

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.

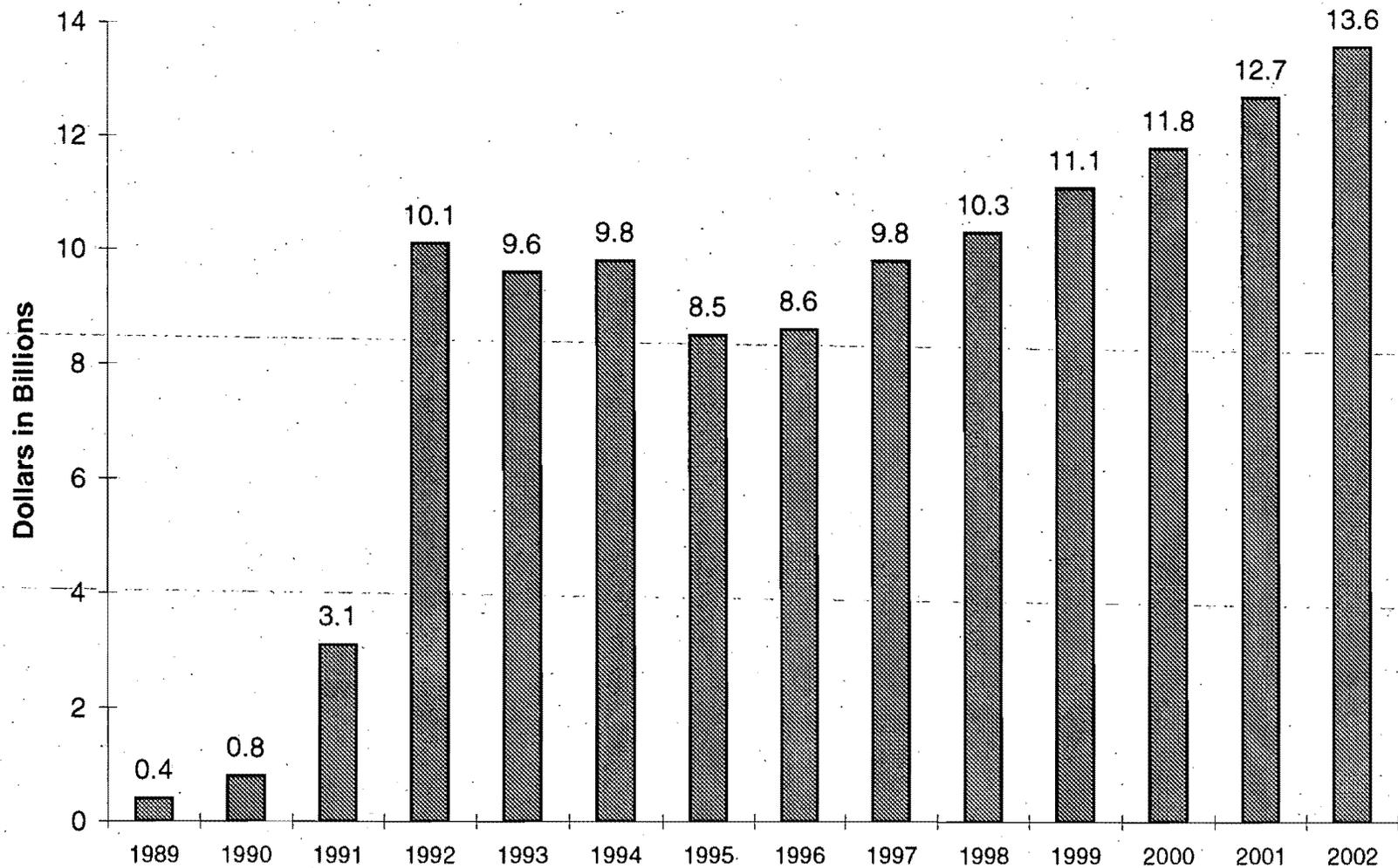
- **It invests about \$13 billion in policies such as:**
 - Allowing States to extend 12 months of continuous coverage to children, and
 - Restoring coverage for some groups who lost it as a result of last year's welfare reform law.

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

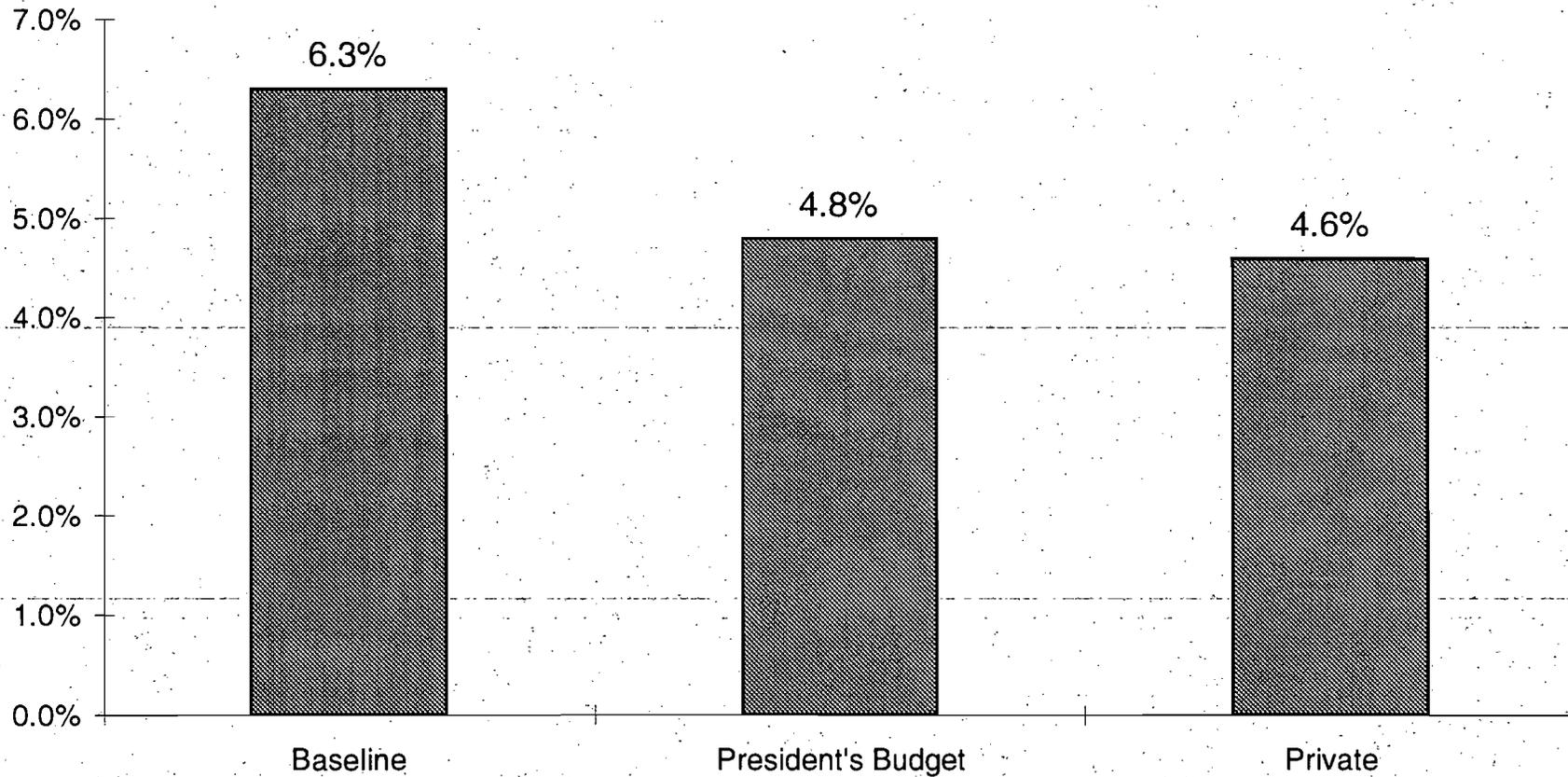


Projections based on CBO's projections of Medicaid spending per beneficiary (including DSH) January 1997

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

MEDICAID FY 1998 PROPOSALS

STATE FLEXIBILITY AND NEW INVESTMENTS

PROMOTING STATE FLEXIBILITY

Increase Flexibility in Provider Payment

o 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.

o 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

o 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.

o **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

o **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.

o **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.

o **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.

o **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.

o **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

o **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.

o **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.

- o **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.

- o **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.

o **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

o **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.

o **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.

o **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.

o **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.

o **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.

o **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.

File (15)

House Budget

**RECONCILIATION HEALTH PROVISIONS
MEDICAID**

	HOUSE	SENATE	ADMIN. POSITION	STATUS
Coverage of SSI Kids	Option to cover certain SSI kids	Not included	Support neither Budget Agreement	Members' issue
DC, Territories	Neither	DC included but not 70%; Includes Territories but w/ different levels	Support Senate if: Higher FMAP	Members' issue
Medicare Premium Assistance for Low-Income Benes	Medicaid pays full premium w/ 100% Federal matching to 135% of poverty; 100% of extra premium to 175% of poverty	Medicare block grant through Medicare	Support House if: Replace 100% extra premium with 100% full premium for higher than 135% of poverty	Members' issue
Cost Sharing for optional coverage	Current Law	Allows states to require limited cost sharing for optional eligibles	Support House	Members' issue but may be accepted by Democrats if subject to comparability, statewideness, and anti-discrimination provisions
DSH Allotments	High-DSH get twice the cut as low-DSH	High-DSH get higher cuts; states using MH DSH get greater cuts	Support neither Prefer some protection for high-DSH states	Members' issue [bipartisan workgroup to begin meeting 7/14]
DSH Retargeting	Excludes DSH from managed care payments	States must prioritize hospitals; Limits payments to Mental Hospitals	Support House & Senate if: Add Federal standard for formula	House is in; Others are Members' issues
Repeal of Cost-Based FQHC/RHC payments	Phase out cost-based reimbursement	No provision	Support repeal if some protection for clinics	Members' issue
1115 demo. extensions	Extend 1115 w/ budget neutrality	Extend 1115 regardless of budget neutrality; exception for AZ	Support House budget neutrality w/ provision for AZ	Members' issue

leg.

	HOUSE	SENATE	ADMIN. POSITION	STATUS
Return to Work	None	Includes demonstration to allow workers with disabilities to buy in	Support Senate, if: Raise income eligibility ceiling from 250% of poverty (too low)	Members' issue
Asset Divestiture	None	Amends HIPAA to provide sanctions for people who help in disposing assets	Oppose Senate Current laws are sufficient	Receded to Senate
Data	Requires MMIS data	None	Support House	Receded to House
Alaska FMAP	None	Increase to 59.8%	Oppose Senate	Members' issue
MC Lock In	6 months	12 months	Support House	Receded to Senate
Privatization	Includes	No provision	Oppose House	Receded to House
Waiver of NY provider tax	No provision	Included	Oppose Senate	Members' issue
Breast cancer coverage	No provision	Included	Support Senate [note: may need to reconsider]	Members' issue
MC Quality	[many]	[many]	Support in general	Resolved at staff level

MEDICAID & CHILDREN IN THE HOUSE AND SENATE BILLS

(FY 1998-2002, in billions of dollars)

	HOUSE	SENATE
MEDICAID SAVINGS		
Budget Agreement		
DSH (1)	-13.1	-12.3
Boren	-1.2	-1.2
FQHC Payment Reform	-0.3	-
Other		
Medicaid Rates for Medicare Cost Sharing (2)	-	-5.0
Veterans' pension treatment	-	-0.1
SUBTOTAL	-14.6	-18.6
SPENDING		
Budget Agreement		
DC	-	0.3
PR and Territories	-	0.2
Premium Asst. for Medicare Benes (3)	1.5	0.0
Indirect Effect of Medicare Changes (4)	1.1	1.9
Children		
SSI children (5)	0.0	-
12-Month Continuous Eligibility	0.7	0.1
New Enrollment	0.6	2.6
OBRA Children Phase-In	-	0.4
Presumptive Eligibility	0.4	-
Other		
Working Disabled	-	0.0
Access to Emergency Care	0.1	0.1
Emergency Services for Aliens	0.1	-
Assuring adequate managed care payments	0.0	0.2
Alaska Match	0.0	0.2
Optional coverage breast cancer	-	0.1
Waiver of Certain Provider Tax Provisions	-	0.2
Continuation of 1115 Waivers	-	0.8
Coverage of Physician Assistants	0.1	-
SUBTOTAL: WITH CHILDREN'S HEALTH	4.6	7.1
SUBTOTAL: WITHOUT CHILDREN'S HEALTH	2.9	4.0
TOTAL MEDICAID: WITHOUT CHILDREN'S HEALTH	-11.7	-14.6
CHILDREN		
Grants (6)	14.2	23.6
Medicaid Spending	1.7	3.1
TOTAL CHILDREN	15.9	26.7

- (1) House DSH offset is lower because CBO assumes that states direct some of the children's funds to these hospitals. Senate DSH savings includes savings from reducing payments to menal hospitals.
- (2) This policy increases Medicare costs by +\$2.9 billion for a net effect of -\$3.1 billion
- (3) The Senate includes a Medicare block grant of \$1.5 billion for this purpose
- (4) The higher cost in the Senate is due to the home health copayment.
- (5) House includes a state option that costs \$45 million over 5 years.
- (6) Includes the \$8 billion from the 20-cent tobacco tax.

BUDGET ISSUES: MEDICAID AND CHILDREN'S HEALTH

MEDICAID

- **Low-income Medicare beneficiary premium protection:**
 - Support House's Medicaid approach (versus Senate's Medicare block grant); support payment of premium, not home health component only
- **DC, Territories, coverage for certain disabled children:**
 - Maintain budget agreement commitments
- **DSH retargeting:**
 - Support Senate's provisions that states prioritize payments to hospitals and phase down payments mental hospitals

CHILDREN'S HEALTH

- **Funding:**
 - Support Senate's \$8 billion revenue from tobacco tax for children's health (other \$6 billion for other children's needs) but with no sunset after 2002. Also, funds in budget should increase annually to account for inflation and enrollment growth.
- **Meaningful benefits:**
 - Support Senate's FEHBP Blue Cross / Blue Shield. If list of options is substituted for FEHBP-only option, could accept most popular state employee HMO plan (may want to specify that it includes well child care) and recommendation from American Academy of Pediatrics as well as FEHBP. Make certain that each plan option includes basic benefits including mental health, vision and hearing.
 - Support Senate's cost sharing protections for children below 150% of poverty; could compromise to allow it to be nominal cost sharing.
- **Accountability:**
 - Oppose House's direct service option which CBO assumes will be funneled to DSH hospitals to reduce their cuts. Support House and Senate's exclusion of mandatory and optional Medicaid children; Senate's financial maintenance of effort if narrowed; Senate's ban on provider taxes and donations for state share.
- **Efficiency:**
 - Support variation on the Senate formula that gives extra matching rate for any new child enrolled in Medicaid (including children currently eligible but not enrolled). Support provision of higher matching rate (or requirement) for states to use schools to education and/or enroll children in programs.

THE PRESIDENT'S FY 1998 BUDGET: PER CAPITA CAP & DSH REDUCTIONS IN THE MEDICAID PROGRAM

The President's budget saves \$9 billion in net savings over five years and takes a number of steps to preserve and strengthen the Medicaid program. It preserves the guarantee of coverage for the 37 million low-income children, pregnant women, people with disabilities, and older Americans who depend on Medicaid for basic health coverage and long-term care, while at the same time strengthening Medicaid's fiscal discipline and building on the success of the past few years in constraining excessive growth in spending.

- **Contains Important Investments in Medicaid.** The President's budget invests about \$13 billion in expanding coverage for eligible children, restoring coverage for some groups who lost it as a result of last year's welfare reform law, and contains other investments, including helping people with disabilities who earn above a certain income level retain their Medicaid coverage.
- **Recognizes That Medicaid Spending Growth Has Slowed and Achieves Modest Savings.** The \$22 billion in gross savings comes from two sources:
 - **Reducing DSH.** Two thirds of the savings, or roughly \$15 billion, comes from reducing the amount the Federal government spends on so-called "disproportionate share hospitals" (DSH).
 - **Implementing a Per Capita Cap.** One third of the savings, or roughly \$7 billion, comes from a "per capita cap" policy that will limit Federal Medicaid spending growth on a per-beneficiary basis.
 - **Funding the Transition.** These savings are net of a \$2.4 billion investment to assist States and providers in the transition to the new DSH and per capita cap policies. About \$1.4 billion over five years will be included in a supplemental fund to help cover the costs of care delivered in Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). In addition, \$1 billion over five years is reserved for a "transition pool" to assist States and safety net providers that are disproportionately affected by the new policies.
- **Reduces DSH Spending (Net Savings of \$15 Billion Over Five Years)**
 - **Controlling DSH Spending.** The Federal government will spend about \$10 billion on DSH in FY 1998, which is an important source of support for many hospitals that serve a disproportionate number of Medicaid and low-income patients. In the late 1980's and early 1990's, DSH spending was growing at double-digit rates, and was the driving force in Medicaid's high growth rates. While DSH growth has moderated--partly because of changes made by the Congress and the Administration in 1991 and in OBRA 1993--both the HCFA actuaries and CBO's analysts believe that the growth will accelerate again.

- **Freezing DSH Spending at the 1995 Levels.** The Administration's policy essentially freezes DSH spending in 1998 at 1995 levels, with a gradual decline to \$8 billion in spending for FY 2000-2002. (Under the CBO baseline, DSH spending would have grown to about \$14 billion by 2002).
- **Distributing DSH Savings Fairly.** DSH savings are achieved by taking an equal percentage reduction from States' 1995 DSH spending, up to an "upper limit." If a State's DSH spending in FY 1995 is greater than 12 percent of total Medicaid spending in that State, the percentage reduction is applied to this 12 percent rather than the full DSH spending amount. This "upper limit" maintains the policy balance struck by Congress in the DSH provisions it enacted in 1991 and 1993, which recognized that some States' Medicaid programs are particularly dependent on DSH spending. Like those earlier Congressional enactments, this "upper limit" policy ensures that the few States with high DSH spending are not bearing most of the impact of the savings policy.
- **Better Targeting DSH Money.** The Administration believes that DSH dollars should be targeted to the providers that need them most: those hospitals that disproportionately serve a high volume of Medicaid patients, the uninsured, and low-income people. We continue to support better targeting of DSH funds. But because implementing a policy to target DSH funds more effectively is technically complex and could have potentially disruptive effects in some States and for providers, our policy does not specify a mechanism for targeting. We want to work with the Congress, the States, providers, policy experts and advocates to develop an appropriate targeting mechanism.
- **Helping FQHCs and RHCs Make the Transition.** To respond to the special needs of critical safety net providers, the President's plan includes a temporary fund of about \$1.4 billion over five years to help cover the costs of care delivered in FQHCs and RHCs. The Administration believes that this supplemental fund will help these providers during the transition to a per capita cap, and will also compensate for our proposed repeal of cost-based reimbursement for these facilities, effective in FY 1999.
- **Implements a Per Capita Cap (\$7 Billion Net Savings Over Five Years).** Under the per capita cap policy, Federal Medicaid spending growth will be limited on a per beneficiary basis. The per capita cap is designed to maximize States' responsiveness to the health care needs of their Medicaid populations. It does this by adjusting the cap when enrollment increases when, for example, there is an economic recession. The per capita cap will work as follows:
 - **Calculating the Cap.** The cap would be the product of three components:
 - 1) State and Federal spending per beneficiary in the base year (FY 1996), including administrative costs;

2) An index specified in legislation (for years between the base year and the current year); and

3) The number of beneficiaries in the current year.

To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the elderly, individuals with disabilities, non-disabled adults, and non-disabled children. The spending for each of the four groups would be combined to establish the spending limit for the State.

Each State would be able to use savings from one group to support expenditures for other groups or to expand benefits or coverage. Once the cap is calculated, it would be multiplied by the State matching rate to determine the maximum Federal spending in each state. The Federal match would continue until the capped amount for the State is reached.

- **Determining the Index.** The index we have used is the growth in nominal GDP per capita (based on a five-year rolling historical average), plus adjustment factors that account for Medicaid's high utilization and intensity. Over the budget period--1998-2002--the index would allow per capita spending to increase by an average of 5 percent per year. By 1999 and subsequent years, the index will be nominal GDP per capita plus 1 percent.
- **Finding the Most Appropriate Index.** Our policy development to this point has focused on an index based on the growth in nominal GDP per capita, but we are reviewing indexes that could more precisely reflect growth in health care costs, and in particular, the volume and intensity inherent in a program that serves many low-income people. Recognizing that there is a debate about which is the most appropriate index, we intend to work with the Congress, the States, policy experts, and other stakeholders in order to facilitate the development of the best index possible.
- **Exempting Spending From the Cap.** Certain aspects of Medicaid spending not tied to individual beneficiaries or not under direct control of the States would not be subject to the cap: vaccines for children, payments to Indian health providers and Indian Health Services, DSH payments, and Medicare premiums and cost-sharing for dual eligibles and qualified Medicare beneficiaries (QMBs). On the other hand, Medicaid expenditures for services and administration delivered under Section 1115 demonstration waivers would be subject to the per capita cap.
- **Assessing the Impact of the Per Capita Cap.** After 2000, when both the HCFA actuaries and CBO's analysts have indicated that they expect Medicaid spending growth on a per capita basis to rise more rapidly again, the per capita cap would constrain Medicaid growth per-person (for non-DSH benefits and administration) to about 5 percent per year.

If the Administration and the States are successful in holding spending growth per beneficiary to about 5 percent a year during this period--which is close to the annual growth rate CBO is projecting for private insurance on a per-person basis--the per capita cap will produce little to no savings. But if the projections that per capita spending growth will rise again turns out to be correct, the Administration's policy will prevent that increase from overtaking our balanced budget.

- **Creates Transition Pool for Those Who Are Disproportionately Affected By New Policy.** We also include about \$1 billion in capped "transition pool" funding over five years to assist States and safety net providers who are disproportionately affected by the Medicaid savings policies.

File California

Medicaid Talking Points for California

I am well aware of your concerns about a Medicaid per capita cap. You should know that we did not design this budgetary constraint mechanism to save significant dollars. We are advocating it to ensure that the program and the taxpayers who support it do not experience a return to the excessive growth rates we saw in the early 1990s.

The fact that our proposal only achieves \$7 billion in savings off of an over \$600 billion baseline illustrates that we are sensitive to the fact that program growth has declined recently. Moreover, the way we designed the per capita cap ensures that there is no significant savings from this mechanism until the turn of the century.

We recognize that some States, including California, are concerned because they have low per person spending in the base year which will be "locked in forever" in the per capita cap funding formula. We certainly do not want to punish States like California who run efficient Medicaid programs, and we are open to discussions about ways to protect against any unfair or disproportionate impact on the State.

Specifically, a number of Members of Congress have asked us to consider applying what is known as differential growth rates to States' Medicaid allocations to start to bring States which have higher base rates much closer to lower base rate states like California. We are working with them and would welcome any suggestions you may have in this regard as well.

I am also aware of your concerns about reductions in Disproportionate Share (DSH) spending. We have designed the savings to be particularly sensitive to California DSH concerns, but I am well aware that savings from this program will pose funding challenges for you. It is our belief, however, that our reinvestments in health coverage -- for children and for legal immigrants in particular -- will help offset DSH savings.

One great challenge will be to better target the remaining DSH dollars to institutions most in need. We are working on ways to do just that and we look forward to working with you on this issue as well.

Lastly, we are quite proud of our commitment to provide additional flexibility to States to better and more efficiently administer their Medicaid programs. Our elimination of burdensome waiver processes that stand in the way to expand into managed care and to provide new home and community based options to institutional care will be particularly empowering to States.

As we review different flexibility options, we welcome any thoughts you may have to make certain we strike the right balance between flexibility and accountability. You should all look at our upcoming discussions on reforming Medicaid as an opportunity to make the program more responsive to the needs of your constituents. I know that this is a mutual goal we both share.

File California
Mealcard
c8

CALIFORNIA

California is a rare example of a state that used to be a high disproportionate share (high DSH) state and, within the last two years, has become a low DSH state. The state and Congressional delegation lobbied hard and successfully for a modification in the Senate-passed DSH funding cut formula that provided for a special DSH freeze calculation. They wish to keep their formula and we are doing nothing to undermine their position. In fact, we are providing "technical" assistance to the budget leaders and are forwarding formulas that explicitly protect the "California" deal.

In addition, although we have consistently advocated for better DSH targeting within the Medicaid formula (a position that California opposes because they feel they already have a targeting mechanism that addresses our concern about hospitals disproportionately serving the uninsured), we have apparently lost the argument. All we are pushing for is a requirement that a state publish a state plan that indicates how they are going to protect vulnerable hospitals. California can more than live with that position.

Suggested Talking Points:

- We recognize the special Medicaid needs of the California delegation. As many of you know, before the original budget agreement was reached, we worked with you to drop the per capita cap provision from the agreement. We will work with you again in the budget agreement and I am confident we will work out an arrangement that is acceptable.
- We all recognize that Medicaid is going to make a contribution to deficit reduction. However, it will be a relatively modest one, particularly when compared with Medicare. However, there is no reason why we cannot mitigate unanticipated and overly negative effects of DSH savings.
- I understand the agreement you reached in the Senate is something you feel, at minimum, you need to have in the final package. It protects California from an overly harsh hit.
- I want you to know that, although Medicaid DSH savings formulas will no doubt change numerous times between now and the time the final balanced budget bill hits the President's desk, we believe that the basic outlines of the Senate agreement can and likely will be retained. We will do nothing to alter that course of action and (without going into details) we are working with the Hill on explicit ways to assure that end.
- Lastly, as you may know, we proposed to better target DSH dollars within the states to ensure that they went to the hospitals who were disproportionately serving the uninsured. We recognize that, since California has developed its own fairly well functioning formula, you may not have wanted this type of Federal direction. It looks like you will win that argument. I will take this opportunity to tell you that we will reluctantly accept that reality. (Buck any unforeseen problems to Chris J.)

Questions & Answers on Medicaid and Children's Health in the Mid-Session Review

- What are the differences in OMB and CBO scoring of the Medicaid provisions?

Net Medicaid savings from the BBA are \$14 billion over five years under CBO scoring and \$8.8 billion over five years under OMB scoring. The scoring of four policies (DSH, Boren Amendment, FQHC reimbursement, and Medicaid rates for Medicare cost sharing) contribute to most of the difference in the savings estimates. In general, the savings are lower under OMB scoring because the OMB Medicaid baseline is lower than the CBO baseline.

- Explain the Children's Health estimates.

Both OMB and CBO scored the Children's Health provisions with \$24 billion in costs over five years. Of the \$24 billion, roughly \$20 billion is for grants to States for the new program and \$4 billion is from Medicaid interactions with the new program.

- Why are five-year Medicaid savings \$0 in the Mid-Session Review?

The Balanced Budget Agreement format was a convenient way for the Administration and Congress to track the major categories of spending and savings during the budget negotiations. In addition to the Medicaid savings policies, many other parts of the budget (e.g., changes for immigrants and Veterans' programs) affected Medicaid indirectly. At the time, these effects were tracked separately.

When you shift to a more traditional budget accounting structure, with all of the changes to Medicaid tracked on a unified basis, OMB estimates that the total net effect on the Medicaid baseline will be \$0 over five years. CBO would estimate that the total net effect on the Medicaid baseline would be approximately \$7.2 billion in savings over the same period.

Medicaid and Children's Health
(Costs/Savings, \$ in Billions)

	Budget Agreement		CBO Scoring of BBA		OMB Scoring of BBA	
	98-02	98-07	98-02	98-07	98-02	98-07
Medicaid	-13.6	-65.5	-14.0	-48.0	-8.8	-31.0
Children's Health	16.0	38.9	23.9	48.1	24.3	51.5
Medicaid Immigrants	1.7	3.0	2.0	3.5	3.5	8.0
VA-Medicaid Costs	1.1	1.1	1.1	1.1	1.2	1.2

- The Budget Agreement called for net Medicaid savings of \$13.6 billion over five years. CBO scored net Medicaid savings of \$14.0 over five years from the BBA. OMB (the HCFA Actuaries) scored net Medicaid savings of \$8.8 billion over five years.

*consistent?
DEFINITION?*

*CP DJM =
OMB = 57.2
CBO = 59.6*

Four Medicaid savings proposals contribute to most of the difference in OMB and CBO scoring. Because the OMB Medicaid baseline is lower than the CBO baseline, the HCFA Actuaries assume less savings from: the new disproportionate share hospital (DSH) payment limits; the repeal of the Boren Amendment; the elimination of 100 percent of cost reimbursement for Federally-qualified Health Centers; and allowing States to pay Medicaid rates for Medicare cost-sharing obligations.

- OMB and CBO scoring of the Children's Health proposals is roughly the same. Of the \$24 billion in spending on children's health over five years, approximately \$20 billion is for grants to States and approximately \$4 billion is from increased Medicaid spending related to children's health. The Budget Agreement called for \$16 billion in spending over five years. The BBA included a tobacco tax, which increased spending on Children's Health to \$24 billion over five years.
- The FY 1998 Mid-Session Review will include OMB scoring of Medicaid and Children's Health provisions in the BBA. Medicaid and Children's Health scoring will be displayed two different ways in the document. The document will show savings and spending that match the categories outlined in the Budget Agreement. The document will also show a total Medicaid savings estimate that includes the effects of all of the BBA proposals (Medicaid, Children's Health, Immigration, and Veterans' proposals) on Medicaid.

- The following tables show the two ways Medicaid savings will be displayed.

Display Similar to the Budget Agreement (Costs/Savings, \$ in Billions)

	1998- 2002	1998-2007
Net Medicaid Savings	-8.8	-31.0
Children's Health*	24.3	51.5
Immigration (total will include Medicaid and SSI costs)	total will include 3.5 in Medicaid	total will include 8.0 in Medicaid
Net Savings from Veterans' Proposals (total will include VA savings and Medicaid costs)	total will include 1.2 in Medicaid	total will include 1.2 in Medicaid

* Children's Health total includes \$4 billion in Medicaid costs over five years, and \$11.8 billion over ten years.

Display Showing a Comprehensive Medicaid Total (Costs/Savings, \$ in Billions)

	1998-2002	1998-2007
Total Medicaid Savings	0.0	-10.0
Children's Health	20.3	39.7

**Medicaid Baseline Comparison - OMB and CBO Post-Reconciliation Baselines
(Fiscal Years, \$ in Billions)**

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 98-02	Growth 97-02	Total 98-07	Growth 97-07
OMB Baseline															
FY 1998 Mid-Session Review Baseline	97.5	103.7	110.7	119.2	128.6	138.6	150.3	163.1	177.3	192.5	209.0	600.8		1,493.0	
Growth		6.3%	6.8%	7.6%	7.9%	7.8%	8.4%	8.5%	8.7%	8.5%	8.6%		7.3%		7.9%
Total Medicaid Effects of 1997 BBA*	0.0	1.1	0.7	-0.1	-0.7	-1.1	-1.6	-1.8	-2.0	-2.1	-2.3	0.0		-10.0	
FY 98 MSR "Post-BBA" Baseline	97.5	104.8	111.5	119.0	127.9	137.6	148.7	161.3	175.3	190.3	206.7	600.7		1,483.0	
Growth		7.4%	6.4%	6.8%	7.5%	7.5%	8.1%	8.5%	8.7%	8.6%	8.6%		7.1%		7.8%
CBO Baseline															
January 1997 CBO Baseline	98.6	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	
Growth		6.8%	7.9%	8.1%	8.1%	8.3%	8.4%	8.2%	8.6%	8.6%	8.7%		7.8%		8.2%
Total Medicaid Effects of 1997 BBA*	0.0	0.6	-0.4	-1.4	-2.9	-3.7	-4.5	-5.2	-5.8	-6.7	-7.7	-7.7		-37.7	
CBO "Post-BBA" Baseline	98.6	105.9	113.2	121.4	129.9	140.1	151.3	163.5	177.3	192.2	208.6	610.6		1,503.5	
Growth		7.4%	6.9%	7.3%	7.0%	7.9%	8.0%	8.1%	8.4%	8.4%	8.5%		7.3%		7.8%

*Includes Medicaid effects of Children's Health, Welfare, Medicare, and Veterans' Provisions



OMB MIDSESSION REVIEW (MSR): HEALTH ESTIMATES

MEDICARE

Savings:	OMB	CBO
	\$150 billion over 5 years	\$112 billion over 5 years*
	\$270 billion over 7 years	\$200 billion over 7 years
	\$513 billion over 10 years	\$386 billion over 10 years

* OMB counts some Medicare that appears in the Medicaid tables against the \$115 b.

ARGUMENTS AGAINST RELEASING OMB ESTIMATES

- **CBO has already projected a surplus:** If we add a new, different set of numbers, it will change the focus from the idea that there is a surplus to why are they different.
- **Equal to vetoed \$270 billion:** 7-year savings is the exact same number -- \$270 billion -- that we vetoed in 1995.
- **Higher than CBO's final scoring of the Republicans' 1995 budget:** OMB's 7-year savings of \$270 billion is higher than the CBO December 1995 estimate of \$226 billion for the Republicans' 1995 budget.
- **Overestimated savings means underestimated deficit:** If the savings are overestimated, OMB will have to increase their deficit projections in December's baseline.

MEDICAID

Savings:

	OMB	CBO
	\$9 billion (0) over 5 years	\$14 billion (7) over 5 years
	\$31 billion (10) over 10 years	\$48 billion (35) over 10 years

* The unbracketed number include spending according to the budget agreement format; the bracketed numbers are OMB's method of counting (includes kids', immigrant, and VA spending).

Concerns:

- **No savings.** OMB wants to display Medicaid numbers so that there are no savings.

How to explain if released:

- **Baseline differences:** OMB assumes that there is lower Medicaid spending in the areas affected by the budget than CBO.

CHILDREN'S HEALTH

Spending:

	OMB	CBO
	\$24 billion (20) over 5 years	\$24 billion (20) over 5 years
	\$52 billion (40) over 10 years	\$48 billion (40) over 10 years

* The unbracketed number include spending according to the budget agreement format; the bracketed numbers do not include the Medicaid children's spending.

Concerns:

- **5 million children covered?** Since costs should be based on coverage, people will appropriately ask if OMB assumes that 5 million children are covered. OMB will not take responsibility for that number.

How to explain if released:

- **Up to 5 million children covered:** The Administration has consistently estimated that up to 5 million uninsured children will be covered by the children's health initiative. In contrast to CBO, we believe that states are more likely to use the Federal funds for coverage than to replace existing state spending.

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

	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>	<u>Total 1998 - 2002</u>	<u>Total 1998 - 2007</u>
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)

	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>	<u>Total 1998 - 2002</u>	<u>Total 1998 - 2007</u>
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/ DSH	0.0	-0.5	-1.5	-2.6	-3.9	-5.4	-6.8	-8.7	-11.1	-13.8	-8.5	-54.3
	-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)

	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>Total 1998 - 2002</u>	<u>Growth 1997 - 2002</u>
<u>CBO January 1997 Baseline</u>									
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%
<u>CBO Scoring of Final FY 1998 President's Budget</u>									
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%
<u>Per Capita Cap Assumptions:</u>									
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%
<u>Estimates of CBO's Private Spending Growth Per Privately Covered Person</u>									
Growth		3.8%	4.9%	4.8%	4.8%	4.6%			4.6%

President Clinton Fought to Protect The Most Vulnerable People

Several provisions in last year's welfare reform bill had nothing to do with the goals of welfare reform. The President said so at the time and promised to work to correct these provisions. He fought to ensure that any agreement protects the most vulnerable in our society.

THE PRESIDENT FOUGHT TO BETTER PROTECT:

CHILDREN

- ✓ **Food Stamps.** Helps put food on the table for ten million American children each month. Last year's welfare reform bill cut food stamps too deeply -- especially for families with children with high housing costs. To help ameliorate these cuts, President Clinton restores the link between benefits for such families and housing costs.
- ✓ **Keeping the Federal Guarantee to Medicaid.** President Clinton fought to preserve the federal guarantee to Medicaid coverage for the vulnerable populations who depend on it.
- ✓ **Medicaid Preserved for Vulnerable Children.** President Clinton fought to allow children now receiving Medicaid to keep their coverage if they lose their SSI eligibility following last year's definitional change.
- ✓ **Medicaid for Legal Immigrant Children.** Because it is the right thing to do, the President worked to ensure that Medicaid covers legal immigrants' children whose families are impoverished.

LEGAL IMMIGRANTS WITH DISABILITIES

- ✓ **Restore SSI and Medicaid.** President Clinton believes, as many Americans do, that law-abiding immigrants who pay taxes, play by the rules, but are disabled should have access to the basic benefits of SSI and Medicaid.

PEOPLE WHO WANT TO WORK BUT CAN'T FIND A JOB

- ✓ **Food Stamps for Childless Adults.** Last year's welfare reform bill harshly restricted food stamps to unemployed childless adults to three months over a 36 month period. This time restriction ignores that finding a job takes time. President Clinton proposes an alternative six month out of 12 restriction. Additionally, this budget establishes new funding to support close to an additional 400,000 more work slots from 1998 to 2002.

FINISH THE JOB OF WELFARE REFORM

- ✓ **Give States and cities the help they need to place the most disadvantaged welfare recipients in lasting jobs.** The Welfare-to-Work Jobs Challenge created by the President would make available the resources needed for States and cities to move one million of the hardest-to-serve recipients into paid employment and keep them there. States and localities could use the WTW Jobs Challenge funds for wage subsidies to private employers, transportation and other post-employment supportive services essential for job retention, and other effective job creation and placement strategies.

- ✓ **Provide incentives for private employers to give welfare recipients the chance they need.** Most welfare recipients very much want to work. The President's welfare-to-work tax credit allows employers to claim a credit of up to 50 percent of the first \$10,000 in wages paid during a year to a worker who had been on welfare for a prolonged period of time. The credit is available for up to two years of work, giving employers a considerable incentive to not just hire but make efforts to retain long-term welfare recipients.

POTENTIAL CHILDREN'S HEALTH INITIATIVES

1. Base Proposal: Premium Assistance to Families with Workers in Transition

Cost and Number Benefiting: About \$2 billion per year. Our FY97 Budget assumed about \$9 billion over 4 years. Our FY97 Budget proposal was estimated to help about 3 million people each year, including 700,000 children. Funding the program for 5 years would increase the number of adults and children helped, but would cost about \$3 billion in 2002.

2. Target the 3 Million Children Now Eligible But Not Receiving Medicaid

Cost and Number Benefiting: \$500-\$800 per child per year, so expanding coverage to 1 million of the 3 million eligible but not enrolled cost the federal government \$500-\$800 million a year.

3. Add State Options to Further Expand Coverage.

Cost and Number Benefiting: Unknown at this time, but because this approach would provide for greater flexibility in designing benefits and copayments, and would -- at states' option -- extend eligibility of children's coverage from one to 12 months, states and health plans would likely be very interested in pursuing this approach.

4. Grants to States to Develop Innovative Partnerships to Insure Children

Cost and Number Benefiting: Flexible. A \$100 million per year federal program could provide preventive service insurance for 2 million children or traditional insurance coverage for 180,000 children. So, for example, a \$550 million investment could provide traditional coverage to about 1 million children. The proposal could be a demonstration or a national program.

5. Health Care to Children in Targeted Communities Through Health Centers

Cost and Number Benefiting: Flexible. Each \$100 million a year could provide services to 500,000 children through school based health centers or to 1 million people including 440,000 children through CHCs each year.

6. Set-Aside Funding to Expand Health Insurance or Services to Children Through Medicaid, Grants to States, and/or Tax Credits.

President Worked to Modernize and Strengthen Medicare and Medicaid

THE PRESIDENT REJECTED THE 1995 REPUBLICAN BUDGET IN LARGE PART BECAUSE OF DEEP CUTS IN MEDICARE AND MEDICAID.

THE 1995 REPUBLICAN BUDGET CONTAINED DANGEROUS MEDICARE STRUCTURAL REFORMS THAT WOULD HAVE UNDERMINED THE PROGRAM AND IMPOSED PREMIUMS AND BURDENS THAT WOULD HAVE HURT OLDER AND DISABLED AMERICANS. IT WOULD HAVE:

- ✂ **Increased premiums from 25% of Part B program costs to 31.5%.** These higher costs would have placed a large financial burden on Medicare beneficiaries -- three-quarters of whom have incomes below \$25,000. In 1996 alone, this would have increased costs per elderly couple by \$268.
- ✂ **Eliminated balance billing protections,** allowing doctors in the new private fee-for-service plan options to overcharge above Medicare's approved amount leaving the elderly vulnerable to higher costs and giving doctors in the fee-for-service program an incentive to switch to private health care plans, reducing access for beneficiaries in the traditional plan.
- ✂ **Encouraged "Cherry Picking" that would have harmed beneficiaries and damaged the Medicare program.** The Republican proposals would have introduced nationwide health plan options, such as medical savings accounts and risky "association" plans, that would have led to risk selection, thereby increasing the costs of what would be a sicker and weaker traditional Medicare program.
- ✂ **Included only \$100 million in investments in preventive benefits.**
- ✂ **Repealed the Medicaid program and replaced it with a block grant.** The plan would have eliminated the Federal guarantee Medicaid provides to poor families. In 2002 alone, 8 million people could have lost their health coverage, because of inadequate funding. In addition, as many as 330,000 people could have been denied nursing home coverage.
- ✂ **Eliminated the guarantee of Medicaid coverage of Medicare deductibles, copayments, and premiums** for older Americans and people with disabilities near or below the poverty line known as "Qualified Medicare Beneficiaries (QMBs)". They set aside less than half the money needed to cover premiums for QMBs and set aside no funding for deductibles or copayments. More than 5 million elderly and disabled poor Americans would have lost their guarantee that Medicaid covers Medicare cost-sharing.

THE PRESIDENT WORKED TO EXPAND COVERAGE FOR CHILDREN

**TEN MILLION AMERICAN CHILDREN TODAY
LACK HEALTH CARE COVERAGE.**

THE 1995 REPUBLICAN BUDGET WOULD HAVE MADE THE PROBLEM WORSE. IT WOULD HAVE:

- ✂ **Created Block Grant that would have increased the number of uninsured children.** The 1995 Republican budget even failed the “do no harm” in the areas of children’s health. That budget eliminated the guarantee of a meaningful Medicaid package for poor children and attempted to replace Medicaid with an insufficiently funded block grant program.
- ✂ **Would have forced states to decrease the number of insured children** by as many as 3.8 million due to a lack of sufficient funds, according to a study by the Department of Health and Human Services.
- ✂ **Eliminated the Medicaid phase-in for children between the ages of 13 and 18.**

THE PRESIDENT’S CHILDREN’S HEALTH INITIATIVE EXPANDS HEALTH CARE COVERAGE FOR MILLIONS OF CHILDREN.:

- *THE PRESIDENT FOUGHT TO ENSURE THAT ANY BALANCED BUDGET AGREEMENT EXPANDS CHILDREN’S HEALTH COVERAGE. HIS CHILDREN’S HEALTH INITIATIVE PROVIDES HEALTH COVERAGE FOR AS MANY AS 5 MILLION ADDITIONAL CHILDREN BY:*
 - ✓ **Improving Medicaid and Adding Medicaid Investments.** The President’s budget works to enroll as many of the 3 million children who are eligible but not enrolled for Medicaid, to expand coverage to children who are above the current income eligibility standards, to provide additional coverage to children and legal immigrants.
 - ✓ **A New Capped Mandatory Grant Program That Provides Additional Dollars to Leverage Federal dollars to Supplement States Efforts** to cover uninsured children in working families.

EXPAND CHILD HEALTH COVERAGE TO AS MANY AS 5 MILLION CHILDREN

- **Children's Health Initiative.** President Clinton has proposed measures that would lead to health coverage for as many as 5 million additional children and includes:
 - ✓ **Medicaid Improvements and Added Medicaid Investments.** The President's budget works to enroll as many of the 3 million children who are eligible but not enrolled for Medicaid, to expand coverage to children who are above the current income eligibility standards, and to provide additional coverage to children and legal immigrants.
 - ✓ **A New Capped Mandatory Grant Program That Provides Additional Dollars to Leverage Federal dollars to Supplement States Efforts** to cover uninsured children in working families.

STRENGTHENED AND MODERNIZED MEDICARE AND MEDICAID

- **Comprehensive Structural Reforms and Improvements.** The President's Medicare proposals make the changes necessary to modernize Medicare and prepare it for the retirement of the baby-boom generation while placing no undue burdens on beneficiaries.
 - ✓ **Contains important structural reforms** that will modernize the Medicare program, preparing it for the Baby Boom generation.
 - ✓ **Extends the solvency of Medicare Trust Fund for at least a decade**
 - ✓ **Provides beneficiaries more options and better information**
 - ✓ **Expands coverage of critical preventive treatments of diseases** such as diabetes and breast cancer.
- **The President remains strongly committed to preserving the federal Medicaid guarantee, while**
 - ✓ **Giving states unprecedented flexibility,** and
 - ✓ **Protecting the Federal Treasury from increased Medicaid costs.**
 - ✓ **Improving Medicaid and Investing for Additional Populations.**

STRONGER ENVIRONMENTAL PROTECTION AND ENFORCEMENT

- **Increasing our Efforts to Safeguard our Resources.** President Clinton is committed to increasing our efforts to safeguard our natural resources as well as ensuring the public health. He has proposed to:
 - ✓ **Accelerate Superfund cleanups** by almost 500 sites by the year 2000.
 - ✓ **Expand the Brownfields Redevelopment Initiative** to help communities cleanup and redevelop contaminated areas with grants and targeted tax incentives.
 - ✓ **Boost environmental enforcement by 9 percent** to protect public health from environmental threats.
 - ✓ **Better protect national parks** through increased funding and improvements.

PROTECT THE MOST VULNERABLE

- **Doing What's Right to Help our Most Vulnerable People.** The Welfare Reform Bill signed last year included overly deep cuts -- unrelated to welfare reform -- that affect legal immigrants, children, and individuals looking for, but unable to find work. President Clinton is seeking to address these problems.
 - ✓ **Restore basic health and disability benefits for immigrants unable to work due to disability.**
 - ✓ **Restore Medicaid coverage for poor legal immigrant children, and all children who lose SSI benefits as a result of changes in the definition of childhood disability.**
 - ✓ **Give refugees and asylees more time to naturalize.**
 - ✓ **Delay imposition of the food stamp ban until October 1, 1997** to give immigrants who are attempting to naturalize time to complete the process.

Welfare Reform
(outlay savings in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	5-Year Savings	10-Year Savings
Immigrants	--	2.7	2.6	2.5	2.0	2.0	2.0	2.0	2.0	1.9	2.0	11.8	21.6
Food Stamps	--	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	1.6	3.3
Welfare to Work	--	0.3	0.5	0.6	0.2	--	--	--	--	--	--	1.6	1.6
Welfare reform, net	--	3.3	3.4	3.4	2.5	2.4	2.4	2.3	2.3	2.3	2.3	15.0	26.5

(Numbers may not add due to rounding)

Description

Immigrants

- Current recipients and new applicants. Restore SSI and Medicaid benefits for all legal immigrant adults who are currently receiving SSI and Medicaid who became disabled after entering the U.S. Provide access to SSI and Medicaid to all legal immigrants who became disabled after entering the U.S. and who are not currently receiving benefits if the immigrant entered before their sponsor was required to sign a legally binding affidavit of support (May, 1997).
- New entrants. Retain SSI and Medicaid for new entrants who become disabled after entering the U.S. New entrants who apply for disability benefits and have legally binding affidavits of support from their sponsors would have the income of their sponsor deemed to them.
- Children. Restore SSI for approximately 6,000 legal immigrant children currently receiving SSI. Provide access to SSI and Medicaid for legal immigrant children who are not currently receiving benefits and do not have legally binding affidavits of support. New entrant children who have legally binding affidavits of support would have the income of their sponsors deemed for SSI and Medicaid.
- Refugees and asylees. Lengthen the exemption for refugees and asylees from the first 5 years in the country to 7 years for SSI and Medicaid.

Food Stamps

- Retain "3 in 36" time limit but redirect \$470 million in existing Food Stamp Employment and Training Program funds and add \$375 million in new funding to create an additional 120,000 work slots monthly for individuals subject to the time limits (includes the cost of providing on-going benefits to individuals fulfilling the work requirements)
- Permit States to exempt 10 percent of the individuals who would lose benefits because of the time limit, enabling States to exempt 40,000 individuals who want to work but are unable to find a job within the three-month time limit.

Welfare to Work

- Add \$1.6 billion to TANF, allocated to States through a formula and targeted within a State to areas with poverty and unemployment rates at least 20 percent higher than the State average. A share of funds would go to cities with large poverty populations commensurate with the share of long-term welfare recipients in those cities. Eligible activities include job retention services; job retention or creation vouchers; and private sector wage subsidies for new jobs lasting 9 months.
- [Include tax incentives to create job opportunities for long-term welfare recipients. The new credit would give employers a 50% credit on the first \$10,000 a year of wages for up to 2 years. Also expand the existing WOTC to able-bodied childless adults ages 18-50 who face work and time limit requirements.]

May 1, 1997