

THE PRESIDENT'S MEDICAID REFORM PROPOSAL

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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.

SUMMARY OF WELFARE REFORM BILL

AFDC, WORK, & CHILD CARE

Medicaid Guarantee	Assures that all categories of people now eligible for Medicaid will be eligible for health care in the future and there will be no loss of coverage, regardless of state welfare changes. At President's insistence, Republicans restored the Medicaid guarantee for welfare recipients and abandoned efforts to block grant Medicaid.
Child Care	Increases child care spending by \$4.5 billion above current law -- \$4 billion more than the bill the President vetoed. Preserves federal child care health and safety standards, which would have been repealed under the vetoed bill.
Work	Provides \$1 billion performance bonus to reward states for placing welfare recipients in jobs. Requires 50% of adults on welfare to be working by the year 2002.
State Funding	Requires states to continue their investment in welfare reform by maintaining 80% of their current spending.
Time Limits	Imposes five year lifetime limit on welfare, but allows states to exempt 20% of caseload from the limit.
Vouchers	Allows states to use federal Social Services Block Grant funds to provide vouchers for children whose parents reach the time limit.
Contingency Fund	Creates a \$2 billion Contingency Fund for states experiencing economic downturn and growing number of children in need.
Family Cap	Allows states to decide for themselves whether to deny assistance to children born to a family on welfare. Under the vetoed bill, states would have had to vote to exempt themselves from a mandatory family cap nationwide.

FOOD STAMPS & CHILD NUTRITION

Food Stamp Program	Maintains national nutritional safety net. Does not allow states to block grant Food Stamps and does not impose a national cap on Food Stamp spending.
	Caps the excess shelter deduction, which was set to expire next year, at near its current level until FY2001. The President wants Congress to fix this provision because over time it will hurt working families.
	Limits food stamp eligibility for childless 18- to 50-year-olds to 3 months every 3 years, with a 3-month extension for laid-off workers.
School Lunch Program	Maintains the current national school lunch program. Drops the school lunch block grant that was in the vetoed bill.

LEGAL IMMIGRANTS

Bans	Over the Administration's objections, imposes 5-year ban on SSI, AFDC and Food Stamps for most legal immigrants, with some exceptions.
Medicaid	Over the Administration's objections, prohibits future immigrants from receiving Medicaid for 5 years. Drops the retroactive ban on current Medicaid recipients, which was included in the House bill.
	The President has said that immigrant children and the disabled should be able to get medical care and the help they need, and is determined to get Congress to fix these provisions.

OTHER PROGRAMS FOR CHILDREN

Child Welfare	Retains current law child protection entitlement programs and services. Drops the child welfare block grant that had been included in the vetoed bill.
Disabled Children	Provides full SSI benefits for children who will receive SSI under stricter eligibility rules. Drops the two-tiered eligibility system in the vetoed bill that would have cut benefits by 25% for more than half of the disabled children coming on the rolls.

DSH only

MEDICAID "CONSENSUS" AMENDMENT

Brief: Medicaid was growing at rates up to 29% in the late 1980's and early 90's. The HHS Inspector General's Office estimated that approximately 50% of the growth in 1991 was attributable to the combination of provider taxes and the use of DSH payments. Changes in 1991 and 1993 in the treatment of provider taxes and DSH, the rapid increase in waiver approval for managed care and slowing of general health care inflation have resulted in Medicaid returning to rates of inflation growth in the single digits. Preliminary estimates from CBO indicate that Medicaid growth may be much lower than anticipated and that we should expect a much reduced baseline for Medicaid in their April reestimate.

"Consensus" Document: Rather than imposing arbitrary caps, etc. that effectively argue we don't know how to control Medicaid spending, the evidence is clearly the opposite of that. We do know how to control spending, have successfully done so and should take additional steps along those lines. Such an alternative could save Medicaid an additional \$40 billion over a seven year period --

- ◆ Reforming and retargeting DSH -- \$30+ billion in savings
- ◆ Repeal the Boren Amendment -- \$1+ billion in savings
- ◆ Allow states to pursue managed care w/out waivers -- \$5 billion in savings
- ◆ Change in the definition of disability -- \$?? billion in savings
- ◆ Additional "consensus" state flexibility provisions -- \$?? billion in savings

Arguments For: Such an alternative stands in sharp contrast to the House GOP Medicaid draft which gains very little in federal savings but allows states to reduce its share of spending sharply -- up to three times the federal savings.

It compares best in what it does **not** do. For example --

- ◆ It does not impose massive bureaucracy and limits
- ◆ It does not put millions of Americans at risk of losing health coverage
- ◆ It does not put health quality at risk (maintains current Title XIX quality standards, including nursing home standards)
- ◆ It does not lock in current inequities among states and make them permanent
- ◆ It maintains the state partnership and commitment to Medicaid
- ◆ It grants states greater flexibility, in the areas that have traditionally complained about most (granting flexibility to reduce costs but not at the expense of coverage and quality)
- ◆ It continues the successful reforms of Medicaid that have been made in the last five years
- ◆ It reforms, and does not repeal, Medicaid

And last, but far from least --

- ◆ 35+ states would clearly fare better under this proposal (the exception would potentially be high DSH states)

**Medicaid Proposal:
Response to Governors' Issues**

- **Federal Entitlement/Right of Action**
 - Eligibles
 - Individual Benefits
 - Provider Payments

- **Benefits**
 - Mandatory
 - Comparability -- Optional Services
 - EPSDT Treatment
 - LTC Options
 - Cost Sharing

- **Eligibility**
 - Simplification
 - Definition of disability
 - Welfare Link

- **Federal Financing**
 - FMAP
 - Growth Rates

Federal Entitlement/Right of Action

- **Administration Proposal** - Preserves the individual federal entitlement to health care coverage for low-income individuals. This means that individuals who qualify for Medicaid under today's federal rules would be guaranteed coverage for a defined and meaningful package of health and long-term care benefits. Individuals would retain the right to sue in Federal as well as state court to enforce their entitlement.
- **Conference Agreement** - Explicitly repeals an individual's federal entitlement to health care coverage. Individuals would not be able to sue in federal court if denied eligibility by a state.
- **Coalition Proposal** - Same as Administration proposal.
- **Governors Concerns - Right of Action:**
 - a. How do we define more precisely our benefit provision -- individual, factual vs. another type of dispute?
 - b. Can we draw a distinction between mandatory and optional eligibles as regards the right of action?

Pending Proposals

There can be no negotiation on the basic issue of preserving the federal entitlement to Medicaid.

We have already agreed to the following clarification of the right to sue:

Eligibility: Maintain the current law requirements under which individuals have a right of action in federal court. However, it could be made explicit that a state administrative process must be exhausted prior to filing in federal court on eligibility-related claims.

Benefits: A working group of staff and counsel in HHS and the White House are developing a proposal for benefits under which the right of action for some benefit issues would remain in federal court, others would be limited to state courts. The following is one approach:

For individualized benefit claims, exhaustion of a health plan or HMO process and a state administrative process could be required, with appeal only to state courts of appropriate jurisdiction, unless the claim exceeds a specified threshold amount.

An "individualized benefit claim" would be defined as a claim by a recipient under this Title solely that an error of fact has been made, under a contract, policy or practice that is not in dispute, in deciding:

- (a) whether to provide or cover a service for the individual, including a determination of medical necessity or a decision as to amount, duration, and scope of services; or
- (b) whether or in what amount to charge a co-payment or deductible to the individual.

Counsel are meeting Tuesday to better develop these options.

Comments

The right to sue in federal court over eligibility disputes is at the heart the federal entitlement to Medicaid; without it, the entitlement is unenforceable and therefore meaningless.

Benefits

- **Administration Proposal** - Retains current law, which requires states to cover mandatory services: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurses practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. States may also cover optional services: prescription drugs, podiatrist, optometrist, dental, physical therapy, ICF/MR, rehabilitative services, etc.

A state's coverage of mandatory and optional benefits must be comparable across all categorically needy groups (e.g., services must be the same for AFDC and SSI eligibles). For medically needy groups, benefits must be the same within each group, but can vary from group to group. Also, states' benefit policies must be the same statewide.

States will now be allowed to impose nominal cost-sharing on HMO enrollees, consistent with cost sharing guidelines for fee-for-service enrollees. However, States may not impose premiums, enrollment fees, or similar charges upon categorically needy Medicaid beneficiaries (e.g., AFDC, SSI). A State may not impose coinsurance copayments, or deductibles on any services for children, family planning, pregnancy related services, emergency services, hospice, in-patient services for spend-down eligibles. A State may impose nominal charges upon other services within Federal regulatory limits.

- **Conference Agreement** - States are not required to provide a minimum benefit package to beneficiaries (exception immunizations to children and pre-pregnancy family planning services and supplies). States would define covered benefits and benefit levels.

Each State would be granted extremely broad discretion to impose cost sharing requirements upon Medicaid beneficiaries. Although no premium could be charged on a family including a pregnant woman or child with income below 100% of the Federal poverty level, these groups could face nominal coinsurance, copayments, and deductibles. Even this protected group could be subject to cost sharing for any services.

- **Coalition Proposal** - Retains current law mandatory and optional services. However, the Secretary would define treatment under EPSDT.

Maintains most current law cost sharing protections, but eliminates the current law requirement that coinsurance, copayments, and deductibles be nominal and replaces it with a requirement that such charges reflect income, resources, and family size of the beneficiary.

• **Governors Concerns -**

1. What flexibility can we offer in the mandatory benefits package?
2. What precise flexibility do we suggest in optional benefits packages:
 - a. ADS/comparability/statewideness, other
 - b. For whom - optional eligibles - some mandatory eligibles?
3. Are there options for dealing with the treatment component of EPSDT?
4. Can we extend, with matching, the ability to extend home and community based services to payment to families for care of relatives, at reasonable cost?
5. Additional flexibility on cost sharing.

Pending Proposals

Mandatory benefits: The core benefits should continue to include the currently mandatory Medicaid services, including inpatient and outpatient hospital, physician services, family planning, diagnostic services, nursing home and home health services, EPSDT, nurse midwife services, etc. Dropping the "provider-based" services such as nurse midwife services would be politically difficult.

Comparability: Some degree of flexibility on comparability of benefits could be considered to allow states to target optional services. Staff have asked the governors' staff to help develop a proposal under which comparability would not be required for the following:

- a. for optional beneficiaries, all optional services
- b. for mandatory beneficiaries, optional services would be divided into two categories with input from governors' staff:
 - some, such as personal care services, would not be subject to comparability requirements;
 - others, such as prescription drugs, would continue to be subject to such requirements (note: split of optional services into two categories to be developed)

EPSDT: We can clarify the "Treatment" provision of current law to specify that comparability and statewideness do not apply: states only have to provide those services which are not covered

under state plan amendments to children who receive EPSDT services. All other Medicaid recipients would only be entitled to the services covered in the state plan amendments.

LTC: Payment for Care of Relations: HHS will pursue discussions with state staff to explore this option.

Cost Sharing: President's plan provides flexibility to extend cost sharing to HMO enrollees.

Comments:

Any further flexibility on benefits could jeopardize the entitlement, because a clearly defined benefit package is necessary to ensure that eligible populations have meaningful coverage. Without a guarantee to a defined and substantial benefits package, the entitlement is hollow. In addition, wider flexibility on benefits could create confusion among both enrollees and providers as to which people are covered for what benefits.

Congressional consultation required.

Eligibility

- **Administration Proposal** - Maintains the current law mandatory and optional groups. Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement
- **Conference Agreement** - States would be required to cover poverty level pregnant women, children under 13, and the disabled (as defined by the state). No other populations would be guaranteed coverage. States would determine eligibility requirements, define income, set asset limits, and could choose to cover only limited subsets of current eligibility groups.
- **Coalition Proposal** - Same as Administration Proposal. Certain expansion populations (1902(r)(2)) would not be allowed after October 15, 1995.
- **Governors Concerns** -
 - a. How do we deal with welfare transitions? How do we delink Medicaid from cash assistance
 - b. How can we deal with definition of disability (federal v. state) and, in particular, concerns about eligibility for those who are alcoholics and substance abusers?
 - c. How can we give states credit for the savings from reduced welfare rolls?
 - d. How can we cover additional people without regard to the budget neutrality adjuster?

Pending Proposals

Eligibility simplification: States could be allowed to simplify Medicaid eligibility by making eligibility optional for a number of "grandfathered" groups that are currently mandatory (these groups, typically shrinking in size over time, qualified under old rules but, under new eligibility standards, would have lost Medicaid eligibility).

Disability/alcoholism/drug abuse: Would retain the federal definition of disability. However, disability as it relates to alcoholism and drug abuse and SSI benefits would be redefined in the context of welfare reform. The Coalition welfare reform plan provides that SSI would not be provided "if alcoholism or drug addiction would ... be a contributing factor material to the Commissioner's determination that the individual is disabled," and would also lose eligibility for Medicaid.

Welfare transitions: Whatever the specific outcomes of welfare reform, changes in welfare-related Medicaid eligibility will be considered.

Comments:

Flexibility beyond what is outlined has potential problems. In particular, replacing Federal with state definitions of eligibility means that cross-state differences will be magnified, possibly causing a "race to the bottom". Also, savings from a per capita cap could deteriorate if states are given broad latitude in defining eligible populations.

Congressional consultation required.

Federal Financing

- **Administration Proposal** - The Administration's proposal retains the current law federal matching rate formula (Federal Medical Assistance Percentage, or FMAP). Under current law, the matching rate in a state is based on per capita income in that state relative to the nation. By law, the minimum FMAP rate is 50 percent and the maximum FMAP rate is 83 percent.

Under the Administration's per capita cap proposal, the federal limit for each state is based on the state's historical Medicaid spending level. All states receive the same growth rate. Thus, there is little redistribution of federal funds across states.

- **Conference Agreement** - Under the Conference Agreement, each state can choose its FMAP from among several options. The agreement also raises the minimum FMAP rate from 50 percent to 60 percent. The effect of the Conference Agreement is to reduce the amount of dollars a state must spend to draw down a given level of federal funds. This approach could lower total (state and federal) funds spent on Medicaid.

Each state's block grant depends partly on historical costs and partly on arbitrary adjustments to a state's historical costs. However, not state has its grant determined by the formula in every year. Instead, grants are determined by the ceiling and floor growth rates. The overall effect of the Conference Agreement's block grant allocations is to favor lower-income, high population growth states at the expense of higher-income, low population growth states.

- **Coalition Proposal** - The Coalition Proposal also retains the current law FMAP formula. The financing structure is conceptually similar to the Administration Proposal. However, the specific methodology differs significantly. As with the Administration Proposal, there is little redistribution of federal funds across states.
- **Governors's Concerns** - Some have suggested employing the Conference Agreement's increased FMAP, and some have suggested differential growth rates.

Pending Proposals

None: the FMAP formula should not be opened up in the current negotiations; it is potential scoring problem issues under a per capita cap, and it could lead to substantial lowering of total funds devoted to health care for the poor. However, establishment of some sort of inter-governmental advisory commission to examine the issue could be considered. A commission could also consider the allocation of funds across states.

Congressional consultation required.

Medicare and Medicaid Savings, and Childrens' Coverage Investment Coming Up Short

Medicare and Medicaid Savings

	<u>FY2002</u>	<u>FY98-2002</u>
Medicare:	\$35 billion	\$138 billion
Medicaid:	\$9.7 billion	\$15-22 billion
Total:	\$45 billion	\$153-160 billion

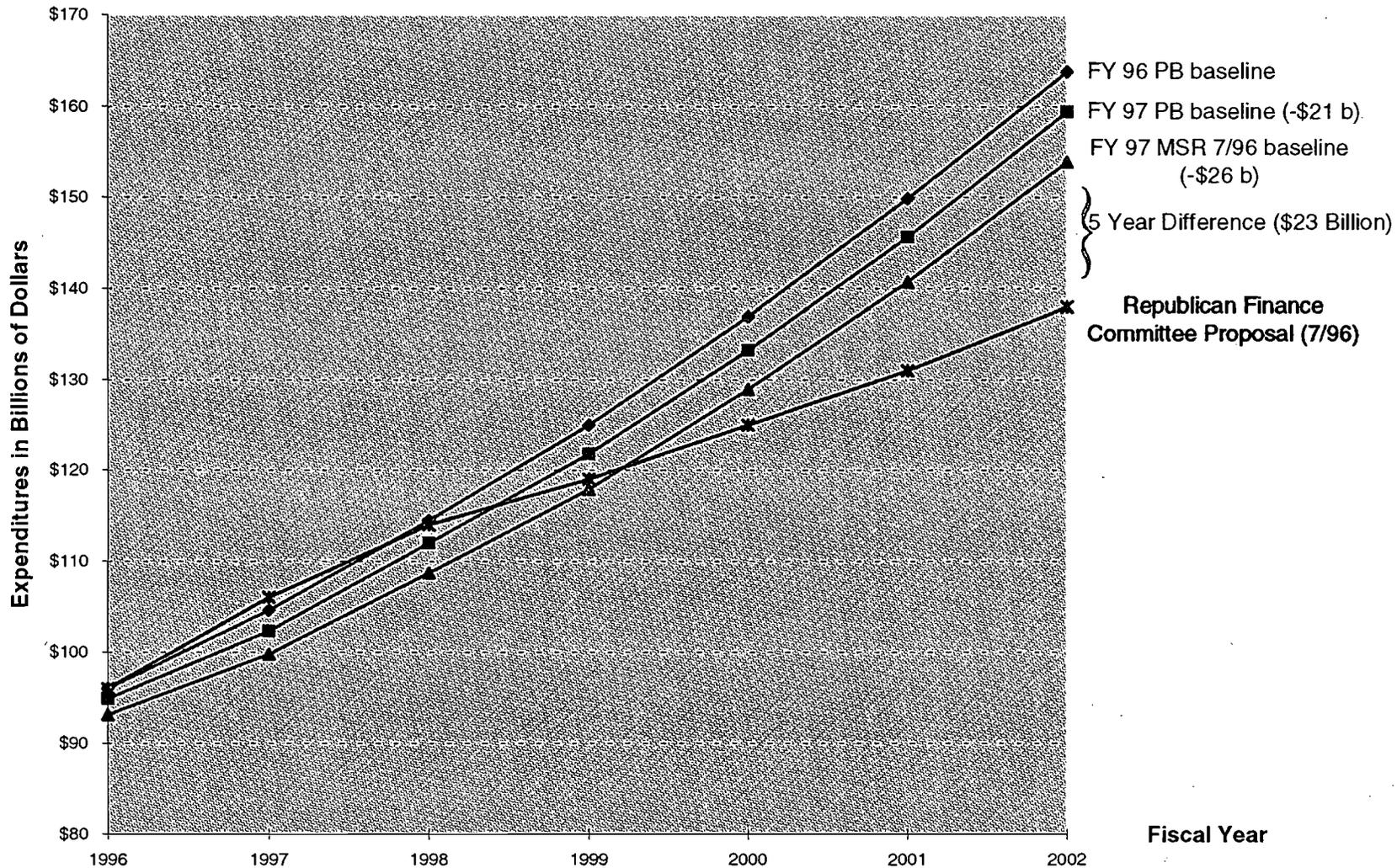
Problems:

- To best address DSH concerns and not go higher than our past public Medicaid per capita cap policy, we should be around \$7-8 billion in FY02 and \$12 billion over 5 years.
- To finance a kids coverage expansion (depending on what the President wants), we need to add back between \$2 and \$3.4 billion in FY02 and \$6-\$12 billion over 5 years.
- **Unfortunately, the groups, the States, and validators who might praise us for the kids' initiative may well reject it, suggesting we drop it if they see it coming directly out of Medicaid per capita cap savings. (A lower number Medicaid number would enable us to get them thinking that the savings could all come from DSH; in the end, this will not be possible because DSH politics will overwhelm concerns with savings coming from our per capita cap.)**
- If we addressed both problems in the most conservative ways, our FY2002 total savings contribution would be about \$40-41 billion -- \$4-5 billion short of our current target.

Solutions:

- The truth is I don't have much. We might be able to get \$1 billion more in Medicare savings, but HHS does not think we can get any more than \$36 billion if we hold at a \$138 billion clip. (Even this will require some interesting backloading.)
- Either a higher Medicare number OR a lower mandatory savings target from the health programs.

Medicaid Baselines, 1996-2002



5 Year Difference of \$23 billion is FY 1998-2002 difference between the FY 97 MSR and the Rep. Fin. Comm. Proposal
 FY97 PB baseline -\$21 billion 96-02 from the FY96 PB baseline. FY97 MSR 7/96 baseline -\$26 billion 96-02 from FY97 PB

FY 1997 President's Budget Medicaid Policy
(Dollars in Billions)

Actual OMB Scoring ^{1/}	
	6-Year Total 1997 - 2002
FY 97 President's Budget Baseline	774.2
Aggregate Growth (97-02)	9.3%
Per Capita Growth (97-02)	6.8%
Savings:	
Per Capita Cap*	-45.4
DSH Reform	-33.6
Transition Pools	20.2
Total Savings	-58.8
Resulting Baseline	715.4
Aggregate Growth (97-02)	4.6%
Per Capita Growth (97-02)	2.4%
*Growth Index of Per Capita Cap (97-02)	3.9%
Adjustment to OMB GDP in 2002	-0.5%

Actual CBO Scoring	
	6-Year Total 1997 - 2002
April 1996 CBO Baseline	802.7
Aggregate Growth (97-02)	9.7%
Per Capita Growth (97-02)	7.0%
Savings:	
Per Capita Cap*	-35.1
DSH Reform	-39.3
Transition Pools	17.7
Total Savings ^{2/}	-53.7
Resulting Baseline	749.0
Aggregate Growth (97-02)	6.3%
Per Capita Growth (97-02)	3.7%
*Growth Index of Per Capita Cap (97-02)	3.7%
Adjustment to CBO GDP in 2002	+0.0%

1/ The FY 1997 President's Budget policies produce \$53 billion in savings when scored off of the FY 1997 Mid-Session Review Baseline.

2/ Total Savings are net of the costs of VA and Medicare interactions with Medicaid.

**FY 1997 President's Budget Medicaid Policy Slipped One Year
Before Baseline Adjustments
(Dollars in Billions)**

<u>Estimated OMB Scoring of OMB Policy</u>		
	5-Yr Total	6-Yr Total
	<u>98 - 02 ^{2/}</u>	<u>98 - 03 ^{3/}</u>
FY 97 Mid-Session Review Baseline ^{1/}	650.1	818.1
Aggregate Growth	9.0%	9.1%
Per Capita Growth	6.4%	6.5%
Savings:		
Per Capita Cap*	-27.7	-45.9
DSH Reform	-25.6	-35.5
Transition Pools	19.7	20.2
Total Savings	-33.6	-61.2
(Total Savings in Last Year of Policy)	-18.4	-27.5
Resulting Baseline	616.5	756.9
Aggregate Growth	6.3%	5.9%
Per Capita Growth	3.7%	3.4%
*Growth Index of Per Capita Cap	3.9%	3.9%
Adjustment to OMB GDP in Last Year	-0.5%	-0.5%

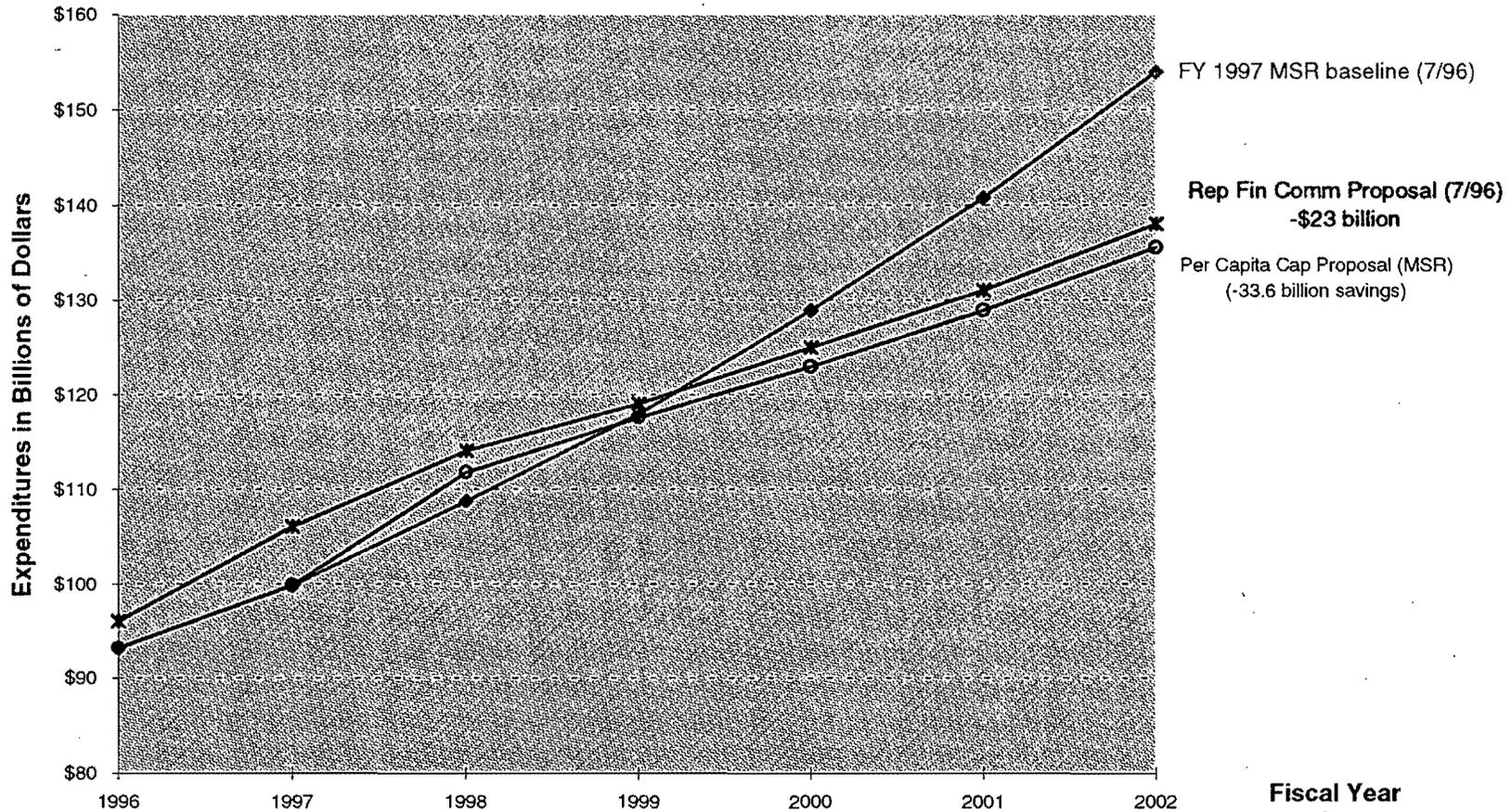
<u>Estimated CBO Scoring of CBO Policy</u>		
	5-Yr Total	6-Yr Total
	<u>98 - 02 ^{2/}</u>	<u>98 - 03 ^{3/}</u>
April 1996 CBO Baseline ^{1/}	697.9	880.9
Aggregate Growth	9.7%	9.7%
Per Capita Growth	7.0%	7.1%
Savings:		
Per Capita Cap*	-19.1	-31.9
DSH Reform	-32.1	-43.1
Transition Pools	17.2	17.7
Total Savings	-34.0	-57.4
(Total Savings in Last Year of Policy)	-17.2	-23.3
Resulting Baseline	663.9	823.6
Aggregate Growth	7.3%	7.3%
Per Capita Growth	4.7%	4.7%
*Growth Index of Per Capita Cap	5.1%	4.9%
Adjustment to CBO GDP in Last Year	+0.5%	+0.0%

1/ The baselines have NOT been adjusted for the impact of welfare reform or FY 1996 actual spending.

2/ Growth rates for the five-year total are measured from FY 1997 - 2002.

3/ Growth rates for the six-year total are measured from FY 1997 - 2003.

Medicaid Spending Adjusted for Reform Proposals, 1996-2002



Rep Fin Comm Proposal (7/96): -\$23 billion off the MSR, FY 1998-2002

PCC = Pres. Budget Medicaid Policy Slipped One Year, Total Savings: -\$33.6 billion

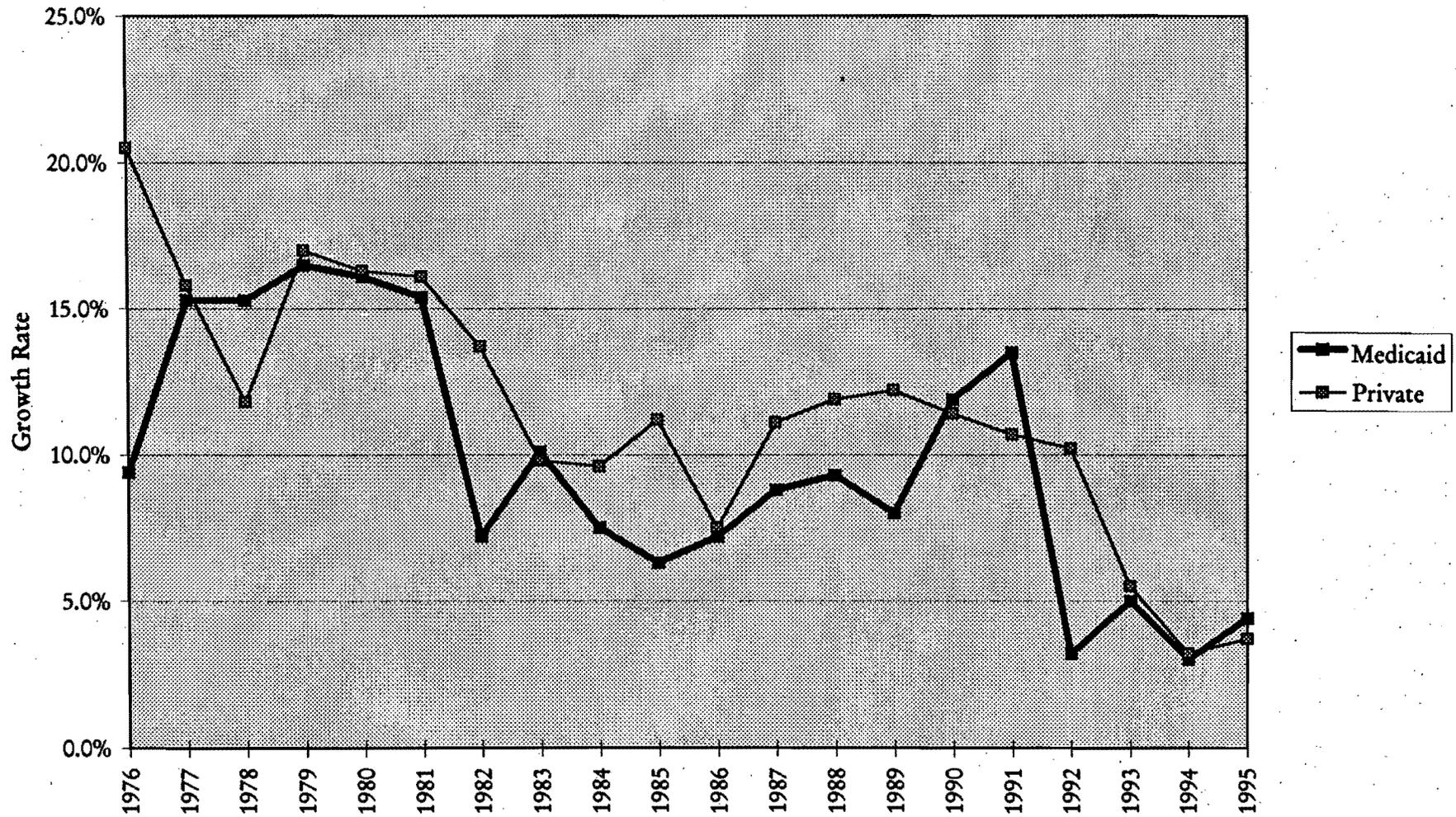
Sources: "Administration Baselines: Federal Medicaid Outlays", OMB, November 18, 1996.

"Medicaid Stream Comparisons", HHS, ASMB, November, 1996.

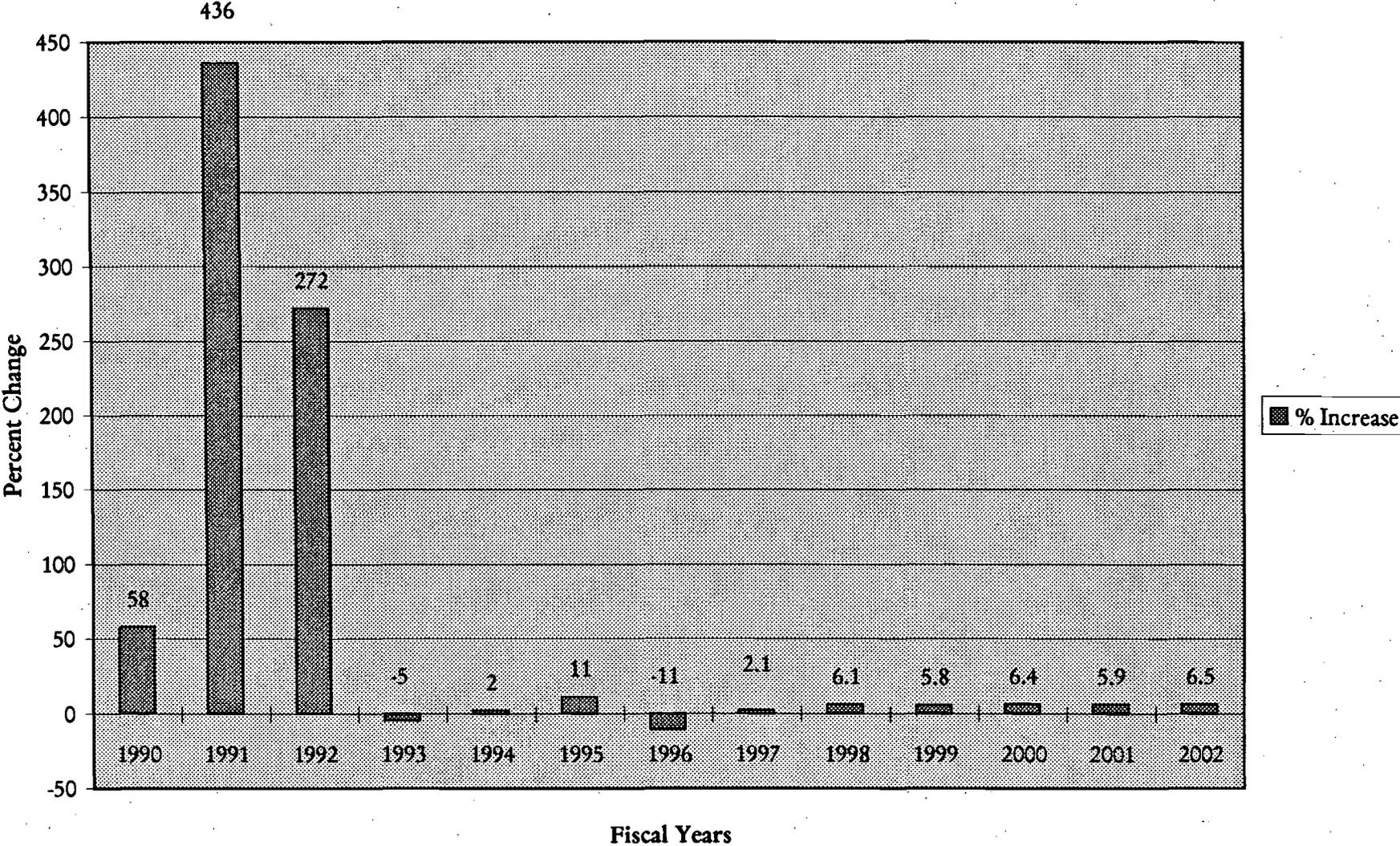
TOTAL STATE PER CAPITA COSTS FOR FY 1995 (In Descending Order)
 (Total Computable Costs excluding DSH)

FY95 Actual Dollars		Average Annual Growth from FY 90-95
NY	\$7,454	4.9%
OR	\$7,116	17.4%
NH	\$6,800	2.2%
DC	\$6,500	6.4%
RI	\$6,129	-4.5%
CT	\$6,026	7.9%
MN	\$6,021	-17.8%
MA	\$5,835	1.1%
ND	\$5,658	1.7%
NJ	\$5,521	3.6%
MD	\$4,840	5.2%
SD	\$4,832	4.1%
WI	\$4,822	7.3%
ME	\$4,715	5.2%
DE	\$4,663	9.4%
MT	\$4,573	5.3%
NE	\$4,552	7.2%
IA	\$4,424	6.7%
PA	\$4,323	7.8%
LA	\$4,308	9.5%
AK	\$4,202	-3.4%
WY	\$4,130	8.1%
OH	\$4,119	8.6%
AR	\$4,094	8.3%
CO	\$4,078	10.2%
WV	\$4,028	16.0%
MI	\$3,948	6.8%
KS	\$3,943	4.2%
NV	\$3,922	1.7%
NC	\$3,770	3.8%
UT	\$3,765	3.7%
WA	\$3,654	3.1%
TN	\$3,461	9.0%
ID	\$3,441	-1.2%
FL	\$3,433	1.8%
IL	\$3,360	9.6%
VT	\$3,343	2.4%
SC	\$3,335	0.2%
KY	\$3,289	5.7%
OK	\$3,255	1.6%
TX	\$3,202	5.2%
AL	\$3,194	5.6%
NM	\$3,170	4.8%
VA	\$3,165	0.5%
IN	\$3,088	-9.4%
MO	\$3,041	5.5%
GA	\$2,995	2.0%
AZ	\$2,908	6.1%
MS	\$2,863	12.5%
CA	\$2,461	4.2%
HI	n/a	12.6%

Annual Percent Increase in Medicaid Expenditures per Enrollee vs. Private Health Insurance



Percentage Change in DSH Spending



DSH Spending	
STATE	DSH Expenditures as a Percent of FY 1995 Medicaid Expenditures.
Louisiana	21.4%
New Hampshire	17.2%
Missouri	15.9%
South Carolina	15.8%
Alabama	15.1%
Maine	11.4%
New Jersey	11.2%
Texas	11.0%
Mississippi	9.3%
Nevada	8.2%
Connecticut	8.1%
Georgia	7.3%
North Carolina	7.2%
Pennsylvania	7.1%
California	6.8%
Kentucky	6.4%
New York	6.3%
Rhode Island	6.2%
Ohio	6.2%
Washington	6.1%
Colorado	6.1%
Indiana	6.0%
Massachusetts	5.7%
Kansas	5.6%
Vermont	5.2%
West Virginia	5.0%
Michigan	4.8%
Illinois	3.4%
Alaska	3.3%
Florida	3.1%
Maryland	3.0%
District of Columbia	2.9%
Virginia	1.7%
Oklahoma	1.5%
Oregon	1.4%
Delaware	1.1%
Iowa	0.7%
New Mexico	0.6%
Nebraska	0.6%
Utah	0.6%
Minnesota	0.6%
Idaho	0.4%
North Dakota	0.3%
Wisconsin	0.3%
South Dakota	0.2%
Arkansas	0.2%
Montana	0.0%
Arizona	0.0%
Hawaii	0.0%
Tennessee	0.0%
Wyoming	0.0%

SIGNIFICANT REVISIONS TO THE SENATE REPUBLICAN MEDICAID PLAN

The Senate Finance Committee's approved changes to the Republican Medicaid proposal may appear to improve the plan significantly, but these revisions do not change the basic facts. This bill is still a block grant. The financing structure still puts states at risk for increases in costs associated with enrollment changes. The coverage guarantees in the bill are conditional on Federal financing -- and Federal financing will be insufficient to meet the States' needs.

Eligibility

Eligibility Phase-In

Restores the eligibility phase-in of children aged 13 to 18 with incomes below poverty as mandatory eligibles.

- ▶ **Children aged 13 to 18 appear to be "guaranteed" coverage. However, these children have no real guarantee of coverage as long as the Federal right of action is repealed.**

Methodology

State discretion to determine eligibility is restricted compared to the original bill. For example, States must use the SSI methodology to determine income and resources for low-income elderly individuals. Similarly, States electing to use the SSI definition for disability must use the SSI methodology to determine income and resources.

- ▶ **However, the states still have enough choices to eliminate coverage for many.**

Services

EPSDT Services

Retains EPSDT treatment services by requiring that EPSDT coverage be equivalent in amount, duration and scope to benefits in effect as of June 1, 1996.

- ▶ **This amendment nominally restores treatment services for children, but does not provide any assurance that children will receive these necessary services as long as funding is insufficient and Federal right of action is repealed.**

Amount, Duration and Scope of Services

Retains current requirements that the amount, duration and scope of covered services be "adequate" to serve Medicaid enrollees.

- ▶ **This amendment retains only part of the current guarantee of a meaningful benefit package. Without comparability and statewideness rules, States could create benefit packages that differ across eligibility groups, such as disabled enrollees and children.**

FOHC and RHC Services

Retains FQHC and RHC services as mandatory Medicaid services, repeals cost-based reimbursement for FQHC/RHC services, and requires States to guarantee that FQHCs and RHCs receive 95 percent the higher of FY 1995 or FY 1996 spending. This permanent set-aside could not be waived. Allows States to establish separate solvency standards for FQHC/RHC-controlled health plans.

- **FQHC/RHC services are “guaranteed” only to the extent that other services are “guaranteed” – and without adequate funding or a Federal right of action, no services are truly “guaranteed”.**

Mental Health Services

Requires States to establish treatment limits and cost-sharing for services treating mental illness that are equivalent to limits on services that treat other conditions.

- ▶ **This requirement explicitly prohibits a Federal right of action, and therefore provides no real guarantee of equal treatment – or even adequate coverage -- for people with mental illnesses.**

Physician Assistants

Adds physician assistant services as a Medicaid service.

- ▶ **This amendment enhances the list of potentially available Medicaid services but does not provide any assurance that enrollees will be able to access this or any other service, as long as funding is insufficient and Federal right of action is repealed.**

Financing

Block Grant Formula

Technical amendments correct errors in the original block grant formula. The bill now conforms to GAO's state-by-state estimates.

- ▶ **These changes do not alter the basic structure of the program—it's still about 97**

percent block grant and 3 percent limited umbrella fund that is available for only one year.

Donations and Taxes

Retains current restrictions on States' use of voluntary donations and provider taxes to generate State share.

- ▶ **The continuation of current law restrictions would ensure that States must use "real" dollars to match block-grant funding.**

Limitation on Uses of Funds

Clarifies that States may not use their Medicaid allotments to supplant services that are currently financed through state-only dollars.

- ▶ **This restriction would prohibit States from using limited Medicaid funds to re-finance other State health programs.**

Supplemental Pools for Undocumented Aliens and Indian Health

Shifts funding for the supplemental pool for services provided to undocumented aliens forward by one year, from 1997-2001 to 1998-2002. Distributes funding from this pool based on the proportion of undocumented aliens compared to total State population, rather than total number of undocumented aliens residing in the State.

Increases funding for the supplemental pool for Indian health services by \$551 million over five years. This increase is offset by a similar decrease in the supplemental fund for undocumented aliens. (Note: The Committee agreed to seek an alternative offset.)

- ▶ **These changes redistribute limited supplemental funding pools across the States. They do not increase overall Federal payments to the States and do not address the inadequacy of the block grant funding mechanism.**

Beneficiary Financial Liability

Cost-Sharing

Restores some limitations on beneficiary cost-sharing. Retains current-law restrictions on cost-sharing for "guaranteed" populations and services, but allows States to impose sliding-scale copayments for optional services provided to optional populations.

- ▶ **These changes would restore financial protections for Medicaid beneficiaries for many services. However, they do not protect beneficiaries from out-of-pocket**

liability for services that States may choose not to cover, given the financial pressure of the under-funded block grant.

Family Farms

Clarifies that States may not place liens against family farms -- and endanger the community spouse -- as a condition of eligibility for long term care services.

- **Community spouses would have additional protection -- but not a right to sue the State in Federal court if the State violates this provision.**

Trusts for Disabled Individuals

Restores current prohibitions against States collecting from trusts that are established for disabled individuals under age 65.

- **Maintaining current law for these trusts would provide additional protection for disabled individuals.**

Balance Billing

Prohibits balance billing and prohibits providers from denying care based on patient's inability to pay cost-sharing or other charges.

- **This change would ensure that beneficiaries will not be charged excess fees above the Medicaid rate or be denied access to care because they cannot make a copayment.**

Quality Standards

Managed Care

Adds quality and program standards for Medicaid managed care programs, including choice of plan, reporting and access standards, based on S. 839 (Chafee-Graham-Conrad). Requires States to implement quality improvement programs and contract for independent quality reviews of managed care plans.

- **These standards would help ensure that managed care enrollees -- nearly one-third of current Medicaid enrollees -- receive high-quality health services. These standards are particularly important since States would be under extreme fiscal pressure to contract with untested, low-bidding health plans.**

Access

Establishes access standards, based on distance, for primary care services and nursing facilities.

- ▶ **These standards would help ensure reasonable geographic access to necessary health services.**

Intermediate Care Facilities

Requires the Secretary to establish, monitor and enforce minimum standards for ICFs/MR. Requires States to ensure compliance with federal health, safety and welfare standards for ICFs/MR and ensure that treatment services are based on an individualized plan to maximize independence.

- ▶ **These requirements would help to ensure quality of care and safety for ICF/MR residents.**

Nurse-Aide Training

Allows States to waive the restriction on training of nurse-aides in nursing facilities under certain circumstances.

- ▶ **This amendment largely conforms with the President's proposal and provides States with additional administrative flexibility. (Note: the amendment does not appear to apply to Medicare and thus poses problems for dually-certified facilities.)**

Indian Health

As amended, the bill clarifies that States that receive an allotment for Indians may use it for tribes and urban Indian organizations as well as for IHS.

- ▶ **This change heightens the inadequacy of the special grants funding, since the funds would be stretched across multiple types of providers.**

The bill still limits special grant funds to states with at least one IHS facility.

- ▶ **The bill still limits special grant funds to States with at least one IHS facility, thus excluding California, which has significant Indian populations and no IHS facilities.**

REVISIONS TO REPUBLICAN MEDICAID PLAN

The House Commerce Committee's approved changes to the Republican Medicaid proposal may appear to improve the plan, but actually are minor or cosmetic in nature and, at the core, do not change the basic facts. This bill is still a block grant. It would do nothing to provide a guarantee to coverage and a meaningful benefit package. The financing structure still puts states at risk for increases in costs associated with enrollment changes.

Eligibility

Methodology

State discretion to determine eligibility is restricted compared to the original bill. For example, certain methodologies and standards that are used in certain parts of the eligibility determination process are required under certain circumstances (e.g., income and assets for determining eligibility for disability are specified, if states elect the SSI definition of disability).

- ▶ **However, the states still have enough choices to eliminate coverage for many.**

Medicaid Coverage for Welfare Transition

Retains and modifies transitional Medicaid coverage for employed former welfare beneficiaries for twelve months. Eliminates the current 1998 sunset provision for this coverage, thus creating a permanent mandatory Medicaid eligibility category.

- ▶ **This superficial improvement does not provide real guarantees of coverage – such as a Federal right of action or any requirement for adequate benefits – for former welfare beneficiaries.**

Eligibility Phase-In

Reinstates the eligibility phase-in of children aged 13 to 18 with incomes below poverty as mandatory eligibles.

- ▶ **Children aged 13 to 18 appear to be “guaranteed” coverage. However, these children have no real guarantee of coverage as long as amount, duration and scope requirements and Federal right of action are repealed.**

Services

FQHC and RHC Services

Retains FQHC and RHC services as mandatory Medicaid services and requires States to

The current restrictions on taxes and donations could be undermined after the first two years because HHS would have no basis for denying waiver requests. There would be no evidence or analysis of abusive practices in the first two years of the program and therefore no new information for developing criteria to use when evaluating waiver requests.

Cost Sharing

The changes to the cost sharing provisions are extensive. They do in fact, limit the liability of Medicaid patients for cost sharing in many instances.

However, as with other changes, they are cosmetic, not real. For every protection that would be provided, there are conflicting provisions that would counteract the effect of the proposed change.

Although the revised proposal would prohibit premiums for the guaranteed population, it would, at the same time, allow States to impose premiums, up to 2 percent of individual gross income, on all other Medicaid beneficiaries.

Imposition of a 2 percent premium may not sound like much, but to a low income person, it is potentially a huge barrier to care.

The bill also permits cost sharing (nominal cost sharing for guaranteed populations, and comparable to HMO cost sharing for other groups) for Medicaid beneficiaries. It is possible that a pregnant woman with a hospital episode of \$5000, for example, could still be at risk for a cost sharing payment of \$300.

The bill prohibits balance billing by providers.

It would nonetheless permit providers to charge cost sharing, and would remove the prohibition on denial of service to a beneficiary unable to pay the cost sharing.

Indian Health

As amended, the bill requires States to include payment provisions for health services provided to Indians in their State plans and requires States to consult with Indian tribes while developing the State plan.

This change provides some minor procedural assurances but does not address the inadequacy of the supplemental pool that appears to be the sole source of Medicaid financing for Indian health care.

New language clarifies that States that receive an allotment for Indians may use it for tribes and

guarantee that FQHCs and RHCs receive 85 percent of FY 1995 spending on FQHC/RHC services through FY 2000. States could request lower set-aside amounts for later years. Allows States to establish separate solvency standards for FQHC/RHC-controlled health plans.

- ▶ **These changes establish a temporary funding guarantee for one type of safety-net provider, but, because the set-aside is based on 1995 spending, the real value of this guarantee would erode with time.**
- **In addition, FQHC/RHC services are “guaranteed” only to the extent that other services are “guaranteed” – and without amount, duration and scope requirements and a Federal right of action, no services are truly “guaranteed”.**

Physician Assistants

Adds physician assistant services as a guaranteed Medicaid service.

- ▶ **This amendment enhances the list of “guaranteed” services but does not provide any assurance that enrollees will be able to access this or any other service, as long as amount, duration and scope requirements and Federal right of action are repealed.**

Financing

Block Grant Formula

Lowers (by comparison to the original bill) the growth of state base allotments for 1997, and adds an additional layer of complexity to the already complex (40 pages of legislative language), block grant formula. The bill now conforms with GAO's state-by-state estimates.

- ▶ **No changes have been made to the basic structure of the program—it's still about 97 percent block grant and 3 percent limited umbrella fund that is available for only one year.**

Donations and Taxes

Retains current restrictions on States' use of voluntary donations and provider taxes to generate State share. Permits HHS to waive these restrictions, at State request, after the first two years. Requires GAO to study States' use of tax and donation schemes under the revised Medicaid program.

- ▶ **The extension of current law restrictions would ensure that, for at least the first two years before the waiver authority begins, States must use “real” dollars to match block-grant funding. Exactly what GAO would study while these practices continue to be prohibited under the revised financing structure is unclear.**

urban Indian organizations as well as for IHS.

- ▶ **This change heightens the inadequacy of the special grants funding, since the funds will be stretched across multiple types of providers.**

The bill still limits special grant funds to states with at least one IHS facility.

- ▶ **The bill still limits special grant funds to States with at least one IHS facility, thus excluding California which has significant Indian populations and no IHS facilities.**

Nurse-Aide Training

Allows nurse-aide training programs to continue in certain rural nursing homes, including those that are subject to an extended survey for quality deficiencies. A similar provision was included in the Medicaid portion of the President's balanced budget proposal.

- ▶ **This amendment largely conforms with the President's proposal and provides States with additional administrative flexibility. (Note: the amendment does not appear to apply to Medicare and thus poses problems for dually-certified facilities.)**

MediGrant II

1. **Base:** Set in legislation (sort of states' choice of 1993, 1994, 1995, but not exactly)

2. **"Needs-Based Amount"**

Product of:

- a. Number of poor people in a state and
- b. State-adjusted national MediGrant spending per poor person

Adjusted for:

State's casemix index (ranges from 0.9 to 1.15)
Medicare hospital wage index times 0.85 plus 0.15

3. **Floors and Ceilings**

The Needs-Based Amount is compared to the Base to yield a growth rate.

That growth rate cannot be :

Greater than ceilings

125% of the national rate for most states

150% of the national rate for 10 states with the lowest federal funding per poor person (e.g., FL, CA)

Less than the floors

3% for most states

90% of the national rate for states with certain rates

Almost all states are at their floors and ceilings for the 1996 to 2002 period. No state gets a needs-based amount for full period.

4. **Scalar:** To ensure that the Federal budget target is hit, all states are multiplied by a scalar or ratio. This occurs within the floor and ceiling growth rates.

President's Proposal

Per Capita Cap

- 1. Base:** 1995 total spending per beneficiary by group is calculated.
Excludes: DSH, Medicare cost sharing, and certain admin. costs
- 2. Index:** Base total spending per beneficiary is multiplied by the index — growth rate constraint on per-beneficiary spending (set in legislation).
Savings from this proposal come from replacing the baseline spending growth per beneficiary with the index.
- 3. Enrollment:** Indexed total spending per beneficiary by group is multiplied by enrollment by group and then summed to yield one total limit.
- 4. Federal Limit:** Total limit is multiplied by the FMAP to yield the Federal limit.

Disproportionate Share Hospital (DSH) Changes

- 1. New Program:** Federal DSH spending is set in legislation.

State allotment is the national pool times the state's share of low-income utilization days (Medicaid and uninsured hospital days and outpt. visits)

States can determine which hospitals gets how much, but give priority to:
Hospitals with > 25% low-income utilization rate; and
Kids' hospitals with > 20% Medicaid inpatient utilization rate

Transition: The new state allotments are phased in to minimize disruption.

<u>Total Allotment =</u>	<u>Phased-Out</u>	<u>+ Phase-In</u>
1997 Allotment =	(1995 Fed payments times 75%)	+ (2000 Fed allotment times 25%)
1998 Allotment =	(1995 Fed payments times 50%)	+ (2000 Fed allotment times 50%)
1999 Allotment =	(1995 Fed payments times 25%)	+ (2000 Fed allotment times 75%)
2000 Allotment =	(1995 Fed payments times 0%)	+ (2000 Fed allotment times 100%)

- 2. Pools:** **Undocumented Persons Pool:** For 15 states with high number of undocumented persons (\$3.5 billion over the period)

Federally-Qualified Health Centers & Rural Health Clinics Pool: For supplemental payments for these facilities (\$3.0 billion over the period)

Transition Pool: For states to assist in transition to reformed program (\$11.2 billion over the period)

Breux-Chafee Proposal

Medical Expenditure Limit

1. **Base:** States' choice of 1993, 1994, or 1995 total spending
Excludes: DSH, Medicare cost sharing, and certain admin. costs

2. **Growth-Adjusted Amount:**
The base (for 1997) or the previous year's growth-adjusted amount (for subsequent years) is multiplied by:

Inflation Adjuster: Growth rate constraint (set in legislation) and

Weighted Average Enrollment Growth Rate: Estimated prior to the start of the fiscal year and updated as enrollment data become available. Adjusted for case mix.

3. **Umbrella:** Process by which estimated enrollment is reconciled with actual enrollment. The adjustment can be both upward and downward.

4. **Hold Harmless:**
The growth-adjusted amount (adjusted by the umbrella) is compared to the base. The total limit is whichever amount is higher

5. **Federal Limit:** Total limit is multiplied by the FMAP to yield the Federal limit.

Disproportionate Share Hospital (DSH) Changes

1. **New Program:** Federal DSH spending is set in legislation.

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1998 Allotment =	(1995 Fed payments times 50%)	+ (2000 Fed allotment times 50%)
1999 Allotment =	(1995 Fed payments times 25%)	+ (2000 Fed allotment times 75%)

Hold Harmless: No state's allotment can be less than 25% of its 1995 allotment.

Key Components to Medicaid Formula

	President	MediGrant	Governors	Chafee-Breaux
BASE				
Fixed or choice	Fixed: 1995	Fixed: state-defined	Choice: 1993, 1994, or 1995	Choice: 1993, 1994, or 1995
DSH in or out	Out	In	In	Out
GROWTH				
Inflation adjusted	Yes	No	Partial (CPI "umbrella")	Yes
Enrollment adjusted	Yes	No	Partial: no downward adjustment to estimates; upward adjustments are not added to the base	Yes
HOLD HARMLESS	No	Yes: Previous year's limit times the "floor" growth rate (3%)	Yes: Previous year's limit	Yes: Base amount
STATE CONTRIBUTION				
FMAP change	No	Yes	Yes	No
Provider taxes & donations repeal	No	Yes	Yes	No

How the proposal is different than a per capita cap

- **Simple formula:** Like the Governors' proposal, this proposal includes only three elements in the funding formula: each state's base, enrollment growth, and an inflation adjuster.
- **State choice of base year:** Like the Governors' proposal, it allows states to choose their base amount from 1993, 1994, or 1995.
- **Greater certainty:** Like the Governors' proposal, the proposal requires that the state allotments are determined in advance so that a state will have a sense of its limit for the coming year.
- **Hold harmless:** Like the Governors' proposal, it offers the states a guaranteed minimum allotment or hold harmless. Regardless of enrollment changes, the allotment will not fall below the state's base amount (note: for the Governors' proposal, the hold harmless is the previous year's allotment).

How the proposal is different than the block grant proposal (MediGrant):

- **Adjusts for enrollment changes:** Like the Governors' proposal, the plan adjusts the funding limit when enrollment growth changes.
- **Adjusts for inflation:** Like the Governors' proposal, this proposal will change the state limit if inflation occurs. This takes states off the hook for cost growth resulting for unexpected economic changes.
- **Maintains state contribution to Medicaid:** The proposal does not change the Federal-state matching rate. This means that the Federal and state governments share equally in the savings from the proposal. Nor does it permit the use of provider taxes and donations, which have been outlawed because of their huge effect on Federal Medicaid cost growth in the late 1980s and early 1990s. Both MediGrant and the Governors' redefine and reduce the state contribution to Medicaid.

How the proposal is different than the Governors' proposal:

- **More targeted DSH funding:** This proposal does not fully incorporate disproportionate share hospital (DSH) payments into the funding formula. Folding this money into the base actually rewards states who had been abusing the system. Instead, it reduces and retargets DSH allotments to states with high needs. It also dedicates a portion of DSH funding to deficit reduction and to a hold harmless, so that states retain a third of their DSH funds for general use.
- **Umbrella adjustments that go up as well as down:** The Governors' plan adjusts the state allotments for unexpected increases in enrollment growth, but not for unexpected decreases. This plan fully adjusts the allotments for enrollment changes (subject to the hold harmless).

Medicaid Financing Proposal

The Medicaid financing proposal has two components:

- A limit on Federal Medicaid spending on medical assistance (health benefits) and
- A reduction and retargeting of the Medicaid spending on disproportionate share hospitals (DSH).

MEDICAL ASSISTANCE LIMIT:

The total amount of state medical assistance expenditures that the Federal government will match will be limited. States will know in advance the preliminary Federal limit or "allotment". The allotment will be revised when data on enrollment for the year become available. The quarterly grants to states will be consistent with the limits. Each state's allotment will be the greater of:

- (A) the base amount or
- (B) the growth amount plus the umbrella adjustments.

The **base amount** for each state includes the expenditures subject to the limit for 1993, 1994 or 1995 (the year chosen by each state).

The **growth amount** for each state is the product of three numbers:

- (A) Previous year's allotment (the base amount for 1997) plus the umbrella adjustments,
- (B) the inflation adjuster, and
- (C) the estimated weighted average enrollment growth rate.

The *inflation adjuster* is a growth-rate limit on the Medicaid spending growth due to health care inflation, utilization and quality changes. It is set in legislation as the sum of the consumer price index (CPI) for previous 12 months and a specified adjustment factor.

The *estimated weighted average enrollment growth rate* is used to adjust base year spending and subsequent year allotments for enrollment changes. It is one rate that is composed of the specific enrollment growth for four groups of Medicaid enrollees: aged, disabled, adults and children. It is estimated in advance of each fiscal year by the Secretary. As the actual enrollment information becomes available, it is folded into the formula through the umbrella adjustment.

The **umbrella adjustment** is the mechanism for adjusting the preliminary allotments to account for the actual enrollment trends. Umbrella adjustments occur midway through the fiscal year, and at the end of the fiscal year when the actual enrollment growth is known.

Process for Determining Medical Assistance Limits:

The Secretary of Health and Human Services is primarily responsible for determining the medical assistance limits. The Secretary will produce: (a) a preliminary allotment for each state, prior to the start of the fiscal year, (b) an interim allotment halfway through the fiscal year to account for more recent enrollment trends, and (c) a final allotment at the close of the fiscal year which incorporates actual enrollment growth. The preliminary allotment will be updated through the "umbrella adjustment" which reconciles the estimated enrollment growth with more recent trends (interim allotment) and the actual enrollment growth in the state (final allotment). The Secretary will make the growth estimate based on (a) state estimates of enrollment growth; (b) Medicaid eligibility criteria and standards in each state; (c) legislation enacted or pending in each state; (d) historical trends; and (e) general economic trends.

DISPROPORTIONATE SHARE HOSPITAL (DSH) LIMITS:

The baseline Disproportionate Share Hospital (DSH) funding is divided into three different uses:

- (A) Deficit reduction,
- (B) A targeted DSH program, and
- (C) General medical assistance.

Deficit reduction will account for about one third of current DSH payments.

The **targeted DSH program** will allocate a share of a fixed Federal funding pool to states based on their share of low-income utilization days in eligible hospitals. The share is determined by the state's percent of the nation's inpatient days and outpatient visits for uninsured and Medicaid patients. States will still contribute to the program through matching payments (using the current matching rates). Funding begins in 1997 and is fully phased in by 2000.

There would also separate streams of funding within the DSH program for (a) states with high numbers of undocumented persons and (b) Federally-qualified health centers and rural health clinics. The 15 states with the highest number of undocumented persons would get a proportionate share of a \$3 billion pool over a five-year period for payments for emergency care for this population. Additionally, a \$3.5 billion pool (\$500 million per year) would be established to supplement payments to Federally-qualified health centers and rural health clinics. Both pools are 100 percent Federally funded.

The **amount of DSH for general medical assistance** is calculated as a percentage of the 1995 Federal payments to states. It is considered as an add-on to the limits described earlier. It is included in neither the base nor the growth amounts for the purpose of the allotment calculation. States will still contribute matching payments for this amount.