

REPUBLICANS ON MEDICAID

The Dole-Gingrich Plan, which President Clinton vetoed, would have eliminated the Medicaid guarantee for 36 million older Americans, children, people with disabilities, and pregnant women.

- The Republicans insisted on \$163 billion in federal cuts from the Medicaid program. Combined state and federal Medicaid cuts could have exceeded \$400 billion if states had spent only the minimum required under their plan.
- The Republican plan would have “block granted” the Medicaid program, undermining the guarantee of coverage. The reduction in federal funds could force states to deny coverage for nearly 8 million people in 2002, including:
 - 3.8 million children
 - 1.3 million people with disabilities
 - 850,000 older Americans, and
 - 330,000 nursing home residents

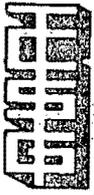
Their proposal would have undermined health care for millions of Americans

- Could have forced many older Americans and people with disabilities to sell their home to qualify for nursing home benefits.
- Undermined protections against spousal impoverishment that were signed into law by President Reagan in 1988. This law has protected spouses of 450,000 nursing home residents, most of whom are women.

Again and Again President Clinton said no to the extreme Republican proposals and preserved the guarantee of health care coverage for millions of Americans.

- President Clinton vetoed the 1995 Dole-Gingrich budget which could cut Medicaid by \$163 billion and would have threatened health care coverage for millions of families, children, pregnant women, people with disabilities.
- President Clinton stood strong again on Medicaid by refusing to sign a welfare bill that contained a proposal to block grant Medicaid and cut up to \$250 billion from the program.

In 1995 the Republican budget contained \$245 billion in tax cuts, and their Medicaid cuts could have exceeded \$163 billion. Now, Republicans are proposing \$548 billion in tax cuts. What kind of extreme Medicaid cuts will they come up with to pay for that?



Best Practice NOTES

On Delivery of Legal Assistance to Older Persons

VOL. 7, NOS. 3 & 4

SEPTEMBER 1996

CONTENTS:

Tobacco is an Elderly Issue Too!... 2
Adult Guardianship Mediation... 6
Alert! Criminalization of Asset Transfers to Qualify for Medicaid... 10
Legal Services Developers Hold 3rd Annual Symposium... 16
Elder Rights Advocates Mourn the Loss of Arthur Flemming... 16
Samuel Simmons Receives 1995 Arthur S. Flemming Award... 17
Recent TCSG Publications Available... 18

TCSG ANNOUNCES NEW NATIONAL GUARDIANSHIP MEDIATION INITIATIVE

The Center for Social Gerontology (TCSG) is delighted to announce that we have been awarded a two-year grant from the William and Flora Hewlett Foundation to undertake a national campaign to promote mediation in adult guardianship cases.

TCSG has long been a leader in the study of guardianship law and practice and in advocating maximum autonomy and independence for older persons. Having grappled with the inadequacies of the court guardianship process, we have, since 1991, pioneered the testing and evaluation of mediation as an effective alternative -- an alternative that promotes autonomy, dignity and well-being of older persons while maintaining, even enhancing, vital relationships with and among family and other caregivers. We have also identified appropriate and inappropriate cases for mediation. TCSG first received funds from the National Institute for Dispute Resolution to pilot a project with the Washtenaw County (Michigan) Probate Court. That pilot was so successful that TCSG sought and received funds from Retirement Research Foundation to expand into four new sites (Tampa, Albuquerque, Chicago and Denver) and to create an extensive, about-to-be-released, training/replication guide, The Adult Guardianship Mediation Manual.

Having demonstrated its value, the challenge now is to make guardianship mediation accessible to the thousands of older and disabled persons and their families who have no alternative to court procedures. The Hewlett grant will enable us to work to change current thinking and practice, and move to this next level, i.e. from pilot programs to bringing guardianship mediation into the mainstream. To achieve this we will work directly with four essential audiences: the mediators/dispute resolution community; the bar, particularly elder law, probate and family law practitioners; the courts, both judges and court administrators; and the aging network which is ideally positioned to affect the way guardianship is pursued.

For more on specific activities to be undertaken as part of this new initiative, see page 9 inside.

THE CENTER FOR SOCIAL GERONTOLOGY, INC.

A National Support Center in Law and Aging

2307 Shelby Avenue • Ann Arbor, MI 48103
Tel: (313) 665-1126 • Fax: (313) 665-2071 • E-mail: tcs@lzy.net

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

MEDICAID COMPROMISE

NEW GENERAL FLEXIBILITY PROVISIONS FOR STATES, including:

- Eliminate federal waiver process for mandatory enrollment in managed care.
- Eliminate federal waiver process for home and community-based care options.
- Repeal the Boren Amendment.
- Repeal the cost-based reimbursement requirement for health centers/clinics.
- Repeal requirements for federal review of managed care contracts exceeding \$100,000.

FINANCING

- Accept and work off the NGA financing formula to achieve CBO scorable savings, (which has no cap and ensures that federal support increases with enrollment), but retain current law with regard to state matching and provider tax rules.

ELIGIBILITY

- Accept NGA definition of eligibility with the exception of two modifications to the kids and disability definitions.
 - Retain current law that phases in kids ages 13-18, but repeal requirement that makes it impossible for states to "roll-back" optional coverage of kids and pregnant women to the mandatory poverty/coverage levels.
 - Retain federal disability designation authority, but restrict it to the definition agreed to in the welfare bill, (which excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids from mandatory coverage).
- Empower states to use any Medicaid savings to provide coverage of anyone under 150 percent of poverty WITHOUT any federal waiver.

BENEFITS

- Accept the NGA benefits definition, but retain appropriate federal standards to ensure that the benefits are meaningful.
 - Retain current law's flexibility in defining benefits' "amount, duration, and scope" as long as it is "reasonable to achieve its purpose," is available statewide, and meets the current law's comparability requirements.
 - Authorize the Secretary to narrow the definition of "treatment" that states must provide for children under the EPSDT benefit.
- Allow states to require nominal copayments for Medicaid HMO coverage.

ENFORCEMENT

- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.
- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.
- Preserve individual federal right of action (through the federal courts) for benefit and eligibility disputes.

STRUCTURE/SECOND TIER ISSUES

- Repeal outdated managed care quality standards, i.e., the private/public-75/25 enrollment rule, and substitute outcomes oriented quality rules.
- Retain federal nursing home standards and enforcement, but eliminate duplicative nursing home resident reviews and allow for nurse-aide training to take place in rural nursing homes.
- Retain current federal family financial protections, like spousal impoverishment and protections against liens on family property.
- Preserve current law protections by drafting reforms off of Title XIX.

PRIVATE RIGHT OF ACTION

A Federal Private Right of Action is Important to Maintaining the Guarantee. The NGA proposal (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

Both Republican and Democratic Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the NGA proposal, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.
- **Significant Limitation of Remedies.** Most state laws establish higher hurdles for plaintiffs and provide less relief than federal law. Under most state statutes that allow courts to review administrative actions, there is no *de novo* review (the record before the court is limited to information considered by the agency) and relief is granted only when a claimant can show that the agency action was arbitrary and capricious, not merely wrong. In addition, most state laws do not allow beneficiaries to recover attorneys' fees, making it more difficult for them to afford legal counsel.

The NGA proposal (and the conference report) maintains a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.
- **Elimination of Remedies under Civil Rights Law.** While it is not clear that the NGA intends to go this far, the conference agreement precludes the right to enforce civil rights laws. Protection against discrimination in state programs has been established under the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990. If this is what the Governors intended, the civil rights community is likely to be very concerned.

Your Proposal Increases Flexibility While Maintaining the Guarantee. Under your plan, you eliminate causes of action by providers over payment rates by repealing the Boren Amendment. This removes state officials' greatest source of concern over litigation and the most frequent basis for cases filed in federal court.

Your proposal maintains current law on private enforcement of beneficiary rights under Medicaid. You could take steps to address the Governors' concerns by separating eligibility claims from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

MEDICAID POLICY IN THE CONTEXT OF WELFARE REFORM

- o First and foremost we will maintain the methodology for determining income and assets. Under current law the Medicaid rules for determining income and assets (what is counted, whose income and assets are counted, what deductions and exemptions are allowed) are found in Title IV-A. This policy would now place these standards in the Medicaid statute so that changes in the welfare statute won't effect Medicaid eligibility.
- o What this means is that for determining income for any child (under 6) or pregnant woman even under 133% of poverty or other children over 6 or non-pregnant women that there will be an income standard in place that is the same as under current law.
- o This provision was also in the House passed Republican bill.
- o Second, once these income and asset standards are again in place for determining eligibility for the "categorically" eligible which include the children up to age 6 and pregnant women under 133 percent of poverty, we can now apply these same standards to the "non-categorically" eligible older children (as they are phased-in) and parents.
- o We will say that a for determining these non-categorically eligible people that if their income, as now as been determined for the family because the children are say eligible for Medicaid, is less than the AFDC standard which the state had in place as of May 1, 1988, then these people will also continue to receive Medicaid.
- o The States can now raise their previous AFDC income standard and make people eligible for Medicaid if they want to and they can also lower the AFDC income standard as long as it is not below the May 1, 1988 level. This is exactly the same flexibility they have under current law with regard to Medicaid.
- o We have also kept the one year welfare to work transition as well as the 5 year cut off protections so that people won't loose Medicaid because of going back to work or because they can't find a job in 5 years.
- o The link from welfare has been severed. The States will now be able to do whatever they want with welfare (within the context of the welfare bill) and not necessarily have to provide Medicaid coverage. However, the big key here is that they can't take Medicaid away from any person who would've been eligible for Medicaid, but for the change in Welfare.

Nany Am

MEDICAID ELIGIBILITY UNDER WELFARE REFORM

o OPTION 1--The "freeze" option.

The first option (based on Levin language) carries over all current AFDC eligibility rules -- definitions of income and assets, dollar thresholds, absence of time limits and other kinds of limits -- to Medicaid. Of the two, it is the preferred option as it offers the most comprehensive protection of eligibility.

As originally drafted, (now noted as subparagraph (a) on the attachment), a state's Medicaid rules for families with children would be locked into its AFDC plan that was in effect June 5, 1996. States would be limited to provisions that were contained in its plan at that point. To correct this problem, a new subparagraph (b) has been added to give states some flexibility to change standards or methods provided the change is "less restrictive." Implementing regulations would define "less restrictive." This additional language is based on a proposal from the Center on Budget and Policy Priorities.

o OPTION 2--The "but-for" option:

The "but-for" option (based on Stark language) is less desirable because its protection is less comprehensive.

As originally drafted, this option protected Medicaid only for persons losing cash assistance because of time limits. Those losing cash for other reasons, especially non-pregnant adults, could have still lost Medicaid along with it. In addition, Medicaid eligibility methods and standards for families with children, including the poverty-level groups, would have been linked to whatever new methods and standards the state devised for its new cash program. This is less desirable than OPTION-1 because these new standards or methods could be more restrictive than current standards and methods.

The attached language aims to broaden the "but-for" approach to other circumstances under which individuals might lose cash benefits. The language also protects those who might fail to qualify because of limits on teen mothers, family caps, or failure to comply with various new behavioral requirements.

OPTION 1 – “Freeze” Amendment

Add to section 408(a):

“(##)(a) CONTINUED ELIGIBILITY FOR CERTAIN ASSISTANCE. -- A State to which a grant is made under section 403 shall assure that persons who would have been eligible for aid in that State under the plan in effect pursuant to part A of title IV as of June 5, 1996 shall be eligible for medical assistance under the State’s plan approved under title XIX.

(b) In applying subparagraph (a), a State may lower its income standards so long as its standards are not less than the levels in effect under the State’s plan on May 1, 1988, and a State may use income and resource standards and methodologies that are less restrictive than the standards or methodologies used under the State plan referred to under subparagraph (a).”

OPTION 2 – “But For” Amendment

Add to section 408(a):

“(##) CONTINUED ELIGIBILITY FOR CERTAIN ASSISTANCE. -- A State to which a grant is made under section 403 shall assure that --

(a) Any family that is denied cash assistance because of the prohibitions described in section 407(e), in paragraphs 2 through 8 of this subsection, or subsection (b) or (d) of section 482 shall be eligible for medical assistance under the State’s plan approved under title XIX.

(b) Any family that becomes ineligible to receive aid under this part because of hours of or income from employment of the parent, having received such aid in at least 3 of the 6 months preceding the month in which such eligibility begins, shall remain eligible for medical assistance under the State’s plan approved under title XIX for an extended period or periods of time as provided under title XIX.

© If a State limits the number of months for which a two-parent family may receive cash assistance, the State shall provide medical assistance to all members of the family under the State’s plan approved under title XIX, without time limitation.

(d) Any family who becomes ineligible for cash assistance as a result (wholly or partly) of the collection of child or spousal support under part D, and who has received such aid in at least three of the six months immediately preceding the month in which such ineligibility begins, shall be deemed to be a recipient of aid under this part for purposes of title XIX for an additional four calendar months beginning with the month in which such ineligibility begins.”

State-by-State Impact of House Republican Medicaid Cuts \$182 billion

The House Republican Medicaid plan is designed to cut federal Medicaid spending by \$182 billion below the Congressional Budget Office's projected Medicaid spending over the next seven years. The state-by-state allocation of federal spending -- and the cut below the baseline -- is based on an extraordinarily complex formula in the bill.

To assess the impact on states, it is necessary to compare two estimates: estimated federal Medicaid spending under the current law baseline, and estimated spending under the proposed plan. Pending further review and assessment of the just-released formula, this impact analysis is based on two publicly-released projections:

- o Baseline spending estimate: the Urban Institute's projection of baseline Medicaid spending state-by-state was published in May and has been in public use since then.
- o Spending under the plan: the General Accounting Office estimated the allocation of federal funds to states under the House Republican formula on September 19, 1995:

The difference between the two provides a preliminary estimate of state impact. It shows:

- o The plan achieves the target of \$182 billion in cuts in federal spending over 7 years -- 19 percent below the seven year baseline, and 30 percent below projected spending in 2002.
- o The range of state impact is extraordinary:
 - By the year 2002, one state -- New Hampshire -- has no cut. All the rest of the states are cut below their baseline estimate.
 - Five other states, however, suffer cuts of more than 40 percent below their 2002 baseline: Alaska (-41 percent); Indiana (-44 percent); Rhode Island (-42 percent); Washington (-43 percent); West Virginia (-42 percent).
- o Financially, the greatest dollar impact is in the largest states -- New York and California.
 - New York is cut by \$24.6 billion below its seven-year baseline estimate -- and 35 percent below its baseline estimate for the year 2002.
 - California is cut by \$18.7 billion below its seven-year baseline estimate -- and 27 percent below its baseline estimate for the year 2002.
 - One-half of the total cut of \$182 billion comes from eight states: California, Florida, Indiana, New Jersey, New York, Ohio, North Carolina, and Texas.

Estimates of the Effects of the House Republican Medicaid Plan on States, 2002 and 1996 - 2002
(Dollars in Millions, Federal Spending, Fiscal Years)

States	2002				1996-2002			
	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction
Total	\$176,931	\$124,077	(\$52,855)	-30%	\$954,338	\$771,972	(\$182,366)	-19%
Alabama	\$2,485	\$2,112	(\$373)	-15%	\$13,823	\$12,668	(\$1,155)	-8%
Alaska	\$373	\$219	(\$154)	-41%	\$2,001	\$1,447	(\$554)	-28%
Arizona	\$2,436	\$1,921	(\$515)	-21%	\$12,903	\$11,575	(\$1,328)	-10%
Arkansas	\$2,084	\$1,353	(\$731)	-35%	\$11,081	\$8,117	(\$2,964)	-27%
California	\$17,955	\$13,050	(\$4,905)	-27%	\$95,663	\$76,971	(\$18,693)	-20%
Colorado	\$1,521	\$1,025	(\$497)	-33%	\$8,163	\$6,210	(\$1,953)	-24%
Connecticut	\$2,345	\$1,643	(\$702)	-30%	\$12,990	\$10,845	(\$2,145)	-17%
Delaware	\$323	\$199	(\$124)	-38%	\$1,728	\$1,313	(\$415)	-24%
District of Columbia	\$846	\$537	(\$308)	-36%	\$4,511	\$3,548	(\$963)	-21%
Florida	\$7,691	\$5,119	(\$2,573)	-33%	\$40,720	\$30,189	(\$10,531)	-26%
Georgia	\$4,900	\$3,267	(\$1,633)	-33%	\$26,050	\$20,274	(\$5,776)	-22%
Hawaii	\$508	\$369	(\$139)	-27%	\$2,732	\$2,288	(\$443)	-16%
Idaho	\$545	\$400	(\$145)	-27%	\$2,933	\$2,358	(\$575)	-20%
Illinois	\$6,207	\$4,423	(\$1,784)	-29%	\$33,242	\$27,108	(\$6,135)	-18%
Indiana	\$4,317	\$2,398	(\$1,919)	-44%	\$23,100	\$15,813	(\$7,287)	-32%
Iowa	\$1,440	\$1,107	(\$333)	-23%	\$7,807	\$6,871	(\$936)	-12%
Kansas	\$1,079	\$939	(\$140)	-13%	\$5,962	\$5,829	(\$133)	-2%
Kentucky	\$3,455	\$2,230	(\$1,225)	-35%	\$18,353	\$13,374	(\$4,979)	-27%
Louisiana	\$6,147	\$4,504	(\$1,642)	-27%	\$33,991	\$28,722	(\$5,269)	-16%
Maine	\$1,092	\$780	(\$312)	-29%	\$5,999	\$5,146	(\$853)	-14%
Maryland	\$2,532	\$1,717	(\$815)	-32%	\$13,478	\$10,962	(\$2,516)	-19%
Massachusetts	\$4,717	\$3,223	(\$1,493)	-32%	\$25,516	\$21,277	(\$4,239)	-17%
Michigan	\$5,992	\$4,496	(\$1,496)	-25%	\$32,153	\$27,900	(\$4,253)	-13%
Minnesota	\$2,701	\$1,914	(\$787)	-29%	\$14,665	\$12,592	(\$2,072)	-14%
Mississippi	\$2,342	\$1,814	(\$527)	-23%	\$12,640	\$10,702	(\$1,938)	-15%
Missouri	\$2,625	\$2,448	(\$177)	-7%	\$14,871	\$15,193	\$321	2%
Montana	\$636	\$401	(\$235)	-37%	\$3,409	\$2,467	(\$943)	-28%
Nebraska	\$822	\$534	(\$287)	-35%	\$4,448	\$3,496	(\$952)	-21%
Nevada	\$540	\$376	(\$163)	-30%	\$2,899	\$2,219	(\$680)	-23%
New Hampshire	\$631	\$631	\$0	0%	\$3,728	\$4,165	\$437	12%
New Jersey	\$5,100	\$3,182	(\$1,918)	-38%	\$28,038	\$21,006	(\$7,032)	-25%
New Mexico	\$1,147	\$876	(\$271)	-24%	\$6,066	\$5,164	(\$902)	-15%
New York	\$22,034	\$14,382	(\$7,652)	-35%	\$119,527	\$94,939	(\$24,588)	-21%
North Carolina	\$5,406	\$3,290	(\$2,116)	-39%	\$29,014	\$20,418	(\$8,596)	-30%
North Dakota	\$457	\$319	(\$138)	-30%	\$2,491	\$1,979	(\$511)	-21%
Ohio	\$7,508	\$5,260	(\$2,248)	-30%	\$40,586	\$32,642	(\$7,944)	-20%
Oklahoma	\$2,060	\$1,329	(\$731)	-35%	\$11,074	\$7,839	(\$3,235)	-29%
Oregon	\$1,649	\$1,195	(\$454)	-28%	\$8,884	\$7,288	(\$1,596)	-18%
Pennsylvania	\$7,102	\$5,519	(\$1,583)	-22%	\$38,448	\$35,315	(\$3,133)	-8%
Rhode Island	\$1,004	\$580	(\$424)	-42%	\$5,465	\$3,827	(\$1,638)	-30%
South Carolina	\$2,756	\$2,290	(\$466)	-17%	\$15,252	\$13,736	(\$1,516)	-10%
South Dakota	\$442	\$323	(\$119)	-27%	\$2,380	\$2,003	(\$378)	-16%
Tennessee	\$4,587	\$3,027	(\$1,560)	-34%	\$24,576	\$18,153	(\$6,424)	-26%
Texas	\$11,358	\$9,089	(\$2,270)	-20%	\$61,167	\$54,166	(\$7,001)	-11%
Utah	\$960	\$669	(\$291)	-30%	\$5,128	\$4,012	(\$1,116)	-22%
Vermont	\$366	\$240	(\$127)	-35%	\$1,982	\$1,581	(\$401)	-20%
Virginia	\$2,434	\$1,604	(\$830)	-34%	\$13,022	\$9,723	(\$3,300)	-25%
Washington	\$3,381	\$1,934	(\$1,447)	-43%	\$18,203	\$12,769	(\$5,434)	-30%
West Virginia	\$2,591	\$1,493	(\$1,098)	-42%	\$13,723	\$9,264	(\$4,460)	-32%
Wisconsin	\$3,066	\$2,183	(\$883)	-29%	\$16,484	\$13,549	(\$2,935)	-18%
Wyoming	\$236	\$146	(\$90)	-38%	\$1,269	\$964	(\$305)	-24%

Notes: Based on the Commerce Committee's formula as of September 18, 1995.

(1) From The Urban Institute's Medicaid Expenditure Growth Model

(2) From the General Accounting Office's estimates of the spending by state under the proposal.

Source: U.S. DHHS

20-Sep-95

Projected Number of Medicaid Beneficiaries, 2002

State	Baseline
United States	45,663,533
Alabama	737,918
Alaska	97,306
Arizona	568,256
Arkansas	514,584
California	6,525,073
Colorado	422,676
Connecticut	453,199
Delaware	98,028
District of Columbia	142,580
Florida	2,796,542
Georgia	1,519,989
Hawaii	161,525
Idaho	150,705
Illinois	1,737,408
Indiana	704,941
Iowa	380,793
Kansas	315,549
Kentucky	856,134
Louisiana	1,081,591
Maine	227,286
Maryland	591,654
Massachusetts	1,054,057
Michigan	1,432,950
Minnesota	531,194
Mississippi	706,300
Missouri	822,420
Montana	111,338
Nebraska	217,171
Nevada	132,513
New Hampshire	108,264
New Jersey	1,082,880
New Mexico	355,684
New York	3,576,932
North Carolina	1,575,219
North Dakota	88,124
Ohio	1,854,988
Oklahoma	549,455
Oregon	497,541
Pennsylvania	1,612,660
Rhode Island	261,101
South Carolina	752,963
South Dakota	96,529
Tennessee	1,265,375
Texas	3,545,644
Utah	226,308
Vermont	107,648
Virginia	929,016
Washington	886,075
West Virginia	548,958
Wisconsin	582,023
Wyoming	68,467

SOURCE: The Urban Institute Medicaid Expenditure Growth Model, 1995

Growth Rates of Medigrant: 2002

United States	4.00%
2% States	
Nebraska	2.00%
Maine	2.00%
Wyoming	2.00%
Rhode Island	2.00%
New Jersey	2.00%
Minnesota	2.00%
New York	2.00%
Connecticut	2.00%
Massachusetts	2.00%
Indiana	2.00%
Washington	2.00%
District of Columbia	2.00%
New Hampshire	2.00%
Delaware	2.00%
Vermont	2.00%
Alaska	2.00%
3% States	
Pennsylvania	3.00%
Maryland	3.00%
Louisiana	3.00%
4% States	
Ohio	4.00%
Hawaii	4.00%
North Dakota	4.00%
Iowa	4.00%
West Virginia	4.00%
Wisconsin	4.00%
Michigan	4.00%
North Carolina	4.00%
Georgia	4.00%
Missouri	4.00%
Kansas	4.00%
South Dakota	4.00%
4.92% States	
Colorado	4.92%
Virginia	4.92%
Illinois	4.92%
Texas	4.92%
Oregon	4.92%
Arizona	4.92%
Montana	4.92%
5.33% States	
Arkansas	5.33%
Utah	5.33%
Tennessee	5.33%
Kentucky	5.33%
South Carolina	5.33%
Alabama	5.33%
6% States	
Idaho	6.00%
New Mexico	6.00%
Mississippi	6.00%
Florida	6.00%
California	6.00%
Oklahoma	6.00%
Nevada	6.00%

MEDICAID POLICY IN THE CONTEXT OF WELFARE REFORM

- o First and foremost we will maintain the methodology for determining income and assets. Under current law the Medicaid rules for determining income and assets (what is counted, whose income and assets are counted, what deductions and exemptions are allowed) are found in Title IV-A. This policy would now place these standards in the Medicaid statute so that changes in the welfare statute won't effect Medicaid eligibility.
- o What this means is that for determining income for any child (under 6) or pregnant woman even under 133% of poverty or other children over 6 or non-pregnant women that there will be an income standard in place that is the same as under current law.
- o This provision was also in the House passed Republican bill.
- o Second, once these income and asset standards are again in place for determining eligibility for the "categorically" eligible which include the children up to age 6 and pregnant women under 133 percent of poverty, we can now apply these same standards to the "non-categorically" eligible older children (as they are phased-in) and parents.
- o We will say that a for determining these non-categorically eligible people that if their income, as now as been determined for the family because the children are say eligible for Medicaid, is less that the AFDC standard which the state had in place as of May 1, 1988, then these people will also continue to receive Medicaid.
- o The States can now raise their previous AFDC income standard and make people eligible for Medicaid if they want to and they can also lower the AFDC income standard as long as it is not below the May 1, 1988 level. This is exactly the same flexibility they have under current law with regard to Medicaid.
- o We have also kept the one year welfare to work transition as well as the 5 year cut off protections so that people won't loose Medicaid because of going back to work or because they can't find a job in 5 years.
- o The link from welfare has been severed. The States will now be able to do whatever they want with welfare (within the context of the welfare bill) and not necessarily have to provide Medicaid coverage. However, the big key here is that they can't take Medicaid away from any person who would've been eligible for Medicaid, but for the change in Welfare.

Levels

6-94

can't go below may 1988

Call Carol

show of need

methodology → ~~cont~~ use more restrictive language

Deeming →

Disable

Disabled certificate → NOT BAN

DRAFT HHS

OPTION 1 -- "Freeze" Amendment

Add to section 408(a):

"(##)(a) CONTINUED ELIGIBILITY FOR CERTAIN ASSISTANCE. -- A State to which a grant is made under section 403 shall assure that persons who would have been eligible for aid in that State under the plan in effect pursuant to part A of title IV as of June 5, 1996 shall be eligible for medical assistance under the State's plan approved under title XIX.

(b) In applying subparagraph (a), a State may lower its income standards so long as its standards are not less than the levels in effect under the State's plan on May 1, 1988, and a State may use income and resource standards and methodologies that are less restrictive than the standards or methodologies used under the State plan referred to under subparagraph (a)."

OPTION 2 -- "But For" Amendment

Add to section 408(a):

"(##) CONTINUED ELIGIBILITY FOR CERTAIN ASSISTANCE. -- A State to which a grant is made under section 403 shall assure that --

(a) Any family that is denied cash assistance because of the prohibitions described in section 407(e), in paragraphs 2 through 8 of this subsection, or subsection (b) or (d) of section 482 shall be eligible for medical assistance under the State's plan approved under title XIX.

(b) Any family that becomes ineligible to receive aid under this part because of hours of or income from employment of the parent, having received such aid in at least 3 of the 6 months preceding the month in which such eligibility begins, shall remain eligible for medical assistance under the State's plan approved under title XIX for an extended period or periods of time as provided under title XIX.

© If a State limits the number of months for which a two-parent family may receive cash assistance, the State shall provide medical assistance to all members of the family under the State's plan approved under title XIX, without time limitation.

(d) Any family who becomes ineligible for cash assistance as a result (wholly or partly) of the collection of child or spousal support under part D, and who has received such aid in at least three of the six months immediately preceding the month in which such ineligibility begins, shall be deemed to be a recipient of aid under this part for purposes of title XIX for an additional four calendar months beginning with the month in which such ineligibility begins."

MEDICAID

"I vetoed the Republican budget plan that was sent to me by Congress . . . because [it included] the most massive cuts in Medicare and Medicaid in history, a tax increase on working people, and deep, deep cuts in education and the environment. . . . My seven year balanced budget plan reflects our values and protects our investments in the future. . . . At stake is far more than just numbers and abstract programs and proposals, and far more than the normal political debates in Washington. This debate is about people, the lives they lead, the hopes they have, the desires they have for a better life."

President Clinton
Radio Address
December 9, 1995

Overview. For 30 years, Medicaid has provided a guarantee to meaningful health benefits for millions of people with disabilities, pregnant women, poor children, and older Americans -- particularly those in need of nursing home care. President Clinton is committed to giving states flexibility to manage the program more efficiently, while retaining the Medicaid guarantee and refusing to go backwards on health care coverage for Americans.

Accomplishments.

- **Flexibility and Coverage Expansions.** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad discretion to waive certain Medicaid requirements in order to set up experimental or demonstration projects. Through this authority, the Clinton Administration has worked with states to test new and innovative approaches to benefits and services, eligibility requirements and processes, payment and service delivery. These waivers are often aimed at saving money, to allow states to extend Medicaid coverage to additional low-income and uninsured people. Since January 1, 1993, comprehensive health care reform demonstration waivers have been approved for 12 states and ten have already been implemented.
- **Improving Quality in Managed Care.** The Clinton Administration has also granted 1915(b) "freedom of choice" waivers that permit states to require beneficiaries to enroll in managed care plans. States often use these waivers to establish primary care case management programs and other forms of managed care. As the number of Medicaid beneficiaries enrolled in managed care has increased, the Clinton Administration has been working closely with states, insurers, health care professionals and consumers to assure the quality of care provided in managed care plans. For example, Medicaid HEDIS (Health Plan Employer Data Information Set), which was released in February 1996, will help monitor and improve quality in managed care plans and educate Medicaid beneficiaries about plan performance.

- **Simplifying and Streamlining Medicaid.** As part of its regulatory reform efforts, the Department of Health and Human Services has simplified the process of obtaining Medicaid home and community-based waivers and changed duplicative nursing home regulation while maintaining strong Federal quality standards.
- **Cracking Down on Fraud and Abuse.** Last year, the President announced a two-year partnership of Federal and state agencies to prevent and detect health care fraud in specific industries. Operation Restore Trust targets five states which together account for about 40 percent of the nation's Medicare and Medicaid beneficiaries.

Statistical Backup.

- Over 650,000 people have received health care coverage under Medicaid because of implemented state demonstrations. When all 12 are implemented, 2.2 million previously uninsured individuals are expected to receive health coverage.
- Regulatory reform efforts across the Department of Health and Human Services will result in an almost 25 percent reduction in total pages of Department regulations.

Agenda.

- The President will not accept the Republican budget proposal to end the Medicaid guarantee to meaningful health benefits for millions of people with disabilities, pregnant women, poor children and older Americans -- particularly those in need of nursing home care.
- Instead, he has put forward a balanced budget proposal that maintains the guarantee while giving states unprecedented flexibility to manage the program. Key elements of the President's Medicaid proposal are:
 - Maintains guarantee of coverage.
 - Constrains Federal spending through a per capita cap that protects states in times of economic downturns, inflation, or other situations that cause enrollment to grow.
 - Gives states flexibility by repealing the Boren Amendment (so that states can determine payment rates without interference) and allowing states to implement managed care without waivers.
 - Maintains federal nursing home quality standards and enforcement.
 - Retains financial protections for families, including protections against impoverishment for spouses of nursing home residents.

Contact: Jennifer Klein or Chris Jennings
Last Update: March 10, 1996

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

Congressional Republicans need hundreds of billions of dollars to finance tax cut and deficit reduction pledges.

Medicaid is seen as major cash cow because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

Speaker Gingrich discussing a 5% cap on Medicaid program growth, which would yield \$130 billion (\$193 billion using CBO numbers) in Federal savings through 2002 and \$375 billion (\$500 billion using CBO) in Federal savings through 2005.

Republican Governors either supportive or staying quiet for now because they philosophically support. Moderate Republicans from states with high growth rates are evaluating just how they could live with these reductions in Federal dollars.

Governor Dean sending signals he might be open to a cap, although most Democratic Governors appear to be extremely nervous about it. Governor Chiles, for example, is very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of the Democrats, however, is the size of potential reductions in Federal support.

Not on NGA agenda for this weekend, although DGA meeting may discuss to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget discussions that may be raised at NGA meeting.

Any block grant deal on welfare reform will serve as precedence and political cover for Republicans who need the Medicaid money.

Weak but vocal advocates are opposed and scared: many of these are considered our traditional Democratic base.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
 - Leaves States at risk during recessions.
 - Places States at risk for cost of aging population.
 - Makes States less able to expand coverage.
 - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
 - Increases number of uninsured.
 - Exacerbates cost shifting.

MEDICAID CAP/BLOCK GRANT BACKGROUND INFORMATION

PURPOSE:

To review the implications for states and for coverage under the Medicaid program of NGA and likely Republican proposals to cap Medicaid spending.

BACKGROUND:

Although not on the formal agenda, it is possible that the topic of capping the Medicaid program may be raised at the upcoming meeting with the Governors. (In all likelihood, if it is raised, it would come up in the context of the balanced budget amendment discussion.)

NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. The NGA staff recognize this "choice" is a political and not a practical policy response to a desire by many Republican Governors to assure that a Medicaid cap/block grant proposal is on the table for consideration. Democratic Governors, like Governor Chiles, have made the point that such a choice would not work in the Congress or in the budget world since states could choose what is best for them financially; as a result, the primary incentive for enacting a cap -- saving Federal dollars -- would likely not be achieved in any significant way.

A number of Governors have been discussing a Medicaid block grant with the Republicans in Congress. Both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about \$375 billion over ten years (over \$500 billion under the CBO baseline). In recent days, however, Governor Dean and his office have made clear he has made no deal and does have concerns.

It is worth pointing out that a 5% cap means that the states (in aggregate) must reduce total program costs by the \$375 billion before they can begin reducing their own spending levels. While there are some low growth with fairly large base levels who could save money in the short-term, it is unlikely they could do so over the long term without cut-backs in services or programs.

Obviously, the Governors are interested in block grants because they free states from federal requirements and oversight. Many Governors appear to be willing to consider reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, if the Administration can come up with proposals that are responsive to the flexibility requests of the States that do not include Federal caps, such an approach could well be more attractive. (Such approaches are discussed at end of the memo).

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. The following outlines these concerns.

Converting from Individual Entitlement to a Block Grant Raises State Concerns:

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.
- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.
- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.
- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by \$130 billion between 1996 and 2002, and by about \$375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over \$500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rises to 35% (40% under CBO baseline). This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from some Republican Governors (and particularly Republicans from the Hill) that large reductions in the growth of federal payments are acceptable because managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings, the savings are not nearly enough to compensate for the very large reductions being discussed with the block grant proposals.

Given the rapid expansion of managed care that already is occurring in states, a significant portion of the potential savings are already being realized. Also, managed care is applied almost exclusively to the nonelderly, nondisabled population, who account for only about one third of Medicaid expenditures. Preliminary OMB estimates show that if all nondisabled, nonelderly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than \$5 billion. However, some states may use managed care as a mechanism simply to make large cuts in provider payments. In reality, this is a cost shifting strategy rather than cost containment.

Under the current baseline, Medicaid enrollment is projected to grow at about 4% annually. Medicaid per capita spending actually is projected to grow at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline would appear to assume either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program (including cuts in eligibility) are acceptable. While some states may be able to adapt to such a large reduction in federal support for a few years, most probably cannot. Over a longer period, few states could respond to this level of reduction without significant program cuts.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. Although a few states might increase spending in response to federal payment reductions, most would likely reduce eligibility, benefits or payment levels.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**

If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

- ▶ In 2002, the increase in state spending would be 32% over baseline projections;
- ▶ In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

- ▶ In 1997, a 6% reduction in hospital payments would be needed;
- ▶ In 2002, a 22.9% reduction in hospital payments would be needed;;
- ▶ In 2005, a 32.8% reduction in hospital payments would be needed.

These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. However, given the magnitude of the reduction in federal payments, even when states spread the cuts over several of these categories, the reductions in each category would still be quite large. For example, a 5% cap would reduce federal payments to states in 2005 by about \$66.3 billion below baseline projections. If a state chose not to increase spending and were to allocate their portion of this reduction roughly equally to reductions in provider payments, benefits and eligibility, it could achieve approximately the necessary savings through:

- ▶ Reducing provider payments by 12 to 13%.
- ▶ Eliminating coverage for prescription drugs and EPSDT, and
- ▶ Eliminating coverage for noncash children and qualified and special Medicare beneficiaries (QMBs).

And, because federal payments would continue to decline, further reductions would be needed in each future year. Other options are, of course, possible. Chart 3 gives you a partial menu of how much the elimination of particular populations and services (on a national level) would save. Some would argue that states would be more likely to choose eliminate AFDC adults rather than noncash kids and QMBs.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- \$ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSION

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put those served by Medicaid at some risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting.** One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

Alternative To Capping Federal Payments that States May Find Attractive.

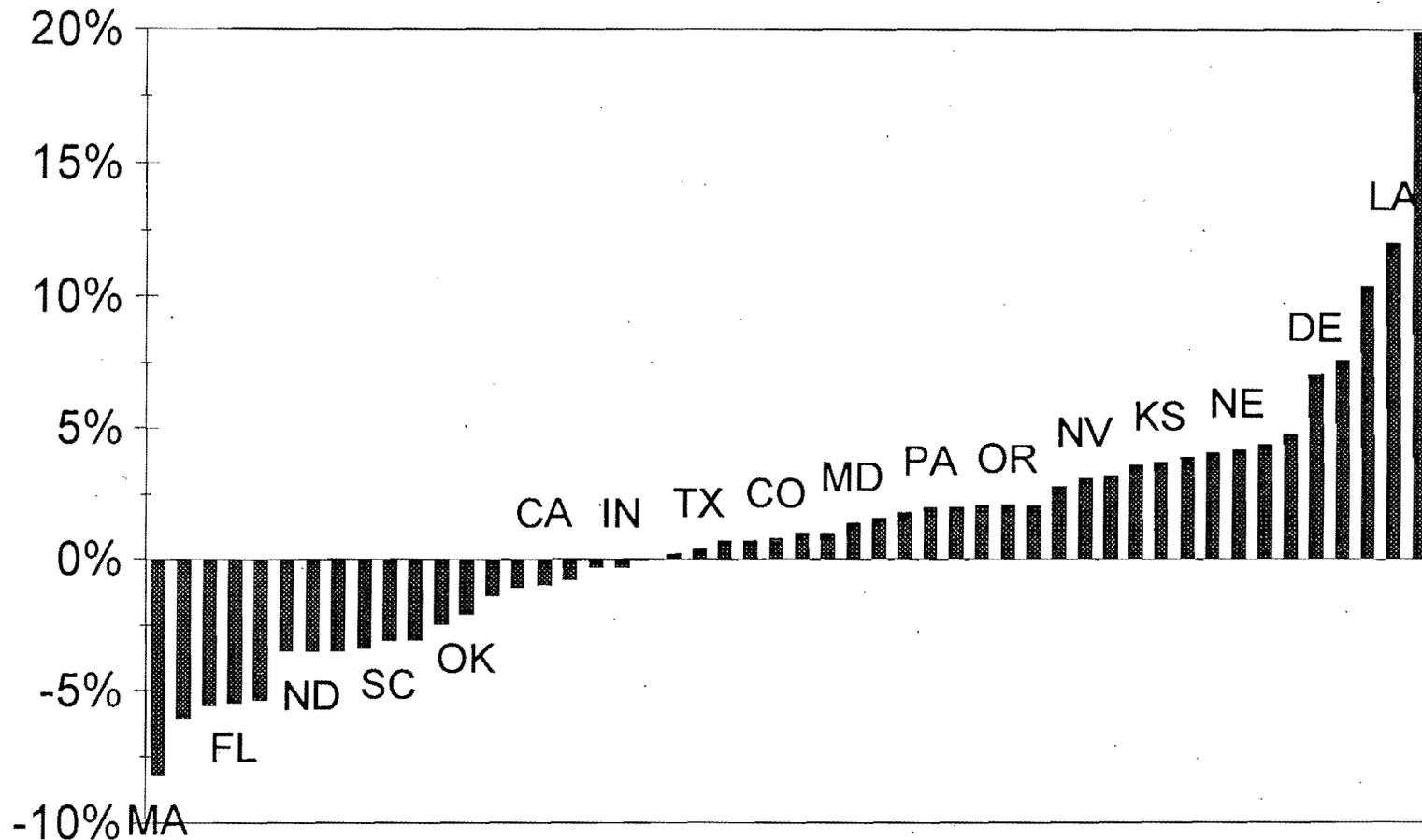
The obvious question is how to be responsive to States' legitimate need and desire for more flexibility without imposing significant reductions in Federal support. We have reviewed the NGA's health policy position paper's recommendations and have conducted our own internal analysis, which included discussions with OMB and HHS, and have come up with some interesting possibilities -- there may be even more -- that Iwe believe would be welcomed by the Governors. (Since Medicaid is not scheduled to come up before the NGA meetings, we probably should discuss when would be the most strategic and opportune time to begin discussions with the Governors on this issue.)

Specific and preliminary options to Medicaid cap now include:

- **Agree to NGA's request to eliminate the 1915(b) waiver approval process for states implementing managed care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.
- **Consistent with NGA request, agree to eliminate the waiver approval process for states implementing home and community-based care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.
- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.
- **Agree to NGA's request to establish safe harbors under the Boren amendment for state hospital payments.**
- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**
- **Agree to NGA's request for substantial modifications to the PASARR provisions under nursing home reform.** For example, agree that the annual resident review should be repealed.
- **Agree to NGA's request for the development of more demonstration programs that investigate the integration acute and long-term care services.**

Variation in State Medicaid Growth

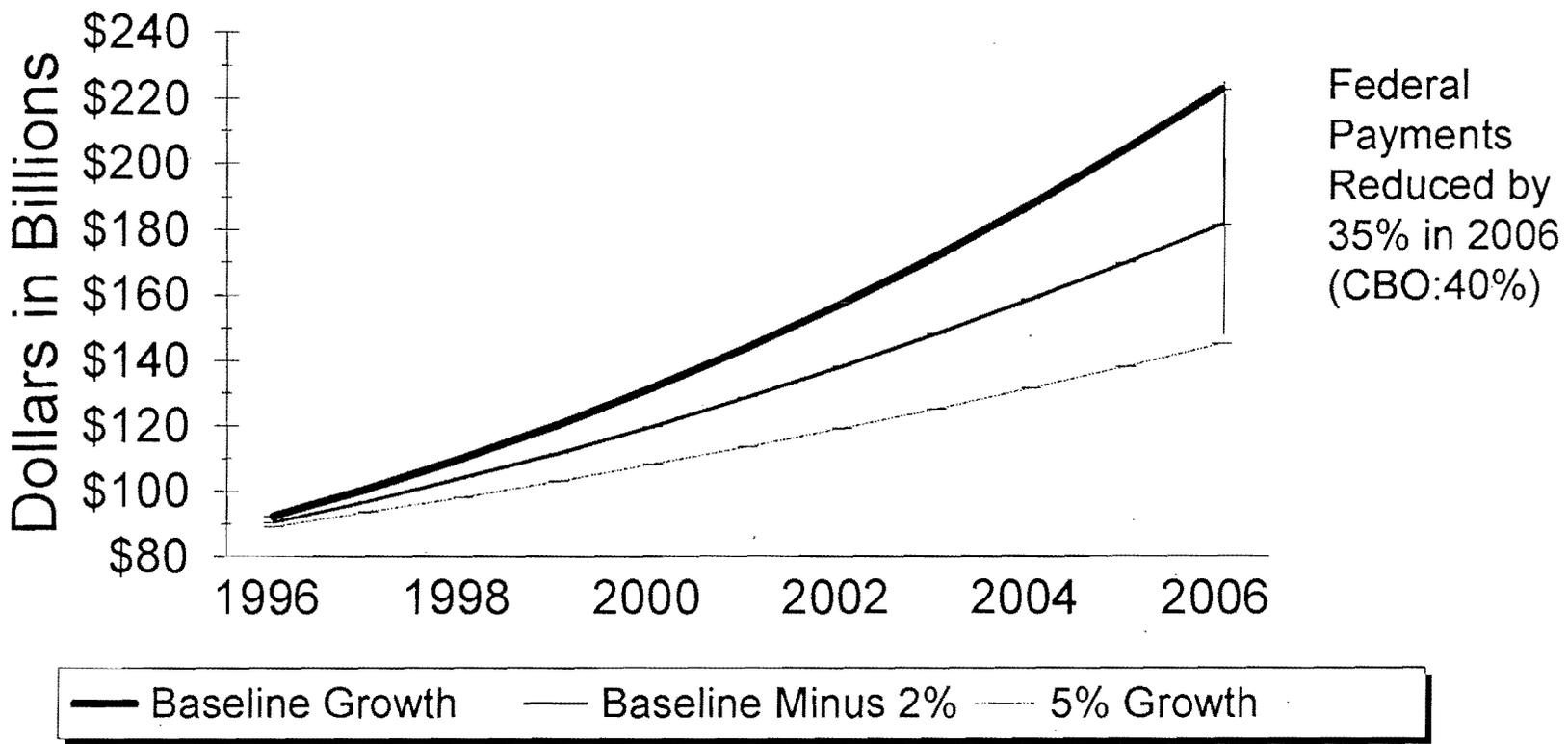
Difference from Average, 1990-1993



* Note: Average annual per capita growth rates, excluding Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Federal Medicaid Payments 1996-2006

Baseline & Capped Federal Payments



This wedge illustrates the cumulative effect of capped expenditures. Over time, the size of the federal payment reduction grows.

**Potential Savings From Eliminating
Selected Services or Recipient Categories**

	1997 \$ in billions	2005 \$ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

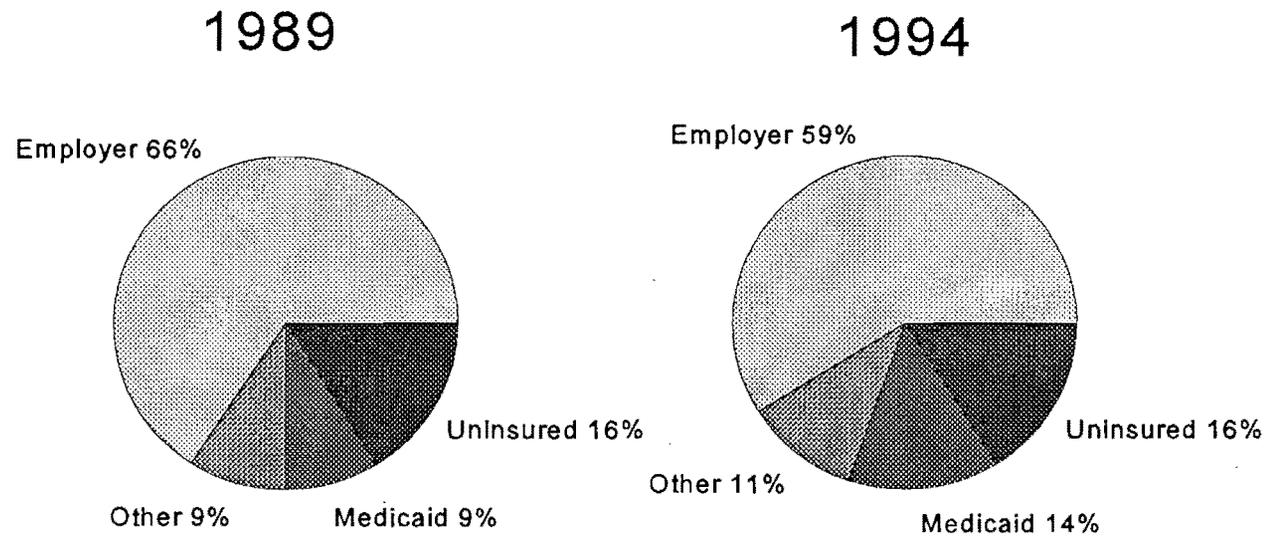
- o The 1997 reductions will not be sufficient over time, because the size of the federal reduction would increase each year. For example, while eliminating dental benefits could achieve 28% of the required savings in 1997, in 2005 this service reduction would produce only 6% of the necessary savings.

- (1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states, and overstate savings, because of interactions in the expenditure categories.

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.