate	9.0%	10.0%	10.1%	10.6%	9.9%	10.0%	10.3%	10.3%		10.2%		10.2%
	CBO 1/97 Baseline	3.8	4.4	5.1	5.5	6.1	6.6	7.2	7.8	30.5		38.3	
	Growth Rate	-2.6%	15.8%	15.9%	7.8%	10.9%	8.2%	9.1%	8.3%		10.4%		10.0%
	Change: April to January	-0.5	-0.3	0.0	-0.2	-0.2	-0.3	-0.4	-0.6	-1.1		-1.7	
	Percent Change	10.6%	5.9%	0.9%	3.4%	2.5%	4.2%	5.2%	6.9%	3.4%		-4.3%	
	Growth Rate Change (pct. points)	-11.6%	5.8%	5.8%	-2.8%	1.0%	-1.8%	-1.2%	-1.9%		0.1%		-0.2%

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ISSUE BRIEF

NATIONAL
HEALTH
POLICY
FORUM

Impact of the New Welfare Law on Medicaid

Friday, February 7, 1997

8:30 to 9:00 am - Continental Breakfast

9:00 am to Noon - Discussion

Hyatt Regency Capitol Hill

400 New Jersey Avenue, NW

Capitol Room

A discussion featuring

Dennis Priest

*Manager, Income Maintenance
Policy Section*

Commission of Income Maintenance
and Employment Preparation
Services

Kansas Department of Social and
Rehabilitation Services

William Waldman

Commissioner

New Jersey Department of Human
Services

Randy Mecham

Director

Welfare Reform Project
Department of Health Services
San Diego County Health and
Human Services Agency

Judith Moore

Acting Director

Medicaid Bureau
Health Care Financing
Administration

Cindy Mann

Director

State Low-Income Initiatives Project
Center on Budget and Policy
Priorities

Kenneth Nibali

*Deputy Associate Commissioner
for Disability*

Office of Disability
Social Security Administration

Registration: Please call **Dagny Canard** at 202/872-1392 as soon as possible.

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Washington
University
WASHINGTON DC

Impact of the New Welfare Law on Medicaid

While Medicaid essentially remained intact as Congress revamped most other programs comprising the nation's safety net, changes contained in the new welfare law could have a profound impact on how states enroll Medicaid recipients and, ultimately, on who receives benefits. Medicaid, the nation's state-federal health program for those on welfare and for other poor children, disabled, and elderly, has had its eligibility closely intertwined with other safety net programs. The dismantling and cutting of other welfare programs has made disruption of the Medicaid rolls and the enrollment process inevitable.

Enacted in August, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) repeals the Aid to Families with Dependent Children (AFDC) cash welfare program and replaces it with block grants to the states known as Temporary Assistance for Needy Families (TANF). Through the act's intent and through state discretion, the nation's welfare population is likely to decline; the law no longer requires states to provide welfare to all eligibles, sets a lifetime limit on benefits, and gives states liberty to set TANF eligibility standards as high, or as low, as they wish. Because AFDC enrollment has been the only door to Medicaid for many, a smaller welfare population would have meant fewer people qualifying for Medicaid.

To avert this scenario, Congress severed the historic eligibility link between the two programs, whereby AFDC qualifying standards were the same used by Medicaid to enroll low-income families. The new law provides that low-income families are still entitled to Medicaid if they meet the state's old AFDC income and related standards, regardless of whether they qualify for TANF. And, while a single application form has been used in welfare offices to judge applicants' eligibility for both cash welfare and Medicaid, the law now allows states to use separate application forms for the two programs if they choose. In effect, the new law requires states to make several decisions about how they will design and operate an eligibility system for a population that was once automatically enrolled. AFDC receipt has triggered Medicaid enrollment for more than one-third of all Medicaid beneficiaries and about half of all Medicaid children.

While these administrative decisions are not the stuff of headline news, they will determine the scope of Medicaid coverage for poor families in the states. States must decide, for example, how simple to make the Medicaid application for those on TANF and how aggressive they will be in identifying people eligible for Medicaid but not for TANF. As time limits are exhausted and eligibility criteria for TANF are tightened in certain states, it is clear that greater numbers of low-income parents and children will be eligible for Medicaid but not for TANF. Because these families were usually identified by welfare offices, the great challenge to state Medicaid agencies will be to reach these people. This group is also expected to grow due to the law's principle intent—to move welfare recipients into jobs. As more parents find work, many of their children will still qualify for Medicaid under federal criteria that grant eligibility to young children on the basis of income and not AFDC receipt.

Another major decision states face is whether to provide Medicaid to legal aliens who have been in the country since before August, coverage which is now optional under the law. This provision is part of a larger package of restrictions the statute places on benefits to current and future legal immigrants and certain disabled children—measures which, when combined, will deny Medicaid to many and create a sizeable administrative workload for the states. While most publicity has focused on the law's cessation of the historic AFDC entitlement, the statute draws 40 percent of its savings from denying most forms of federal aid to legal immigrants.

ISSUE BRIEF/No. 697

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Along with a potential Medicaid loss, with certain exceptions, legal aliens already in the country will also lose food stamps and Supplemental Security Income (SSI), a monthly federal cash payment to poor elderly and disabled persons and some disabled children. New legal immigrants will face a minimum five-year ban on receiving Medicaid and TANF benefits and be barred from SSI and the Food Stamps Program. State Medicaid agencies will face the hefty job of assessing whether hundreds of thousands of resident immigrants and disabled children who lose SSI—which, in most states, has provided automatic eligibility to Medicaid—can still qualify for the program. A small portion of these people may lose Medicaid because they lack other qualifying criteria to remain eligible.¹

In reality, all of these administrative decisions will be made in a political context. Some states will view the delinking of Medicaid from TANF as an opportunity to erase Medicaid's welfare stigma and market it as an insurance program for low-income families. Yet, for years governors have complained that federal Medicaid mandates have been consuming an excessive share of state budgets, and some may take the opportunity through more restrictive eligibility or a barrier-ridden enrollment process to curb current or future Medicaid growth. Ultimately, providers will experience the fallout from these state decisions, since both physicians and hospitals stand to lose Medicaid reimbursement for a portion of the patients they serve.

Finally, the longer-term impact of P.L. 104-193 is expected to pose problems for local health and welfare budgets, as well as providers serving large numbers of immigrants. As more legal immigrants face the SSI and Medicaid ban and those earning their way off of welfare join the ranks of the uninsured, they will be turning to counties (or, in some cases, cities) for general relief and health care. Hospitals and providers in areas with high numbers of immigrants will be particularly burdened as they lose Medicaid reimbursement for non-emergency care and as the Medicaid ban on new legal immigrants swells their emergency rooms.

At this Forum session, speakers will discuss the impact of welfare law changes on state Medicaid agencies and recipients, with particular emphasis on legal immigrants and aliens and children losing SSI benefits. Attention will also be given to how counties, especially those with large immigrant populations, are reacting to the new law.

SEVERING MEDICAID FROM CASH WELFARE ELIGIBILITY

Under the old AFDC law, children and parents who received cash welfare were automatically enrolled in the Medicaid program. Because the new block grant eliminates the entitlement to welfare, sets a time limit to benefits receipt, and allows states to set their own eligibility standards for welfare, access to Medicaid for those who qualified solely on the basis of AFDC receipt—now some 1.3 million poor children over age 13 and more than 4 million low-income, mainly single, parents—would have been threatened if Congress had not provided a remedy.²

P.L. 104-193 avoids this problem by preserving the Medicaid entitlement for children and parents who would have met states' old AFDC income and asset standards in place on July 16, 1996 (as well as those rules that limited AFDC largely to single-parent families), whether or not they are eligible for the TANF program.³ The law also guarantees 12 months of transitional Medicaid benefits for those who lose eligibility because of increased earnings, regardless of whether they were on TANF. States have until July 1, 1997, to enact their Medicaid eligibility provisions relating to those on TANF.

The delinking of Medicaid from cash welfare eligibility poses challenges to states in determining Medicaid receipt for the welfare population. A recent study by the Center on Budget and Policy Priorities (CBPP) highlights the problem of Medicaid enrollment when it is not automatically linked to cash aid. The study found that, in 1994, 2.7 million children under age 11 who were not on welfare but eligible for Medicaid were not enrolled in the program; these children, who lacked any other type of health insurance, accounted for 45 percent of children under 11 who were uninsured that year.⁴ To reach people who never get on or lose cash assistance, "states have to think of Medicaid as not something that's just linked to welfare [but to] income. If they don't start marketing, they'll be missing larger and larger segments of the eligible population," says Cindy Mann, analyst at the CBPP.

In practice, it was the single AFDC application which also served as the application form for Medicaid that made Medicaid enrollment so easy for those qualifying for cash aid. The new law gives states the option to impose separate applications for Medicaid and TANF. According to John Peller, analyst with the American Public Welfare Association, some states are

interested in a separate Medicaid process so they can erase the welfare stigma from Medicaid and market it as a health insurance program. However, he says, most states would like to stick with a single eligibility process to make Medicaid enrollment for those seeking TANF as automatic as possible. But, for a number of reasons, even with a single application form, eligibility between cash welfare and Medicaid will no longer be a perfect fit. A number of states, for example, will choose to set TANF eligibility either below or above current Medicaid eligibility. And certain provisions in the new law guarantee that some people will be denied TANF but can maintain their Medicaid (teen parents who live in an unsupervised setting are such an example).

As stated before, in those states that choose to tighten TANF eligibility standards to limit enrollment, a single application could not capture those who never applied for TANF because their incomes were too high. States that liberalize their TANF criteria can, however, raise eligibility and asset requirements for Medicaid, although some states believe there is a fiscal disincentive to doing so.⁵ Increasing AFDC income and resource limits to encourage work by allowing those with higher earnings to receive cash aid was, in fact, one of the most popular changes states enacted through welfare waivers, according to DHHS. The Health Care Financing Administration (HCFA) may even propose changing rules to allow recipients in two-parent families to work more hours under Medicaid to achieve a better eligibility match between the programs.

But a few states have already voiced concern over the cost of creating more generous Medicaid criteria. Raising income, asset, and work hour standards in Medicaid would open the program not just to those on TANF (as was generally the case in welfare waiver states) but also to other low-income families who meet the more generous criteria. For these reasons, states like New Jersey and Virginia are seriously considering separate eligibility criteria for the two programs. It is unclear how many states would choose to liberalize welfare eligibility under the block grant. Doing so under the old AFDC program entailed a federal match for each new recipient, but under the block grant states are allotted fixed amounts of money. The net effect, however, of a state's having criteria for TANF that are more generous than those for Medicaid is that people could lose their Medicaid coverage before ever leaving TANF.

The severing of Medicaid from TANF also has the potential to alter the risk pool of beneficiaries enrolled

in Medicaid managed care plans, the bulk of which serve the AFDC-related population. Depending on the success of Medicaid outreach efforts, low-income people may not enroll in Medicaid until an illness brings them to a hospital or other provider, leaving a smaller, sicker population enrolled in managed care plans. This, in turn, would disrupt current capitation rates, which have counted on a larger, healthier population to keep premiums down. At the same time, the delinking of the two programs could minimize current disruptions in managed care enrollment caused until now by states experimenting with a variety of welfare sanctions that tied failure to comply with certain requirements to a loss of both AFDC and Medicaid. The new law gives states the option to deny Medicaid to parents (other than pregnant women) who are on TANF but refuse to work; however, with regard to behavioral or other sanctions states may impose, the loss of TANF will not trigger the loss of Medicaid.

MEDICAID AND IMMIGRANTS

For purposes of receiving Medicaid, the law places more restrictions on new legal immigrants than on those already in the country. With the exception of refugees and asylees, the act sets a five-year ban on Medicaid for legal aliens entering the country on or after August 22, 1996. After that, the incomes of aliens' sponsors will be counted toward Medicaid eligibility (a procedure known as sponsor deeming) until the immigrants complete another 40 quarters of work or are naturalized. More liberal sponsor deeming criteria had already been in effect for the Food Stamp Program, SSI, and AFDC (generally, refugees were the only newly arrived legal aliens eligible for these entitlements). P.L. 104-192 now applies stricter deeming standards to these programs and adds Medicaid to the list. The Congressional Budget Office (CBO) estimates that, by 2002, more than 600,000 legal immigrants will be barred from Medicaid coverage at a total federal savings of \$5.3 billion,⁶ with most of the savings coming from the Medicaid ban for new immigrants.

Medicaid coverage for legal immigrants in the country before August 22 will be at states' option, with certain exceptions. States choosing not to cover this group can terminate benefits as of January 1, 1997. But because the federal match would continue if states opt to cover legal aliens, most states are expected to do so.

P.L. 104-192 specifies certain exceptions to aliens' restrictions to health care. The law preserves Medicaid

coverage for emergency care for all legal and nonlegal immigrants. Legislative conferees said it was their intent that prenatal care and delivery services that are not strictly of an emergency nature not be covered under the law,⁷ but the bill does not cite this exclusion, and HCFA will have to rule on whether these services will be included. States will also be allowed to continue providing immunizations and testing and treatment for communicable diseases to legal and nonlegal aliens, but only with public health system and "discretionary" program monies, not Medicaid.

Immigrants and SSI

The loss of SSI for aliens already living here brings to play other problems that might affect their access to Medicaid. Within a year, most legal aliens will be cut from the SSI program, which in most states has granted them automatic eligibility for Medicaid. The Social Security Administration (SSA) has until the end of March to notify noncitizen SSI recipients of the law and until August 22, 1997, to complete terminations. While the majority of these aliens are expected to be able to retain Medicaid coverage through states' option, technicalities and administrative procedures threaten coverage for some.

In December 1995, 785,000 legal aliens were receiving SSI; the law will eliminate benefits for all but one-quarter of this group.⁸ Restricting SSI benefits from current and future legal immigrants was a significant cost saver in the welfare law, with projected total savings in fiscal 2002 of over \$13 billion, according to CBO.⁹

Aliens cut from SSI will receive letters from their respective state Medicaid agencies telling them they will be redetermined for Medicaid eligibility. Those states that opt to cover qualified aliens will need to determine whether the aliens, who before automatically qualified for Medicaid due to their SSI receipt, fall within another category of eligibility. This is not a problem for the majority of states, which have either medically needy or optional categorically needy categories under which the aliens would fall. But eight states (Alabama, Delaware, Indiana, Missouri, New Mexico, Ohio, South Dakota, and Texas) run more restrictive programs with neither category.¹⁰ Together, these states account for about 9 percent of the SSI alien population,¹¹ and they face a large disincentive in trying to continue Medicaid for this group. These states would have to create an optional eligibility category that would, in turn, grant Medicaid to all those in the state

who meet its more generous income criteria, not just the subset of aliens for whom it would be created.

This issue is particularly problematic for Texas, which is home to over 7 percent of all aliens affected by the welfare bill and whose governor has indicated an interest in covering qualified aliens, but which lacks an eligibility category for those immigrants who lose SSI. The Texas Interagency Workgroup on Welfare Reform estimates that over 37,000 aliens receiving SSI would lose Medicaid even if the state opted to continue coverage for qualified aliens.¹²

Advocates have urged HCFA to solve this problem by deeming aliens who lose SSI as categorically eligible for Medicaid, arguing that not doing so would defeat the law's intent of permitting states to choose whether to continue Medicaid coverage for legal aliens. However, according to HCFA official Marty Svolos, the agency believes there is no legal basis for making this change. HCFA is considering a short term fix for this problem and, says Svolos, the administration is interested in seeking a statutory remedy.

Medicaid's redetermination process for aliens and disabled children (see below) cut from SSI may also be a point of concern. Even prior to the welfare reform law, Medicaid rules have required state agencies to conduct a redetermination for any recipient cut from SSI to see whether he or she qualifies for Medicaid under an alternative category. However, HCFA acting Medicaid director Judy Moore says she has discovered that in at least two states the Medicaid agency automatically cuts Medicaid benefits for recipients who have been terminated from the SSI program. In response, HCFA is sending memos to the states clarifying rules on redetermination, and, in recognition of states' heavy caseloads, has extended the time states have to conduct such reviews. HCFA has also made it clear that Medicaid coverage will continue for ex-SSI recipients during the time of their redetermination and any appeals to termination decisions. In practice, continuing Medicaid eligibility may rest on the extent of the burden states place on beneficiaries to prove eligibility. Advocates worry that the extra paperwork recipients would have to provide during a redetermination process may discourage them from complying.

States' Option to Cover Qualified Aliens

P.L. 104-193 essentially creates three categories of immigrants for purposes of Medicaid eligibility: "excepted" groups that states are required to cover,

“qualified aliens” whom states can opt to cover with federal matching funds, and another very small group of immigrants previously eligible for Medicaid whom states can no longer serve with the federal match. The mandatory group includes refugees, asylees, those whose deportation is being withheld by the Immigration and Naturalization Service, those with a strong work history (at least 40 quarters covered by Social Security based on their own work or that of spouses or parents), and veterans or active duty military personnel. The largest group, qualified aliens, includes those immigrants lawfully admitted to this country for permanent residence. The small group the law excludes from the qualified alien category are aliens defined as “permanently residing under color of law,” including those granted indefinite voluntary departure, those who have lived in the United States continuously since 1972 but never became citizens, and those granted stays of deportation.¹³

It is too early to know how many states will opt to cover qualified aliens, but there is a general sense that most—including those with heavy immigrant populations like California—will continue to do so. While California was originally considering cutting off Medicaid to qualified aliens, Republican governor Pete Wilson’s budget proposal released in early January gave no such indication, in part because such a measure would have to be approved by the legislature, which recently turned Democratic. However, in submitting their TANF plans to DHHS, as of November, five states—Alabama, Kentucky, Louisiana, South Carolina, and Wyoming—expressly elected not to offer qualified aliens cash welfare under TANF; a number of other states reported they would revisit this question next year, according to the National Immigration Law Center.

DISABLED CHILDREN, SSI, AND MEDICAID

The law tightens the definition of childhood disability for the SSI program, in part to keep children with certain behavior disorders off the rolls and to ensure that only children with severely disabling conditions qualify. CBO projects that this change will terminate benefits in fiscal year 1999 for about 156,000 of the estimated one million children already on SSI and that, by 2002, some 315,000 children who would have qualified under the old rules will be barred from receiving benefits. (Children slated to lose SSI benefits will

not be terminated until July 1.) However, HCFA says that most children terminated from SSI will remain eligible for Medicaid, largely because their family incomes are low enough to qualify. It is the older teens losing SSI who will comprise the bulk of the children expected to lose Medicaid coverage.¹⁴

The SSI definition change comes in response to a sharp debate in Congress over allegations that undeserving children were feigning behavior disorders to try to get onto the SSI rolls and that SSA’s standards for determining eligibility were too liberal, as well as over the widespread belief that certain behavior problems are not disabling enough to merit a monthly federal cash payment. Before this change, children had two ways of qualifying for SSI: their conditions could be found on a listing of medical impairments devised by the Social Security Administration or an individualized functional assessment (IFA) could be conducted to assess the extent to which the child could function at an age-appropriate level. Most decisions determined through the IFA process are for children with mental impairments. The IFA was instituted in 1990 in response to a Supreme Court decision requiring SSA to equalize the SSI eligibility process between children and adults. Previously, children could qualify only if their conditions were either on a prescribed list of medical impairments or were equal in severity to those on the list. In contrast, adults could receive an assessment of their functional and vocational capacities even if their conditions did not meet the listings (see NHPF Issue Brief No. 661, *SSI for Children: Looking at Enrollment Concerns and Program Intent*). The IFA was used to better actualize the original law’s vague definition of childhood disability, that is, an impairment of “comparable severity” to that which disables an adult.

P.L. 104-193 makes three major changes to tighten the disability determination process for children: it eliminates the IFA; removes the reference to maladaptive behavior from the personal/behavioral domain of the childhood mental listings, one of several domains of functioning used to assess whether a child’s condition meets the medical listings; and replaces the “comparable severity” standard with a new childhood disability definition. A child is now considered disabled if he or she has “a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for . . . 12 months.”

SSA official Barry Eigen reports that letters have gone out to about 263,000 children requiring them to be redetermined. Most of these children got on the program through an IFA, but some qualified under the medical listings on the basis of maladaptive behavior. Eigen says that some of the children who qualified through an IFA will have conditions severe enough to meet the medical listings. While the final estimate of children affected by the new definition is unclear, some in SSA believe CBO's projection is too high. Both the new definition and its impact will be clarified once the SSA issues rules for the interpretation of "marked and severe."

IMPACT ON STATES, LOCALITIES, AND PROVIDERS

When combined, the impact of welfare loss due to time limits, potential stricter eligibility criteria for Medicaid than for TANF, the loss of federal benefits for new and resident legal aliens, and the loss of Medicaid for certain disabled children, stand to impose significant cost burdens on state and, ultimately, county health and welfare budgets, as well as providers. States and counties will see a demand swell for general assistance as the hundreds of thousands of immigrants losing SSI payments turn to them for cash aid. (However, because many general relief programs impose restrictions on aliens, a number of these immigrants will not qualify.) Loss of Medicaid coverage for many will place particular strain on counties in the more than 20 states that require them by law to serve as health providers of last resort.

These issues are already playing out in California, home to about 40 percent of all legal immigrants on SSI.¹⁵ The state's 58 counties shoulder the entire cost of California's general assistance program and are obligated to provide health care to the indigent. San Diego County health officer Randy Mecham says his county lacks capacity to raise the revenue required to serve the number of legal immigrants that, over time, will accumulate in San Diego and seek county health services because of the Medicaid ban. Counties are urging the state to enter as a partner in funding local general relief and health programs. Language in the new federal law may provide an escape hatch for counties like San Diego that serve large numbers of immigrants and are obligated to provide indigent care. The statute allows states to deny state-funded public benefits to qualified aliens, but it is unclear whether this provision can hold up to a constitutional challenge in court. The Supreme

Court has invalidated state laws that exclude legal immigrants from receiving state welfare benefits solely on the basis of their alienage, ruling that such exclusions are a violation of the Fourteenth Amendment.¹⁶

Because of the Medicaid and other food program restrictions for immigrants, Blair Sadler, president of Children's Hospital of San Diego, says he expects to see a sicker population of children coming through his doors and worries both about the well-being of these children and his hospital's adequate reimbursement for their higher costs. With Medicaid's ban on preventive care for most new immigrants, early detection of problems and conditions will be foregone. "There is no question that we will see kids in our ERs and our ORs and our clinics over time whose conditions could have been prevented or corrected much earlier, who would have been having a better quality of life if treated earlier," he says.

WAIVERS

There are two instances in which both the law and HCFA-proposed rules affect treatment of Medicaid in welfare waiver states. First, the law provides that, in states that run AFDC waivers in which different (often more liberal) income, asset, and family composition standards apply to Medicaid, those altered Medicaid criteria can continue beyond the life of the waiver. As of this writing, HCFA has not yet issued proposed rules, but the agency is expected to waive requirements for budget neutrality in states that enacted waivers to extend transitional Medicaid assistance (TMA) when recipients leave welfare for work (usually up to two years instead of one). According to HCFA, 11 states have enacted TMA waivers to help former welfare recipients stay employed; in six of these states the waivers are statewide. Budget neutrality will be waived throughout the life of the waiver, but the requirement is expected to be in place for any new waiver requests for transitional Medicaid assistance. This issue arose because, previously, states were able to justify the costs of extending Medicaid by showing expected savings through reduced AFDC and food stamp costs associated with leaving welfare for work. The need for HCFA's ruling arose because the law eliminates fungibility of cost savings among the three programs.

The proposed rule requiring new TMA waivers to prove budget neutrality will make it more difficult for states to be awarded such waivers, since savings would have to come only from the Medicaid budget.

TECHNICAL ASSISTANCE MONEY

Given the amount of work required to restructure eligibility systems and conduct Medicaid redetermination for the hundreds of thousands of immigrants and children who lose SSI, states are balking at the four-year, \$500 million fund the law provides them to implement changes to the Medicaid program. "It's just a drop in the bucket when [you] talk about administrative dollars," says Dennis Priest, director of welfare and Medicaid programs for Kansas and chair of a Medicaid directors' workgroup examining these issues. The costs in his state of developing and maintaining a new software system to link Medicaid with TANF eligibility will be quite high, he claims.

Complicating this issue is a restriction the law puts on states' use of the money. The statute qualifies that states can use the money only to pay for the increased costs of changing Medicaid eligibility due to TANF. State groups have asked to use the funds to pay for Medicaid redetermination of immigrants and children who have lost SSI benefits, but HCFA says the statute does not allow for this. However, HCFA is expected to allow states to use the funds for SSI redetermination in which recipients requalify for Medicaid under its AFDC-related category.

HCFA analyst Deirdre Duzor says the agency has tentative plans to apportion the funds in two ways: each state would get an equal base amount of between \$1 million and \$2 million total; the rest would be allocated based on states' historic Medicaid administrative expenditures, their numbers of AFDC-related eligibles, and their caseloads of SSI children and legal immigrants needing redetermination. Certain activities such as outreach and client education would be matched at a higher rate.

THE FORUM SESSION

Speakers at this Forum session will focus their comments on the following issues:

- Political and programmatic issues states are considering as they design a Medicaid eligibility process for low-income families.
- The impact of the SSI ban for legal immigrants on access to Medicaid and any HCFA proposed rulings to address coverage loss.
- The impact of Medicaid restrictions for legal immigrants on state and local health budgets as well as providers.

- SSA's interpretation of the law's new childhood disability definition and what this means for children's loss of SSI and Medicaid coverage.

Speakers

Dennis Priest will begin the session by discussing the major concerns of states in both implementing Medicaid eligibility systems for the welfare population and in dealing with SSI and immigrant provisions of the bill affecting Medicaid receipt. Mr. Priest is the manager of the Income Maintenance Policy Section in the Commission of Income Maintenance and Employment Preparation Services at the Kansas Department of Social and Rehabilitation Services, where he is responsible for Medicaid and welfare policy. He also serves as the chairman of the Eligibility Technical Assistance Group within the National Association of State Medicaid Directors.

Cindy Mann will offer background on the legislative negotiations that resulted in the law's Medicaid provisions and talk about the technical assistance states will need to enroll Medicaid eligibles. Ms. Mann is director of the State Low-Income Initiatives Project at the Center on Budget and Policy Priorities, where she assists states in the redesign and implementation of low-income programs. She was also involved in congressional deliberations on the Medicaid provisions of the welfare law.

William Waldman, commissioner of the New Jersey Department of Human Services, will discuss his state's concerns in designing a Medicaid eligibility system for the TANF population. Commissioner Waldman operates the state's largest public agency, which administers both Medicaid and welfare programs, along with a host of community-based programs for children and families, the elderly, and mentally ill and developmentally disabled persons.

Randy Mecham will discuss the implications of the new law on border counties in terms of new pressures on their health budgets, as well as their public health duties. Mr. Mecham is director of a welfare reform project at the San Diego County Department of Health Services, a part of the Health and Human Services Agency. The county recently merged its health and welfare departments into one agency.

Kenneth Nibali will provide a brief overview of how the law's changes in the SSI childhood disability definition will alter SSA's disability determination process,

SSA's interpretation of the definition, and the extent to which the new definition will reduce current and future enrollment. Mr. Nibali is deputy associate commissioner for disability at the Social Security Administration.

Judith Moore will be on hand to explain HCFA's proposed rules regarding a number of issues, including covering immigrants and children who lose SSI and do not qualify for Medicaid, HCFA's definition of emergency care as related to Medicaid coverage for aliens, and decisions on how the law's \$500 million fund can be used in the states. Ms. Moore is acting director of HCFA's Medicaid Bureau.

ENDNOTES

1. This statement is conditioned on whether states opt to provide Medicaid to qualified aliens losing SSI eligibility.
2. 2.AFDC was not the only qualifying category under Medicaid for younger children. Federal law provides that children under age 6 with family incomes at or below 133 percent of poverty qualify for Medicaid, along with children ages 6 through 12 with family incomes up to the federal poverty line.
3. States have the option to deny Medicaid to parents (other than pregnant women) who lose TANF eligibility because of a failure to comply with work requirements.
4. Laura Summer, Sharon Parrott, and Cindy Mann, "Millions of Uninsured and Underinsured Children Are Eligible for Medicaid," Center on Budget and Policy Priorities, December 9, 1996.
5. 5.A state may increase its income or resource standards, but not by more than the change in the consumer price index. States may also use less restrictive methods for counting income and assets than those methods in effect on July 16, 1996, according to Health Care Financing Administration Fact Sheet #1, "Link between Medicaid and Temporary Assistance for Needy Families (TANF)"; available at <http://www.hcfa.gov/medicaid/wrfs1.htm>; Internet; accessed January 3, 1997.
6. Congressional Budget Office, "Federal Budgetary Implications of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," *CBO Memorandum*, December 1996, 27.
7. "Conference Report on H.R. 3734, Personal Responsibility and Work Opportunity Reconciliation Act of 1996," *Congressional Record*, July 30, 1996, H8926.
8. Those allowed to retain benefits are refugees who have been in the United States for less than five years, aliens with a strong work history (at least 40 quarters of work covered by Social Security), and veterans or those still in the military.
9. "Conference Report on H.R. 3734."
10. National Immigration Law Center, *Immigrants Rights Update*, 10 (November 22, 1996), no. 9: 8.
11. Claudia Schlosberg, staff attorney. National Health Law Program. Personal interview, January 1997.
12. Claudia Schlosberg, Trish Nemore, and Josh Bernstein, "Welfare Reform Implementation: Continuing Medicaid Coverage for Qualified Aliens," National Health Law Program, November 1996, 2; available at <http://www.healthlaw.org/hcfamem.html>; Internet; accessed January 3, 1997.
13. Health Care Financing Administration, Fact Sheet #3, "Link between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996"; available at <http://www.hcfa.gov/medicaid/wrfs3.htm>; Internet; accessed January 3, 1997.
14. The severing of Medicaid and TANF eligibility will work to the advantage of some older teens losing SSI, who will qualify for Medicaid because they meet old AFDC asset and income standards.
15. Testimony of Carolyn Colvin, SSA Deputy Commissioner for Programs and Policy, on SSI and welfare reform implementation before the California State Senate, Health and Human Services Committee, October 10, 1996; available at <http://www.ssa.gov/welfare/colvin.html>; Internet; accessed January 3, 1997.
16. *Graham v. Richardson*, 403 U.S. 365 (1971).

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**THE IMPACT OF THE BUDGET
RESOLUTION CONFERENCE AGREEMENT
ON MEDICAID EXPENDITURES**

**John Holahan
David Liska**

July 1995

67-27930

Overview and Key Findings

In this report we estimate the reduction in federal Medicaid payments and the distribution of these reductions among states under the compromise proposal set forth by the Budget Resolution Agreement in June, 1995. This report follows several earlier Policy Briefs analyzing the impact of other proposals seeking to limit Medicaid expenditure growth over the next 7 years. We continue to provide information on the impact of this proposal on potential reductions in beneficiaries and expenditures by type of service. The following are our principal conclusions:

Reductions in Expenditures

- Federal Medicaid expenditures are projected to grow by \$86.6 billion or 10.1% annually under current policy over the 1996-2002 period. Under the compromise proposal, federal expenditure growth would be limited to \$35.5 billion, or 4.9% per year on average.
- We estimate that the compromise proposal would yield \$171.8 billion in federal savings between 1996 and 2002.
- Under this proposal, more than half of the savings would be achieved in the years 2001 and 2002. Over \$91 billion are achieved in the final two years, in contrast to \$80 billion in savings in the first five years.
- The expenditure reductions are distributed unevenly across states. In general, high-income states, e.g., Connecticut, New York and Massachusetts, that have historically spent much more on Medicaid would receive smaller percentage reductions in federal payments. Conversely, low-income states, e.g., Florida, West Virginia and New Mexico, that have historically spent much less on Medicaid would have higher percentage reductions.
- Four states—California, Florida, New York and Texas—would account for over a third of the total savings.

Reductions in Beneficiaries

- The number of Medicaid beneficiaries would grow relative to 1995 levels, but much less so than would have occurred without the spending reductions. We anticipate that states will attempt to reduce expenditures per beneficiary by reducing provider payment rates, cutbacks in some optional services, and increased use of managed care. Assuming that states were able to hold expenditure per beneficiary growth to general inflation only, 19.4% of the necessary spending cuts would have to come from reducing the number of people eligible for the program; beneficiaries would need to be reduced by an estimated 8.3% or by 3.8 million individuals in the year 2002. Using a less optimistic assumption of inflation plus approximately 2% for expenditure per beneficiary growth, 51.7% of the cuts would need to come from beneficiaries—a 19.3% reduction or 8.8 million individuals in 2002 relative to our baseline projections.

- The enrollment reductions are also distributed unevenly across states. They tend to be greater in states in the south and in mountain states and lower in the east and midwest. Greater enrollment reductions can come from either large expenditure reductions or in low projected expenditure per beneficiary growth. States with low expenditure per beneficiary growth must reduce more beneficiaries—all else equal—since they have limited opportunity to achieve savings from managed care, optional services, or lowering provider payment rates.
- States with high levels of DSH expenditures, e.g., Alabama, Kansas, Louisiana, Missouri, and New Hampshire, have lower relative beneficiary reductions. Since the expenditure caps are applied to total Medicaid expenditures (DSH and non-DSH), high-DSH states would indirectly be allowed to let non-DSH expenditures (i.e., medical services and administrative costs) grow at rates higher than the caps.

Reductions by Type of Service

- We assume proportionate spending reductions between acute care and long-term care services. Under this assumption most states would achieve the majority (60%) of the savings from acute care. If long-term care services proved more difficult to cut, more of the reductions would come from acute care, and vice versa.

Background

In the last few months, the Senate and House Budget Committees set forth major proposals for restructuring the Medicaid program and dramatically reducing its expenditure growth.¹ The Senate proposal was not specific with regard to retaining the entitlement nature of the program or changes in eligibility, benefits, or payment rates. The House budget proposal was more specific in calling for a block grant in which states would be given widespread discretion over the use of federal funds to provide health services to low-income individuals.

The proposal which emerged as a compromise is most similar to the one that originated in the House. The Medicaid program is essentially converted into a block grant based on 1995 federal Medicaid spending by state. The grants are uniformly increased across states by 7.2% in 1997, 6.8% in 1998 and 4% per year thereafter.

The Senate Budget Committee proposal would have reduced Medicaid spending by \$173 billion relative to the Urban Institute's estimates of future Medicaid expenditure increases. The House Budget proposal would have reduced Medicaid spending by \$174 billion. The compromise proposal, though similar in design to the House proposal, is estimated to result in \$171.8 billion in savings to the federal government.² None of the proposals to date have suggested in detail how the

¹The reader is referred to The Impact of the House and Senate Budget Committees' Proposals on Medicaid Expenditures also from the Kaiser Commission on the Future of Medicaid for a discussion of these proposals.

²Our savings estimate for the compromise proposal is less than for the original Senate proposal not only due to the differences in growth caps, but as a direct result of the treatment of DSH payments; the Senate proposal explicitly froze DSH spending at 1995 levels, where the compromise proposal does not. Though similar in design

also have lower percentage reductions because their DSH payments are frozen under current law; by assuming that DSH spending for these states remains constant, non-DSH expenditures can grow at rates above the caps—making it easier to live within them.

Reductions in Beneficiaries

It is unlikely that states are going to be able to reach these levels of expenditure reductions through reducing expenditures per beneficiary alone; any savings that remain would need to come from enrollment reductions. We assumed, however, that states would first attempt to control spending per beneficiary by enrolling beneficiaries in managed care, reducing covered services and cutting provider payment rates—only after adopting such policies would they reduce enrollment. We further assume that states would control their own spending to the federal growth rates. We then made two alternative assumptions about states' success in controlling expenditures per beneficiary; the first is that states would control spending to the rate of general inflation⁶ (more optimistic) and second that they would control growth in spending per beneficiary to the rate of general inflation plus 1.9% (less optimistic).⁷

It is important to note that Medicaid has been estimated to cover 36.3 million individuals in 1995. Under all the assumptions discussed below there would be increases in enrollment relative to 1995 levels, but less than would have occurred without the spending reductions. Enrollment growth in the baseline reflects the number of individuals eligible under current rules because of increases in population, the number of individuals in poverty, and increased participation.

Using the more optimistic assumption of holding expenditures per beneficiary to inflation only, 19.4% of the total spending reductions would remain unaccounted for. States would have to reduce beneficiaries by 8.3% or by 3.8 million individuals in the year 2002 (Table 4). We assume that this is distributed proportionately across eligibility groups and would therefore affect 407,965 elderly, 599,850 disabled individuals, and 2.7 million adults and children in families.

Assuming that states are only able to hold expenditure per beneficiary to inflation plus 1.9%, over half (51.7%) of the program savings in the year 2002 would have to come from reducing the number of beneficiaries. We assume that this is distributed proportionately across eligibility groups and would therefore affect 407,965 elderly, 599,850 disabled individuals and 2.7 million adults and children in families. States would have to reduce beneficiaries by 19.3% or by 8.8 million individuals (Tables 4 and 6). Assuming again, that these are distributed equally across beneficiary groups states would reduce enrollment of 920,477 elderly, 1.4 million disabled and 6.3 million adults and children in families.]

In general, states that would have the greatest reduction in eligibility tend to be those who face greater overall expenditure reductions (Tables 4, 5, and 6); this usually means states with a higher proportion of acute care services because these are growing faster than long-term care. In addition, states will have greater eligibility reductions if they have slower growth in spending per beneficiary—due perhaps to greater proportion of less costly types of enrollees—because less of the

⁶As measured by the implicit GDP price deflator.

⁷This is equivalent to reducing the real rate of growth in spending per beneficiary by one-half.

required reductions can come from cuts in benefits. In general, states in the south and mountain regions have the largest reductions in eligibility. For example, states with the largest percentage reductions include Florida, Georgia, Montana, North Carolina, Virginia, and West Virginia. States with opposite characteristics, usually because of higher proportions of long-term care or high DSH spending, tend to have smaller reductions in enrollment. In addition, states with higher growth in spending per beneficiary—because of the composition of their populations—tend to have fewer cuts in beneficiaries because more of the savings can come from controlling per beneficiary costs..

Reductions by Type of Service

Finally, we examined the reduction in expenditures by type of service. Under the compromise proposal total spending—federal and state—would decline by \$88.9 billion in the year 2002. Assuming a proportionate distribution of expenditure reductions across acute care and long-term care, Table 7 shows that there would be a reduction of \$54.2 billion in acute care expenditures, \$29.0 billion in long-term care, and \$4.5 billion in DSH payments. For most states there would be greater cuts in acute care services than for long-term care. For states such as Connecticut, Minnesota and New Hampshire that have relatively higher expenditures on long-term care services, there would be greater reductions in long-term care than in acute care.

Coverage Loss Under the Conference Agreement Medicaid Block Grant

- The Republican Conference Agreement block grant proposal will reduce Federal Medicaid spending by \$164 billion between 1996 and 2002 — a 28% cut in the year 2002 alone.
- Even if states were able to reduce program spending through provider payment and service reductions, they could be forced to eliminate coverage for as many as 7.7 million Americans in 2002 alone. This includes:
 - 850,000 low-income seniors;
 - 1.3 million people with disabilities; and
 - 3.8 million children.
- Medicaid is the primary payer of nursing home care — today, 68% of nursing home residents rely on Medicaid to pay bills that average \$38,000 annually. Under the Republican block grant proposal, as many as 330,000 residents of nursing homes could lose coverage in 2002.
- States also count on Medicaid to provide health coverage for their rural residents. The Republican proposal could force states to eliminate coverage for about 1.9 million rural residents in 2002.

**Draft Estimates of the Number of People Losing Coverage Under the Republican Block Grant
By Group, 2002 (rounded to the nearest 100)
November 16, 1995**

	TOTAL	BY GROUP			SUBSET Children
		Aged	Disabled	Families	
Total	7,765,100	861,600	1,300,200	5,583,600	3,845,000
Alabama	42,400	5,100	10,800	26,700	18,800
Alaska	16,400	800	1,400	14,100	9,300
Arizona	47,800	16,000	16,800	15,000	10,400
Arkansas	112,000	14,800	28,700	70,600	48,700
California	723,000	58,300	81,000	672,700	356,600
Colorado	101,800	11,200	17,800	73,200	50,200
Connecticut	107,100	10,800	17,800	76,600	63,800
Delaware	3,100	200	600	2,400	1,700
District of Columbia	21,800	1,600	4,700	15,300	10,700
Florida	454,000	60,700	61,000	342,200	272,000
Georgia	354,100	38,100	59,100	256,900	174,700
Hawaii	28,200	2,600	4,300	21,300	14,500
Idaho	22,700	2,000	3,700	17,000	11,900
Illinois	183,300	14,700	37,400	131,200	92,300
Indiana	163,800	15,300	28,500	139,100	93,000
Iowa	66,900	7,000	9,400	39,500	28,400
Kansas	12,100	1,400	1,900	8,900	6,000
Kentucky	197,400	20,400	49,700	127,300	84,500
Louisiana	458,200	42,300	78,500	329,400	234,400
Maine	45,800	5,700	9,600	30,600	20,500
Maryland	97,800	8,900	18,800	70,200	49,700
Massachusetts	232,200	26,600	46,300	157,300	104,700
Michigan	123,500	8,800	24,400	80,300	57,800
Minnesota	76,900	8,900	10,600	66,300	38,400
Mississippi	62,800	6,800	11,200	34,800	25,200
Missouri	0	0	0	0	0
Montana	27,800	3,000	5,700	18,600	10,300
Nebraska	58,000	6,300	7,600	42,200	31,400
Nevada	23,200	2,600	3,700	17,000	11,800
New Hampshire	38,300	17,800	13,700	8,800	4,800
New Jersey	297,100	27,400	52,000	217,700	142,500
New Mexico	14,500	1,400	3,100	10,000	6,800
New York	863,200	87,800	132,800	632,600	454,800
North Carolina	497,600	86,600	69,800	341,100	223,600
North Dakota	21,200	3,200	2,800	15,200	10,600
Ohio	300,700	33,200	61,500	216,000	147,300
Oklahoma	131,400	14,800	17,300	89,300	68,300
Oregon	24,400	1,800	3,200	19,400	12,800
Pennsylvania	189,900	17,100	38,400	112,400	81,700
Rhode Island	79,600	12,300	17,400	50,100	33,800
South Carolina	92,200	13,200	15,300	63,700	45,500
South Dakota	12,400	1,500	2,200	8,700	6,300
Tennessee	188,000	21,300	46,600	120,100	85,700
Texas	368,000	34,800	35,500	285,900	204,300
Utah	47,400	2,900	6,600	38,000	25,000
Vermont	8,000	1,100	1,600	6,400	4,000
Virginia	246,800	33,800	38,100	174,900	122,500
Washington	259,700	18,400	41,800	199,500	129,500
West Virginia	168,800	16,000	31,800	121,200	72,800
Wisconsin	77,900	10,800	19,100	48,100	35,400
Wyoming	10,800	700	1,300	8,600	6,200

Total coverage loss was distributed proportionally across groups using the distribution of coverage loss across groups in the July report. The number of kids was estimated by multiplying the 1994 percentage of kids in families with children by the state's number of people in families losing coverage.

18-Nov-95

Coverage Loss Under the Conference Agreement Medicaid Block Grant

- The Republican Conference Agreement block grant proposal will reduce Federal Medicaid spending by \$164 billion between 1996 and 2002 — a 28% cut in the year 2002 alone.
- Even if states were able to reduce program spending through provider payment and service reductions, they could be forced to eliminate coverage for as many as 7.7 million Americans in 2002 alone. This includes:
 - 850,000 low-income seniors;
 - 1.3 million people with disabilities; and
 - 3.8 million children.
- Medicaid is the primary payer of nursing home care — today, 68% of nursing home residents rely on Medicaid to pay bills that average \$38,000 annually. Under the Republican block grant proposal, as many as 330,000 residents of nursing homes could lose coverage in 2002.
- States also count on Medicaid to provide health coverage for their rural residents. The Republican proposal could force states to eliminate coverage for about 1.9 million rural residents in 2002.

Repub Han

House Republican Medicaid Plan: Placing Families of All Generations at Risk

Medicaid Guarantee to Meaningful Benefits No Longer Secure for Millions Of Americans. The House Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts possibly reaching up to \$250 billion and States having complete flexibility to decide the amount, duration, and scope of Medicaid benefits, States could be forced to deny health benefits to millions of families, children, people with disabilities, and older Americans. As a result, beneficiaries could pay more to maintain current coverage or go without care.

Coverage of Critical Health Services Is Jeopardized.

Significant funding cuts proposed by the Republicans may force States to cut back or altogether eliminate optional Medicaid benefits, critical to older Americans and people with disabilities. These benefits include: prescription drugs, home and community-based care, and assistive devices such as wheelchairs.

Beneficiaries' Out-of-Pocket Costs Could Increase.

Under the House Republican plan, States, driven by significant funding cuts, could reduce the scope of benefits they cover to inadequate levels. As a result, beneficiaries may be forced to pay more out-of-pocket to maintain their current coverage. For example, if physician services were limited to 2 visits per month, the elderly or children with disabilities, who see physicians more often because of medical need, would have to pay more to get the proper care.

Protections for Nursing Home Residents and Their Spouses Are Eroded.

Many older Americans and persons with disabilities are at risk of selling their family home to qualify for Medicaid nursing home benefits. Protections against spousal impoverishment may be further eroded if States reduce the amount of assets that community spouses are allowed to keep or if spouses pay for benefits no longer covered by Medicaid.

Access to Nursing Home Care May Be Limited.

The House Republican plan does not require states to provide a comparable level of services throughout the state. In effect, states could discriminate among beneficiaries by reducing services to arbitrary or insufficient levels, or by providing more limited benefits to certain geographic areas or groups.

Families Vulnerable to Paying More to Care For Elderly Parents.

The House Republican plan allows States to shift costs to families by imposing higher levels of copayments, deductibles, and premiums for all services to some seniors. Families could pay more just to preserve the coverage their elderly parents receive.

Health Care Services for Children may Cost Families More.

Under the House Republican plan, states would not be required to cover the care needed to treat a medical condition or illness diagnosed during a child's health screen and exams. Additionally, States could require children and pregnant women to make co-payments toward all needed health services.

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE

June 21, 1996

Conference
Report

THEY ARE STILL INSISTING ON A BLOCK GRANT FORMULA THAT THE GOVERNORS HAVE ALREADY REJECTED. *The Federal-State partnership is severed. Republican proposal does not meet the Governors' principle that funding must automatically adjust for all changes in enrollment.* Under the Republican proposal, fully 97% of Federal Medicaid spending is a block grant. The remaining 3% is dedicated to an umbrella fund posing as protection for States with high enrollment growth. However, this umbrella is full of holes because it is difficult to access and provides only a one-time payment for population increases, not sustained support for States with higher than expected enrollment.

MEDICAID CUTS COULD STILL TOTAL \$250 BILLION. While the Republicans cut Federal Medicaid spending by \$72 billion, the total Medicaid cuts could still reach \$250 billion over 6 years if States spend only the minimum required to receive their full grant allocation. This is because the Republican proposal reduces State matching requirements.

MEDICAID GUARANTEE TO MEANINGFUL BENEFITS NO LONGER SECURE FOR MILLIONS OF CHILDREN, PEOPLE WITH DISABILITIES, AND OLDER AMERICANS.

The House Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts possibly reaching up to \$250 billion, States could be forced to deny health benefits to millions of children, people with disabilities, and older Americans, putting millions of middle class families at risk of paying for health care for their parents, children or family members with disabilities.

- **Children.** Deep total cuts in Medicaid would put severe financial pressure on States to reduce health benefits for many of the 18 million children who currently receive Medicaid.
- **People with Disabilities.** The Republican plan still jeopardizes the Medicaid guarantee for the over 6 million people with disabilities who currently receive Medicaid by allowing States the option to define who meets the disability criteria. The Republican's excessive Medicaid cuts may force States to restrict the scope of eligible disabling conditions, or cut back on benefits.
- **Older Americans.** Many of the Medicaid benefits critical to older Americans and people with disabilities are optional -- including prescription drugs, home and community-based care, and assistive devices such as wheelchairs and communication devices -- and cuts reaching up to \$250 billion could force States to cut back on these optional benefits.

THE GUARANTEE OF FINANCIAL PROTECTION FOR THE MIDDLE CLASS IS ENDED.

Under the Republican plan, most Medicaid beneficiaries could be forced to sell their home in order to qualify for Medicaid nursing home benefits. The Republican plan repeals the current protections for the homes of all but the poorest Medicaid beneficiaries. States would have the option to count homes as assets in determining Medicaid eligibility, which could force older Americans and people with disabilities to sell their home or family farm in order to qualify for nursing home benefits.

In addition, the Republican plan could put overwhelming pressure on states and providers to shift nursing home care costs to patients and their families. Because it makes deep funding cuts and weakens the current protections against excessive cost-sharing requirements, many patients and their families would pay more for less.

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.

June 21, 1996

Conference
Report

THE REPUBLICANS' FINANCING PROPOSAL -- CENTRAL TO MEDICAID REFORM -- IGNORES THE GOVERNORS' RECOMMENDATIONS. Unanimously, the Nation's Governors agreed to a financing formula that increases Federal funding when caseload and inflation increase. *The Republican bill's financing formula does not meet this principle.*

- **It is still a block grant.** The Federal-State partnership in financing Medicaid is severed. Under the Republican bill, fully 97 percent of Federal Medicaid spending is block granted. The Federal spending formula is permanently set in legislation so that if States experience a recession or a period of inflation, they are virtually unprotected.
- **Funding does not follow the people.** There is no component of the block grant that adjusts for caseload increases. Without incorporating caseload increases, funding will not keep pace with the caseload, possibly forcing States to deny health benefits to millions of children, people with disabilities, and older Americans.
- **The "umbrella" is full of holes.** Although 97 percent of Federal Medicaid spending is fixed in the block grant, there is a small "umbrella" fund that is supposed to protect states with high enrollment growth. However, this "umbrella" fund is full of holes because it is difficult to access and provides only additional payments for year-to-year population increases, not sustained support for States with higher than expected enrollment.

THE REPUBLICAN BILL GOES BACK TO A MEANINGLESS BENEFITS PACKAGE. The NGA proposal moved towards standards for the amount, scope, duration, of benefits.

- **The Republican bill moves away from the NGA acknowledgement of the need for benefits standards.** Without standards, there is no such thing as meaningful benefits or a guarantee of coverage. In addition, the limits of federal funds may force States to offer meaningless benefits. For example, "coverage" of inpatient hospital care could consist of one day a year.

THE REPUBLICAN BILL ENDS A GUARANTEE OF FINANCIAL PROTECTION FOR MIDDLE CLASS FAMILIES. The NGA proposal did not remove protections against excessive cost sharing requirements for Medicaid beneficiaries.

- **The Republicans will likely force families to pay more for less.** The Republican bill removes current protections against excessive cost sharing requirements -- although the NGA proposal did not endorse this. Since total Medicaid spending will be cut by \$250 billion over six years under the Republican proposal, providers will face overwhelming financial incentives to shift long-term care costs to patients and their families.

VACCINES FOR CHILDREN PROGRAM (VFC) IS ELIMINATED. The NGA proposal did not recommend that the Vaccines for Children program be repealed.

- **Children would suffer without adequate vaccinations.** The Republican bill ends the Vaccine for Children program and lets States establish their own vaccinations programs. Repeal of VFC funding will reduce the number of children immunized.

THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

Conference Report

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable federal guarantee of coverage for a defined benefit package
- Adequate and appropriately shared federal and state financing
- Beneficiary protections through quality standards and accountability

House Version

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, the House Commerce Republican bill would alter existing eligibility criteria thereby eliminating the guarantee of coverage. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal Poverty Level (FPL).**
- **offers each state the option of using either: 1) the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of current policy, which has a federal definition. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.
- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**
- **eliminates the current guarantee of transitional medical assistance for individuals losing cash assistance due to proposed time limits or other provisions in welfare reform.**
- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid. For example, it appears states may even have flexibility to restrict eligibility based on home ownership. Under current law, a home of any value does not affect a person's eligibility. Under the Republican bill, home owners could be found ineligible.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefit packages. There would be no “required” services for optional eligibility groups.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the “amount, duration, and scope” of benefits).** The Secretary does not have clear authority to affect states’ decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.
- **Statewideness requirements would be eliminated.** States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain populations that tend to live in specific areas.
- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries). Alternatively, states could provide richer benefits to favorable groups.

“Treatment” under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services. Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they would be optional services.
- **The Vaccines for Children Program is repealed,** while making childhood immunization a mandatory service. States are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.
- **Federal funding for abortion services would be permanently limited to instances of rape, incest, or where the life of the mother is in jeopardy.**
- **Family planning services are limited to “pre-pregnancy” family planning services and supplies.**

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in

federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** Beneficiaries could file a petition for certiorari before the Supreme Court of the United States, but only after all state appeal mechanisms are exhausted. Otherwise, only the Secretary of HHS would be able to sue in federal court on behalf of individuals. No federal right of action means there are no guaranteed enforceable federal benefits for individuals.
- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.
- Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns, and from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The base funding formula in the Republican bill has been seen before: it's the basic Medigra II formula. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigra II block grant formula. About 3 percent is attributable to the new umbrella fund.

The funding formula provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.
- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they may be forced either to raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to decrease total Medicaid funding and the state contribution required to generate the capped federal share of dollars spent on Medicaid. States have the incentive to withdraw large amounts of state Medicaid funding, making total cuts much larger than the proposed \$72 billion in federal cuts.
- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year. Repealing these limitations would give states the incentive to use these schemes to reduce the state contribution to Medicaid even further.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.
- **The Republican bill does not include critical federal quality standards for institutions caring for people with mental retardation and developmental disabilities.** There are no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.
- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.
- **The Republican bill expands states' ability to impose cost sharing on Medicaid beneficiaries.** Unlike current law, which bars states from imposing co-payments on children or on pregnancy related services, the Republican bill would allow cost sharing for children and pregnant women for any service except preventive and primary services, as defined by the state. In addition, co-payments could be imposed for all other services to the elderly and disabled.

Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as “nursing home services.” Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.
- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries. Assets, including the home, needed by survivors could be at risk of being claimed by the state.

Medicaid Expenditures:

MEDICAID

Medicaid Expenditure Data (Using Administration Projections):

- ◆ The projected Medicaid growth rates from the recent mid-session review have decreased compared to the President's FY 97 budget, especially in earlier years (see chart). In 1996, the aggregate growth rate was projected to be 3.1 percent in the mid-session review compared to 6.5 percent in the President's FY 97 budget.
- ◆ The Medicaid growth rate hit a high point of 17.4 percent in 1991. There has been a steady decline since that year. In 1996, the Medicaid growth rate was at 3.1%. The following chart shows the Medicaid growth rates since 1989, and the seven year average growth rate of 17.4 percent compared to the projected seven year growth rate of 8.7 percent:

HISTORICAL MEDICAID EXPENDITURES (Expenditures in Billions)

	1978	1979	1980	1981	1982	1983	1978-83
Medicaid Spending	\$10.0	\$11.5	\$13.3	\$15.7	\$16.7	\$18.4	\$85.6
% Growth	11.1	14.1	15.9	18.5	6.5	9.8	13.0
Per Capita Spending (Fed+State) -in dollars	\$827	\$964	\$1,113	\$1,296	\$1,404	\$1,545	\$1,192
Per Capita Growth	15.5	16.5	15.5	16.5	8.3	10.0	13.0

	1984	1985	1986	1987	1988	1989	1984-89
Medicaid Spending	\$19.6	\$21.7	\$23.5	\$26.6	\$29.0	\$32.7	\$153.1
% Growth	7.0	10.2	7.7	12.6	8.4	12.3	11.0
Per Capita Spending (Fed + State) -in dollars	\$1,649	\$1,800	\$1,879	\$2,061	\$2,254	\$2,467	\$2,018
Per Capita Growth	6.7	9.1	4.4	9.7	9.3	9.5	8.4

	1990	1991	1992	1993	1994	1995	1996	1990-96
Medicaid Spending	\$38.9	\$51.5	\$66.6	\$72.3	\$79.0	\$86.5	\$93.1	487.9
% Growth	18.5	31.7	28.0	8.5	9.7	10.0	3.1	16.0
Per Capita Spending (Fed + State) - in dollars	\$2,721	\$3,200	\$3,720	\$3,766	\$3,932	\$4,182	\$3,794	\$3,616
Per Capita Growth	10.3	17.6	16.2	1.2	4.4	6.4	2.7	5.7

- ◆ The reasons for the decline in the growth rates include reductions in disproportionate share hospital payments and donations and taxes; expansion of managed care; declines in welfare caseload tied with an improved economy; and decreases in overall health inflation and efficiencies in the rest of the health care system that also benefitted Medicaid.
- ◆ Additional Medicaid savings, projected to be over \$6.2 billion between FY 96 and 2002, are expected due to the recent welfare law (including loss of Medicaid eligibles due to changes related to SSI children and immigration). Additional savings may occur due to Medicaid coverage loss related to the "delinking Medicaid from welfare," although HCFA actuaries have not officially projected savings over the seven year period.

WELFARE REFORM PROJECTED SAVINGS
(Expenditures in Billions)

	1996	1997	1998	1999	2000	2001	2002	TOTAL
Savings	0	.05	.6	.9	1.2	1.6	1.9	6.25

- ◆ The recent savings of over \$26 billion in the mid-session review, combined with additional Medicaid savings due to welfare reform argue for reducing the savings, or no savings at all, required from the Medicaid program in the next round of budget talks.
- ◆ The projected Medicaid per capita growth rate of 6.7 percent over the next 7 years compares favorable to those in private sector and Medicare of 7.7 percent¹ and 7.6 percent, respectively.

¹ This number does not reflect FY 97 mid-session review. This is a 1995 budget figure, since this data is figured late in the year.

ADMINISTRATION'S MEDICAID BASELINE 1997 PROJECTIONS
(Expenditures in Billions)

	1997	1998	1999	2000	2001	2002	1997-02
Current Spending Proj. Fed/ mid-session	\$99.8	\$108.7	\$117.9	\$128.9	\$140.7	\$153.9	\$750
% Growth	7.3	8.9	8.5	9.3	9.2	9.4	9.0
Change in Spending from FY 97 President's Budget	(\$2.5)	(\$3.3)	(\$3.9)	(\$4.3)	(4.9)	(\$5.5)	(\$24.4)
Total Spending - Fed + State	\$175.1	\$191.0	\$207.0	\$226.1	\$247.0	\$270.0	\$1,312.2
Per Capita Spending - Fed + State - in dollars²	\$3,987	\$4,271	\$4,544	\$4,861	\$5,213	\$5,612	\$4,748
Per Capita Growth	5.1	7.1	6.4	7.0	7.2	7.7	7.0

	1997	1998	1999	2000	2001	2002	1997-02
FY 97 President's Budget - Fed Spend.	\$102.3	\$112.0	\$121.8	\$133.2	\$145.6	\$159.4	\$774.3
% Growth	7.8	9.5	8.8	9.4	9.3	9.5	9.0
Per Capita Growth	4.6	6.4	5.9	6.8	7.0	7.4	6.7

² This number does not include disproportionate share hospital payments or administrative costs.

CBO BASELINE 1996-97 PROJECTIONS
(Expenditures in Billions)

	1997	1998	1999	2000	2001	2002	1997-02
Current Spending 9/96							
% Growth							
Change in Spending from 3/96		NOT Updated					
Total Spending - Fed + State							
Per Capita Spending - Fed + State - in dollars ³		Yet					
Per Capita Growth							

	1997	1998	1999	2000	2001	2002	1997-02
Current Spending 3/96 (Fed)	\$105	\$116	\$127	\$138	\$152	\$167	\$805
% Growth	9.6	10.1	9.5	9.3	9.6	9.9	9.7
Per Capita Spending	\$4,830	\$5,182	\$5,534	\$5,889	\$6,317	\$6,766	\$5,753
Per Capita Growth	5.6	7.3	6.8	6.4	7.3	7.1	7.0

* CBO has not yet updated 97-2002 baseline numbers. The August update was only for FY 96.

³ This number does not include disproportionate share hospital payments or administrative costs.

**COMPARISON BETWEEN 1996 AND 1997
TOTAL MEDICAID SPENDING**

	1996	1997	1998	1999	2000	2001	2002	1996-2002
Pres' Budget - 1996	\$96.0	\$104.5	\$114.5	\$124.5	\$136.3	\$149.8	\$163.8	\$889.4
Mid-session - 1996	\$96.1	\$104.5	\$114.4	\$124.5	\$136.4	\$149.4	\$163.2	\$888.5
Change from 96 Pres' Budget to Mid-session	0.1	0	(0.1)	0	0.1	(0.4)	(0.6)	(0.9)
Pres' Budget - 1997	\$94.9	\$102.3	\$112.0	\$121.8	\$133.2	\$145.6	\$159.4	\$869.2
Change from mid-session 1996 to Pres' Budget 97	(1.2)	(2.2)	(2.4)	(2.7)	(3.2)	(3.8)	(3.8)	(19.3)
Mid-session - 1997	\$93.1	\$99.8	\$108.7	\$117.9	\$128.9	\$140.7	\$153.9	\$843
Change from 97 Pres' Budget to Mid-session	(1.8)	(2.5)	(3.3)	(3.9)	(4.3)	(4.9)	(5.5)	(26.2)
TOTAL REDUCTION	(2.9)	(4.7)	(5.8)	(6.6)	(7.4)	(9.1)	(9.9)	(46.4)

- ◆ There was a decrease of \$900 million from the President's 1996 budget to the 1996 mid-session review.
- ◆ There was a \$19.3 billion reduction from 1996 mid-session to the President's 1997 budget.
- ◆ There was \$26.2 billion in projected savings from the President's 1997 budget to the 1997 mid-session review.
- ◆ The total reduction from the President's 1996 budget to the 1997 mid-session review was \$46.4 billion.

Director Briefing

Medicaid Section 1115 Demonstration Waivers

As Medicaid reform legislation has stalled, states are increasingly using the section 1115 Medicaid demonstration waiver authority to pursue major statewide health reform initiatives. In order to further control costs and sometimes to expand eligibility beyond the upper limits in Medicaid law, states apply for these waivers of Medicaid law. OMB plays a major role in the negotiation of these waivers with HHS and the states, especially in the area of "budget neutrality."

→ use to expand eligibility

History

- Since the original Medicaid legislation was passed in 1965, §1115 of the Social Security Act has given the Secretary of HHS the authority to waive certain requirements of the Medicaid program to support "an experimental, pilot or demonstration project."
- The §1115 authority allows the Secretary to waive more aspects of Medicaid law than the more limited §1915(b) waiver authority (known as a freedom of choice waiver) which states use even more frequently to move their eligible populations into managed care.
- The Administration has approved 12 statewide §1115 waivers and is in the process of evaluating 11 more. Prior to the Clinton Administration, only Arizona had received approval for a statewide §1115 waiver in 1984. Montana's behavioral health waiver application was disapproved. New Jersey and Washington are expected to submit waiver proposals this summer. Tab A includes a list of all the waivers with their approval or disapproval dates and waivers yet to be approved.
- Of the 13 approved statewide waivers, 9 states have implemented their programs. Florida, Kentucky, Massachusetts and Ohio have yet to obtain approval for their program from the state legislatures.
- In FY 95 acute care spending in States with approved waivers comprised 14% of total Medicaid spending. Acute care spending in states with pending §1115 waivers comprised 23% of total Medicaid spending. Since most demonstrations do not incorporate all State Medicaid acute care spending, these figures probably overstate the percentage of Medicaid expenditures attributable to the §1115 waivers.
- When all of the currently approved demonstrations are implemented, nearly 2.2 million individuals who did not receive Medicaid coverage will be eligible for services.

rapid increase of waivers under Clinton.

- States typically use the §1115 waiver process to:
 - move their AFDC, and more recently their disabled populations, into managed care;
 - obtain federal matching funds for costs that are not otherwise matchable under Title XIX (i.e. private health insurance premiums for the working poor);
 - use the managed care savings and other waiver-related revenues to cover traditionally non-Medicaid populations;
 - waive statutory enrollment requirements (e.g., the "75/25" rule that requires the enrollment of at least 25 percent privately insured patients in a managed care entity);
- After approval of the waivers, states later often seek federal approval for amendments to the waiver. Most often, the amendments are designed to reduce the costs of the waiver program by reducing the number of new eligibles or by reducing the costs per new eligible by a reduction in services or by imposing higher premiums.
- HCFA has funded an evaluation of five of the waivers (Tennessee, Hawaii, Rhode Island, Oklahoma, and Vermont). The evaluation should answer questions regarding how these demonstrations work, how they affect individuals, what they cost, and whether they are able to provide care that is as good as or better than that provided under the current Medicaid program. The final evaluation report is expected in September of 1998.

managed
care
cover
traditionally

Non-statewide §1115 Waivers

- In addition to the statewide waivers which move large portions of a state's Medicaid population into managed care, states have also used the §1115 waiver authority to affect changes in smaller portions of their programs. Like the statewide §1115 waivers, these waivers also must be budget neutral.
 - *Family Planning Demonstrations* -- Several states have received waivers to extend coverage of family planning services to women who would lose their Medicaid eligibility post-partum. More recently, states are applying for waivers to extend family planning benefits to all women who would become Medicaid eligible if they became pregnant. These waivers also must be budget neutral. States must prove that the averted expenditures on new Medicaid births would outweigh the expenditures on expanded family planning services.

Family planning - it must be demonstrated that f.p. services offset by less Medicaid births.

- *Integration of Medicaid and Medicare Financing* --States are beginning to experiment with combining Medicare financing of acute care services with Medicaid financing of wrap-around acute care services and long-term care services. In these waivers, a managed care organization would receive one capitated payment for all Medicaid and Medicare services. Minnesota has already received a waiver to do this, although it is not yet implemented. Several other states have recently applied for similar waivers. The most recent Republican Medicaid proposal on May 22, 1996 would authorize HCFA to approve 10 such demonstrations.
- *Special Populations* -- Maryland received a waiver to provide enhanced case management to Medicaid recipients whose expenditures were or were anticipated to be in the top 10% of all recipients. The District of Columbia received a waiver to enroll disabled children into a specialty managed care plan designed to address their needs.

Budget Neutrality Process

- In 1993, the Administration recognized the desire and the need of states to have greater flexibility in reforming their Medicaid systems. At the same time, the Administration has also stated that the waivers must be budget neutral to the federal government. Although budget neutrality is not required by law, an agreement was reached on this issue with the National Governors Association (NGA) that was published in the Federal Register on September 27, 1994.
- The agreement with the NGA, includes the following guidelines:
 - HCFA now establishes a well-defined review schedule for each waiver with a target decision date that is approximately four months from HCFA's receipt of the proposal;
 - HCFA may make only one consolidated request for additional information about a proposal;
 - HCFA will not limit the lifespan of the waivers to 4-5 years;
 - OMB, HCFA and HHS review the waiver proposal concurrently to expedite the process;
 - demonstration waivers can now be used to test similar policies in more than one state and are no longer required to be unique;

- HCFA will provide states with technical assistance through a contract with the National Academy for State Health Policy;
- HCFA will assess cost neutrality over the lifetime of the project;
- and, when an experiment is successful, the Administration will seek legislation to allow for permanent change and the Administration will consider extensions to existing waivers that are successful until legislative authority is granted.

Budget Neutrality Negotiations

- OMB plays a major role in the negotiations between the states and the federal government to assure budget neutrality.
- Though the Administration has pledged to remain open to new methodologies for calculating budget neutrality, a budget-neutral waiver expenditure limit is generally set by projecting a state's "without-waiver baseline" current-law expenditures as follows:

- **Per-capita method.** Budget neutrality can be defined solely in terms of per-capita costs as follows:

Baseline Expenditures = Projected Per-Capita Spending x Actual Enrollment - *don't want to be held accountable for increase in enrollment*

All but two states thus far have chosen this methodology because it does not hold them at risk for unexpected increases in enrollment.

- **Aggregate method.** Budget neutrality may also be defined in the aggregate, relying on projections of both per-capita costs and enrollment, as follows:

Baseline expenditures = Projected Per-Capita Spending x Projected Enrollment

Only Tennessee and Florida have chosen an aggregate cap.

- The budget neutrality calculation generally includes only the services and recipients eligible for waiver services. Typically states do not include beneficiaries dually eligible for Medicaid and Medicare, residents of institutions, and medically needy eligibles under the waiver. States also do not usually include long-term care services.

- The budget neutrality discussions with the states generally focus on the development of an appropriate estimate of federal spending in a *base year* without the waiver, as well as appropriate *trend factors* over the five year life of the waiver. The federal without-waiver baseline is the limit of what the federal government will spend on the people and services under the waiver.
- In the budget neutrality negotiations, the state's incentive is to increase the without-waiver baseline as much as possible, especially if they are expending eligibility or services. As a result, most of the budget neutrality discussions with states have revolved around the following issues:
 - "*Current Services*" *Baseline v. "Current Law" Baseline* -- Several states have wanted to project their without-waiver costs by including expenditures necessary to maintain their current program, i.e. a current services baseline, although federal or state law had changed, which would make that current services baseline impossible to support. For example, the OBRA 93 hospital-specific limits may reduce some states ability to continue to fund DSH at its historic levels.
 - *Hypothetical Eligibles* -- §1902(r)(2) of the Social Security Act allows states to expand eligibility for children under 10, pregnant women, the medically needy and qualified Medicare beneficiaries (QMBs) by liberalizing statutory income standards. For example, several states have incorporated into their without-waiver baseline eligibility expansions authorized under §1902(r)(2), but which are not yet implemented. The Administration policy has been to allow the baseline to be increased to reflect these hypothetical eligibles, if the state intends to include them in their waiver.
 - *Hypothetical Services* - Some states have requested including services in the without-waiver baseline that they have not yet provided under Medicaid, but intend to under the waiver. Administration policy has been to only include in the base year expenditures services which are currently being offered.
 - *DSH Payment Projections* -- Due in large part to the full implementation of the OBRA 93 hospital-specific payment caps in FY 96, it is difficult to estimate base year spending and to forecast growth in these expenditures in states which have been affected by the implementation of this law.
 - *Mixed §1115/§1915(b) Approach* -- States have begun to use the §1115 waiver authority to move their current Medicaid eligibles into managed care without an expansion in services or coverage. Section 1115 is supposed to be used only for "an experimental, pilot or demonstration project," although several states are using the waiver mostly to move recipients into managed care. States prefer a §1115 waiver to a §1915(b) waiver because they can lock enrollees into a managed care organization for a specified time period, can use managed care organizations that enroll less than 25%

private payors, and can obtain federal match for services not otherwise matchable. Allowing states to use the §1115 waiver process, however, could undermine the §1915(b) process. On the other hand, a §1115 waiver does subject a state to a more strict “budget neutral” standard, whereas a §1915(b) waiver is only held to a “cost effectiveness” standard.

- *Certified Public Expenditures (CPE)* -- CPE are costs incurred by states or local public agencies in the provision of Medicaid services. Under a §1115 waiver, the definition of Medicaid services and Medicaid eligibles can be expanded almost without limit. Thus, States have requested extending the base of federally-matchable expenditures to include local expenditures for non-Medicaid services, such as public health services, by using CPE.
- *Provider Taxes* -- The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 were enacted to curb the tremendous growth in the DSH program, in part, by restricting the ability of states to use certain types of provider taxes. Several states with §1115 waiver applications have been alerted that the expenditures supported by these taxes may be disallowed if the tax is determined to be impermissible. It is not yet clear how these potentially disallowable expenditures will be accounted for in the without-waiver baseline.
- *Current Managed Care Savings* -- Several states are requesting §1115 waivers which will cover Medicaid recipients already enrolled in a §1915(b) waiver. The Administration’s policy has been that the savings that have accrued from currently implemented §1915(b) managed care waivers should be reflected in the base year expenditures. States have argued that this unfairly penalizes “good” states which have been pursuing managed care all along.

Criticisms of Administration’s Waiver Policy

- In two reports, the GAO has criticized the Administration for approving waivers GAO considers not to be budget neutral to the federal government. GAO studied 4 of the §1115 waivers and found that only Tennessee was budget neutral, while Oregon, Hawaii and Florida were not budget neutral. GAO conclusion’s are based on its judgment that budget neutrality calculations should rely on the use of the average of the 50 states’ baseline rates of growth (i.e. the national Medicaid growth rates), instead of the more flexible approach based on individual state experience that has been taken by the Administration. The Administration responded by describing the flaws in GAO’s methodology and pointing out that the Administration had crafted without-waiver baselines which promote fairness and State flexibility by taking into consideration the complexity and variation of a State’s program, while also evaluating the robustness and appropriateness of the historical data in comparison to national trend rates.

COMPREHENSIVE HEALTH CARE REFORM DEMONSTRATIONS (05/17/96)			
STATE	KEY DATES	PROJECT OFFICER	TEAM LEADER/ BUDGET NEUTRALITY ANALYST
APPROVED - IMPLEMENTED (9)			
Arizona	Implemented: 1982 Amendments Under Review	Joan Peterson (410) 786-0621	Mike Fiore Ed Hutton
Delaware	Submitted: 1/29/94 Awarded: 5/17/95 Implemented: 1/1/96	Alisa Adarno (410) 786-6618	Paul Boben
Hawaii	Submitted: 4/19/93 Awarded: 7/16/93 Implemented: 8/1/94 Amendment Under Review	Anne Wade (410) 786-4175	Mike Fiore Ed Hutton
Minnesota	Submitted: 7/27/94 Awarded: 4/27/95 Implemented: 7/1/95	Bruce Johnson (410) 786-0615	Paul Boben
Oklahoma	Submitted: 1/6/95 Approved: 10/12/95 Implemented: 3/1/96	Patricia Seliger (410) 786-2672	Mike Fiore Paul Boben
Oregon	Submitted: 8/15/91 Awarded: 3/19/93 Implemented: 2/1/94 Amendment Under Review	Bruce Johnson (410) 786-0615	Sid Trieger Paul Boben
Rhode Island	Submitted: 7/20/93 Awarded: 11/1/93 Implemented: 8/1/94 Amendment Submitted	Debbie Van Hoven (410) 786-6625	Sid Trieger Paul Boben
Tennessee	Submitted: 6/16/93 Awarded: 11/18/93 Implemented: 1/1/94 Amendments Under Review	Rose Hatten (410) 786-6630	Sid Trieger Ed Hutton
Vermont	Submitted: 2/24/95 Awarded: 7/28/95 Implemented: 1/1/96	Sherric Fried (410) 786-6619	Mike Fiore Ed Hutton
APPROVED - PENDING IMPLEMENTATION (4)			
Florida	Submitted: 2/9/94 Awarded: 9/15/94 No Legislation	Alisa Adarno (410) 786-6618	Sid Trieger Paul Boben
Kentucky	Submitted: 5/26/93 Awarded: 12/9/93 Revised: 6/22/95 Amendment Approved: 10/6/95 Proposed Implementation: 1/1/97	Maria Boulmeis (410) 786-0552	Mike Fiore Ed Hutton
Massachusetts	Submitted: 4/15/94 Awarded: 4/24/95 Proposed Implementation: 9/1/96 Waiting for Legislation	Ed Hutton (410) 786-6616	Ed Hutton
Ohio	Submitted: 3/2/94 Awarded: 1/17/95 Proposed Implementation: 7/1/96	David Walsh (410) 786-6628	Debbie Van Hoven Paul Boben

COMPREHENSIVE HEALTH CARE REFORM DEMONSTRATIONS (05/17/96)			
STATE	KEY DATES	PROJECT OFFICER	TEAM LEADER/ BUDGET NEUTRALITY ANALYST
FRAMEWORK APPROVED (1)			
South Carolina	Submitted: 3/1/94 Framework Approved: 11/18/94 Suspended: 4/95	Sherrie Fied (410) 786-6619	Paul Boben
DISAPPROVED (1)			
Montana Behavioral Health	Submitted: 6/15/95 Disapproved: 9/13/95	Nancy Goetschius (410) 786-0707	Mike Fiore Paul Boben
PROPOSAL UNDER REVIEW (11)			
Alabama	Submitted: 7/10/95	Marie Boufemets (410) 786-0552	Mike Fiore Paul Boben
Georgia Behavioral Health	Submitted: 9/1/95	Nancy Goetschius (410) 786-0707	Debbie VanHoven Ed Hutton
Illinois	Submitted: 9/14/95	Gina Clemons (410) 786-9644	Lu Zawistowich David Walsh
Kansas	Submitted: 3/23/95	David Walsh (410) 786-6628	Mike Fiore Ed Hutton
Louisiana	Submitted: 12/31/94 Financial Proposal Disapproved: 6/8/95	Alisa Adamo (410) 786-6615	Lu Zawistowich Paul Boben
Maryland	Submitted: 5/3/96	Gina Clemons (410) 786-9644	Bruce Johnson Ed Hutton
Missouri	Submitted: 6/30/94 Revised: 3/24/95	Nancy Goetschius (410) 786-0707	Ed Tieger Paul Boben
New Hampshire	Submitted: 6/14/94 Revised Concept Papers Submitted: 6/13/95 9/20/95 1/96	Mike Fiore (410) 786-0623	Lu Zawistowich Ed Hutton
New York	Submitted: 3/20/95	Debbie Van Haven (410) 786-6625	Lu Zawistowich Paul Boben
Texas	Submitted: 9/6/95	Alisa Adamo (410) 786-6618	— Paul Boben
Utah	Submitted: 7/7/95	David Walsh (410) 786-6628	Ed Hutton
PRE-APPLICATION (2)			
New Jersey	Expected: 5/96	Bruce Johnson (410) 786-2615	Debbie Van Hoven
Washington	Concept Paper Submitted: Proposal Expected: 4/17/96 5/96	—	—

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Medicaid Briefing

May 23, 1996

MEDICAID

Part I of this briefing document puts national health expenditures and insurance coverage into perspective and describes how federal spending, and Medicaid in particular, are a major part of these expenditures and a major source of coverage. After illustrating the magnitude of health spending, this section illustrates the Clinton Administration's efforts at health reform in a shifting environment - from universal coverage to deficit reduction. Finally, this section puts the Medicaid program into perspective, by comparing Medicaid coverage and costs to private sector coverage and costs, as well as comparisons with various pieces of the states' and federal budgets.

Part II of this document briefly describes the Medicaid program, including who is eligible for benefits, what benefits are covered, how the program is financed, how much it costs, how it is administered, and who are the major constituencies of the Medicaid program and players in the national Medicaid reform debate.

Part III of this document describes recent trends in Medicaid eligibility, financing, and service delivery - focusing on recent policy issues of particular concern to OMB.

Part IV of this document illustrates baseline Medicaid spending projections and then describes the major Medicaid reform policies that have been proposed as part of the continuing balanced budget debate of 1995 and 1996, up to the latest Republican proposal, which was released on May 22, 1996.

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Part I: Medicaid in "Perspective"

Part I of this briefing document puts national health expenditures and insurance coverage into perspective and describes how federal spending, and Medicaid in particular, are a major part of these expenditures and a major source of coverage. After illustrating the magnitude of health spending, this section illustrates the Clinton Administration's efforts at health reform in a shifting environment - from universal coverage to deficit reduction. Finally, this section puts the Medicaid program into perspective, by comparing Medicaid coverage and costs to private sector coverage and costs, as well as comparisons with various pieces of the states' and federal budgets.

National Health Expenditures

- In 1993, the United States spent more than \$884 billion on health care. As a share of the Gross Domestic Product, health care spending grew from 9.3 percent in 1980 to 13.9 percent in 1993. The last projections available project health spending to be almost 18 percent of GDP in 2005.
- Of the \$884 billion in health spending in 1993, more than one-third was spent on hospital services. Almost one-fifth was spent on physician services.

Sources of Health Insurance Coverage and Payments

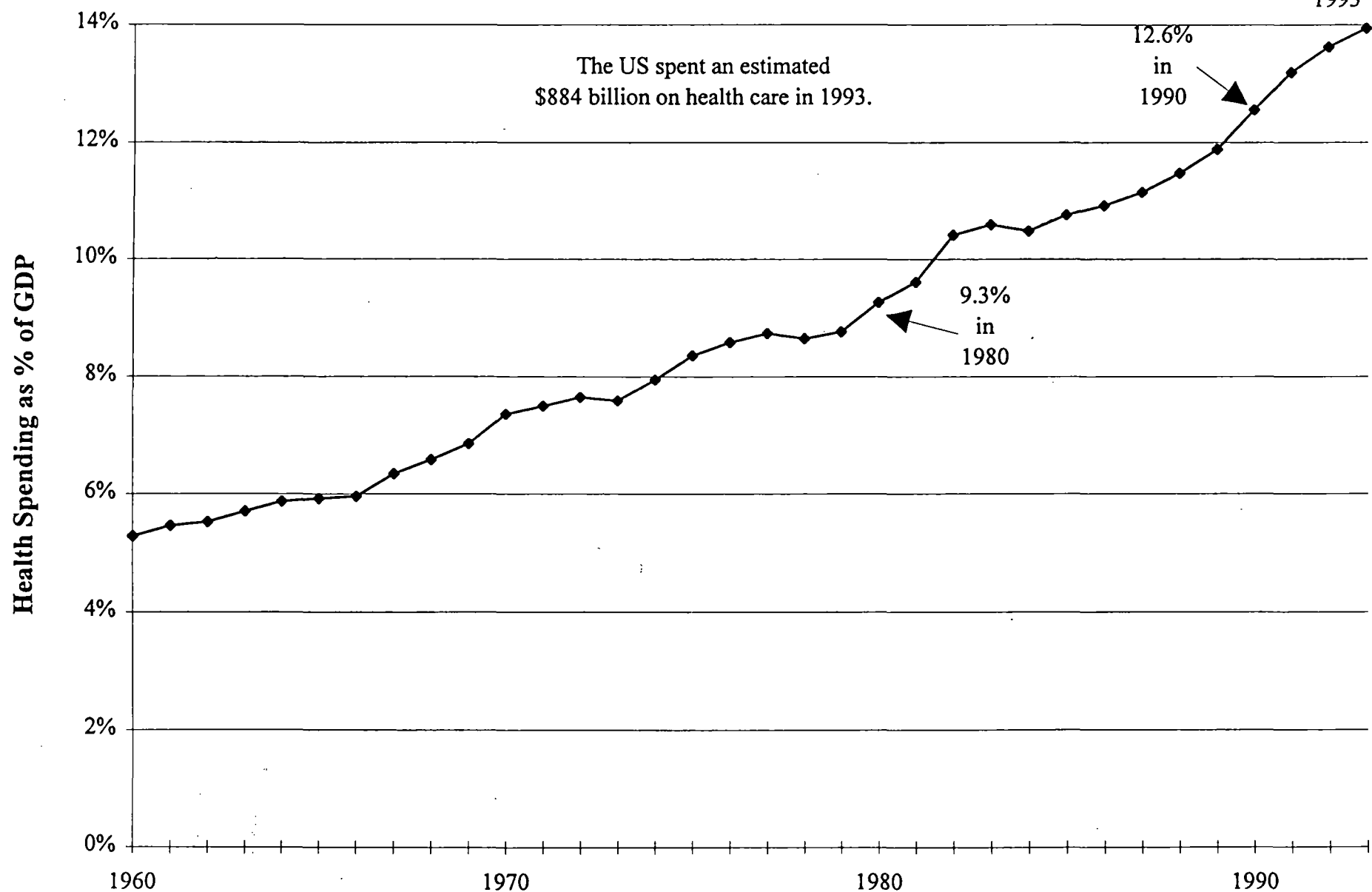
- In 1994, employer-sponsored insurance was the biggest source of health coverage among all individuals. More than 12 percent of individuals were covered by Medicaid. And more than 15 percent of individuals were uninsured.
- Private funds, mostly private health insurance and out-of-pocket payments, accounted for more than one-half of all health spending in 1994. Medicaid accounted for almost 14 percent of all health spending, while Medicare accounted for almost 18 percent of all health spending.

The Evolution of the Administration's Health Care Reform Initiative

- In 1993, one of the Administration's top priorities was reducing the budget deficit. As part of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Medicare and Medicaid spending was reduced by \$63 billion from FY 1994 through FY 1998.

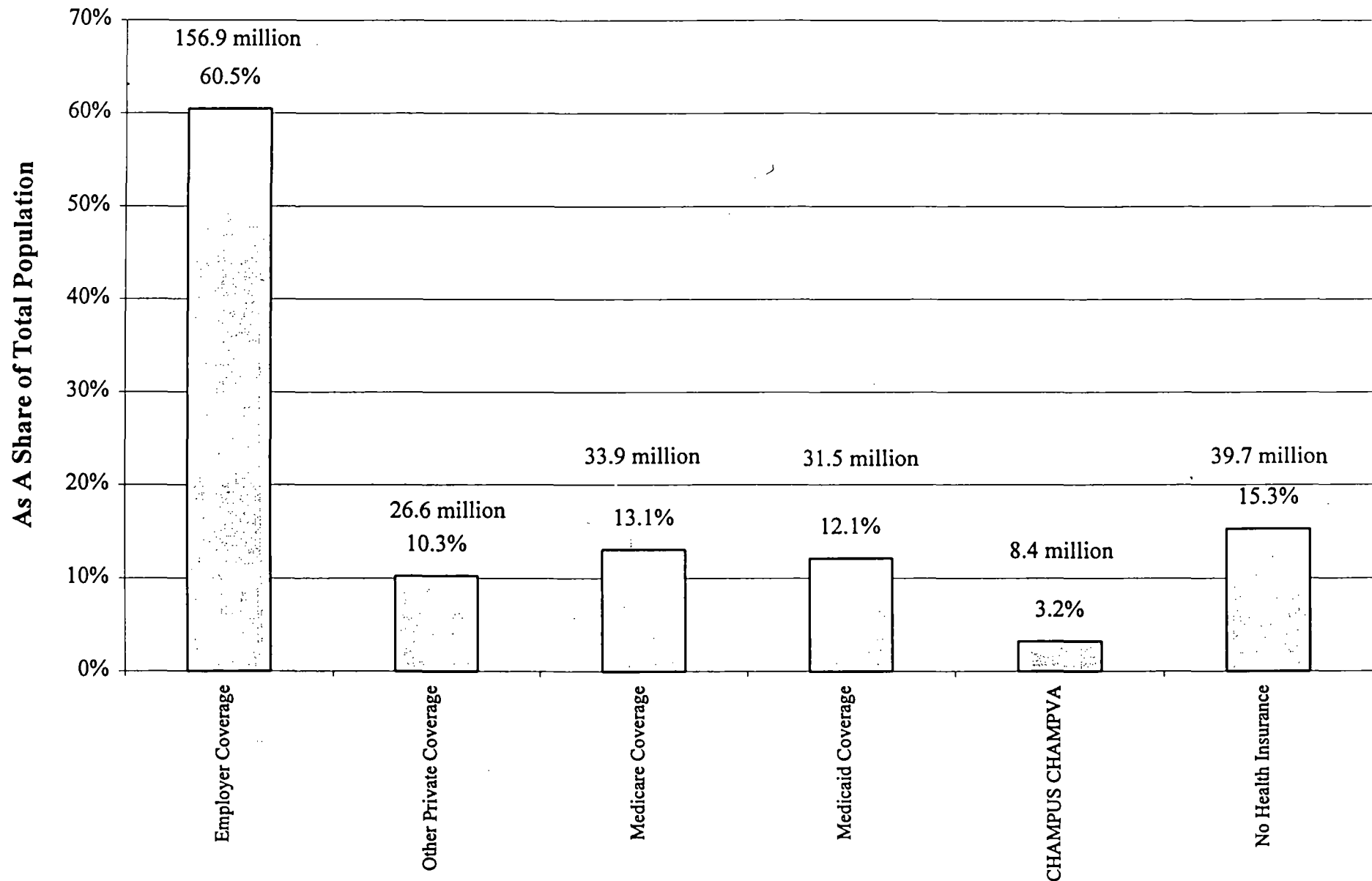
- After successfully passing its deficit reduction bill in mid-1994, the Administration focused its attention on reforming the overall health care system. In its Health Security Act, the Administration proposed to control the growth in health care spending and, at the same time, guarantee coverage to all Americans. In addition, there would have been a small decrease in the deficit (\$59 billion from FY 1995-2000).
 - Medicare savings (-\$118 billion) and Medicaid savings (-\$61 billion) were part of a broad financing package used for low-income subsidies (+\$110 billion), a Medicare drug benefit (+\$69 billion), long-term care (+\$62 billion), and programs to promote public health.
- After this unsuccessful attempt to reform health care, the Administration turned its attention, once again, to deficit reduction. As part of the FY 1997 Budget, the President released his proposal to balance the budget by 2002. Under this proposal, Medicare and Medicaid savings (-\$130 billion and -\$59 billion, respectively) are used mostly to reduce the deficit (-\$172 billion). Medicare and Medicaid are also reformed; Medicaid is maintained as an entitlement but states are given substantially more flexibility to manage their programs.
 - Some of the Medicare savings are used to expand Medicare benefits, resulting in net Medicare savings of \$124 billion.
 - The proposal also includes grants to states to provide health insurance for temporarily uninsured workers (+\$9 billion) and increases the health insurance tax deduction for the self-employed (+\$2 billion).

National Health Expenditures as a Share of Gross Domestic Product Calendar Years 1960-1993



Source: HCFA Office of the Actuary

Sources of Health Insurance, Total Population Calendar Year 1994



Source: Employee Benefits Research Institute, Analysis of the March 1995 Current Population Survey, February 1996

Medicaid in "Perspective", continued

Federal Medicaid Expenditures

- Federal Medicaid benefit expenditures have grown from \$39 billion in FY 1985 to \$90.7 billion in FY 1996. Average annual growth of benefit expenditures is projected to be 9.4 percent from FY 1996 to FY 2002.

Medicaid as a Share of National Health Expenditures

- Medicaid has grown as a percentage of total national health expenditures. Total state and federal Medicaid spending accounted for 7.3 percent of national health expenditures in 1970 and has grown to 13.6 percent in 1994.

Medicaid as a Percentage of State and Federal Budgets

- Medicaid has grown as a percentage of both state and federal budgets over the past 10 years. Federal Medicaid spending accounted for approximately 3 percent of federal outlays in FY 1987 and has grown to 6 percent in FY 1996. State spending on Medicaid has dramatically increased as a percentage of their budgets. State Medicaid spending accounted for 10 percent of total state budgets in FY 1987 and has grown to almost 16 percent in FY 1996.

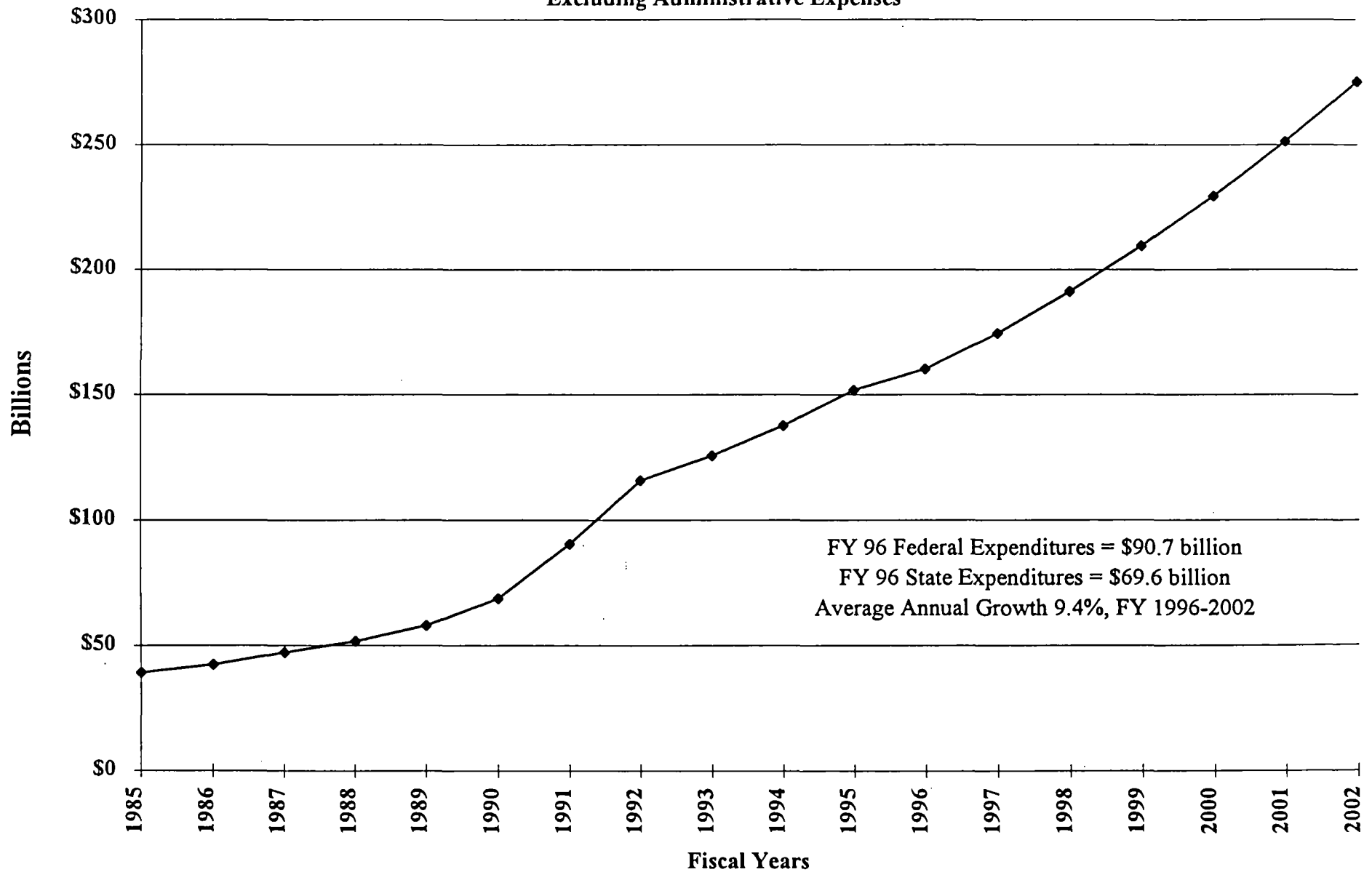
Medicaid and Other Sources of Health Coverage

- Medicaid coverage increased from 8.5 percent of the total population in 1989 to 12 percent in 1994. During that same period, employer sponsored health coverage declined from 61.5 percent of the total population in 1989 to 60.5 percent in 1994.
- While Medicaid covered only 12.6 percent of individuals under 65 in 1994, it covered more than 60 percent of children in poverty and almost half of the non-elderly under poverty. Private health insurance covered only about one-fifth of children and the non-elderly under poverty.

State and Federal Medicaid Expenditures

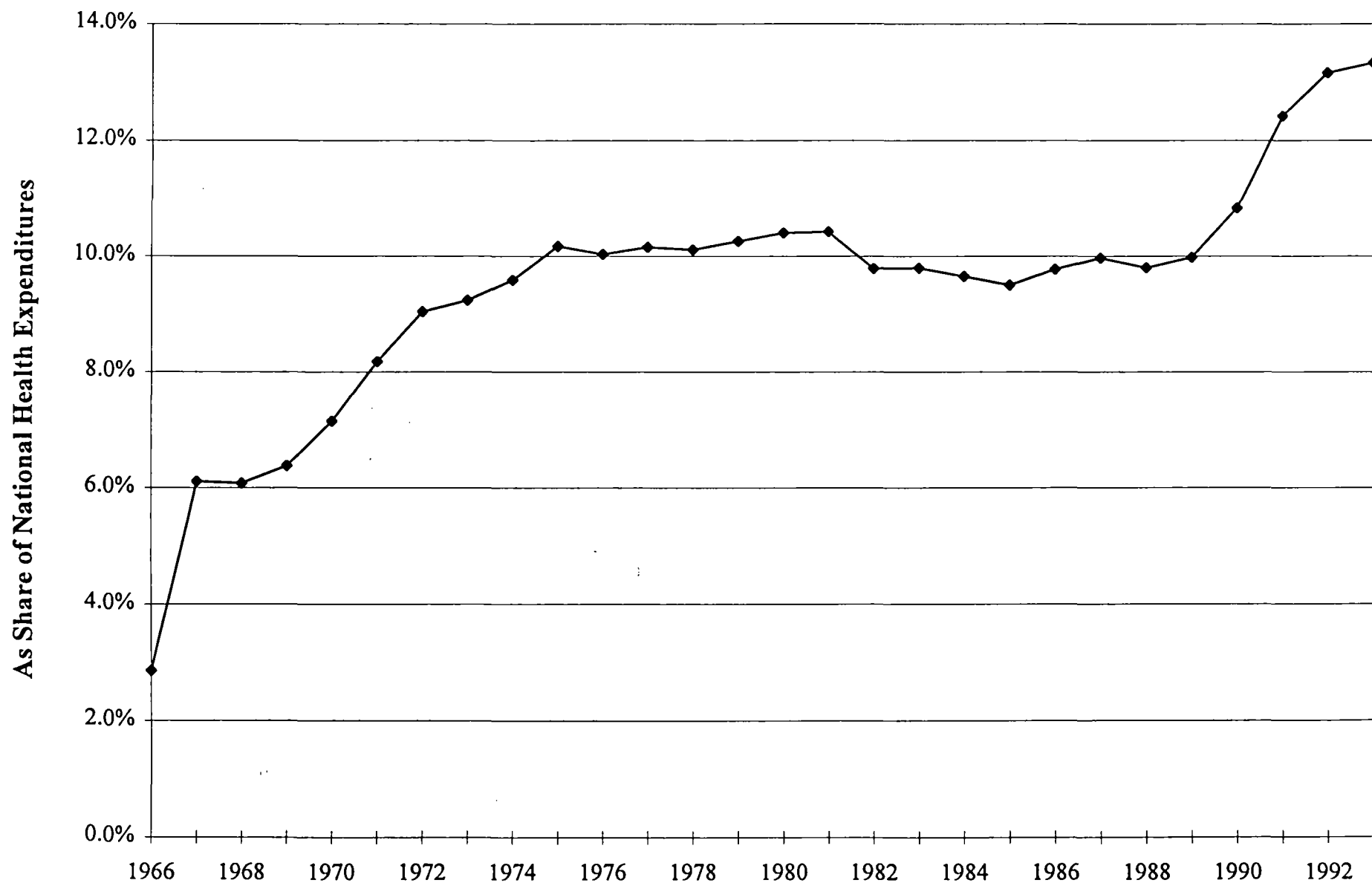
Fiscal Years 1985-2002

Excluding Administrative Expenses



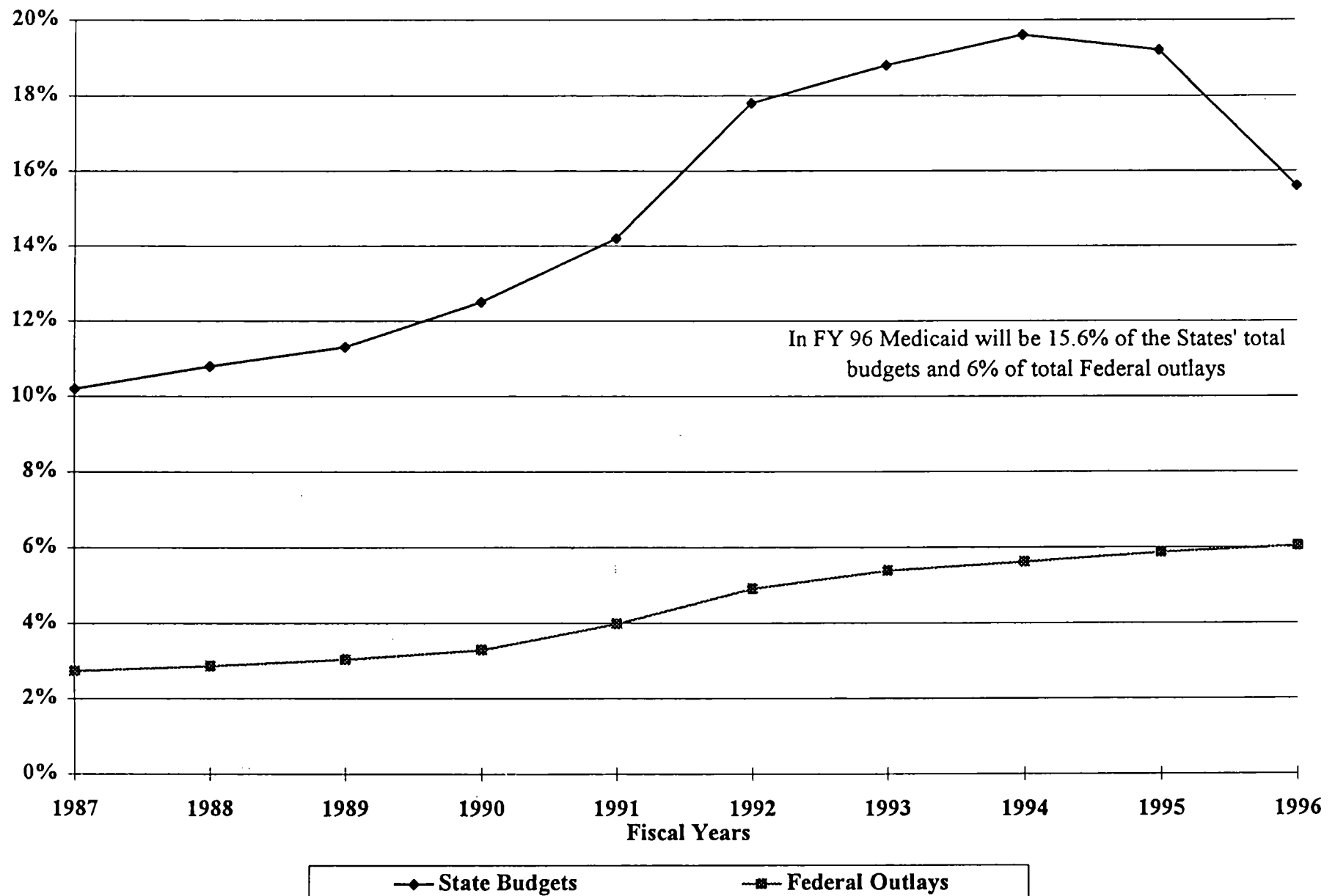
Source: HCFA Office of the Actuary

Medicaid (Federal & State) As Share of National Health Expenditures Calendar Years 1966-1993



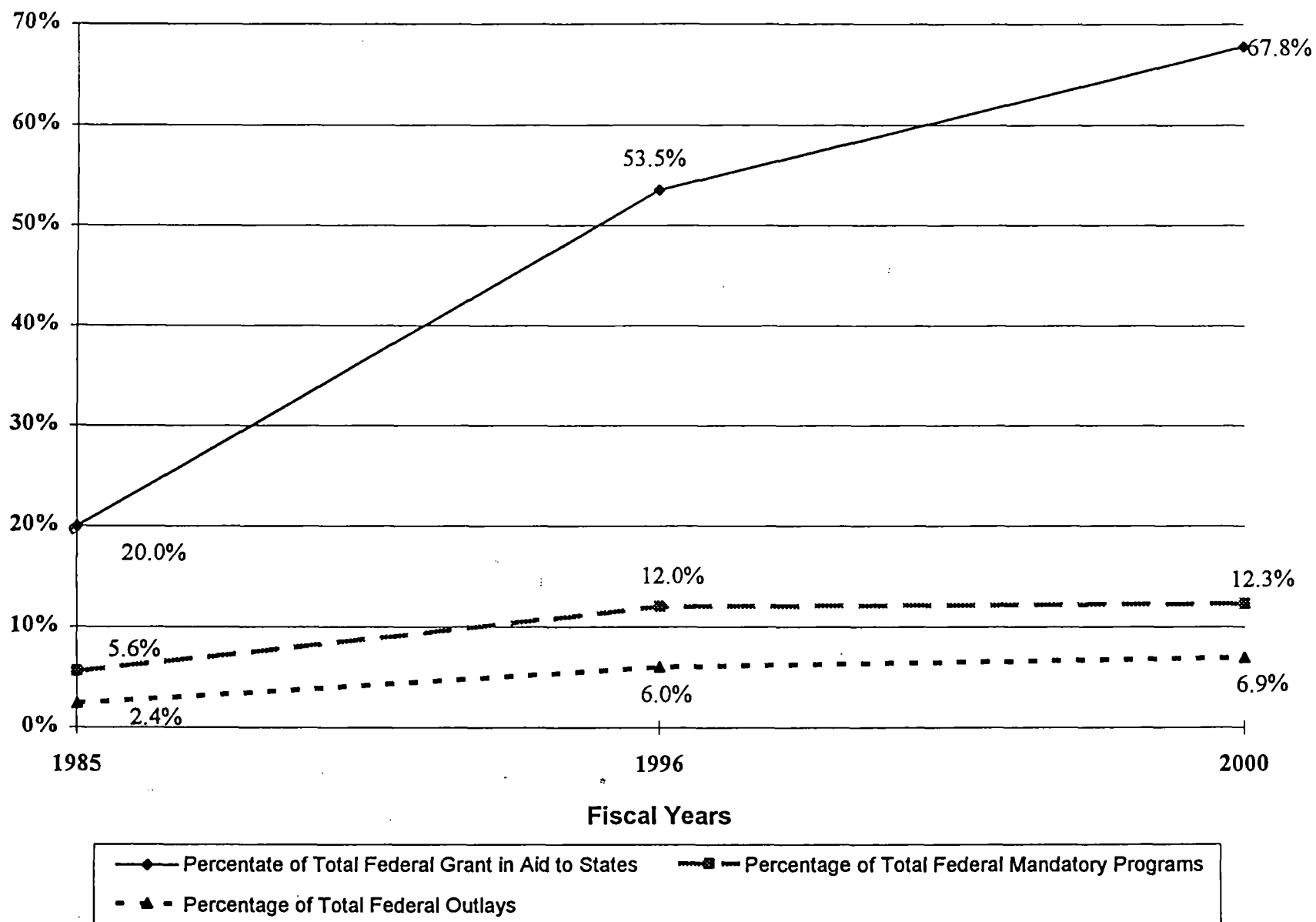
Source: HCFA Office of the Actuary

Medicaid as a Percentage of State and Federal Budgets



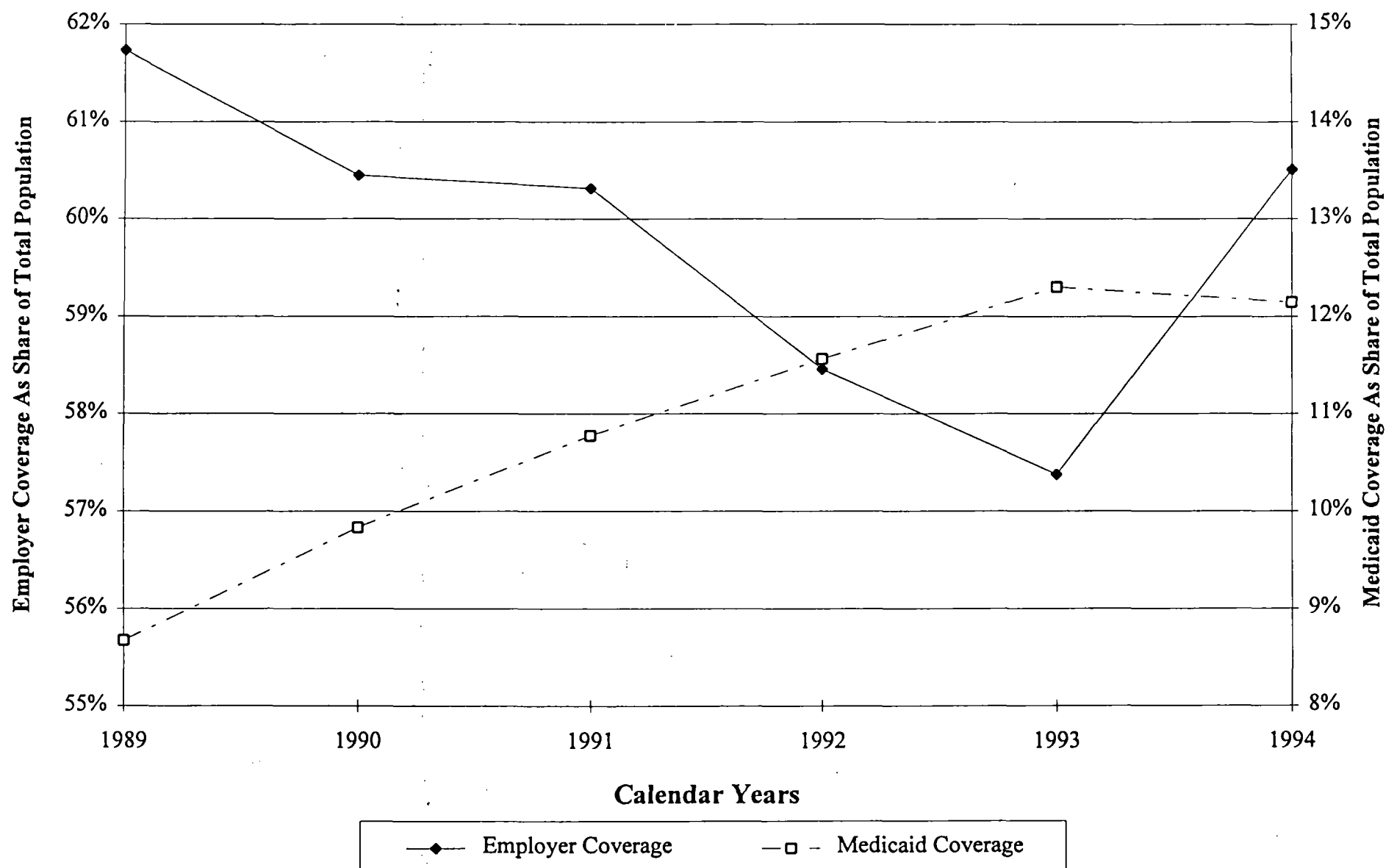
Source: FY 1997 President's Budget NASBO 1995 State Expenditure Report

Federal Medicaid Spending As A Share of Federal Spending Fiscal Years 1985-2000



Source: FY 1997 President's Budget

Employer Provided Coverage Has Declined While Medicaid Coverage Has Increased



Source: Employee Benefit Research Institute, Analysis of the March 1995 Current Population Survey, February 1996

Part II: Medicaid Overview

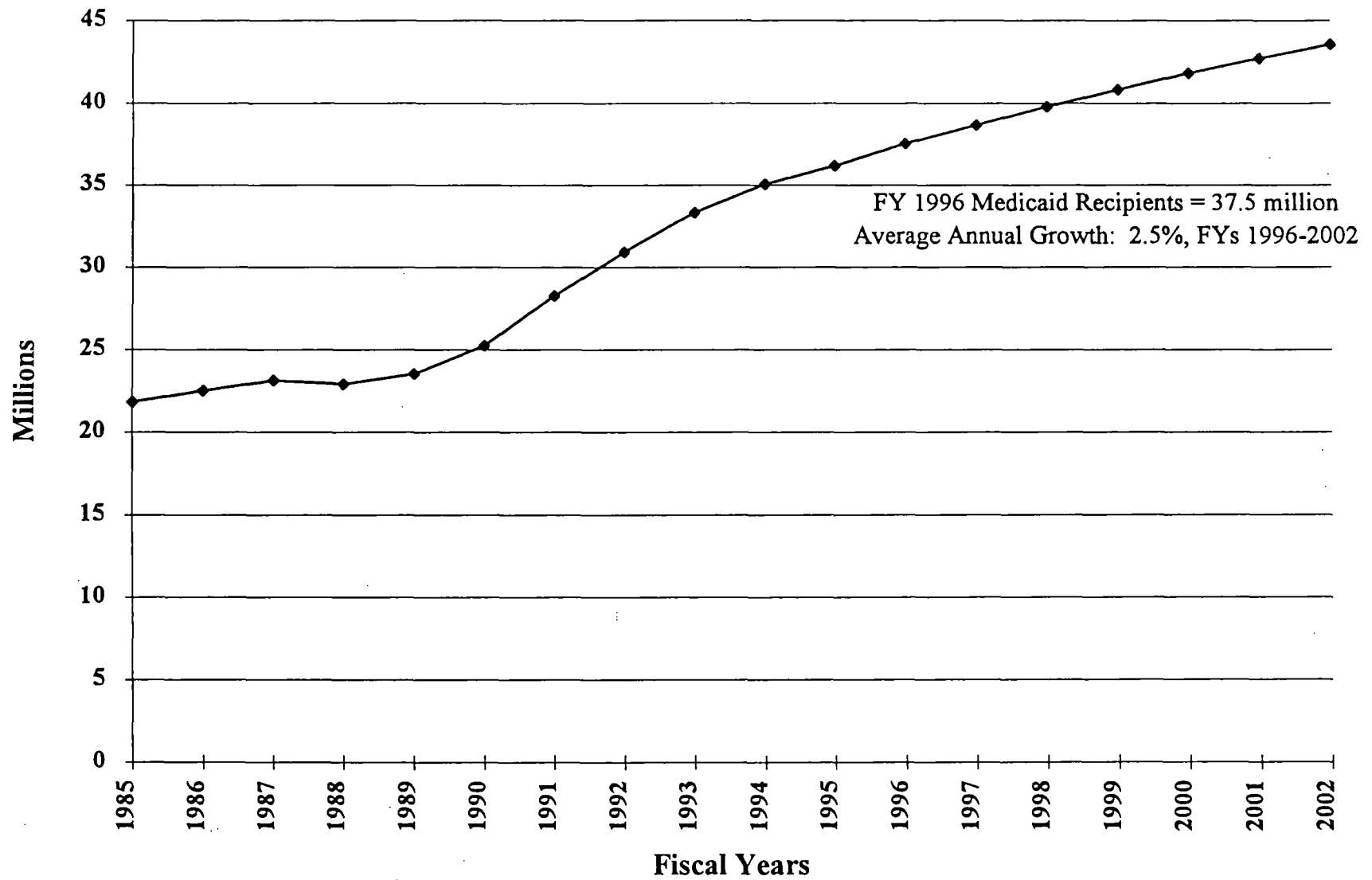
Part II of this Medicaid briefing document briefly describes the Medicaid program, including who is eligible for benefits, what benefits are covered, how the program is financed, how much it costs, how it is administered, and who are the major constituencies of the Medicaid program and players in the national Medicaid reform debate.

What is Medicaid?

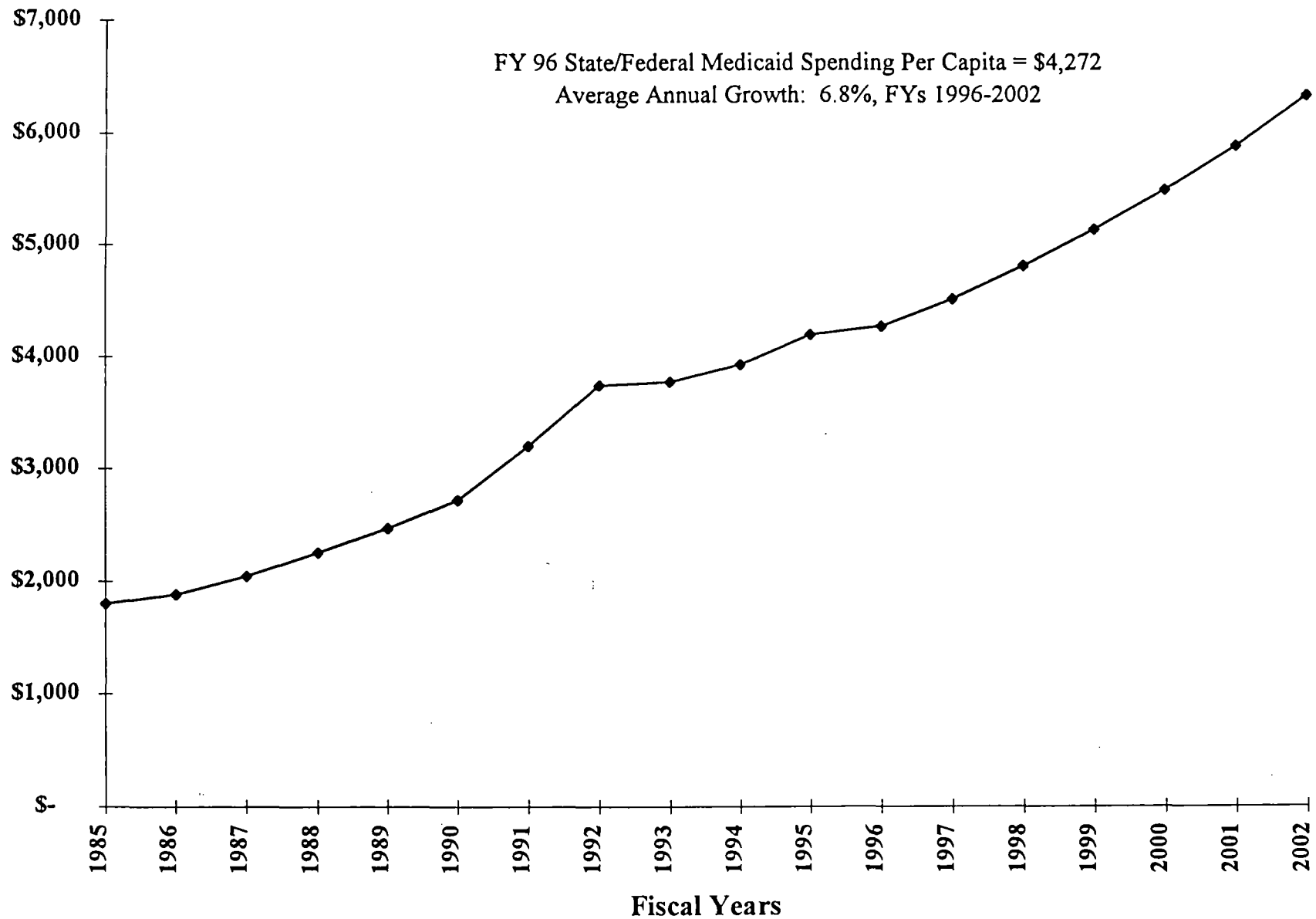
- Medicaid is the nation's major public financing program for providing medical and long-term care coverage to millions of low-income people.
- Initially designed in 1965 to pay for the health care of recipients of welfare assistance, by 1996 37.5 million people--more than 1 in 10 Americans-- will be covered by Medicaid at a federal cost of \$94.9 billion for benefits and administration.
- Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by state and federal government -- approximately 43 percent from the states and 57 percent from the federal government in FY 1996. Medicaid is administered by the states within broad federal guidelines. Within these guidelines, states set eligibility and provider payment levels and define benefits.
 - Federal guidelines require states to cover specific groups of people and benefits. States that comply with the federal eligibility and benefit guidelines receive federal matching payments based on the state's per capita income.
 - The federal share--or federal medical assistance percentage ("FMAP")-- can range from 50 to 83 percent of total Medicaid expenditures. For example, if a state's average per capita income is very high, its federal matching rate will be at the minimum of 50 percent. Alternatively, if a state's average per capita income is very low, its federal matching rate will be at the maximum of 83 percent.

The charts and graphs on the following pages illustrate the growth in federal and state spending on Medicaid and the growth in Medicaid recipients.

Medicaid Recipients



State and Federal Medicaid Spending Per Capita



Source: HCFA Office of the Actuary

Medicaid Overview, continued

Who is Covered by Medicaid?

- Medicaid law defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's option. Although Medicaid has increasingly been used to expand coverage to the low-income population, it covers only 48 percent of poor Americans who are under age 65, mainly because:
 - In general, Medicaid only covers persons who fall into particular eligibility "categories" (such as AFDC or SSI recipients) or who are pregnant women or children.
- The number of Medicaid recipients has grown from 22.6 million in FY 1985 to 37.5 million in FY 1996.
- The distribution of Medicaid recipients by eligibility category and the distribution of Medicaid spending by eligibility category vary widely.
 - Although adults and children are estimated to make up almost 71 percent of Medicaid recipients in FY 1996, they account for only 26.8 percent of total spending on benefits.
 - The aged and disabled make up only approximately 30 percent of the Medicaid population in FY 1996, but account for approximately 63 percent of benefit expenditures.
 - Disproportionate share hospital payments (i.e., special payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients) make up the remaining 10.3 percent of benefit expenditures in FY 1996, but they are not attributable to a specific group of Medicaid recipients.

The chart on the following page lists the major Medicaid eligibility categories. The two graphs on the following pages illustrate the distribution of Medicaid recipients by eligibility category, how Medicaid recipients have increased over time, and the distribution of Medicaid spending by recipient category.

Major Medicaid Eligibility Categories

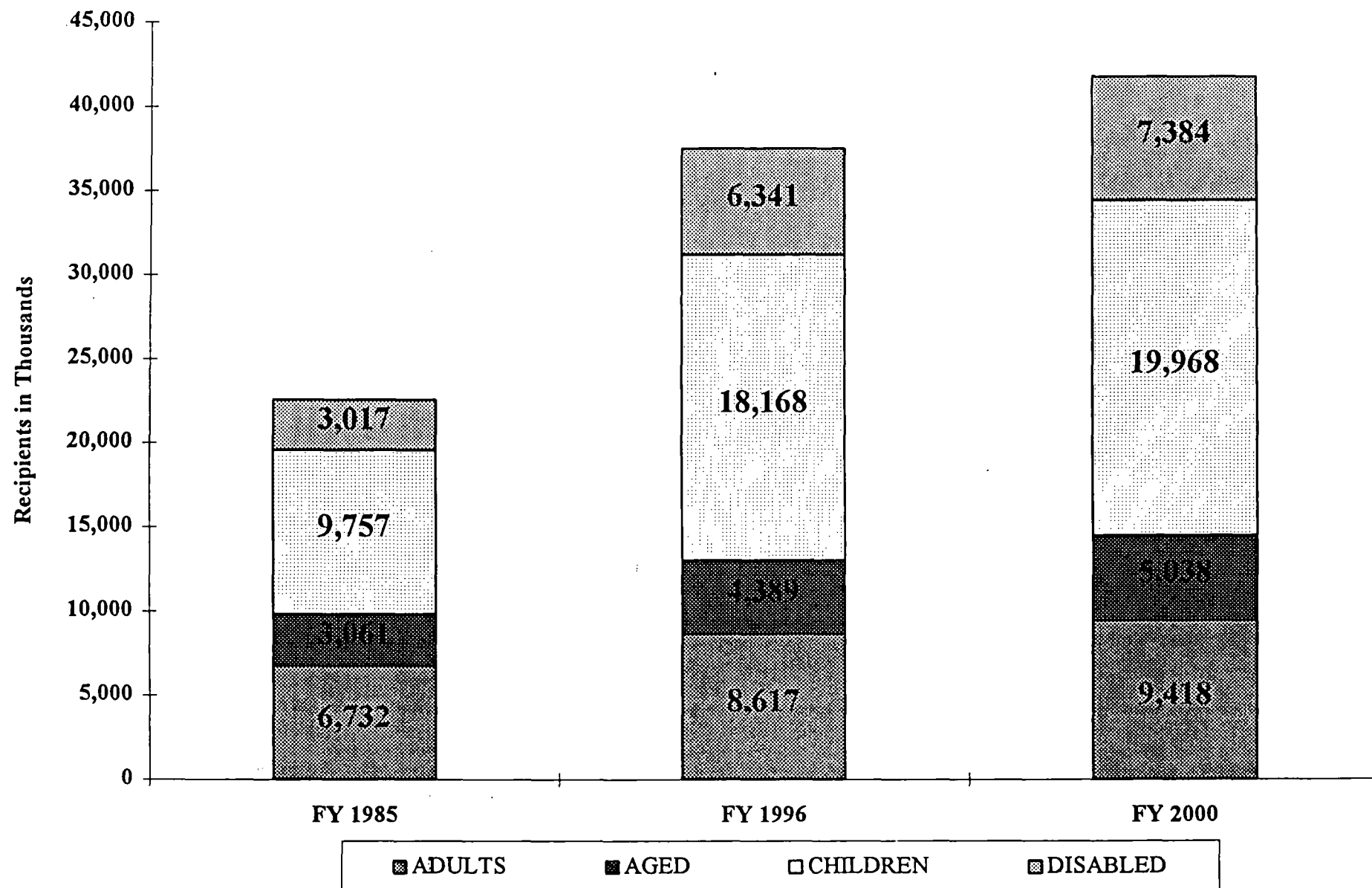
Federally-Mandated Coverage Groups

- *Current and some former recipients of cash assistance*, either AFDC, which covers single-parent families and two-parent families with an unemployed principal earner, or SSI, which covers low income persons who are aged, blind or disabled;
- *Low-income pregnant women and children* under age 6 with family incomes below 133 percent of poverty and children under age 12 (this is being phased-in to age 19 by 2002) in families whose income is less than 100 percent of poverty;
- *Low-income Medicare beneficiaries* ("QMBs" and "SLMBs") for whom Medicaid will pay Medicare cost-sharing (premiums, deductibles, coinsurance);

Optional Coverage Groups

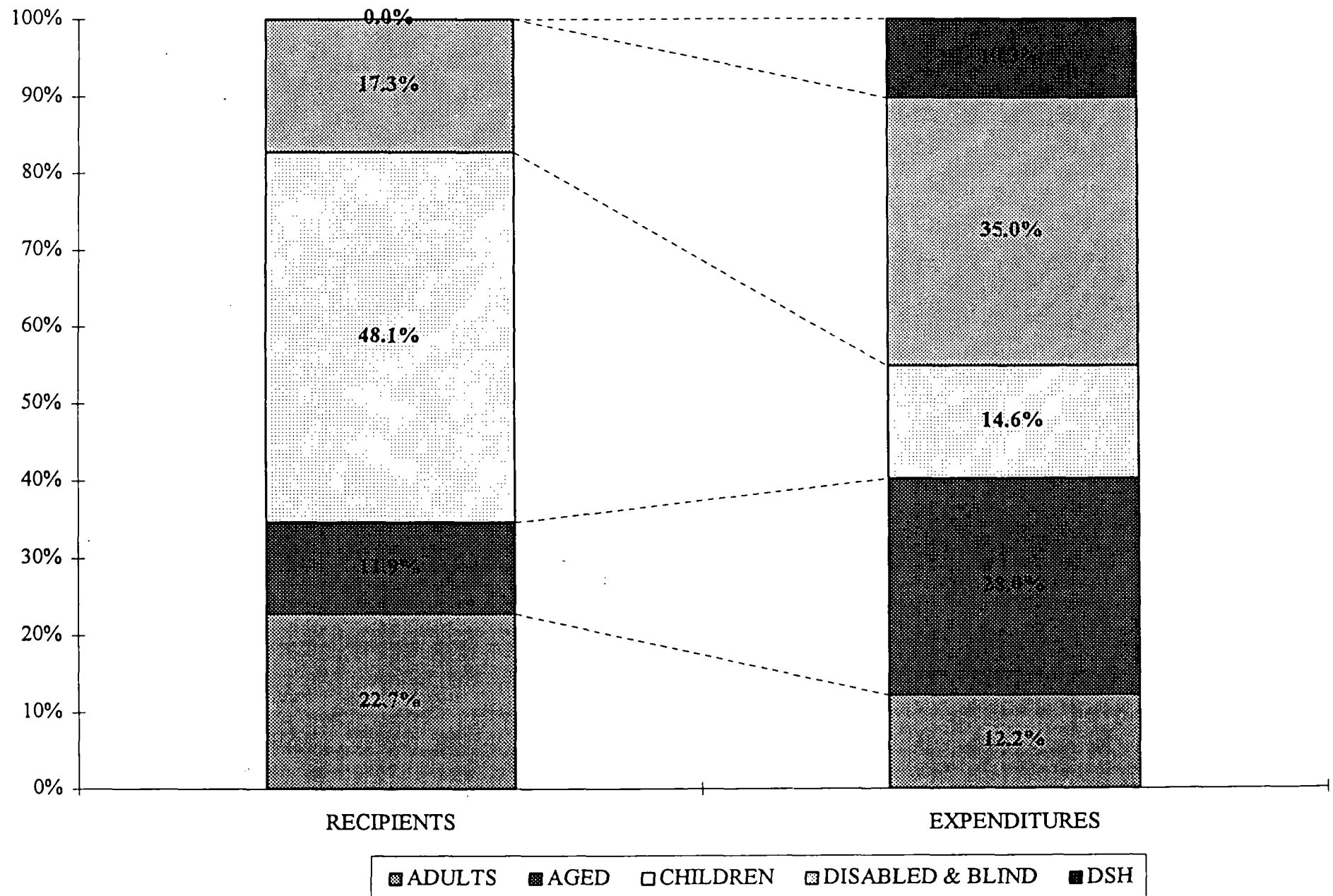
- *Low-income pregnant women and infants* with family incomes below 185 percent of poverty, but above 133 percent of poverty;
- *Medically needy* persons who meet the nonfinancial standards for inclusion in one of the groups covered under Medicaid and who have medical expenses such that when subtracted from their income, puts them within eligibility standards;
- *Persons requiring institutional or other long-term care* who, like the medically needy, "spend down" their resources on medical expenses which puts them within eligibility standards;
- *Low-income persons losing employer coverage* for whom the State may pay their COBRA premiums;
- *§1115 waiver expansions* have allowed States to expand eligibility to populations above poverty if the expansion is offset by other savings in the program.

Growth In Medicaid Recipients by Eligibility Group



Source: HCFA Office of the Actuary

Medicaid Recipients and Expenditures by Eligibility Category FY 1996



Source: HCFA Office of the Actuary

Medicaid Overview, continued

What Services are Covered by Medicaid?

- Medicaid covers a broad range of services to meet the health needs of the beneficiaries.
- Because of the limited financial resources of beneficiaries, few or no cost-sharing requirements are imposed.
- States that choose to cover the medically needy may offer more restricted benefits to these beneficiaries than to those who meet categorical eligibility criteria.
- In addition to services directly related to Medicaid beneficiaries, under federal law, states may make payments (either direct or through higher payment rates than other hospitals) to hospitals that serve a disproportionate share of Medicaid and uninsured patients, which can result in a high level of uncompensated care.
- A state's level of disproportionate share hospital (DSH) funding is unrelated to the number of poor people or uninsured people in the state. Given the loose federal eligibility rules, states can designate almost any hospital as eligible for DSH payments. (See Medicaid Trends section for a complete discussion of DSH and special financing.)

The chart on the following page lists the major Medicaid benefits in each category. The graph on the following page illustrates the distribution of spending on Medicaid benefits by major service category.

Medicaid Covered Benefits

Federally-mandated services for categorically-eligible Medicaid beneficiaries include:

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

States are required to provide to their *medically needy* populations prenatal and delivery services, ambulatory services, and home health. States are required to provide more services if the state provides services to the medically needy in Institutes for Mental Disease (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

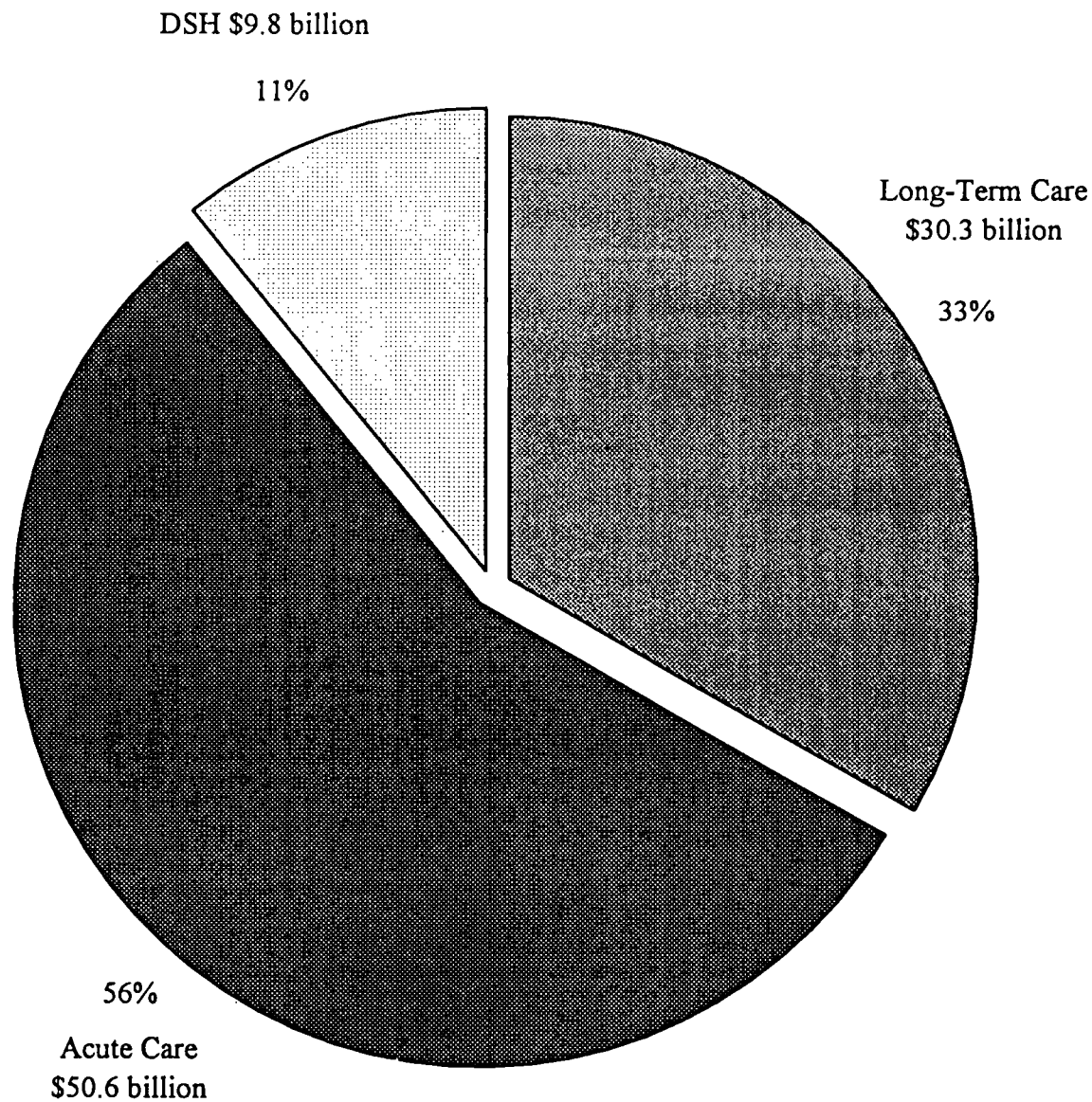
Commonly offered *optional* services for both categorically and medically-needy populations include: *

- prescription drugs
- clinic services
- prosthetic devices
- hearing aids
- ICF-MRs & IMD
- podiatrist, optometrist, chiropractor services
- dental & dentures
- eyeglasses
- physical, occupation, speech & respiratory therapy
- hospice
- case management
- personal care

*states still receive federal matching funds for optional services

Federal Medicaid Spending by Service Category, FY 1996

Total Federal Spending (excluding administration): \$90.7 Billion



Medicaid Overview, continued

How is Medicaid Administered?

- The Medicaid program is administered by state agencies under the general oversight of the Health Care Financing Administration (HCFA).
- HCFA is responsible for promulgating regulations and other guidance which explains HCFA's interpretation of Medicaid law. HCFA sets the federal standards for Medicaid eligibility, provider payment, and coverage of benefits. States design their programs in accordance with these standards. In addition to these broad responsibilities, HCFA is also responsible for setting the standards for a variety of other program administration activities, including provider standards and certification and quality control.

Medicaid is Really 56 Different Programs

- Within the broad federal guidelines described above, states and territories are free to design their Medicaid systems to fit local circumstances. As a result, there is wide variation among states in who is determined eligible for Medicaid, what services will be covered, and how those services are delivered and at what rate they are reimbursed.
- Although states are required to cover certain mandatory eligibility groups and certain mandatory benefits, only 44 percent of total Medicaid benefit payments (excluding DSH payments) in FY 1993 was spent on mandatory benefits for mandatory populations. The remaining 56 percent of benefit payments was spent at the states' option - on services for optional eligibility groups or optional services for mandatory eligibility groups.

The table on the following page illustrates the diversity of states' poverty populations, Medicaid spending, Medicaid benefits offered, and federal financing.

Degree of Variation Among State Medicaid Programs

State	Total (Federal/State) Medicaid Spending Per Enrollee ¹	Percentage of Poor Individuals Covered by Medicaid ²	Number of Optional Medicaid Services Covered ³	FMAP ⁴
New York	\$ 5,498	53.70	25	50.0
D.C.	\$ 4,484	60.50	26	50.0
Nevada	\$ 3,066	28.80	26	50.0
West Virginia	\$ 2,560	55.50	24	74.6
Missouri	\$ 2,129	48.70	17	59.9
Mississippi	\$ 1,832	50.80	21	78.6
California	\$ 1,697	51.60	29	50.0

¹Actual FY 1994 Federal and State Non-DSH Spending

²In 1990-1992

³Reported by HCFA as of October 1, 1994

⁴Federal Medical Assistance Percentage for FY 1996

Medicaid Overview, continued

Who Cares about Medicaid?

Constituencies

- The constituencies affected by Medicaid are diverse. They include low-income pregnant women and children, the elderly, people with disabilities, and people with AIDS.

Congress

- The Senate authorizing Committee responsible for Medicaid is the Finance Committee. Democratic Senators on the Committee with a particular interest in Medicaid include: Senator Moynihan (NY), Senator Breaux (LA), Senator Rockefeller (WV), Senator Pryor (AR), and Senator Graham (FL). Other Democratic Senators active in Medicaid include Senator Daschle (SD) and Senator Dodd (CT). The Republican Senator most active in Medicaid is Senator Chafee (RI).
- The House authorizing Committee responsible for Medicaid is the Commerce Committee. Democratic Representatives on the Committee with a particular interest in Medicaid include: Rep. Waxman (CA), Rep. Dingell (MI), and Rep. Markey (MA). The Republican Representative most active in Medicaid is the Committee Chairman, Rep. Bliley (VA).

Interest Groups

- Other active players in the Medicaid reform debate include: Governors and State Legislators, represented by the National Governors Association (NGA) and the National Conference of State Legislators (NCSL); State Medicaid Directors, represented by the American Public Welfare Association, urban and public hospitals, represented by organizations including the National Association of Public Hospitals; and nursing homes, represented by organizations including the American Health Care Association.
- Other active lobbies include the Children's Defense Fund, AARP, Families USA, the Kaiser Commission on the Future of Medicaid, and the Center for Budget and Policy Priorities.

Part III: Medicaid Program Recent History and Trends

Part III of this document describes recent trends in Medicaid eligibility, financing, and service delivery - focusing on recent policy issues of particular concern to OMB. This list is not exhaustive and represents only a sample of the issues surrounding the Medicaid program.

Recent Medicaid Eligibility Expansions

The "categorical link" between Medicaid and the receipt of cash assistance benefits was broken in the late 1980's, causing Medicaid eligibility to increase dramatically. Congress passed legislation both mandating eligibility expansions and granting states options to expand eligibility. These mandates put fiscal pressure on state budgets and continue to be a source of some controversy.

History

- Between 1984 and 1990, Congress amended Medicaid law 10 times to expand Medicaid eligibility for pregnant women, infants, and children by both mandating coverage for certain groups and giving states options to expand coverage beyond the mandates.
- The last two major expansions occurred as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and OBRA 1990 legislation. The children affected by these eligibility expansions are often referred to as "Waxman kids," named after Rep. Henry Waxman, the major sponsor of the legislation.
 - OBRA 89 required that states cover, at 133 percent of the federal poverty level, all pregnant women and children under age six.
 - OBRA 90 required that states phase in coverage to those children under the federal poverty level who were born after September 30, 1983, until all children under age nineteen are covered. This fiscal year, states began covering children who are 12 years old.
 - OBRA 89 and 90 also gave states the option to expand Medicaid coverage of pregnant women, infants, and children beyond federal mandates. Currently, 34 states have expanded coverage of pregnant women and infants above the mandated 133 percent of the federal poverty level.

Medicaid Program Recent History & Trends, continued

Growth in Disproportionate Share Hospital Payments and Special Financing Mechanisms

In response to mounting fiscal pressures and the discovery of loopholes in Medicaid law, states found creative ways to increase the federal share of Medicaid spending while decreasing their relative share of spending. The growth in disproportionate share hospital spending increased rapidly as a result of these loopholes. While legislation has been passed to curb some of the abuses, the amount and distribution of federal payments to disproportionate share hospitals continue to be a significant policy issue.

History

- During the late 1980s and early 1990s, federal spending on Medicaid increased much faster than historical growth. A study sponsored by the Kaiser Commission estimated that about one-fifth of this Medicaid growth occurred as a result of higher state spending on disproportionate share hospital (DSH) payments.
- Under federal law, states may make payments (either in a lump-sum or through increased payment rates) to hospitals that serve a disproportionate share of Medicaid and uninsured patients. Serving these patients can result in a high level of uncompensated care costs.
- Total Medicaid DSH spending increased from about \$0.4 billion in 1988 to almost \$17 billion in 1993 -- translating into an average annual growth rate of 106.7 percent per year. Most of the growth occurred during the period from 1990 to 1993. During this period, DSH grew at an average annual rate of 130.8 percent per year while program spending increased by 22.0 percent per year.
- During this period, states used DSH payments and related special financing mechanisms, such as provider taxes, donations, and intergovernmental transfers to effectively lower the state share of Medicaid spending, while increasing the federal share of Medicaid payments.
 - Provider tax and donation programs generally follow the following pattern: a state makes a DSH payment to a provider in excess of the provider's uncompensated care costs, the federal government matches the state's full DSH payment at the state's federal medical assistance percentage (FMAP), the provider then sends back part of the DSH payment (generally the part in excess of cost) to the State in the form of either a provider tax or donation. The effect is to

“recycle” state funds and receive federal matching funds in excess of the state’s FMAP.

- Some of the federal funds generated by these financing schemes were used to cover Medicaid expenses, whereas, some funds were used for non-health related expenses, such as building roads and bridges.
- In 1991 and 1993, two laws were enacted - the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and OBRA 1993 - which have limited, but not completely restrained, states’ use of provider taxes and donations and curbed growth in the DSH program.

Impact

- Since 1993, DSH spending growth has moderated. From FY 1993 to FY 1995, DSH spending increased from \$16.6 billion to \$19.5 billion (about 12.8 percent of program spending) -- an average annual growth rate of 8.3 percent per year. DSH spending growth was in line with total average annual program growth of 10.1 percent for FY 1993-95.
- Under the FY 1997 President’s Budget Baseline, DSH spending is projected to grow by about 5.9 percent per year from FY 1996 through 2002. This is lower than total program growth, which is expected to grow by an average rate of 9.4 percent during this time.

Recent Policies

- Although growth in Medicaid DSH spending has slowed, Medicaid DSH funds are still distributed inequitably among states and proposals for reducing and retargeting the program have been included in all of the recent reform bills, including the President’s plan (see below).
- As a result of the recent legislation, many States are having difficulties in raising state funds to sustain their Medicaid programs, which depended on the use of special financing mechanisms. Some states are seeking legislative relief from the laws:
 - Louisiana and New Hampshire were especially successful in using provider taxes and donations to recycle DSH funds. For example, Louisiana managed to finance 50 percent of their Medicaid program through such mechanisms.
 - The Omnibus Consolidated Rescissions and Appropriations Act of 1996 (OCRA 96) contained two provisions that provided temporary federal financial relief to Louisiana and New Hampshire.

- States still have the ability to recycle funds in several ways. Many of them involve overpayments to public facilities which then transfer excess funds back to the State, commonly referred to as “intergovernmental transfers.”
 - GAO has detailed how states have continued to use these creative, but legal, financing arrangements to obtain additional federal funds - even after the implementation of OBRA 93.

Medicaid Program Recent History & Trends, continued

Growth in Medicaid Managed Care

In an attempt to control rising health care costs, states, like private employers, are looking to managed care to both control costs and improve the access to health care for Medicaid beneficiaries. Managed care is defined as any health care delivery system where a patient must seek the approval of his or her primary care physician gatekeeper before receiving services.

History

- Medicaid has increasingly relied upon managed care to deliver care. As of June 1995, 11.6 million Medicaid beneficiaries, predominately poor children and their parents, are receiving health care services through a broad array of managed care arrangements, including Health Maintenance Organizations (HMOs) and less structured primary care case management (PCCM) systems.
- This dramatic growth in managed care in recent years is due largely to pressures to contain Medicaid costs, and in response to concerns about access to health care for low-income individuals.
 - In 1983, 3 percent of the Medicaid population was enrolled in managed care, compared to 14.4 percent of the Medicaid population in 1993. The latest figures show that today, 32.1 percent of all Medicaid recipients are in managed care. Medicaid managed care enrollment has grown an average of 44 percent per year in the 1990's.
- In order to establish Medicaid managed care, states must obtain one of two waivers from HCFA, using two different legal authorities in the Social Security Act. OMB staff review all Medicaid waivers in conjunction with HCFA, focusing mainly on assuring that the waiver does not cost the federal government more than the status quo (i.e., budget neutrality issues discussed later).

Impact

- Medicaid managed care has the potential to improve access to quality care, because managed care can decrease the fragmentation of service delivery that beneficiaries experience in Medicaid fee-for-service arrangements. In addition, research has shown that Medicaid managed care is likely to reduce the use of emergency rooms as a service site, as access to primary