THE WHITE HOUSE

WASHINGTON

3/24/97

FYI—

Here is the information that Chris Jennings brought to his meeting on the Hill today.

Executive Secretariat

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

Name: Bruce Reed

Address: White House

Message: PLEASE CALL TO CONFIRM RECEIPT OF TRANSMITTAL.
THANK YOU

Telephone: Office: FAX: 456-2878

Number Of Pages Being Transmitted (Including This One) 10

FROM: DINAH BEMBO

FAX NUMBER: (202) 205-8870
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

TO: Jack Lew
Bruce Reed
Chris Jennings
Dan Mendelson

FR: LaVarne Burton LB
Executive Secretary

RE: Memo for the President on Commercial Health Plans Withdrawing From Medicaid

Attached is the signed Memorandum for the President from the Secretary that was sent to Erskine Bowles today. Please let me know if you have any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

August 6, 1998

MEMORANDUM FOR ERSKINE BOWLES

The President requested an evaluation of recent media reports which suggested that commercial health plans are withdrawing from participation in Medicaid managed care.

A review and evaluation of these reports have been completed as the President requested. Attached is Secretary Shalala's memorandum to the President advising him of our findings.

Elizabeth Sunny For
Mary Beth Donahue

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 6 1998

MEMORANDUM FOR THE PRESIDENT

Recent media reports have suggested that commercial health plans (primarily for-profit HMOs) are withdrawing from participation in Medicaid managed care. At your request, we have evaluated these reports over the past several weeks by speaking to a wide variety of researchers, plan officials, and state and federal regulators and by reviewing research on this issue. Our review generally supports the conclusion that some commercial plans have withdrawn from Medicaid, but that their withdrawal has had little or no effect on access to managed-care coverage in most areas. The number of local and Medicaid-only health plans participating in Medicaid continues to grow, and for now these health plans are assuring adequate capacity for the continued expansion of Medicaid managed care. The growing dominance of Medicaid-only health plans, however, raises important policy issues about Medicaid beneficiary access to mainstream health care.

Below we discuss the participation of commercial health plans in Medicaid, the reasons for its decline, and some of the policy implications for beneficiary access and quality of care.

Commercial Plan Participation in Medicaid

Recent media reports of plans leaving the Medicaid market (including articles in the *Wall Street Journal* 4/7/98 and the *New York Times* 7/6/98) have focused on commercial health plans, plans whose primary business is non-Medicaid. Although we cannot yet confirm this trend with program data, anecdotal reports and our review of the issue generally support the conclusion that some commercial plans are pulling out of the Medicaid market. Some plans have left the market entirely while others have left states that they view as unreliable business partners.

The Medicaid managed care market is still evolving. Overall, enrollment in full-risk managed care plans was about 25 percent of all Medicaid beneficiaries in 1996, up from about 5 percent in 1991. Between 1993 and 1996, the number of managed care plans serving Medicaid beneficiaries more than doubled, with the largest increase occurring in Medicaid-only plans (plans in which Medicaid beneficiaries comprise 90-100 percent of total enrollment). Medicaid-only plans include those established by public hospitals and other Federally Qualified Health Centers, as well as those that are subsidiaries of commercial plans, provider-sponsored plans, and new plans that have been specifically created to capture the Medicaid managed care market. According to a 1997 survey by the National Association of Public Hospitals, approximately three-fourths of the urban safety-net hospitals surveyed have formed their own health plans, primarily to serve the Medicaid population.

The number of commercial plans serving Medicaid also grew rapidly during this period, increasing from 102 plans in 1993 to 199 plans in 1996. Commercial health plans initially viewed the Medicaid market as a complementary line of business to their other commercial operations. Many chose to expand into this market at a time when plans were vigorously competing for overall market share.

More recently, however, some commercial plans have begun to question the financial advisability of continued participation in Medicaid. Commercial plans that have left Medicaid (entirely or in selected states) have cited concerns over low payment rates, high administrative burdens, and high

volatility in enrollment as reasons for their declining interest in Medicaid. Perhaps more importantly, the market analysts that follow these publicly traded HMOs have begun to raise questions about the potential risk to plan profits posed by Medicaid participation. The understanding appears to be growing among plans that the Medicaid market is very different from the commercial market and that participation in Medicaid requires significant investments in developing new systems and new provider relationships that may not be rewarded by the low payment rates available in many states.

The pattern of withdrawals varies across the country. In some states, commercial participation appears to be stable. In other states, large commercial plans (predominantly those that are publicly traded) are beginning to question whether their future participation in Medicaid is viable. Specific examples of withdrawals of commercial plans over the last two years have been identified in at least 11 states (California, Connecticut, Delaware, Florida, Georgia, Maryland, Massachusetts, Missouri, New Jersey, New York, and Ohio). Precise numbers are difficult to obtain because of mergers and consolidation in the managed care industry.

These withdrawals do not appear to be causing problems for access to managed-care coverage in most areas, although no systematic quantitative data have been collected to date. (In one state, Georgia, some managed-care enrollees will have to shift to fee-for-service Medicaid, at least temporarily.) Even as some large commercial plans leave the Medicaid managed care market, local health plans and plans serving primarily Medicaid beneficiaries are replacing them in most areas, and the overall number of these plans has been growing. Many of these plans have developed outreach programs, networks, and management systems that may be more appropriate for the Medicaid population and have shown a willingness to meet the special Medicaid requirements imposed in some states. The potential implications of the growing dominance of these Medicaid-only plans is discussed later in this memo.

Reasons for Decline in Commercial Plan Participation

Although the Medicaid population has health and behavioral characteristics distinct from the general population, many commercial HMOs believed they could provide coverage by expanding their existing business and building on their infrastructure and organizational systems. Rates would typically be set by the government rather than the market, but health plans believed that Medicaid was plagued by inefficient utilization patterns that, if corrected, would allow them to make a return on investment.

Large managed health plans withdrawing from the Medicaid market over the past year or two cite several reasons for their decisions:

- better understanding of the business;
- low capitation rates; and
- burdensome contract requirements.

Commercial health plans have learned that covering the Medicaid population is not simply an expansion of current business, but rather a new and different line of business. The health and

behavioral needs of the population and the nature of the program (e.g., monthly eligibility) require distinct systems to be successful. Participation in Medicaid often also requires health plans to form relationships with new groups of providers (including safety-net providers) that have traditionally served Medicaid patients. As a result, the cost of covering the Medicaid population can be much higher than many health plans had initially projected.

Many health plans contend that when states set capitation rates, they do not reflect costs or demand, (although they sometimes involve competitive bidding). Under federal law, capitation rates in the Medicaid managed care market cannot exceed the amount of money that would have been spent to provide a comprehensive benefit package in Medicaid fee-for-service (FFS). This constraint has two components, each of which may contribute to suppressing capitation rates. The first is the low reimbursement rates the Medicaid program has historically paid in FFS. A 1991 study by the Physician Payment Review Commission showed that average Medicaid physician fees were about 62 percent of Medicare's (which in turn were lower than those in the private sector). The second is any under-utilization of services in FFS, resulting from both low physician participation in Medicaid and the less organized system of care delivery characteristic of FFS medicine.

Over time, plans have perceived Medicaid capitation rate increases as inadequate. In fact, in about half the states where we have information, rates have been cut, in some instances up to 10 percent to 15 percent over several years. A number of health plans argue that capitation rates (or least the annual adjustments after rates are first calculated) are often arbitrary; they do not reflect an actuarial analysis of an organization's true costs of serving this population. A number of HMO officials and financial analysts view states' rate-setting procedures as primarily "political." Plans are doubtful of their ability to raise capital or to make an adequate return on their investment over the long run.

Health plans also perceive Medicaid contracting requirements as more onerous than those imposed by private employers and Medicare. As purchasers, Medicaid agencies are looking both to ensure access to the range of Medicaid benefits and to monitor quality. As states learn how to design comprehensive contracts, their contracts with health plans increasingly include provisions for services particularly relevant for the Medicaid population – such as screening for elevated lead levels, medical and mental health care for children in the child welfare and juvenile justice systems, and asthma management programs and assessment. In addition, Medicaid agencies purchasing a managed care benefit package seek to ensure that adequate, quality health care is delivered to beneficiaries through various reporting requirements such as: utilization/encounter data, including hospital inpatient days; quarterly quality assurance reports; and patient satisfaction surveys. While there is significant overlap in requirements between Medicaid and either Medicare or large employer health plan contracts, there are a number of provisions unique to Medicaid. Although these differences appear largely to be the result of Medicaid managed care contracts conforming to the Medicaid benefit package, health plans believe that some of the requirements are arbitrary or poorly thought out.

Most states' experience with Medicaid managed care is only a few years old. As a result, they are still learning, for example, what contract requirements are an effective means of ensuring quality or access. A recent foundation-funded study of contract requirements, along with growing experience

nationwide, has the potential to bring some stability. But in the meantime, the uncertainty plans often face in negotiations adds to the perception that states are inflexible business partners.

We should note that HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act. Whether commercial plans view these provisions as an added burden or as an impetus toward greater uniformity among states remains to be seen.

Medicaid's structure also creates challenges for health plans. The most frequently cited example is the "churning" in Medicaid enrollment, that is, beneficiaries cycling on and off Medicaid. Churning hinders health plans' ability to provide comprehensive care, particularly cost-effective preventive services such as prenatal care, as Medicaid beneficiaries may not be enrolled in a health plan for a sufficient period of time for outreach and managed care education to take place. For example, one plan recounted the experience of Medicaid beneficiaries enrolling in the seventh month of their pregnancy. This problem is partially addressed in the Balanced Budget Act through requirements for guaranteed eligibility. Another complexity is created in states where Medicaid contracts are written at the county level, generating additional management and reporting obligations for health plans. These structural challenges may contribute to the perception that Medicaid managed care is an arduous undertaking for commercial plans, particularly those with no previous Medicaid experience.

For all plans, there is a substantial investment associated with succeeding in Medicaid managed care (particularly if there is broad choice). Plans will not make that investment without reason to believe they will be able to form a long-term business relationship with a state. State practices that plans perceive to be arbitrary or political discourage that investment, particularly for commercial plans for which this population is not critical to their market share. Other practices that appear on their face to be reasonable also may discourage commercial plans, because they do not assure adequate return on investment. Examples of such state practices include permitting a large number of plans to compete in each area (which may lead to inadequate enrollment in any one plan), or establishing auto-assignment methods, used when beneficiaries fail to choose a plan, that favor certain plans (usually public plans operated by safety-net providers).

Policy Implications

States have two central and sometimes competing goals for Medicaid managed care. First, they are looking to control their costs, expecting that plans will use resources more wisely. Second, states may view managed care in Medicaid as a means of improving access, which may mean either more utilization or better providers. The second goal might be addressed in two different ways – by seeking to mainstream Medicaid beneficiaries and by requiring contracting plans to address the special needs of the Medicaid population and the unique benefits and other requirements of the program itself.

Recent experience in Medicaid, however, suggests that these goals are difficult to achieve simultaneously. For example, ensuring that payments to safety-net providers are sufficient to maintain their financial status sometimes conflicts with efforts to reduce costs. The withdrawal of

some commercial plans, if it continues, raises questions about whether Medicaid managed care can provide access to mainstream providers.

Mainstreaming as a Policy Goal

For years, a key debate in fee-for-service Medicaid has been whether beneficiaries have access to an adequate range of providers and, specifically, to the same providers that serve other Americans. Research suggests that so-called "Medicaid mills" have arguably contributed to poorer health outcomes.

This same issue now arises in Medicaid managed care. Some argue that having the same health plan card as anyone else can be empowering to the beneficiary and avoid the stigma of welfare status. The concern raised by reports of commercial plans leaving this market is that mainstream plans (particularly national plans) will not participate in Medicaid managed care unless conditions are favorable – thus jeopardizing the goal of mainstreaming.

At the same time, there is an issue of whether commercial plans, for which the Medicaid population is only one line of business, in fact make the same effort to serve the special needs of this population as plans created specifically to serve this population. In addition, there is evidence that some commercial plans essentially operate a separate, smaller provider network within their plans for Medicaid beneficiaries – achieving the goal of mainstreaming in name only.

The Role of Medicaid-Only Plans

Given the apparent trend toward more reliance on Medicaid-only plans, it is important to understand the ability of these plans to serve the Medicaid population. Even if withdrawals by commercial plans do not persist, changes made by the Balanced Budget Act (i.e., elimination of the need to get a waiver if less than 25 percent of a plan's enrollment is non-Medicaid) may accelerate the growth of Medicaid-only plans. Little research has been done to date on these plans, although some work has been funded by private foundations.

Medicaid-only plans may have particular strengths. They can be designed to meet the specific needs of Medicaid enrollees and, because of their focus on Medicaid, can develop particular expertise in diagnosing and treating conditions that disproportionately affect the Medicaid population. They also may be more likely to invest in enabling services, such as transportation and translation services, that assist Medicaid beneficiaries in obtaining needed services.

Furthermore, Medicaid-only plans are likely to be operated by or contract with the same providers that have traditionally served beneficiaries under fee-for-service Medicaid. In particular, they often collaborate actively with – or are owned or sponsored by – safety-net providers. In short, these providers are located in the communities where beneficiaries live and have the cultural competencies appropriate for this population.

There are questions, however, about the long-range viability of Medicaid-only plans, specifically about their ability to cope with the same low payment rates and regulatory requirements faced by

other plans. These plans lack the ability to cross-subsidize from other lines of business, creating a potentially greater risk of insolvency. Some of these organizations may survive only as a result of special protections – for example, special tax status, lower financial requirements, or government subsidies – that can avert insolvencies or their consequences.

Medicaid-only plans also face other challenges. Because they tend to be smaller than other plans, they have a harder time spreading fixed costs, such as the investment in information systems that are important for internal management, Medicaid reporting requirements, and performance measurement. Their smaller size may also make them more vulnerable to fluctuations in the Medicaid rolls. Because they are often newer entrants to the market, some may lack administrative or other needed expertise.

Conclusion

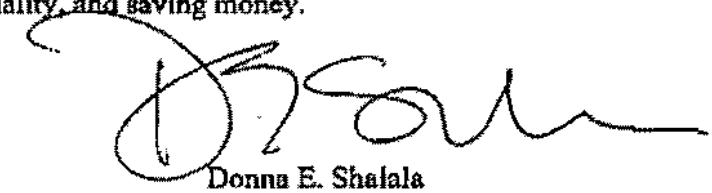
Although we cannot yet quantify the magnitude of the drop-off in commercial health plan participation in Medicaid, there are certainly growing numbers of plans choosing not to participate in selected geographical areas. This trend may not affect significant numbers of Medicaid managed care enrollees, either because these plans have low enrollment or because other managed care options are available to affected beneficiaries. However, as the interest of commercial plans in Medicaid wanes, the prospects of using managed care to mainstream Medicaid beneficiaries clearly become more limited. Whether or not the Medicaid population can be better served by Medicaid-only plans is a question that remains to be answered.

Regardless of the type of plan, payment rates based on historically low fee-for-service payment may not provide adequate flexibility to improve access in ways that proponents of Medicaid managed care have envisioned. Ideally, additional services can be financed by savings due to greater efficiency and avoidance of unnecessary services, such as costly emergency room care. Whether this can be accomplished in practice is uncertain given the historical access deficiencies of Medicaid. These issues will become even more difficult as greater numbers of more costly populations (i.e., the disabled and the elderly) join Medicaid managed care. Further study of capitation rates (both methodologies and levels) will be important.

Viewed against the backdrop of all the concerns outlined here, the significant adjustments to managed care models that health plans are compelled to make to meet Medicaid program requirements and beneficiary needs must be recognized. HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act, which may add to the administrative burden for health plans. This rule will amplify the difficult tradeoffs between the goals of assuring quality and protecting rights of beneficiaries on the one hand, and the objective of ensuring broad plan participation and choice on the other.

The Department will continue to analyze these issues further to ensure that decisions made by commercial health plans do not have an adverse impact on access to health care for Medicaid beneficiaries. One component of this effort will be increased surveillance, including factors such as what types of plans are participating, how much choice is available, and how these patterns vary by

state and market area. A second component will be research on some of the underlying issues discussed in this memo (e.g., plan capitation payments and the characteristics of Medicaid-only plans). Finally, additional consideration will be given to the overall goals of the Medicaid program and Medicaid managed care initiatives in particular, with attention to the tradeoffs between improving access, assuring quality, and saving money.



Donna E. Shalala

THE WHITE HOUSE

WASHINGTON

June 11, 1998

Bruce/Gene -

Please, in particular, read the "our thoughts" section. Has much broader implications than just this "100 hour rule" issue. We may want to ask Jack Lew for a principals meeting. Thanks

Chris

TO: Bruce R., Gene S.

FROM: Chris J., Diana F., Jeanne L.

RE: **Resolving the Medicaid "100-Hour Rule" issue**

cc. Elena K., Sally K.

This is an update on an important Medicaid coverage issue that we would like to resolve as soon as possible, but that may be at an impasse. HHS has proposed a regulatory change to the definition of an unemployed parent for Medicaid purposes (i.e., allow alternatives to defining "unemployed" as working less than 100 hours per month). This change gives states the option of allowing two-parent families meeting the other eligibility criteria to qualify for Medicaid. States with pre-welfare reform waivers of this provision say it's important both in their welfare to work efforts and in encouraging two-parent families. However, the Actuaries have estimated that, for the 17 or so states without a pre-welfare reform waiver of this rule, this reg will cost about $850 million over 5 years. OMB, HHS and White House staff all support the policy, and it is an important reg to the Governors. However, OMB is currently insisting that HHS find an offset for its cost since they are uncomfortable with its size. HHS has refused to do so because it is: (1) virtually impossible for OMB and HHS to find this amount in Medicaid (particularly in a way that the States will support), (2) against HHS policy and politically unviable to use Medicare savings to offset Medicaid costs, and (3) an OMB policy that has not been used in other health reg during this Administration.

We would like to get a decision on this issue, one way or the other, for two reasons. First, states and advocates continue to ask for this reg and wonder why it is delayed; and, second, if we decide to go forward with this reg, we would like to announce it at the Family Conference on June 22. We think that OMB and HHS may be trying to work out this issue tomorrow, but think that we ought to weigh in as well, especially if it does not get resolved.

BACKGROUND

"100-hour rule." The proposed regulation would allow states to cover two-parent families that meet other state Medicaid eligibility rules. It would do so by changing an old AFDC "deprivation" requirement that restricted AFDC / Medicaid eligibility to families that include a child who was deprived of parental support or care by reason of death, absence (single parents), incapacity, or unemployment of the parent. The old AFDC regs defined "unemployment" as working less than 100 hours per month. Before welfare reform, 31 states received statewide and another 6 states received substate 1115 waivers of this rule because they thought it overly strict and anti-family. However, because welfare reform locked in place the rules in effect in 1996, states without those waivers want this change in regulation.

Post-welfare reform history. This reg was one of several that were contemplated immediately after welfare reform. In fact, had it been drafted in 1996, its costs probably would have been included in the Medicaid baseline released in January 1997. However, because of the huge regulatory schedule that resulted from welfare reform, this reg was put off. The final rule with comment was signed by Shalala and submitted to OMB on January 30, 1998.

On substantive health and welfare reform grounds, OMB, HHS and White House staff all support this policy. It not only allows states to align their TANF and Medicaid eligibility, but could serve as a way for states to cover low-income parents, should they choose to do so. This could be especially helpful in the tobacco debate.

OMB concerns. Since its submission, OMB expressed concern about the cost of this reg and recommended that HHS use a Medicare offset for this provision. Specifically, they worry about:

- **Spending the surplus**: Since this reg's costs were not included in the post-welfare reform baseline, they would represent an increase to the baseline / decrease in the surplus if not accompanied by an offset. This goes against both the BBA and the President's "Social Security First" pledge.

- **Bad precedent**. This reg's cost are high. Allowing it to be published without an offset could encourage agencies to ignore the cost implications of administrative changes, and could make OMB vulnerable on the Hill, which has become aware of this issue.

HHS reaction. HHS disagrees with OMB for two main reasons.

- **Not a new precedent**. HHS points to the fact that several regs (e.g., change in the timing of SSI payments $10 million, SSI "bucket" reg $1.4 billion over 5 years) that did or could have had cost implications were not required to have offsets.

- **Even if they concede the cost issue, no acceptable options**. HHS thinks that it would be nearly impossible to find a Medicaid administrative offset of this size, and have policy concerns about using non-Medicaid savings -- in particular, Medicare savings. Although HHS support reducing Medicare spending, they are concerned about both enacting them because of the regulation and the political challenge of explaining why a Medicare change is needed for a Medicaid regulation.

As much as they want the reg, they are not willing to come up with an offset for it.

Our thoughts. We believe that this reg is important and should be published one way or another. It would be particularly appropriate for the Family Conference, because it would give the President an opportunity to talk about how he has changed Medicaid from being a program for single mothers to families. It also can help us fight off States desire to use CHIP for adults.

However, we think that there is a bigger issue here. While OMB is right that such a reg could decrease the surplus, the decision to hold regulatory actions to the same budget rules as legislative actions has important ramifications. First, it may result in delays in publishing regs, since agencies may start holding regs with savings so that they can be published at the same time as with regs with cost. Forcing a coupling of regs with savings and costs could cause political as well as policy problems. Second, we are already uncomfortable with the extent to which often extremely uncertain cost estimates influence policy decisions. Given that reg effects are typically smaller and probably more difficult to estimate, we don't think making cost estimates the central concern in whether to publish a reg is good policy. Third, it is only a small step from requiring an offset for a regulation to requiring an offset for other administrative actions (e.g., executive orders, Secretarial initiatives). Should the offset requirement be broadly applied, we are, in essence, placing a new, important restriction on executive authority. And, lastly, at a time when the Congress is rushing to spend the budget surplus, a legitimate question needs to be raised about the advisability of restricting our ability to address priorities administratively, consistent with our legal authority, even if there are cost implications.

We have had preliminary conversations with OMB, and they may eventually give on this reg if HHS promises to find offsets for all future regs. We are hoping to have some news tomorrow and will keep you informed.

Medicaid — Waivers

THE WHITE HOUSE

WASHINGTON

January 21, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings CJ

SUBJECT: Waivers and the Children's Health Insurance Program

cc: Bruce Reed, Gene Sperling, Jack Lew, Josh Gotbaum, Elena Kagan

This memo seeks your guidance on how much, if any, additional flexibility should be given to states in the Children's Health Insurance Program (CHIP) through the use of §1115 waivers. Although waivers have been instrumental in modernizing and reforming welfare and Medicaid, questions have been raised about the feasibility and advisability of granting waivers for the new children's health care program so soon after its enactment.

Despite acknowledging the great amount of flexibility given to the states in the new CHIP grant program, the Governors asked — soon after the law's enactment — if additional flexibility would be given through waivers. HHS's interim response was that it would be difficult to review and evaluate the merits of waiver proposals until we had some experience with the implementation of the new law. Your advisors agreed that this was the appropriate, initial response, but we also underscored that this was not necessarily our final position.

The National Governors Association (NGA) immediately responded by formally requesting that we affirm states' ability to seek new CHIP grant program §1115 waivers. Since then, two other issues have been raised: (1) Will we approve new Medicaid §1115 waivers in the Medicaid option within CHIP, and (2) Will we allow states with current Medicaid §1115 waivers to expand those programs through CHIP (even though some have provisions below the CHIP minimums).

All of your advisors agree that the HHS Secretary does have the authority to grant waivers for CHIP, whether administered through a new non-Medicaid grant program or through Medicaid. They also generally agree that the CHIP waiver policy need not conform to existing waiver policy. However, they (HHS, OMB, Treasury, NEC/DPC) disagree on whether and under what circumstances HHS should approve waivers in CHIP.

Because HHS is holding state conferences this month on CHIP and the annual NGA conference is in February, it is important that we receive direction from you in short order on this issue. This memo, developed in collaboration with HHS and OMB, outlines these issues, provides policy options for your consideration, and summarizes where your advisors stand on these options.

BACKGROUND

Your Administration has given states unprecedented flexibility for their health care programs. Since 1993, we have granted 15 comprehensive Medicaid waivers that test approaches not allowed in Medicaid like experimenting with premiums and cost sharing for low-income populations, waiving benefits, and accelerating enrollment in managed care. States have also used waivers to expand coverage to millions of Americans. In addition, with the Administration's strong support, the Balanced Budget Act secured much greater administrative flexibility for the Medicaid program (e.g., eliminated the need for a waiver for a managed care program, repealed the Boren amendment, and reduced cost-based reimbursement requirements for community health centers). In so doing, we eliminated the need for many time-consuming waivers that we heretofore required from states.

The BBA also created CHIP, which has fewer Federal guidelines than any other health insurance program that the Government oversees. Unlike Medicaid, CHIP allows states that opt to expand through a new, non-Medicaid grant program to cap the number of children covered (i.e, no entitlement requirement); to limit programs to parts of the state; to not cover Medicaid's EPSDT (Early, Periodic, Screening, Detection and Treatment) benefit; and to charge beneficiaries long-sought-after (although limited) cost-sharing. Alternatively, states may expand using the enhanced Federal match through the now more flexible Medicaid program. However, states choosing this option must follow Medicaid rules (e.g., no benefits changes or cost sharing).

Although extremely flexible, CHIP includes standards for accountability, benefits, and cost sharing limits; these were secured by you and Congressional Democrats. Accountability provisions include limits on the type of state contribution (e.g., no provider taxes and donations) and provisions to prevent "crowd out" (substitution of the new coverage for existing coverage). For the new non-Medicaid grant program, we developed a benefit standard that simultaneously ensures that it is valuable but provides great flexibility to states in benefits design. Cost-sharing is allowed in the grant program but limited to moderate premium and copayment schedules for those below 150 percent of poverty and to 5 percent of family income for those above 150 percent. As under current law, states electing the Medicaid option must follow Medicaid rules for benefits (including EPSDT) and cost sharing (for children, none is allowed).

Despite the flexibility in CHIP, some states have indicated that they want §1115 waivers. There are three types of waivers that states are seeking. First, several states want to waive provisions for non-Medicaid, CHIP grant programs (e.g., California wants to impose greater cost sharing above the CHIP limits). Second, others want to waive Medicaid provisions within CHIP's Medicaid option since states choosing the Medicaid option must use all Medicaid rules (e.g., Missouri wants to waive the Medicaid requirement to cover non-emergency transportation). Third, most states that already have Medicaid §1115 waivers want to expand those programs to more children to receive CHIP's higher matching rate — even though some include provisions that are significantly below the new CHIP minimums (e.g., Arkansas has higher cost sharing requirements than allowed in CHIP). It is important to note that the provisions that states want most to waive are the benefits and cost sharing minimums we worked to secure before signing off on the budget agreement.

CONSENSUS RECOMMENDATION: DEFERRING NON-MEDICAID CHIP WAIVERS

Your advisors have achieved consensus on one of the major issues. For CHIP non-Medicaid grant programs, we believe the Administration should consider waiver applications only after a state has had at least a year's worth of experience, followed by an evaluation of its children's health insurance program. As we gain experience with the new CHIP grant program, we will have a better understanding of what types of CHIP demonstrations are appropriate and will develop guidelines at that point.

We believe that deferring approvals for waivers of the already extremely flexible CHIP is advisable because this enables us to see how the program you signed into law last summer will work. Granting waivers now would place great pressure on us to weaken the accountability and benefits standards that we secured in the Balanced Budget negotiations that base Democrats and advocates think are too modest anyway. Having said this, waiver policy for CHIP may well be advisable after we have had time to learn about the program's strengths and weaknesses.

If you agree, we will inform Governors of this policy in a response to their letter. While we believe that Governors will be disappointed with this position, they will likely appreciate that our policy is temporary and that we open up the prospect for waivers soon after they implement their children's health programs.

Decision

_____Agree on deferring non-Medicaid grant program waivers until plans in place for one year

_____Let's discuss

ISSUE: POLICY FOR MEDICAID WAIVERS

The other types of waivers, about which there is disagreement amongst your advisors, concern the Medicaid option within CHIP. We all agree that our Medicaid waiver policy should be modified to acknowledge the fact that the Congress did pass legislation that explicitly outlines new guidance on balancing the need for greater flexibility with the need for accountability. However, we differ on how our policy should be modified to reflect this policy change and, more specifically, the extent to which we would hold Medicaid waivers to the CHIP standard.

There are two questions. The first is whether we grant new waivers to states that expand CHIP coverage through Medicaid. States have indicated that they are interested in expanding coverage through the Medicaid option, but since the law allows no flexibility from Medicaid rules, they want waivers, particularly in the area of cost sharing. The second question is whether we allow states that already have Medicaid §1115 waivers to expand those programs, without change, to get the CHIP allotment and higher match. The following are the options proposed by your advisors.

OPTION 1 (HHS): Defer new Medicaid CHIP waivers (with minor exceptions) and allow expansions of existing Medicaid waivers if consistent with CHIP standards for non-Medicaid grant programs. HHS recommends that we apply the same policy for new Medicaid and non-Medicaid, grant program waivers. It would hold off on approving any new Medicaid waiver under CHIP until we have at least a year's experience plus an evaluation. (The only exception would be for waivers for small, incidental provisions that have little or no effect on most children — like Missouri's desire to waive the Medicaid requirement for non-emergency transportation.) For states that have waivers already, HHS would allow them access to the new enhanced matching dollars only if they met CHIP's non-Medicaid grant program standards.

Although HHS/OMB have, in years past, approved a number of Medicaid waivers that have less generous benefits than even the new CHIP grant program, HHS believes the new law set a floor that we should not fall below. They fear that once we open the door to waivers, we will have a difficult time maintaining these standards. In addition, they are concerned that waiver negotiations will delay implementation of new programs in a number of states. Rapid implementation is one critical component to covering our target 5 million uninsured children.

If you choose this option, the Democrats and children's health advocates will applaud our decision to respect the rules enacted in the widely praised new health insurance program for children. However, Governors — who are hoping that we will allow some type of Medicaid waivers — will surely react strongly and negatively to this policy.

OPTION 2 (NEC/DPC): Allow Medicaid CHIP waivers (new or old) if <u>generally</u> consistent with CHIP standards for non-Medicaid grant programs. This option would allow new waivers through the Medicaid option of CHIP <u>if</u> those waivers were consistent with the standards provided under the new CHIP grant model. In other words, states choosing the Medicaid CHIP option could waive Medicaid rules as long as the benefits, cost-sharing and other accountability provisions are in line with the CHIP grant program standards. Existing (old) Medicaid §1115 waiver programs could also receive the higher matching rate, but they too would have to meet CHIP standards; in a number of cases, this would mean they would have to strengthen some of their benefits/cost-sharing protections to access these additional dollars. Although a few states would have to reduce cost sharing requirements to comply with CHIP, we believe that the higher matching rate available under CHIP would be sufficient to offset these costs.

DPC/NEC believes that this option strikes an appropriate balance by maintaining the integrity of the CHIP program and the Balanced Budget Act and giving the new standards time to be tested. It also removes an important disincentive for states to use the Medicaid option in CHIP. Many states would prefer to use their already-in-place Medicaid programs because it is administratively simple. Moreover, having a seamless Medicaid program serving both poor and children of working parents has obvious advantages. However, allowing any new Medicaid waivers through CHIP will be criticized by our base Congressional Democrats, some Republicans, and advocates. They believe that their support for the flexibility in the non-Medicaid CHIP program was conditional on no new flexibility in Medicaid. The Governors would like this approach better than the HHS option, but they could be counted on to say that it is still not flexible enough.

Within this option, NEC/DPC also recommends that the Secretary have the authority to approve Medicaid CHIP waivers that may be modestly below those standards provided for in the new CHIP grant program. While we strongly believe that the CHIP standards should be the guiding principle for Medicaid waivers, we also recognize that it is unwise and unrealistic to treat the new law's standards as "lines in the sand" that can never be crossed regardless of a waiver's merits. One good example is in the area of cost sharing.

In both previous Medicaid waivers and our internal policy positions, we have allowed limited cost sharing that exceeds the CHIP grant program standards. Such cost sharing can appropriately increase beneficiaries' cost sensitivity in using health services and decrease possible employer insurance dropping problems, since such a policy would more accurately mirror marketplace coverage. While we recommend providing this additional flexibility authority, we also believe that waivers of the CHIP grant standards for children not be granted below 133 percent of poverty -- the level your Administration advisors had previously concluded (during the balanced budget discussions) achieved the balance between appropriate and excessive cost-sharing.

While some might point out that it is inconsistent to allow flexibility below CHIP standards for Medicaid and not the grant option, we believe that the advantages of this approach far outweigh this criticism. First, the CHIP standards were designed for the grant program — not Medicaid. Second, Medicaid waivers are quite variable and have never been publicly held by Democrats and advocates to the same standards as legislated changes to public programs. And thirdly, as described above, having an additional incentive to administer the children's health program through Medicaid is desirable.

Giving HHS the authority to allow any cost sharing flexibility in Medicaid will likely anger base Congressional Democrats and some moderate Republicans. They will argue (as does HHS) that once we sanction higher cost sharing below 150 percent of poverty, decisions will be perceived as arbitrary, making it difficult to say no to states that demand even greater flexibility. We believe these are valid concerns and should be seriously considered. However, we are also well aware of states (such as Wisconsin) who will be requesting cost-sharing levels just under 150 percent (i.e., 143 percent of poverty) that we would find difficult to oppose on purely policy grounds.

OPTION 3 (OMB & TREASURY): Allow new CHIP Medicaid waivers if consistent with CHIP standards for non-Medicaid, grant programs, but allow existing Medicaid waivers to expand with no change. For states requesting *new* Medicaid waivers, OMB/Treasury agree with DPC/NEC option that the CHIP standards should guide approval of such waivers (also allowing for greater cost sharing for families no less than approximately 133 percent of poverty). This policy should be re-evaluated after states gain experience with their programs, at the same time the Administration is re-considering non-Medicaid, grant program waivers.

For states with waiver programs already approved (since the 1994 NGA waiver agreement), OMB and Treasury recommend that we recognize their history and different situation and not hold them to the CHIP standards. We anticipate that these 11 states will want to expand their current waiver programs under CHIP; OMB and Treasury think they should be permitted to do so with no changes. Although this option provides only a few more states with additional flexibility in cost-

sharing or benefits under CHIP than the DPC/NEC option, it helps these states avoid significant coordination problems by sanctioning CHIP programs consistent with approved waiver programs. In addition, lower income children in these states might pay more in premiums than the higher income children newly eligible under CHIP. Waiver states will consider the Administration to have reneged if we don't permit them to carry their waivers to CHIP. This option excludes pre-NGA agreement waivers (e.g., Tennessee) since states have been held to a higher standard since then.

Allowing existing Medicaid waivers into CHIP unchanged will surely be noticed and strongly opposed by base Democrats and children's advocates. They believe that some of the waivers that we have approved to date, such as Tennessee and Arkansas, have gone too far by allowing states to impose "excessive" cost sharing on low-income beneficiaries and waive EPSDT. Ironically, this policy may also be criticized by some Congressional Republicans, who think that many of our CHIP implementation decisions are steering states toward the Medicaid option. It would, however, be the most acceptable option to the NGA and the relevant (existing waiver) states.

Decisions

Medicaid Waivers

_____OPTION 1: Defer new Medicaid waivers in CHIP (with minor exceptions)
Allow existing waivers to expand through CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 2: Allow new & existing Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 3: Allow new Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
Allow existing waivers (post-NGA agreement) to expand through CHIP with no program changes even if they fall significantly below new CHIP grant standards

_____Let's discuss

Cost Sharing Flexibility

_____OPTION 1: Hold all Medicaid waivers to the cost sharing in CHIP for non-Medicaid, grant programs

_____OPTION 2: Authorize the Secretary to approve, within limits, Medicaid waivers in CHIP with cost sharing below CHIP standards for non-Medicaid, grant programs

_____Let's discuss

STATES WITH MEDICAID 1115 WAIVERS (Chronological Order)

STATE	Approved	Eligibility Limit	Benefits for New Eligibles	Cost Sharing: New Eligibles
Arizona	10/82	Existing eligibles	Medicaid benefits	None
Oregon	3/93	People < 100% PL	Prioritized benefits	Premiums: $6 to 28 No copays or deductibles
Hawaii	7/93	People < 300% PL, plus assets test	No long-term care	Premiums: $142 - 168 Copays: $5
Maryland	10/93 10/96	Children 133-185% PL Existing eligibles	No inpatient, outpatient, emergency room, some EPSDT; no long-term care Medicaid benefits	Copay: $5 None
Rhode Island	11/93	Children < 250% PL	Medicaid benefits	Premiums: From 185-250% PL: $1.50 - $10.75 No copays or deductibles
Tennessee	11/93	People up to 400% PL, with enrollment cap	Medicaid benefits	Premiums: $14.25 to 475 Deductibles: $250 / $500 Coinsurance: 2 to 10%
Florida	*9/94*	*People < 250% PL*	*Excludes some EPSDT, transportation, some long-term care and mental health*	*Premiums: $90 - 550 / mo* *Deductibles: Up to $500* *Copays: $10-200 or 20%*
Ohio	1/95	People < 100% PL	Medicaid benefits	None
Massachusetts	4/95	People < 200% PL	Medicaid benefits	Premiums: Variable Deductibles:$100 / $250 Copays: $5 / 10
Minnesota	4/95	Children < 275% PL	Medicaid benefits	Premiums: $4 to 104 / mo No copays or deductibles
Delaware	5/95	People < 100% PL	Medicaid w/ small changes	None
Vermont	7/95	People < 150% PL	No transportation, long-term care	Premiums: Above 25% PL: $5 to $20 every 6 months Copays: $3 for dental
Kentucky	*10/95*	*Existing eligibles*	*Medicaid benefits*	*None*
Oklahoma	10/95	Existing eligibles	Medicaid benefits	None
Illinois	*7/96*	*Existing eligibles*	*Medicaid benefits*	*None*
Alabama	12/96	Existing eligibles	Medicaid benefits	None
New York	7/97	Home relief pop.	Medicaid benefits	None
Arkansas	8/97	Children < 200% PL	No EPSDT, limited long-term care & mental health	Copays: $10 outpatient; 20% inpatient ; $5 for drugs

Italics indicated approved but not implemented. States above the line were approved prior to NGA 1994 agreement.

Medicaid

THE WHITE HOUSE

WASHINGTON

September 22, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Jack Lew, Josh Gotbaum, Chris Jennings

SUBJECT: New York Medicaid Provider Tax Issue

In response to schemes in many states to tax health care providers and then rebate funds to obtain additional Federal Medicaid matching, Congress in 1992 passed a limitation on the eligibility for matching of certain state provider taxes. One of the vetoed items in the Balanced Budget Act was a provision that would have legislatively exempted several New York taxes on health care providers from the 1992 law. In BBA negotiations, the Administration offered an alternative to target the particular taxes (i.e., those on regional providers) that should have been exempted, but these were rejected.

At the time of the cancellation, the Administration said that it would seek to use its existing regulatory authority to allow matching of the regional provider taxes. In a letter to Governor Pataki on September 10, you promised that Frank Raines would call and work with the state to resolve these issues. Since then, HHS, OMB, Justice and the White House reviewed the situation, not just for New York but for all states. Within the two weeks, we expect that HHS will be able make an announcement along the following lines:

- A regulatory notice that would modify the test for regional provider taxes. (This would allow NY state to get matching funds for these taxes, which account for almost two-thirds of its 1993 to 1997 claims);

- Other limited changes in the current HHS tests that would make eligible other state provider taxes; and

- Disapproval of waiver requests on other taxes from various states (including some NY taxes). This, in turn, would begin a process under which HHS audits and then possibly negotiates with states to decide both (a) that states will cease levying inappropriate provider taxes, and (b) how much of the arrearages (matching funds already paid on those taxes) the state must repay.

We are developing a plan for announcement of these changes. Within New York, there is intense interest not only from Pataki, but also from the New York delegation (Moynihan and Rangel in particular), Dennis Rivera and the unions and the hospital associations. For other states, the news will be mixed, since many state taxes (including some NY taxes) will continue to be ineligible and those states will have an obligation to repay them. Regardless of whether these actions are announced jointly or separately, a careful roll-out strategy is in order before any public announcement.

NEW YORK LINE-ITEM VETO

Q: POLITICIANS IN NEW YORK ARE SAYING THAT YOU HAVE AGREED TO WORK OUT THE PROVIDER TAX ISSUE. HAS THE ADMINISTRATION AGREED TO A COMPROMISE TO HELP THE STATE OF NEW YORK?

A: **I have not changed my position on the line-item veto of the New York provider tax provision.** Some provider taxes have been used in the past to drive up the costs of Medicaid. Many of them are clearly impermissible under law. Others, such as New York's regional tax, might be allowable. During the budget negotiations, we offered a legislative proposal that would have clarified its permissibility. Congressional negotiators rejected this solution so that there was no other choice but to veto the provision.

I have directed the Department of Health and Human Services, OMB and my staff to look into administrative clarifications of provider tax provisions. They expect to get back to the state of New York and other states with similar provider tax issues within the next two weeks.

Medicaid

THE WHITE HOUSE

WASHINGTON

March 19, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ

SUBJECT: Response to the Suggestion of Increasing Medicaid Obstetrician and Gynecologists' Fees to Improve the Health of Infants

cc: Bruce Reed

The February 21 Council of Economic Advisor's Weekly Economic Briefing (attached) suggested that "a 50 percent rise in Medicaid fees would decrease the incidence of low birth weight babies (for women on Medicaid) by more than 20 percent." It suggested that "roughly 75 to 100 percent of the direct cost is offset by reductions in expensive hospital services.". Given these statistics, you understandably asked if we should integrate this provision into the budget.

Because (a) there is little to no evidence that such a policy would reduce poor birth outcomes and (b) it runs directly contrary to the trend to provide state flexibility and avoid state mandates, I would recommend against such a policy at this time.

BACKGROUND

- **Poor birth outcomes are common in the United States.** While last year the infant mortality rate declined (from 8.0 to 7.5 deaths per 1,000 live births) and the proportion of mothers getting prenatal care increased modestly (80.2% to 81.2% received care in the first trimester), the United States still ranks nearly last among industrialized countries in infant mortality rates. At least as disturbing, the National Center on Health Statistics reports that the proportion of low birth weight babies has reached its highest level (7.3 percent of all births) in almost 20 years. This problem requires an aggressive response.

- **Medicaid is the primary payer for births, making it a logical place to begin to address this serious problem.** Medicaid is the single largest purchaser of maternity care. In 1994, an estimated 1.4 million births — nearly 40 percent of all births — were covered by Medicaid. Thirty-four states have used Medicaid's options to expand eligibility to pregnant women above mandatory levels.

- **However, mandating that states increases their Medicaid payment rates for obstetricians and gynecologists does not appear to be the solution.**

  - **Higher rates may not result in greater access.** Some argue that higher Medicaid rates lead to improved birth outcomes since they attract more doctors who provide more prenatal care. Yet, Medicaid obstetrical care fees are already the closest to private rates of all Medicaid fees and vary the least across states.

Therefore, factors besides Medicaid's reimbursement such as its population's greater difficulty with compliance (due to lower education and poor health behaviors) and the reluctance of some providers to serve minorities have been suggested as reasons why some obstetricians and gynecologists limit their Medicaid participation.

- **Greater access may not significantly reduce low birth weight.** Even if rate increases did increase Medicaid-covered prenatal care, successful birth outcomes are not guaranteed. While universally supported, prenatal care has not conclusively been proven to yield higher birth weight and lower infant mortality. In fact, it appears to be equally or less effective than interventions such as nutritional counseling, social services, or smoking cessation. Most importantly, education improves mothers' chances of delivering healthy babies. Women are more likely to seek and follow prenatal care and modify their behaviors in ways that lead to better outcomes when they have more education (see attached chart).

- **Study cited is methodologically flawed.** The primary analysis cited by the WEB is an unpublished dissertation that, itself, acknowledges that previous research on this topic has been inconclusive and contradictory. Its methodology is flawed in that it did not control for education which, according to most studies, is a major predictor of birth weight.

- **Mandating rate increases contradicts our policy to give states more rather than less flexibility in the administration of Medicaid.** Raising obstetrical fees would require a mandate on states. Currently, states have latitude in setting physician fees. We propose giving states more control over provider payment policies by repealing the Boren amendment. To mandate a rate increase for ob/gyns would contradict this commitment to give states more flexibility.

  Furthermore, almost all states have voluntarily raised their ob/gyn rates in an attempt to reduce poor birth outcomes. They, like us, recognize the seriousness of this problem. As states continue to try to improve their care, we remain committed to matching their efforts.

CONCLUSION

Raising Medicaid obstetrician and gynecologists' fees by itself is not likely to reduce poor birth outcomes. Medicaid reimbursement is one — and probably a small — contributor to addressing this problem. As indicated above, educational, social, economic and biological conditions are probably more important to decreasing infant mortality and low birth weight.

Your budget reflects the need for a comprehensive, multi-faceted strategy to address this problem. Specifically, it increases funding for (1) WIC to promote full participation, (2) substance abuse treatment and prevention, with a special emphasis on pregnant women, and (3) abstinence education and family planning to prevent teen pregnancy, which all too often ends in poor birth outcomes. Perhaps most importantly, your budget has a heavy emphasis on education. All the health care and other information may fall on deaf ears if the educational attainment of women remains low.

THE PRESIDENT HAS SEEN
2-24-97

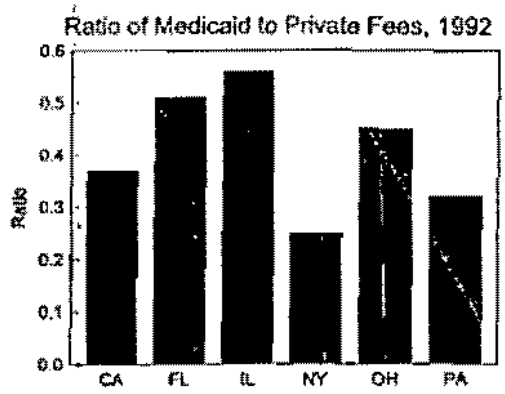
cc Board (Chicago)

SPECIAL ANALYSIS

Medicaid Fee Policies and the Health of Infants

Many state Medicaid programs pay very low fees for the services of obstetrician/gynecologists. Research suggests that raising ob/gyn reimbursement rates for Medicaid patients could be an effective policy for improving infant health outcomes.

Medicaid payments for ob/gyn services. Medicaid reimbursements for ob/gyn services are quite low compared to those in the private sector. In 1979 the ratio of Medicaid to private fees was about 55 percent nationally. By 1992 it had crept up to about 58 percent. Despite the modest upward trend, Medicaid payments remain substantially below those in the private sector in virtually all states (see chart for the ratios in some large states). Many observers claim that the supply of obstetrician/gynecologists willing to treat Medicaid beneficiaries is inadequate. The Physician Payment Review Commission found, for example, that 38 states identified low fees as a major cause of low physician participation rates in the Medicaid program.



Medicaid policies and pediatric health. Expansions in Medicaid over the past several years have made more pregnant women eligible for the program. But the low fees paid to ob/gyns appear to have restricted the supply of doctors willing to provide these services and have limited access to such care. The lack of adequate prenatal care raises the probability that pregnant women and their newborns will require expensive medical services in hospitals. Even after this expensive care, however, many of these infants may be less healthy than if their mothers had received appropriate care while pregnant.

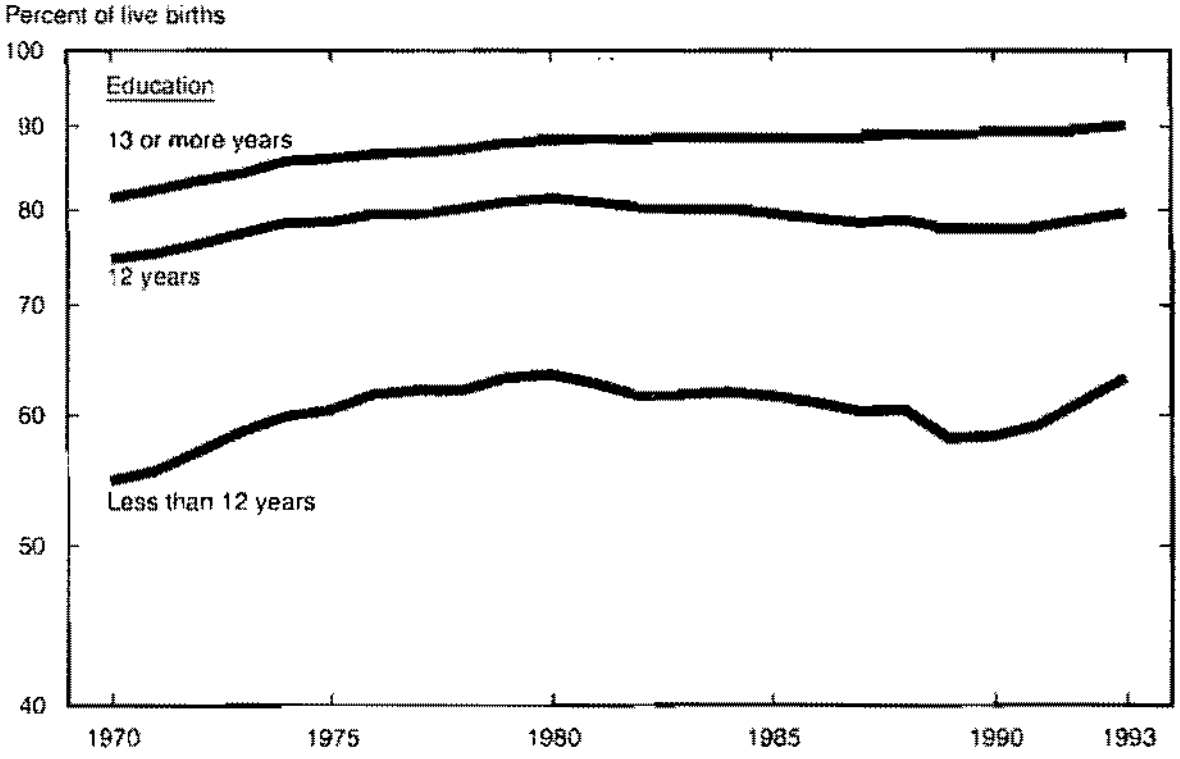
Effects of raising Medicaid fees. Research suggests that higher Medicaid payments for ob/gyn services can result in improved infant health outcomes. One recent study predicts that a 50 percent rise in Medicaid fees would decrease the incidence of low birthweight babies (for women on Medicaid) by more than 20 percent. A second analysis finds that a comparable increase in Medicaid fees would significantly reduce the infant mortality rate.

Interestingly, these studies find that the cost increases associated with higher ob/gyn reimbursement rates are likely to be quite modest. Most evidence suggests that roughly 75 to 100 percent of the direct cost is offset by reductions in expensive hospital services. In short, higher Medicaid ob/gyn fees may be a very cost-effective method of improving the health of infants.

Should this be included in budget?

Prenatal Care

Figure 34. Receipt of early prenatal care among mothers 20 years of age and over by maternal education: United States, 1970–93



NOTES: Data shown only for States with education of mother and prenatal care items on their birth certificates. The number of States reporting both items increased from 35 in 1970 to 50 and the District of Columbia starting in 1992 (see Appendix I). Percents are plotted on a log scale.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. See related *Health, United States, 1995*, table 7.

■ In 1993, 90 percent of mothers 20 years of age and over with more than 12 years of education received early prenatal care, compared with 80 percent of mothers with 12 years of education, and 63 percent of mothers with fewer than 12 years of education. This assocation between maternal education level and the likelihood of receiving first trimester prenatal care has been observed since these data were first collected.

■ The percent of mothers with fewer than 12 years of education who received first trimester prenatal care increased by 16 percent between 1970 and 1980, decreased by 8 percent between 1980 and 1990, then increased 9 percent from 1990–93. In contrast, at no point between 1970 and 1993 did receipt of early prenatal care by mothers with more than 12 years of education decline.

■ In 1993 black mothers were less likely to receive early prenatal care than were white mothers at every educational level. Among black mothers with fewer than 12 years of education, 55 percent received first trimester care, compared with 65 percent among white mothers. Among mothers with more than 12 years of education, 79 percent of black mothers and 92 percent of white mothers received first trimester prenatal care.

OMB Estimates of the FY 1998 President's Budget Medicaid Proposals
(dollars in billions)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Total 1998 - 2002	Total 1998 - 2007
FY 1998 President's Budget Baseline	104.4	111.2	119.6	129.1	139.2	150.8	163.4	177.4	192.2	208.4	603.4	1,495.5
Savings												
Per Capita Cap	0.0	0.0	-0.8	-2.4	-4.0	-6.6	-9.9	-13.6	-17.7	-22.3	-7.2	-77.2
DSH (net of pools)	0.2	-1.6	-3.3	-4.9	-5.6	-7.0	-7.6	-8.2	-8.9	-9.6	-15.2	-56.4
Subtotal Savings	0.2	-1.6	-4.1	-7.3	-9.7	-13.6	-17.5	-21.8	-26.6	-31.8	-22.4	-133.6
Welfare												
Legal Immigrant Provisions	0.6	0.8	1.0	1.2	1.3	1.5	1.6	1.7	1.9	2.0	4.9	13.5
Keep Medicaid for Disabled Kids	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.3	0.6
Refugee/Asylee Exemption	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Kids Initiatives												
12 Month Eligibility	0.3	0.5	0.7	1.0	1.2	1.3	1.4	1.5	1.6	1.8	3.6	11.2
Indirect Impact of Kids Health Demos	0.1	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.5	1.1	3.4
Other												
Puerto Rico	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Extension of VA Sunset	0.0	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	1.2	3.2
Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Raise DC FMAP to 70%	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.9	2.3
Interactions												
Part B Premium Interactions	0.0	0.0	0.1	0.2	0.4	0.6	0.9	1.2	1.5	1.8	0.8	6.8
Total Net Savings	1.4	0.4	-1.4	-3.9	-5.8	-9.0	-12.4	-16.1	-20.3	-24.9	-9.3	-91.9
New Outlays	105.8	111.6	118.2	125.2	133.4	141.8	151.0	161.3	171.9	183.5	594.2	1,403.6

CBO Estimates of the Final FY 1998 President's Budget Medicaid Proposals
(dollars in billions)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Total 1998 - 2002	Total 1998 - 2007
CBO 1/97 Baseline	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4	1,541.2
Savings												
Per Capita Cap 1/	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-6.8	-8.7	-11.1	-13.8	-8.5	-54.3
DSH	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-7.7	-8.9	-10.2	-11.6	-16.6	-61.5
Pool Amounts												
FQHC/RHC	0.0	0.5	0.4	0.3	0.2	0.1	0.0	0.0	0.0	0.0	1.4	1.5
Transition Pool 1/	0.0	0.4	0.3	0.2	0.1	0.1	0.0	0.0	0.0	0.0	1.0	1.1
Subtotal Savings	-0.3	-1.7	-4.6	-6.8	-9.2	-11.8	-14.5	-17.6	-21.3	-25.4	-22.7	-113.2
Welfare												
Legal Immigrant Provisions	0.9	0.9	1.1	1.3	1.6	1.9	2.3	2.8	3.3	3.8	5.8	19.9
Keep Medicaid for Disabled Kids	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	1.0	2.5
Refugee/Asylee Exemption	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kids Initiatives												
12 Month Eligibility	0.9	0.9	1.0	1.0	1.1	1.2	1.2	1.3	1.4	1.4	4.9	11.4
Outreach - Kids Health Demos	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	1.8
Other												
Puerto Rico	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
Extension of VA Sunset	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	1.1	3.1
Working Disabled	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Raise DC FMAP to 70%	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9	2.3
Eliminate Vaccine Excise Tax	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1
Interactions												
Part B Premium Interactions	0.0	0.1	0.2	0.2	0.4	0.6	0.8	1.1	1.3	1.6	0.9	6.3
Total Net Savings	1.8	1.1	-1.6	-3.3	-5.1	-7.0	-8.9	-11.2	-14.0	-17.1	-7.0	-65.3
New Outlays	107.1	114.7	121.3	129.5	138.7	148.9	159.8	171.9	185.0	199.1	611.3	1,476.0

1/ **Memorandum:** The per capita cap and transition pool policies assumed in the initial CBO estimates do not reflect final policy decisions. The per capita cap growth rate in the final policy is equal to the growth in nominal GDP per capita plus 2% in 1997 and 1998 and 1% thereafter. Additionally, the transition pool in the final policy totals $1.0 billion over five years. CBO provided unofficial estimates of the final policy. CBO unofficially estimated gross savings of $22.7 billion over five years and net savings of $7.0 billion over five years from the final policy.

Medicaid Per Capita Cap and DSH Policies
CBO January 1997 Baseline
(Dollars in Billions)

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Total 1998 - 2002	Growth 1997 - 2002
CBO January 1997 Baseline									
Total Outlays	98.6	105.3	113.6	122.9	132.8	143.8	155.9	618.4	
Growth		6.8%	7.9%	8.1%	8.1%	8.3%	8.4%		7.8%
Per Capita Spending	2,876	3,031	3,219	3,429	3,653	3,900	4,179		
Growth		5.4%	6.2%	6.5%	6.5%	6.8%	7.1%		6.3%
CBO Scoring of Final FY 1998 President's Budget									
Per Capita Cap Savings	0.0	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-8.5	
DSH Savings	0.0	-0.3	-2.1	-3.8	-4.7	-5.6	-6.6	-16.6	
Pools	0.0	0.0	0.9	0.7	0.5	0.3	0.2	2.4	
Total Cap/DSH Savings	0.0	-0.3	-1.7	-4.6	-6.8	-9.2	-11.8	-22.7	
Resulting Baseline	98.6	105.0	111.9	118.3	126.0	134.6	144.1	595.7	
Growth		6.5%	6.6%	5.7%	6.5%	6.8%	7.0%		6.4%
Resulting Per Capita	2,876	3,023	3,171	3,300	3,466	3,651	3,862		
Growth		5.1%	4.9%	4.1%	5.0%	5.3%	5.8%		4.9%
Per Capita Cap Assumptions:									
Growth in Nominal GDP Per Capita	3.90%	3.80%	3.70%	3.70%	3.80%	3.90%	4.00%		
Additive Factors	2.00%	2.00%	1.00%	1.00%	1.00%	1.00%	1.00%		
Index Growth	5.90%	5.80%	4.70%	4.70%	4.80%	4.90%	5.00%		5.0%
Estimates of CBO's Private Spending Growth Per Privately Covered Person									
Growth		3.8%	4.9%	4.8%	4.8%	4.6%			4.6%

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

- **Repeal Boren Amendment**

  Repeal the Boren amendment for hospitals and nursing homes, while establishing a clear and simple public notice process for rate setting for both hospitals and nursing homes.

  Modify the process for determining payment rates for hospitals, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to add a public notification process that provides an opportunity for review and comment, which should result in more mutually agreeable rates.

- **Eliminate cost-based reimbursement for health clinics**

  Federal requirements that most Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) be paid based on costs would be removed beginning in 1999; and a capped, temporary funding pool would be established to help these facilities during the transition.

Increase Flexibility in Program Eligibility

- **Allow Budget Neutral eligibility simplification and enrollment expansion**

  Enable States to expand or simplify eligibility to cover individuals up to 150 percent of the Federal poverty level through a simplified and expedited procedure. Current rules would be retained to the extent they are needed to ensure coverage for those who do not meet the eligibility criteria of the new option. Federal spending would be restrained by the per capita cap for current eligibles and such expansions would be approved only if they were demonstrated to be cost neutral (i.e. no credit for persons who were not otherwise Medicaid eligible in the determination of cap number).

  This proposal enables States to expand to new groups that are not eligible under current law without a Federal waiver. Administration would be streamlined and simplified in that States would be able to use the same eligibility rules for everyone eligible under the new percent-of-poverty option in place of the current plethora of different rules for different groups. Integrity of Federal spending limits would be maintained by the cost neutrality requirement.

- **Guarantee eligibility for 12 months for children**

  This proposal would permit States to provide 12-month continuous Medicaid eligibility for children ages 1 and older. (Continuous coverage was enacted for infants by OBRA 90.)

  This proposal would provide stable health care coverage for children -- particularly children in families with incomes close to the eligibility income limits, who often lose eligibility for a month due to an extra pay period within a month. This proposal would also reduce State administrative burden by requiring fewer eligibility determinations.

Eliminate Unnecessary Administrative Requirements

- **Eliminate OB/Peds physician qualification requirements**

  Federal requirements related to payment for obstetrical and pediatric services would be repealed. States would only have to certify providers serving pregnant women and children based on their State licensure requirements

  The minimum provider qualification requirements under current law do not effectively address quality of care. In addition, current law fails to recognize all bodies of specialty certification, so certain providers are precluded from participation in Medicaid (e.g., foreign medical graduates). Congress amended the law in 1996 to include providers certified by the American Osteopathic Association and emergency room physicians.

- **Eliminate annual State reporting requirements for certain providers**

  States would no longer have to submit reports regarding payment rates and beneficiary access to obstetricians and pediatricians.

  Current law assumes that access is linked to payment rates. However, the State-reported data do not reveal much regarding the link between payment rates and access.

- **Eliminate Federal requirements on private health insurance purchasing**

  Eliminate requirement that States pay for private health insurance premiums for Medicaid beneficiaries where cost-effective.

  The current law provision is not necessary. States have an inherent incentive to move Medicaid beneficiaries into private health insurance where it is cost-effective. The proposed per capita spending limits increase this incentive. The current, detailed, one-size-fits-all Federal rules hinder States from designing programs that most effectively suit local circumstances.

- **Simplify computer systems requirements**

  Eliminate detailed Federal standards for computer systems design. State systems would be held to general performance parameters for electronic claims processing and information retrieval systems.

  Current detailed requirements for system design were developed for an earlier time in which technology was primitive and detailed Federal rules were necessary to move States closer to what was then state-of-the-art. This is no longer the case. It is now sufficient to require States merely to show that their State-designed system meets performance standards established under an outcome-oriented measurement process.

- **Reduce unnecessary personnel requirements**

  We would work with States and State employees to replace the current, excessively detailed, and ineffective Federal rules regarding administrative issues that are properly under the purview of States, such as personnel standards, and training of sub-professional staff.

Increase Flexibility Regarding Managed Care

- **Modify upper payment limit for capitation rates**

  Modify upper payment limit and actuarial soundness standards for capitation rates to better reflect historical managed care costs by requiring actuarial review of the rates.

  The current Medicaid upper payment limit for managed care contracts (i.e., 100% of fee-for-service) is not an accurate payment measurement for Medicaid managed care plans. It does not reflect historical managed care costs and States claim it is inadequate to attract plans to participate. This proposal would modify the definition of the UPL to more accurately reflect Medicaid spending. It would also modify actuarial soundness standards.

- **Convert managed care waivers [1915(b)(1)] to State Plan Amendments**

  Permit mandatory enrollment in managed care without federal waivers. States would be able to require enrollment in managed care without applying for a freedom of choice waiver [1915(b)(1)]. States would be allowed to establish mandate enrollment managed care programs through a State plan amendment. Qualified IHS, tribal, and urban Indian organization providers would be guaranteed the right to participate in State managed care networks.

  This proposal would provide States greater flexibility in administering their State Medicaid programs by eliminating the freedom-of-choice waiver application process. States would not have to submit applications for implementation or renewal. The Administration is pursuing strategies to assure quality in Medicaid managed care that are more effective and less burdensome than the assurances added through the waiver process. Guaranteeing urban Indian organization providers the right to participate in State Medicaid managed

care networks integrates ITUs into managed care delivery systems and recognizes their unique health delivery role.

- **Modify Quality Assurance with new data collection authority while eliminating 75/25 enrollment composition rule**

Replace the current enrollment composition rule with a new quality data monitoring system under a beneficiary purchasing strategy with new data collection authority.

As part of the continuous effort to ensure Medicaid managed care beneficiaries receive quality care, HCFA proposes to implement a "beneficiary-centered purchasing" (BCP) strategy. BCP will replace certain current federal managed care contract requirements. The current enrollment composition rule (i.e., 75/25 rule) requires that no more than 75 percent of the enrollment can be Medicare and Medicaid beneficiaries. The current requirement is a process-related, ineffective proxy for quality. This requirement would be replaced with a quality monitoring system based on standardized performance measures.

HCFA, in collaboration with States, would define and prioritize a new standard set of program performance indicators, including a new quality monitoring system. These measures would be used to quantify and compare plans' quality of care, provide purchasers and beneficiaries with the means to hold plans accountable, and provide HCFA with comparable data to compare the performance of State programs to effectively hold States accountable as well.

This proposal would enhance the Secretary's ability to ensure that beneficiaries' interests are being protected as enrollment in managed care increases, and to detect and correct possible abuses by managed care plans. A more outcome oriented quality review process is vital to the Federal and State oversight of managed care plans to ensure that Medicaid beneficiaries are receiving the highest quality care possible. Data would be vital to the success of such an effort.

- **Change threshold for federal review of contracts**

Raise the threshold for the federal review of managed care contracts from the current $100,000 threshold to $1 million contract amount (or base threshold for federal review on lives covered by plan).

This proposal would provide greater State flexibility in management and oversight of Medicaid managed care programs. It would also reduce the number the of managed care plan contracts requiring HCFA review and approval.

- **Nominal copayments for HMO enrollees**

  Permit States to impose nominal copayments on HMO enrollees.

  This proposal would bring policy on Medicaid copayments for HMO enrollees more in line with Medicaid copayments that a State may elect to impose in fee-for service settings. It would also allow HMOs to treat Medicaid enrollees in a manner similar to how they treat non-Medicaid enrollees. However, impact on beneficiaries would not be harmful since copayments, if imposed, would still have to be nominal.

Increase Flexibility Regarding Long-Term Care

- **Convert Home and Community Based Waivers (1915(c)) to State Plan Amendments**

  Give States the option to create a home and community-based services program without a Federal waiver, through a State plan amendment. This proposal would benefit States and beneficiaries by eliminating the constant and costly necessity of renewing the waivers, while ensuring a high level of care.

- **Increase the Medicaid Federal financial participation rate from 75 percent to 85 for nursing home Survey and Certification activities**

  Raise the Medicaid Federal financial participation (FFP) rate to 85 percent.

  Federal funding is important to maintain both quality standards established by OBRA 87 and resulting enforcement activities. Increasing the Medicaid federal financial participation percentage to 85 percent would encourage States to increase total spending on nursing home survey and certification activities.

- **Permit waiver of prohibition of nurse aide training and competency evaluation programs in certain facilities. Clarify that the trigger for disapproval of nurse aide or home health aide training and competency evaluation programs is substandard quality of care (Medicare and Medicaid).**

  This would allow States to waive the prohibition on nurse aide training and competency evaluation programs offered in (but not by) a SNF or Medicaid NF if the State: (1) determines that there is no other such program offered within a reasonable distance of the facility; (2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and (3) provides notice of such determination and assurances to the State long-term care ombudsman. The proposal would also make clear that a survey finding substandard quality of care, rather than the mere occurrence of an extended or partial extended survey is what triggers the sanction of the training program.

  The current prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing home where a community college or other training facility may be inaccessible to nurse aides. This proposal would safeguard the availability of nursing homes which might otherwise stop participation in Medicare and Medicaid as a

result of losing a training program's approval. This proposal is also a part of the Vice-President's Reinventing Government initiative. A clarification of the circumstances under which a program must be sanctioned is needed because the fact that an extended or partial extended survey is conducted is not, in itself, an indication that substandard quality of care exists in the SNF, NF, or HHA.

- **Eliminate repayment requirement for alternative remedies for nursing home sanctions**

  Eliminate the requirement for repayment of federal funds received if a State chooses to use alternative remedies to correct deficiencies rather than termination of program participation.

  This proposal would allow States to promote compliance by employing alternative remedies on nursing facilities. This provision for alternative remedies gives States the flexibility for more creative implementation of the enforcement regulations.

- **Delete Inspection of Care requirements in mental hospitals and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Eliminate the duplicative requirement for Inspection of Care (IOC) reviews in mental hospitals and ICFs/MR. The survey and certification reviews that currently take place in mental hospitals and ICFs/MR would remain in place.

  Inspection of Care (IOC) reviews were originally designed to ensure that Medicaid recipients were not being forgotten in long term care facilities. The current survey process has been improved through a new outcome-oriented process that protects recipients in mental hospitals and ICFs/MR from improper treatment. Consequently, IOC reviews are no longer needed and are, in fact, in direct conflict with the revised ICF/MR survey protocol. The current requirement for two reviews (IOC and the ICF/MR survey) has become duplicative. If the IOC were eliminated, the ICF/MR survey and certification process would remain in place.

- **Alternative sanctions in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

  Provide for alternative sanctions in ICFs/MR that already are available for nursing homes. Alternative sanctions that currently are available in nursing homes include: directed in-service training, directed plan of correction, denial of payment for new admissions, civil monetary penalties and temporary management.

  Sanctions other than immediate termination were established for nursing homes under the OBRA-87 legislation, but not for ICFs/MR. This proposal would extend the alternative sanction option to ICFs/MR.

THE PRESIDENT'S FY 1998 BUDGET: MEDICAID PROPOSAL

- OVERVIEW
- DISPROPORTIONATE SHARE HOSPITAL POLICY
- PER CAPITA CAP POLICY
- MEDICAID FLEXIBILITY PROVISIONS

THE PRESIDENT'S BUDGET'S MEDICAID PROPOSAL

The President's budget produces **$9 billion in net savings** between FY 1998 and 2002.

- **It saves $22 billion in gross savings from two policies:**
  - About two-thirds of the savings (**$15 billion**) come from reductions in payments to disproportionate share hospitals (DSH), and
  - About one-third of the savings (**$7 billion**) from a per capita cap.
- **It invests about $13 billion in policies such as:**
  - Allowing States to extend 12 months of continuous coverage to children, and
  - Restoring coverage for some groups who lost it as a result of last year's welfare reform law.

The President's budget also offers unprecedented flexibility so that States, not the Federal government, can determine how best to improve Medicaid's efficiency.

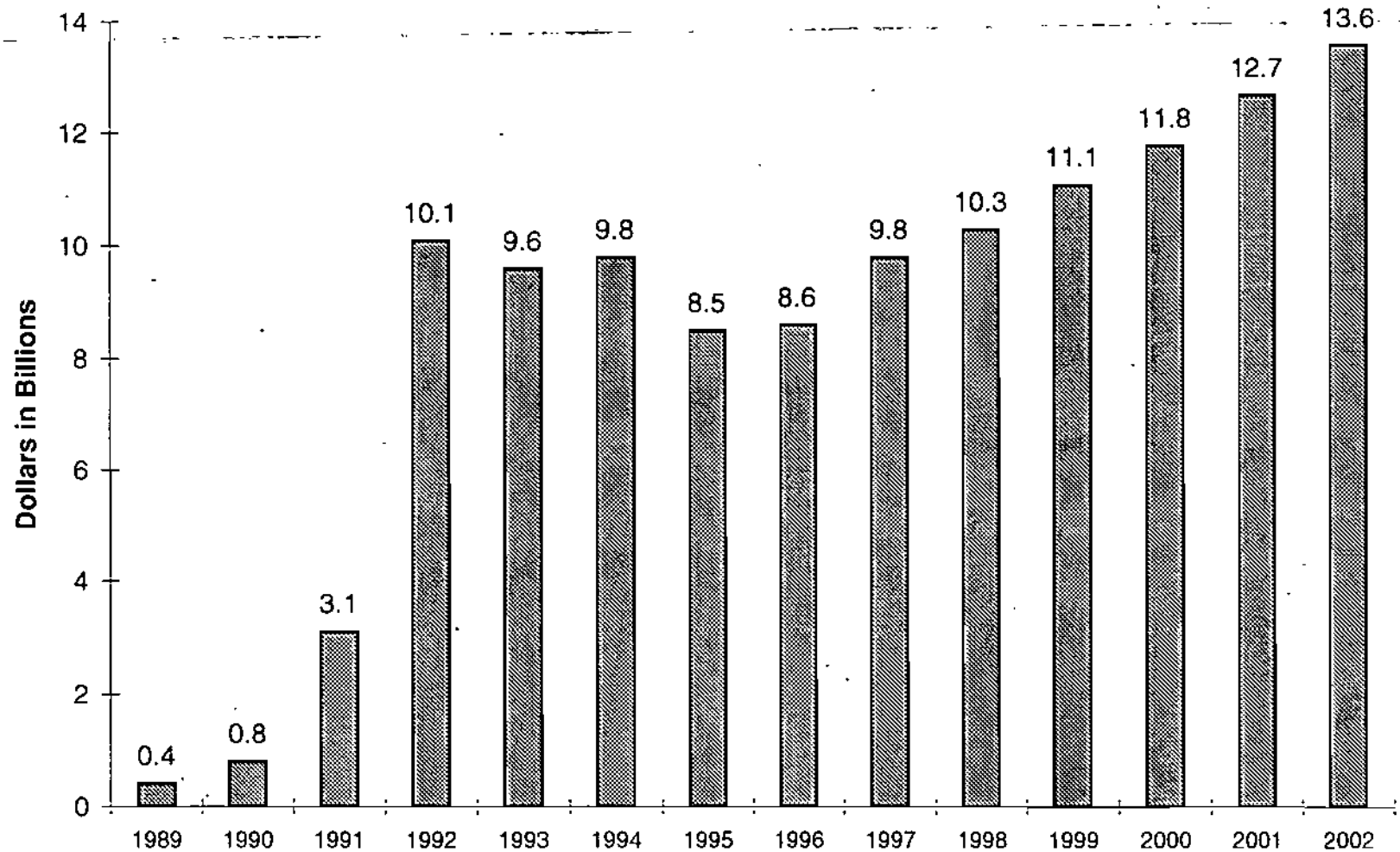
WHY REDUCE DSH SPENDING

- **DSH spending skyrocketed in the early 1990s.** Between 1989 and 1992, Federal payments for Medicaid DSH rose by over 250 percent.

- **Today, the Federal government spends nearly $10 billion on DSH.**
  - Its growth has moderated due to laws passed in 1991 and 1993.
  - However, about one-third of DSH funds still may not be received by the hospitals it is intended to help, according to an Urban Institute study.

- **Both CBO and OMB predict that DSH grow rates will rise.**
  - By 2002, the Federal government will spend an estimated $13 to 14 billion on DSH. Its growth rate in 2002 alone will be 7.4 percent according to CBO.

Federal Disproportionate Share Hospital Payments



Projections based on CBO January 1997 baseline

DSH REDUCTIONS IN THE PRESIDENT'S BUDGET

- **The President's budget reduces Federal Medicaid spending in DSH.** Specifically, it saves $15 billion, or about 25 percent, relative to the 1998 to 2002 CBO baseline. It:
  - Freezes Federal DSH spending at 1995 levels for 1998,
  - Reduces it to $9 billion in 1999, and
  - Funds DSH at $8 billion per year for 2000 and subsequent years.
- **Equal reductions, with an upper limit.** Savings are achieved by taking an equal reduction from each States' 1995 DSH spending, up to an "upper limit". These percentage reductions are:
  - 0 percent in 1998,
  - 15 percent in 1999, and
  - 25 percent in 2000 and equal subsequent year.

  If a State's DSH spending in 1995 is greater than 12 percent of its total Medicaid spending, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount.

  - The upper limit recognizes, like the laws enacted in 1991 and 1993, that some States' Medicaid programs are particularly dependent on DSH funding. The upper limit also ensures that the few States with high DSH spending are not bearing the entire impact of the policy.

BETTER TARGETING OF DSH FUNDS

- **Currently, almost all hospitals qualify as "disproportionate share hospitals."** Under current law, any hospital with more than 1 percent of its patients covered by Medicaid is eligible for disproportionate share funding.

- **As DSH funding is tightened, directing the funds within States' allotments to safety net providers becomes more important.** Limited Federal funding should be better targeted to providers that need it most: hospitals that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income patients.

- **Collaboration on exact formula.** Because targeting funds is technically complex and could have potentially disruptive effects in some States and for some providers, we want to work with Congress, States, providers, policy experts and advocates to develop an appropriate targeting mechanism.

FUNDS FOR CERTAIN HEALTH CLINICS

- **Helping FQHCs and RHCs make the transition.**
  - Federally qualified health centers (FQHCs) and rural health clinics (RHCs), like disproportionate share hospitals, play an important role in the safety net.
  - They may be disproportionately affected by the proposal to repeal the requirement of cost-based reimbursement for these facilities.

- **Temporary FQHC / RHC fund.** The President's plan includes a temporary fund of $1.4 billion over five years (from the DSH savings). It would sunset at the end of 2003.
  - Funds from this pool would be paid directly to facilities.

WHY INTRODUCE A PER CAPITA CAP

- **Medicaid spending growth has been volatile.**
  - In the early 1990s, Medicaid spending per beneficiary rose rapidly.

- **While Medicaid growth is low today, it may well rise again in the future.**
  - In fact, CBO projects that Medicaid spending growth per beneficiary will rise to nearly 7 percent by 2002.

Growth in Medicaid Spending per Beneficiary

Projections based on CBO's projections of Medicaid spending per beneficiary (including DSH) January 1997

THE PRESIDENT'S PER CAPITA CAP PROPOSAL

- **The President's budget constrains spending growth responsibly.** The President's per capita cap proposal savings $7 billion over five years. The per capita cap:

  - **Creates an incentive to reduce cost growth without reducing coverage.**

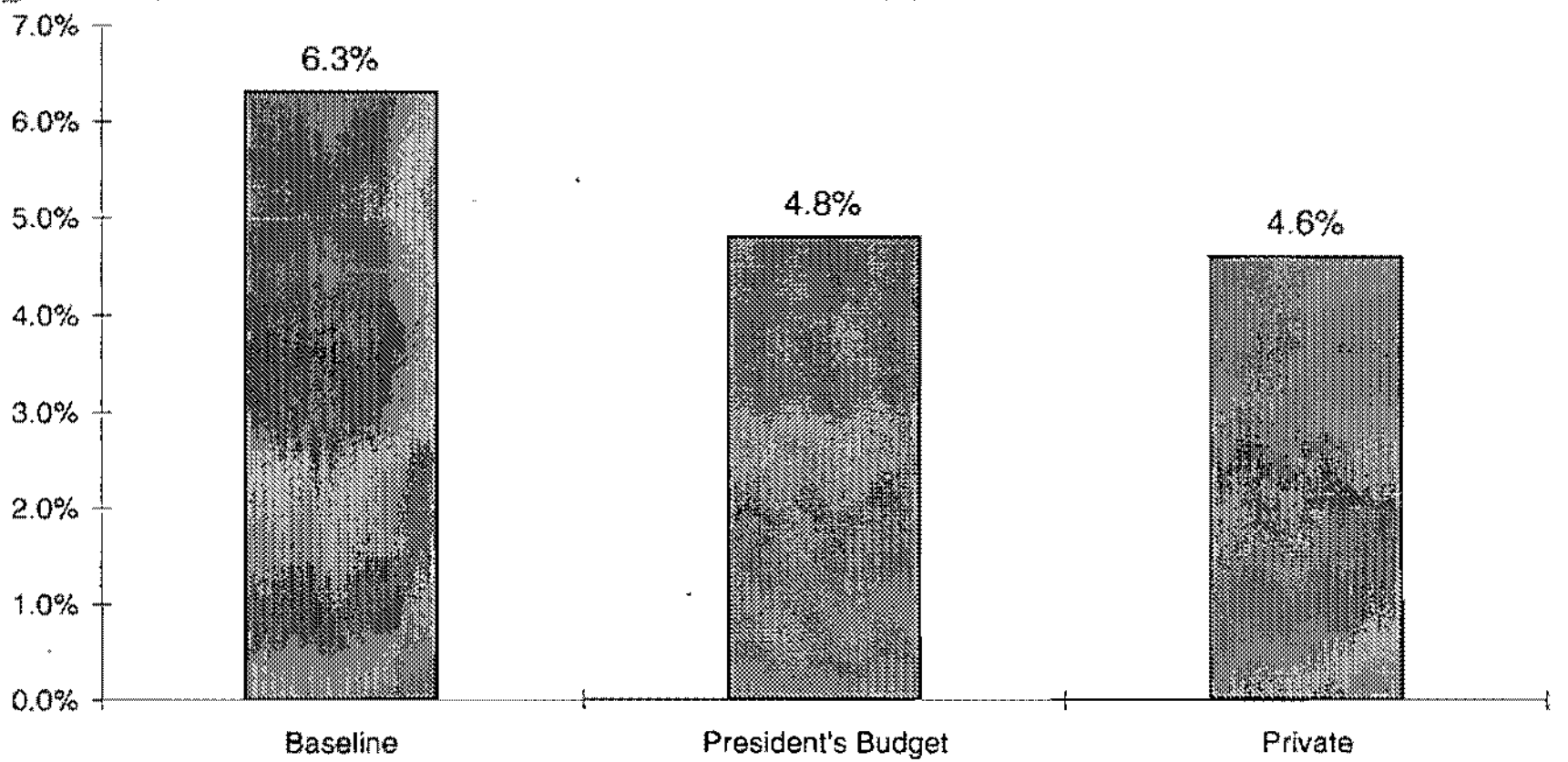
  - **Preserves the Federal - State partnership.** The Federal government will continue to share in the States' costs when they face unexpected recessions or changes in demographics.

  - **Lets States decide how to improve efficiency.** States will decide how best to reduce their costs through a flexible spending limit and increased program flexibility offered in the President's budget.

  - **Keeps spending growth in line with the private sector.** Medicaid spending will only be constrained if today's growth rates rise excessively. The growth limit, which parallels the rate of private spending growth, will not be breached unless Medicaid inflation rises.

  - **Increases taxpayer confidence in the program.** By requiring a much greater level of budgetary accountability, the per capita cap enhances the public support for Medicaid.

Comparison of Medicaid and Private Growth Rates Per Beneficiary 1997 to 2002



"Baseline" is CBO's January 1997 Medicaid baseline growth per beneficiary (including DSH); "President's Budget" reflects CBO's estimated Medicaid outlays under the Budget; "Private" is CBO's projected private spending growth divided by its projected growth in privately insured people. Fiscal Years.

HOW THE PER CAPITA CAP WORKS

- **Setting the Federal limit.** Each State will have one spending limit for its Medicaid benefits spending. This limit is calculated by multiplying:
  - 1996 Medicaid spending per beneficiary (separately for aged, disabled, adults & children) by
  - An inflation adjuster, set in legislation, by
  - The actual number of beneficiaries covered by the States (by type of beneficiary).

  The Federal government will match State expenditures as under current law up to this limit.

- **Excluded expenditures.** Spending not counted toward this limit includes all DSH, Medicaid spending on Medicare cost sharing, and other miscellaneous expenditures unrelated to benefits.

- **Setting the inflation adjuster.** The President's budget limits Medicaid spending growth to the average growth in nominal GDP per capita plus 2 percentage points in 1998, and plus 1 percentage point for all subsequent years. This averages about 5 percent between 1997 and 2002.

  Recognizing that there is a debate about what is the most appropriate index, we intend to work with Congress, States, researchers and others to develop the best inflation adjuster.

FLEXIBILITY OF THE PER CAPITA CAP

- **Adjusts for changes in a State's population.**
  - Each State has a unique and changing mix of people it covers through Medicaid.
  - Consequently, the per capita cap explicitly adjusts for changes in both the number and mix of beneficiaries.
  - For instance, a State that experiences a rapid rise in its elderly population will receive a greater increase in their limit than a State with an equal rise in Medicaid children, given the higher cost of care for the elderly.

- **Allows savings from one area to offset overspending in another.** There is only one limit per State. This means that if a State is able to produce extra savings from its elderly program but overspends on its children, it may use those savings to offset the extra spending, thus receiving full matching payments.

ADDRESSING DIFFERENCES ACROSS STATES

- **Helping in the transition.** The budget includes about $1 billion (from the per capita cap savings) in a capped, temporary pool to assist States and other entities who may be disproportionately affected by the new Medicaid policies.

- **Medicaid Commission.** The per capita cap represents a major change in Medicaid financing. The President's budget will establish an independent, impartial commission to examine:

  - **Differences in base year spending.** The commission will examine States' Medicaid spending patterns to better understand why there are differences.

  - **Alternative Medicaid matching rates.** The commission will also assess whether the current Medicaid matching rate, created in the 1960s, is still a fair and accurate formula.

  At the end of two years, the commission will recommend any changes to the Medicaid matching rate, per capita cap growth rates or base year spending that ensure equitable treatment across states.

MEDICAID FLEXIBILITY PROVISIONS

- **Unprecedented flexibility.** The President's proposes unprecedented flexibility in Medicaid so that States, not the Federal government, can determine how best to achieve the savings targets in the budget. Under the plan, States can:
  - Reform their programs without the need for a waiver,
  - Set provider payment and managed care rates with less Federal micromanagement, and
  - Administer their programs with fewer and simpler Federal requirements.

FREEDOM FROM WAIVERS

- Managed care without a waiver (1915(b)) with new quality standards
- Home and community-based care programs without a waiver (1915(c))
- Expansion to people with incomes up to 150 percent of poverty without a waiver (1115)

FLEXIBILITY IN PROVIDER PAYMENTS AND MANAGED CARE

- Repeal Boren amendment
- Eliminate cost-based reimbursement requirement for Federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Replace "75 / 25" enrollment composition rule with reasonable quality standards
- Reduce the number of managed care contracts subject to Federal review
- Revise outdated upper payment limits for managed care
- Allow States to let managed care plans use nominal copayments

SIMPLIFICATION OF ADMINISTRATIVE REQUIREMENTS

- Eliminate a series of unnecessary Federal requirements, including:
  - Requirement for private health insurance purchasing when cost effective
  - Computer systems requirements
  - Increase matching payment for nursing home survey and certification requirements

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March 20, 1997

Mr. Bruce Reed
Advisor to the President for
Domestic Policy
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. Reed:

Thank you for arranging the opportunity for us to present our views on the privatization of the Medicaid and Food Stamp programs. It should be clear from our discussion that we think the federal government would be ill-advised to permit the deputation of private companies to administer these public welfare programs for at least the following reasons:

<u>The Food Stamp Act and Medicaid Place Broad Restrictions on Delegation of Administrative Functions to Non-Public Employees, and a Waiver of These Protections Would be Vulnerable in a Legal Challenge.</u>

Discretionary decisionmaking in these two programs is to be performed by public officials and employees. For example, the statutory language governing certification of eligibility for food stamps is clear that eligibility determinations must be made by public employees. Specifically, the Food Stamp Act states that "the State agency personnel utilized in undertaking . . . certification shall be employed in accordance with the current standards for a Merit System of Personnel Administration . . ." 7 U.S.C. § 2020(e)(6). The Department of Agriculture's regulations reinforce the fundamental principle that public employees must conduct certification interviews and certify households for food stamps:

> State agency employees [employed in accordance with a merit system of personnel administration] shall perform the [eligibility] interviews required in § 473.2. **Volunteers and other non-State agency employees shall not conduct certification interviews or certify food stamp applicants.**

7 C.F.R. § 272.4(a)(2) (emphasis added).

Similarly, Medicaid requires that States establish or designate a single State agency for administering their Medicaid plans, and provides that "the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan" -- that is, by public employees. 42 U.S.C. § 1396a(a)(5). The accompanying regulations echo this point, directing that the State agency "must not delegate, to other than its own officials, authority to (i) [e]xercise administrative discretion in the administration or supervision of the plan, or (ii) [i]ssue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e).[1]

The foregoing statutory and regulatory provisions plainly demonstrate Congress' and the Executive Branch's clear expectation that administrative functions in the Food Stamps and Medicaid programs are to be handled by public employees -- an expectation which we believe is firmly grounded in compelling policy arguments, set forth below, in favor of public administration of public benefits programs. The Administration should not act in a manner contrary to legislative intent in evaluating proposals implicating these provisions.

Waiver authority under these programs is limited, and privatization of discretionary administrative functions will in most instances exceed that authority. Both the Food Stamps and Medicaid programs authorize waiver of certain requirements under certain limited circumstances.[2] The scope of administrative waiver authority is

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[1] It is worth noting, as we discuss in greater detail below, that one area where HHS has permitted privatization -- i.e., outstationing of intake functions at hospitals -- remains overwhelmingly public.

[2] It is our understanding that no waiver request has been submitted in connection with the proposed privatization of numerous programs by the State of Texas. Given the clear statutory language mandating eligibility determinations by public employees in the Food Stamps and

constrained by important elements of these programs. Only limited changes in the provision of services are permitted, subject to individual assessment and approval of a particular state's waiver request.

The Secretary of USDA may waive requirements of the food stamp program only for pilot projects of a limited duration and only "to the extent necessary for the project to be conducted." 7 U.S.C. § 2026(b)(1)(A), as amended by P. L. 104-193, § 850. "[I]mprov[ing] program administration" and "allow[ing] greater conformity with the rules of other programs" are among the permissible purposes of a waiver arguably relevant to the issue at hand, id., but any such initiative "must be consistent with the food stamp program goal of providing food assistance to raise levels of nutrition among low-income individuals." House Rep. 104-725, accompanying H.R. 3734, at 479. Thus, in order to justify a waiver of the public eligibility determination requirement, the Secretary would need to demonstrate (1) that the waiver was necessary for the project in question; (2) that the project furthered a permissible purpose, e.g., that is, that the project would actually improve program administration; (3) that the project furthers the goal of providing food assistance to low-income individuals; and (4) that the project is of a limited duration. For the reasons set forth below, we believe a studied review of an actual request to privatize eligibility determinations will reveal that contrary to improving program administration, privatization will in reality have a detrimental effect on program administration as well as on benefit recipients. Consequently, we believe approval of a waiver request seeking to privatize eligibility determinations will be vulnerable in any subsequent judicial review.

Similarly, while the Secretary of HHS is permitted to waive requirements of the Medicaid statute for an "experimental, pilot, or demonstration project" which is "likely to assist in promoting [statutory objectives]", 42 U.S.C. § 1315(a), that authority is not without its limits. Rather, "§ 1315(a) plainly obligates the Secretary to evaluate the merits of a proposed state project, including its scope and its potential impact on [benefit] recipients." Beno v. Shalala, 30 F.3d 1057, 1068 (9th Cir. 1994). In other words, "[o]n its face, the statute allows waivers only (1) for experimental, demonstration or pilot

---

Medicaid programs, it is manifest that no privatization is permissible in those programs unless the federal government approves a State waiver request following notice, comment, and agency evaluation of any such request. In any case, we do not believe a waiver permitting privatization of eligibility determinations would be permissible under the standards set forth in the statutes, as described in more detail above.

projects, which (2) in the judgment of the Secretary are likely to assist in promoting the objectives of the Social Security Act and only (3) for the extent and period she finds necessary." Id. at 1069 (emphasis added). As with waivers under the Food Stamp program, we believe careful scrutiny of a proposal to privatize eligibility determinations in the Medicaid program will reveal that such an approach contravenes the purposes and objectives of the Social Security Act, compromises a strong policy in favor of public administration, and negatively impacts Medicaid recipients. Consequently, we believe such a waiver would be vulnerable under judicial review.

TANF did not alter these fundamental principles. When the Congress passed, and the President signed, the most sweeping repeal of an entitlement program since the Social Security Act was passed, Congress stopped short of expanding private administration and eligibility determinations in the Food Stamp and Medicaid programs even as they were allowing private actors to play a greater role in former AFDC functions. For all the changes in administrative procedures which the new law allowed, it made precious few changes in Food Stamp and Medicaid administration. In fact, while one version of the 1995 welfare bills struck the merit-based requirement for food stamps, it was restored in the conference committee. Given this legislative history, it would be particularly distressing if the Administration now chose to move in a policy direction which Congress rejected in favor of public provision of services.

Publicly-Funded Benefit Programs Deserve Public Accountability

Federal benefit programs funded by taxpayer dollars, and especially programs of the magnitude of Food Stamps and Medicaid, deserve full public accountability, which we believe is best provided through public administration by public employees. Private contractual arrangements cannot sufficiently assure the requisite level of public accountability. Moreover, privatization of public benefit eligibility determinations raises numerous other problems, described in greater detail below. For these reasons, as State waiver requests are received, we believe the Administration would be well advised to disapprove requests for private administration and eligibility determinations.

Privatization of Public Benefit Programs Faces an Array of Problems

Discretionary control over access to public programs. As we illustrated in our discussion, the intake processes around Medicaid and Food Stamps are replete with instances where personnel are making judgements about the validity of information and

the weight of various factors. Under private determinations, this discretion is exercised under the direct influence of financial incentives which may work counter to public goals.

During our discussion, the issue of private control over distribution of public benefits in the Pell Grant and Guaranteed Student Loan programs was raised. However, these programs, and the types of private activities conducted under them, are in no way comparable to Food Stamps and Medicaid. First, it is important to point out that Congress expressly contemplated significant activity by private actors in these programs, contrary to the Food Stamp and Medicaid programs. Furthermore, the Pell Grant and Guaranteed Student Loan programs are extremely small compared to the billions of dollars spent under Food Stamps and Medicaid. Unlike student loans, food and medicine are fundamentally more important to survival than are other categories of benefits. The types of clients and the nature of the decision being made are more complex. What is more, the incentives under Pell Grants and Guaranteed Student Loans would encourage oversupply of loans, not restrictions on benefits as would be the case for food stamp or Medicaid eligibility under private determinations. It is worth noting that just two days ago Pell Grants were the subject of a Wall Street Journal article highlighting fraud problems involving overpayment by colleges.

Unlike student aid, the private entities which would be asked to determine Food Stamp and Medicaid eligibility have no particular expertise in these programs and are being asked to enter a policy area undergoing dramatic change. Finally, the food stamp program includes specific, detailed provisions governing the behavior of eligibility workers (e.g., face-to-face interviews, etc.) and even the facilities in which interviews can occur (in order to preserve privacy). This detail suggests that the framers of the legislation understood that the benefits and information they were dealing with are uniquely sensitive and must be protected through merit-based personnel. Taken together, the combination of discretion, financial incentives, lack of expertise, and vitally important benefits argues strongly against private eligibility determination in these programs.

Eligibility determination related to appeals process. It is important to remember that the lead staff person on eligibility is also responsible for informing clients of their appeal rights. We believe that allowing private contractors to stand between clients and the right to appeal will raise serious issues around due process. We fear that private contractors are both more likely to deny clients due to financial incentives and less likely to be forthcoming about appeal rights than are public servants.

Private internal accounting process can disadvantage clients. Particularly in social service areas, measurement issues influence outcomes. For example, President Nixon used administrative authority instead of legislation to reduce welfare payments by changing "quality control" measures to look only at overpayments. Even if states make no legislative changes, private firms have every reason to monitor themselves only in ways that reduce payments. Sometimes this will match public goals and sometimes it will not. These issues are extremely difficult to specify in advance through contract arrangements, given the control over internal accounting which private firms will always enjoy.

Contractual boundaries are not as protective as direct public accountability. Privatization advocates will argue, in the abstract, that private contracts can capture all contingencies. We don't believe this. It is simply untenable that a written agreement with private firms can adequately safeguard against all contingencies. The essence of public, merit-based service provision is the emphasis on public accountability, procedural guidelines, and extensive written records. Complete protection of public trust through contract language is unrealistic. Public provision of services acknowledges that all contingencies cannot be predicted, replacing the rigidity of contracts with direct democratic accountability. Privatization places supervisors and auditors outside the process of determinations, forcing them to evaluate reports without being able to assess the capabilities of the individuals who compiled the information or the validity of the documents upon which they are based. Line supervisors, on the other hand, are in direct contact with the individuals responsible for eligibility determination. The accountability is direct, personal, and informed by practice. In private settings, ultimate accountability is to shareholders, not elected leaders. Taxpayers don't elect the CEO of Lockheed. It is the combination of discretion over vital benefits and financial incentives to limit their distribution that troubles us.

Accurate accounting requires vast monitoring expense. We do not believe it is possible to effectively monitor contracts in a manner that is less costly than public provision. Cost estimates for private contracts never fully account for the cost of public monitoring. Moreover, private contracts run the risk of generating both public and private layers of management, auditing, and processing functions. If the federal action allows states to hand off contracts, the federal government will end up spending more on administrative oversight or risk political and financial problems.

The potential for fraud and cost over-runs appears high. Current practice proves that contract monitoring must be taken very seriously. As mentioned in our meeting, Canadian experience with the same contractors that are pursuing contracts in Texas raises serious questions about cost over-runs and performance. The Department of Public Works and Government Services canceled their $44.5 million contract with Andersen when the company failed to meet its obligations and demanded a doubling of the contract cost.

Experience in the U.S. also encourages caution. Lockheed and Martin Marietta, for example, have paid millions of dollars in fines related to bribery lawsuits. In December, Lockheed Martin paid over $5 million to settle a lawsuit involving overcharging. In Texas, former state officials have left public service specifically to pursue more lucrative private contracts. Andersen Consulting's contract for the Child Support Enforcement Tracking System is currently four years behind schedule and the contract cost has grown 600 percent. The Texas auditor's report noted that Andersen underestimated the complexity of the tasks and made insubstantial provisions for a changing environment.

From the individual level all the way to corporate policy, public monitoring of private contractors would have to be extremely vigilant -- and even then there will be problems which involve misuse of federal dollars. Moreover, the cost-sharing relationships which exist in these programs open the federal government to greater financial and legal exposure when contracts go awry.

Confidentiality issues. We are concerned that the full extent of confidentiality problems have not been addressed. Eligibility determiners enter social security data, unemployment insurance databases, and other public program benefit files. Allowing private individuals connected to private firms to access these databases raises a wide range of confidentiality issues, some of which will be unforeseeable.

Private encroachments into Medicaid already go too far. We acknowledge that private firms are entering new areas related to Medicaid right now. But these incursions only illustrate the negative consequences. We believe the Administration has gone too far in allowing private actors to encroach upon the Medicaid program. For example, new positions called Health Benefits Manager should be public, not private. The honest broker role may not be "honest" if private, self-interested parties are involved. Mathematica's evaluation of Medicaid managed care in California (May 1996) illustrates

this problem. They describe the privatized enrollment process as "chaotic and problematic". The solution proved even worse:

> Recognizing the confusion, DHS allowed providers to assist individuals to enroll but this actually led to even greater problems. Doctors (and clinics) worked with patients to complete enrollment forms designating themselves as primary care provider (in whatever plan they belonged to). Unfortunately, however, since many clients visit more than one provider, many clients enrolled in several plans, selected several doctors as their primary care physicians, or both.

Ultimately, DHS had to step in to untangle the problems and the study notes that "DHS admits it had too few staff to fully monitor the conversion." With crucial health and nutrition benefits on the line, we believe it is inappropriate to risk similar problems on a national scale.

The Outstationing Experience. HCFA has acknowledged the constraints placed by the Medicaid statute on eligibility determinations. It did so in the context of promulgating regulations to enforce the requirements of OBRA 1990 that states provide for the receipt and initial processing of applications of certain persons at locations other than welfare offices. Such "outstation" locations include certain hospitals and health clinics. In interpreting what "initial processing" means for purposes of this requirement, HCFA explained that "[i]f we were to define initial processing to include making a determination of eligibility, the definition would conflict with the requirement of [42 U.S.C. § 1396a(a)(5)]. Under [that] section, the plan must be administered by a single State agency and determination of eligibility is restricted by this section to the Medicaid agency, the title IV-A agency, or SSA when administering the SSI program." Medicaid and Medicare Guide, para. 42,662 at 41,820.

We question whether HCFA exceeded its authority by bifurcating initial processing and eligibility determinations in this way, and by permitting initial processing to be performed by private actors. These eligibility functions are closely related, and do not lend themselves to such an artificial division of labor, as indicated by the apparent reluctance of states to utilize private actors at outstations. In any case, outstationing remains overwhelmingly public. Only a handful of states have health care provider staff trained to be outstationed eligibility workers. (Medicaid Source Book, CRS, 1993). Two of the largest programs, Los Angeles County and New York City, use public workers for

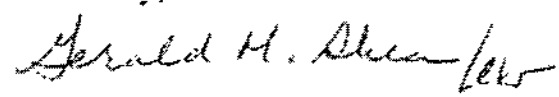
these functions. The State of Ohio outstationed these functions to county public health providers who were public employees. Similarly, in New Mexico, even though private workers are involved in application intake, a public welfare worker is on-site and involved in the process. In other words, even when given the opportunity to privatize, states are quite reticent, for good reasons, to permit private providers to engage in eligibility functions.

As the foregoing discussion demonstrates, we believe any decision to expand private functions within the Medicaid and Food Stamps programs will put federal dollars, federal agencies, important federal programs, and recipients of federal benefits at risk.

While our discussion last Friday did not focus on the severe impacts on the almost 500,000 public employees whose jobs potentially are in danger, I would like to close this letter by noting that these are enormous issues in their own right. The public employees who currently administer the Food Stamps and Medicaid programs are commited public servants who have devoted their energies and talents to important social programs. They deserve our appreciation and respect. Privatization of the administration of these programs could well result in dedicated employees losing their jobs and job-related benefits, to the advantage of private corporations with an incentive to maximize profits by keeping wages and benefits as low as possible. However, because we believe proposals to privatize the administration of Food Stamps and Medicaid fail for the reasons detailed in this letter, we have not focused here on the extensive worker protections, standards, and programs that would be required in any privatization initiative.

I would appreciate your prompt consideration of these points.

Sincerely,



Gerald M. Shea
Assistant to the President

cc: Gene Sperling
Ken Apfel

MEMORANDUM

TO: Distribution List

FR: Chris J.

RE: Medicaid Growth Rate Changes

Attached is a copy of the "Decline in Medicaid Growth Rate and Baseline" memo that Carol requested. It reviews current and future possible declines in the Medicaid baseline, and summarizes the potential impact they may have on budget and health policy.

I thought you would be interested in seeing a copy. Please feel free to call me at 456-5560 with any questions.

Health Care - Medicaid

September 23, 1996

MEMORANDUM TO THE PRESIDENT

FROM: Carol Rasco and Chris Jennings

SUBJECT: Decline in the Medicaid Growth Rate and Baseline

Largely unnoticed, Medicaid baseline reductions have made a significant contribution to the decline in the Federal deficit. In fact, in their recently-released budget outlook report that reduced the 1996 Federal deficit to $116 billion, the Congressional Budget Office (CBO) stated that "the largest single re-estimate is a (1 year) $4 billion reduction in Medicaid outlays." The reduction in expenditures has produced an aggregate Medicaid growth rate of 3 percent between 1995 and 1996, the lowest growth rate in over 20 years. This translates into an astounding 1 to 2 percent per capita (or per person) increase in spending -- well below the 20-year average annual Medicaid per capita growth rate of 11 percent.

Since you unveiled your balanced budget last year, the CBO Medicaid baseline has declined by $52 billion. The comparable reduction in the Administration Medicaid baseline is about $20 billion; (it is less because OMB started with a lower spending base, has been assuming lower growth rates, and has integrated more accurate economic assumptions all along.) This trend will continue as we fully expect this winter's baseline adjustments (off both the CBO and OMB baselines) to produce tens of billions of dollars of additional savings. As a result, without enacting a single Medicaid cut, you will preside over a program whose CBO baseline (after this winter's adjustment) will have been reduced in the budget window by as much as (if not more than) $80 billion since 1995, and more than $50 billion off of the OMB baseline during that same period.

Many factors have contributed to the decline in the Medicaid baseline. They include: (1) increased utilization of managed care and other cost-cutting initiatives implemented by the states; (2) an improved economy with much lower inflation; and (3) reduced use of "creative" Disproportionate Share and provider donation financing mechanisms by states.

The fact that Medicaid's growth has slowed so rapidly is good news. It mirrors the positive news about health care inflation in the private sector you occasionally cite. However, we must be cautious about heralding it too much because it tends to undermine our criticism of the magnitude of the Republicans' Medicare cuts. For example, we appropriately criticized the Republicans' Medicare cuts, but their proposal (at the time of the veto) would have allowed for a 4.9 percent per person growth rate -- above what the 1995 to 1996 per capita Medicaid growth rate was by 2 to 3 percentage points. In short, when we highlight the success of the private and Medicaid sectors in constraining costs, we risk someone charging that we are being inconsistent in not suggesting that Medicare be held to the same standard.

Most health economists are dubious that last year's low growth rate can be extended for a prolonged period. They believe that much of the savings represent a one-time constriction of excess capacity and inefficiency in the health care system. Moreover, because of historically high health inflation (recall the 11 percent average per capita over the last 20 years), CBO and OMB estimators are extremely weary of lowering their projected Medicaid growth rates, particularly in the out-years. While they may lower their budget window per capita growth rates from 7 percent to 6 percent or at most 5 percent (which is probably the range that they will assume private sector growth rates will be), the estimators will not lower their projected growth rates to anywhere near last year's unofficial Medicaid per capita number of between 1 and 2 percent.

Regardless of the final projections, it is clear that our current Medicaid 5 percent per capita cap proposal will not score significant savings off the downsized CBO Medicaid 5 to 6 percent average per capita baseline. If we do need or want additional savings, we will need to tighten up the allowable average growth rates to probably no more than 4 percent over the budget window. The primary outstanding question is: Can this program sustain this level of constraint without undermining the care it provides to its population?

Clearly, medical and general health inflation have significantly moderated. Very few health care analysts would have projected two years ago that health inflation would be running as low as it is. If current trends are sustained, holding the Medicaid program to a 4 percent average per capita growth rate is conceivable.

Having said this, since Medicaid would have to grow 20-30 percent below what will likely be the revised CBO average private sector per capita rate (of 5-6 percent), we probably could not get many health care economists to validate such a low, sustained growth rate. This is particularly the case because of the increasing numbers of high-cost elderly and disabled populations served by Medicaid.

More importantly, we might re-open the door to another serious block grant debate, since states would be more likely than ever to reject such reductions in Federal support without the elimination of virtually all Federal strings. Coverage expansion through or with Medicaid would have to be put off for a while, since no or few states would have the appetite and the resources to take it on. And lastly, reducing Federal financing might place overwhelming pressures on the states to demand that their waivers (old or new) be exempted from changes in financing. If this occurred, we would have even a greater rush to grant and grandfather-in politically-charged state waiver applicants. If this happened, Medicaid savings would be much more difficult to achieve.

We still believe that the Medicaid flexibility reforms you have proposed can achieve savings for the states (and the Federal Government) and are good policy. Moreover, we probably could get some limited savings from a slightly tighter per capita cap, as well as some additional contributions from DSH. Having said this, as we continue to witness billions of dollars of additional Medicaid baseline reductions help lower the deficit, we may want to start lowering our expectations of how much savings we can or should include in our next budget proposal.

SPECIAL ANALYSIS

THE PRESIDENT HAS SEEN
1-27-97

The Impact of Medicaid Expansions

Until 1984, the close historical tie between Medicaid eligibility and participation in Aid to Families with Dependent Children (AFDC) limited Medicaid to single-parent households with very low incomes. Since 1984, eligibility has been expanded substantially. The increased coverage associated with these expansions has improved the health of infants and children. But the net increase in coverage was far less than the increase in eligibility.

Medicaid expansions and health outcomes. The period from 1984 to 1987 saw incremental increases in Medicaid eligibility to populations with circumstances similar to AFDC families. For example, coverage was extended to children of two-parent families meeting the AFDC income criteria and pregnant women who would become eligible for the program once their children were born. After 1987, Medicaid and AFDC eligibility were virtually decoupled. By 1992, states were required to provide Medicaid coverage to all children under the age of 6 living in households with incomes no more than 133 percent of the poverty line and to all pregnant women in such households.

These expansions produced important health improvements. For instance, making expectant mothers eligible for Medicaid greatly increased their chances of receiving prenatal care in the first trimester of pregnancy. Increased eligibility between 1984 and 1992 was associated with ~~roughly a 1.6 percent decline in low-birthweight~~ babies, a 7.3 percent decline in infant mortality and an 8.8 percent decline in child mortality.

Effects on Medicaid eligibility and coverage. Although eligibility expanded greatly, take-up rates in means-tested programs like Medicaid are relatively low and many of the newly eligible already had private health insurance. Hence, the net increase in Medicaid coverage was much smaller than the increase in eligibility. Between 1984 and 1992, the fraction of children eligible for Medicaid rose from 16 to 31 percent while the proportion actually covered by Medicaid increased from 13 to 21 percent. Among women, an increase in eligibility of more than 25 percentage points led to an increase in coverage of only about 2 percentage points for some types of expenses.

The net increase in health insurance coverage is even smaller, because the Medicaid expansions also decreased private health insurance coverage. Some families may have replaced costly private insurance with free Medicaid coverage, even though some family members who were not eligible for Medicaid may have lost coverage altogether as a result. Some employers may have reduced their coverage because they thought more of their employees would be eligible for Medicaid coverage.

Medicaid

THE WHITE HOUSE

WASHINGTON

January 16, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING

CC: FRANK RAINES, BRUCE REED, JOHN HILLEY

SUBJECT: Child Health Investments and Medicaid Update

As you have recently inquired about our child health investments, I asked Chris Jennings and Nancy-Ann Min to provide you with a summary of the child health care initiatives in our FY98 budget. Secretary Shalala's memo is also attached.

Child Health Initiative. Your budget includes a new 5 year, $8.5 billion investment to cover uninsured children. It includes all of major initiatives outlined in Secretary Shalala's memo to you. Chris and Nancy Ann believe that this new initiative will cover between 4 and 5 million uninsured children by the end of 2000, when combined with your Workers Between Jobs Health Initiative.

Medicaid. Even though your children health initiative is likely to be popular, base Democrats, governors, liberal health advocates, and providers, are likely to be less enthusiastic about your $22 billion Medicaid reduction which uses a per capita cap and disproportionate share (DSH) payment cut to achieve the savings. On the other hand, because it will be viewed as fiscally responsible, moderates are likely to be relatively receptive to your proposal as a responsible way to protect the Medicaid guarantee.

While we don't want to give out exact details on our budget at this time, you can establish that your proposal will meet the following 4 principles:

1. Protect the fundamental guarantee of Medicaid, recognizing its importance to our core values -- protecting health care for children in poor families, the disabled, and safeguarding health care for millions of middle class families with family members in nursing homes.

2. Must have a real long term budget safeguard that ensures that outyear spending does not rise too quickly, and overall entitlement do not grow out of control.

3. Provide more coverage for uninsured children. [When we decide to talk about details of our budget, we could let groups know that our $22 billion reduction actually works out to a modest $9 billion savings after the Medicaid and welfare improvements are netted out]

4. Provide states with the flexibility to meet their unique needs, while covering more people and ensuring the integrity of the individual guarantee of solid Medicaid health benefits.

Leon, Erskine, Chris Jennings, Nancy-Ann Min, and I did a conference call with governors this week, and Chris, Nancy-Ann and I met with the AARP yesterday. In both conversations, strong concerns were raised about reports that we were including a Medicaid per capita cap. Without confirming details, we stressed our belief that inclusion of a responsible budget safeguard would help protect the individual guarantee because with no budget constraint, it could open the door to Republicans seeking to re-propose a Medicaid block grant.

THE WHITE HOUSE

WASHINGTON

January 15, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Nancy-Ann Min

SUBJECT: Children's Health Investments and Medicaid Update

You recently asked Gene Sperling for the status of your children's health care investments. What follows is a summary of your policy and a brief review of the likely reaction to your Medicaid and health investments from advocates, the Hill, and the Governors.

Uninsured Children and FY 1998 Budget.

There are currently about 10 million uninsured children in the nation. Your budget includes a new 5-year, $8.5 billion investment to cover uninsured children. It includes all major initiatives outlined in Secretary Shalala's attached memo to you. We believe that these proposals, in combination with your Workers Between Jobs Health Initiative (which will extend coverage to 700,000 children annually) and the 1 million children (aged 14-18) who will be added to Medicaid during your second term under current law, will cover between 4 and 5 million uninsured children* by the end of 2000.

Specifically, your FY 1998 budget includes four new initiatives explicitly designed to expand coverage and/or services to children:

(1) **Support for Innovative State/Private Children's Coverage Expansions for Populations Above Medicaid Eligibility Line.**
Investment: $3.75 billion. Coverage: About 1 million children.
Indirect Investment: $1.1 billion Coverage: About 400,000 (These indirect numbers are the result of the actuaries' assumption that Medicaid eligibles will be enrolled when they apply for the state innovation proposal outlined above.)

(2) **State Option to Extend Medicaid Coverage To 12 Months Without Eligibility Re-Determination.**
Investment: $3.6 billion. Coverage: About 1 million children.

(3) **Outreach to the 3 Million Medicaid Eligibles Not Enrolled.**
Investment: None. Future baseline. Coverage: Now Unknown. Perhaps 1-2 million.

(4) **Support for Increased Access to Services through School-Based and other Community Health Centers.**
Investment: At least $25 million. Coverage: Increases services/not coverage.

Medicaid and Health Investments: Likely Reaction to the FY'98 Budget

While the public may embrace your proposal to expand coverage to children and workers in-between jobs, the base Democrats, the Governors, the advocates, and providers will not necessarily share such enthusiasm. They will be displeased about our $22 billion Medicaid reduction and our use of a per capita cap and disproportionate share (DSH) payment cut to achieve this savings number. Not surprisingly, all of these groups claim that the baseline has come down so far as to no longer justify more savings. They also fear that any savings number will only increase during negotiations.

Our response to these groups will be three-fold: (1) Our $22 billion reduction actually works out to a modest $9 billion savings number after the Medicaid and welfare improvements are netted out; (2) Our retention of the per capita cap is primarily a budget safeguard that assures that out-year spending does not rise too quickly; and (3) Supporting a fiscally responsible per capita approach is in the long-run interest of the program (as protection against future moves to block grant it).

In general, we believe that the Blue-Dog Democrats and the Republicans will be relatively receptive to your Medicaid proposal. The Blue-Dogs will like it because it is fiscally responsible and consistent with their past policy. The Republicans will like it because they will think they can simply tighten up the per capita cap's index to achieve more savings. They will also like it because it gives them cover with their Republican Governors. (In short, the Republican Leadership does not want to have a block grant fight; they do want to blame us, however, for the need to stick with a per capita cap.) It remains unclear how both these groups will respond to your health investments. They will probably want to see how much room they have to operate under the new CBO baseline and how much steam your proposals pick up before being either overly supportive or critical.

We will keep you apprised of developments on the Hill with regard to the proposal to expand coverage to children. In brief, Senator Daschle and Congressman Gephardt are pushing for a fairly expensive and difficult to administer tax credit; Senators Kennedy and Kerry are advocating for a costly subsidy program; and Senators Rockefeller and Chafee appear to be quietly working on more modest, targeted approaches. Tomorrow the Democrats are scheduled to hold a press conference on Kid's Health Initiative.

Because of the interest in tax credits/deductions by the Leadership (and perhaps some Republicans), we will write you a separate memo on the strengths and weaknesses of this type of approach. Even though there may well be insurmountable administrative and structural problems (e.g., the amount of substitution of private and state dollars that takes place with higher subsidies and tax credits/deductions), being overly critical of any kids' investment proposal seems unwise until after the Congress has locked in on an investment number for a kids coverage expansion.

* **There will be double-counting or overlap in a number of our policies. We believe, however, that our future Medicaid outreach initiatives (which are not now scored in the budget) will make it possible for us to credibly claim that your policies will expand coverage to about 5 million children. Having said this, since there appears to be an increasing uninsured problem, coverage of 5 million more children may not represent half the uninsured children in 2000. Therefore, while many will infer we are going to address "half" of the problem, we may want to avoid specifically stating it ourselves until/unless we get outside validation for doing so.**