

Differences between the Republicans' and the President's Medicaid Plans

- **In reality, Republicans reduce Medicaid spending by nearly 150 percent more than the President.** The Republicans are telling only half the story. They say that the Federal savings of the Republican proposal equal those of the President's proposal. While this may be true, they are hiding the huge reduction in the state contribution to Medicaid. The Republicans change the Medicaid matching rate, which means that the states' contribution shrinks, as does total spending. According to the Center on Budget and Policy Priorities, the Republican proposal would reduce total spending by about \$250 billion between 1996 and 2002— significantly more than the about \$100 billion reduction in the President's proposal.
- **The Republican proposal reduces the spending growth per beneficiary to rates below inflation.** When taking the decline in the state contribution into account, the average annual spending growth per beneficiary under the Republican proposal is 2.7 percent – below general inflation. This rate is over a third less than the President's average rate of growth between 1995 and 2002. Since the payments will not keep up with inflation, this is a real cut.
- **Capping Federal Medicaid risk coverage loss.** The fundamental difference between the Republicans' and the President's plan is the commitment to health care coverage. The President's plan maintains an enforceable guarantee to health care for 36 million Americans and a funding structure that responds to changes in coverage. In contrast, the Republican plan removes an enforceable guarantee to meaningful health care while placing a lid on Federal Medicaid spending. This means that even there is a recession which lowers employer-sponsored health coverage, the Federal Medicaid spending is set in statute, unable to adjust. With neither a Federal commitment to states to share in unexpected costs nor a Federal guarantee to meaningful health benefits, the seniors, nursing home residents, children and people with disabilities who rely on Medicaid are at risk.
- **All states pay for some states' excesses.** The Republicans' proposal allows states to keep and increase their Federal disproportionate share hospital (DSH) payments. This is in sharp contrast to current law and the President's proposal which limit this spending growth. The growth is limited because of a loophole in the Federal regulations which allowed for large payments in this program. A small set of states took advantage of this loophole – and are rewarded by the Republicans for doing so. Since the Republicans' treatment of DSH funding will eventually increase Medicaid spending relative to current law, all other states have tighter growth rates to offset the increased DSH spending for these states.

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.

Disproportionate Share Hospital (DSH) Policy and Pool Payments in the Administration's Plan.

Background

The disproportionate share hospital (DSH) program was created to provide special Medicaid payments to hospitals with large Medicaid shortfalls and uncompensated care burdens. However, due to the structure of the program, it has become a vehicle for a number of states to draw down extra Federal matching payments and also to substitute for the state share of the program. Both DSH payments and overall Medicaid payments grew at unprecedented and unsustainable levels between 1989 and 1993. The differential use of DSH financing by states also led to an inequitable distribution of DSH funds across states; many states with high numbers of needy hospitals did not receive DSH funds and vice versa. Laws passed in 1991 dramatically slowed the growth of DSH spending, but the money is still in the system, and the lack of a correlation between states with high need and high DSH payments continues.

General Policy and Savings

The President's Medicaid plan saves \$59 billion in Federal expenditures over seven years. The plan has three components: new flexibility for states to administer the program, a per capita cap, and reduced and retargeted DSH spending.

The President's plan would reduce and retarget the amount of Federal Medicaid DSH payments. The DSH program would remain a Federal-state partnership, with maximum Federal payments constrained by state "allotments". However, the program would be made optional and the allotments would shift from a historical basis to a need basis. Additionally, DSH savings will be used to fund three payments pools that help in the transition from the current Medicaid program to the reformed program. The spending for these programs is described below:

Federal DSH Spending under the President's Plan, 1996 to 2002 (Current CBO seven-year Federal DSH baseline is \$87.1 billion)

- \$47.8 billion for the Targeted DSH Program and
- \$39.3 billion in DSH savings distributed in the following way:
 - \$3.5 billion for the Undocumented Persons' Pool;
 - \$3.0 billion for the FQHC/RHC Pool;
 - \$11.2 billion for the Transition Pool; and
 - \$21.6 billion for deficit reduction.

Specific Policy

State Allotments in the Targeted DSH Program: Beginning in FY1997, the plan would phase out states' Federal DSH payments, and phase in a new optional DSH program by FY2000. This transition would occur in 25 percent increments (e.g., in 1997, a state's allotment would be 75 percent of its 1995 DSH payments, and 25 percent of its new, 2000 allotment).

In FY2000 and subsequent years, state DSH allotments would be based on each state's share of low-income patient days for a core set of providers. A "core provider" would be (1) a hospital whose low-income utilization rate exceeds 25 percent and (2) children's hospitals whose low-income utilization rate exceeds 25 percent or whose Medicaid inpatient utilization rate exceeds 20 percent or is one standard deviation above the mean receiving Medicaid payments in the state. A "low-income patient day" would be defined as either an inpatient day or a day with one or more outpatient visits for uninsured and Medicaid patients. These days would be summed for the core providers in each state. Each state's allotment would be determined by multiplying the total Federal limit in the year by the state's days divided by the nation's days.

DSH Payments: During the transition, the plan would continue current laws regarding DSH. New program rules would begin on October 1, 1999. States with a DSH program would pay core providers and give them the option of paying additional providers. The plan would retain limits on maximum payments to facilities and rules about payment proportionality.

POOLS: The President's plan uses some of the savings from the DSH program to fund three capped pools for payments to specific states and providers to help them transition to the new Medicaid program. The undocumented persons pool will help states with high numbers of undocumented persons pay for emergency health services. The Federally Qualified Health Centers and Rural Health Clinics Pool (FQHC/RHC) will provide payments for FQHCs and RHCs. The transition pool (hold harmless pool) will assist states in transitioning to the new Medicaid program.

MEDICAID COMPROMISE B

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.
- Consistent with NGA formula, assure states that their federal allotments can never fall below the previous year's actual federal spending in the state, even if enrollment declines.

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 mandatory 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. However, exempt optional benefits (with the exception of prescription drugs) from all but the adequacy standard, (i.e., exempt optional benefits from the comparability and statewideness 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.
- Make services provided by community health centers an optional, rather than a mandatory benefit.

ENFORCEMENT

- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.
- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.
- Allow eligibility and benefit cases to be heard in state (rather than federal) court if the state makes all federal remedies and processes available.

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 resident reviews and allow 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.
- Accept NGA proposal to draft a new Medicaid title, but use current law as the statutory foundation to ensure that protections are not unintentionally repealed.

MEDICAID BACKGROUND

Attached are two recent memos outlining our concerns about the National Governors' Association (NGA) Medicaid agreement and possible acceptable alternatives. The February 20th memo outlines our fall-back position and the March 19th memo outlines where the Breaux/Chafee coalition now stands on Medicaid. (The good news about Breaux/Chafee is that their current -- as yet unreleased -- provisions have addressed ALL of our major concerns about the NGA proposal).

In short, the concerns we have about the Governors' proposal can be classified into four broad categories: (1) Eligibility; (2) Benefits; (3) Enforcement; and (4) Financing. These categories also can be used to help describe the make up of the Medicaid "guarantee" (it is best not to use the word entitlement) that the President seeks to protect.

- (1) **Eligibility: Who gets the guarantee?** Under the Governor's proposal, 2.5 million kids ages 13-18 and an untold number of people with disabilities (because states will now be allowed to define disability) will no longer be guaranteed coverage. (The Breaux/Chafee plan retains current law with regard to these populations.)
- (2) **Benefits: What benefits are guaranteed?** While the Governors maintain the current required benefit package, it does not retain the standards to make certain these benefits are real. For example, it does not require that these benefits are provided statewide and could allow states to define benefits in a discriminatory way for different populations.
- (3) **Enforcement: How is the guarantee legally enforced?** The NGA proposal eliminates the right of action within the Federal court system for those recipients who feel they have not been provided the services with which they are guaranteed. Instead, it proposes to have 50 different state courts enforce this guarantee, thus virtually ensuring that there will be multiple definitions of the national Medicaid guarantee of eligibility and benefits. As far as we know, this would be the first Federal statute that eliminates this right for eligibility disputes.
- (4) **Financing: How is the financing guaranteed?** The NGA proposal improved on the Republican block grant in that it ensured that states will automatically get increased federal support should enrollment unexpectedly increase (such as in an economic downturn.) However, their provision to allow states to lower their state matching dollars and still collect the same amount of Federal dollars, combined with their expansion in the use of provider taxes to access Federal funds, will either significantly increase Federal costs or, if the Federal match is capped, will effectively be a block grant. Neither outcome is acceptable.

Current Administration Position Vis a Vis Medicaid

We are now talking to the Democratic Governors about finding a way for them to exit from the NGA discussions. It is becoming more and more clear that the Republicans on the Hill are simply using the Governors for cover to cut and block grant Medicaid. The latest rumors indicate that the Republicans are even rejecting the most positive element of the NGA agreement, i.e., their provision to ensure that Federal dollars will follow enrollment increases. (They may release their new "vision" of the NGA agreement as early as next week.)

If the Republicans go back to capping (block-granting) the Medicaid program, the Democratic Governors will use this as an excuse to break free from the NGA process. They will say that the only way to get an acceptable agreement that can be enacted is to conduct Medicaid reform discussions on the Hill in a bipartisan manner. They will likely cite the Breaux/Chafee coalition as a good example of this. We will also be asking the Democratic Governors to publicly state that welfare reform should not be held hostage to ongoing (and yet to be concluded) discussions on Medicaid.

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

OVERVIEW

I. IMPLEMENTING MANAGED CARE

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

II. FLEXIBILITY IN PROGRAM PAYMENT

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

III. FLEXIBILITY IN PROGRAM BENEFITS

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

IV. FLEXIBILITY IN PROGRAM ELIGIBILITY

- Income Levels for Infants and Pregnant Women

V. FLEXIBILITY IN STATE ADMINISTRATION

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

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

I. IMPLEMENTING MANAGED CARE

REPEAL OF REQUIREMENT FOR FEDERAL WAIVERS FOR MANAGED CARE

Administration Proposal:

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

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

Background:

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

FREEDOM OF CHOICE WAIVER ACTIVITY
(1993-1996)

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

TOTAL

162

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

REPEAL OF MANAGED CARE CONTRACTING RULES

Administration Proposal

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

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

Background

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

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

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

Administration Proposal:

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

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

Background:

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

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

FEDERAL APPROVAL OF MANAGED CARE CONTRACTS
Annual Estimate

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

II. FLEXIBILITY IN PROGRAM PAYMENT

REPEAL OF THE BOREN AMENDMENT

Administration Proposal:

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

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

Background:

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

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

ELIMINATION OF SPECIAL PAYMENT REQUIREMENTS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

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

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

Background

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

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

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

III. FLEXIBILITY IN PROGRAM BENEFITS

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

Administration Proposal:

States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

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

Background:

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

See attached chart for affected states.

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

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

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

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

Administration Proposal:

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

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

Background:

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

IV. FLEXIBILITY IN PROGRAM ELIGIBILITY

INCOME LEVEL FOR INFANTS AND PREGNANT WOMEN

Administration Proposal:

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

Background

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

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

INCOME AND ELIGIBILITY LEVELS: INFANTS AND PREGNANT WOMEN

The 33 Highlighted states could take advantage of this provision

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

* States with effective income levels above the nominal statutory maximum use the authority in section 1902(r)(2) to disregard higher than usual amounts of income.

** States using higher income level as part of demonstration under section 1115.

V. FLEXIBILITY IN STATE ADMINISTRATION

REFORMING MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

Administration Proposal:

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

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

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

Background:

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

REVISE AND SIMPLIFY MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REQUIREMENTS

Administration proposal:

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

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

Background:

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

PROVIDER QUALIFICATIONS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

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

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

Background:

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

Implications of the current policy are significant.

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

ELIMINATION OF REQUIREMENTS TO PAY FOR PRIVATE HEALTH INSURANCE

Administration proposal:

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

Background:

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

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

ELIMINATION OF PERSONNEL REQUIREMENTS

Administration proposal:

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

Background:

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

ELIMINATION OF REQUIREMENT FOR COOPERATIVE AGREEMENTS

Administration Proposal:

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

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

Background:

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

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

Administration proposal:

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

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

Background:

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

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

MEDICAID

Building off the foundation of the National Governors' Association (NGA) resolution, a Medicaid compromise is within reach. Although there are second tier issues that need to be fleshed out (e.g., issues relating to quality, family financial protections, and bill drafting), the key issues that need to be resolved to reach a bipartisan compromise are:

Financing: Accept and work off the NGA financing formula, which has no cap and is intended to ensure that Federal support increases with enrollment. Ensure the formula can be scored for adequate savings without undermining the "dollars follow people" principle. (To do this, it may be necessary to delete or modify the lower state matching requirement and the provider tax provisions included in the NGA resolution.)

Eligibility: Accept NGA definition of eligibility with two modifications: (1) Retain current law that phases in kids ages 13-18 and (2) maintain Federal eligibility designation authority, but respond to Governors' concerns by restricting disability eligibility to definition outlined in welfare bill (that excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids).

Benefits: Accept the NGA benefits definition, but work to ensure that Federal standards are in place to ensure that the benefits are meaningful, are provided to all eligible populations and cannot be designed to discriminate against certain populations. Amend the NGA recommendation on the children's preventive benefits (EPSDT) to at least include optional benefits.

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 Federal right of action for eligibility disputes, but work on approaches that limit access to Federal courts over most benefit disputes.

Congressional Moderates' Position on Medicaid Reform

	House Coalition	Senate Moderates
FLEXIBILITY		
<u>President's flexibility package</u> -- Managed care and home and community services without Federal waivers. Flexibility on quality standards.	+	+
FINANCING		
<u>Dollars follow people/economic downturn formula.</u>	+	+
<u>No reduction in state matching rate.</u>	+	+
<u>Provider tax protections.</u>	+	+
ELIGIBILITY		
<u>Coverage for kids 13-18</u> -- retains current law that phases in kids.	?	+
<u>Federal definition of disability</u> -- with welfare exclusion of alcoholics, chemical & substance abusers from mandatory coverage.	+	+
BENEFITS		
<u>Retain 'adequacy' standards</u>	+	+
<u>Retain statewideness/comparability standards.</u>	+	+
<u>EPSDT</u> --have Secretary designate benefits that are being abused.	+	+
ENFORCEMENT		
<u>Repeal Boren amendment.</u>	-	+
<u>Federal right of action</u> -- preserve Federal right of action for eligibility and benefits disputes.	?	?
STRUCTURE/SECOND TIER ISSUES		
<u>Preserve current law protections by drafting off of Title XIX.</u>	+	+
<u>Quality assurance: managed care/nursing home standards, enforcement.</u>	0	+
<u>Family financial protections.</u>	+	+
OVERALL SAVINGS		
Administration \$59 billion; House Coalition \$85 billion; Senate \$62 billion.		

(+) indicates a position that is consistent with the Administration; (-) indicates position inconsistent with the Administration; (0) indicates partial support; (?) indicates unclear position.

CHANGES TO ORIGINAL 1995 MEDICAID PROPOSAL

FINANCING: MOVING TOWARDS THE GOVERNORS

- **Original Position:** Per capita cap that adjusts federal support as enrollment increases or declines. A 33 percent Disproportionate Share Hospital (DSH) cut with no hold harmless provision and no specifics as to how dollars were used.
- **Compromise Position:** Adopts the National Governors' Association (NGA) financing formula, with some modifications to assure CBO scoring. Unlike the per capita cap, this approach provides a hold harmless provision that ensures that states can keep their base allotment (they get to choose from the best of 1993, 1994, or 1995), even if they decrease the Medicaid recipient enrollment below levels of their base year. Institutes a DSH hold harmless provision and targets dollars to facilities disproportionately serving the uninsured and other needy hospitals defined by the states.

ELIGIBILITY: EXPANDING STATE FLEXIBILITY

- **Original Position:** Maintained current law that prohibited states from rolling back their optional expansions of kids and pregnant women to mandatory poverty/coverage levels. In addition, required that states maintain current federal disability eligibility definition requirements.
- **Compromise Position:** Gives states the authority to roll back optional coverage of kids to minimum poverty/coverage levels and substitutes the disability eligibility reforms included in the bipartisan welfare bill, (which no longer requires states to cover alcoholics, chemical and substance abusers and some SSI kids.)

BENEFITS: REDUCING COSTS AND TARGETING ABUSES

- **Original Position:** Maintained current law requirements.
- **Compromise Position:** Provides states the authority to apply nominal copayments for Medicaid HMO coverage. Also, to address concerns about EPSDT benefit abuses, authorizes the Secretary to limit inappropriately utilized benefits.

ENFORCEMENT: DECREASING LITIGATION AND COSTS

- **Original Position:** Restructured, but did not totally repeal the Boren amendment. Retained individuals' current access to Federal court system.
- **Compromise Position:** Totally repeals the Boren amendment and requires that all state administrative appeals be exhausted prior to any court appeal on eligibility or benefits disputes.

FLEXIBILITY TO INCREASE COVERAGE WITHOUT WAIVERS

- **Original Position:** Although the President's June, 1995 proposal did eliminate the federal waiver process for managed care and home and community based alternatives, states that achieved savings through the new flexibility provisions could not plow those savings back into targeted coverage expansions without a federal waiver.
- **Compromise Position:** Empowers states to use Medicaid savings to provide coverage for any population up to 150 percent of poverty without a federal waiver. (As a result, states can either pocket the savings or use it to expand coverage to any population it wants provided they are under specified poverty threshold.)

SAVINGS INCREASE EVEN AS CBO MEDICAID BASELINE DECLINES

- **Original Position:** \$54 billion off of a much higher CBO Medicaid baseline.
- **Compromise Position:** \$59 billion off of the new CBO Medicaid baseline, which is over \$25 billion lower than the December CBO Medicaid baseline and \$55 billion lower than the baseline used to score the budget proposals passed by the Congress in 1995.

MEDICAID

Building off the foundation of the National Governors' Association (NGA) resolution, a Medicaid compromise is within reach. Although there are second tier issues that need to be fleshed out (e.g., issues relating to quality, family financial protections, and bill drafting), the key issues that need to be resolved to reach a bipartisan compromise are:

FINANCING: The Conference Agreement provides for fixed ("block-granted") federal payments. The Administration proposal limits federal spending growth per recipient and reduces disproportionate share (DSH) payments. The NGA proposal combines elements of both a block grant and a per capita cap. It provides for a minimum federal base payment, but allows federal payments to increase when enrollment increases. (Although an oral agreement on the financing formula appeared to be reached at the March 12th NGA meeting in Chicago, we are waiting for written specifics as of March 18th.)

- **Areas of Potential Agreement:** Accept and work off the NGA financing formula, which has no cap and is intended to guarantee that Federal support increases with enrollment. Ensure the formula can be CBO-scored for adequate savings without undermining "dollars follow people" principle. To achieve this outcome, it may be necessary to delete or modify certain provisions in the NGA resolution, including the lower state matching requirements and the provider tax provisions.
- **Principals' Issues:** Staff will likely need direction from the Principals at some point about allocation of dollars, particularly DSH dollars, to the states. However, most of the outstanding issues should be able to be worked out if staff is given direction to produce the financing scheme around the parameters outlined above.

ELIGIBILITY: The Conference Agreement allows the states to define eligibility and has no minimum federal eligibility definitions. In lieu of federal standards, states are required to spend certain percentages of their block grant ("set-asides") on low income families, people with disabilities and seniors. The Administration proposes to retain current federally-defined eligibility categories. The NGA proposal retains current law's eligibility categories with the exceptions of the phase-in of coverage of poor children ages 13-18 and the federal definition of disability.

- **Areas of Potential Agreement (Eligibility):** Accept NGA eligibility definitions with two modifications: (1) Retain kids phase-in and (2) retain the federal disability eligibility definition, but redefine it to mirror the welfare reform definition of eligibility. (This excludes from mandatory coverage alcoholics, chemical and substance abusers, and some definitions of functionally impaired kids.)
- **Principals' Issues:** Because it is the most visible non-financing issue, closure on the outstanding eligibility definition issues will be difficult to achieve without authorization and direction from the Principals.

BENEFITS: With the exception of the current requirement that states cover vaccines and limited family planning services, the Conference Agreement leaves the definition of the benefit package up to the individual states. The Administration maintains the current, federally defined benefits package. The NGA resolution resembles the Administration's proposal in that it retains the federal list of basic benefits now covered. However, the proposal provides no federally-defined standard of adequacy, it eliminates the comparability and statewideness protections for both mandatory and optional benefits, and it limits the treatment portion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children. Specifically, states would no longer be required to cover any treatment prescribed from the screening process; only mandatory services would be guaranteed.

- **Areas of Potential Agreement:** With the exception of EPSDT, accept the NGA list of covered benefits, but work to develop standards to ensure that they are meaningful, i.e., that they are provided to all eligible populations (statewideness) and cannot be designed to discriminate against certain populations (comparability). Standards related to optional benefits could be significantly liberalized. On EPSDT, develop an alternative that addresses real abuses of the benefit, but without sacrificing required coverage of optional benefits.
- **Principals' Issues:** Providing general parameters to staff on their philosophy of defining appropriate standards to assure that the benefits package is "meaningful." In addition, we may need direction on negotiations related to the EPSDT benefit.

ENFORCEMENT: All three proposals (the Conference Agreement, the President's proposal, and the NGA resolution) repeal the primary legal and financial headache for the Governors -- the Boren Amendment. The Conference Agreement and the NGA resolution go further and eliminate all provider right of actions. They also eliminate the federal right of action for Medicaid recipients who have eligibility or benefit disputes and require recipients to exhaust the state administrative appeal process prior to filing any court appeal. (The court appeal would be processed through the state court system.) The President's proposal retains the federal right of action for disputes by recipients.

- **Areas of Potential Agreement (Enforcement):** Accept NGA proposal to eliminate all provider right of action suits. Preserve federal right of action for Medicaid recipients, but accept NGA proposal that requires all state administrative appeals to be exhausted prior to any Court appeal being permitted to be filed.
- **Principals' Issues:** Any discussions related to the elimination of the federal right of action for Medicaid recipients.

SAVINGS: The Conference Agreement provides for \$133 billion in savings from the program over 7 years, although the Republican Leadership moved to an \$85 billion Medicaid reduction number in January. The Administration 7-year savings number is \$59 billion. (The Breaux/Chafee compromise calls for \$62 billion over 7 years.)

- **Areas of Potential Agreement:** Regardless of the number chosen, the staff can work out formulas that achieve the savings target. However, the higher the number, the more difficult it will be to allocate politically acceptable reductions in federal support to the states.
- **Principals' Issues:** This is a budget and politically-driven number that must be provided by the Principals.

HERE YOU GO BRIDGETT:

Please call John Dingell sometime today to request that he draft an Op Ed piece to highlight the biggest victory the President (and John Dingell, a unified Democratic party, and a number of moderate Republicans) achieved in the version of welfare reform that was passed -- **the preservation of Medicaid's guarantee of health care for 36 million Americans**. He is expecting your call and his staff strongly supports the idea. (In fact, a close friend of ours and a former HHS employee -- Bridgett Taylor -- is already secretly beginning to draft the Op Ed piece.)

Background

During the last year and a half, the Administration has been working closely with Congressman Dingell's staff to help coordinate with the Democratic Leadership a unified position of strong opposition to Republican proposals to block grant the Medicaid program. His staff was extremely effective in our successful efforts to assure that the conservative Democrats stayed on (and moderate Republicans crossed over to) our side of the fence. In fact, the key reason why Congressman Dingell felt he could vote for the welfare bill was because we preserved the Medicaid "guarantee."

Although Congressman Dingell does not feel he did a lot, he (through his staff and his backing) was a, if not the, key Congressional player on Medicaid. I saw him earlier today to tell him our important we thought he was to our Medicaid success, but I did not mention that you were going to call to make this request. He seemed very appreciative that we recognized his role, but was shy about taking the credit.

Possible Talking Points

- We need your help to help us better communicate how much stronger this welfare bill is than the ones the President previously vetoed. The President always said that he would veto any welfare bill that included the "poison pill" of block granting Medicaid.
- With your incredible help, the President won the Medicaid fight. We not only preserved Medicaid, but I believe we have strengthened it for years to come. Your and our efforts have shown the public that this program is not just for the poor, but it is safety net for Americans of all ages and all incomes.
- We want to better highlight this victory and were hoping that you would consider drafting up an Op Ed piece to help us (and the Democrats who voted for welfare reform) remind our base constituency of what we achieved.

5280
JJB 528

NATIONAL ORGANIZATIONS OPPOSING THE HOUSE GOP MEDICAID PROPOSAL

Aging Advocates

American Geriatrics Society
Long Term Care Campaign
National Association of Retired Federal Employees
National Council for Senior Citizens
National Council on Aging
National Senior Citizen Law Center
Older Women's League

Childrens Groups

Association for the Care for Children's Health
Children's Defense Fund
Committee for Children
National Association of Child Advocates

Disability Groups

Bazelon Center for Mental Health Law
Center on Disability and Health
Consortium for Citizens with Disabilities
Justice For All
March of Dimes
National Community Mental Healthcare Council
National Easter Seals Society
National Mental Health Association
Spina Bifida Association of America
The ARC
United Cerebral Palsy Association

Healthcare Providers

American Academy of Family Physicians
American Association of Eye and Ear Hospitals
American Association of Medical Colleges
American College of Physicians
American Hospital Association
American Nurses Association
American Osteopathic Health Care Association
American Psychological Association
American Rehabilitation Association
Association of Women's Health, Obstetric and Neonatal Nurses
Automated Health System's Inc.
Catholic Health Association
Council on Women's and Infants' Specialty Hospitals
Federation of American Health Systems
InterHealth
National Association of Children's Hospitals
National Association for Homes and Services for Children
National Association of Public Hospital and Health Systems
National Association of School Nurses
National Association of School Psychologists
Premier

VHA Inc.

Other Health Groups

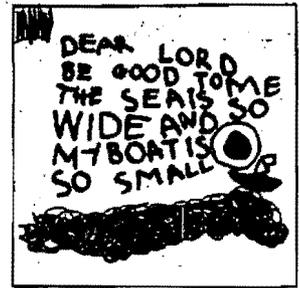
AIDS Action Council
AIDS Policy Center for Children, Youth and Families
Alzheimers Association
American Counseling Association
American Public Health Association
American Speech-Language-Hearing Association
Association of Reproductive Health Professionals
Gay Mens Health Crisis
National Association of Social Workers
National Association of Developmental Disabilities Councils
National Health for the Homeless Council
National Minority AIDS Council
National Osteoporosis Foundation
National Treatment Consortium
National Women's Health Network
Planned Parenthood

Religious, Labor & Consumer Groups

American Association of University Women
American Civil Liberties Union
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Network of Community Options and Resources
Americans for Democratic Action
B'nai B'rith
Catholic Charities
Center for Community Change
Center for Science in the Public Interest
Center for Women Policy Studies
Citizen Action
Coalition on Human Needs
Consumer Coalition for Quality Health Care
Consumers Union
Families USA
Family Service America
Fundors Concerned About AIDS
Human Rights Campaign
International Brotherhood of Teamsters
International Ladies' Garment Workers' Union
International Union of Electronic, Electrical, Salaried, Machine
and Furniture Workers
International Union of United Auto Workers
Legal Action Center
Mennonite Central Committee
National Association of Counties
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Citizens' Coalition for Nursing Home Reform
National Coalition for the Homeless
National Education Association
National Family Planning and Reproductive Health Association

National Jewish Community Relations Advisory Council
National Gay and Lesbian Task Force
National Latino Gay and Lesbian Organization
Neighbor to Neighbor Action Fund
NETWORK: A National Catholic Social Justice Lobby
OMB Watch
Service Employees International Union
Unitarian Universalist Service Committee
Women's Health Coalition
Women's Legal Defense Fund
World Hunger Year
YWCA of the USA

FAX COVER SHEET



Children's Defense Fund

TO: Sarah Bianchi
ORGANIZATION: White House
FAX #: 456-5572

FROM: **Stan Dorn, Director
Health Division**

DATE: _____ TIME: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): 2

NOTES: Call if you want the report.
Nice talking to you!
Please give my regards to Chris, Marilyn,
Jennifer & the rest of the crew!

If you have any problems receiving this fax, please contact me
at (202) 662 - 3595.

Table 1
LOW-INCOME CHILDREN LOSING GUARANTEED
MEDICAID COVERAGE UNDER NGA PROPOSAL

	Children not receiving AFDC under current law	Children receiving AFDC under current law	TOTAL
Alabama	65,200	17,600	82,800
Alaska	6,700	3,300	10,000
Arizona	47,100	20,000	67,100
Arkansas	41,500	9,100	50,600
California	367,900	291,700	659,600
Colorado	21,600	12,300	33,900
Connecticut	1,800	16,900	18,700
Delaware	5,200	3,500	8,700
District of Columbia	6,600	7,300	13,900
Florida	212,300	75,000	287,300
Georgia	119,900	48,800	168,700
Hawaii	8,000	7,400	15,400
Idaho	17,400	1,500	18,900
Illinois	97,800	78,800	176,600
Indiana	53,900	21,300	75,200
Iowa	18,700	10,700	29,400
Kansas	25,500	8,900	34,400
Kentucky	46,500	30,700	77,200
Louisiana	91,700	33,000	124,700
Maine	10,000	7,900	17,900
Maryland	12,800	23,200	35,800
Massachusetts	27,700	35,200	62,900
Michigan	70,200	74,900	145,100
Minnesota	31,300	19,300	50,600
Mississippi	71,200	24,700	95,900
Missouri	57,900	29,800	87,700
Montana	7,900	3,900	11,800
Nebraska	11,200	4,100	15,300
Nevada	16,100	3,200	19,300
New Hampshire	6,800	2,000	8,800
New Jersey	46,100	46,800	92,900
New Mexico	40,200	9,500	49,700
New York	210,600	149,400	360,000
North Carolina	95,600	34,800	130,400
North Dakota	4,800	1,700	6,500
Ohio	78,900	75,900	154,800
Oklahoma	46,300	14,800	61,100
Oregon	25,800	11,200	37,000
Pennsylvania	84,300	74,000	158,300
Rhode Island	6,500	5,700	12,200
South Carolina	72,400	20,000	92,400
South Dakota	9,400	2,500	11,900
Tennessee	58,800	36,100	94,900
Texas	341,100	84,800	425,900
Utah	31,300	6,500	37,800
Vermont	3,800	3,400	7,200
Virginia	47,400	22,100	69,500
Washington	29,800	28,900	58,700
West Virginia	30,100	14,300	44,400
Wisconsin	31,600	23,300	54,900
Wyoming	3,700	1,700	5,400

NOTES: (1) The children listed are ages 13 through 18. (2) The first column reports the number of children who would be denied guaranteed Medicaid coverage in FY 2002. Roughly one-third of the children listed in that column are covered today and would lose guaranteed coverage immediately under the NGA proposal. (3) The second column reports numbers of children in FY 1993. (4) The first column uses the most recent, reliable state-level data. When these numbers are added, they total 2.9 million. More recent national data show that, altogether, 3.1 million children will be affected. The latter, national number is used in the report.

SOURCES: Census—March 1992-94 Current Population Surveys, Resident Population of States 1990-94, and Population Projections for States, 1993-2020; DHHS—AFDC Recipient Characteristics in FY1991-93.

Calculations by the Children's Defense Fund, 2/16/96

Congressional Moderates' Position on Medicaid Reform

	House Coalition	Senate Moderates
FLEXIBILITY		
<u>President's flexibility package</u> -- Managed care and home and community services without Federal waivers. Flexibility on quality standards.	+	+
FINANCING		
<u>Dollars follow people/economic downturn formula.</u>	+	+
<u>No reduction in state matching rate.</u>	+	+
<u>Provider tax protections.</u>	+	+
ELIGIBILITY		
<u>Coverage for kids 13-18</u> -- retains current law that phases in kids.	?	+
<u>Federal definition of disability</u> -- with welfare exclusion of alcoholics, chemical & substance abusers from mandatory coverage.	+	+
BENEFITS		
<u>Retain 'adequacy' standards</u>	+	+
<u>Retain statewideness/comparability standards.</u>	+	+
<u>EPSDT</u> --have Secretary designate benefits that are being abused.	+	+
ENFORCEMENT		
<u>Repeal Boren amendment.</u>	-	+
<u>Federal right of action</u> -- preserve Federal right of action for eligibility and benefits disputes.	?	+
STRUCTURE/SECOND TIER ISSUES		
<u>Preserve current law protections by drafting off of Title XIX.</u>	+	+
<u>Quality assurance: managed care/nursing home standards, enforcement.</u>	0	+
<u>Family financial protections.</u>	+	+
OVERALL SAVINGS		
Administration \$59 billion; House Coalition \$85 billion; Senate \$62 billion.		

(+) indicates a position that is consistent with the Administration; (-) indicates position inconsistent with the Administration; (0) indicates partial support; (?) indicates unclear position.

THE PRESIDENT'S MEDICAID REFORM PROPOSAL

1. Overview

2. Financing

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

3. Flexibility

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

1. OVERVIEW

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

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

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

2. FINANCING

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

- Responsiveness: A per capita cap maintains the responsiveness of Federal funding to states' unexpected costs.
 - Under the President's proposal, the Federal government shares in the unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
- Responsible: The per capita cap and Disproportionate Share Hospital payment reductions achieve responsible levels of Federal savings.
 - The President's proposal provides states with sufficient Federal funds to maintain coverage for the millions of Americans who rely on Medicaid.

The following section reviews:

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

Responsive and Responsible Federal Financing

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

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

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

- President's plan saves the Federal government \$59 billion over seven years.
- Republicans' plan saves the Federal government \$85 billion over seven years.
 - This is \$26 billion -- or 44 percent -- higher than the savings proposed by the President.
 - Under the Republican plan, spending growth per beneficiary would be significantly below private spending growth per person (7 percent).
 - By 2002, Federal funding to states will be inadequate and states will be forced to reduce payments, benefits and deny coverage for millions of Americans.

Per Capita Cap: What Is It

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

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

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

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

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

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

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

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

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

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

The cap adapts automatically to state enrollment changes

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

Per Capita Cap: Adapting to State Spending

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

Disproportionate Share Hospital (DSH) Changes and Pool Payments

Disproportionate Share Hospital Payments Changes:

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

Pool Payments:

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

3. FLEXIBILITY

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

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

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

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

Provider Payment Flexibility

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

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

Managed Care Flexibility

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

• **Elimination of Need for a Waiver:** (NGA Recommendation) States will be able to implement managed care programs without the need for Federal waivers, so long as beneficiaries have a choice of plans, except in rural areas. States will be permitted to enroll Medicaid beneficiaries into their health plans for up to six months and to guarantee Medicaid eligibility during this enrollment period.

✓ **Outdated Quality Standards are Repealed:** (NGA Recommendation) The 75/25 enrollment composition rule will be eliminated.

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

✓ **Federal Contract Review is Eliminated:** The Federal government will no longer review states' contracts with managed care plans that exceed \$100,000.

✓ **HMO Copayments are Allowed:** (NGA Recommendation) States will be able to require HMO enrollees to make nominal copayments, consistent with their ability to require copayments in fee-for-service settings.

Eligibility and Benefits Flexibility

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

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

Administrative Flexibility

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

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