



Medicaid Restructuring Plan

RESTRUCTURING MEDICAID

Concepts, Issues, and Alternatives

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INTRODUCTION

As part of a broader strategy to balance the federal budget, the U.S. Congress has adopted a budget resolution that includes expenditure targets to reduce the rate of growth in costs of the Medicare and Medicaid programs. As individual entitlements, these programs are designed to adjust automatically to increases in the number of eligibles and to increases in program costs and utilization. As a result, there is no upper limit on annual program spending growth. In the case of Medicaid, the program is projected to grow at more than ten percent each year for the next five to seven years—a rate in excess of twice the consumer price index.

This paper will examine some of the major issues in restructuring Medicaid. It begins with a presentation of program flexibility issues associated with the current Medicaid program. This is followed by a brief discussion of why differences exist among states in current Medicaid expenditures. The third section examines the financing and policy issues that surface when limiting the growth of Medicaid. Finally, the last section identifies some specific programmatic issues that arise under a capped entitlement. An appendix is included that highlights the basic elements of the Medicaid program.

This paper is designed solely to stimulate discussion. In some cases, alternatives and options will be presented. In other cases, not. The alternatives and options are intended to help define the breadth of the issues, not to limit the debate. In short, this paper is not an endpoint, but rather it is a beginning.

PROGRAM FLEXIBILITY

For the last five years, Governors have been unified in their call for more flexibility in the Medicaid program. NGA flexibility proposals were developed within the context of a program that has an individual entitlement to eligibility and services. Governors' calls for flexibility focused on service delivery systems with less emphasis on eligibility and benefits. With proposals under consideration that could eliminate all or part of the Medicaid individual entitlement, the scope of flexibility is virtually boundless. Flexibility discussions take on an air of a federalism debate. Specifically, what level of direction, oversight, and accountability should be retained at the federal level when the federal government is making a significant financial contribution to the program, but the state has responsibility for its design and implementation. For example, the most flexible proposal for Medicaid is one where there are no federal parameters on eligibility, benefits, service delivery systems, and quality assurance; nor are there any maintenance-of-effort requirements for state spending. The following is a listing of major program areas and alternatives for flexibility.

ELIGIBILITY

The current Medicaid program specifically defines who is eligible for Medicaid services. The federal statute defines nine mandatory eligibility groups and allows states to choose from an additional seven. In broad terms, the program covers certain poor adults, poor pregnant women and children, certain persons with disabilities and certain elders in need of long term care.

There are several broad options that might be considered in making eligibility more flexible for states. The following is a list of some of those options. This list is not exhaustive.

1. **Total State Discretion.** The federal law would be completely silent on who is eligible for the program and would leave the decision solely to states.
2. **Minimally defined optional categories.** The federal law would stipulate that federal funds must be spent in some general categories like poor families and children, persons with disabilities, the elderly. States would be given the option to operationally define the categories by setting income or age limits and defining disability according to state standards.
3. **Explicitly defined optional categories.** The federal law would stipulate that states could use federal funds to provide care to only certain categories of people; for example, children and adults below 100 percent of poverty, persons needing nursing home care below 200 percent of poverty. States could select from among these categories. However, there would be no entitlement to benefits if one met those eligibility criteria.
4. **Mandatory categories.** The federal law would stipulate who is eligible for the program and that they are entitled to some level of care if they meet the eligibility requirements.

BENEFITS

Federal Medicaid statutes explicitly define services that are reimbursable under the program. Currently the program has thirteen mandatory services categories. States may choose to offer up to 33 other services. (It should be noted that these optional services are only for the adult population. All services are mandatory for any child under age 22 currently enrolled in the program.) There are several broad options that might be considered in defining service categories that are more flexible for states. The following is a list of some of those options. This list is not exhaustive.

1. **State Discretion as to Covered Services.** The federal law would be completely silent on what services are allowable under the program. All decisions would be left to each state.
2. **Optional Covered Services.** The federal law would stipulate that states could use federal funds to provide care in certain categories (e.g., inpatient services, outpatient services, physician visits, home health care). States would be free to select from the options, determine the amount duration and scope of services, and set reimbursement rates. However, there would be no entitlement to benefits. Under this option, the federal government would set up parameters for the use of federal funds.
3. **Mandatory Services.** The federal law would require states to provide a menu of mandated services to those who are eligible for the program and specify that they are entitled to some level of care if they meet the eligibility requirements.

SERVICE DELIVERY SYSTEMS

The following is a listing of some areas where the Medicaid program might be made more flexible and streamlined for states.

Managed Care. At recent count, 43 states have some form of managed care in their programs. Yet, states must submit waiver applications and apply for waiver renewals every two years. Moreover, states are limited in their ability to establish networks of care in geographic locations with large Medicaid populations because federal statutes prohibit Medicaid beneficiaries from

being served in health maintenance organizations where more than 75 percent of the enrollees are Medicaid and Medicare beneficiaries. This statutory requirement was thought to assure quality in such HMOs, but there has been no evidence that this proxy has ever worked. It could be repealed. States could be given the ability to establish networks of care (including fully and partially capitated systems) under a restructured Medicaid program as part of its regular program administration and without any waiver requirements.

Home and Community-Based Care Programs. Home and community-based care (HCBC) programs are an important alternative to institutional care for frail elderly and persons with disabilities. However, existing Medicaid statutes have a programmatic bias toward institutional care. There are more than 100 different HCBC programs across the nation, and each state has at least one program. States are required to use the waiver process to establish such programs. Statutes could be revised to give states the authority to establish these programs through a plan amendment process; however, states must retain the authority to limit the number of individuals who could enroll for such care.

Nursing Home Reform Mandates in the Omnibus Budget Reconciliation Act of 1987. Congress mandated extensive new quality assurance measures for the Medicaid nursing home program in 1987 that allows the federal government to micro-manage state nursing home programs. States could be given more flexibility to administer their programs efficiently. Toward that end, Congress could repeal the Preadmission Screening and Annual Resident Review (PASARR) requirements. PASARR has been costly, and states have developed other strategies to assure the appropriate placement of individuals with disabilities. In addition, the specialized annual resident review for mental illness and mental retardation is duplicative of existing annual review processes and could be eliminated. Serious consideration must be given to the extent to which quality standards remain mandated by the federal government as compared to a federal mandate that says that states must have quality assurance systems but the states are given the freedom to determine what those standards might be.

REIMBURSEMENT SYSTEMS AND RATE SETTING

States remain saddled with the inflexible provider reimbursement standards of the Boren Amendment. These standards limit states in their ability to establish institutional (e.g. inpatient hospital and nursing home) reimbursement rates. The Boren Amendment could be repealed and assurances be put in place to protect states from federal and judicial intrusion in the rate setting process. It should be noted that because of the revolutionary changes in American health care system, the Boren Amendment is much less relevant today to hospital rates than just a few years ago. Because of these market changes, states are negotiating with health care networks for more comprehensive health care packages that include hospital care. As such, the rate negotiation for hospital care is between the hospital and the health care network not the hospital and the state. While the impact of the Boren Amendment on hospital rates is declining, the Boren amendment also applies to nursing homes. Therefore, repeal or other forms of relief are needed.

States could be given the opportunity to explore alternative strategies for provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement could be repealed. Moreover, strategies that try to tie access to care to certain reimbursement rates could be eliminated from Medicaid statutes.

ACCOUNTING FOR EXPENDITURE DIFFERENCES AMONG STATES

While labeled under the national rubric of Medicaid, the Medicaid program functions, for better or worse, as a state/federal partnership. The federal government establishes broad parameters to meet national policy objectives; the states design and implement their programs within those parameters; and the states and federal government share in the financing of the program. The federal government pays about 57 percent of costs and the states pay about 43 percent. As might be expected, significant differences exist among states in federal expenditures. These differences can be explained by the federally determined financing structure of the program, state options, and state economic factors.

FEDERAL LEGISLATION

Under the Medicaid program, states and the federal government share in the cost of the program. States may pay as much as 50 percent of all service costs or as little as 17 percent depending upon a matching formula. The formula is based on a comparison of the state's per capita income compared to national per-capita income. States with higher per-capita income are required to pay a greater share of expenditures than states with lower per-capita income. Each state's sharing arrangement is adjusted annually to reflect the state's per-capita income compared to the nation. Moreover, because the Medicaid individual entitlement is linked, in part, to measures of poverty, as a state's economy worsens, the number of persons eligible for the program grows.

STATE CHOICES

As described earlier, states may add up to seven optional eligibility categories and up to 33 additional services beyond those that are required by federal law. States differ significantly in their selection of optional eligibility and service categories. States also set the amount, duration and scope of services as well as the reimbursement for those services (Boren Amendment notwithstanding). Expenditures are generally higher in those states that adopt more options. Finally, almost all states make supplementary payments to hospitals under the Medicaid Disproportionate Share Hospital (DSH) program. Prior to 1991, states were free to determine the size of the program. Although the program's growth is now capped, differences among states in DSH spending remains.

STATE ECONOMIC CONDITIONS AND DEMOGRAPHIC CHARACTERISTICS

Finally, economic and demographic differences exist among states. Differences exist in the overall cost of doing business as well as in the costs of medical care. For example, states with more mature managed care markets have a higher percentage of Medicaid beneficiaries in managed care and are able to reap the financial benefits of networks of care. The amount of excess hospital or nursing home capacity can also affect price. State demographic characteristics also affect spending. For example, states with greater proportions of elderly and children are likely to have more Medicaid enrollees than those who do not.

In short, a complex matrix of federal action, state-based policy decisions, and economic conditions contribute to the differences among states.

LIMITING MEDICAID GROWTH

THE 1996 BUDGET RESOLUTION

In late June 1995, Congress adopted the federal fiscal year 1996 budget resolution. It calls for limiting the growth of spending in the Medicaid program. The provisions of the resolution that pertain to Medicaid:

- permit \$773.1 billion in federal Medicaid spending over seven years,
- propose to save \$181.6 billion in federal funds from current baseline estimates through programmatic changes,
- limit annual Medicaid growth to 7.2% in federal fiscal year 1996, 6.8 % in 1997, and 4% for each year thereafter, and
- reaffirm the current state/federal matching arrangements (so states will be required to spend state dollars in order to draw down federal funds).

The agreement makes no reference, however, to block grants as a strategy to restructure the program and leaves it to the authorizing committees to determine the best strategy to meet the targets outlined in the resolution. This resolution, while not binding, provides the framework in which appropriations and authorizing committees will conduct their work.

STRATEGIES TO LIMIT GROWTH IN MEDICAID EXPENDITURES

The Congressional authorizing committees are expected to consider an assortment of restructuring options in order to limit federal spending in the program and meet the budget targets. A number of different alternatives are available for their consideration.

Preserving the Policy Objectives of the Current Medicaid Program

While the Congressional leadership has expressed interest in eliminating the individual entitlement in the Medicaid program, strategies exist that will allow for program savings while preserving the entitlement nature and policy-making of the current program.

1. **Current Medicaid—Streamlined and Downsized.** In this approach, Medicaid would be kept as an individual entitlement. To bring program costs under control, Congress could make statutory changes that make program operations more cost efficient and, if necessary, they could legislate reductions in eligible populations and services. In addition, they would establish in statute streamlined service delivery systems. The Congressional Budget Office would have to estimate that the financial impact of the programmatic changes are consistent with budget targets.
2. **Current Medicaid With Changes In Federal Matching Percentages.** In this approach, Congress could streamline the program but would maintain the individual entitlement. To achieve the federal savings, the federal share of the program would be lowered for each state (e.g. from a national average of 57 percent to 38 percent). As such, states would be required to increase their spending to accommodate the reduction in federal funds. Like the first option, the Congressional Budget Office would have to estimate that the financial impact of the programmatic changes are consistent with budget targets.

- 3. Current Medicaid With Limited Federal Funds.** In this approach, Medicaid would be kept as an individual entitlement and there would be little or no change to the existing program structure. Congress would limit, however, the amount of federal funds that could be spent in the program in any year. If the program costs exceeded the available federal funds, states would be required to make up the difference. While somewhat draconian, this would give Congress budget certainty in the program.

Alternatives to the Existing Program—Capping Strategies

It is certainly true that Congress could achieve budget savings or perhaps attain budget certainty while preserving the existing Medicaid program. It does not seem very likely that they will take such an approach. Rather, proposals have surfaced that partially or completely break the individual entitlement and achieve budget savings by placing an expenditures cap on the entire program (i.e. and aggregate cap) or place limits on spending for any individual (per-capita cap). By breaking the individual entitlement, Congress could subject the Medicaid program to annual appropriations. Doing so, however, would subject states to great financial uncertainty. Legislative language is expected that will give the states certainty in their access to federal Medicaid dollars perhaps through the establishment of an "entitlement to states".

- 4. Aggregate Annual Growth Cap.** Under an aggregate growth cap, annual increases in program expenditures are pre-determined federally and cannot be exceeded. This can be done by establishing a national growth rate to which each state must adhere (e.g. each state cannot grow more than 7 percent annually) or by allowing states to grow at different pre-determine rates, through a formula allocation, as long as the national growth does not exceed the pre-determined national limit.
- 5. Per-Capita Annual Growth Cap.** Under a per-capita growth cap, average annual spending per Medicaid enrollee is determined. For example, a state could not spend more, on average, than \$2,500 annually per Medicaid enrollee. (In practice it would be necessary to calculate caps separately for different eligibility groups such as the elderly, children, or persons with disabilities.) The federal government then defines an annual growth rate that could be applied nationally or on a state-by state basis. For example, in a given state, Medicaid spends on average \$2,500 for each enrollee. If a 5% annual growth rate is imposed for the following year, the state would be permitted to spend, on average, \$2,625 for each enrollee. Total program costs would be calculated by estimating the number of people in the program and multiplying that number by the per-capita cost. The Congressional Budget Office would have to estimate that the financial impact of the programmatic changes are consistent with budget targets.

Capping Strategies and Individual Entitlements. Congress could choose to could maintain an individual entitlement to eligibility and benefits under an aggregate cap. In fact, Option 3 above is such an example. In fact, if Congress tries to impose any individual entitlement requirements in the program, states could be at risk of continuing to pay for care even if federal funds run out. In order to establish a per-capita cap and keep within federal budget limits, the federal government must define those populations eligible for care (i.e. establish an individual entitlement to eligibility). In fact, the federal government would be required to establish mandatory eligibility categories.

Strengths and Weaknesses of Aggregate and Per-Capita Caps. Significant differences exist between aggregate and per-capita caps in both their implementation and policy objectives. An aggregate cap is relatively simple to administer—formula allocation issues aside. Because the growth is calculated in the aggregate, states could be given significant flexibility to define who is eligible for the program and what services can be offered. To make it politically acceptable, the aggregate cap may require some reallocation of funds. Aggregate caps also offer the federal government complete predictability in federal expenditures. On the downside, some but not all of the factors that have resulted in differences among states in the current Medicaid program remain (e.g. changes in population, economic downturn, differences in cost of care). Some of these might be addressed in a formula allocation. However, depending on the level of federal funding, there could be winners and losers.

With regard to per-capita caps, the individual entitlement to eligibility would be retained, and states would be assured of per-capita payments for each eligible beneficiary irrespective of changes in population demographics or economic downturn. The federal government would still have to establish a growth rate to be applied to the per-capita cap. However, this growth rate would only have to reflect differences in utilization patterns and medical inflation. This approach retains an individual entitlement to services, if a state was interested in redefining eligible populations, other strategies (i.e. waivers) would be required. While giving protections for populations, this approach does not offer the financial certainty to the federal government on expenditures since the financial impact of changes in population demographics and the economy can be modeled but not determined with certainty.

ALLOCATION OF FEDERAL FUNDS UNDER CAPS

Congress may decide to use existing annual federal expenditures to define the base year and use a uniform annual growth percentage for all states. Or they may opt to define some other allocation strategy. In the following sections, factors and issues associated with the allocation of funds are presented. This issue is complex and highly political. The reader should not assume that the detailed discussions of alternative allocation strategies is an endorsement for any allocation strategy or that an alternative allocation strategy is needed at all. Rather the detail represents an attempt to assure that the reader understands the range of issues that could be considered in an allocation debate.

Allocation Factors

The following is a list of some factors that might be considered in any allocation discussions. They fall into three broad policy categories—beneficiary-related, state financial capacity, and outcome-based incentive factors. Neither within nor across categories is this list exhaustive. In some cases, different proxy measures are presented for the same underlying policy objective. This was done because proxies are always imperfect measures of underlying phenomena. Any changes in allocation might incorporate two or more of these factors.

Beneficiary-Related Factors. These attempt to allocate funds based on the distribution among states of those potentially served by the program:

Poverty Population—General. The federal government has established a national definition of poverty, that is calculated annually. Through census data, the number of people in poverty in each state may be calculated.

Poverty Population—Below Age 65. This measure is a proxy for AFDC-related beneficiaries in the current program.

Poverty Population—Below Age 21. This measure is another proxy for AFDC-related beneficiaries in the current program since most of them are children.

Low Income Population—Over Age 65. Given the high cost of nursing home care, this measure is a proxy for the elderly populations in the current program.

Low Income Population Over Age 75 (or 85) This measure is also a proxy for the elderly populations in the program. A higher age cutoff is thought to better reflect those who might have need of nursing home care.

Supplemental Security Income (SSI) Population. The SSI Program is a federal cash assistance program for certain poor persons with disabilities and the elderly. Under current law, SSI beneficiaries are automatically entitled to Medicaid. Under a capped entitlement, this measure is a proxy for the distribution of persons with disabilities among states. There is some thought, however, that an SSI measure is not necessary if a poverty measure is included in the formula. The SSI eligibility is, in-part, based on poverty program, and the distribution of SSI beneficiaries among states is similar to the overall distribution of poverty across states.

State Financial Capacity and Cost Factors. Congress may choose to adopt a policy that adjusts the distribution of program funds not solely on beneficiary distribution but also on the capacity of states to provide care for the population. In the current Medicaid program, this policy is reflected in the federal matching percentage. States that have higher per-capita income relative to the nation must pay a greater share of costs than states with lower per-capita income. The budget resolution suggests retaining the Medicaid matching percentage. Congress could consider other factors (like the ones listed below) to establish the matching rate. However, nothing precludes Congress from using state capacity and cost factors in any other allocation formulas.

Per Capita Income. This measure is a proxy for revenue-raising capacity of the state. It is calculated annually on a state-by-state basis by the Department of Commerce, Bureau of Economic Analysis. This measure is calculated by dividing total income in the state by the total population in the state as measured by the Bureau of the Census.

Unemployment Rate. This measure is another proxy for the economic health of a state. It is calculated and available monthly on a state by state basis. Unlike per-capita income, this measure is assumed to be a more current measure of the state's health.

Total Taxable Resources (TTR). TTR is a proxy measure for the capacity of a state to generate revenues through its tax structure. The measure is calculated annually on a state-by-state basis by the Department of the Treasury and reflects personal income as well as a state's gross state product.

Consumer Price Index. This measure is a proxy for the cost of providing services. It is calculated by the Department of Commerce for the nation and for specific geographic areas but not on a state-by-state basis. Because of its methodology, the consumer price index is not considered a reliable measure for comparison among states.

Medicare Hospital Wage Index. This measure is a proxy for the cost of doing health care business in a state. It is calculated by the U.S. Department of Health and Human Services and is used in the Medicare program. The data are not currently available on a state-by-state basis however, the calculation can be done from the existing data set.

Outcome-Based Incentives. In recent years, business and government has moved toward performance or outcome based measures of program success. Unlike most of the preceding factors, those listed below are general categories that would need more exploration and refinement before being considered in an allocation formula.

Efficiency-Related Factors. These are factors that would increase allocations of funds to states based on program administration such that those states that administer programs more efficiently would be rewarded. Two examples of factors that might be considered in this category are proportion of beneficiaries in managed care and proportion of spending allocated to administration as compared to services.

Effectiveness-Related Factors. These factors would provide allocations to states based on how successful a state has been in meeting certain health related goals. For example, allocations could be made based upon the number of children under age two who are immunized. Some examples of these measures are described in the U. S. Public Health Service's *Healthy People 2000* document or in states' version of this document.

Weighting

Once the factors have been chosen, decisions must still be made concerning the weighting of each of the factors in the final equation. For example, since the elderly and disabled represent about 70 percent of spending in the current program, should measures of the elderly receive a higher weight? What weight should state financial capacity factors have in the formula? This set of decisions is as difficult and complex as the decisions that guide the selection of factors themselves.

Allocation Strategies

In the following sections, three broad options to allocate or re-allocate funds among states are presented. The first most closely represents existing expenditures. The second makes adjustments to growth, and the third makes adjustments to base year and growth. While a basic approach is taken in the latter two options, a number of additional modifications can be made to fine tune the formula.

These options are not allocation formulas. Rather, they are conceptual approaches to the allocation of funds.

- 1. Use Existing Base Year Expenditures and Allocate Growth Proportionally Among States.** Under this approach, the new federal dollars would be distributed among states proportionally using the same percentage. The growth would be calculated against actual base year expenditures in the state. Proponents of this approach would argue that the current program represents the state's financial commitment to those served by Medicaid and the state's commitment should be preserved. They also argue that changes in the base would cause serious disruptions in services.

2. **Use Existing Base Year Expenditures and Allocate Growth According to Formula.** Under this approach, the new federal dollars would be distributed among states using some agreed upon formula that reflects some new set of policy objectives for the program. Over time, distribution of all federal funds among states will begin to approximate the underlying policy objectives of the new program. Proponents of this option would argue that the federal government is attempting to make the distribution of federal funds among states more consistent with the new policy objectives and it protects the base so that serious disruptions in services do not occur.
3. **Reallocate Both Base Year and Growth Funds.** The goal of this option is to assure that federal Medicaid funds are distributed among states according to some accepted policy objectives. Proponents of this option argue that the federal government is committed to assuring that all federal funds are distributed according to new policy objectives. Because this option pools base and growth funds and reallocates them, from the outset, some states could see significant financial windfalls while others could see major reductions. Congress might consider a transition period in which to implement such changes. This can be done by placing upper and lower limits on annual change. Once the distribution of total expenditures is consistent with the policy objectives, adjustments among states could be dealt with solely through the allocation of annual growth funds.

Allocation Formulas, Aggregate and Per-Capita Caps. The factors that might contribute to allocation formulas for aggregate caps and per-capita caps differ in a number of ways. The most obvious example is the allocation of growth funds under a per-capita cap. Because the per-capita cap assumes an individual entitlement, distribution of growth dollars do not have to account for state differences in caseload growth and economic health. However, since states differ significantly in per-capita spending under the current program, the same arguments regarding reallocation apply.

PROGRAMMATIC ISSUES UNDER A CAPPED ENTITLEMENT

The following is a partial listing of programmatic issues that will arise as if the Medicaid program is changed from an uncapped to a capped entitlement.

Transition to a New Program. Major changes in the Medicaid program will take time. In many cases, the changes will require concomitant changes in state legislation. Such changes may require hearings and publication of new state rules and regulations all of which will take time. Operationally, states will need to redesign their computer systems, develop new program operating standards, establish new reimbursement rates and reimbursement systems, and states will have to begin retraining of policy and service delivery staff. Again, all of this takes time.

Of all transition issues, however, the most important is financial. The federal government operates its accounting system on a cash basis. That is, state Medicaid expenditures are credited to the year in which the bill is paid, not based on the date of service of the bill. All health care systems have a lag between the time that the service is provided and the time that the bill is paid. In Medicaid, this is typically 30 to 90 days but the lag can be as long as a year. As a result, during the first three months of the fiscal year in which the cap is implemented, states will be paying bills which were

incurred when the program was operating as an uncapped entitlement. States may have insufficient time to streamline the program to operate within the federally set expenditure limits.

Administration. Under the current Medicaid program, administrative costs, like service costs, are not capped. The Congress must decide how states should be reimbursed for administrative costs.

Section 1115(a) Waivers. More than ten states have had section 1115(a) waivers approved by the federal government. In many, but not all cases, these states have negotiated for expanded populations and expect to incur additional program costs in the future. Since most have not been operating in federal fiscal year 1995, they will not have incurred expenditures in the year that may become the base year for the program. Therefore, they may not have a sufficiently large base to implement waiver population expansions. In addition, a number of states have negotiated annual growth rates that are greater than those in the budget resolution.

Expanding Eligibility Under A Per-Capita Cap: As has been mentioned previously, per-capita caps would require federally defined eligibility categories. Such a requirement could preclude states from using federal dollars for other populations as they currently do under the existing 1115(a) waiver process. If Congress wants to continue giving states authority to change or expand eligibility under a per-capita cap, some mechanism, probably a waiver process, would be needed to assure that the state is spending no more than might have been expended if the federal eligibility requirements had remained in place. It should be noted that Governors have objected to the burdens associated with a waiver process in the past.

Medicaid/Medicare Dual-Eligibles. Some 40 percent of the SSI-related beneficiaries are enrolled in both the Medicaid and Medicare programs. These people are referred to as "dually eligible". States pay Medicare Part B premiums, and, in some cases, Part A premiums, copayments and deductibles for dual eligibles. If Medicaid funds are limited, the relationship between Medicare and Medicaid must be streamlined as well so that states can more efficiently and effectively coordinate the benefits between the two programs. In addition, Congress must be aware that increases in premiums, copayments, and deductibles in the Medicare program will result in increased Medicaid costs.

Quality and Performance Standards. The current Medicaid program contains a variety of statutory and regulatory requirements that govern quality and access to care. Under a capped entitlement, the federal government will still have an interest in assuring that the states are accountable for the use of the funds. States and the federal government must decide what types of requirements might be necessary to assure accountability.

MEDICAID BASICS

Introduction

Since its inception, Medicaid has been a program designed to give states options in eligibility, services, reimbursement rates, and service delivery systems. Although described as a national program, Medicaid is really a conglomeration of 56 different state Medicaid programs. Originally designed as an adjunct to welfare, its public policy objectives have grown beyond a welfare-related health program to one that provides an extremely broad range of coverage to persons with disabilities, the elderly, and to poor children and poor pregnant women.

Beneficiaries

Medicaid provides health coverage to more than 33 million poor and near-poor people each year. About 50 percent of those covered are generally healthy children, about 23 percent are generally healthy adults, 12 percent are elderly and about 15 percent are adults and children who are blind or who have disabilities. There are nine federally mandated eligibility categories that all states must cover and seven optional eligibility categories that states may choose to cover.

For programmatic convenience the various eligibility groups can be divided into two general categories.

AFDC-Related Group—AFDC adults, poor pregnant women, and generally healthy, but poor children.

SSI-Related Group—The elderly and persons who are aged, blind, and disabled.

Services

Medicaid offers a broad array of services to meet the complex needs of the program beneficiaries. They include both acute care services as well as long-term care (nursing homes, institutions for mental diseases, facilities for the mentally retarded, and home and community-based care).

- About two-thirds of all service costs are for acute care services.
- About one-third of costs are for long term care.

Program Characteristics

- The AFDC-related group represents about 71 percent of all Medicaid recipients but accounts for only about 30 percent of all spending.
- The SSI-related group represents about 29 percent of all Medicaid recipients but accounts for about 69 percent of all spending.
- Finally, 40 percent of the SSI-related group have some Medicare coverage. For these people, Medicare is the primary payer of acute care services. Medicaid pays for almost all long-term care and serves as a "wrap-around" program for acute care services, paying Medicare copayments and deductibles; covering some additional services (e.g., prescription drugs); and, in some cases, paying Medicare Part B premiums.

Growth and Trends

- Between 1988 and 1992 Medicaid costs grew nationally, on average, about 20 percent per year. In 1993 Medicaid growth dropped to 9 percent.
- Recent Congressional Budget Office (CBO) estimates show that:
 - ⇒ despite the 1993 drop, Medicaid is expected to grow nationally at an annual rate of about 10.3 percent for the next five to seven years;
 - ⇒ about 33 percent of the growth in the program over the next five years can be accounted for because of more beneficiaries coming onto the rolls; and
 - ⇒ the average annual growth in the gross domestic product over the next seven years is expected to be about 5.1 percent.
- States differ significantly in their projected growth rates for this program.
- Medicaid represents, on average, about 20 percent of total state spending and comprises about 38 percent of all federal funds to state and local government.

Medicaid Waivers

In recent years, a growing number of states are making fundamental changes to their program through research and demonstration authority under Section 1115(a) of the Social Security Act. This section gives states broad authority to test innovative strategies in administering their programs. States have been most interested in two types of changes. First, they are interested in broadening the eligibility criteria to some more uniform level of poverty. Second, they are interested using managed care in their programs.

In many cases, these waivers make fundamental changes in the service delivery system and have explicit agreements with the federal government on growth rates and eligible populations.

Medicaid Flexibility Fib

→ Chris J - My list from yesterday

Jack

Flexibility

Managed care

1. PCCM w/out waiver
2. Mandatory managed care w/out waiver (w/choice)
3. Allow mandatory managed care in rural area subject to options for out-of-network services
4. Elimination of 75/25
5. Elimination of Sec. approval of contracts over \$100,000
6. Eliminate external quality review of managed care if other managed care quality provisions are retained
7. Allow states to guarantee Medicaid eligibility for 6 months for any managed care enrollee

Services

1. HCB w/out waiver (subject to scoring issues)
2. EPSDT - administrative simplification; and discuss w/states how to deal w/coverage issue
3. Elimination of requirement to pay for private health insurance

Payment

1. Loosening of Boren
2. Elimination of cost-based payment for RHCs, FQHCs
3. Elimination of OB/Gyn payment rate requirements

Administration

1. Elimination of physician qualification requirement
2. Revision in MMIS
3. Elimination of state personnel requirements
4. Elimination of requirement for cooperative agreements
5. Revise, simplify MEQC
6. Remove some of detailed federal rules on certain optional program features

Eligibility

1. Eligibility expansion - 150 percent
2. Remove some of detailed rules related to the extension of Medicaid for those entering workforce

LTC

1. Permit states greater flexibility in nurse aide training in rural areas
2. Eliminate duplicate annual state resident assessments under PASSAR

Per capita cap**Caps**

non-disabled child;
non-disabled adult;
elderly;
disabled

Base 1995; multiplier - derived to hit \$54 assuming DSH savings (GDP +)

Exclude dsh, medicare cost sharing, IHS, fraud, survey and cert, IEVS, vaccines

DSH: 33% reduction; balance flexibility for states/interests of some providers - consider setting aside a portion of remaining DSH \$ for high DSH, FQHC, RHC?

Draft - Newstuff

ADDITIONAL PROGRAM FLEXIBILITY
"A" List

The following are ideas to provide States with more flexibility under a per capita cap. Some of these ideas are also included in other per capita cap proposals circulating on the Hill (these are so identified).

Eligibility:

In general, the Federal government is seeking to ensure low-income individuals' continued entitlement to health care services through Medicaid. The current mandatory groups -- AFDC and SSI recipients, and poverty-level pregnant women and children -- need to be maintained.

However, additional flexibility could be offered consistent with maintaining core eligibility protections.

- **Revise and simplify the Medicaid Eligibility Quality Control system.**

The current system for ensuring that States are not making excessive (and costly) errors in determining eligibility is labor-intensive beyond the pay-off that it delivers. Reviews take place even where a State may be doing a good job. This system could be replaced with a less labor-intensive, more hands-off system that monitored enrollment trends and intervened only when aberrant patterns developed. States unable to explain aberrant growth would have their aggregate caps adjusted by the median national growth rate in numbers of enrollees.

- **Transitional Medicaid**

States do not like the reporting and procedural requirements, the limits on premiums, and the various conditions and requirements attached to the Medicaid wrap-around option and the use Medicaid funds to buy coverage from other sources (employer plan, State employee plan, State uninsured plan, HMO). We could provide significantly greater State flexibility in operation but should retain this as a required service for consistency with welfare reform and child support objectives.

Services:

- **Greater Flexibility for EPSDT**

Under current law, States are required to provide services to "treat or ameliorate a defect, physical or mental illness, or a condition" identified by an EPSDT screen - regardless of whether the service is otherwise included under the State's Medicaid plan.

States claim this treatment requirement is a major contributing factor to uncontrollable state Medicaid expenditures.

- The Secretary could define the treatment services that must be covered under the treatment component of the EPSDT program. (Stenholm proposal)

Managed Care:

In managed care, States are primarily interested in additional flexibility to mandate that Medicaid beneficiaries enroll in managed care plans and greater freedom to contract with managed care plans.

While we expect that they will welcome the bill's additional flexibilities, we anticipate that States may object to quality of care and information collection requirements that are included in the per capita proposal. States could also object to provider payment requirements.

- **Quality of Care and Accountability**

Annual External Quality Review

Under current law, States are required to contract with outside entities to annually, retrospectively review quality of care for HMO enrollees. This requirement could be modified (semi-annually?) or repealed if other the quality of care and accountability requirements included in the per capita draft are enacted.

- **Other Flexibility Options**

Guaranteed Eligibility Option

In the past, States have sought authority to guarantee Medicaid eligibility to managed care enrollees for up to six months, regardless of whether an individual remains eligible for the entire time frame. States believe that the managed care industry may be more willing to contract for Medicaid enrollees with this guaranteed enrollment window. However, guaranteed eligibility may be particularly problematic when scored in a per capita cap environment, since it (by definition) extends eligibility to individuals who would not otherwise be eligible for Medicaid. This proposal may therefore include scorable costs.

Choice of Plan -- Single HMO in Rural Areas

During negotiations with the NGA in 1993, the Administration agreed to consider permitting States to contract with a single managed care organization in rural areas under a mandatory

enrollment system. The Administration could consider adopting this policy if options for receiving services out of network, such as a Point-of-Service structure, are available to enrollees.

Long-term care:

These proposals were included in REGO II and are also in the Senate reconciliation bill.

- **Changes to Nurse Aide Training Requirements**

The prohibition on nurse aide training and competency evaluation programs causes a special problem for rural nursing homes where training facilities may be inaccessible to nurse aides. Rural facilities can face a serious shortage of trained and competent staff due to the expense and inconvenience of sending prospective aides to remote locations.

- Greater Flexibility for Rural Areas

Permit States, under both Medicare and Medicaid, to approve nurse aide training and competency evaluation programs offered in (but not by) a nursing facility subject to an extended (or partial extended) survey or certain other sanctions if the State determines that there is no such program offered within a reasonable distance, provides notice of the approval to the States long-term ombudsman, and assures, through an oversight effort, that an adequate environment exists for such a program.

- **Preadmission Screening and Annual Resident Review (PASARR) of Mentally Ill and Mentally Retarded Residents**

Currently a State is required to conduct an annual review for each nursing facility resident who is mentally ill or retarded. In addition, every nursing facility is required to conduct an annual assessment of each resident. Resident assessments and reassessments required under the general nursing home requirements are adequate to assure the residents' continuing care needs are properly assessed and met.

- Eliminate Duplicative Requirements

Eliminate the duplicate State annual resident assessment under PASARR. Instead, require States to conduct a review when informed by a nursing facility of a significant change in the resident's physical or mental condition. Preadmission screening, which deters inappropriate admissions, should continue.

MEDICAID FLEXIBILITY OPTIONS

FILE

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

STATE FLEXIBILITY PROVISIONS:

● Services

● Additional services.

- Repeal the IMD exclusion and permit optional coverage of IMD services;
- Add optional coverage of nurse-supervised clinics;
- Expand optional coverage of vocational training for severely disabled.

● Payment

- Restructure Boren Amendment provider reimbursement provisions by establishing pre-approved methods for states' payment rates. These safe harbors would include Medicare rates and rates established by competitive bidding. HHS would investigate the relationship between quality, access and provider payment to address the need for adequate access of Medicaid beneficiaries.
- Repeal Ob/Peds and other payment requirements.
- Repeal requirement for States to pay for private insurance when cost-effective.

● Delivery systems

- Allow States to mandate enrollment in managed care delivery systems and to provide home and community based services as State plan options, without the need for Federal waivers. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.
- Modify the managed care contracting requirements by repealing the 75/25 provision, the upper payment limit for managed care contracts, Federal prior approval of HMO contracts over \$100,000, and the Statewideness requirement; and by extending six-month lock-in to all plans.

● Administration

- Replace separate Medicaid standards on conditions of participation with Medicare conditions of participation and private accreditation for hospitals, nursing facilities, hospices, and home health agencies, except for entities that only serve Medicaid enrollees (ICFs/MR).

- Repeal physician qualification requirements.
- Repeal Federally-mandated administrative requirements, but retain States' authority to establish similar requirements:
 - TPL process requirements (e.g. cost avoidance vs. pay and chase);
 - Transfer of asset and estate recovery requirements;
 - MMIS Subsystem design requirements -- except where they affect the use of standardized claims formats, and standardized HCFA reporting requirements;
 - Personnel-related requirements (e.g., merit personnel standards, training of sub-professional staff);
 - Cooperative agreement requirements.
- Re-engineer the MMIS systems requirements to retain the required use of standardized claims formats, standardized HCFA reporting requirements.

Eligibility Expansions and Simplification

- Allow States to expand or simplify eligibility through two mechanisms.

First, States could make modest eligibility changes within certain parameters under a simplified and expedited procedure with limited Federal involvement. Federal matching would remain limited by the aggregate limit, which would be based on current law eligibility and be constrained to the lower of the aggregate cap for current eligibles or projected State spending below the cap. Parameters for these simplified eligibility changes could be specified as either within a certain percentage of the Federal poverty level (e.g., in the 100 to 150 percent range), or within a certain threshold level of enrollee expansion (e.g., 30 percent).

Second, States could pursue more significant changes in a budget-neutral manner under waiver authority, i.e., the state would still be required to stay under the aggregate limit. These expansions would require greater Federal oversight because their larger scope would place current eligibles at greater risk for service reductions. States would also need to demonstrate budget neutrality in this context.

FEDERAL OVERSIGHT PROVISIONS:

- **Eligibility**
 - All current mandatory and optional eligibility groups, including AFDC and SSI cash and non-cash groups, poverty level children and pregnant women, medically needy, and QMB/SLMB would be retained. However, eligibility expansions and simplifications would be permitted. The proposal would allow States to expand or simplify eligibility in ways not generally allowed in law through two mechanisms. (See eligibility expansion section above.)

- Add a gross income test as an upper income eligibility limit for 1902(r)(2).
- Retain spousal impoverishment provisions.
- **Services**
 - Retain the requirement that states continue to offer all Medicaid mandatory services, including EPSDT.
- **Payment**
 - Retain the prohibition on copayments that are more than nominal or other cost-sharing burdens on recipients unless they are reasonably related to income.
 - Retain requirement for Federal matching as well as DSH payment requirements both from the 1987 and 1991 laws, and per hospital limits included in OBRA 93. Retain taxes and donations provisions. [See DSH paper for options to reduce and re-target DSH.]
- **Administration**
 - Expand eligibility quality control system (MEQC) to better ensure that only individuals eligible and enrolled in the program are included in the per capita limit calculation.
 - Retain Federal data and reporting authority. Refine current reporting requirements to develop an enforcement mechanism for per capita limits.
 - Retain quality of care provisions, such as OBRA-87 nursing home reform provisions and PRO utilization review provisions. Add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.
 - Continue requirements for beneficiary protections and retain the administrative provisions that require States to ensure quality of care:
 - Use a single State agency to administer or supervise the administration of the plan;
 - Provide reasonable opportunities for all citizens to appeal and obtain a hearing on State actions;
 - Submit proposed program changes to public review and comment;
 - Make post-decisional records publicly available (e.g., policy guidelines, correspondence, court filings);
 - Consult with medical experts and establish procedures regarding medical appropriateness and standards of care paid for under Medicaid;

- Safeguard information about recipients.
- Retain current fraud and abuse provisions, and retain an uncapped funding for the State Fraud Control Units.
- Modify requirements related to State contracts with health plans to maintain State and Federal oversight on managed care as follows:
 - states must develop an overall quality improvement strategy, including plan standards, monitoring strategies, and data analysis;
 - states must collect and analyze encounter data from contracting health plans [or States may require plans to report certain information from the plan's encounter data];
 - health plans must demonstrate capacity to deliver all contracted services for all populations; and
 - health plans must maintain an internal quality assurance program and a grievance process.

- **Current Demonstration Waivers**

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

- **Enrollment Base**

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

- **Covered Services and Growth Rates**

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

- **Interaction with DSH Changes**

The proposal would retain DSH expenditures within the per capita base if States choose Option 1.

Medicaid Flexibility File

MEDICAID - DRAFTING SPECIFICATIONS

I. Overview

The Medicaid proposal includes:

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

Overview of State flexibility

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

The areas of increased flexibility would include:

- o **Services:** within the cap, states could provide optional coverage of IMD services, nurse supervised clinics, vocational training for the severely disabled.
- o **Payment:** the Boren amendment would be repealed. A limited set of safe harbors for the States would be created, including Medicare rates, private rates, and rates created by competitive bidding. Links between quality, access, and payment rates would be studied.
- o **Delivery systems:**
 - States could mandate enrollment in managed care plans as a state plan option (without seeking a waiver), so long as enrollees have a choice of plans or delivery systems. Managed care contracting requirements would also be modified to be more flexible while enhancing quality protocols.
 - States could also provide home and community-based services as a state plan option.
- o **Administration:** Replace separate Medicaid standards on conditions of participation with Medicare conditions, except in the case of entities that serve only Medicaid enrollees (ICFs/MR). A number of Federally-mandated administrative requirements would be repealed, and the physician qualification requirements would be repealed.

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

- o Eligibility: Maintain current mandatory and optional eligibility groups.
- o Services: Maintain current Medicaid mandatory services.
- o Payment: Maintain cost sharing limits, the Federal matching structure of the program, as well as DSH payment requirements and limits (subject to new DSH policy), and taxes and donation policy.
- o Administration: expand Medicaid eligibility quality control (MEQC) system to monitor the per capita cap calculation; retain data and reporting authority, and refine it to enforce per capita cap; retain nursing home reforms, beneficiary protections, and fraud and abuse provisions.

DETAIL of STATE FLEXIBILITY PROVISIONS:

• **Services**

• **Additional services.**

- Repeal the IMD exclusion and permit optional coverage of IMD services;
- Add optional coverage of nurse-supervised clinics;
- Expand optional coverage of vocational training for severely disabled.

• **Payment**

- **Repeal Boren Amendment provider reimbursement provisions.**

Establish new system with pre-approved methods for states' payment rates. These safe harbors would include Medicare rates, private rates, or rates established by competitive bidding. Safe harbors would allow states to develop payment rates in certain fashions (e.g. paying the prevailing local rate) that would be free from Federal review and precluded from legal challenge by providers.

HHS would investigate the relationship between quality, access and provider payment to address the need for adequate access of Medicaid beneficiaries.

- **Repeal Ob/Peds and FQHC requirements.**
- **Repeal requirement for States to pay for private insurance when cost-effective.**

• Delivery systems

- Allow States to mandate enrollment in managed care delivery systems and to provide home and community based services as State plan options, without the need for Federal waivers. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.
- Modify the managed care contracting requirements by repealing the 75/25 provision, the upper payment limit for managed care contracts, Federal prior approval of HMO contracts over \$100,000, and the Statewideness requirement; and by extending six-month lock-in to all plans.
 - Repeal the upper payment limit for managed care contracts (i.e., 100 percent of FFS).
 - Repeal 75/25 provision.
 - Repeal freedom of choice requirement in all "managed care" situations -- HMO, PCCM, HIO, case management, home-community based services, etc. States would continue to be required to offer Medicaid enrollees a choice of plan or delivery system.
 - Modify current disenrollment requirements to allow States to lock enrollees into a health plan for up to six months, but retain enrollees' right to disenroll for cause.
 - Repeal Federal prior approval of HMO contracts over \$100,000.
 - Repeal Statewideness requirement for managed care to enable States to operate managed care programs in limited geographic areas without needing Federal waivers.

• Administration

- Replace separate Medicaid standards on conditions of participation with Medicare conditions of participation and private accreditation for hospitals, nursing facilities, hospices, and home health agencies, except for entities that only serve Medicaid enrollees (ICFs/MR).
- Repeal physician qualification requirements.
- Repeal Federally-mandated administrative requirements, but retain States' authority to establish similar requirements:
 - MMIS Subsystem design requirements -- except where they affect the use of standardized claims formats, and standardized HCFA reporting requirements;

- Personnel-related requirements (e.g., merit personnel standards, training of sub-professional staff);
- Cooperative agreement requirements.
- Re-engineer the MMIS systems requirements to retain the required use of standardized claims formats, standardized HCFA reporting requirements.
- Repeal all enhanced matching rates for administrative activities.

Eligibility Expansions and Simplification

- Allow States to expand or simplify eligibility.

States could make modest eligibility changes within the following parameters under a simplified and expedited procedure with limited Federal involvement. Parameters for these simplified eligibility changes would be specified as either within a 150 percent of the Federal poverty level, or within a 30 percent threshold level of enrollee expansion. Federal matching would remain limited by the aggregate limit, which would be based on current law eligibility and be constrained to the lower of the aggregate cap for current eligibles or projected State spending below the cap.

FEDERAL OVERSIGHT PROVISIONS:

- **Eligibility**
 - All current mandatory and optional eligibility groups, including AFDC and SSI cash and non-cash groups, poverty level children and pregnant women, medically needy, and QMB/SIMB would be retained. However, eligibility expansions and simplifications would be permitted. The proposal would allow States to expand or simplify eligibility in ways not generally allowed in law through two mechanisms. (See eligibility expansion section above.)
 - Add a gross income test as an upper income eligibility limit for 1902(r)(2).
 - Retain eligibility provisions, such as
 - Spousal impoverishment;
 - TPL process requirements (e.g. cost avoidance vs. pay and chase); and
 - Transfer of asset and estate recovery requirements.
- **Services**
 - Retain the requirement that states continue to offer all Medicaid mandatory services, including EPSDT as currently

defined.

● **Payment**

- Retain the prohibition on copayments that are more than nominal or other cost-sharing burdens on recipients unless they are reasonably related to income.
- Retain requirement for Federal matching as well as DSH payment requirements both from the 1987 and 1991 laws, and per hospital limits included in OBRA 93. Retain taxes and donations provisions. [See DSH paper for options to reduce and re-target DSH.]

● **Administration**

- The MEQC sample size would be expanded to a level to be determined by the Secretary to ensure statistical validated of the findings. Reduce the number of beneficiaries used to calculate the cap to the same extent as erroneous eligible individuals exceed 3 percent of total eligibles. Error rates would be determined for each of the four groups.
- Retain quality of care provisions, OBRA-87 nursing home reform provisions and PRO utilization review provisions. Add a requirement that States utilize a Federally-developed outcome-oriented framework for measuring quality for all services.
- Continue requirements for beneficiary protections and retain the administrative provisions that require States to ensure quality of care:
 - Use a single State agency to administer or supervise the administration of the plan;
 - Provide reasonable opportunities for all citizens to appeal and obtain a hearing on State actions;
 - Submit proposed program changes to public review and comment;
 - Make post-decisional records publicly available (e.g., policy guidelines, correspondence, court filings);
 - Consult with medical experts and establish procedures regarding medical appropriateness and standards of care paid for under Medicaid;
 - Safeguard information about recipients.
- Retain current fraud and abuse provisions, and retain an uncapped funding for the State Fraud Control Units.

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- **Modify requirements related to State contracts with health plans to maintain State and Federal oversight on managed care as follows:**
 - states must develop an overall quality improvement strategy, including plan standards, monitoring strategies, and data analysis;
 - states must collect and analyze encounter data from contracting health plans [or States may require plans to report certain information from the plan's encounter data];
 - health plans must demonstrate capacity to deliver all contracted services for all populations; and
 - health plans must maintain an internal quality assurance program and a grievance process.
- **Retain Federal data and reporting authority. Refine current reporting requirements to develop an enforcement mechanism for per capita limits.**
 - Data elements reported in the HCFA-37 would have to be modified. States would have to be required to break out spending projections by categories of eligibility that are the basis for the per capita limits (e.g., separate projections for children, the elderly, etc.). They now report enrollment projections by eligibility category (by average number of person years), but break out spending only by service type.
 - Grant awards would equal State estimates if the estimate does not exceed the spending limit. Otherwise, grant awards would equal the spending limit.
 - Quarterly HCFA-64 reports from States to HCFA showing actual spending (as well as adjustments from previous quarters) would continue to be the basis for verifying earlier projections made regarding spending limits and estimated spending for the quarter. The HCFA-64 would be expanded to include enrollment data and to cross-walk expenditure with enrollment categories. The form would show the State's actual spending per enrollee per month for the quarter.
 - States would continue to submit enrollment data on HCFA-2082 forms. The 2082 would continue to serve as the basis for Medicaid statistical information.
- **Current recoupment mechanisms could continue (i.e., reducing future grant awards).**

A penalty provision would be authorize the Secretary to

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levy a penalty of "x" dollars for a State which shows a pattern of filing non-qualifying claims for Federal match. Such an approach would enhance the effectiveness of disallowances under a cap structure and better ensure against inappropriate use of Federal Medicaid funds.

- HCFA would continue to audit State expenditure reports for unallowable expenditures, providing an additional avenue for ensuring that States do not exceed per capita limits.
- Enrollment counts and enrollee categorization would also be audited to ensure that State counts are accurate, verify that enrollees are Medicaid-eligible, and ascertain that enrollees have been counted in the appropriate category.
- **Current Demonstration Waivers**

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

- **Enrollment Base**

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

- **Covered Services and Growth Rates**

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

- **Interaction with DSH Changes**

The proposal would retain DSH expenditures within the per capita base if States choose Option 1.

Medicaid Flexibility
File



GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO:

CHRIS

FAX NO.:

FROM:

Jeanne

DATE:

PAGES INCLUDING THIS
COVER SHEET:

COMMENTS:

Flex
I CAN'T SEEM TO FIND THE
OPTIONS PAPER, BUT THIS IS
WHAT YOU PASSED OUT LAST
YEAR; WHAT ARE YOU PLANNING
FOR THIS YEAR - YOU SHOULD BE
CLEAR ABOUT THE NATURE OF THE
DOCUMENT SOONER THAN LATER.

THE PRESIDENT'S MEDICAID REFORM PROPOSAL

1. Overview

2. Financing

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

3. Flexibility

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

1. OVERVIEW

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

- **Responsive and responsible Federal funding:**
 - Federal funding is not fixed but responds to unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
 - Federal reductions are responsible, providing states with sufficient funds to maintain coverage for the millions of Americans who rely on Medicaid.

- **State flexibility:** The top concerns of the Governors have been addressed, including:
 - Repeal of the Boren Amendment regulating provider payments;
 - End to the burdensome waiver process for managed care and home and community-based waivers;
 - Eligibility simplification and expansions without waivers; and
 - Elimination of many unnecessary and duplicative administrative requirements.

2. FINANCING

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

- **Responsiveness:** A per capita cap maintains the responsiveness of Federal funding to states' unexpected costs.
 - Under the President's proposal, the Federal government shares in the unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.

- **Responsible:** The per capita cap and Disproportionate Share Hospital payment reductions achieve responsible levels of Federal savings.
 - The President's proposal provides states with sufficient Federal funds to maintain coverage for the millions of Americans who rely on Medicaid.

The following section reviews:

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

Responsive and Responsible Federal Financing

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

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

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

- **President's plan saves the Federal government \$59 billion over seven years.**
- **Republicans' plan saves the Federal government \$85 billion over seven years.**
 - This is \$26 billion -- or 44 percent -- higher than the savings proposed by the President.
 - Under the Republican plan, spending growth per beneficiary would average 2 percent over the period-- less than inflation and significantly below private spending growth per person (7 percent). By 2000, the rates are very low since the Republican cuts are backloaded, taking effect after the turn of the century.
 - By 2002, Federal funding to states will be inadequate and states will be forced to reduce payments, benefits and deny coverage for millions of Americans.

Per Capita Cap: What Is It

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

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

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

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

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

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

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

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

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

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

The cap adapts automatically to state enrollment changes

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

Per Capita Cap: Adapting to State Spending

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

Disproportionate Share Hospital (DSH) Changes and Pool Payments

Disproportionate Share Hospital Payments Changes:

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

Pool Payments:

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

3. FLEXIBILITY

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

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

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

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

Provider Payment Flexibility

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

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

Managed Care Flexibility

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

- **Elimination of Need for a Waiver: (NGA Recommendation)** States will be able to implement managed care programs without the need for Federal waivers, so long as beneficiaries have a choice of plans, except in rural areas. States will be permitted to enroll Medicaid beneficiaries into their health plans for up to six months and to guarantee Medicaid eligibility during this enrollment period.
- **Outdated Quality Standards are Repealed: (NGA Recommendation)** The 75/25 enrollment composition rule will be eliminated.

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

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

Eligibility and Benefits Flexibility

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

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

Administrative Flexibility

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

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

MEDICAID STATE FLEXIBILITY

The Alternative Medicaid Reform Proposal dramatically increases State flexibility in Medicaid program administration. At the same time, it achieves Federal Medicaid savings through the use of per capita caps which provide States with substantial protections against eligible population growth due to demographic changes, economic downturns, and other uncontrollable events. Finally, the level of savings proposed by the alternative is substantially less than a third of what the Republicans are seeking. Thus, States would have the flexibility to tailor their Medicaid programs to meet their local needs without the substantial funding losses and financial risks inherent in the Republican block grant proposals.

The State flexibility of the alternative plan is illustrated by the fact that many of the Medicaid flexibility proposals requested by the States over the past several years are included explicitly in the plan. The following chart reflects items requested by the NGA in its 1993 summary of State Recommendations for Statutory Change and its Medicaid Policy adopted in January 1995.

Flexibility Proposals Contained in the Alternative Medicaid Proposal

NGA Medicaid Proposals	Alternative Proposal
1. Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
<ul style="list-style-type: none"> • States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95) 	Included.
<ul style="list-style-type: none"> • Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95.) 	Included.
<ul style="list-style-type: none"> • Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93) 	Included.
2. OBRA '87 Nursing home reform modifications:	Addressed.
<ul style="list-style-type: none"> • Eliminate restrictions on training sites for nurse aides. (NGA '93) 	Eliminates prohibition on providing nurse-aide training in rural nursing homes.
<ul style="list-style-type: none"> • Eliminate PASARR. (NGA '93, NGA '95) 	Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.
3. States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers (subject to CBO scoring).
4. Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs.

<p>5. Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95)</p>	<p>Addressed. Boren amendment is repealed for hospitals and nursing homes. Process options, such as hearings and public comment -- to be determined.</p>
<p>6. Provider Qualifications</p>	<p>Addressed.</p>
<ul style="list-style-type: none"> ● Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93) 	<p>Included.</p>
<ul style="list-style-type: none"> ● Repeal the annual reporting requirements for OB and pediatric care. (NGA '93) 	<p>Included.</p>
<p>7. Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)</p>	<p>Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.</p>
<p>8. Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)</p>	<p>Addressed. Managed care and home and community-based care no longer require waivers.</p>
<p>9. Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)</p>	<p>Addressed. To allow for some eligibility simplification, continued State innovation, and some eligibility expansions; States would have the option of covering individuals up to 150 percent of poverty if "budget neutral" (subject to CBO scoring). Current coverage would be maintained.</p>
<p>10. Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)</p>	<p>Affirms current law that personal care services can be delivered by providers other than home health agencies.</p>

<p>11. OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93)</p>	<p>Affirms current law to allow the targeting of state enforcement resources.</p>
<p>12. Impose no unilateral caps for federal spending on Medicaid entitlement.</p>	<p>Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. The DSH definition would be expanded to include FQHCs/RHCs.</p>