



EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF MANAGEMENT AND BUDGET

WASHINGTON, D.C. 20503

THE DIRECTOR

MEMORANDUM

TO: Distribution
FROM: Alice Rivlin
DATE: April 7, 1995

The attached material on the Medicaid program is for discussion at our meeting on Monday, April 10.

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What is Medicaid? Medicaid is the nation's major public financing program for providing health and long-term coverage to millions of *low-income* people. Initially designed to pay for the health care of recipients of welfare assistance and certain other needy people, in 1995, 36.1 million people--more than 1 in 10 Americans--were covered by Medicaid at a *federal* cost of \$88.4 billion.

Authorized under Title XIX of the Social Security Act, Medicaid is a *means-tested entitlement program* financed by state and federal government and administered by the states. Federal guidelines place requirements on states for coverage of specific groups of people and benefits. States that comply with the federal eligibility and benefit guidelines, receive federal matching payments based on the state's per capita income. The *federal share*--or federal medical assistance percentage ("FMAP")--ranges from 50 to 83 percent of Medicaid expenditures.

53 different programs. Within certain federal guidelines, states are free to design their Medicaid systems to fit local circumstances. The programs' complexity surrounding who is eligible, what services will be paid for, and how those services can be paid for is a source of much confusion. The attached table illustrates the wide variation in selected states' Medicaid programs.

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Variation in Selected State Medicaid Programs

	1994 AFDC Payment Standard ¹	Number of Optional Services Offered ²	Coverage Options for Pregnant Women & Kids ³	Physician Office Visit Reimbursement Rate ⁴	Medicaid Spending Per Person In Poverty ⁵
DC	\$420/month	26	185%	\$20	\$4,356
NY	\$577 (New York City)	26	185%	\$11	\$6,703
TN	\$426	17	185%	\$22	\$2,681
VA	\$354	21	133%	\$20	\$2,858
Range of Variation:	\$164 (AL) - \$680 (CT) ⁶	15 (DE) - 31 (WI)	133% (required) - 275% (MN)	\$11 (NY) - \$28 (MA) <i>m.h. note</i>	\$1,646 (OK) - \$8,212 (CT)
Other Comment:		There are 34 optional services.	34 States above 133% requirement	Limited office visit, established patient.	

¹1994 Green Book, Table 10-16. This means, for example, in DC a family of three must make \$420 or less in order to qualify for AFDC and be categorically eligible for Medicaid.

²Medicaid Services State by State, HCFA, October 1994.

³National Governors' Association, "State Coverage of Pregnant Women and Kids-July 1994", August 1994.

⁴Holahan, John. "Medicaid Physician Fees, 1990: The Results of a New Survey", October 1991.

⁵General Accounting Office, "MEDICAID: Spending Pressures Drive States Toward Program Reinvention", April 1995.

⁶Comparison excludes Alaska and Hawaii.

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Who is Covered? Although Medicaid has increasingly been used to expand coverage to the low-income population, it *covers only 58 percent of poor Americans*. There are two reasons for this: only persons who fall into particular "categories" are eligible and many recipients must meet income limits that are based on cash assistance program (AFDC and SSI) standards which are usually well below the poverty level.

Despite the complexity of Medicaid eligibility, most covered populations can be divided into six basic groups:

- *Current and former recipients of cash assistance*, either AFDC, which covers single-parent families and two-parent families with an unemployed principal earner, or SSI, which covers low income persons who are aged, blind or disabled;
- *Low-income pregnant women and children* under age 6 with family incomes below 133% of poverty and children under age 11 (this is being phased-in to age 19 by 2002) in families whose income is less than 100% of poverty;
- *Medically needy* persons who meet categorical restrictions (i.e., meet the nonfinancial standards for inclusion in one of the groups covered under Medicaid) and who have medical expenses such that when subtracted from their income, puts them within eligibility standards;
- *Persons requiring institutional or other long-term care* who, like the medically needy, qualify because of the high cost of their needed care;
- *Low-income Medicare beneficiaries* ("QMBs" and "SLMBs") for whom Medicaid will pay Medicare cost-sharing (premiums, deductibles, coinsurance); and
- *Low-income persons losing employer coverage* for whom Medicaid will pay premiums for continued private coverage through COBRA.

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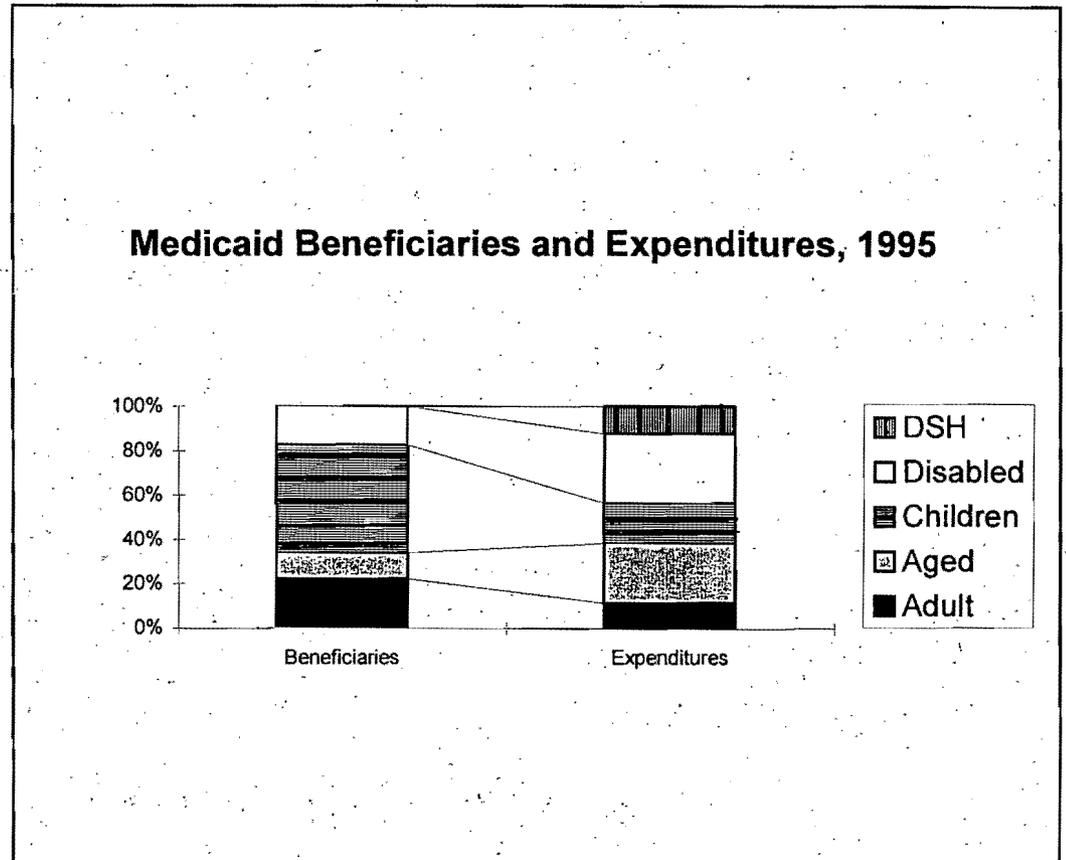
Other mandatory and optional groups who are eligible. There are other Medicaid beneficiaries who do not fit neatly into the six categories above. They include:

- AFDC-related groups: states are *required* to provide Medicaid to persons who otherwise meet AFDC eligibility standards but do not actually receive cash payments because the payments would be less than \$10 or persons whose payments are reduced to zero because of recovery of previous overpayments. At state *option*, Medicaid coverage is available to children who meet the income and resource standards of AFDC but do not meet the definition of "dependent child," (e.g. children in two-parent homes where the primary earner is *not* unemployed).
- Non-AFDC Pregnant Women and Children: States are permitted to cover pregnant women and infants under age 1 with incomes up to 185% of poverty.
- SSI-related groups: States, at their option, may provide Medicaid to individuals who are not receiving SSI but are receiving State-only supplementary cash payments.

Disjuncture between beneficiaries and expenditures.

Although adults and children in low income families make up nearly 70% of beneficiaries, they account for only 29% of Medicaid spending. The elderly and disabled account for the majority (57%) of spending because of their intensive use of acute and long-term care services. Per capita spending ranges from \$888 for non-disabled children to \$5,200 for aged beneficiaries.

Disproportionate share hospital (DSH) payments account for 12% of Medicaid spending, but cannot be attributed to a beneficiary or service category.



What Services are Covered? Medicaid covers a broad range of services to meet the complex needs of beneficiaries. Because of the limited financial resources of beneficiaries, *few or no cost-sharing requirements are imposed*. States that choose to cover the medically needy may offer *more restricted benefits* to these beneficiaries than to those who meet categorical eligibility criteria. Furthermore, states may offer optional services to the categorically needy only or to both categorically and medically needy.

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

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

States are required to provide to their *medically needy* populations prenatal and delivery services, ambulatory services, and home health. Broader requirements apply if the state provides services in ICF/MRs or IMDs.

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

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

*states still receive federal matching funds for optional services

Recent Beneficiary and Expenditures Growth.

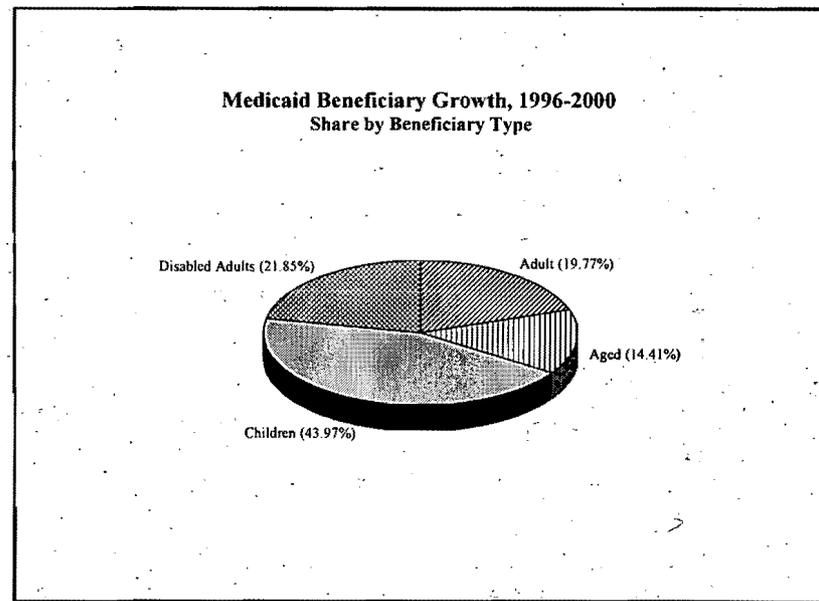
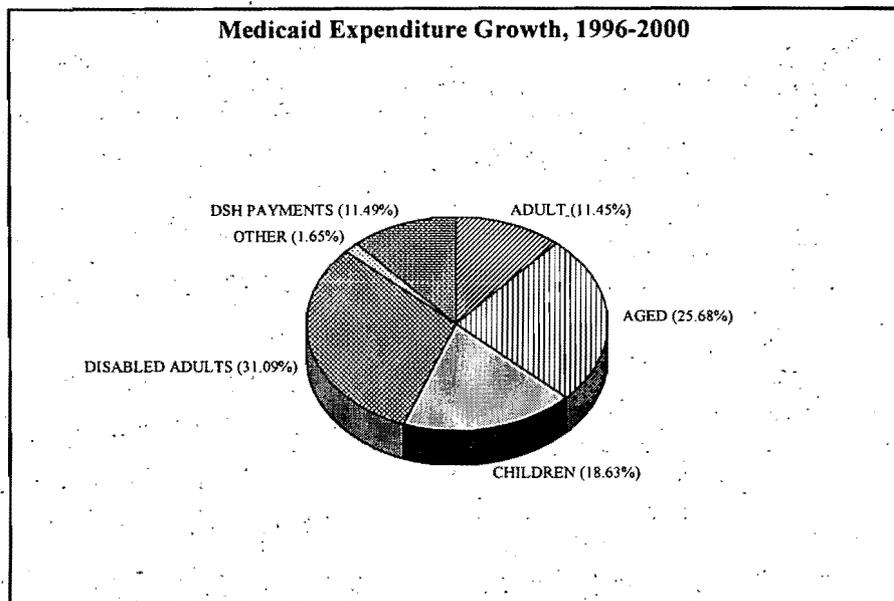
Beneficiaries. Recently, Medicaid enrollment has risen dramatically, reaching 36.1 million beneficiaries in 1995--up considerably from 25.3 million in 1990. *Growth has been mostly attributable to expanded coverage of low-income pregnant women and young children and increases in the number of blind and disabled beneficiaries.*

Expenditures. In recent years, Medicaid expenditures have escalated rapidly: *average annual increases of almost 17%* resulted in Medicaid expenditures more than doubling between 1990 and 1995. *Federal* expenditures have increased from \$41.1 billion to \$88.4 billion. The rise in spending in that period was attributable to a combination of health care inflation, states' use of alternative financing mechanisms (e.g., DSH payments, provider taxes and donations), and a rise in enrollment. DSH payments were the most important cost driver in 1991 and 1992, when Medicaid spending grew by 27% and 29%, respectively. In 2 years, DSH payments grew from slightly less than \$1 billion to \$17.4B. Only a small fraction of spending growth was attributable to the expansions in coverage of low-income pregnant women and children, however. The rate of growth in Medicaid spending has slowed more recently. The

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Effect on States. According to the National Association of State Budget Officers, in most states, Medicaid became the single largest and fastest growing item in the states' budgets. By 1993, Medicaid accounted for 18.4% of total states' expenditures.

Future growth mimics past growth. While the rate of growth in Medicaid spending has slowed recently, both the Administration and CBO expect the rate of growth to increase in the future. The Administration projects average annual growth rates of 9.3% for the period from FY 1996 through FY 2000 (CBO projects average annual growth rates of 10.5% over the same period). For the FY 1996 to FY 2000 period, the Administration projects Medicaid enrollment will grow at an average annual rate of 3.8% while prices, volume, and intensity are expected to grow by an average annual rate of 5.4%. As the charts below indicate, over the next 5 years, much (44%) of Medicaid beneficiary growth is expected to be among children and expenditure growth among the aged and disabled adults (57%).



How is Care Delivered? While traditional fee-for-service financing arrangements still predominate, an increasing number of states are enrolling their Medicaid populations in managed care programs. As of June 1994, 7.8 million Medicaid beneficiaries were enrolled in managed care, up dramatically from 2.7 million in 1991. Medicaid managed care models range from HMOs using prepaid capitated care to loose networks contracting with selected providers for discounted services and gatekeeping to control utilization. *States have initially targeted low-income families for enrollment rather than aged or disabled beneficiaries. There is very little experience with managed care for disabled populations who need institutional care.*

Movement toward Medicaid Waivers.

Section 1115 Research and Demonstration Waivers. Section 1115 of the Social Security Act allows the Secretary to waive requirements for what a State plan must include (e.g., *statewideness; amount, duration, and scope; eligibility*) and any requirement that defines the payments to states, including capitation contract requirements. Recently, states have been using Section 1115 to obtain waivers of federal statutory requirements to undertake statewide, mandatory managed care demonstration programs and expand coverage. The Administration has awarded Section 1115 waivers to seven states and twelve more have applied and are in the process of negotiation.

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1915(b) managed care waivers. The §1915(b) waivers are much more limited than the §1115 waivers. The Secretary can waive only those requirements which may be necessary to: 1) implement a primary case management system or a specialty physician services arrangement which limits freedom of choice; 2) allow a locality to act as a central broker to help enrollees select a plan; 3) provide additional services with the savings from managed care; or 4) restrict provider choice. States can use §1915(b) authority to establish managed care plans, but also to restrict providers for inpatient hospitals, nursing home facilities and transportation. States sometimes prefer 1115 waivers to allow for more extensive managed care development. For example, under 1915(b) authority, states cannot waive the requirement that no more than 75% of enrollment can be Medicaid beneficiaries for HMOs, nor can they waive "lock-in" provisions for recipients. Moreover, Section 1915(b) waivers must be renewed every two years.

1915(c) home and community-based services waivers. Presently, over three-fourths of Medicaid spending for long-term care is on institutional services in nursing homes. Increasingly, home and community-based services waivers are being used by states to shift services delivery away from costly nursing home care to community-based care. Although all states have home and community-based services waivers, most projects are limited in scope and the population served remains small.

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I. §1115 Medicaid Waivers

Since the original Medicaid legislation was passed in 1965, §1115 of the Social Security Act has given the Secretary of Health and Human Services the authority to waive certain requirements of the Medicaid program to support an "experimental, pilot or demonstration project" that will "assist in promoting the objectives of the Medicaid program." Under authority of §1115 , the Secretary allow States to:

- cover traditionally non-Medicaid populations and streamline eligibility rules;
- waive statutory (§1915(b)) HMO requirements, such as voluntary disenrollment and the 75/25 rule;
- extend the statutory HMO lock-in period and limit recipient choice to one delivery system; and
- provide Federal matching funds for costs that are not otherwise matchable under Title XIX.

States may apply for §1115 waivers for various reasons, including the desire to support broader State health reform initiatives, to increase coverage, to reduce the level or growth of Medicaid spending, or to maintain or increase Federal funding. Florida's waiver request, for example, was an integral part of the State's legislated goal to ensure access to affordable health care coverage for all Floridians by December 21, 1994. Although the legislature has yet to pass the Florida Health Security Plan upon which the waiver is based, the State has already established the Community Health Purchasing Alliances which are voluntary insurance buying pools for small businesses.

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II. §1115 Waiver Activity

- The Administration has approved seven Statewide §1115 demonstration projects since taking office. Of these seven, four have implemented their programs and one, Kentucky, recently submitted an amendment to scale back their program to eliminate eligibility expansions. Total acute care spending in States with approved Statewide demonstrations accounts for over 11% of all Medicaid expenditures -- operational waiver States account for 3.8% of national acute care expenditures. Since most demonstrations do not incorporate all State Medicaid acute care expenditures, these figures probably overstate the percentage of Medicaid expenditures attributable to §1115 demonstrations.
- The Administration is currently reviewing waiver proposals from an additional 12 States. Total acute care spending in States with pending applications (not including Kansas) represents an additional 17.4% of total Medicaid spending.
- The attached table 3.1, from a recent GAO report, lists the dates of submittal, approval, and implementation for States that have received or applied for §1115 waivers.
- The attached table 3.2, also from a recent GAO report, lists the approximate size and nature of eligibility expansions for States with approved waivers.

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Table 3.1: Section 1115 Statewide Demonstration Waivers Applied for Since 1991, by Submission Date

State	Submission	Approval	Implementation
Oregon	Aug. 1991 ^a	Mar. 1993	Feb. 1994
Kentucky	Mar. 1993	Dec. 1993	^b
Hawaii	Apr. 1993	July 1993	Aug. 1994
Tennessee	June 1993	Nov. 1993	Jan. 1994
Rhode Island	July 1993	Nov. 1993	Aug. 1994
Florida	Feb. 1994	Sept. 1994	^b
Ohio	Mar. 1994	Jan. 1995	^b
South Carolina	Mar. 1994	^c	
Massachusetts	Apr. 1994		
New Hampshire	June 1994		
Missouri	June 1994		
Delaware	July 1994		
Minnesota	July 1994		
Illinois	Sept. 1994		
Louisiana	Jan. 1995		
Oklahoma	Jan. 1995		
Vermont	Feb. 1995		
New York	Mar. 1995		
Kansas	Mar. 1995		

^aOregon's initial proposal was denied in August 1992. The state revised and resubmitted the proposal, which was approved in March 1993.

^bAwaiting state legislature approval.-Waiver amendment submitted 4/95.

^cHCFA has approved South Carolina's waiver proposal framework. However, certain issues must be resolved before the state is allowed to implement its demonstration program.

Source: HCFA.

Table 3.2: Estimated Maximum Number of New Eligibles Under Approved Statewide Section 1115 Waivers, by State

State	New eligibles ^a	Eligibility requirements
Florida	1,100,000	Individuals and families with incomes below 250% of the federal poverty level (FPL) are eligible for subsidized private insurance. Individuals and families are eligible only if uninsured for 12 months or recently disenrolled from Medicaid.
Hawaii	80,000	Uninsured persons below 300% of FPL.
Kentucky	201,000	Individuals with incomes below FPL.
Ohio	395,000	Individuals and families with incomes below FPL.
Oregon	112,000 ^b	Individuals and families with incomes below FPL
Rhode Island	11,000	Pregnant women and children up to age 6 with family incomes between 185% and 250% of FPL. Extension of family planning services for women for 2 years after giving birth.
Tennessee	500,000 ^c	All uninsured, regardless of employment or income status, including individuals who cannot obtain coverage because of a preexisting condition. (Enrollment capped for newly entitled, not capped for traditional Medicaid recipients. Eligibility restricted to those uninsured prior to a date within the last year.)

^aIncludes expansions to optional groups of Medicaid eligibles.

^bActual new enrollment as of March 3, 1995.

^cIn January 1995, Tennessee closed enrollment to the uninsured; demonstration enrollment was 438,000 in February 1995.

Source: State waiver proposals and supporting documentation.

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III. The §1115 Review Process

- Upon taking office, this Administration recognized the desire and the need of States to have greater flexibility in reforming their Medicaid systems. This Administration is committed to minimize the burden States may encounter in the waiver application process.
- The Administration has pledged to try to review waivers in an expedited fashion. States are encouraged to seek pre-waiver guidance from HHS. To facilitate an expedited review process, HHS and OMB now also review waivers simultaneously.

Administration review of §1115 waivers generally proceeds as follows:

1. *Initial Review.* About a month after the State submits its proposal, ORD collects questions from HHS and OMB and forwards them to the State.
2. *Fact-Finding and Clarification.* After the State responds to these questions -- and sometimes even before they respond -- the Administration and the State begin a series of informal staff-level conference calls or face-to-face meetings to provide a factual basis for negotiations.
3. *Negotiations.* This multi-stage process typically includes additional information requests to the State, additional meetings with the State, and periodic requests for policy guidance.

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IV. §1115 Budget Neutrality Policy

- Although not required in law, budget neutrality has been a federal policy for all §1115 waivers since 1984.
- A State meets the test of budget neutrality by demonstrating that, over the (generally) five-year life of the waiver, projected Federal costs under the waiver do not exceed projected Federal costs without the waiver.
- Though the Administration has pledged to remain open to new methodologies, a budget-neutral waiver expenditure limit is generally set by calculating baseline current-law expenditures as follows:

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

$$\text{Baseline Expenditures} = \text{Projected Per-Capita Spending} * \text{Actual Enrollment over time}$$

This approach has been taken with each waiver approved by the Administration, with the exception of Tennessee and Florida, who preferred an aggregate budget cap.

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

$$\text{Baseline Expenditures} = \text{Projected Per-Capita Spending} * \text{Projected Enrollment}$$

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- The budget neutrality calculation generally includes program components affected by the waiver, e.g., acute care for AFDC and AFDC-like recipients, though Tennessee chose to impose a budget cap on their entire Medicaid program.
- Budget neutrality discussions generally focus on the development of an appropriate estimate of without-waiver spending in a *base year*, as well as appropriate *trend factors* over the life of the waiver.
- In a report issued April 4 reviewing Administration enforcement of the budget neutrality requirement, the General Accounting Office concluded that budget neutrality calculations should rely on the use of Federal baseline rates of growth, rather than the more flexible approach taken by the Administration. The GAO concluded that one of the waivers approved by the Administration, TennCare, was budget neutral while three others, Hawaii, Florida, and Oregon, were not budget neutral.

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V. Budget Neutrality and Financing Issues

- Negotiations over budget neutrality and other financing issues can be long and complicated, with States engaging in a broad spectrum of approaches aimed at securing optimal funding limits and sources. Two examples of such innovations:

- *hypothetical expenditures*. States may assert that they would have expanded eligibility under current law without a waiver (under authority of §1902(r)(2)), thus avoiding the need to create savings under the waiver budget cap to expand coverage to these populations; and
- *certified public expenditures (CPE)*: CPE are defined in regulations as costs incurred by State or local public agencies that represent allowable Medicaid expenditures, i.e., expenditures for Medicaid services attributable to Medicaid eligibles. Certification is intended to obviate the need for State agencies and local governments to transfer funds to the States before the State claims Federal matching funds. Under a §1115 waiver, the definition of Medicaid services and Medicaid eligibles can be expanded almost without limit, potentially encompassing significant portions of local public health programs. Under a waiver, local expenditures for certain public health programs may be used to claim Federal matching funds. Tennessee, for example, is able under the terms of its waiver to claim Federal matching funds for the costs incurred by local public hospitals for most indigent care and for TennCare underpayments.

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I. Tennessee's Pre-Waiver Medicaid Program

- *General State Characteristics.* In 1993, Tennessee was the 17th largest State with 5.1 million residents. Tennessee ranked 20th in gross State product and 36th in total taxable resources (in 1991). The State has a relatively low average per-capita income, and thus had the 15th highest Federal match rate in 1993: 67.57%.
- *General Program Characteristics.* As of October, 1991, Tennessee offered 19 optional services out of 31 possible, ranking 35th among all States. Tennessee was one of 27 States to cover pregnant women and children up to 185% of poverty and had an AFDC income threshold of 43% of the Federal poverty level -- nearly exactly the national average. Tennessee covered 13.4% of its population through the Medicaid program, compared to a national average of 11%, and ranked 12th in the nation in FY 1993 in per-capita Medicaid spending.
- *Rising Costs.* Over the 1987-1993 period, State Medicaid expenditures tripled. Urban Institute analysis indicates that Tennessee ranked about 17th in average annual growth in Medicaid expenditures between 1988 and 1993 (about 2% above the national average), 8th in average annual growth in beneficiaries (about 6% above the national average), and 39th in average annual growth in per-beneficiary expenditures (about 4% below the national average).

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- *Uninsured Populations.* The State estimated that 775,000 residents were uninsured in 1993: 16.0% of Tennessee's non-elderly population was uninsured in 1993, compared to a national average of 16.6%. To address the large percentage of uninsured that were employed (70%), in 1987 the State established a PPO-type insurance program for people who either had health conditions that caused them to be uninsurable or who are involuntarily terminated from coverage. Only 3,900 people were enrolled in the program due to the high premiums.
- *Inappropriate Utilization.* Tennessee had a high rate of emergency room visits in 1993 -- 475.8 per 1,000 population, compared to a national average of 371 per 1,000. In 1991, Tennessee had the 12th highest infant mortality rate in the nation.
- *Expiring Provider Tax.* Tennessee relied heavily on two provider taxes to fund its Medicaid program: a hospital tax that raised roughly \$320 million annually (generating about \$1 billion in Federal matching funds) and a nursing home tax that raised roughly \$35 million annually (generating over \$100 million in Federal funds). The politically unpopular hospital tax was set to expire in early 1994 and was suspected by HCFA to be in violation of certain requirements of the 1991 Federal law limiting State use of provider taxes and donations. The hospital tax was included in a list issued by HCFA in December, 1994, of 23 States with tax programs that do not meet certain requirements of the law as implemented by regulations published in August, 1993. These States may apply for waivers of the statutory requirements. The nursing home tax was included in a list of nine States that have collected taxes that appear to HCFA to be impermissible. Waivers are not available for these nine States.

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II. The TennCare Program

- *Basic Structure.* TennCare is a Statewide program that provides a standard package of basic health care benefits via managed care and in a managed competition environment to Medicaid beneficiaries, uninsured State residents, and those whose medical conditions render them uninsurable.
 - *Premiums and Cost-Sharing.* Participants with incomes exceeding the Federal poverty limit pay some portion of their premiums on a graduated fee schedule. Deductibles and copayments are also required on non-preventive services for all participants except mandatory Medicaid eligibles. Most, if not all, premium revenue collected by the State counts towards the State share of Medicaid expenditures. The State had early difficulties collecting premiums.
 - *Managed Care/Managed Competition.* Enrollees are served in one of 12 capitated managed care organizations (MCOs) that are either HMOs or PPOs. The State has developed an age-adjusted community capitation rate to pay plans (currently averaging about \$1,300 per year). The State originally planned to move to a competitive rate-setting mechanism, with rates equal to the lowest cost MCO in each community, but it is unclear at this point when they will move forward with that approach.
-
- *Enrollment.* Enrollment is capped at 1.5 million. Within six weeks after being awarded the waiver, Tennessee began enrolling both Medicaid and new eligibles into TennCare. To date about 1.2 million people have enrolled, including roughly 440,000 previously uninsured. A survey by the University of Tennessee in 1994 found that 94.1% of Tennessee residents had insurance coverage, an increase of 4% over a one-year period. Due to funding constraints, the State closed enrollment in the program for the uninsured in January, 1995.

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- *Budget Neutrality.* The TennCare budget neutrality agreement incorporates all State Medicaid expenditures under an aggregate expenditure cap that grows at roughly 8.5% per year between SFY 1993 and SFY 1998, based on projected baseline growth of 17% from SFY 1993 to SFY 1994 (the base year) and about 6.6% annually thereafter. Total Medicaid expenditures in Tennessee had grown at roughly 21% annually over the 1988-1993 period.

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III. Can TennCare be Replicated in Other States?

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Financing. The concept of allowing other States to mandate managed care for their acute care populations and use the savings to cover more uninsured people is attractive, but because of the variation among State Medicaid programs, there are real questions about whether other States could accomplish this, whether it would be done in a budget neutral manner, and whether it would preserve a sustainable Federal/State financing relationship:

- *A unique definition of budget neutrality was used in Tennessee.* In establishing a budget-neutral cap for TennCare, the Administration assumed that Tennessee's Medicaid program would remain unchanged without the waiver both in terms of programmatic components and expenditures. In other words, the Administration assumed that neither the State nor the Federal government would reduce the Medicaid program and that both the State and Federal government would continue funding at pre-waiver levels, which had supported a 21% annual growth rate over the 5 years preceding the waiver. This assumption means that the State's disproportionate share hospital program, which had been spending about \$430 million per year financed largely through the provider taxes mentioned above, was assumed to continue, and thus was made part of the State's "baseline." In other waivers, the Administration has made some judgment as to likely programmatic and funding changes absent the waiver. Without such judgments -- or if the judgments prove to be incorrect -- §1115 waivers may turn out not to be budget neutral.
- *Expanded definition of State matchable expenditures.* Under their waiver, Tennessee was able to reclassify significant amounts of local public health expenditures as Medicaid expenditures eligible to generate Federal matching payments [see Tab 2, Part V for an explanation of this waiver financing mechanism]. Since the TennCare waiver was approved, several other States have asked for similar treatment of State health expenditures. Louisiana, for example,

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has requested Federal matching payments for a wide range of State and local health expenditures that do not currently qualify as Medicaid expenditures. If applied in other States, the TennCare precedent could lead to a significant increase in the percentage of total public health expenditures born by the Federal government.

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- *Financial instability.* Though TennCare was designed in large part to help preserve Federal funding for Tennessee's Medicaid program and to expand coverage, the State's ability to continue its share of the funding at this level remains uncertain -- potentially imperiling the long-run success of the demonstration (see "Provider Concerns" below). TennCare is currently running a deficit of \$99 million. According to the State, this may be because of a higher than expected level of enrollment (\$62 million) and in because of lower than expected premiums collections from the working poor (\$37 million). It may also be that new financing sources made available under the waiver did not fully offset the lost revenue from the expiring provider tax. The State's financial report for TennCare's first year of operation is due this summer. This report should provide additional information on actual TennCare funding and expenditures.

Implementation. In a rush to meet the self-imposed short implementation schedule, TennCare appears to have encountered some significant implementation problems during its start-up phase:

- The enrollment process in Tennessee seems to have been significantly compromised by the short implementation period. In Tennessee's rush to enroll people, they asked people to choose an MCO even before the MCOs had been officially licensed. As a result, some people chose MCOs that in the end decided not to participate.

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- At least in the initial implementation stages, the sufficiency of the provider networks was seriously in question. Only one of the MCOs -- Blue Cross/Blue Shield -- had a relatively comprehensive provider network at the time during the initial enrollment period. Most physicians had no idea of what MCO they would join at the time when enrollees were being asked to choose an MCO. Some provider networks that the MCO claimed were in place turned out to be illusory. When patients obtained a list of participating providers, they frequently found out that the providers were no longer participating or were not available to provide treatment. Some patients had difficulty in accessing care because their MCOs contain significant service gaps. During the initial implementation period, only the largest MCOs had developed provider panels with a complete spectrum of specialty services.
- Requiring low income populations to enroll into managed care in a short time frame placed significant pressure on health plans to enroll members quickly and in large numbers. New plans especially needed to enroll large numbers of people to offset expensive start up costs. Several MCOs practiced questionable and even illegal marketing practices in order to gain a larger market share. In their April, 1994 report on TennCare implementation, the National Association of Public Hospitals cited repeated, though undocumented reports that beneficiaries had been offered hams, turkeys or cash in exchange for enrolling in an MCO.
- Other than Blue Cross/Blue Shield coverage of State employees, Tennessee had little experience with managed care before TennCare. Less than 5% of the State's population was enrolled in HMOs in 1992, compared to a national average of 16%. Roughly 4% of Medicaid recipients were enrolled in managed care in 1992, compared to a national average of 12%.

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- Many of the State's problems with the provider community and administering the program were caused by the quick implementation schedule, which could have been accelerated due to the pending expiration of the provider tax. Implementing the program more slowly would have allowed more time to acquire staff expertise, to develop a community base of support, to create an organizational structure and administrative operation and to educate staff, providers and beneficiaries.

Counterpoint: Tennessee's rapid implementation schedule and ambitious reform plans helped create in the State a momentum for change and a critical mass of support for the program -- a program that may now be too large and entrenched for the State legislature or providers to undo.

Ongoing Provider Concerns.

- The Tennessee Medical Association brought suit unsuccessfully against TennCare because they believed the physician rates were too low. Physicians have been critical of the "cram down" rule, which requires physicians providing services to Blue Cross/Blue Shield-covered State employees to participate in TennCare. Although many physicians had dropped out of the State employees program initially, most have since returned.
- The Tennessee Pharmacists Association has complained that pharmacy rates for people in nursing homes are too low.
- Hospitals are also beginning to feel TennCare's pinch. Tennessee originally planned to set up a pool of funds to make supplemental payments to hospitals for medical education, continuing uncompensated care costs, and the unusual costs associated with high-volume Medicaid providers. Because of funding constraints, the State recently

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abandoned plans to make \$217 million in annual payments from this pool to hospitals for indigent care and graduate medical education. Since TennCare began, several major hospitals in the State have experienced financial problems, including the State's largest Medicaid hospital in Memphis, which has eliminated 100 beds, laid off 218 employees (and may soon lay off another 190), and eliminated cardiology and cancer services.

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**Illustrative Medicaid Capped Growth Scenarios Being Considered by Congress
Benefits Only--FY 1996 President's Budget Baseline Estimates**

(fiscal years, billions \$)

	5 Years (1996-2000)	7 Years (1996-2002)	10 Years (1996-2005)
Medicaid Benefits Under Baseline	554.3	855.5	1,419.2
Benefit Growth	9.3%	9.3%	9.2%
5 % Cap	-62.3	-130.5	-299.3
7 % Cap	-32.5	-70.3	-165.6

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Illustrative Medicaid Savings Proposals Being Considered by Congress

		Savings (\$ in billions)		
		1996 - 00	1996 - 02	1996 - 05
DSH				
Reduce DSH payments by one-third	1/	(42.5)	(63.8)	(101.0)
Replace DSH with a Vulnerable Population Adjustment	1/	(43.0)	(65.0)	(103.8)
Welfare Reform Effects				
Restrict Medicaid Benefits for Legal Aliens	2/	(13.9)	n/a	n/a
Deny SSI/Medicaid to Drug Addicts & Alcoholics	2/	(1.0)	n/a	n/a
Deny SSI/Medicaid to Certain Children	2/	(0.6)	n/a	n/a
Reimbursement				
Repeal the Boren Amendment		n/a	n/a	n/a
Eliminate 100% Cost Reimbursement for FQHCs		n/a	n/a	n/a
Eligibility				
Tighten Asset Transfer and Estate Recovery Rules		n/a	n/a	n/a
Managed Care				
Mandatory Managed Care for AFDC Adults and Children and Non-Cash Children (assumes a 5% one-time reduction in costs)	1/	0.9	(0.6)	(3.7)
Mandatory Managed Care for AFDC Adults and Children and Non-Cash Children (assumes a 10% one-time reduction in costs)	1/	(1.2)	(4.5)	(10.8)

1/ Staff Estimate using FY 1996 President's Budget Baseline

2/ Preliminary OACT Estimate

n/a = Savings estimates are not available

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Medicaid Reform Options Being Considered by Congress

Growth in the Medicaid program could be controlled and the program could be restructured in a number of ways.

1. Comprehensive Medicaid Reform

One way to control growth in the Medicaid program would be to institute a major structural reform of the program, eliminating the matching rate system, but leaving in place the individual entitlement. Federal savings would be guaranteed by controlling the program's rate of growth and converting the disproportionate share hospital (DSH) program into a smaller vulnerable population adjustment pool that would grow by the rate of growth in the nominal GDP.

States would be given a fixed per capita amount to provide a standard Medicaid benefit package. The initial amount would be based on an estimate of per capita Medicaid costs for the services in the standard benefit package. This estimate would assume some initial savings from gains in program efficiency. The per capita amount would increase by the rate of growth in the nominal GDP per capita. States would be at risk for additional increases in costs per capita, but not for increases in enrollment.

This option contains three major elements:

- The current array of Medicaid services would be reconfigured into one standard Medicaid benefit package across all states. States would continue to have the option of providing additional benefits at their own expense.
- Recipients could be required to pay nominal cost-sharing for most services.
- States would be given the flexibility to continue determining eligibility within new Federal guidelines, move Medicaid recipients from a fee-for-service delivery system into managed care systems, and more efficiently administer the program.

Under this option, you could choose not to limit the growth of benefits in order to allow states to expand coverage. Alternatively, you could limit growth to some level below current baseline levels (growth in nominal GDP per capita plus adjusted recipient growth (about 7.7%)). The table following the pros and cons (Illustrative Savings Option 1) illustrates the savings generated from limiting benefit growth and alternatively, streamlining eligibility without a limit on benefit growth. The table also shows savings generated from converting the DSH program into a Vulnerable Population Adjustment pool.

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Pros:

- Because a per capita block grant retains the individual entitlement, Medicaid could still serve as an economic stabilizer during times of recession. A per capita block grant limits Federal liability by holding the states at risk for increased costs per recipient and provides state flexibility.
- Defining a standard benefit package reduces the variation in the generosity of benefits among states. The standard benefit package would more closely resemble the benefits offered under private insurance indemnity plans, such as the Blue Cross & Blue Shield standard benefit package.
- Requiring nominal cost-sharing payments from recipients would also more closely resemble private insurance plans. Cost-sharing would promote more responsible utilization of services, which could lower per capita costs.
- Federal eligibility guidelines could be reworked to be based solely on income as a percent of the Federal poverty level. This would rationalize access to Medicaid services by offering more equitable and uniform eligibility standards. Alternatively, states could be given broader leeway to determine eligibility under tighter overall rules, which may include tightening eligibility requirements for the non-cash aged population or the SSI population. Changes in eligibility for these populations could be made by tightening SSI eligibility for drug addicts, alcoholics, immigrants, and certain children; and/or by tightening spenddown and asset transfer rules.
- The block grant would allow states greater flexibility to administer their programs by allowing them to place recipients into managed care arrangements without having to seek a waiver.

Cons:

- If eligibility is determined solely based on income, e.g., 100 percent of Federal poverty level, some individuals who are currently ineligible for Medicaid (single males) could become eligible, while others currently eligible (pregnant women and children with incomes at 133 percent of the Federal poverty level) would become ineligible.
- States are at risk if Medicaid costs grow faster than the allowed rate of growth in the per capita amount.
- Limiting Federal Medicaid funding to payments for a standard set of benefits would have widely varying impacts across States

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relative to the Federal funding for their current Medicaid programs. For example, a State with generous benefits, i.e., Wisconsin, could lose a large proportion of its Federal matching payments, while a State with minimal benefits, i.e., Delaware, could gain Federal payments under the block grant.

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**Illustrative Savings Option 1
Comprehensive Reform
(Fiscal Years, \$ in billions, Federal Share Only)**

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		Total 1996 - 2000	Total 1996 - 2002	Total 1996 - 2005
Capped Growth for Benefits	1/2/	(44.9)	(84.4)	(176.9)
Convert DSH into a VPA Pool	1/	(43.0)	(65.0)	(103.8)
Savings Proposals Total		(87.9)	(149.4)	(280.7)

1/ Savings Estimated from data behind the FY 1996 President's Budget

2/ Capped growth achieved by limiting expenditure growth to growth in nominal GDP per capita and adjusted recipient growth (about 7.7%).

One Alternative to Capping Benefits

		Total 1996 - 2000	Total 1996 - 2002	Total 1996 - 2005
Streamline Eligibility without Cap	1/2/	(9.3)	(19.8)	(47.5)
Convert DSH into a VPA Pool	1/	(43.0)	(65.0)	(103.8)
Savings Proposals Total		(52.3)	(84.8)	(151.3)

1/ Savings Estimated from data behind the FY 1996 President's Budget

2/ Savings generated from tightening certain eligibility rules for the elderly and disabled.

Another Alternative to Capping Benefits

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		Total 1996 - 2000	Total 1996 - 2002	Total 1996 - 2005
Per Capita Block Grant without Caps	1/	0	0	0

1/ Note this assumes a current baseline growth for benefits.

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2. Block Grant with State Flexibility

Under such a block grant, the Federal government would grant the states a large degree of flexibility to administer the Medicaid program, removing the existing Medicaid matching structure and individual entitlement status. In turn, the states would be at risk for any costs associated with their Medicaid programs above the level of the Federal grant. The Federal grant would reflect savings realized from converting the disproportionate share hospital (DSH) program into a smaller vulnerable population adjustment pool that grows by the rate of growth in the nominal GDP. **States would determine the level of eligibility, benefits and reimbursement rates for their programs.**

The level of the Federal grant would be determined using a base year adjusted for tightening eligibility rules for SSI and the non-cash aged and adjusted for savings in per capita expenditures from anticipated program efficiencies. For example, these efficiencies could include limiting the amount of intergovernmental transfers or reducing variation in reimbursement for nursing homes and ICFs/MR. The growth rate for the block grant would be based on a predetermined index that accounts for recipient growth under the tightened eligibility rules and nominal GDP per capita.

The table following the pros and cons (Illustrative Savings Option 2) illustrates specific policies states may pursue to offset the loss of federal funds under a block grant.

Pros:

- The Federal government, by lowering the growth rate of the new block grant, can achieve savings.
- States are provided with the greatest flexibility to determine eligibility, benefits, reimbursement levels, and delivery systems.
- Congress could achieve savings without proposing specific reductions in eligibility, payments, or services.
- The Federal liability is capped and predictable.
- The ability of states to game Medicaid in the future could be reduced.

Cons:

- States' ability to manage a program with an annual cap varies considerably.

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- Depending upon the index used, Medicaid may not serve as a limited safety net for insurance coverage during a recession.
- States may be forced to shift resources from the AFDC-related population to the aged and disabled population because this population is growing faster and has higher per capita costs.
- Accountability for Federal funds could be reduced.
- Some states could reap a "profit" if no state maintenance of effort is required.

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**Illustrative Savings Option 2
Block Grant With State Flexibility
(Fiscal Years, \$ in billions, Federal Share Only)**

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		Total 1996 - 2000	Total 1996 - 2002	Total 1996 - 2005
<u>Reimbursement Reductions</u>				
Reduce Inpatient Hospital Payments	1/2/	(9.7)	(14.6)	(23.2)
Reduce Nursing Facility Payments	1/2/	(10.2)	(15.4)	(25.0)
Convert DSH into a VPA Pool	1/	(43.0)	(65.0)	(103.8)
<i>Subtotal, Reimbursement</i>		(62.9)	(95.1)	(152.0)
<u>Elimination of Benefits</u>				
Eliminate Coverage for Home Health Services	1/	(6.8)	(10.6)	(18.0)
Eliminate Coverage for Personal Care Services	1/	(11.9)	(18.2)	(29.6)
Eliminate Coverage for Dental Services	1/	(6.0)	(9.4)	(15.6)
Repeal EPSDT Mandate	3/			
<i>Subtotal, Benefits</i>		(24.7)	(38.2)	(63.2)
<u>Elimination of Eligibility Categories</u>				
Eliminate Coverage for Medically Needy Adults	1/	(6.3)	(9.8)	(16.5)
<u>Managed Care</u>				
Mandatory Managed Care for AFDC Adults & Children, Non-Cash Children	1/	0.9	(0.6)	(3.7)
Interactive Effects	4/	12.5	19.7	32.9
Savings Proposals Total		(80.5)	(124.0)	(202.5)

- 1/ Savings Estimated from data behind the FY 1996 President's Budget
- 2/ Reduction in Inpatient Hospital or NF expenditures could result from utilization controls or lower rates.
- 3/ No pricing available
- 4/ Interaction assumes a 25% offset

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3. Federally-directed Approach

The Federal government could pursue specific policies to reduce Federal spending to meet the savings necessary in a capped growth scenario.

Eligibility rules for SSI and the non-cash aged populations could be tightened to achieve savings. Current optional services (except prescription drugs, including ICFs/MR) could be capped at the current levels and allowed to grow by the rate of growth in the nominal GDP. The disproportionate share hospital program could be eliminated and replaced with a smaller vulnerable population adjustment pool that would grow by the rate of growth in the nominal GDP.

The table following the pros and cons (Illustrative Savings Option 3) illustrates specific policies the federal government could pursue to limit Medicaid spending under a capped growth scenario.

Pros:

- The individual entitlement and match rate system for Medicaid is retained.
- Savings are achieved by specific policies to slow the rate of growth in eligibility, and the rate of growth in optional service expenditures.
- Accountability and Federal oversight are retained.

Cons:

- This approach makes no fundamental changes to the Medicaid program.
- There is no limit to overall Federal liability nor are states given greater flexibility to administer the program.
- States' ability to game Medicaid in the future has not been controlled.

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**Illustrative Savings Option 3
 Federally-Directed Approach
 (Fiscal Years, \$ in billions, Federal Share Only)**

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		Total 1996 - 2000	Total 1996 - 2002	Total 1996 - 2005
<u>Reimbursement Proposals</u>				
Repeal Boren Amendment	1/			
Convert DSH into a VPA Pool	2/	(43.0)	(65.0)	(103.8)
<u>Eligibility Proposals</u>				
Limit Eligibility for Certain Aged Recipients	2/	(11.4)	(24.0)	(56.4)
<u>Benefits Proposals</u>				
Block Grant Optional Services	2/	(13.8)	(29.2)	(67.4)
<u>Managed Care Proposals</u>				
Mandatory Managed Care for AFDC Adults & Children, Non-Cash Children	2/	0.9	(0.6)	(3.7)
Interactive Effects	3/	6.1	13.5	31.9
Savings Proposals Total		(61.2)	(105.4)	(199.4)

1/ No pricing available

2/ Savings Estimated from data behind the FY 1996 President's Budget

3/ Interaction assumes a 25% offset

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S. ___: Medicaid Managed Care Act of 1995

Senator Chafee is circulating a draft copy of this bill. The bill amends the Social Security Act to permit greater flexibility for States to enroll Medicaid beneficiaries in managed care arrangements, to remove barriers that prevent States from using managed care to provide Medicaid services, to establish quality standards for Medicaid managed care plans, and for other purposes.

- States may require Medicaid recipients to enroll in managed care plans without applying for a waiver.
 - However, states may not mandate enrollment for (1) children with special health care needs (i.e., children who are disabled, on SSI, or in foster care); (2) qualified Medicare beneficiaries; (3) homeless; or (4) migrant agricultural workers. (§new 1931)
- The current federal requirements governing managed care under Medicaid are repealed.
- The bill establishes, and Medicaid managed care plans must abide by, standards for:
 - nondiscrimination; quality assurance; due process for plan providers and enrollees; and treatment of children with special health care needs.
- The bill includes provisions to prevent fraud in Medicaid managed care plans.
- The bill also includes sanctions for noncompliance by Medicaid managed care plans.

The bill also contains the following provisions affecting §1115 and §1915 waivers.

- The bill grandfathers approved §1115 and §1915(b) Medicaid waivers until the expiration date of the waiver.
- The Secretary must, prior to extending any §1115 or §1915 waiver, conduct an evaluation of existing and pending waivers and submit a report to Congress recommending whether States requesting an extension of such waivers be required to comply with the new Medicaid managed care requirements found in this bill.
- The Secretary may not waive, pursuant to §1115 or §1915, any of the provisions contained in this bill except for one specific provision regarding the treatment of children with special health care needs by managed care plans.

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S 634: State Medicaid Savings Incentive Act of 1995

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Senator D'Amato introduced this bill on March 28, which was referred to the Finance Committee. The bill includes the following provisions:

- At the beginning of each fiscal year, the Secretary of Health and Human Services would be required to set a Medicaid baseline for each state based on historical growth in the state and other factors she deems appropriate.
- If a State achieves a rate of growth for a fiscal year which is less than the state's baseline rate, the Secretary would be required to make an incentive payment to the state.
- The incentive payment would be equal to the amount that is 20 percent of the difference between the amount the federal government would have paid to a state in that fiscal year, if state Medicaid expenditures had increased by the expected state baseline growth rate and what the state actually spent in that fiscal year.

Comments: This system would cause complex and highly political negotiations between HCFA and the states about the choice of a base year, which years should be included in growth rates, and which "other factors" should be included.

States with historically high growth rates from donations and taxes and DSH payment schemes could benefit from having a baseline set based on historical growth. Through incentive payments, states could recoup some of the federal funds that they would have otherwise lost as a result of the 1991 and 1993 laws. HHS would be required to refund part of the difference between states' inflated baselines and actual state expenditures that were in compliance with the DSH laws. This would undoubtedly result in increased federal expenditures.

A Historic Note: OBRA 81 established caps for federal Medicaid spending and incentives for states. Total federal reimbursement received by each state in FY 1982, 1983, and 1984 was reduced by 3 percent, 4 percent, and 4.5 percent respectively. A state's reduction could be lessened one percentage point for each of the following conditions: operating a qualified hospital review program; an unemployment rate exceeding 150 percent of the national average; or fraud and abuse recoveries equal to one percent of federal payments to the state.

States could also decrease their reductions by spending less than their "target" amounts. Each state's target amount for FY 1982 was 109 percent of the state's estimate of the federal share of FY 1981 Medicaid expenditures. Target amounts for the subsequent years

were adjusted based on changes in the MCPI-U. For each dollar under its target amount, a dollar was offset from the state's total reduction.

The provisions were repealed in FY 1985. Many dispute whether the Reagan cap actually had an impact on the program, since there were so many ways in which states could lessen the percentage reductions set in the law.

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THE BASICS OF MEDICAIDTERMS AND DEFINITIONS

- ADLs** Activities of Daily Living. General categories used to measure an individual's level of functional impairment -- dressing, bathing, toileting, eating, and mobility.
- ALJ's** Administrative Law Judges - preside over hearings regarding disputes over eligibility determinations.
- AMP** Average Manufacturer Price - Average unit price paid to a manufacturer for a covered outpatient drug in the States by wholesalers for drugs distributed to the retail class of trade. Basis for rebates.
- APWA** American Public Welfare Association.
- Assignment of Rights** Requirement that States secure the right of recovery from any liable third party who can or must contribute or pay for covered Medicaid services. Medicaid recipients sign a statement authorizing the State to recover from third party payors.
- Best Price** Lowest price at which a manufacturer sells single source or innovator multiple source drugs to any purchaser in any pricing structure. Basis for rebates.
- Bona Fide Effort to Sell** Exclusion of any resource which an individual has tried unsuccessfully to sell. There is no time limitation on this exclusion. This is an SSI procedure.
- Boren Amendment** Section 1902(a)(13)(A) of the Act, known by the name of its principal sponsor, which provides that State payment rates for hospitals and nursing facilities must be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in accordance with State and Federal laws and regulations and quality and safety standards.
- Buy-in** Refers to the requirement under section 1903(a)(1) of the Act. States must "buy-in" or purchase private or public health insurance for certain

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- individuals. The "buy-in" of Medicare costs for the elderly and working disabled is the most common example of this. (see QMB and QDWI)
- CPI** Consumer Price Index
- Capitation** Payment of a rate per recipient per month or for any designated period
- Case Management** When a specific person or agency is responsible for locating, coordinating, and monitoring all primary care and other medical services on behalf of a recipient.
- Comparability** The requirement that, with certain exceptions, services available to the categorically needy must be no less in amount, duration, and scope than those available to the medically needy. Also, services to individuals must be equal in amount, duration and scope for those within the categorically needy group and for those within a covered medically needy group.
- Cost Avoidance** Third Party Liability requirement that States must require providers to obtain payment from other liable parties before the Medicaid program will reimburse for covered services.
- DD** Developmentally Disabled - defined in the Developmental Disabilities Act of 1984 (P.L. 98-527)
- DME** Durable medical equipment, such as wheelchairs, oxygen tanks, and apnea monitors.
- DRG** Diagnosis Related Grouping - rate-setting system for Medicare. Some States reimburse inpatient hospital expenses under their own DRG System.
- Deeming** Considering income or resources which are available to an individual not receiving assistance as available to an individual receiving assistance. In Medicaid, income and resources are only deemed from parent to child or from spouse to spouse. (Be aware that AFDC deeming rules are different from those of Medicaid and that there has been a great deal of litigation on that issue.)

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- DSH** Disproportionate Share Hospital. A hospital which serves a higher than average proportion of medically indigent patients. States pay these hospitals at a rate which compensates them for their care to non-paying patients.
- Dual Eligibles** Individuals eligible for both Medicare and Medicaid.
- DUR** Drug use review. Program required of all States by OBRA 90. Retrospective and prospective review of prescriptions is made to assure they are appropriate, medically necessary and that they will not result in adverse medical outcomes.
- EPSDT** Early and Periodic Screening, Diagnostic and Treatment services - screening/diagnostic services to determine physical or mental problems in recipients under 21; includes treatment to correct or ameliorate any defects and chronic conditions.
- ESRD** End Stage Renal Disease
- Entitlement** Program or benefit available as a matter of right to all who meet the specified eligibility criteria.
- Essential Spouse** The spouse of an aged, blind or disabled recipient of cash benefits who lives with the individual, whose needs were included in determining the amount of cash payment, and who is determined essential to the individual's well being.
- FFP** Federal Financial Participation - The amount of money paid to a State by the Federal government for Medicaid services provided to a recipient and for administration of the Medicaid program in the State. For services, FMAP is the rate used to calculate FFP. Administration and Medicaid Management Information System costs are matched at other uniform rates.
- FMAP** Federal Medical Assistance Percentage - the percentage of the total cost of medical care provided through the Medicaid program that is paid for by the Federal government. FMAP is based on the relationship between a State's per capita personal income and that of the nation as a whole.

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for three previous years. FMAP's vary from 50 to about 80 percent. (See Appendix C for a complete listing.)

- IV-D Agreements** As part of its TPL program a State must have a written agreement with a local child support enforcement agency for recovery of funds for the Medicaid program from an absent parent and/or his/her insurance benefits.
- Freedom of Choice** A principle of Medicaid which allows a recipient freedom to choose providers. Can be waived (see WAIVERS).
- Grandfathered Groups** Certain groups which Congress exempts by law from new requirements, e.g., stricter eligibility requirements.
- HHA** Home health agency - an entity that provides medical services to patients in their homes.
- HIO** Health Insuring Organization - an entity that pays for medical services provided to recipients in exchange for a premium or subscription charge paid by the State and assumes an underwriting risk.
- HMO** Health Maintenance Organization - a prepaid health plan that renders a comprehensive range of health care services to enrollees in return for predetermined premium payments or a capitation rate.
- Hospice** Term used to refer to a facility that cares for terminally ill patients, or to the care itself.
- ICF** Intermediate Care Facility - See NF. Prior to OBRA 87 an ICF was an institution furnishing health-related care and services to individuals who did not require the degree of care provided by hospitals or skilled nursing facilities (SNFs).
- ICF/MR** Intermediate Care Facility for the Mentally Retarded - an institution which provides appropriate supervision and active treatment to Mentally Retarded and Developmentally Disabled residents, in addition to providing necessary health and medical care.

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- IEVS** **Income Eligibility Verification System** - a computerized system using Internal Revenue Service (IRS) data to verify an individual's income and resources reported on the Medicaid application. States must have an agreement with IRS to use their data and to protect the confidentiality of the data.
- IOM** **Institute of Medicine** - chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public.
- IMDS** **Institution for Mental Diseases.** A hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services.
- Income Disregard** Income which is not counted towards an individual's total income when determining Medicaid eligibility.
- MEQC** **Medicaid Eligibility Quality Control** - see QC
- MMIS** **Medicaid Management Information System** - the federally mandated computer system used by State Medicaid Agencies for claims processing and information retrieval.
- Medigap** **Private insurance policies** designed to cover costs not reimbursed by Medicare.
- NF** **Nursing Facility** - An institution providing skilled nursing care, rehabilitation services, and health-related care to individuals who because of their mental or physical condition require care and services which can be made available to them only through institutional facilities.
- 1902(e)(3) Disabled Children** **The Tax Equity and Fiscal Responsibility Act of 1982** established an optional program whereby States may provide home care to disabled individuals 18 years of age or younger through regular State Plan services if the estimated cost of caring for the

 THE BASICS OF MEDICAID

child in the home is not greater than the estimated cost of caring for the child in the appropriate institutional setting (e.g., hospital, skilled nursing facility, intermediate care facility). Income deeming rules for institutionalized individuals are used.

- PASARR** Preadmission Screening and Annual Resident Review - OBRA 87 requirement for nursing facilities to determine appropriate placement and treatment for mentally ill.
- PHP** Prepaid Health Plan - similar to an HMO except that it provides less than a comprehensive range of services.
- PNA** Personal Needs Allowance - The amount of an institutionalized person's own money he is allowed to keep in a month to pay for personal incidentals. The minimum established PNA is \$30 per individual, \$60 per couple, although some States permit larger allowances.
- Pass-through groups** Individuals who do not receive AFDC or SSI cash benefits but are eligible for Medicaid because they lost their eligibility due to changes in law in 1972 and 1977 which raised their income over the limit allowed under the cash program.
- Pay-and-Chase** The practice whereby a State reimburses a provider for the cost of covered services rendered and then recovers funds from liable third parties.
- "Pickle" people** A specific group of people who have retained their Medicaid eligibility despite the fact that they have lost other benefits due to cost of living adjustments (named for Congressman Jake Pickle, sponsor of the enabling legislation).
- Post-Eligibility** For individuals in institutions, all income is considered available to pay for cost of care, except for amounts protected for the use of the individual or his family (such as the PNA or various reparation payments). Post-eligibility is the process by which these protected amounts and their value are determined.

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- QA** Quality Assurance - Process by which a State monitors or audits care rendered to Medicaid recipients to assure that all applicable Federal and/or State standards are met.
- QC (MEQC)** Quality Control (Medicaid Eligibility Quality Control) - a system designed to reduce erroneous expenditures by monitoring eligibility determinations, third-party liability activities, and claims processing.
- QDWI** Qualified Disabled and Working Individuals. Title II disability beneficiaries who have lost benefits due to earnings in excess of SGA (\$500/mo.) but with income less than 200 percent of the federal poverty level and resources less than twice the SSI level, and who are not otherwise Medicaid eligible. States are required to "buy-in"/ pay Medicare Part A premiums, deductibles and coinsurance for such individuals.
- QMB** Qualified Medicare Beneficiaries. Medicare Part A eligible individuals with income at or below a specified percentage of the federal poverty level (95% in 1991), and who do not have resources exceeding twice the SSI level (\$4,000 per individual and \$6,000 per couple in 1991). State Medicaid agencies are required to pay the cost of Part A and B premiums, deductibles and coinsurance for such individuals.
- Qualifying Trust (Medicaid Qualifying Trust)** Trust or similar legal device established by an individual (or spouse or parent) under which: a) the individual is the beneficiary of all or part of the payments from the trust, and b) the amount of such distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed. The establishment of the trust and its structure of payments to the beneficiary allow the beneficiary to meet Medicaid income eligibility standards without having to spend down to income and resource guidelines. The maximum payments that could be made by the trust to the beneficiary are counted as available resources whether or not the payments are actually made.

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- SAVE** Systematic Alien Verification for Entitlements: The Immigration Reform and Control Act of 1986 (P.L. 99-603) requires that States use SAVE, an INS system, to verify the immigration status of aliens applying for public/medical assistance. Section 1137(d)(3) of the SSA, includes SAVE as part of the IEVS requirements.
- SMDA** State Medicaid Directors' Association - A professional, nonprofit organization of representatives of State agencies, D.C. and the territories; since 1979 affiliated with the APWA. Purpose is as focal point for communication between the States and Federal government.
- SMG** State Medicaid Group - A joint body composed of the Executive Committee of the SMDA and senior officials of the HCFA.
- SNF** Skilled Nursing Facility - an institution which has in effect a transfer agreement with one or more participating hospitals, and which is primarily engaged in providing to inpatients skilled nursing care and restorative care services, and meets specific regulatory Medicare certification requirements.
- 1634 Agreement** Agreement under which a State contracts with the Social Security Administration to conduct all SSI-related Medicaid eligibility determinations. Other States do their own eligibility determinations using SSI criteria.
- 1619** See Work Supplementation
- Spenddown** Individuals in 209(b) States or those eligible under the Medically Needy program often have to make payments on medical bills until their income minus expenses incurred for medical care falls to or below the State-prescribed income level. The amount they must spend down each period is determined at the time eligibility is determined.
- State Supp** State Supplemental Payments - When SSI was enacted in 1972, in some States the new SSI cash payment amount was smaller than the payments made to individuals under the previous cash program. States were required to make up the difference

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- with a mandatory State supplement. States may also pay optional State supplements.
- Statewideness** A requirement that covered services and administration be equitable throughout the State. This requirement can be waived (see WAIVERS).
- TAG's** Technical Advisory Groups which serve as subcommittees to the six standing committees of the SMDA.
- TEFRA Kids** see 1902(e)(3)
- TPL** Third Party Liability - Medicaid is the payor of last resort for medical expenses. If a third party such as an insurance company is liable for some or all medical bills, the State must determine the liability and may either pay the amount remaining or pay the full amount and seek reimbursement from the third party. Order of liability: 1) recipient, 2) insurance company, 3) Medicare, and 4) Medicaid.
- 209(b)/ Amendments or 1902(f)** Section 209(b) of the 1972 Social Security Act codified as section 1902(f) of the Act. Refers to the statutory authority allowing States to have more restrictive financial methodologies for the aged, blind, or disabled than those of the SSI program.
- Work Supplementation** Program under section 1619 of the Act in which blind or disabled individuals who would normally be limited to earning a certain amount of income in order to retain blindness or disability status are allowed to continue working. Income is subject to the SSI income disregards; if income is more than the SSI standards, they may still receive Medicaid as long as they earn less than the amount they would lose if they lost SSI and Medicaid.