

MEDICAID POLICY BRIEFING

BACKGROUND MATERIALS

FEBRUARY 23, 1996

RESTRUCTURING MEDICAID

PREAMBLE

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics.

Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the elderly. This year, states and the federal government combined will spend more than \$140 billion in this program providing care to more than 28 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained and those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

THE NEW PROGRAM

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the nation's Governors proposal that blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens.

Program Goals. The program is guided by four primary goals.

- 1. The basic health care needs of the nation's most vulnerable populations must be guaranteed.*
- 2. The growth in health care expenditures must be brought under control.*

3. States must have maximum flexibility in the design and implementation of cost-effective systems of care.
4. States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.

Eligibility. Coverage remains guaranteed for:

- Pregnant women to 133 percent of poverty.
- Children to age 6 to 133 percent of poverty.
- Children age 6 through 12 to 100 percent of poverty.
- The elderly who meet SSI income and resource standards.
- Persons with disabilities as defined by the state in their state plan. States will have a funds set-aside requirement equal to 90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities.
- Medicare cost sharing for Qualified Medicare Beneficiaries.
- Either:
 - Individuals or families who meet current AFDC income and resource standards (states with income standards higher than the national average may lower those standards to the national average); or
 - States can run a single eligibility system for individuals who are eligible for a new welfare program as defined by the state.

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act.

Coverage remains optional for:

- All other optional groups in the current Medicaid program.
- Other individuals or families as defined by the state but below 275 percent of poverty.

Benefits

- The following benefits remain guaranteed for the guaranteed populations only.
 - Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The

"T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

- *At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.*
- *States have complete flexibility in defining amount, duration, and scope of services.*

Private Right of Action

- *The following are the only rights of action for individuals or classes for eligibility. All of these features will be designed to prevent states from having to defend against an individual's suit on benefits in federal court.*
 - *Before taking action in the state courts, the individual must follow a state administrative appeals process.*
 - *States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.*
 - *Following action in the state courts, an individual or class could petition the U.S. Supreme Court.*
 - *Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.*
- *There should be no private right of action for providers or health plans.*

Service Delivery

- *States must be able to use all available health care delivery systems for these populations without any special permission from the federal government.*
- *States must not have federally imposed limits on the number of beneficiaries who may be enrolled in any network.*

Provider Standards and Reimbursements

- *States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.*
- *The Boren amendment and other Boren-like statutory provisions must be repealed.*
- *"One hundred percent reasonable cost reimbursements" must be phased out over a two year period for federally qualified health centers and rural health clinics.*

- *States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.*
- *For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.*

Nursing Home Reforms

- *States will abide by the OBRA '87 standards for nursing homes.*
- *States will have the flexibility to determine enforcement strategies for nursing home standards and will include them in their state plan.*

Plan Administration

- *States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration.*
- *The plan and plan amendment process must be streamlined to remove HCFA micromanagement of state programs.*
- *Oversight of state activities by the Secretary must be streamlined to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan.*
- *HCFA can only impose disallowances that are commensurate with the size of the violation.*
- *This program should be written under a new title of the Social Security Act.*

Provider Taxes and Donations

- *Current provider tax and donation restrictions in federal statutes would be repealed.*
- *Current and pending state disputes with HHS over provider taxes would be discontinued.*

Financing. Each state will have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation is available only if the state puts up a matching percentage (methodology to be defined). The allocation is the sum of four factors: base allocation, growth, special grants (special grants have no state matching requirement) and an insurance umbrella, described as follows:

1. Base. In determining base expenditures, a state may choose from the following—1993 expenditures, 1994 expenditures, or 1995 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.
2. Growth. This is a formula that accounts for estimated changes in the state's caseload (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the best available data.
3. Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirement to gain access to these federal funds.
4. The Insurance Umbrella. This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.

Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups—persons with disabilities and the elderly.

Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

1. States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.
 2. Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.
5. Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.
 6. Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for

low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

Provision for Territories. The National Governors' Association strongly encourages Congress to work with the Governors of Puerto Rico, Guam, and other territories towards allocating equitable federal funding for their medical assistance pr. ---



FEB 15 1996

MEMORANDUM FOR LAURA TYSON

From: The Secretary *Don E. Shole*
Subject: Questions on NGA Medicaid plan

OVERVIEW

The President's stand on Medicaid throughout the budget debate has been very successful because it is grounded in sound principles that are reinforced by his well-known personal commitment to health care coverage. He has received a great deal of credit by insisting on a balanced approach to Medicaid reform that:

- preserves the federal guarantee of a Congressionally-defined benefit package for Medicaid beneficiaries;
- preserves Medicaid protection for currently eligible groups;
- maintains our shared financial partnership with states as they provide health coverage to needy individuals;
- provides unprecedented new flexibility to states in how to operate their programs, pay providers of care, and operate managed care and other arrangements, with continuing programmatic and fiscal accountability, and federal savings that contribute to the balanced budget plan.

Last week, the National Governors Association (NGA) approved the outlines of a plan that they are now refining. The lead Democratic Governors in those negotiations worked long and hard to convince their Republican colleagues to agree to a financing alternative to the block grant that allows the federal funding to appear to be more responsive to enrollment changes. As the President has indicated, those discussions and that movement on the financing structure have been helpful.

QUESTIONS ABOUT THE NGA MEDICAID PLAN

However, as we continue to review the evolving NGA policy, it is clear that it does not meet the principles that have served as the basis for the President's position. The attached documents review the key issues. In brief, the governors' plan repeals title XIX, the current Medicaid program, and replaces it with a new program that falls short of the President's principles.

Eligibility/Benefits/Enforcement

While the NGA policy retains the States' entitlement to federal funding, it repeals the existing federal entitlement or guarantee of Congressionally-defined health benefits for Medicaid beneficiaries. It is important to note that when we use the phrase federal "guarantee" it has a different meaning than when others use it. For us, it means an entitlement, with three key interrelated components – definitions of eligible groups, benefits, and enforcement. The NGA plan provides for a "guarantee" of coverage that makes marginal improvements in the Republican block grant, but it is only a nominal guarantee.

- **Eligibility.** While the NGA plan includes a number of mandatory groups, it repeals the current law phase-in of Medicaid coverage for children ages 13-18 in families with income below the federal poverty level – repealing a coverage expansion signed into law in the last Administration. Further, the plan repeals the federal standard for defining disability, replacing it with state definitions – making uncertain coverage and benefits for populations such as those with HIV; and it is unclear about guaranteed coverage of cash assistance populations and those making the transition from welfare to work;
- **Benefits.** While the NGA plan lists required benefits for the mandatory populations, it provides "complete" flexibility in defining the adequacy of those benefits (amount, duration and scope). It is silent on whether benefits must be comparable among or within groups and areas of the state; makes an unspecified change in the currently required treatment component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and sets no standard for benefits for optional beneficiary groups.
- **Enforcement.** The NGA plan repeals the federal right of action for individuals and limits claims that a state is violating federal law to resolution by state courts. Medicaid would be the sole federal statute conferring no possibility of federal enforcement by its intended beneficiaries.

Financing

The NGA plan's proposed financing may be responsive to enrollment changes -- a change that Democratic governors have insisted on -- but more details are needed. We need to continue to work with the Democratic governors to help them assure that the plan specifics reflect the need for a financing structure that truly adapts to enrollment changes.

Apart from gaining more details about the federal structure, the real financing problem is that the plan could substantially lessen state contributions to health coverage under Medicaid.

- The maximum state matching percentage drops from 50 percent to 40 percent. In the context of a capped program, this could increase the total Medicaid funding cuts

substantially. Analyses of a comparable provision in the Republican plan indicate that an \$85 billion federal cut could yield additional state cuts of over \$200 billion under this approach. Alternatively, in an open-ended financing approach, this provision could substantially increase federal costs, as states could capture more federal matching for the same amount of state funds.

- Moreover, the "real" state share could change because of another provision in the NGA approach. The plan allows states to use questionable provider donation and tax provisions without limits, like those in the late 1980s and early 1990s that significantly drove up federal program costs and reduced actual state spending -- ultimately states could take all of their funds out of the program with these mechanisms. Bipartisan legislation in 1992 closed these financial loopholes.

The federal costs and savings of the proposal are important in the context of the President's balanced budget plan, which includes \$59 billion in federal Medicaid savings. At this point, it is unclear whether the NGA plan will achieve federal savings of the type envisioned in the balanced budget plan.

Quality/Beneficiary Financial Protections/Accountability

By repealing title XIX, the NGA plan repeals beneficiary financial protections, and quality and fiscal standards that are essential components of the Medicaid program. For example:

- The NGA plan does not appear to include requirements for quality standards for managed care plans.
- The NGA plan retains the Republican Conference Agreement approach of eliminating federal enforcement of the nursing home standards.
- The NGA plan is silent on beneficiary financial protections: these include spousal impoverishment protections as well as financial protections for the adult children of aged nursing home residents.

NEXT STEPS

The NGA took an important and logical step that reflects the legitimate interests of the governors. The Democratic governors did a good job in moving the Republican governors in the direction of a per enrollee financing structure. However, we should all recognize the inherent constraints on any process driven solely by any one interest, including the governors. The majority of the governors are Republicans who had already signed on to the block grant approach that the President vetoed. In addition, it is difficult, if not impossible, for even our strongest Democratic governors to argue personally with fellow governors for federal standards in many areas that have been central to the President's position, despite the unprecedented flexibility that is already

offered in the President's plan.

The President's approach should continue to serve as the basis for Democratic unity on Medicaid. As the NGA proceeds to flesh out its plan, we need to foster discussions among the Democratic governors and members of Congress about how best to adapt the President's proposal to meet our shared goals.

ATTACHMENTS

- **ENTITLEMENT: ELIGIBILITY/BENEFITS/ENFORCEMENT**
- **FINANCING**
- **ACCOUNTABILITY**

ENTITLEMENT TO A MEANINGFUL BENEFIT PACKAGE

Overview

The most fundamental principle underlying the President's Medicaid reform plan is the concept that beneficiaries are entitled to a meaningful benefit package. So long as they meet the eligibility requirements, certain categories of individuals have an absolute and enforceable guarantee of benefits--a guarantee upon which they can rely. There are three basic components to the Medicaid entitlement:

- Eligibility
- Benefits
- Enforcement

Eligibility

The NGA resolution provisions on eligibility include a number of groups as "guaranteed" eligibles, i.e., coverage is "guaranteed" for the following:

- Pregnant women, and children to 133% of poverty
- Children to age 6 up to 133% of poverty
- Children 6-12 to 100% of poverty
- The elderly who meet SSI income and resource standards
- Persons with disabilities - "disability" defined by the state
- Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs)
- Families who meet current AFDC income and resource standards; or states may run a single eligibility system for those who are eligible for "new welfare."

Coverage is optional for the following groups:

- All other current law optional groups
- Other individuals or families as defined by the state but below 275% of poverty

However, the NGA resolution fails to address certain key populations.

- Medicaid would no longer be phased in for children 13 - 18 under 100% of poverty as would be the case under current law. This coverage was enacted with bipartisan support.
- States can apply more limited definitions of disability than exist under federal law. This provision could lead to severely restricted definitions of disability resulting in very limited coverage for a population whose service needs are among the most costly. For example, states could define disability in ways that preclude individuals with certain diagnoses (HIV, or mental illness) from being able to receive needed services under Medicaid. This is particularly significant because the disabled are unable to work and therefore less likely to have other health insurance.

- It is important to note current welfare reform proposals include changes in key areas in the definition of disability to address substantive concerns raised by states and others.
 - In the case of drug addicts and alcoholics, the proposal (accepted by the Administration) would change program eligibility to exclude drug addiction and alcoholism as a qualifying disability for purposes of SSI and Medicaid.
 - In the case of disabled children, effective in 1998, the proposal would change the eligibility process by eliminating the Individual Functional Assessment (IFA) process and eliminating maladaptive behavior from inclusion in the Social Security Act.
- Welfare related coverage is very unclear, and the NGA resolution provides insufficient information about the links between new welfare definitions and Medicaid coverage.

Benefits

The NGA resolution includes the following list of benefits that are "guaranteed" but only for "guaranteed" coverage groups.

- Inpatient and outpatient hospital
- Physician
- prenatal care
- nursing facility
- home health
- family planning and supplies
- laboratory and x-ray
- pediatric and family nurse practitioner
- nurse midwife
- EPSDT, with limitations on requirements for treatment

The resolution stipulates that all other services would be optional, and there would be a broadened long term care benefit.

Even given the apparent progress made in defining a mandatory benefit package, there are still serious concerns with the provisions of the NGA resolution.

- A responsible health care program must provide benefits that are adequate to achieve their purpose. Under the NGA resolution, states would be given complete flexibility to define the amount, duration and scope of the benefits to be provided. These provisions taken as a whole raise serious concerns about whether the Secretary would have any ability, in the case of over-restrictive state plans, to disapprove a benefit package that would be effectively meaningless.

- Because the NGA resolution is silent about requirements for comparable services for all eligible groups, or provision of services on a statewide basis, there is concern that states might structure benefit packages that are more limited for more costly populations, (e.g., the disabled), or might provide less comprehensive services in certain parts of the state. There are serious questions about the equity that might result under the NGA approach.
- The NGA would limit the treatment option under EPSDT in a manner that is still unclear.
- The Administration has indicated a willingness to discuss additional flexibility--offering optional benefits to optional beneficiaries in the context of the President's plan.

Enforcement

The third essential component of the entitlement is enforcement. The NGA resolution contains provisions requiring states to provide a guaranteed state right of action, but eliminates any federal right of action for individuals and providers. The only access to federal court would be the opportunity to petition the U.S. Supreme Court for review from a decision of state's highest court. The NGA provisions pose a number of serious questions and concerns.

- Implicit in the concept of defined populations and defined benefits is the back-up of a meaningful enforcement mechanism. A federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States.
- Under the NGA proposal, Medicaid would be the single federal statute conferring no possibility of federal enforcement by its intended beneficiaries; seeking enforcement of title XIX would be the one cause of action arising under federal law that would be barred from the federal courts. Such an unprecedented step would be seen by important constituencies as a signal of second-class status and would set off massive reaction from beneficiary groups and their allies. Advocates for the poor would be restricted to the remedies and procedures available under state law, which are often stricter than those under federal law.
- The largest number of suits against states have been filed by providers over payment rates. Under the administration's plan, the Boren Amendment would be repealed, thereby eliminating these causes of action by providers. Going further, the Administration has indicated a willingness to specify that there would be no right of action by providers over payment rates under statutory provisions other than the Boren Amendment. Thus, under the Administration's plan, state concerns about limiting their exposure to suit in federal court would be largely resolved. Given the broader federal policy and the reality that beneficiary suits have not been a problem, further changes to individual right of action would appear to be unnecessary.

- **Those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. Efficiency and predictability are best served by using the federal court system, when the same question arises across multiple jurisdictions. Moreover, when Medicaid-based claims interact, as they often do, with other areas of federal law (Medicare, Social Security), the federal courts are more experienced in analyzing these statutory relationships and are better able to understand and decide cases with potentially broad ramifications.**
- **There is no indication that federal judges--the vast majority of whom were appointed by Republican presidents--ignore or take lightly the legitimate concerns of state administrators.**

FINANCING

The National Governors' Association resolution would replace the current financing system with a combination of a fixed federal payment, and a payment adjustment for unexpected excess enrollment. The minimum federal contribution to the financing of Medicaid would increase from 50 percent to 60 percent, and states' use of provider tax and donation schemes (which are currently prohibited) would be permitted.

From the beginning of the current Medicaid debate, the President has maintained that Medicaid must be financed through a federal-state partnership that ensures a reasonable and appropriate amount of funding to provide meaningful benefits to eligibles while also protecting states from increases in enrollment. Although growth in federal expenditures for Medicaid can be slowed, any adjustments must be based on who a state covers, not an arbitrary ceiling (Block Grant) that does not provide states with enough federal funds to provide coverage and benefits in times of economic downturn or increased enrollment.

- Although the NGA resolution reflects progress toward a financing structure based on enrollment, there are still some questions that must be addressed. Many of these questions will not be answered until there is sufficient specificity to enable some assessment of the budget implications of the NGA resolution. We should continue to work with Democratic governors to maintain their progress on this issue.
- Raising the minimum federal match rate from 50 percent to 60 percent will allow states to reduce their spending by over \$200 billion over the next seven years, and will raise the average federal share of total program costs from 57 percent to 63 percent.
- Also, permitting the use of provider tax and donation schemes will allow states to reduce the amount of "real" state dollars which they contribute to the program. During the late 1980s and early 1990s, many States took advantage of these schemes, costing the federal government billions of dollars and helping drive growth rates up to well over 20 percent. The Inspector General continues to express concerns about such financing schemes.

ACCOUNTABILITY

The President's plan proposes unprecedented new flexibility for the states in how to operate their programs, pay providers, and use managed care and other delivery arrangements. At the same time, it retains core standards related to quality and beneficiary financial protections.

The NGA resolution would repeal title XIX and create a new title for the Medicaid program. This has the *de facto* effect of compromising seriously the existing framework for accountability that provides governance for the Medicaid program today. The NGA resolution is silent in many areas that affect Medicaid reform. And in areas where the resolution is specific, some long-standing protections would be reduced or eliminated.

- The NGA resolution eliminates the federal role in monitoring nursing home quality assurance--yet without federal monitoring and enforcement of state and facility compliance, the uniform quality standards established by OBRA 87 are meaningless.
- Nearly a third of all Medicaid beneficiaries are currently enrolled in some form of managed care. The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care.
- The NGA resolution does not address beneficiary and family financial protections such as spousal impoverishment and family responsibility that have been central to the Medicaid program for years. These protections are maintained in the President's plan. The NGA resolution also does not address the imposition of copayments and other cost sharing for Medicaid beneficiaries.
- There are ways, similar to the approach taken in the President's plan, to provide states with considerably expanded flexibility in management and operation of their Medicaid programs, without reducing the framework of responsible accountability to meaninglessness. There must be at least a modicum of reporting requirements and monitoring in a program that spends over \$100 billion federal dollars. The NGA resolution expands federal funding and reduces ongoing congressional and executive management of the program.

COMPARISON OF MEDICAID PLANS

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
STRUCTURE	<p>Block grant</p> <p>New title of Social Security Act</p>	<p>Block grant and insurance umbrella for unexpected excess enrollment</p> <p>New title of Social Security Act</p>		<p>Per capita cap and DSH reductions.</p> <p>Retain title XIX</p>	<p>Per capita cap and DSH reductions.</p> <p>Retain title XIX</p>
ELIGIBILITY	<p>Coverage "guaranteed" for:</p> <ul style="list-style-type: none"> -Pregnant women, and children under 6 under 133% of poverty -Children 6-12 under 100% of poverty -People with disabilities (as defined by the state) who meet SSI standards -Elderly who meet SSI income and resource standards. <p>All other eligibility groups would be optional. States may cover individuals up to 275% of poverty</p>	<p>Coverage is "guaranteed" for:</p> <ul style="list-style-type: none"> - Pregnant women, and children under 133% of poverty - Children 6-12 under 100 % of poverty - Persons with disabilities (as defined by the state) - Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs) - Elderly who meet SSI income and resource standards - Families who meet current AFDC income and resource standards, or eligibles for "new welfare". <p>Coverage is optional for: all other optional groups as defined by the current law, and other individuals or families as defined by the state but below 275% of poverty.</p>		<p>Maintains all current law mandatory and optional groups, including:</p> <ul style="list-style-type: none"> - Pregnant women and children age 1-6 under 133% of poverty - Children age 6 through 12 under 100 % of poverty - Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered - AFDC cash recipients, - SSI Aged, Blind, and Disabled - QMBs <p>- All current law optional groups, including the Medically Needy</p> <p>Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.</p>	<p>Maintains all current law mandatory and optional groups, including:</p> <ul style="list-style-type: none"> - Pregnant women and children age 1-6 under 133% of poverty - Children age 6 through 12 under 100 % of poverty - Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered - AFDC cash recipients, - SSI Aged, Blind, and Disabled - QMBs <p>- All current law optional groups, including the Medically Needy</p> <p>Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
BENEFITS	<p>"Guaranteed" for low income families: Inpatient/outpatient hospital, physicians' surgical and medical services, Diagnostic tests, Childhood immunizations, and pre-pregnancy planning services and supplies.</p> <p>Long term care services for the elderly and disabled</p> <p>States are not required to provide any other services.</p>	<p>Does not require FQHC and RHC services.</p>	<p>"Guaranteed" coverage for mandatory populations: inpatient/outpatient, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT*, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>*See EPSDT below under "Like MediGrant II"</p> <p>All currently optional services would remain optional</p>	<p>Retains current law requiring States to cover: inpatient and outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>States may also cover optional services (drugs, physical therapy, dental services, etc.)</p>	<p>Retains current law requiring States to cover: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>States may also cover optional services (drugs, physical therapy, dental services, etc.)</p>
Amount, Duration, and Scope	Eliminates requirements	"Complete" State flexibility		Retains current state flexibility within comparability and statewideness requirements	Retains current state flexibility within comparability and statewideness requirements
EPSDT	<i>No specific requirement for early, periodic, screening, diagnosis and treatment services (EPDST) for children under age 21.</i>	<i>Unclear: "redefines" treatment - no specifics how it will be redefined.</i>		Retains current law for treatment mandating coverage of services to treat or ameliorate a defect, physical and mental illness, or condition identified by a health screen.	Changes treatment: The Secretary, after consultation with States and provider organizations, would define treatment under EPSDT.
Comparability Statewideness	Eliminates requirements	<i>No provision</i>	<i>No provision</i>	Retains current law requirement that services be comparable and available statewide	Retains current law requirement that services be comparable and available statewide
Vaccines for Children Program	Eliminated	<i>No provision</i>	<i>No provision</i>	Maintained	Maintained
Home and Community-Based Services	Optional service, states no longer needs waiver to provide	<i>Unclear - proposal "broadens" long-term "options." No specifics how options are broadened.</i>	<i>Unclear - proposal "broadens" long-term "options." No specifics how options are broadened</i>	Makes home and community-based services an optional service - States no longer need waivers to cover these services.	Current law

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
RIGHT OF ACTION	<p>No federal right of action for individuals or providers</p> <p><i>Silent on state court right of action</i></p> <p>Individuals can bring issues and/or complaints to the attention of the Secretary</p> <p>Secretary's action re individual complaints is limited to investigation and subsequent notification to the Congress and/or chief executive of the state</p>	<p>No federal right of action for individuals or providers.</p> <p>States must provide state court right of action</p> <p>Must use state administrative mechanisms before going to state court</p> <p>Can petition US Supreme Court for review after all state court action completed</p> <p>Secretary can bring suit in federal court on behalf of individuals or classes.</p>		<p>Maintains current law individual right of action for individuals to bring suit in federal court.</p>	<p>Maintains current law individual right of action for individuals to bring suit in federal court.</p>
FAMILY PROTECTIONS	<p>Allows states to require adult children of nursing home residents with incomes above the state median income to contribute to their parents' nursing home care.</p>	<p><i>No provision</i></p>	<p><i>No provision</i></p>	<p>Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.</p>	<p>Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.</p>
Spousal Impoverishment	<p>Retains current law</p>	<p><i>No provision</i></p>	<p><i>No provision</i></p>	<p>Retains current law</p>	<p>Retains current law</p>
Copayments	<p>States have broad flexibility to develop cost sharing schedules that differentiate between income groups, types of services. Greater restrictions on cost sharing for children and pregnant women.</p>	<p><i>No provision</i></p>	<p><i>No provision</i></p>	<p>Maintains current limitations that copayments be nominal and only for some individuals/benefits. New authority to impose similar nominal copayments on HMO enrollees.</p>	<p>Allows States to impose copayments scaled to income and family size for individuals/benefits currently subject to copayments.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
FINANCING Federal Spending Limit	Fixed federal payments set by formula: Federal spending will be \$839 billion between 1996-2002 (savings of \$85 billion).	Partially fixed: For base spending, Federal payments are set by a formula. A state gets this amount even if it reduces benefits or enrollment. Federal spending and savings are not known.	Partially responsive: An "Insurance Umbrella" allows for higher Federal payments when enrollment for mandatory and some optional groups is unexpectedly high. Federal spending and savings are not known.	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of \$865 billion between 1996-2002 (savings of \$59 billion).	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of \$839 billion between 1996-2002 (savings of \$85 billion).
State Spending	State matching rates are significantly lowered. Estimated state spending over seven years: \$493 billion (savings of \$205 billion). Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.	State matching rates are significantly lowered. State spending and savings are not known. Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.		Current matching rates are maintained. Estimated state spending over seven years: \$653 billion (savings of \$45 billion). Current restrictions on the use of provider taxes and donations are retained.	Current matching rates are maintained. Estimated state spending over seven years: \$633 billion (savings of \$65 billion). Current restrictions on the use of provider taxes and donations are retained.
Funding Formula	1996 allotments are set in legislation. Subsequent years' allotments are based on the product of the number of poor people and the state-adjusted spending per person, subject to maximum or minimum growth rates. Actual enrollment is not included in the formula.	Base funding is set by multiplying the base year -- the states' choice of 1993, 1994, or 1995 spending -- by an inflation factor and estimated enrollment growth. DSH spending is included in the base, but is not grown if DSH is greater than 12% of total spending.	The "Insurance Umbrella" allows states to get Federally-matched capitation payments for mandatory and some optional beneficiaries who are above the estimated enrollment for the year.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary (product of the average 1995 spending by beneficiary group and nominal GDP growth per person (5-year average) plus an adjustment factor). The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary. The spending limit per beneficiary is the product of a rolling average spending by beneficiary group and CPI (3-year average) plus adjustment factors. The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
PROVIDER PAYMENTS, PROGRAM OPERATION, AND SERVICE DELIVERY	<p>Repeals all provider payment rules -- hospitals, nursing homes, hospice, FQHC/RHC and home and community-based services.</p> <p>Repeals requirement that rates be sufficient to guarantee access to services.</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Repeals all provider payment rules.</p> <p><i>Unclear. May repeal requirement that rates be sufficient to guarantee access to services.</i></p>	<p>Repeals Boren Amendment</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Repeals Federal payment rules for hospitals, nursing facilities, FQHCs and RHCs (except for Indian FQHCs/RHCs) and home and community-based services.</p> <p>Retains current requirement that rates be sufficient to guarantee access to services.</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Retains current federal payment rules.</p> <p>Retains current requirement that rates be sufficient to guarantee access to services.</p> <p>No change to payment rules for obstetrical and pediatric care</p>
Special Provider Qualifications	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Retains physician qualification requirements.
Managed Care	<p>States' ability to mandate managed care enrollment would be unrestricted.</p> <p>Beneficiaries would have no guarantee of choice of plan or provider.</p> <p>Payments to managed care plans must be based on actuarial methods</p>	<p>States may implement managed care without a waiver</p> <p><i>Unclear. Beneficiaries may have no guarantee of choice of plan or provider.</i></p> <p><i>No provision</i></p>	<p>States may implement managed care without a waiver</p> <p><i>Unclear. Beneficiaries may be guaranteed a choice of plan or provider.</i></p> <p><i>No provision</i></p>	<p>States could mandate enrollment in managed care, except:</p> <ul style="list-style-type: none"> - Beneficiaries must have a choice of plan or delivery system; - States may not require enrollment for Medicare cost-sharing; <p>States may not restrict choice of provider for family planning services.</p> <p>Retains current law -- payments to managed care plans must be actuarially sound.</p>	<p>States could mandate enrollment in managed care, except:</p> <ul style="list-style-type: none"> -Beneficiaries must have a choice of plan or provider; -States may not require special needs individuals to enroll in managed care plans. <p>Applies the current "reasonable and adequate" payment standard to managed care systems.</p>
Contracting and Solvency	<p>Repeals all statutory contracting rules.</p> <p>Health plans must meet commercial solvency standards.</p>	<p><i>Unclear. May repeal all contracting rules.</i></p> <p><i>No provision</i></p>	<p><i>Unclear. May retain some current contracting rules.</i></p> <p><i>No provision</i></p>	<p>Repeals problematic contracting rules: 75/25 rule; HHS approval of HMO contracts; payment rules for managed care-contracting FQHCs.</p> <p>Provides new authority for solvency standards.</p>	<p>Repeals current contracting rules.</p> <p>Establishes new solvency standards.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II Like Administration		ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
Managed Care Quality	No quality requirements for States or managed care plans.	<i>Unclear</i>	<i>Unclear</i>	Requires States to develop quality improvement programs, which must include access standards and monitoring activities. Establishes new reporting and fraud prevention requirements for health plans.	Establishes new quality requirements for managed care systems, including statutory guarantees of accessibility and timeliness of services, information-sharing requirements, prior authorization and grievance procedures, and encounter data.
Nursing Home Quality	"Retains" current rules, but actually eliminates significant quality standards and protections for nursing home residents. Significantly diminishes Federal authority to enforce quality standards.	<i>Unclear. May eliminate some current standards, like MediGrant II.</i> States may decide how nursing home standards will be enforced		Retains current nursing home standards and enforcement.	Retains current nursing home standards and enforcement.
Administration	Federal administrative oversight curtailed. Financial penalties would be proportional and permitted only for "substantial" violations.	Disallowances must be proportional to violation. Federal oversight limited and intervention permitted only when State "fails substantially" to comply with law or program.		Repeals and revises various administrative and systems requirements.	No change to current administrative requirements.

PRESIDENT CLINTON'S MEDICAID PLAN:

SUMMARY OF MAJOR PROVISIONS

February 23, 1996

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 be significantly below private spending growth per person (7 percent).
 - 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.
- **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:

- Special transition pools would be created to ease the transition to the reformed Medicaid program.
 - **Undocumented Persons Pool:** A special 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 Pools:** Additional federal funds would be allocated through special pools designed to ease the transition to the new program and allow states to plan now for program changes.

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.

PRESIDENT CLINTON'S MEDICAID PLAN:

EXAMPLES OF FLEXIBILITY FOR STATES

February 23, 1996

EXAMPLES OF FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PLAN

OVERVIEW

I. IMPLEMENTING MANAGED CARE

- Repeal of Requirement for Federal Waivers for Managed Care
- Repeal of Managed Care Contracting Rules
- Elimination of Requirement for Federal Review of HMO Contracts over \$100,000

II. FLEXIBILITY IN PROGRAM PAYMENT

- Repeal of the Boren Amendment
- Elimination of Special Requirements for Obstetricians and Pediatricians

III. FLEXIBILITY IN PROGRAM BENEFITS

- Elimination of Requirement for Federal Waivers for Home and Community-Based Waivers
- Enabling States to Require Nominal Copayments for HMO Enrollees

IV. FLEXIBILITY IN PROGRAM ELIGIBILITY

- Income Levels for Infants and Pregnant Women

V. FLEXIBILITY IN STATE ADMINISTRATION

- Reforming Medicaid Eligibility Quality Control (MEQC)
- Revise and Simplify Medicaid Management Information System Requirements
- Provider Qualifications for Obstetricians and Pediatricians
- Elimination of Requirements to Pay for Private Health Insurance
- Elimination of Personnel Requirements
- Elimination of Requirements for Cooperative Agreements
- Elimination of Requirements for Preadmission Screening and Annual Resident Review (PASARR)

EXAMPLES OF STATE FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PROPOSAL

I. IMPLEMENTING MANAGED CARE

REPEAL OF REQUIREMENT FOR FEDERAL WAIVERS FOR MANAGED CARE

Administration Proposal:

The Administration's proposal would allow states to implement managed care programs without the need for Federal waivers. States could implement managed care programs with a state plan amendment.

- 43 States will no longer need to apply for waivers or waiver renewals. These States have initiated 162 requests -- either initial waivers or renewals -- over the last three years.
- States can implement managed care by submitting state plan amendments.
- This simplified process will save states the considerable administrative burden associated with preparing freedom-of-choice waiver requests.

Background:

Currently, states must apply for Federal waiver approval to implement Medicaid managed care programs. Waiver requests are administratively burdensome and repetitive -- freedom-of-choice waivers must be renewed every two years. States generally spend three to six months preparing freedom-of-choice waiver requests, although this effort varies widely depending on the scope and complexity of the program. All but five states with freedom of choice waivers have more than one such waiver, each of which requires separate processing. HCFA's review and approval process must be completed within 90 days; however, this time period may be extended substantially if the State must provide additional information. See attached table for affected states.

**FREEDOM OF CHOICE WAIVER ACTIVITY
(1993-1996)**

State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers
Alabama	2	Kentucky	4	North Dakota	3
Alaska		Louisiana	2	Ohio	3
Arizona		Maine	3	Oklahoma	1
Arkansas	5	Maryland	3	Oregon	3
California	18	Massachusetts	3	Pennsylvania	7
Colorado	5	Michigan	5	Rhode Island	
Connecticut	1	Minnesota	2	South Carolina	2
Delaware		Mississippi	4	South Dakota	3
D.C.	2	Missouri	4	Tennessee	
Florida	4	Montana	2	Texas	7
Georgia	5	Nebraska	2	Utah	3
Hawaii		Nevada	1	Vermont	
Idaho	2	New Hampshire		Virginia	3
Illinois		New Jersey	1	Washington	14
Indiana	2	New Mexico	3	West Virginia	5
Iowa	4	New York	8	Wisconsin	4
Kansas	2	North Carolina	5	Wyoming	1

TOTAL

162

The numbers indicated include approved and pending new waivers, renewals, and modifications.

REPEAL OF MANAGED CARE CONTRACTING RULES

Administration Proposal

Under the Administration proposal, States will be able to contract with Medicaid-only managed care plans. States will also be able to enroll Medicaid beneficiaries into managed care plans for up to six months at a time. Some States -- Hawaii and Rhode Island -- have developed demonstration programs in order to implement managed care programs with these features.

- States will no longer need to apply for demonstration authority to receive waivers of these statutory provisions.
- States will be able to contract with a broader range of managed care entities.
- Six-month lock-in provisions will attract more managed care plans to contract with Medicaid programs.

Background

Currently, Medicaid managed care plans must maintain a commercial enrollment base of twenty-five percent. This requirement -- the "75/25 rule" -- prohibits States from contracting with Medicaid-only managed care plans. In addition, Medicaid beneficiaries must be able to disenroll from most managed care plans on a month-to-month basis, thus disrupting enrollment stability.

If these provisions were repealed, the programmatic elements (but not eligibility expansions) of some demonstration programs (Hawaii and Rhode Island) could be operated without demonstration waivers. Other demonstration States, such as Oregon, require more complicated waivers of Medicaid law and would therefore still need waiver authority to operate their demonstration programs.

ELIMINATION OF REQUIREMENT FOR FEDERAL REVIEW OF HMO CONTRACTS OVER \$100,000

Administration Proposal:

Under the Administration's proposal, states will no longer need to seek Secretarial approval for HMO Contracts over \$100,000.

- All States with pre-paid managed care programs will avoid unnecessary and duplicative Federal oversight of their contracting and rate-setting procedures.
- This new flexibility will save states time and effort.

Background:

Currently, states must obtain HCFA's approval of all contracts with HMOs that exceed \$100,000 in expenditures. This prior approval requirement represents an unnecessary double-check on the state's contracting and rate-setting procedures. HCFA approval generally takes between two and forty-five days.

See attached chart for state-by-state contract numbers.

FEDERAL APPROVAL OF MANAGED CARE CONTRACTS
Annual Estimate

STATE	NUMBER OF CONTRACTS	STATE	NUMBER OF CONTRACTS	STATE	NUMBER OF CONTRACTS
Alabama	0	Kentucky	0	Ohio	14
Alaska	0	Louisiana	0	Oklahoma	12
Arizona	7	Maine	0 (6-8 next year)	Oregon	36
Arkansas	0	Maryland	6	Pennsylvania	9
California	16	Massachusetts	11	Puerto Rico	2
Colorado	7	Michigan	12	Rhode Island	5
Connecticut	11	Minnesota	9	South Carolina	0
Delaware	4	Mississippi	0	South Dakota	0
D.C.	4	Missouri	6	Tennessee	12
Florida	30	Montana	2	Texas	1 (8 next year)
Georgia	0	Nebraska	7	Utah	5
Hawaii	5	Nevada	0 (4 next year)	Vermont	0
Idaho	0	New Hampshire	3	Virginia	10
Illinois	7	New Jersey	25	Washington	30
Indiana	2	New Mexico	0	West Virginia	0
Iowa	8	New York	130	Wisconsin	11
Kansas	6	North Carolina	1	Wyoming	0
		North Dakota	0	ESTIMATED TOTAL	466

II. FLEXIBILITY IN PROGRAM PAYMENT

REPEAL OF THE BOREN AMENDMENT

Administration Proposal:

The Boren Amendment will be repealed, and replaced with a process for notifying the public about facility rates. Thus, states can establish hospital and nursing home payment rates without federal requirements.

- States will have flexibility to negotiate payment rates with providers.
- States would no longer be required to submit assurances of the adequacy of their payment rates to HHS.
- States will no longer face costly law suits from providers demanding higher payments.

Background:

Under current requirements, states are required to assure that payment rates for institutional facilities are reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated facility.

Since 1984, plaintiffs have filed at least 173 cases alleging that States have failed to comply with the Boren Amendment. Under the Administration's proposal, these suits would not be possible.

ELIMINATION OF SPECIAL PAYMENT REQUIREMENTS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

The current burdensome requirements for data collection to document that states are meeting special payment rate requirements for obstetricians and pediatricians will be repealed.

- States will no longer have to collect and submit data on payment rates for obstetrical and pediatric services.
- States will no longer have to submit state plan amendments for the Ob/Peds information that can range from 30 pages to over 300 pages in size.

Background

States are required to report the following information by April 1 of each year:

- payment rates for obstetrical and pediatric services for the coming year;
- data to document that the states' rates are sufficient to ensure access to these services is comparable to the access enjoyed by the general population;
- data that document that payment rates to HMOs take into account fee-for service payment rates for ob/ped services;
- data on the average statewide payment rates.

The data collection and analysis required to fulfill these requirements involve, on average, at least 5 people in each state Medicaid agency. In addition, staff from State licensing boards and provider offices are called upon to help states review and define data. Preparation of the final report alone takes, on average, 2 weeks. State plan amendments for the Ob/Peds information range from 30 pages to over 300 pages in size depending on the state.

III. FLEXIBILITY IN PROGRAM BENEFITS

ELIMINATION OF REQUIREMENT FOR FEDERAL WAIVERS FOR HOME AND COMMUNITY BASED SERVICES PROGRAMS

Administration Proposal:

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.

- 49 States with a total of 517 home and community-based waiver programs will no longer need to obtain federal approval and renewal authority.
- States can provide tailored home and community-based services simply by submitting a state plan amendment.
- This simplification will save states approximately 6 months preparing new and renewal home and community-based waiver requests.

Background:

Currently, states must apply for Federal waiver approval to provide home and community-based services to elderly and disabled Medicaid beneficiaries. Waiver requests are administratively burdensome and repetitive because initial waiver approvals only last three years and must be renewed every five years. States spend approximately 180 hours to prepare each new and renewal home and community-based waiver request and approximately forty hours preparing an amendment to approved waivers. All 49 states with HCBS waivers have more than one such waiver, with separate processing requirements for each.

See attached chart for affected states.

**HOME AND COMMUNITY-BASED WAIVER ACTIVITY
(1993-1996)**

STATE	1915(C)HOME AND COMMUNITY-BASED WAIVERERS	STATE	1915(C) HOME AND COMMUNITY-BASED WAIVERS	STATE	1915(C)HOME AND COMMUNITY- BASED WAIVERS
Alabama	12	Kentucky	6	North Dakota	4
Alaska	12	Louisiana	12	Ohio	13
Arizona		Maine	12	Oklahoma	9
Arkansas	10	Maryland	8	Oregon	2
California	10	Massachusetts	3	Pennsylvania	14
Colorado	18	Michigan	12	Rhode Island	6
Connecticut	7	Minnesota	17	South Carolina	13
Delaware	7	Mississippi	6	South Dakota	8
D.C.		Missouri	11	Tennessee	15
Florida	17	Montana	5	Texas	22
Georgia	7	Nebraska	12	Utah	7
Hawaii	4	Nevada	9	Vermont	7
Idaho	4	New Hampshire	7	Virginia	7
Illinois	15	New Jersey	18	Washington	16
Indiana	24	New Mexico	4	West Virginia	3
Iowa	23	New York	15	Wisconsin	16
Kansas	7	North Carolina	13	Wyoming	8
				TOTAL	517

The numbers indicated include approved and pending new waivers, renewals, and modifications.

ENABLING STATES TO REQUIRE HEALTH MAINTENANCE ORGANIZATION ENROLLEES TO MAKE NOMINAL COPAYMENTS

Administration Proposal:

The Administration's proposal would allow States and health plans to require nominal copayments from Medicaid beneficiaries who are enrolled in HMOs to the extent that copayments could be imposed if the beneficiary were not enrolled in an HMO. For example, states could not require children to make copayments, nor charge copayments for pregnancy-related services or emergency services.

- o States and health plans would have the flexibility to control unnecessary utilization better,
- o States could reduce their capitation payments based on plans' anticipated copayment revenues, and
- o Plans would still be required to provide services, regardless of enrollees' ability to make a copayment.

Background:

Currently, states cannot require categorically-eligible Medicaid beneficiaries who enroll in HMOs to make any type of cost-sharing payment, including copayments. This restriction prohibits States and Medicaid-contracting health plans from using all available tools to control unnecessary utilization of and payment for services. States currently have the ability to impose nominal copayments in the fee-for-service portion of the Medicaid program.

IV. FLEXIBILITY IN PROGRAM ELIGIBILITY

INCOME LEVEL FOR INFANTS AND PREGNANT WOMEN

Administration Proposal:

The 33 States that choose to cover pregnant women and infants above the minimum 133% of the Federal Poverty Level (FPL) will be given the option to lower this income eligibility threshold back to the minimum level. Currently, once a State chooses to expand Medicaid coverage to include populations at an income level above 133% FPL, they are prohibited from lowering the income threshold back to 133% FPL.

Background

States that used a percentage of poverty for eligibility level for pregnant women and infants that was above the minimum percentage required before OBRA 89 are currently prohibited from reducing that percentage.

The attached chart shows the 33 states that could take advantage of this provision today.

INCOME AND ELIGIBILITY LEVELS: INFANTS AND PREGNANT WOMEN

The 33 Highlighted states could take advantage of this provision

STATE	PERCENT OF POVERTY	STATE	PERCENT OF POVERTY	STATE	PERCENT OF POVERTY
Alabama	133	Kentucky	185	North Dakota	133
Alaska	133	Louisiana	133	Ohio	133
Arizona	140	Maine	185	Oklahoma	150
Arkansas	133	Maryland	185	Oregon	133
California	200*	Massachusetts	185	Pennsylvania	185
Colorado	133	Michigan	185	Rhode Island	250**
Connecticut	185	Minnesota	275*	South Carolina	185
Delaware	185	Mississippi	185	South Dakota	133
D.C.	185	Missouri	185	Tennessee	185
Florida	185	Montana	133	Texas	185
Georgia	185	Nebraska	150	Utah	133
Hawaii	300**	Nevada	133	Vermont	225*
Idaho	133	New Hampshire	185	Virginia	133
Illinois	133	New Jersey	185	Washington	200*
Indiana	150	New Mexico	185	West Virginia	150
Iowa	185	New York	185	Wisconsin	185
Kansas	150	North Carolina	185	Wyoming	133

- * States with effective income levels above the nominal statutory maximum use the authority in section 1902(r)(2) to disregard higher than usual amounts of income.
- ** States using higher income level as part of demonstration under section 1115.

V. FLEXIBILITY IN STATE ADMINISTRATION

REFORMING MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

Administration Proposal:

The Administration's proposal reduces the complex accounting and individualized cost accounting currently required under MEQC, by requiring that states address only the numbers of ineligible and the average cost per ineligible in the appropriate group.

- o Details of spending on each ineligible case will not have to be documented, and
- o Disallowances will not be distorted and excessively inflated when the ineligible sample includes a very few very high cost cases.

All states will benefit from this reduction in individualized tracking. Though only a few States have excessive error rates (the national average has hovered around 2 percent for several years), all states are currently required to go through the entire determination, adjudication, cost accounting process every six months.

Background:

Federal matching funds are disallowed to the extent that a State makes excessive errors in determining ineligible persons to be eligible for Medicaid or understates the amount of medical bill that a person must be responsible for before becoming eligible. "Excessive" means erroneous payments in excess of 3 percent of total payments. In certain circumstances, disallowances may be waived (e.g., if excessive errors are explained by events beyond the State's control).

REVISE AND SIMPLIFY MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REQUIREMENTS

Administration proposal:

States would have new flexibility to design, structure, and operate their Medicaid Management Information Systems within general federal parameters rather than being required to comply with the detailed systems design requirements and planning documentation requirements in effect today.

- All states will be able to operate MMIS systems that are more tailored to State circumstances and thus more cost-effective.
- The Secretary will retain appropriate oversight authority and the ability to enforce general Federal parameters, but the States will not be hamstrung by a Medicaid equivalent of "mandatory sentencing."
- Because current financial penalties for non-compliance will be repealed, HCFA's on-site reviews of State MMIS systems would be less frequent and less intrusive. States would no longer need to dedicate several staff members to month-long preparations for these reviews.

Background:

Currently, as a requirement for federal administrative matching, all States must operate a Medicaid Management Information System that meets highly detailed Federal requirements. Compliance is continuously and rigorously monitored. Non-compliance results in financial penalties, which are elaborated in considerable statutory detail.

PROVIDER QUALIFICATIONS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

The administration proposal would eliminate the detailed minimum provider qualifications that specify requirements that must be met by physicians serving pregnant women and children.

The requirements that would be eliminated are difficult for practitioners in large urban and underserved rural states to meet. This proposal would make state licensure requirements the only qualification requirements practitioners serving pregnant women and children would have to meet.

Background:

Section 1903(I) establishes provider qualifications for physicians serving pregnant women and children. Physicians must be certified in family practice or pediatrics, affiliated with an FQHC, have admitting privileges at a hospital participating in a State plan, a member of the National Health Service Corps, or certified by the Secretary as qualified to provide physicians' services to pregnant women.

Implications of the current policy are significant.

- New York estimated that only 1/3 of its physician provider population would remain eligible to treat pregnant women and children.
- Rural states e.g., Montana have indicated that the only source of physician care in some counties is from physicians who do not meet one of the qualifications.
- New Mexico conducted a quick review of disciplinary actions under licensure and found that all of the involved physicians met the Medicaid standards.
- The AMA estimates that approximately one third of the nation's physicians are not board certified.

ELIMINATION OF REQUIREMENTS TO PAY FOR PRIVATE HEALTH INSURANCE

Administration proposal:

The current Federal requirements in this area would be repealed. States will have the option to purchase health insurance for their Medicaid population under flexible terms of negotiation with insurers. States will be free to negotiate benefit packages, premiums, and cost sharing rates (deductible and co-payments). States would continue to have the option to continue such "buy-out" kinds of programs -- particularly cost-effective "buy-out" arrangements.

Background:

Currently, states must pay premiums and all other cost-sharing obligations for a private insurance plan for Medicaid eligibles when this strategy provides cost-effective coverage.

Free of federal restrictions, states should be able to do a better job of restraining costs by moving people into private insurance. This is because Federal requirements require states to consider all cost-sharing related to private insurance. Because private plan deductibles and coinsurance amounts typically exceed the Medicaid rate for the same services, this requirement restricts the number of cases where a "buy-out" would be cost-effective. Also, the requirement is virtually impossible for states to administer since every plan may have different payment rules.

ELIMINATION OF PERSONNEL REQUIREMENTS

Administration proposal:

Prescriptive Federal personnel standards and requirements that currently must be met by states would be replaced with a simple requirement that states provide methods of administration which are necessary for the proper and efficient operation of the plan. The detailed state plan requirements and documentation currently required would be eliminated.

Background:

Federal statute and regulations mandate in some detail that states must provide methods of administration for the establishment and maintenance of merit system-based personnel standards, and states must use professional medical personnel for administration and supervision. Many of these federal requirements are duplicative of state requirements and processes. States are required to provide considerable documentation for this portion of their state plan.

ELIMINATION OF REQUIREMENT FOR COOPERATIVE AGREEMENTS

Administration Proposal:

The current requirements for entering into cooperative agreements with numerous other state agencies would be repealed. Also repealed would be any requirements that states provide documentation, as a part of their state plan, that the agreements are in place and current.

The repeal of these requirements would alleviate considerable administrative burden for states, and would allow flexibility to pursue management of Medicaid within the circumstances within each state's administrative practices and circumstances.

Background:

Section 1902(a) requires that a State Plan must "provide for entering into cooperative arrangements" with other State agencies. Some States have interpreted this to mean they must submit state plan amendments with the actual agreements every time an agreement is established or there is a change to an existing agreement. The requirement, however, is for states only to indicate in their State plan that agreements exist and identify which agencies the agreements are with. States are not required to submit the actual agreements.

ELIMINATION OF REQUIREMENTS FOR PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)

Administration proposal:

Replace the requirement for an annual resident review for all residents, with a requirement that States conduct an annual resident review on an exception basis. Under the Administration proposal, reviews would be conducted only when the NF resident assessment indicates a significant change in the physical or mental condition of the resident.

This would provide considerable administrative flexibility to focus scarce resources on those residents whose condition indicates there is a need for additional intervention and assessment. This proposal relieves the states of burdensome, costly, annual reviews of every resident which duplicate, in large part, the required evaluations and add little value to meeting the needs of residents.

Background:

States are required to perform resident assessments promptly after admission, after a significant change in physical or mental condition and no less often than annually thereafter for all mentally retarded or mentally ill individuals residing in facilities.

Although each state administers their reviews differently, the state of Washington can be looked to as a case example. In 1991, Washington conducted 400 annual resident reviews at a cost of \$750,000. Under the administration's proposal, the State of Washington's burden would be reduced significantly because duplicative reviews would be eliminated. However, the actual reduction cannot be quantified.



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FOLLOWING 4 PAGES

TO: Chris Jennings

FAX # 9456-7431

FROM: Charlie Salem

DATE: 3/5 TIME: 9:40A

NOTE: _____

Christina

FedEx Delivered El Camino Reservoir

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Kathy LMJ

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Best Sydney

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- 2. There is a second question regarding a possible CPI adjustment. In the Adjustment Factor section described above, the factor is fixed in the legislation and there is no CPI adjustment. Some have advocated, however, that the adjustment factor should float using CPI as a component. So, for example, the adjustment factor could have two components—CPI plus an additional factor. A state would then receive population growth + CPI + 2 percent. This approach would protect states against future cost increases during high inflation. [It should be noted that if the adjustment factor is allowed to float, CBO may have a scoring problem.]*
- 3. The third question is whether or not there should be an adjustment, over time, to lessen the differences between high and low cost per-beneficiary states. Should staff develop several alternatives to meet this goal?*

The Path of the Adjustment Factor Overtime. The adjustment factor that is written into the legislation will be higher in the early years and lower in the out years. For example, if the average adjustment factor over seven years is 4.3 percent it would have a path such as 6.0, 5.5, 5.0, 4.0, 3.5, 3.0, 3.0 over 1-7.

The State Allocation. An executive agency board will estimate each states' allocation every year for the next three years. This allocation would be based on the states unique projected growth and the national adjustment factor. The next year will represent a permanent allocation that will represent a minimum state allocation if matched by the state. The two additional years would represent a planning horizon that would be updated each year.

Efficiency Incentives. Each year for the seven years, each state would receive the full adjustment factor applied to the prior year base regardless of their actual per capita expenditure. If states become more efficient and reduce per capita spending they would reap savings which could be used to expand health care to other low-income populations.

Actual and Proxy Variables may be used for Prospective Allocation. As just stated, each year the executive board will project for the next three years the amount of money that will be available to each state for their base allocation. The projection will represent the board's best estimate of the

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Financing of the NGA Proposal

Base. In determining base expenditures a state may choose from the following—1993, 1994, or 1995 expenditures. The base includes disproportionate share spending.

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Growth. The growth in a states base over time will be composed of two factors. First, a weighted average of the projected growth in the guaranteed populations of that state and second, an adjustment factor. Both factors will be applied to the entire base including disproportionate share as long as a states share of disproportionate share is below the 12 percent national average. If a states disproportionate share is above 12 percent. The disproportionate share portion will not receive any growth until it falls to 12 percent.

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The average weighted population growth will reflect the prospective growth in the seven guaranteed population categories in a given state. The growth will be weighted by the average per beneficiary cost in a state for each particular population using the base year chosen by the state.

CFB
adjustment

The Adjustment Factor. The adjustment factor will be a percentage by which each state's base will be adjusted (along with the unique average weighted population growth for the state) each year to account for increases in the cost of providing health care services. The adjustment factor will be specified in the legislation over the seven year period and cannot be altered. The adjustment factor will never be below 3 percent for any year. For example, if the legislation allowed for a national spending growth of 7.9 percent annually and the national weighted average of population growth was 3.2 percent annually over the seven year period then every state would receive a 4.7 percent annual adjustment factor as well as their unique state weighted average of population growth.

There are three unresolved questions:

1. *There is a question whether the national annual growth rate is a fixed number written into the legislation (as the adjustment factor is) or whether the national growth rate is updated each year. If it is the former then the total allocation to states over seven years would be fixed in the legislation. If it is updated annually, then the total amount could fluctuate slightly up or down on a year-to-year basis. [From a scoring standpoint, the two approaches may be similar, but the concept is slightly different.]*

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guaranteed population but will be applied to the entire base. The prospective allocation will be based on recent actual state Medicaid data and, only when necessary the use of proxy variables. Some proxy variables may be collected by the Bureau of the Census, the Bureau of Economic Analysis, or other federal agencies for each of the seven categories. It is true that some of these proxy variables are already projected by some federal agencies. The use of any proxy variables will also be specified by the executive board.

Reconciliation or Tying Up. At the end of each quarter of the fiscal year there would be a look back to see if states provided care to more of the guaranteed populations than was estimated in the original allocation. If there was additional case load growth above that assumed in the states allocation, states could draw from the umbrella funds. For each guaranteed population as well as the optional elderly, optional disabled, and medically needy, individual states would be paid the state per capita spending with adjustment for that category of that population. (The per capita spending would not include disproportionate share spending.) States would have to use any surplus funds resulting from a population over-estimate in one guaranteed population category to offset a deficit in another guaranteed population prior to being able to draw from the umbrella fund. The matching share would be the same for the umbrella as the base program. The draw-down from the umbrella would be automatic since it would be an entitlement to the state. It would not be capped and it would not need to be appropriated. This reconciliation would be done on a quarterly basis. However, a federal agency would audit the states population draw-downs, after the fact.

Rollover Provision. Unobligated funds that have not been drawn down by a state will remain available to the state in future years.

Funding Formula

In any given year, a state's maximum federal Medicaid allocation would be established under the following formula:

$$[\text{Sum of } A \times B \times C \text{ for Each Population Group}] \times D = E$$

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$$E + F + G = H$$

- A = State-specific estimate by an impartial executive branch board of the percentage increase (or decrease) in the number of eligibles for the particular population group. Each estimate must be based on the best available state-specific data. Only when necessary should the board use relevant population growth indices as proxies (e.g., poverty count, SSI county, Census and economic data, as appropriate). The board would use rigorous, analytically-sound estimating techniques.
- B = Federal share of the state's per beneficiary costs for the particular population in the base year chosen by the state.
- C = This is an adjustment factor that will be specified in the legislation. It would represent the difference between the weighted national growth rate and the budget target for each of the seven years. To the extent possible, C will represent an annual projection of national health care cost increases. However, in no case will C be less than 3 percent.
- D = Federal share of the state's projected base allocation for the prior year (i.e., the state's prior year B or, in the case of the first year, the federal share of the state's actual total spending in the base year selected by the state). Disproportionate share hospital (DSH) spending would be included. However, if DSH spending is more than 12% of a state's total Medicaid spending in the base year or prior year, the DSH portion would not grow, i.e., it would be frozen in real dollars.
- E = The state-specific federal allocation in the particular year for base costs, growth, and the adjustment factor for health care inflation.
- F = Federal share of funding (if any) made available under the umbrella to accommodate unexpected population growth in particular populations.
- G = Federal funding provided to the state under the special grants (if applicable).

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H = Maximum federal allocation for the particular year.

No given year's E (sum of prior year's base, projected growth, and projected health inflation) would be less than the prior year's projected E for that state.

The three populations subject to A, B, and F above would be the following:

1. All children with guaranteed eligibility
2. All pregnant women with guaranteed eligibility.
3. All other adults with guaranteed eligibility.