



GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

Brems - Chutee  
Balanced Budget

File

(Also put in  
Baseline File)

Pl <sup>do</sup> ~~to~~ His Sr:  
- Blue dog  
- Prop. \$167 million  
- Our \$114 Billion

TO:

CHRIS

FAX NO.:

FROM:

DATE:

PAGES INCLUDING THIS  
COVER SHEET:

COMMENTS:

You owe me  
a \$1.

05-16-96 09:58AM

TO 83898

P002/002

## CHAFEE-BREAUX MODERATE BUDGET PLAN

(\$ billions)	1997	1998	1999	2000	2001	2002	2003	5-year	1997
<b>CBO Capped Baseline</b>	166	176	182	191	194	210	226	—	—
Adjustments 1/	3	2	2	1	1	1	1	10	17
<b>Adjusted Baseline</b>	169	178	184	192	195	211	227	—	—
<b>DISCRETIONARY</b>									
EA freeze	-11	-16	-34	-52	-76	-93	-112	-281	-393
Defense changes to a freeze	-1	-1	1	3	7	5	5	13	18
Nondefense changes to a freeze	4	11	15	18	28	21	18	88	192
<b>Total, discretionary</b>	-8	-7	-18	-31	-48	-67	-89	-179	-286
<b>MANDATORY</b>									
Medicare	-3	-10	-15	-20	-26	-32	-48	-106	-134
Medicaid	0	-2	-5	-8	-11	-15	-21	-41	-62
Welfare /ETC	-2	-6	-7	-8	-10	-12	-13	-45	-68
CPI	-4	-7	-12	-17	-22	-29	-34	-91	-125
Other Mandatory	-3	-3	-4	-6	-8	-10	-12	-37	-62
<b>Total, mandatory</b>	-13	-27	-45	-60	-77	-97	-130	-319	-450
<b>REVENUE CHANGES:</b>									
Tax relief	2	18	21	21	21	22	24	107	130
Corporate reforms	-2	-2	-3	-4	-4	-4	-5	-20	-25
Expiring tax provisions	1	-3	-1	1	1	1	0	4	-8
<b>Total, revenue changes</b>	1	14	17	18	18	18	19	92	105
<b>TOTAL POLICY</b>	-20	-20	-47	-72	-107	-145	-200	-412	-612
<b>NET INTEREST</b>	-1	-2	-3	-6	-11	-17	-28	-40	-67
<b>TOTAL CHANGES</b>	-21	-22	-50	-76	-118	-163	-227	-452	-679
<b>UNIFIED DEFICITS</b>									
	147	164	134	114	77	49	-3	—	—

1/ Adjustments for enactment of 1996 appropriations bill, student loans, corrections to CBO baseline and related interest.

## COMPARISON OF BUDGET PLANS: 6-YEAR SAVINGS

(\$ billions)

	President's Budget	Chafee-Breaux Budget	Republican Budget
<b>Spending Cuts:</b>			
Discretionary	-230	-178	-298
Mandatory:			
Medicare	-117	-106	-167
Medicaid	-54	-41	-72
Other health	8	0	10
Welfare/EITC	-43	-45	-70
CPI outlays 1/	0	-56	0
Spectrum auctions	-37	(?)	-19
Other mandatory	-24	-37	-19
Subtotal	-265	-284	-337
<b>Revenues:</b>			
Tax relief and other	99	107	180
Corporate reforms 2/	-40	-20	-21
CPI revenues 1/	0	-35	0
Other proposals	-5	0	(?)
Expiring provisions 2/	-43	-0	-36
Subtotal	11	51	122
Policy Savings	-485	-412	-511
Debt Service	-41	-40	-56
<b>Total Savings</b>	<b>-525</b>	<b>-452</b>	<b>-567</b>
<b>2002 Deficit/Surplus</b>	<b>0</b>	<b>-49</b>	<b>0</b>

1/ Assumes a 0.5% reduction in CPI.

2/ The Republican plan restricts a net tax change of \$122 billion over 6 years, but includes reserve fund language that allows for additional tax cuts on a revenue neutral basis. The revenue figures for the Republican plan show gross tax cuts assuming that the Republicans adopt the corporate reforms contained in the Balanced Budget Act and certain tax provisions that have expired since last year.

# A DEMOCRAT'S INTRODUCTION TO MEDICAID

(DRAFT, 11/5/96)

This is a primer on the nation's second largest health care program. It is written by the staff of the House Democratic Policy Committee for Democratic Members and staff of the 105th Congress, who will be called upon to decide the future of program in the context of balancing the Federal budget.

During the 104th Congress, Republicans tried twice to repeal Medicaid altogether, eliminating its entitlement of basic health and long-term care coverage for over 36 million elderly, disabled, and women and children, and establishing a new block grant to the States. Under the Republican block grant, Federal spending would have been cut sharply, State spending would have declined precipitously, and State discretion over billions in Federal funds would have increased dramatically, with far-reaching implications for Democratic constituencies and Democratic officeholders at all levels. Fortunately, the Republicans accomplished almost none of their extreme Medicaid agenda during the 104th.

Whether the Republicans resume their efforts to repeal Medicaid in the 105th Congress remains to be seen. At a minimum, however, they will continue to push for maximum State control over the use of Federal Medicaid dollars, if only because nearly 80 percent of the nearly \$100 billion in Federal funds flow to States with Republican Governors. This "management flexibility" will have enormous consequences for the families and children and elderly and disabled that Medicaid now covers, as well as for the hospitals, nursing homes, health centers, and physicians that now serve them.

While the 104th Congress did not enact the Republican Medicaid repeal, it did enact two laws -- welfare (P.L. 104-193) and immigration (P.L. 104-208) -- that made significant changes in the program. For additional information about these, see the Democrat's Guide to Medicaid-related Legislation in the 104th Congress (November, 1996), available through the House Democratic Policy Committee.

Reforming a program as large and complex as Medicaid in a way that beneficiaries and other Democratic constituencies don't get hurt is a complicated business. More detail on 10 of the major issues that the 105th Congress is likely to face may be found in the Democrat's Briefing Book on Medicaid Issues in the 105th Congress (November, 1996), also available through the House Democratic Policy Committee.

## Contents

Medicaid at a Glance

What Is Medicaid's Impact?

Who Gets Medicaid?

What Does Medicaid Cover?

What Does Medicaid Cost, and Why?

Who Runs Medicaid?

Who Pays for Medicaid?

Distribution of Federal Medicaid Funds Among States (FY 1995)

What Didn't Happen to Medicaid in the 104th Congress?

The Republican 1996 Medicaid Repeal and Block Grant

The President's 1996 Medicaid Proposal

The Coalition's 1995-6 Medicaid Proposal

## MEDICAID AT A GLANCE

**Medicaid is a Federal-State entitlement program.** Enacted in 1965, at the same time as Medicare, in 1965, Medicaid makes Federal matching funds available to States for the costs of paying for covered services to eligible Americans. Those Americans who meet the program's eligibility standards are entitled to have payment made on their behalf for covered services. States that elect to participate are entitled to Federal matching funds for their costs of paying for covered services for eligible residents.

**Medicaid covers basic health and long-term care services.** Medicaid covers hospital, physician, clinic, nursing home, prescription drug, and other health and long-term care services. Nationally, about 63 percent of what Medicaid spends on services pays for hospital, physician, and other acute care; the remaining 37 percent of Medicaid service dollars is spent on nursing home and other long-term care.

**Medicaid covers three main groups of low-income Americans: the elderly, the disabled, and women and children.** In 1996, Medicaid covered nearly 37 million Americans. About 4 million of these were elderly, about 6 million were disabled, over 18 million were children, and roughly 8 million were low-income women.

**Although half of all Medicaid eligibles are children, nearly 60 percent of all Medicaid funds are spent on the elderly and disabled.** In 1996, 50 percent of all Medicaid eligibles were children, but payments for services to the elderly (27 percent) and the disabled (31 percent) accounted for about 58 percent of all Medicaid spending. Only 16 percent of all Medicaid spending that year paid for services to children.

**Medicaid cost the Federal government \$92 billion in FY 1996, an increase of 3 percent.** Federal Medicaid spending in the year ending September 30, 1996, was \$91.8 billion, or \$4 billion below the amount projected by the Congressional Budget Office (CBO) in April, 1996. This translates into an annual growth rate of 3 percent, by far the lowest the program has experienced in the 1990's. Federal Medicare spending in FY 1996 was \$124 billion for Part A (hospital benefits), an increase of 9.2 percent, and \$69 billion for Part B (physician services), an increase of 6.0 percent.

**The Federal Government pays at least half of the cost of Medicaid in every State (57 percent on average).** The Federal share of the cost of Medicaid is at least 50 percent in every State and can go as high as 83 percent, depending on a State's per capita income (relatively poorer States receive a higher matching rate). On average, the Federal government finances 57 percent of total program costs.

**The States administer Medicaid within Federal guidelines.** The program is administered on a day-to-day basis by State Medicaid agencies, subject to oversight of Federal funds by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services.

## WHAT IS MEDICAID'S IMPACT?

**Medicaid is America's 2nd largest health care program, covering almost as many Americans as Medicare.** According to CBO, Medicaid covered about 36.8 million Americans in FY 1996 at a total cost of \$161 billion (\$91.8 billion Federal, \$69.2 billion State). By way of comparison, CBO estimates that Medicare covered 37.5 million Americans in FY 1996 at a total cost to the Federal government of \$192.7 billion. (About 4.9 million aged or disabled Medicare beneficiaries received assistance from Medicaid during FY 1996).

**Medicaid is America's largest single purchaser of nursing home services and other long-term care.** The Federal government, through Medicaid, spent an estimated \$30 billion on long-term care in FY 1996, the States another \$22.7 billion. These figures represent nearly 1/3 of all program spending. Most of the long-term care paid for by Medicaid is delivered in nursing homes; Medicaid pays for about half of all the nursing home care provided in this country. Of the 1.5 million nursing home residents nationwide, about two thirds, or 1.0 million, are covered by Medicaid.

**Medicaid covers about one fourth of the children in America.** Of the over 71 million children in America in 1996, an estimated 18.6 million are covered by Medicaid. Under current law, by the year 2001, all American children under 18 who live in families with incomes below the Federal poverty line will be eligible for Medicaid coverage.

**Medicaid is America's largest single purchaser of maternity care.** Medicaid pays for about one third of the births in the country (1.4 million deliveries in 1993), including prenatal care, delivery, and post-partum care.

**Medicaid is the safety net for nearly 5 million Medicare beneficiaries.** In FY 1996, Medicaid paid the monthly Medicare premiums, deductibles, and coinsurance for about 4.9 million poor and near-poor elderly and disabled Americans who are covered by Medicare. For roughly half of these, Medicaid will also pay for nursing home care, prescription drugs, and other needed services that Medicare does not cover.

**Medicaid affects thousands of health care providers and hundreds of thousands of health care workers.** According to HCFA, in 1996, Medicaid made payments to over 5,000 community hospitals, over 1,000 mental and rehabilitation hospitals, nearly 12,000 nursing homes, over 7,000 facilities for the mentally retarded, and over 400 managed care organizations.

**For teaching hospitals, public hospitals, children's hospitals, and rural and urban health centers, Medicaid is a major source of revenue.** On average, Medicaid accounts for about 15 percent of the net revenues of teaching hospitals (1994), 25 percent of the net revenues of public hospitals (1994), 45 percent of the gross revenues of children's hospitals (1994), and 36 percent of the revenues of community health centers (1995).

## WHO GETS MEDICAID?

Three basic groups of people are eligible for Medicaid:

- **Elderly.** More than 4 million adults 65 and over were eligible for Medicaid in FY 1996. About one third of these were eligible because they were receiving cash assistance through the Supplemental Security Income (SSI) program. Others had too much income or resources to qualify for SSI, but "spent down" to Medicaid eligibility by incurring high medical or long-term care expenses. Finally, perhaps 2 million of these were eligible as "Qualified Medicare Beneficiaries," or QMBs: their incomes were below 100 percent of the poverty level and they received Medicaid assistance with their Medicare premiums, co-insurance, and deductibles (but not for nursing home care or prescription drugs).
- **Disabled.** About 6 million disabled individuals were eligible for Medicaid in FY 1996. Most of these were eligible because they received cash assistance through the SSI program. The remainder "spent down" to qualify by incurring large hospital, prescription drug, nursing home, or other medical bills.
- **Women and Children.** Over 18.6 million low-income children and about 7.8 million low-income women were eligible for Medicaid in FY 1996. The majority of these were eligible because they were receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program. (The new welfare law, P.L. 104-193, breaks the 30-year old link between receipt of cash assistance and automatic eligibility for Medicaid for poor families).

There are some eligibility groups that States choosing to participate in Medicaid must cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal poverty level. There are also 13 statutory categories of individuals that States may elect to cover with the assistance of Federal Medicaid matching funds.

All Medicaid eligibles must have incomes and resources (i.e., savings and other assets) below specified levels. These levels are determined by the States within Federal guidelines, and they vary from State to State.

Meeting State income and resource standards is not sufficient to qualify for Medicaid. An individual must also fit into a covered eligibility category. Millions of poor Americans, including childless couples and single adults who are not aged or disabled, cannot receive Medicaid unless their States have obtained Federal demonstration waivers.

To qualify for Medicaid, individuals must, in general, be American citizens. Illegal aliens cannot qualify for Medicaid coverage except with respect to emergency care (including emergency labor and delivery). Legal resident aliens who entered the country before August 22, 1996, may, at State option, qualify.

## WHAT DOES MEDICAID COVER?

States that choose to participate in Medicaid must cover a minimum set of benefits for certain populations. However, benefit packages vary from State to State due to the different ways in which States exercise their discretion under current law.

**Services that States must cover.** Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary:

- hospital care (inpatient and outpatient)
- nursing home care
- physician services (including abortion, but only when necessary to save the life of the mother or in cases of rape or incest)
- laboratory and x-ray services
- immunizations and other early and periodic screening, diagnostic, and treatment (EPSDT) services for children
- family planning services
- health center and rural health clinic services
- nurse midwife and nurse practitioner services

**Services that States may cover.** States have the option of covering additional services and receiving Federal matching funds for those services, which include:

- prescription drugs
- institutional care and community care for individuals with mental retardation
- home- and community-based care for the frail elderly
- dental care and vision care for adults

**Services must be adequate in amount, duration, and scope.** States have discretion to vary the amount, duration, or scope of the services that they cover, but in all cases the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." For example, a State may not limit coverage for inpatient hospital care or nursing home care to 1 day per year.

**Services must be comparable throughout the State.** States may not vary the amount, duration, or scope of services based on the individual's residence. For example, a State may not offer coverage for 30 hospital days per year to residents of urban areas but only 20 hospital days per year to residents of rural counties.

**States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, type of illness, or condition."** For example, States may not exclude individuals with AIDS from coverage for hospital care, or individuals with Alzheimer's from coverage for nursing home or home health care.

**States may impose nominal copayments on some services.** States may impose nominal copayments on prescription drugs and certain other non-emergency services, except with respect to children, pregnant women, and nursing home residents.

## THE COST OF THE MEDICAID PROGRAM

**Federal Medicaid spending in FY 1996 was \$91.8 billion, about \$4 billion less than CBO had projected.** In April, 1996, CBO projected Federal Medicaid spending at \$95.7 billion for FY 1996. Actual Federal spending for FY 1996 was \$91.8 billion, in part because the number of eligibles did not grow as fast as CBO had anticipated, perhaps because of the strong national economy.

**Overall Federal Medicaid spending increased 3 percent.** In April, 1996, CBO projected that Federal Medicaid spending would rise 7.5 percent between FY 1995 and FY 1996. The actual increase was 3 percent, from \$89.1 billion to \$91.8 billion.

**The CBO Medicaid baseline for FY 1997 through FY 2002 will drop at least \$28 billion.** CBO's current projection of Federal Medicaid spending under current law over the next 7 years was issued in April, 1996. CBO will not formally revise its Medicaid baseline until January, 1997. However, CBO analysts have indicated that the \$4 billion in Federal spending that the current CBO baseline overestimates for FY 1996 will be taken out of its January, 1997, baseline; as a result, CBO's projection of Federal Medicaid spending over the next 7 years will drop at least \$28 billion.

**Most -- about 70 percent -- of the growth in Federal Medicaid spending is caused by an increase in the number of eligible Americans and inflation in the price of medical and long-term care services that Medicaid buys.** According to CBO, in 1995 there were four causes for the increase in Federal Medicaid spending:

- an increase in the number of low-income Americans eligible for the program
- inflation in the price of the hospital, nursing home, physician, and other services that Medicaid buys
- State payments to disproportionate share (DSH) hospitals
- other factors, such as the use of covered services by eligible beneficiaries, and State decisions as to whether to cover optional benefits or services.

The first two causes, CBO estimated, explained about 41 and 31 percent, respectively, of the growth in Federal Medicaid spending in 1995. State payments to DSH hospitals accounted for only about 3.5 percent; all other factors explained the other 24 percent.

**Double-digit Medicaid cost increases are a historical artifact.** Republicans typically cite the experience between 1988 and 1993, when, according to CBO, Federal Medicaid spending grew at an average annual rate of 19.6 percent. Reforms enacted by Congress in 1991 and 1993 curbed the principal source of these increases: the exploitation, by some States, of Federal matching payments to "disproportionate share" (DSH) hospitals and provider-based financing schemes. Federal Medicaid spending increases are unlikely to stay as low as 3 percent each year, if only because the number of beneficiaries is likely to rise more rapidly than that during periods of economic downturn. However, persistent double digit increases are equally implausible.

## WHO PAYS FOR MEDICAID?

**Medicaid is paid for by Federal and State governments.** Unlike Medicare, which is financed by the Federal government and Medicare beneficiaries (through premiums), Medicaid is paid for by Federal and State governments (some States require their localities to contribute toward the State share). The Federal government matches State Medicaid spending for covered services on behalf of eligible populations. Most Medicaid beneficiaries do not pay premiums because they are unable to afford them.

**State participation in Medicaid is voluntary.** Federal Medicaid law does not require any State to participate in the program. However, if a State chooses to participate, it is entitled to receive Federal matching payments for its spending on covered services for eligible populations. All States have chosen to participate (the last State to join the program, Arizona, did so in 1982).

**On average, the Federal government pays 57 percent of the costs of the Medicaid program.** The Federal share of the cost of Medicaid is at least 50 percent in every State and can reach 83 percent, depending on a State's per capita income (relatively poorer States receive a higher matching rate). On average, the Federal share is at least 57 percent (due to what GAO has called "illusory" financing arrangements in some States, the actual Federal share is higher).

**Medicaid is far and away the single largest source of Federal funds to the States, and represents 40 percent of all Federal grants-in-aid to States.** In FY 1996, the Federal Medicaid matching payments to States totalled \$92 billion, or nearly 40 percent of the \$238 billion in Federal grants-in-aid to the States. Federal Medicaid payments dwarfed those for highways and mass transit (\$25.2 billion), education (\$13.3 billion), housing (\$12.4 billion), and food stamps (\$29.8 billion) and welfare (\$16.9 billion).

**About half of all Medicaid spending is for populations and services that are not mandatory.** As a condition of participating in Medicaid, States are required to cover certain populations (e.g., pregnant women below 133 percent of poverty) and certain services (e.g., medically necessary physician care). However, States also have the option of covering populations and services that are not mandatory and receiving Federal matching funds to help pay for the cost of this coverage. About half of all Medicaid spending is for populations or services that States are not required to cover.

**In FY 1995, States headed by Republican Governors received over three fourths of all Federal Medicaid dollars, and nearly four fifths of all Federal Medicaid DSH spending.** The accompanying table shows the amount of Federal Medicaid matching payments each State received during FY 1995, as well as the amount of Federal Medicaid matching funds for payments to "disproportionate share" (DSH) hospitals. States with Republican Governors in 1995 received 76.6 percent of all Federal Medicaid matching funds and 79.7 percent of all Federal DSH matching payments.

## DISTRIBUTION OF FEDERAL MEDICAID FUNDS FY 1995

(Dollars in thousands)

State	Total Federal Payments	Federal Payments as % of National Total	Federal DSH Payments	Federal DSH as % of Total DSH
Alabama	1,394,059	2%	294,099	3%
Alaska	177,091	less than 1%	10,059	less than 1%
Arizona	1,112,131	1%	81,268	1%
Arkansas	898,204	1%	2,391	less than 1%
California	8,603,803	10%	1,095,718	11%
Colorado	840,222	1%	92,571	1%
Connecticut	1,290,554	1%	204,467	2%
Delaware	178,557	less than 1%	3,535	less than 1%
District of Columbia	394,702	less than 1%	23,120	less than 1%
Florida	3,491,022	4%	188,078	2%
Georgia	2,244,233	3%	254,569	3%
Hawaii	337,807	less than 1%	unknown	unknown
Idaho	252,325	less than 1%	1,460	less than 1%
Illinois	3,132,830	4%	201,734	2%
Indiana	1,317,242	2%	124,284	1%
Iowa	744,861	1%	3,833	less than 1%
Kansas	572,952	1%	51,979	1%
Kentucky	1,509,374	2%	136,549	1%
Louisiana	3,037,495	3%	865,245	9%
Maine	605,919	1%	104,646	1%
Maryland	1,282,901	1%	71,550	1%
Massachusetts	2,501,409	3%	287,645	3%
Michigan	3,013,317	3%	248,972	3%
Minnesota	233,416	less than 1%	16,009	less than 1%
Mississippi	1,231,773	1%	143,493	1%
Missouri	1,697,659	2%	436,415	4%
Montana	262,959	less than 1%	168	less than 1%
Nebraska	408,115	less than 1%	4,000	less than 1%
Nevada	238,628	less than 1%	36,780	less than 1%
New Hampshire	382,680	less than 1%	52,350	1%
New Jersey	2,567,168	3%	547,057	5%
New Mexico	592,138	1%	4,944	less than 1%
New York	12,323,482	14%	1,511,935	15%
North Carolina	2,450,917	3%	277,784	3%
North Dakota	211,647	less than 1%	827	less than 1%
Ohio	3,862,723	4%	382,301	4%
Oklahoma	841,519	1%	16,317	less than 1%
Oregon	960,995	1%	19,566	less than 1%
Pennsylvania	4,197,870	5%	521,376	5%
Rhode Island	566,799	1%	61,539	1%
South Carolina	1,448,377	2%	310,952	3%
South Dakota	221,120	less than 1%	730	less than 1%
Tennessee	2,229,545	3%	unknown	unknown
Texas	5,716,963	7%	957,899	10%
Utah	427,232	less than 1%	3,324	less than 1%
Vermont	219,164	less than 1%	17,583	less than 1%
Virginia	1,071,279	1%	33,989	less than 1%
Washington	1,587,788	2%	174,392	2%
West Virginia	972,244	1%	64,044	1%
Wisconsin	1,540,917	2%	6,581	less than 1%
Wyoming	111,154	less than 1%	unknown	unknown
<b>Total:</b>	<b>87,509,281</b>	<b>100%</b>	<b>9,950,127</b>	<b>100%</b>

SOURCE: Data reported by the States to the Health Care Financing Administration.

## WHAT DIDN'T HAPPEN TO MEDICAID DURING THE 104TH CONGRESS?

During the 104th Congress, three major proposals were advanced to cut Federal Medicaid spending: the Republican Medicaid block grant, the President's "per capita cap" proposal, and the Coalition's "per capita cap" proposal. None of these was enacted. However, the 104th did enact a welfare block grant (P.L. 104-193) and restrictions on benefits for legal immigrants (P.L. 104-208); the impact of these changes on Medicaid are discussed in a Democrat's Guide to Medicaid-related Legislation in the 104th Congress (November, 1996).

Although they were not enacted, the three major Medicaid proposals were "scored" by the Congressional Budget Office, which estimated that the 1996 version of the Republican block grant would cut Federal Medicaid spending over 6 years by \$72 billion, the President's plan by \$54 billion, and the Coalition's by \$67 billion. However, these differences in the level of cuts achieved are dwarfed by the differences in the structural changes they would make in Medicaid:

- **Entitlement.** The Republican proposal would repeal the individual Medicaid entitlement and replace it with a new block grant to the States; the President and the Coalition would retain the current individual entitlement.
- **Limits on Federal Matching Payments.** The Republican proposal would set a fixed annual limit on the amount of Federal Medicaid funds available nationally for distribution among the States in the form of block grants, supplemented with a small "umbrella" fund for States with high population growth. In contrast, the President's and the Coalition's plan, recognizing that people, not States, get sick, would limit the annual rates of increase in Federal Medicaid payments to each State on a "per capita" (i.e., per beneficiary) basis.
- **Disproportionate Share (DSH) Hospital Payments.** The Republican proposal would repeal the current law requirement that States make payment adjustments to hospitals serving a "disproportionate share" of Medicaid and other low-income patients. The President's and Coalition's plans would revise, but not repeal, the current law requirement so as to reduce and retarget Federal "DSH" payments.
- **Provider Reimbursement.** Both the Republican and the President's proposals would repeal the "Boren" amendment; the Coalition plan would retain it.
- **Managed Care.** The Republican bill would repeal all current policy with regard to Medicaid managed care; the President's and the Coalition's plans would revise current policy while giving States more (but not unlimited) flexibility.
- **State Share.** The Republican bill would raise the minimum Federal matching rate from 50 to 60 percent. The President's and Coalition's plans would retain the current Federal-State matching arrangements.

## THE REPUBLICAN 1996 MEDICAID BLOCK GRANT: A BRIEF OVERVIEW

On May 22, 1996, Republicans in the House and Senate introduced bills (H.R. 3507, S. 1795) creating a welfare block grant and a Medicaid block grant. This is a summary of the major provisions of the Republican Medicaid block grant as reported by the House Budget Committee on June 13, 1996, as H.R. 3734 (H. Rept. 104-651).

**CBO Estimates.** According to CBO, the Republican bill would cut Federal Medicaid spending by \$71.7 billion over the six-year period FY 1997 - FY 2002. Nearly 70 percent of these cuts -- \$49.8 billion -- would occur in the last two years.

**Entitlement Repeal.** The Republican bill would repeal the current Medicaid individual entitlement effective October 1, 1996, and would instead entitle each State to a specified amount of Federal dollars each year. The bill specifies certain population groups and certain services which States receiving Federal block grant funds must "guarantee;" however, States have complete discretion with respect to the amount, duration, or scope of these "guaranteed" benefits offered to any particular individual, and the enforcement of these "guarantees" in Federal court is expressly prohibited.

**Limit on Federal Matching (Per Capita Cap).** The Republican bill would establish a block grant to the States for providing medical assistance to low-income individuals and families. The bill specifies, for each of the fiscal years 1997 through 2002, a precise amount of Federal dollars available nationally for the Medicaid block grant, as well as the formula for allocating these funds among the States. The bill also specifies the amount of supplemental funds to certain States for services provided to undocumented immigrants (\$3.5 billion over 5 years) and to Indians (\$500 million over 5 years). Finally, the bill provides a limited, one-time "supplemental umbrella allotment" to States with high population growth, estimated by CBO to cost about \$26 billion over 6 years, or 3 percent of the total Federal funding available to States under the bill.

**"DSH" Payments.** The Republican bill would repeal the current law requirement that States make payment adjustments to hospitals serving a "disproportionate share" of Medicaid and low-income patients. States would have complete discretion with respect to participation of these facilities in the program and levels of reimbursement, if any.

**Provider Reimbursement.** The Republican bill would repeal the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

**Managed Care.** The Republican bill would allow States to require eligible individuals to enroll in a managed care organization selected, regulated, and paid by the State.

**State Share.** The Republican bill raises the minimum Federal matching percentage to 60 percent and authorizes the Secretary to waive the current law limitations on State use of revenues from provider taxes and donations, effective FY 1998.

## THE PRESIDENT'S 1996 MEDICAID PROPOSAL: A BRIEF OVERVIEW

On May 24, 1996, OMB transmitted to the Congress the text of the bill implementing the President's balanced budget plan. This is a summary of the major provisions of the Medicaid title of that bill, which was not introduced.

**CBO Estimates.** In its April, 1996, analysis of the President's FY 97 budget, CBO estimated \$54 billion in reduced Federal Medicaid spending over the 6-year period FY 1997 - FY 2002. About \$35 billion, or nearly two thirds of this amount, was attributable to the imposition of a "per capita cap" on increases in Federal Medicaid matching payments; the remaining \$19 billion reflected net reductions in Federal payments to States for "DSH" (disproportionate share) hospitals.

**Entitlement.** The President's plan retains the current Medicaid individual entitlement, including the current minimum eligibility requirements, the current basic benefits requirements, and the current administrative due process and judicial protections.

**Limit on Federal Matching (Per Capita Cap).** The President's plan would impose, effective FY 1997, a 5 percent annual limit on the rate of increase in Federal Medicaid matching payments, determined on a per beneficiary basis for each State. This limit on the increase in Federal payments would not apply to payments for "DSH" hospitals, for low-income Medicare beneficiaries (QMBs), or for certain other types of expenditures.

**"DSH" Payments.** The President's plan would phase-in a reduction in the total amount of Federal Medicaid matching payments to "disproportionate share" hospitals nationally from \$10.7 billion in FY 1996 to \$4.0 billion by FY 2002. A portion of the Federal savings attributable to this change would offset the cost of 3 new grant programs established by the bill: \$11 billion over the FY 1997 - FY 2000 period to assist States and hospitals with the transition away from the current "DSH" policy; \$3.5 billion over the FY 1997 - FY 2001 period for 15 States with large numbers of undocumented immigrants; and \$3 billion over the FY 1997 - FY 2002 period in grants to Federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

**Provider Reimbursement.** The President's plan would repeal the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

**Managed Care.** The President's plan would allow States to require beneficiaries to enroll in a managed care plan that serves only Medicaid eligibles, so long as the beneficiary has a choice between 2 plans (except in rural areas).

**State Share.** The President's plan maintains the current law Federal-State matching formula as well as the current law limitations on State use of revenues from provider taxes and donations.

## THE COALITION'S 1995-6 MEDICAID PROPOSAL: A BRIEF OVERVIEW

During the budget process in both 1995 and 1996, the Coalition, a group of moderate and conservative Democrats in the House, offered an alternative to the Republican and the President's balanced budget proposals. This is a summary of the major provisions of the Medicaid portion of that balanced budget alternative.

**CBO Estimates.** In July, 1996, CBO estimated \$67.5 billion in net reductions in Federal Medicaid spending over the 6-year period FY 1997 - FY 2002. Of this amount, \$36.8 billion, about 55 percent, was attributable to the imposition of a per capita cap on increases in Federal Medicaid matching payments. The remaining \$30.7 billion reflected reductions in Federal payments to States for "DSH" (disproportionate share) hospitals, net of \$5 billion in direct payments to Federally qualified health centers (FQHCs) and rural health clinics (RHCs) for unfunded costs.

**Entitlement.** The Coalition's plan retains the current Medicaid individual entitlement, including the current minimum eligibility requirements, the current basic benefits requirements, and the current administrative due process and judicial protections.

**Limit on Federal Matching (Per Capita Cap).** The President's plan would impose, effective FY 1997, an annual limit (starting at 3.5 percent and declining to 1.0 percent) on the allowable rate of increase in Federal Medicaid matching payments, determined on a per beneficiary basis for each State. This limit on the increase in Federal payments would not apply to payments for "DSH" hospitals, for low-income Medicare beneficiaries (QMBs), or for certain other types of expenditures.

**"DSH" Payments.** The Coalition's plan would phase in a reduction in the total amount of Federal Medicaid matching payments to "disproportionate share" hospitals nationally from \$10.7 billion in FY 1996 to \$6.0 billion by FY 2002. A portion of the Federal savings attributable to this change would offset the \$5.0 cost of a new grant program to cover the unfunded costs of Federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

**Provider Reimbursement.** The Coalition's proposal would retain the current "Boren amendment" requirement that States pay "reasonable and adequate" rates for inpatient hospital and nursing home services covered under their Medicaid programs.

**Managed Care.** The Coalition's plan would allow States to require most beneficiaries to enroll in a managed care plan that serves only Medicaid eligibles, so long as the beneficiary has a choice between 2 plans (except in rural areas).

**State Share.** The Coalition's plan maintains the current law Federal-State matching formula as well as the current law limitations on State use of revenues from provider taxes and donations.

# MEDICAID-RELATED LEGISLATION IN THE 104TH CONGRESS:

## A DEMOCRAT'S GUIDE

(November, 1996)

The 104th Congress, which adjourned *sine die* on October 4, 1996, marked the failure of Republican efforts to repeal the Medicaid entitlement and replace it with a block grant to the States, and to cut Federal payments to the States by as much as \$182 billion over the next 7 years. The Republicans were, however, successful in enacting major changes in welfare and immigration policy that will have an impact on many Medicaid beneficiaries, on hospitals and clinics that serve low-income Americans, and on State Medicaid programs. In addition, the 104th Congress enacted a number of bills which include provisions affecting Medicaid, as well as a few minor Medicaid-specific bills.

This Guide reviews the Medicaid-related legislation enacted by the 104th Congress, as well as the significant legislation not enacted. It is designed to accompany the Democrat's Introduction to Medicaid and the Democrat's Briefing Book on Medicaid Issues for the 105th Congress, both of which are also available through the House Democratic Policy Committee.

Additional information on the major new enactments is available from the Congressional Research Service. Cost estimates and intergovernmental mandate estimates for these enactments are available directly from the Congressional Budget Office.

## **Table of Contents**

Medicaid-related Legislation Not Enacted in the 104th Congress

Republican Medicaid Cuts: A Scorecard for the 104th Congress

Medicaid-related Legislation Enacted in the 104th Congress

Medicaid-related Provisions in the Republican Welfare Law (P.L. 104-193)

Medicaid-related Provisions in the Illegal Immigration Law (P.L. 104-208)

Section 1115 Medicaid Waivers Granted During the 104th Congress

## MEDICAID-RELATED LEGISLATION NOT ENACTED BY THE 104TH CONGRESS

Despite their majority status in both the House and the Senate, the Republicans failed to enact their Medicaid repeal agenda in the 104th Congress.

### 1st Session (1995)

**Budget Resolution.** On June 29, 1995, the House and Senate adopted a budget resolution (H. Con. Res. 67) directing a cut in Federal Medicaid spending of \$182 billion over the 7-year period FY 1996 through FY 2002.

**Reconciliation.** On November 17, 1995, the House and the Senate adopted a budget reconciliation conference report (H.R. 2491, "The Balanced Budget Act of 1995") that, among other things, would have repealed the current Medicaid program and replaced it with a block grant to the States ("Medigrant") and cut Federal Medicaid spending by \$163.4 billion (under the March, 1995, CBO baseline) over the 7-year period FY 1996 through FY 2002. (Under the December, 1995, CBO baseline, the cut would have been \$133 billion). On December 6, 1995, the President vetoed H.R. 2491.

### 2nd Session (1996)

**NGA Medicaid Proposal.** On February 6, 1996, the National Governors' Association adopted a 6-page proposal entitled "Restructuring Medicaid." On May 22, 1996, Republicans introduced the "Personal Responsibility and Work Opportunity Act of 1996," (H.R. 3507, S. 1795), which contained a repeal of the Aid to Families with Dependent Children (AFDC) program as well as a repeal of the Medicaid program. The Medicaid repeal was titled the "Medicaid Restructuring Act of 1996." On May 29, 1996, Democratic Governors wrote to the Chairmen of the House and Senate committees of jurisdiction to inform them that "your Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year...."

**Budget Resolution.** On June 12 and 13, 1996, the House and Senate adopted a budget resolution for FY 1997 (H. Con. Res. 178) directing a cut in Federal Medicaid spending of \$72 billion over the 6-year period FY 1997 through FY 2002. In contrast to the FY 1996 resolution, this resolution called for the enactment of not one, but three separate reconciliation bills: one relating to welfare and Medicaid and tax relief; one relating to Medicare; and one relating to taxes and miscellaneous direct spending.

**Reconciliation.** On July 31 and August 1, 1996, the House and Senate adopted the conference report on the first reconciliation bill, H.R. 3734, from which the Republican "Medicaid Restructuring Act of 1996" was excluded. The legislation repeals the current AFDC program and replaces it with a block grant. The President signed H.R. 3734 on August 22, 1996 (P.L. 104-193).

**REPUBLICAN MEDICAID CUTS: A SCORECARD FOR THE 104TH CONGRESS**  
(Totals in billions, 7-year period: FY 1996 - FY 2002)

<b>Legislation Proposing Cuts in Federal Medicaid Spending</b>	<b>Amount of Cut Proposed</b>
FY 1996 Budget Resolution (6/29/95)	- \$182.0
FY 1996 Budget Reconciliation Conference Report (vetoed 12/6/95)*	- \$163.4
FY 1996 Budget Reconciliation Conference Report (reestimated under new CBO baseline, 12/11/95)*	- \$133.0
FY 1997 Budget Resolution (6/13/96)	- \$ 72.0
FY 1997 Budget Reconciliation ("Welfare and Medicaid Reform Act") (6/27/96)*	- \$ 71.7
 <b>Medicaid Cuts Enacted</b>	 <b>Amount</b>
Termination of SSI Benefits and Medicaid Coverage for Individuals Disabled by Alcoholism or Drug Abuse (Section 105(b) of P.L. 104-121) (3/29/96)*	- \$ 0.6
Welfare Law (P.L. 104-193)(8/22/96)*	- \$ 4.1

\*Final Congressional Budget Office estimates.

## MEDICAID-RELATED LEGISLATION ENACTED BY THE 104TH CONGRESS

**Abortion.** Both the Omnibus FY 1996 Appropriations Act (P.L. 104-134), and the Omnibus Consolidated Appropriations Act for FY 1997 (P.L. 104-208) contain "Hyde Amendment" language that prohibits the use of Federal Medicaid matching funds for any abortion except when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

**Administrative Simplification.** Section 262 of the "Health Insurance Portability and Accountability Act of 1996" (P.L. 104-191)(Kennedy-Kassebaum) directs the Secretary of HHS to adopt standards and data elements for "transactions" (e.g., eligibility, enrollment, claims processing) that will enable information to be exchanged electronically among Medicare, Medicaid, HMOs, and insurers. Under these standards, every health care provider and plan will have a unique identifier that will apply to most public and private payors, including Medicaid, thereby facilitating the identification and exclusion of fraudulent or abusive providers.

**Aliens.** For an overview of the changes affecting Medicaid eligibility of both illegal and legal aliens, see the summaries of the welfare law (P.L. 104-193) and the illegal immigration law (enacted in the omnibus FY 1997 appropriations legislation, P.L. 104-208) elsewhere in this Guide.

**California County Health Insuring Organizations.** This amends demonstration authority enacted in 1985 to enable county-operated health insuring organizations (HIOs) to serve beneficiaries in more than one county. This change will permit the enrollment of about 12,000 Medicaid beneficiaries living in Napa County into the Solano County HIO (P.L. 104-240, signed into law on October 8, 1996).

**Continuation of Medicaid Eligibility Standards for Families with Dependent Children.** Since the enactment of Medicaid in 1965, States that elect to participate have been required to extend Medicaid coverage to members of families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. Of the 36.8 million Americans eligible for Medicaid in FY 1996, 8.8 million are children up to age 18, and 4.2 million are mothers or other adults in households receiving AFDC benefits. Under the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," H.R. 3734, the AFDC entitlement is repealed effective October 1, 1996, and is replaced with a block grant to the States for "Temporary Assistance for Needy Families." Recipients of aid or assistance under this new block grant are not eligible for Medicaid on the basis of their receipt of cash or other assistance (although they may be eligible on some other basis). Section 114 of H.R. 3734 provides that States must extend Medicaid coverage to individuals who, now or in the future, would be eligible for cash assistance under the AFDC program in effect in the State as of July 16, 1996, whether or not those individuals are receiving assistance under the new

block grant. (For purposes of Medicaid eligibility, States have the option of lowering their AFDC income standards to those in effect as of May 1, 1988). H.R. 3734 was signed into law on August 22, 1996 (P.L. 104-193). For additional information, see the summary of P.L. 104-193 elsewhere in this Guide.

**FY 1996 and First Quarter FY 1997 Funding.** Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to States for the last 3 quarters of FY 1996 was contained in the 7th continuing resolution for FY 1996, H.R. 1358, which was signed into law on January 6, 1996 (P.L. 104-91). Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to the States for the last quarter of FY 1996 for unanticipated costs incurred for FY 1996, and for matching payments for the first quarter of FY 1997, was contained in the Omnibus FY 1996 Appropriations bill, H.R. 3019, signed into law April 26, 1996 (P.L. 104-134).

**FY 1997 and First Quarter FY 1998 Funding.** Budget authority for the Secretary of HHS to make Federal Medicaid matching payments to States for FY 1997 and the first quarter of FY 1998 is contained in the Omnibus Consolidated Appropriations Act for FY 1997, H.R. 4278, signed into law on September 30, 1996 (P.L. 104-208).

**Fraud and Abuse.** The "Health Insurance Portability and Accountability Act of 1996" (P.L. 104-191)(Kennedy-Kassebaum) contains a major expansion in Federal civil and criminal fraud and abuse authorities, several of which directly affect Medicaid. Section 201(a) authorizes and appropriates additional funding to the DHHS Inspector General for FY 1997 and each subsequent fiscal year in order to expand the enforcement of fraud and abuse laws with respect to Medicare and Medicaid. Section 221 directs the Secretary of HHS to establish, by January 1, 1997, a national health care fraud and abuse data bank which contains information on "adverse actions" (e.g., civil judgments, criminal convictions, exclusions) taken against health care providers by Medicaid, Medicare, other Federal health care programs, as well as private health plans. Section 231(h) creates a new civil monetary penalty for offering inducements to Medicaid beneficiaries to receive services from a particular provider or managed care plan. Section 231(d) increases the burden that prosecutors must meet in establishing the liability of providers for civil monetary penalties under Medicaid (and Medicare) by requiring a showing that an individual acted with "deliberate ignorance or reckless disregard" of the truth or falsity of the information provided.

**Line-Item Veto (Enhanced Recission).** S. 4, the Line-Item Veto Act, gives the President the authority to "cancel in whole... any item of new direct spending" (including Medicaid expansions). The President's cancellation is effective unless disapproved by the Congress in a disapproval bill signed by the President or enacted over his veto. This new Presidential authority is effective with respect to laws enacted on or after January 1, 1997. S. 4 was signed into law on April 9, 1996 (P.L. 104-130).

**Louisiana Enhanced Federal Matching Rate.** Section 519 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, raises the Federal Medicaid matching rate for the

State of Louisiana. If the State elects, it may receive an effective Federal matching rate higher than its current 71.9 percent: 84.3 percent for the 9-month period ending 6/30/96; 81.6 percent for the 12-month period 7/1/96 through 6/30/97; and, subject to subsequent appropriations acts, 78.2 percent for the 12-month period 7/1/97 through 6/30/98. In order to qualify for these higher matching rates, the State would have to agree to a specified limit on the amount of Federal Medicaid matching funds it could draw down during each of these periods. All existing Federal Medicaid requirements relating to eligibility, benefits, reimbursement, etc., would continue to apply; however, eligible individuals and providers would have an individual entitlement only against the State, not against the Federal government. The Omnibus Consolidated Appropriations Act for FY 1997, P.L. 104 - 208) did not authorize the election of the 78.2 percent matching rate for the 12-month period 7/1/97 though 6/30/98.

**Managed Care "75-25" Rule Waivers.** Five managed care plans have received statutory waivers of the current 75 percent/25 percent public/commercial enrollment mix requirement for Medicaid managed care contractors: the Dayton Area Health Plan (P.L. 104-87, signed on December 29, 1995); D.C. Chartered Health Plan, Inc. (Section 517 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134); and Fidelis Health Plan of New York, Managed Healthcare Systems of New York, and Health Partners of Philadelphia (P.L. 104-267, signed into law on October 9, 1996).

**Medicare-Medicaid Coverage Data Bank Repeal.** Under current law (section 1144 of the Social Security Act), the Secretary is required, effective January 1, 1994, to establish a data bank to collect information from employers regarding the employees covered under their group health plans; this information is to be used to identify third parties (e.g., insurers and managed care plans) responsible for payment for health care services received by Medicare and Medicaid beneficiaries. This legislation (H.R. 2685) repeals the current law requirement (P.L. 104-226, signed into law October 2, 1996).

**New Hampshire (and certain other States).** Section 214 of the Omnibus FY 1996 Appropriations Act, P.L. 104-134, directs the Secretary of HHS to pay Federal Medicaid matching funds to States, up to a limit of \$54 million, in connection with certain reimbursements to State-operated psychiatric hospitals and contracting providers with respect to which the Secretary had notified the State of an intent to defer matching payments. The largest of the claims at issue is that of New Hampshire (\$44.7 million).

**Nursing Home Resident Review.** This legislation (H.R. 3632) repeals the Medicaid requirement that nursing home residents with mental illness or mental retardation be reviewed annually by a State agency to determine whether continued nursing home placement is necessary. The legislation requires that nursing facilities participating in Medicaid promptly notify State officials of a significant change in the physical or mental condition of a resident with mental illness or mental retardation, and requires that, promptly after receiving such notification, the appropriate State agency review the need for continued placement of the resident in the nursing home (P.L. 104-315, signed into

law on October 19, 1996). (A companion bill, H.R. 3633, relating to nurse aide training programs, was not enacted).

**Physician Quality Requirements: Technical Corrections.** Under current law, in order to qualify for Medicaid reimbursement for physician services delivered to children or pregnant women, a physician must meet at least one of six different quality criteria other than licensure by the State. One of these criteria relates to certification by a medical specialty board; the legislation (H.R. 1791) clarifies that this includes certification by specialty boards recognized by the American Osteopathic Association. The legislation also adds a seventh qualifying criterion: delivery of services in the emergency department of a hospital participating in Medicaid. Finally, the legislation provides that physicians may qualify for Medicaid reimbursement if they are certified by the State in accordance with policies of the Secretary (P.L. 104-248, signed into law on October 9, 1996).

**Termination of Medicaid Coverage for Certain Disabled Children.** Section 211 of H.R. 3734 (the welfare bill, P.L. 104-193) narrows the current law definition of disability for purposes of establishing the eligibility of children for cash assistance under the Supplemental Security Income (SSI) program. Children could no longer establish eligibility for SSI disability benefits based on an individualized functional assessment, and maladaptive behavior would be removed from the regulatory medical listings used to establish whether a child has a medically determinable physical or mental impairment of sufficient severity to qualify. In some cases, children who now qualify for Medicaid based on their eligibility for SSI benefits, and who lose SSI as a result of the changes made by the bill, would not be able to reestablish their eligibility for Medicaid on some other basis (such as poverty status), and would therefore lose coverage.

**Termination of Medicaid Coverage for Certain Legal Aliens.** Section 403 of H.R. 3734, the welfare law (P.L. 104-193), bars most legal aliens who enter the country on or after August 22, 1996, from receiving Medicaid coverage (other than with respect to the treatment of emergency medical conditions) for 5 years from the date of entry. Section 402(b) of H.R. 3734 gives States the option of denying Medicaid coverage (other than with respect to the treatment of emergency medical conditions) to most legal aliens, including those now residing in the U.S. who are currently covered. The illegal immigration law, enacted as part of the Omnibus Consolidated Appropriations Act for FY 1997 (P.L. 104-208), contains additional provisions affecting the eligibility of legal aliens for Medicaid; see the summary of this bill elsewhere in this [Guide](#).

**Termination of Medicaid Coverage for SSI Recipients Due to Alcoholism or Drug Addiction.** Section 105(b) of H.R. 3136 (P.L. 104-121) terminates Supplemental Security Income (SSI) benefits for individuals who are eligible on the basis of disability and for whom alcoholism or drug addiction is a "contributing factor" material to a determination of disability. For new applicants, this policy is effective on enactment (March 29, 1996); for current beneficiaries, it is effective 1/1/97. There is no provision for continued Medicaid coverage for individuals terminated from SSI on this basis.

CBO estimates that the Federal government will save \$650 million over the next 7 years in Federal Medicaid matching funds as a result of the loss of Medicaid coverage by some 40,000 to 50,000 individuals each year.

**Transfer of Assets Criminalization.** Section 217 of the "Health Insurance Portability and Accountability Act of 1996," H.R. 3103 (Kennedy-Kassebaum) makes it a crime, effective January 1, 1997, to "knowingly and willfully" dispose of assets in order to qualify for Medicaid if the disposal would result in the imposition of a period of ineligibility for Medicaid. Under prior law (which remains in effect), individuals who, within 3 years prior to application for benefits (5 years in the case of trusts), dispose of assets for less than fair market value in order to qualify for Medicaid nursing home coverage are subject to a period of ineligibility for Medicaid. The effect of section 217 is to subject these same individuals to the possibility of criminal prosecution in addition to the period of ineligibility for Medicaid. H.R. 3103 was signed into law (P.L. 104-191) on August 21, 1996.

**"Unfunded Mandates."** The Unfunded Mandates Reform Act of 1995, P.L. 104-4, signed into law on March 22, 1995, establishes points of order against in both the House and the Senate against legislation that would increase the direct costs of "Federal intergovernmental mandates" by an amount in excess of certain thresholds, unless the legislation provides full Federal funding for the excess costs. Although participation in the Medicaid program is voluntary with the States, and although the Federal government pays about 57 percent of the program costs, P.L. 104-4 defines as a "Federal intergovernmental mandate" any amendment to the Medicaid program that would either "increase the stringency of conditions of assistance to State governments" or "place caps upon or otherwise decrease" the Federal government's responsibility for funding the program, except where the States have the authority to "amend their financial or programmatic responsibilities to continue providing required services."

**Welfare.** For a summary of provisions affecting Medicaid eligibility of low-income mothers and children, legal aliens, and disabled children, see the discussion of the welfare law (P.L. 104-193) elsewhere in this Guide.

**"Welfare to Work" Transitional Medicaid Coverage.** Under current law, members of families that lose cash assistance under the AFDC program due to earnings are entitled to continued Medicaid coverage for up to 12 months after the loss of cash assistance, so long as the family continues to report earnings, and so long as the family's income does not exceed 185 percent of the poverty level. Section 114 of H.R. 3734, the welfare bill (P.L. 104-193), extends the sunset date for this 12-month transitional coverage, currently September 30, 1998, through September 30, 2001.

**SUMMARY OF MEDICAID-RELATED PROVISIONS IN  
REPUBLICAN WELFARE CONFERENCE REPORT (H.R. 3734)  
(P.L. 104-193, signed into law August 22, 1996)**

**CBO Estimates.** Over the 6-year period FY 1997 through FY 2002, CBO estimates that the conference report would reduce Federal Medicaid spending by a net of \$4.1 billion. This reflects total cuts of \$5.8 billion (\$5.3 billion attributable to the provisions relating to legal aliens and \$0.5 billion attributable to changes in the provisions relating to disabled children and child support enforcement), offset by new spending of \$1.7 billion (\$0.5 billion for State administrative costs relating to eligibility determinations and \$1.2 billion for the 3-year delay in the sunset of "welfare-to-work" transitional coverage).

**Medicaid Coverage of Mothers and Children.** In contrast to current law, under which mothers and children receiving cash assistance under the AFDC program are automatically eligible for Medicaid, receipt of cash or other assistance under the new welfare block grant would not be a basis for Medicaid eligibility. Instead, States would be required to extend Medicaid coverage to all mothers and children who meet the income and resource standards, and the family composition rules, in effect under the State's AFDC program as of July 16, 1996. As under current law, States would have the option of lowering their income standards to those in effect as of May 1, 1988. They could also use less restrictive methodologies in determining income and resources. State administrative costs attributable to these Medicaid eligibility determinations during the first 3 years of implementation of the welfare block grant would qualify for increased Federal matching funds as specified by the Secretary (subject to a limit of \$500 million over the period FY 1997 through FY 2000).

States would have the option of terminating Medicaid coverage for individuals (other than pregnant women and minor children who are not heads of households) receiving cash assistance under the new welfare block grant who lose their cash assistance because of refusing to work. The legislation's denial of benefits to individuals convicted of drug-related felonies is limited to the denial of welfare block grant and food stamp benefits, and would not extend to a denial of Medicaid coverage.

As under current law, mothers and children losing eligibility for Medicaid due to increased earnings from employment would be entitled to 12 months of transitional Medicaid coverage. Those losing eligibility for Medicaid due to collection of child support would be entitled to 4 months of transitional Medicaid coverage. The current law sunset of the 12-month "welfare to work" transitional Medicaid benefit would be extended from September 30, 1998, to September 30, 2001.

**Termination of Medicaid Coverage for Certain Legal Aliens.** (Note: some of these provisions were amended by the illegal immigration law (P.L. 104-208), described elsewhere in this Guide). The welfare legislation, P.L. 104-193, would bar Medicaid coverage (for all but the treatment of emergency medical conditions) to otherwise

eligible legal aliens who enter the U.S. on or after the date of enactment for a period of 5 years from the date of entry. This five-year bar would not apply to refugees, asylees, veterans, or active-duty members of the armed services.

In addition, States would have the option of denying Medicaid coverage (for all but the treatment of emergency medical conditions) to otherwise eligible legal aliens who entered the U.S. prior to enactment, or who entered on or after enactment but are no longer subject to the 5-year bar. This optional denial of Medicaid eligibility would not apply to permanent residents with a 10-year work history who did not receive public benefits during that time, to veterans or active duty members of the armed services, or, for 5 years after entry, to refugees or asylees. Current resident legal aliens now receiving Medicaid benefits could not be denied coverage until January 1, 1997.

The legislation would also bar legal aliens, whether currently in the U.S. or future entrants, from receipt of cash assistance under the Supplemental Security Income (SSI) program (subject to a transition period of up to one year for currently eligible aliens). Exempt from this prohibition are refugees and asylees (but only for 5 years), permanent residents with a 10-year work history who did not receive public benefits during that time, and veterans and active duty members of the armed services. Those legal aliens who are currently eligible for Medicaid based on their receipt of SSI benefits and who lose their SSI eligibility under this legislation may also lose their Medicaid coverage if they are unable to establish an alternative basis for eligibility.

For purposes of determining eligibility for Medicaid coverage (for all but the treatment of emergency medical conditions), the income and resources of all legal aliens entering the U.S. after enactment would be deemed to include the income and resources of sponsors and their spouses. (Sponsors of aliens entering after enactment would be required to sign legally enforceable affidavits of support obligating them to reimburse the State and Federal governments for Medicaid expenditures other than for treatment of emergency medical conditions on behalf of the aliens they are sponsoring).

**Termination of Medicaid Coverage for Certain Disabled Children.** The legislation would narrow the current law definition of disability for purposes of establishing the eligibility of children for cash assistance under the Supplemental Security Income (SSI) program. Under the legislation, children would be disabled for SSI purposes if they have a medically determinable physical or mental impairment which results in marked and severe functional limitations and has lasted (or can be expected to last) for 12 months or could result in death. Children could no longer establish eligibility for SSI disability benefits based on an individualized functional assessment, and maladaptive behavior would be removed from the regulatory medical listings used to establish whether a child has a medically determinable physical or mental impairment of sufficient severity to qualify. In some cases, children who now qualify for Medicaid based on their eligibility for SSI benefits, and who lose SSI as a result of the changes made by the bill, would not be able to reestablish their eligibility for Medicaid on some other basis (such as poverty status), and would therefore lose Medicaid coverage.

**SUMMARY OF MEDICAID-RELATED PROVISIONS OF THE  
ILLEGAL IMMIGRATION REFORM AND IMMIGRANT RESPONSIBILITY ACT  
(Enacted in P.L. 104-208, signed into law on September 30, 1996)**

The FY 1997 omnibus appropriations bill (P.L. 104-208) contains the "Illegal Immigration Reform and Immigrant Responsibility Act of 1996," which includes provisions that affect the Medicaid eligibility of both legal and illegal aliens. A number of these provisions amend similar provisions contained in the welfare law (P.L. 104-193) enacted one month earlier (August 22, 1996).

**CBO Estimates.** The Congressional Budget Office does not attribute any significant Federal savings or costs to the enactment of the public benefits provisions affecting aliens in P.L. 104-208. The previous CBO estimates with respect to the alien provisions in the welfare law (P.L. 104-193) remain unchanged (i.e., Federal Medicaid spending attributable to legal aliens would be reduced by \$5.3 billion over 6 years).

**Denial of Medicaid to Illegal Aliens.** Under the welfare law, P.L. 104-193, illegal aliens (generally, aliens who are not refugees, asylees, or lawfully admitted for permanent residence) are not eligible for Medicaid coverage except for services necessary for treatment of an emergency medical condition. (As under current law, States must provide coverage for treatment of emergency medical conditions for otherwise-eligible illegal aliens). The illegal immigration law in P.L. 104-208 amends the welfare law provisions to exempt from the general prohibition of Medicaid coverage illegal aliens who have been battered or subjected to extreme cruelty in the U.S. by a spouse or parent, so long as the individual responsible for the battery or cruelty does not reside in the same household.

**"Deeming" of Sponsor's Income and Resources.** The welfare law denies Medicaid coverage to most legal aliens who enter the U.S. on or after August 22, 1996, for a period of 5 years from the date they enter the country, except with respect to treatment of an emergency medical condition. The welfare law also requires that States, in determining the eligibility of a legal alien for non-emergency Medicaid services after the 5-year exclusion period, "deem" the income and resources of the alien to include the income and resources of a sponsor (and the sponsor's spouse) who has executed a affidavit of support meeting certain requirements.

The illegal immigration law replaces the welfare law's requirements relating to these affidavits of support with the following requirements. The affidavit must be a contract (1) in which the sponsor agrees to maintain the sponsored alien at an annual income of at least 125 percent of the Federal poverty level; (2) that is legally enforceable in Federal or State court against the sponsor by the Federal government, State Medicaid agencies, or health care providers that deliver Medicaid services to the sponsored alien; and (3) that is enforceable with respect to benefits provided to the sponsored alien until the date the alien is naturalized as a citizen, or, if earlier, until the alien has worked 40 qualifying calendar quarters for Social Security purposes.

In addition, the illegal immigration law also requires States to obtain from the sponsor reimbursement for the costs of providing any Medicaid benefits, including emergency care, to the sponsored alien. Finally, the illegal alien law also amends the welfare law's sponsor "deeming" requirements by carving out two limited exceptions: (1) in cases where the sponsored alien has been determined to be indigent due in part to lack of adequate support from the sponsor, and (2) in cases where the alien has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent, and the individual responsible for the battery or cruelty no longer resides in the same household.

**"Public Charge."** The welfare law does not speak to the issue of "public charge." The illegal immigration law provides that an alien who is seeking admission to the U.S. or is applying for permanent resident status is excludable from the U.S. if the individual "is likely at any time to become a public charge." This "public charge" test may, in the discretion of the Attorney General, be satisfied by the filing of an affidavit of support by a qualified sponsor. The legislation is silent as to whether receipt of emergency or non-emergency Medicaid benefits would trigger a finding that an individual is likely to become a "public charge." These new provisions do not apply to legal aliens residing in the U.S. before (at least) September 30, 1996.

**Exemption of Nonprofit Charitable Organizations from Verification Requirements.**

The welfare law directs the Attorney General to issue regulations requiring verification that individuals applying for non-emergency Medicaid services (and other "Federal public benefits") have legal immigration status. Within 2 years of issuance of these regulations, States administering Medicaid programs must comply. The illegal immigration law amends this provision by exempting any nonprofit charitable organization providing Medicaid benefits from a requirement to determine, verify, or otherwise require proof of eligibility of any applicant for Medicaid benefits.

**Federal Reimbursement for Costs of Emergency Care to Illegal Aliens.** Under current law, the Federal government matches, at the regular matching rates (57 percent on average), State Medicaid expenditures for emergency medical services for eligible illegal aliens. Under the illegal immigration law, States and localities are eligible for reimbursement by the Federal government for the costs of emergency care provided to illegal aliens through public hospitals and clinics after January 1, 1997, but only if: (1) the costs aren't otherwise reimbursed through Medicaid (including, presumably, Medicaid "disproportionate share" payment adjustments); (2) the hospital or clinic is unable to recover the costs from the alien or "another person;" (3) the immigration status of the alien has been verified (presumably by the hospital or clinic); and (4) the Federal funds are provided in advance through appropriations acts.

## SECTION 1115 MEDICAID WAIVERS GRANTED DURING THE 104TH CONGRESS

(October 30, 1996)

With the exception of the welfare block grant, the 104th Congress enacted no significant structural changes in Medicaid. Nonetheless, structural changes did occur as a result of administrative rather than legislative action. During 1995 and the first 10 months of 1996, the Secretary of Health and Human Services granted 8 States (Delaware, Illinois, Maryland, Massachusetts, Minnesota, Ohio, Oklahoma, and Vermont) waivers of Federal Medicaid requirements which enable them to make major changes in the delivery of services under their programs while continuing to receive Federal matching funds.

These "demonstration" waivers are granted by the Secretary of HHS under section 1115 of the Social Security Act and are required to be budget neutral (from the Federal government's standpoint) over their 5-year terms. In general, they apply on a statewide basis. (The Medicaid statute also authorizes the Secretary of HHS to grant "section 1915(b)" waivers to enable States to increase managed care enrollment and "section 1915(c)" waivers to enable States to offer home-and community-based services to individuals at risk of nursing home care).

Republican efforts during the 104th Congress to enact legislation directing the Secretary of HHS to approve section 1115 Medicaid waiver applications from Michigan (H.R. 3562) and Wisconsin (H.R. 3507) were unsuccessful.

All of the section 1115 Medicaid demonstrations maintain the current individual entitlement, the currently required eligibility categories, and the current Federal-State matching arrangements. Most of them affect hospital, physician, and other acute care services, not nursing home and other long-term care. Almost all of them enable States to require beneficiaries to enroll in managed care organizations that serve primarily or exclusively Medicaid enrollees.

**Operational States.** The following 10 States are operating statewide Medicaid demonstrations under section 1115 waivers: Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. (Florida, Kentucky, Maryland, Massachusetts, and Illinois have also received section 1115 waivers but were not operational as of October 1, 1996). California received a section 1115 Medicaid waiver to enable Los Angeles County to restructure its hospital and clinic system. The 10 States operating section 1115 statewide Medicaid waivers as of October 1, 1996, covered about 3 million beneficiaries, or about 8 percent of the 36.8 million Medicaid beneficiaries nationwide. About 500,000 of these were individuals who would not be eligible for Medicaid under traditional eligibility rules, but who are receiving coverage under the terms of their State's waiver.

A more detailed discussion of section 1115 statewide Medicaid waivers is found in the Democrat's Briefing Book on Medicaid Issues for the 105th Congress.

# A DEMOCRAT'S BRIEFING BOOK ON MEDICAID ISSUES FOR THE 105TH CONGRESS

(DRAFT, November 8, 1996)

During the 104th Congress, Congressional Republicans, urged on by the 32 Republican Governors, made repeated -- but unsuccessful -- efforts to repeal the Medicaid entitlement and replace it with a block grant. While the debate turned largely on whether the Republican Medicaid repeal would, as they asserted, have continued the "guarantee" of health care for the 36 million Americans now covered -- of course, it would not have -- their bill raised many other issues.

Whether the Republicans continue their efforts to repeal Medicaid in the 105th Congress remains to be seen. At a minimum, they can be expected to push for maximum control over Federal Medicaid funds, perhaps under the code of "entitlement reform" or "management flexibility." (Republicans control the Governorships in States that receive over 75 percent of all Federal Medicaid funds -- roughly \$70 billion in FY 1996).

The purpose of this Briefing Book is to help prepare Democratic Members and staff for the next Republican attack on Medicaid. Written by staff of the House Democratic Policy Committee, it summarizes 10 key Medicaid policy issues that arose during the 104th Congress and that are likely to resurface during the 105th.

This Briefing Book supplements A Democrat's Introduction to Medicaid and A Democrat's Guide to Medicaid-Related Legislation in the 104th Congress, both of which are also available through the House Democratic Policy Committee.

Obviously, there are far more than 10 important policy issues in a program that buys basic health and long-term care services for over 36 million Americans. Moreover, these 10 issue summaries are just that -- summaries. Additional information on these and other Medicaid issues can be obtained from:

- Center on Budget and Policy Priorities (202) 408-1080
- Congressional Budget Office (202) 226-2673
- Congressional Research Service (202) 707-5863
- Democratic Governors' Association (202) 479-5153
- General Accounting Office (202) 512-7114
- Health Care Financing Administration (202) 690-5960
- Kaiser Commission on the Future of Medicaid (202) 347-5270

## **. Contents**

**Boren Amendment**

**Children's Coverage**

**Disproportionate Share Hospitals (DSH)**

**Federal Matching Rate Formula**

**Federally Qualified Health Centers (FQHCs)**

**Flexibility**

**Managed Care**

**Provider Taxes**

**Qualified Medicare Beneficiaries (QMBs)**

**Section 1115 Medicaid Waivers**

## BOREN AMENDMENT

Named after its principal author, former Senator David Boren (D-OK), this provision of Federal Medicaid law requires States that elect to participate in Medicaid to pay for inpatient hospital services and nursing home care using rates that are "reasonable and adequate." This requirement does not apply to any other Medicaid-covered services. For almost all other Medicaid-covered services, there is no Federal minimum payment standard; the Medicaid statute requires only that payments to providers be "consistent with efficiency, economy, and quality of care," and that they be "sufficient to enlist enough providers so that care and services are available under the [State's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area." (The principal exception is the requirement that States pay 100 percent of the costs of services provided by Federally-qualified health centers and rural health clinics to Medicaid beneficiaries).

Nationally, inpatient hospital services account for about 18 percent of all Medicaid spending on services (1995) (about 28 percent if additional payments to "disproportionate share" (DSH) hospitals that are not mental hospitals are included). Nursing home services account for another 26 percent of all Medicaid spending (1995). Since the reimbursement rate is one important factor in determining these expenditure levels, the Boren amendment and its implementation are a central concern for the States. The amendment is also important to the nursing home industry, which on average receives about 50 percent of its revenues from Medicaid. While the hospital industry overall receives a lower percentage of its revenues from Medicaid (about 13 percent in 1994), some types of hospitals are highly dependent on Medicaid, including children's hospitals (45 percent of gross revenues in 1994), public hospitals (25 percent of net revenues in 1994), and teaching hospitals (15 percent of net revenues in 1994).

The enforcement of the Boren amendment against States through the Federal courts (by both hospitals and nursing homes) has led to calls from Governors for its repeal. At the same time, increasing Medicaid beneficiary enrollment in managed care is gradually achieving a *de facto* repeal of the Boren amendment with respect to hospitals, because as interpreted by HCFA, the amendment does not apply to inpatient hospital services delivered through Medicaid managed care plans.

**History.** Ironically, in light of current calls from Governors for its repeal in the name of State flexibility, the Boren amendment was originally enacted to give the States greater flexibility. Congress first enacted the Boren amendment in the 1980 budget reconciliation bill (P.L. 96-499), and applied it to nursing homes. Prior to OBRA '80, States were required to pay nursing homes on a reasonable cost-related basis using cost-finding methods approved and verified by the Secretary of HHS (at that time, Medicare was reimbursing skilled nursing facilities (SNFs) on a reasonable cost basis). The thrust of the Boren amendment was to move away from payment of "reasonable

cost" to payment through "reasonable and adequate" rates that were determined using methods developed by the State. The Congress extended this same policy to payment for inpatient hospital services in OBRA '81 (P.L. 97-35); prior to this change, States had been required to pay for Medicaid hospital services on the same retrospective, reasonable cost basis that the Medicare program was using, unless they obtained a waiver from the Secretary.

In OBRA '87 (P.L. 100-203), Congress established new minimum Federal quality standards for nursing homes participating in Medicaid, effective October 1, 1990. In doing so, Congress modified the Boren amendment to require that States adjust their Medicaid payment rates to nursing homes to reflect the facilities' costs of complying with the new standards (nursing homes receiving waivers of minimum nurse staffing requirements might find their rates adjusted downward). In OBRA '90 (P.L. 101-508), Congress clarified that the nature of these compliance costs, as reflected in the statutory language set forth below.

In 1990, the Supreme Court ruled that hospitals have the right to seek judicial review in Federal court of State compliance with the requirements of the Boren amendment, Wilder v. Virginia Hospital Association, 110 S. Ct. 2510 (1990). As a result, both hospitals and nursing homes dissatisfied with State Medicaid payment rates have sought relief from the Federal courts, or have used the threat of litigation in negotiations over payment rates with their State Medicaid agencies. According to information supplied by HCFA, between 1991 and 1995 alone there have been 27 reported Federal court decisions involving the Boren Amendment; about half of these involve hospitals, the other half, nursing facilities.

**Current Law.** The Boren amendment appears at section 1902(a)(13)(A) of the Social Security Act. Implementing regulations are found at 42 C.F.R. 447.253 and 42 C.F.R. 447.272 (upper payment limit). The "DSH" hospital payment rules appear at section 1923 of the Act.

**Hospitals.** The Boren amendment requires that States pay for inpatient (but not outpatient) hospital services delivered to Medicaid patients "through the use of rates (determined in accordance with methods and standards developed by the State...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality."

**"DSH" Hospital Payments.** The Boren amendment also requires that, in setting rates for inpatient hospital services, States use methods and standards that "take into account the situation of hospitals which serve a disproportionate number of

low income patients with special needs." This element of the Boren amendment has evolved into the Medicaid "Disproportionate Share (DSH) Hospital" program, which is summarized elsewhere in this Briefing Book).

**Nursing Homes.** The Boren amendment requires that States pay for nursing facility services (and services in an intermediate care facility for the mentally retarded (ICF/MR)) provided to Medicaid beneficiaries "through the use of rates...which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards...."

The Boren amendment further provides that the rates must be "determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of complying with ["nursing home reform" requirements relating to provision of services, residents' rights, and administration and other matters]."

In addition, in the case of nursing facilities that have received waivers of the minimum nurse staffing requirements in the "nursing home reform" provisions of the Medicaid statute, the Boren amendment requires that, in setting rates, the States provide for "an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care."

**Upper Payment Limit.** The Boren amendment essentially sets a floor Medicaid under payment rates for inpatient hospital and nursing home services. By regulation, 42 C.F.R. 447.272, HCFA has established aggregate ceilings on payments to these providers. Aggregate Medicaid payments in any year for inpatient hospital services, nursing facility services, and ICF/MR services may not, under these regulations, exceed the amounts that would have been paid for each of these groups of services under Medicare payment principles. (Medicaid payment adjustments to DSH hospitals are not subject to these aggregate ceilings; as discussed elsewhere in this Briefing Book, they are subject to separate facility-specific and State-specific caps).

**Managed Care.** As interpreted by HCFA, the Boren amendment applies only when a State Medicaid program pays a hospital directly for inpatient care. When Medicaid beneficiaries enroll (or are required to enroll) in a managed care organization (MCO) that contracts with the State to provide hospital care and other Medicaid-covered services, the only Federal requirement is that the State's payments to the MCO be made on "an actuarially sound basis." What the MCO in turn pays to its affiliated hospitals for delivering inpatient care to its Medicaid enrollees is a matter of negotiation between the MCO and the hospital; it could be more or less than the rate that would apply under the Boren amendment.

**CBO Estimates.** In April, 1995 CBO staff estimated that repealing the Boren amendment with respect to hospitals would reduce Federal Medicaid spending by a total of \$1.1 billion over 7 years (FY 1997 - FY 2002). Although it is not possible to predict how CBO might score this proposed policy change for the budget debate in 1997, it is unlikely that the estimated Federal savings would be any greater than \$1.1 billion, since the number of Medicaid eligibles receiving hospital services through managed care plans rather than on a fee-for-service basis has increased rapidly.

The same April, 1995 CBO staff estimate found that repealing the Boren amendment with respect to nursing homes would reduce Federal Medicaid spending by a total of \$1.3 billion over 7 years (FY 1997 - FY 2002). It is unknown what the CBO estimate of this proposed policy change would be for purposes of the budget debate in 1997.

**Most Recent Republican Proposal.** Under both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795), the current Boren amendment, as it applies both to inpatient hospital and nursing home services, would have been repealed. States receiving block grant funds would have had complete discretion with respect to whether a particular hospital or nursing home could participate in the block grant program (either as a fee-for-service provider or as a subcontractor to a managed care plan) and with respect to the amount of reimbursement that the hospital or nursing home would receive for inpatient services provided to eligible individuals (whether directly from the State or from a managed care plan). Both versions of the Republican Medicaid block grant would also have barred private rights of action by providers or beneficiaries, effectively prohibiting any hospital or nursing home from bringing suit in Federal court to enforce compliance by a State with any requirements under the block grant. Finally, both versions would have made any existing Federal court orders entered against States to remedy violations of the Boren amendment inapplicable to the States under the block grant and would have authorized the States to return to court to seek the abrogation of those orders.

## MEDICAID COVERAGE OF CHILDREN

Medicaid is a voluntary social contract. States can choose to participate or not. However, if States want Federal Medicaid matching dollars to help pay for nursing home and other long-term care expenses for their elderly and disabled residents, they must also extend basic health care coverage to certain categories of children (and pregnant women). Because all 50 States have opted to participate in this social contract, the Medicaid program is currently the health insurer for one fourth of all the children in America (18.6 million in FY 1996, according to CBO). Children represent about 50 percent of all Medicaid eligibles, but they account for less than 15 percent of all program spending. According to the Census Bureau, in 1995, about 10 million children under 18 -- nearly 14 percent of all children -- had no health insurance coverage whatsoever. In the absence of the Medicaid program, the number of uninsured children would be at least twice as high. None of these children -- whether insured or not -- is eligible to vote in State (or Federal) elections.

Of all the population groups that Medicaid covers, children are, on average, the least expensive. CBO estimates that, in FY 1996, the Federal government spent an average of \$820 per non-disabled child under Medicaid. This compares with an average of Federal Medicaid spending of \$2200 per beneficiary for all Medicaid eligibles that year, \$4850 per disabled individual, and \$5930 per elderly individual.

**History.** For most of the first 2 decades of Medicaid's existence (1965 - 1983), almost all children who qualified for Medicaid coverage were eligible because they were members of families receiving cash welfare under the Aid to Families with Dependent Children (AFDC) program. Beginning in the mid-1980's, and extending through 1990, the Congress enacted, over the objections of the Reagan and Bush Administrations, a series of incremental expansions in Medicaid coverage for children and pregnant women under which eligibility was based on Federally-determined minimum income standards, not on receipt of cash assistance (children in AFDC households continued to receive Medicaid coverage).

One of these incremental expansions is still being implemented. In OBRA '90 (P.L. 101-508), Congress extended Medicaid coverage to all children born after September 30, 1983, in families with incomes at or below the Federal poverty level (\$12,980 for a family of 3 in 1996). As of October 1, 1996, the oldest of these children turned 13; all poor children younger than 13 are covered. This mandatory coverage for children in poor families continues to be phased in for those older than 12, up to age 19, one year at a time. By the year 2002, Medicaid will cover all children under 19 living in families with incomes at or below the Federal poverty level. (According to CBO staff estimates, an additional 250,000 poor children per year are covered by Medicaid under this phase-in).

The welfare law (P.L. 104-193), signed on August 22, 1996, breaks the 30-year-

old linkage between receipt of AFDC cash assistance and eligibility for Medicaid. Whether a State, under its welfare block grant, decides to give cash assistance to a family will have no bearing on whether the children (or parents) in that family are eligible for Medicaid. Instead, the P.L. 104-193 requires States to provide Medicaid coverage to children (and parents) in families whose income and resources meet the State's AFDC income and resource standards as in effect on July 16, 1996, and who meet the AFDC family composition requirements in effect as of that date (i.e., a one-parent family with a minor child, or a two-parent family with a minor child in which the principal wage earner is unemployed). The purpose of this provision is to ensure that the loss of welfare benefits by a child under the new block grant does not result in the loss of Medicaid coverage if the child would have been eligible for AFDC prior to the enactment of the welfare law. Whether this objective is actually achieved as States implement their new welfare block grants remains to be seen.

**Current Law.** The current Medicaid coverage categories for children, both mandatory and optional, are set forth in section 1902(a)(10) of the Social Security Act; the "poverty-related" categories are found at section 1902(l). States are given the discretion to use more liberal methodologies for determining income and resource eligibility for certain categories of children in section 1902(r)(2). The new rules relating to Medicaid eligibility for children whose families would have qualified for AFDC cash assistance under previous law are found at section 1931.

States electing to participate in Medicaid must extend basic coverage to certain "mandatory" categories of children. They may also obtain Federal Medicaid matching funds to help pay for the cost of coverage of basic services for certain "optional" categories. From the child's (and parent's) point of view, there may be several pathways to eligibility for Medicaid coverage. In order to qualify, a child need only meet the requirements of one of the eligibility categories in effect in his or her State. Here are the major Medicaid eligibility categories for children:

**"Mandatory" Eligibles:**

- States must cover children up to age 6 with family incomes at or below 133 percent of the Federal poverty level (\$17,263 for a family of 3 in 1996). States are not required to apply a resource test to this population, and few do so.
- States must cover children up to age 19 born after September 30, 1983, with family incomes at or below 100 percent of the Federal poverty level (\$12,980 for a family of 3 in 1996). As of October 1, 1996, all of these children were at least 12 years old. States are not required to apply a resource test to this population, and few do so.
- States must cover children in families that meet the income and resource standards and family composition rules in effect under their State's AFDC plan as of July 16, 1996. Given that State AFDC payment standards averaged about

40 percent of poverty for a family of 3 in 1996, most of the children eligible for Medicaid under this category will also be eligible under one of the "poverty-related" categories described above. The practical effect of this particular requirement is to assure coverage for children aged 13 to 19 in families that meet their State's July 16, 1996, AFDC income and resource standards until the Medicaid coverage for all children in poverty has been completely phased in.

- States must either (1) cover disabled children receiving Supplemental Security Income (SSI) benefits or (2) cover disabled children who meet the Medicaid eligibility standards in effect in the State as of January 1, 1972. As of July 1, 1996, only 11 States had chosen not to extend Medicaid coverage automatically to children (and adults) receiving SSI benefits (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia).

#### **"Optional" Eligibles:**

- States have the option of receiving Federal Medicaid matching funds for covering "medically needy" children -- those with large, recurring medical expenses which, when applied against their family incomes, bring them below the "medically needy" income eligibility threshold set by the State. (In contrast, under the mandatory "poverty related" eligibility categories described above, children may not "spend down" into eligibility by incurring medical expenses; if a child's family countable income is \$1 above the relevant poverty level, the child is not eligible for Medicaid, no matter how high his or her medical care costs).
- States have the option of receiving Federal Medicaid matching funds for covering infants up to age 1 (and pregnant women) with family incomes above 133 percent of the Federal poverty level up to 185 percent of the poverty level (\$24,013 in 1996).
- States have the option of applying less restrictive "methodologies" for determining income (and resource) eligibility for "poverty-related" children. For example, in determining whether a family of 3 meets the income "standard" of poverty (\$1,082 per month), a State that wants to encourage work might choose to use a "methodology" which disregards the first \$541 per month of the family's earnings, allowing it to earn \$1,623 per month, or 150 percent of poverty, and still qualify). As of August, 1996, 13 States (Colorado, Connecticut, Delaware, Kansas, Maine, Minnesota, New Hampshire, New Mexico, North Carolina, North Dakota, Vermont, Washington, Wisconsin) had used this option to effectively raise their income eligibility standards for children (in varying age categories) to as high as 225 percent of poverty (Vermont).

**"Waiver Eligibles:"** Under section 1115 of the Social Security Act, the Secretary has the discretion to authorize States, as part of a demonstration project, to

receive Federal Medicaid matching funds for populations, including children, for which Federal matching is not available under current Medicaid law (Title XIX of the Act). As of October 1, 1996, the following States were operating section 1115 Medicaid waivers that extended Medicaid to some 564,000 "waiver eligibles," many of whom are children (Delaware, Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, and Vermont).

**Basic Benefits.** As the 1996 version of the Republican Medicaid block grant makes crystal clear, eligibility for coverage is meaningless unless the coverage itself has some content. Under current law, "mandatory" eligibles have an individual entitlement to have payment made on their behalf for the following services, when "medically necessary:" hospital care (inpatient and outpatient), physicians' services, laboratory and x-ray services, family planning services and supplies, Federally-qualified health center (FQHC) and rural health clinic (RHC) services, pediatric or family nurse practitioner services, and early and periodic screening, diagnostic, and treatment (EPSDT) services. In general, States may impose limits on the amount, duration, or scope of covered services, but the service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." (42 C.F.R. 440.230(b)). However, States may not any impose amount, duration, or scope limitations on "Treatment" services for children to correct or ameliorate defects and physical and mental illnesses and conditions discovered by EPSDT screenings.

**Cost-Sharing.** Under current law, States may not impose deductibles, coinsurance, copayment, or similar cost-sharing requirements on any service with respect to Medicaid-eligible children under 18, whether the child qualifies under a "mandatory" or "optional" eligibility category, and whether or not the child is enrolled in a managed care organization (MCO). In addition, States may not impose any premiums with respect to coverage of children under 18 who qualify under a "mandatory" eligibility category; however, they may impose income-related premiums with respect to coverage of children who qualify for Medicaid under certain "optional" eligibility categories, such as the "medically needy."

**Medicaid and Private Health Insurance.** Some poor or near-poor children are covered as dependents under a health insurance policy offered through a parent's employer. This insurance coverage has no effect on the child's Medicaid eligibility, which depends solely on whether they meet the requirements of one of the above statutory requirements. However, the parent is required, as a condition of Medicaid eligibility for herself and the child, to assign to the State Medicaid agency any right to insurance payments under such a policy and to cooperate with the State in recovering payments from the health insurer.

**Implementation.** Medicaid does not cover all poor children in America; the Census Bureau reports that, in 1995, over 3 million poor children (about one fifth of all poor children) had no Medicaid coverage and no private health insurance coverage. There are two main reasons. First, a significant number of children who meet the Medicaid eligibility standards in effect in their States do not participate in the program. (GAO

recently reported that, in 1994, 2.9 million children -- about 30 percent of uninsured children that year -- were eligible for Medicaid but did not receive it). Secondly, while States can receive Federal matching funds for covering all poor children under 19, they are not currently required to do so, and many of them do not. (As discussed above, coverage for all poor American children under 19 is being phased in one year at a time; as of October 1, 1996, all poor children under 13 were covered).

The accompanying chart shows the August, 1996 income eligibility thresholds in each State for 4 groups: pregnant women and infants; children under 6; children age 6 through 12; and children age 13 through 18. Over half the States (26) have elected to cover infants (and pregnant women) with family incomes up to 185 percent of poverty or above. Ten States have chosen to raise their income standards for children under 6 above the 133 percent of poverty required under current law. Ten States have established income thresholds for children age 6 through 12 higher than the 100 percent of poverty required under current law. Finally, 21 States have opted to set Medicaid income standards for children age 13 through 18 at levels higher than those under their former AFDC programs. In all cases, States with higher than minimum eligibility standards receive Federal Medicaid matching funds for the costs of covering those children made eligible as a result.

Increasingly, Medicaid coverage for children equates to enrollment, often mandatory, in managed care organizations (MCOs), many of which serve only or primarily Medicaid patients. Concerns have been raised by journalists and child health advocates regarding the quality and accessibility of covered services, including EPSDT services, for Medicaid-eligible children in some MCOs.

**Most Recent Republican Proposal.** The two Republican efforts to repeal Medicaid during the 104th Congress and replace it with a block grant to the States would have left many, if not most of the 18 million children now covered by Medicaid uninsured.

Under the 1996 version of the Republican Medicaid block grant (H.R. 3507, S. 1795), the current Federal entitlement to coverage for basic health care benefits for all Medicaid-eligible children would have been repealed, effective October 1, 1996. States would have been required to provide coverage for a so-called "guaranteed benefits package" to certain categories of children (e.g., those under 6 with family incomes at or below 133 percent of the poverty level, those aged 6 to 12 (phased in to 19) with family incomes at or below 100 percent of the poverty level). The so-called "guaranteed benefit package" would have included inpatient and outpatient hospital services, physician care, and early and periodic screening and diagnostic (EPSD) services (without the current "Treatment" component). However, eligible children would not have been entitled under Federal law to coverage for any services. Moreover, States would not have been required to cover these so-called "guaranteed services" when medically necessary, and States would have had complete discretion in determining the amount, duration, and scope of any of the benefits in the so-called "guaranteed benefit package" (e.g., 2 days of hospital care per year, etc).

## MEDICAID COVERAGE OF CHILDREN

(August 1996 Income Eligibility Thresholds as a percentage of the Federal Poverty Guideline)

State	Infants	Children to Age 6	Children 6 to 13	Children 13 to 19
Alabama	133%	133%	100%	15%
Alaska	133%	133%	100%	76%
Arizona	140%	133%	100%	32%
Arkansas	133%	133%	100%	19%
California	200%	133%	100%	100%
Colorado	133%	133%	100%	39%
Connecticut	185%	185%	185%	81%
Delaware	185%	133%	100%	100%
District of Columbia	185%	133%	100%	39%
Florida	185%	133%	100%	28%
Georgia	185%	133%	100%	100%
Hawaii	300%	300%	300%	300%
Idaho	133%	133%	100%	28%
Illinois	133%	133%	100%	35%
Indiana	150%	133%	100%	27%
Iowa	185%	133%	100%	39%
Kansas	150%	133%	100%	100%
Kentucky	185%	133%	100%	100%
Louisiana	133%	133%	100%	18%
Maine	185%	133%	125%	125%
Maryland	185%	185%	185%	35%
Massachusetts	185%	133%	100%	52%
Michigan	185%	150%	150%	45%
Minnesota	275%	133%	100%	48%
Mississippi	185%	133%	100%	34%
Missouri	185%	133%	100%	100%
Montana	133%	133%	100%	41%
Nebraska	133%	133%	100%	34%
Nevada	133%	133%	100%	32%
New Hampshire	185%	185%	185%	185%
New Jersey	185%	133%	100%	41%
New Mexico	185%	185%	185%	185%
New York	185%	133%	100%	61%
North Carolina	185%	133%	100%	100%
North Dakota	133%	133%	100%	100%
Ohio	133%	133%	100%	32%
Oklahoma	150%	133%	100%	28%
Oregon	133%	133%	100%	100%
Pennsylvania	185%	133%	100%	39%
Rhode Island	250%	250%	100%	51%
South Carolina	185%	133%	100%	19%
South Dakota	133%	133%	100%	100%
Tennessee	185%	133%	100%	54%
Texas	185%	133%	100%	17%
Utah	133%	133%	100%	100%
Vermont	225%	225%	225%	225%
Virginia	133%	133%	100%	100%
Washington	200%	200%	200%	200%
West Virginia	150%	133%	100%	100%
Wisconsin	185%	185%	100%	48%
Wyoming	133%	133%	100%	55%

NOTE: The 1996 Federal poverty guideline for a family of 3 is \$12,980; 133% of this income level is \$17,263; 185% of this income level is \$24,013. Data in column 4 for States below 100% poverty reflects AFDC payment standard for family of 3.

SOURCE: Data from National Governor's Association (August, 1996).

## DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Under current law, States electing to participate in Medicaid are required to make special Medicaid payments to hospitals serving a "disproportionate share" of low-income patients. These payments are in addition to the reimbursement these "DSH" hospitals receive from the Medicaid program for providing inpatient services to eligible individuals, and they are intended to help offset the costs these facilities incur in providing care to uninsured and under-insured low-income patients. Medicaid DSH payments can be particularly important to children's hospitals, public hospitals, and other hospitals with high volumes of Medicaid patients. However, a number of States (and localities) have also used the DSH payments, in combination with provider tax or intergovernmental transfer mechanisms, to increase the amount of Federal Medicaid matching funds flowing into the State (and locality) without a commensurate increase in State (or local) funding.

CBO estimates that, in FY 1996, Federal Medicaid matching funds for payments to DSH hospitals totalled \$10.7 billion, or 11.2 percent of total Federal Medicaid spending. Over the next 7 years, Federal Medicaid DSH spending is projected by CBO to rise at an average annual rate of 5 percent, to \$14.3 billion in FY 2002 (April, 1996 baseline). In the Medicaid proposals advanced by both the President and the Coalition in the House, reductions in Federal Medicaid DSH spending accounted for 35 percent and 45 percent, respectively, of the total reductions in Federal spending sought over 7 years.

**History.** Since 1981, Federal Medicaid law has required States to make payment adjustments to hospitals serving a disproportionate share of low-income patients. However, States did not begin to implement this requirement until the late 1980's, when a number of them seized on the "DSH" provisions, in combination with provider taxes or donations, as a mechanism for drawing down large amounts of Federal funds. Between 1988 and 1992, Medicaid DSH spending (Federal and State) climbed from \$449 million to \$17.5 billion, an average increase of 250 percent per year. Obviously, neither the number of true "disproportionate share" hospitals, nor the number of low-income patients they served, was increasing at that rate, so Congress intervened.

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), the Congress imposed State-specific caps on the total amount of Federal Medicaid matching funds a State could draw down for payments to DSH hospitals each year. In the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), the Congress imposed facility-specific caps on the amount of Medicaid DSH payments, set at the amount of costs a hospital incurs each year in serving Medicaid and uninsured patients that is not otherwise recovered from those patients. To ease the transition for certain "high disproportionate share" public hospitals, the Congress provided for a transition period to 1995 during which they could receive up to twice their uncompensated costs of operation in Medicaid DSH payments.

**Current Law.** The Federal DSH payment requirements are found at sections 1902(a)(13)(A) and 1923 of the Social Security Act. Implementing regulations have been issued, 42 C.F.R. 447.296 - 447.299.

Under the "Boren" amendment, States are required to reimburse hospitals for inpatient services at rates that are "reasonable and adequate," using methods and standards that "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." States have considerable discretion in determining which facilities qualify as DSH hospitals and what the amount of DSH payment adjustments to those hospitals should be. This discretion is not unlimited, however:

- States must, at a minimum, make Medicaid DSH payments to hospitals that either (1) have a high proportion of Medicaid inpatients (i.e., a Medicaid inpatient utilization rate that is at least one standard deviation above the mean for hospitals in the State), or (2) have a high proportion of Medicaid and charity care patients (i.e., a low-income utilization rate of at least 25 percent).
- States cannot treat a hospital as a Medicaid DSH hospital unless at least 1 percent of its inpatients are covered by Medicaid.
- A State may not receive more in Federal Medicaid matching funds for payment adjustments made to all DSH hospitals in the State in a year than a fixed dollar amount determined under a statutory formula. These State-specific dollar allotments are published annually in the Federal Register by HCFA.
- A State may not make Medicaid DSH payment adjustments to any specific DSH hospital in an amount greater than 100 percent of the cost incurred by that facility in providing inpatient or outpatient services to Medicaid beneficiaries or uninsured individuals, less the amount of Medicaid and other reimbursement the hospital recovers from those patients (other than Medicaid DSH payments).

**Implementation.** The accompanying table shows the distribution of Federal Medicaid DSH funds among the States in FY 1995 (information on the number and types of DSH hospitals by State, and the amount of Medicaid DSH payments these facilities receive, is unavailable):

- On average, Federal DSH payments represent about 11 percent of all Federal DSH spending; however, the variation from State to State is great. As a percent of total Federal matching payments, Federal DSH payments range from less than 1 percent in Arkansas, Montana, North Dakota, South Dakota, Wisconsin and Wyoming to 28 percent in Louisiana.
- Federal DSH spending is concentrated in certain States. The 10 States with the

largest amounts of Federal DSH payments (New York, California, Texas, Louisiana, New Jersey, Pennsylvania, Missouri, Ohio, South Carolina, and Alabama) account for about 75 percent of all Federal DSH spending.

**Most Recent Republican Proposal.** In the 1995 version of the Republican Medicaid block grant (contained in the budget reconciliation bill, H.R. 2491, vetoed by the President on December 6, 1995), all of the current Federal statutory provisions relating to DSH would simply have been repealed. States would have been required only to describe in their block grant plans what provisions, if any, were made for expenditures for hospitals with high low-income utilization rates; however, States would not have been required to allow these hospitals to participate in the program, to reimburse them at any particular level, or to make DSH payments to them or to any other facilities. In establishing the FY 1996 block grant allotments for each State, the Republican bill incorporated historical Federal DSH payments in each State's base funding level.

The 1996 version of the Republican Medicaid block grant, as reported out by the House Commerce and Senate Finance Committees (H.R. 3734, S. 1795) followed the same approach with respect to DSH as the 1995 version. This approach, which preserved for each State the historical Federal Medicaid DSH spending while at the same time repealing the requirement that these funds actually be spent on hospitals serving disproportionate numbers of low-income patients, was to the obvious benefit of the 10 States with 75 percent of all Federal Medicaid DSH payments. All but one of these States is headed by a Republican Governor.

## FEDERAL MEDICAID DSH PAYMENTS FY 1995

(Dollars in thousands)

State	Federal DSH Payments	Total Federal Payments	Federal DSH as % of Total Payments
Alabama	294,099	1,394,059	21%
Alaska	10,059	177,091	6%
Arizona	81,268	1,112,131	7%
Arkansas	2,391	898,204	less than 1%
California	1,095,718	8,603,803	13%
Colorado	92,571	840,222	11%
Connecticut	204,467	1,290,554	16%
Delaware	3,535	178,557	2%
District of Columbia	23,120	394,702	6%
Florida	188,078	3,491,022	5%
Georgia	254,569	2,244,233	11%
Hawaii	unknown	337,807	unknown
Idaho	1,460	252,325	1%
Illinois	201,734	3,132,830	6%
Indiana	124,284	1,317,242	9%
Iowa	3,833	744,861	1%
Kansas	51,979	572,952	9%
Kentucky	136,549	1,509,374	9%
Louisiana	865,245	3,037,495	28%
Maine	104,646	605,918	17%
Maryland	71,550	1,282,901	6%
Massachusetts	287,645	2,501,409	11%
Michigan	248,972	3,013,317	8%
Minnesota	16,009	233,416	7%
Mississippi	143,493	1,231,773	12%
Missouri	436,415	1,697,659	26%
Montana	168	262,959	less than 1%
Nebraska	4,000	408,115	1%
Nevada	36,780	238,628	15%
New Hampshire	52,350	382,680	14%
New Jersey	547,057	2,567,168	21%
New Mexico	4,944	592,138	1%
New York	1,511,935	12,323,482	12%
North Carolina	277,784	2,450,917	11%
North Dakota	827	211,647	less than 1%
Ohio	382,301	3,862,724	10%
Oklahoma	16,317	841,519	2%
Oregon	19,566	960,995	2%
Pennsylvania	521,376	4,197,870	12%
Rhode Island	61,539	566,799	11%
South Carolina	310,952	1,448,377	21%
South Dakota	730	221,120	less than 1%
Tennessee	unknown	2,229,545	unknown
Texas	957,899	5,716,963	17%
Utah	3,324	427,232	1%
Vermont	17,583	219,164	8%
Virginia	33,989	1,071,279	3%
Washington	174,392	1,587,788	11%
West Virginia	64,044	972,244	7%
Wisconsin	6,581	1,540,917	less than 1%
Wyoming	unknown	111,154	unknown
<b>Total:</b>	<b>9,950,127</b>	<b>87,509,281</b>	<b>11%</b>

SOURCE: Data reported by the States to the Health Care Financing Administration.

## FEDERAL MEDICAID MATCHING FORMULA

Medicaid is financed through Federal dollars matching State expenditures. If a State chooses to participate in Medicaid, it is entitled to have the amount of State funds it spends on behalf of eligible populations for covered services matched by the Federal government at a specified rate. In the case of State spending for acute and long-term care services, this rate, which is determined under a statutory formula described below, varies from 50 to 83 percent, depending on a State's per capita income. In the case of State spending for administration, the Federal matching rate is set at 50 percent, with exceptions for certain functions (such as nursing home inspections) that are matched at higher rates. On average, the Federal government pays at least 57 percent of the cost of the program. In reality, the Federal share is higher because of techniques that some States have used to substitute Federal dollars for the State dollars that should be used to draw down Federal Medicaid matching funds.

**History.** The current Medicaid matching formula was first enacted in 1965, when the program was created. Despite criticism of the formula from GAO and others for its dependence on per capita income, the formula has not been significantly altered since that time. The same matching formula was also used in the Aid to Families with Dependent Children (AFDC) program, which the welfare law (P.L. 104-193) repealed.

**Current Law.** The current matching formula, known technically as the Federal Medical Assistance Percentage (FMAP), is found at section 1905(b) of the Social Security Act.

The statutory formula for calculating each State's Federal matching rate is:

$$[1 - (\text{State per capita income}^2 / \text{National per capita income}^2) * .45]$$

Under this formula, a State's Federal Medicaid matching rate is based on the ratio of its per capita income to the average per capita income of all States. States with per capita incomes above the national average receive a lower Federal matching percentage; States with per capita incomes below the national average receive higher percentages. The formula is constructed so that the Federal government will never match less than 50 percent or more than 83 percent of a State's spending. The percentages are recalculated each Federal fiscal year based on State and national income data from the most recent 3-year periods.

This formula applies to State spending on all covered services except family planning services and supplies, for which current law specifies a Federal matching rate of 90 percent in all States.

Here's how Federal-State matching works. Say that a State has a Federal matching rate of 57 percent. If it spends \$100 on Medicaid services for eligible

individuals, the State is entitled to receive \$57 from the Federal government in Medicaid matching payments. The remaining \$43 is the State's share. If the State's rate increases to 70 percent, it will receive \$70 from the Federal government, and its share will be \$30.

**Implementation.** The accompanying table shows each State's Federal matching rates under the statutory formula for both FY 1996 and FY 1997. Eleven States and the District of Columbia, the majority of which are from the Northeast or Mid-Atlantic region, have statutory matching rates of 50 percent in FY 1997 (Alaska, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, and New York). Nine States, all of which are in the South or the West, have statutory matching rates of more than 70 percent in FY 1997 (Arkansas, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Utah, West Virginia).

In a number of instances, the statutory formula understates the actual proportion of the cost of a State's Medicaid program that the Federal government is assuming.

In the case of Louisiana, the effective Federal matching rate for most of FY 1996 was not the statutory formula rate of 71.9 percent, but 84.3 percent. For most of FY 1997, Louisiana's effective matching rate will be 81.6 percent, not the statutory formula rate of 71.4 percent. This matching rate enhancement was authorized in section 519 of the Omnibus FY 1996 Appropriations Act (P.L. 104-134).

The more common reason that some States have actual Federal matching rates higher than those determined under the statutory formula is that they have used what GAO calls "creative financing mechanisms," including intergovernmental transfers, provider taxes, and disproportionate share (DSH) hospital payments, to effectively replace State share funds with Federal matching funds. The GAO describes how one State used intergovernmental transfers to raise its effective Federal matching rate in FY 1993 from the statutory rate of 56 percent to an actual rate of 68 percent:

- ...Michigan's 1994 DSH program included a single \$489 million payment to the University of Michigan Hospital... This single payment included \$276 million in Federal matching funds and \$213 million in State funds. On the same day that it received the payment, the hospital returned the entire amount to the State through an intergovernmental transfer. As a result, the State realized a net benefit of \$276 million from the federal share of the DSH payment that the State could use to fund \$633 million in additional Medicaid payments. (GAO/HEHS-96-76R State Medicaid Financing Practices).

Although the Congress in 1991 and 1993 enacted restrictions on provider taxes and DSH payments to limit their use as "creative financing mechanisms," there are no direct restrictions on the use of intergovernmental transfers. However, the facility-specific caps on DSH payments enacted in OBRA '93 (limiting the total amount of DSH payments to the facility's uncompensated costs of serving Medicaid and uninsured

patients) has had the effect of limiting the use of intergovernmental transfers by some State and county hospitals.

**Most Recent Republican Proposal.** In the 1996 version of the Republican Medicaid block grant, H.R. 3507/S. 1795, States would be given three options for a Federal Medicaid matching rate (FMAP): (1) the current law FMAP; (2) a minimum FMAP of 60 percent; or (3) the lesser of (a) a new FMAP or (b) the current law FMAP plus 10 percentage points. The new FMAP would use a State's total taxable resources (TTR) rather than per capita income as a measure of State fiscal capacity, and would also include a measure of relative need for Medicaid spending.

The accompanying table shows estimates by the Congressional Research Service of the Federal matching rates that would apply in each State in FY 1996 under the Republican proposal, assuming each State chose the option most favorable to it. On average, the Federal share rises from 57 to 63 percent. Twenty-two States (and the District of Columbia) benefit from the option allowing them to increase in the minimum Federal share to 60 percent.

Of course, the Republicans proposed this change in the Federal matching formula in the context of a repeal of the current Medicaid entitlement and the enactment of a new block grant to the States. In the context of a block grant, raising the average Federal share from 57 to 63 percent of program costs does not result in increased Federal outlays, since the block grant itself puts an absolute limit on how much each State will receive in Federal matching payments each year. If this change in the Federal matching formula were proposed in the context of the current open-ended matching program, it could cost the Federal government tens of billions of dollars.

Raising the average Federal matching rate as the Republicans proposed in their block grant could drastically reduce the total State and Federal funds going to health and long-term care for the poor. This is because under a block grant, with its limit on the total Federal matching funds available, a higher Federal matching rate means that a State will be able to receive the same amount of Federal funds for a smaller State expenditure. Moreover, once the State hits its limit on available Federal block grant funds, every additional dollar it spends on Medicaid will bring in no new Federal funds. In short, the State has strong incentives to withdraw some of its current State funding.

For example, assume Federal matching payments under the Republican block grant are capped at \$100. If a State has a Federal matching rate of 50 percent, it can spend \$200 on Medicaid, with \$100 coming back from the Federal government in the form of matching payments. However, if, as the Republicans have proposed, the State's Federal matching rate is increased from 50 to 60 percent, then the State only has to spend \$66.67 in order to receive \$100 in Federal matching funds (the State spends \$166.67, of which 60 percent, or \$100, is matched by the Federal government). The change in the matching rate alone has reduced total Federal and State spending on Medicaid services for the poor by almost 17 percent: from \$200 to \$166.67.

## FEDERAL MEDICAID MATCHING RATES

State	Current FMAP FY 1996	Current FMAP FY 1997	Republican Block Grant FMAP FY 1996
Alabama	70%	70%	70%
Alaska	50%	50%	60%
Arizona	66%	66%	66%
Arkansas	74%	73%	74%
California	50%	50%	60%
Colorado	52%	52%	60%
Connecticut	50%	50%	60%
Delaware	50%	50%	60%
District of Columbia	50%	50%	60%
Florida	56%	56%	66%
Georgia	62%	62%	62%
Hawaii	50%	50%	60%
Idaho	69%	68%	69%
Illinois	50%	50%	60%
Indiana	63%	62%	63%
Iowa	64%	63%	64%
Kansas	59%	59%	60%
Kentucky	70%	70%	73%
Louisiana	72%	71%	78%
Maine	63%	64%	63%
Maryland	50%	50%	60%
Massachusetts	50%	50%	60%
Michigan	57%	55%	62%
Minnesota	54%	54%	60%
Mississippi	78%	77%	79%
Missouri	60%	60%	62%
Montana	69%	69%	69%
Nebraska	60%	59%	60%
Nevada	50%	50%	60%
New Hampshire	50%	50%	60%
New Jersey	50%	50%	60%
New Mexico	73%	73%	73%
New York	50%	50%	60%
North Carolina	65%	64%	65%
North Dakota	69%	68%	69%
Ohio	60%	59%	60%
Oklahoma	70%	70%	70%
Oregon	61%	61%	61%
Pennsylvania	53%	53%	60%
Rhode Island	54%	54%	60%
South Carolina	71%	70%	71%
South Dakota	67%	65%	67%
Tennessee	66%	65%	68%
Texas	62%	63%	67%
Utah	73%	72%	73%
Vermont	61%	61%	61%
Virginia	51%	52%	60%
Washington	50%	51%	60%
West Virginia	73%	73%	78%
Wisconsin	60%	59%	60%
Wyoming	60%	60%	60%
United States:	57%	57%	63%

SOURCE: Congressional Research Service, "Medicaid Reform: Estimates of the Distribution of Federal Funds Under H.R. 3507/S.1795," 96-704 EPW (July 24, 1996).

## FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Clinics have long been an important source of outpatient care in rural and urban areas -- not just for Medicaid beneficiaries, but also for families with private health insurance and for the uninsured. The Federal Medicaid statute gives special coverage and reimbursement status to two types of free-standing (i.e., not part of a hospital) clinics: Federally-qualified health centers (FQHCs), and rural health clinics (RHCs). The services delivered by these clinics must be included in each State's basic Medicaid benefits package, and each State's Medicaid payment rates must cover the costs incurred by these clinics in providing those services.

Nationwide, about 1800 FQHCs and 2500 RHCs benefit from these statutory protections, which are intended to help make these clinics financially stable -- and therefore available as a source of outpatient care to underserved residents of the rural and urban areas in which they are located. The recent trend toward enrollment of Medicaid beneficiaries in managed care organizations (MCOs) has major implications for the continued financial viability of many FQHCs and RHCs.

**History.** Since the enactment of the Medicaid program in 1965, States have had the option of covering clinic services as part of their Medicaid benefits package and receiving Federal Medicaid matching funds for the cost of those services. States have broad discretion in defining clinic services (they include "any preventive, diagnostic, therapeutic, or rehabilitative services furnished at the clinic by or under the direction of a physician"). States also have broad discretion in setting payment rates for these services (there is no statutory floor under these payment levels).

In the Rural Health Clinic Amendments of 1977, P.L. 95-210, the Congress made rural health clinic (RHC) services one of the benefit categories that States are required to cover under Medicaid for the mandatory eligibles. Congress also required that States pay for RHC services at rates equal to 100 percent of the reasonable costs of providing these services (P.L. 95-210 also made RHC services a benefit under Medicare). State payments for RHC services are matched with Federal Medicaid funds at each State's regular matching rate. The purpose of the legislation was to increase access to health care for residents of rural medically underserved areas by assuring that physicians, as well as other practitioners such as physician assistants and nurse practitioners, would be adequately paid for the services they delivered to Medicare and Medicaid patients.

In OBRA '89 (P.L. 101-239), the Congress applied the coverage and reimbursement strategy of the 1977 RHC legislation to another category of clinics: Federally-qualified health centers, or FQHCs. Again, the Congress required that States include the ambulatory services delivered by FQHCs as a covered Medicaid benefit for the mandatory eligibles. The Congress also specified that States pay the FQHCs at rates equal to 100 percent of the reasonable cost of delivering these services. (In OBRA '90, P.L. 101-508, Congress made FQHC services a Medicare benefit). The purpose of the

OBRA '89 policy was to assure that FQHCs, whether in urban or rural areas, would not have to cross-subsidize part or all of the cost of caring for Medicaid beneficiaries due to low Medicaid payment rates or restrictive Medicaid coverage.

**Current Law.** FQHC services are defined at section 1905(l)(1) of the Social Security Act, RHC services at section 1905(l)(2). FQHC and RHC services are set forth as part of the basic Medicaid benefit package at section 1905(a)(2)(B) and (C), respectively. The requirement that States reimburse on a cost basis is found at section 1902(a)(13)(E).

**FQHCs.** The FQHC provider category includes 3 main types of clinics:

- community health centers, migrant health centers, health care for the homeless programs, and public housing clinics that receive Federal grant funds under section 330 of the Public Health Service (PHS) Act to deliver primary care to medically underserved populations; in 1995, according to the National Association of Community Health Centers, there were 635 such centers delivering care through some 2400 sites.
- "look-alike" clinics that do not actually receive Federal grant funds under section 330 of the PHS Act but which the Secretary of HHS, through the Public Health Service, certifies as meeting the requirements for receiving such funds; according to HCFA, there were 214 "look-alike" clinics in FY 1995.
- outpatient health programs or facilities operated by Indian tribes or by urban Indian health organizations; according to HCFA, there were 42 such clinics in FY 1995.

Clinics certified by the Secretary of HHS as FQHCs for purposes of the Medicare program, which also covers the services of these providers, are automatically qualified as FQHCs for purposes of Medicaid.

With respect to fee-for-service Medicaid patients, FQHCs are entitled to payment from the Medicaid program for "100 percent of costs which are reasonable and related to the costs of furnishing [FQHC] services." By regulation, 42 C.F.R. 447.371, the Secretary of HHS has imposed a national cap on Medicaid (and Medicare) payments for a patient visit, which is updated annually. The 1995 cap levels for FQHC payments were \$84.47 per visit in an urban area and \$72.63 in a rural area.

**RHCs.** To be certified as an RHC, a clinic must, among other things: (1) provide both physician and physician assistant or nurse practitioner services primarily on an outpatient basis; (2) have a nurse practitioner, physician assistant, or certified nurse midwife available at least 50 percent of the time the clinic operates; and (3) be located in a non-urbanized area that has been designated by the Secretary of HHS as an area with a shortage of primary health care practitioners.

RHCs, like FQHCs, are entitled to payment under the Medicaid program for "100 percent of costs which are reasonable and related to the costs of furnishing [RHC] services." By regulation, the Secretary has imposed a cap on the Medicaid (and Medicare) payment per visit, which is updated annually. In 1995 the RHC cap was set at \$55.53 per visit.

Clinics certified by the Secretary as RHCs for purposes of the Medicare program are automatically qualified as RHCs for purposes of Medicaid.

**FQHCs and RHCs.** Although the majority of FQHCs are rural (398 out of 635 in 1995), FQHCs and RHCs are different. The 3 main differences stem from requirements in the PHS Act to which FQHCs are subject (and RHCs are not): (1) FQHCs typically offer a broader range of services than do RHCs, including pharmacy services, dental care, and "enabling" services such as outreach, transportation, and health education; (2) FQHCs must be either private non-profit or public, while RHCs may be for-profit, non-profit, or public; and (3) FQHCs are required to serve all residents of their service areas, regardless of ability to pay, while RHCs are not obligated to serve the uninsured.

**Managed Care.** As discussed elsewhere in this Briefing Book, States have the option of entering into contracts with managed care organizations (MCOs) to provide covered services specified by the State to Medicaid eligibles on a risk basis. States may continue to pay for RHC or FQHC services for managed care enrollees directly on a fee-for-service basis ("carving" these services out of the contract with the MCO), or, as is more commonly the case, they may include these services within their contract with the MCO. In this circumstance, the capitation rate paid by the State to the MCO must "reflect fully" the 100 percent of reasonable cost rate to which FQHCs are entitled. The FQHC, in turn, has the right to payment from the MCO at 100 percent of reasonable cost, or it can elect to negotiate a different rate in connection with negotiations on patient referrals, risk, and other issues. There is no similar statutory requirement with respect to RHCs, although States must still cover the RHC benefit.

**CBO Estimates.** In April, 1995, CBO staff estimated that repealing the requirement that FQHCs be reimbursed on a reasonable cost basis would reduce Federal Medicaid spending by \$50 to \$60 million per year. Thus, over 6 years, the maximum savings that CBO would have attributed to this policy change in 1995 would be about \$360 million. Although it is not possible to predict how CBO would estimate this change in 1997, it is unlikely that the Federal savings would be any greater, since the number of FQHCs receiving payments from managed care plans rather than on a fee-for-service, reasonable cost basis has increased.

**Implementation.** The accompanying table shows the number of RHCs in each State, as well as the amount of Federal Medicaid matching funds flowing to these providers in the States for which information was available. According to a July, 1996, report by the HHS Inspector General, the number of RHCs has been growing rapidly in recent years;

nearly 90 percent of the 2,530 RHCs as of October, 1995, were certified since 1991 ("Rural Health Clinics: Growth, Access, and Payment," OEI-05-94-00040). As of October, 1995, about 60 percent of all the RHCs were concentrated in 11 States (California, Florida, Arkansas, Georgia, Illinois, Iowa, Kansas, Missouri, Mississippi, North Carolina, and Texas).

The table contains data (supplied by the National Association of Community Health Centers) on the number of FQHCs participating in Medicaid in each State during 1995 and the amount of Federal Medicaid funds received by those FQHCs in that year, based on revenue data supplied by the FQHCs. During 1995, Medicaid accounted for about 36 percent of the revenues, on average, of community health centers, migrant health centers, and other FQHCs receiving Federal grants, according to the National Association.

**Most Recent Republican Proposal.** The 1996 version of the Republican Medicaid block grant (H.R. 3507, S. 1795) would have repealed not only the current entitlement of Medicaid eligibles to coverage for services delivered by FQHCs or RHCs, but also the requirement that States pay for those services on a reasonable cost basis. Instead, the 1996 version of the Republican Medicaid block grant would have required that States to spend a minimum amount under their block grants on FQHC and RHC services, set at 85 percent of what the State paid for these services in FY 1995; States could lower this "set aside" amount beginning in FY 2001. The legislation also required States to pay for FQHC and RHC services on a reasonable cost basis for the first 2 years of implementation of the block grant; thereafter, they would have had complete discretion with respect payment levels.

While the Republicans were unsuccessful in repealing the current Medicaid statutory protections for FQHCs and RHCs, the 104th Congress did enact a change in the Public Health Service Act authorizations for the FQHCs. P.L. 104-[ ] consolidates the separate authorizations for community health centers, migrant health centers, health care for the homeless programs, and public housing clinics, into one authorization (section 330 of the PHS Act). The new law continues to authorize the Secretary of HHS to make grants for the operation of health centers delivering primary health services to medically underserved populations, subject to the appropriation of such sums as may be necessary for each fiscal year through FY 2000. Clinics receiving these grant funds will continue to qualify as Medicaid (and Medicare) FQHCs.

**MEDICAID FQHCS AND RHCS**  
(Dollars in Thousands)

State	FQHCS (as of 1995)	RHCS (as of 10/95)	Federal Matching Funds for FQHC Services (FY 1995)	Federal Matching Funds for RHC Services (FY 1995)
Alabama	17	61	14,306	2,146
Alaska	15	9	1,801	47
Arizona	17	7	12,783	0
Arkansas	9	95	3,567	2,094
California	99	146	63,391	77,633
Colorado	18	26	11,882	268
Connecticut	12	0	8,880	0
Delaware	4	0	785	0
District of Columbia	4	0	733	0
Florida	35	98	20,500	17,472
Georgia	21	90	8,991	4,523
Hawaii	13	2	3,226	0
Idaho	8	22	2,380	760
Illinois	35	113	13,222	5,793
Indiana	7	12	3,132	196
Iowa	6	98	2,454	1,655
Kansas	8	133	2,434	1,902
Kentucky	12	34	9,388	3,637
Louisiana	12	49	5,991	2,300
Maine	14	26	3,807	300
Maryland	12	0	32,727	0
Massachusetts	27	0	12,355	0
Michigan	33	82	13,593	1,671
Minnesota	15	36	3,971	unknown
Mississippi	22	139	14,262	10,113
Missouri	14	115	10,630	5,027
Montana	10	24	1,891	703
Nebraska	4	57	1,174	161
Nevada	9	1	1,324	257
New Hampshire	6	14	1,342	680
New Jersey	12	0	11,059	0
New Mexico	19	10	7,144	1,908
New York	47	11	64,130	unknown
North Carolina	21	105	6,747	5,870
North Dakota	4	69	833	1,543
Ohio	18	4	14,338	720
Oklahoma	22	78	3,847	2,157
Oregon	14	21	8,435	unknown
Pennsylvania	32	33	16,023	5,174
Rhode Island	11	1	5,749	55
South Carolina	21	52	8,886	3,465
South Dakota	10	44	1,208	899
Tennessee	20	70	9,856	256
Texas	42	367	18,618	unknown
Utah	7	14	2,243	143
Vermont	2	16	555	1,287
Virginia	22	27	3,632	864
Washington	23	32	16,219	876
West Virginia	28	41	11,530	12,615
Wisconsin	16	33	16,929	696
Wyoming	4	13	712	138
<b>Total:</b>	<b>913</b>	<b>2,530</b>	<b>515,615</b>	<b>178,004</b>

SOURCE: FQHC data (columns 1 and 3) from National Association of Community Health Centers.  
RHC data (columns 2 and 4) from Office of Inspector General, DHHS, "Rural Health Clinics: Growth, Access, and Payments," (July, 1996).

## FLEXIBILITY

The financing and the administration of Medicaid are shared by the Federal and State governments. Inherent in such a program structure is a tension over the amount of managerial and fiscal discretion available to the States, which run the program on a day-to-day basis. Because the Federal government pays, on average, at least 57 percent of the program's cost, and because the Federal investment is close to \$100 billion per year, there is a strong Federal interest in assuring State accountability for the efficient and effective expenditure of these Federal funds. States, on the other hand, implement and managed the Medicaid program. They have a natural interest in maximizing the amount of Federal Medicaid funds they receive and determining – in their sole discretion – the purposes to which those funds will be applied. This tension between these State and Federal interests defines the issue of "State flexibility."

From the standpoint of the Republican Governors, States have little flexibility under the current Medicaid program. In testimony before the Congress in April, 1996, Governor Engler of Michigan denounced what he described as "micromanagement" of Medicaid by Washington bureaucrats," which he contended was adding "billions of dollars" to health care costs in this country. (The purest legislative statement of the Republican Governors' view of "flexibility" was the Medicaid block grant proposal reported by the House Commerce Committee on September 22, 1995, and incorporated into the 1995 Budget Reconciliation bill (H.R. 2491)).

The Congressional Budget Office does not share Governor Engler's view. To the contrary, it believes that States have "significant flexibility" under the current Medicaid program. In a June 10, 1996, letter to Representative Thomas J. Bliley (R-VA.), June O'Neill, the Director of CBO, explained that capping Federal Medicaid spending on a per capita basis would not constitute an unfunded mandate because "states would have significant flexibility to offset reductions in federal funding with reductions in optional services and beneficiaries.... Courses of action available to states include eliminating or reducing some optional services, such as prescription drugs or dental services, and not serving some optional beneficiaries, such as the medically needy or pregnant women and children whose family income is between 133 percent and 185 percent of poverty. These options provide substantial flexibility to states. A frequently cited figure is that 60 percent of Medicaid spending is optional. Even though this flexibility varies dramatically between states, all states have significant flexibility."

The "significant flexibility" that States currently enjoy under Medicaid with respect to eligibility, benefits, provider payment, and other elements of the program has produced a startling variation in Medicaid spending from State to State. For example, in 1995, total Medicaid spending (Federal and State) varied from \$7,750 per beneficiary in New York to \$3,857 in Illinois to \$3,013 in California. (The Federal Medicaid matching rate in each of these States is 50 percent).

**Current Law: Flexibility States Have.** State participation in Medicaid is entirely voluntary; there is no statutory or constitutional requirement that States use Federal Medicaid funds to help pay for health and long-term care services for the poor. Moreover, those States that choose to participate have what CBO describes as "significant flexibility" in administering their programs. For example:

**Eligibility.** While there are certain categories of individuals that States must cover -- the "mandatory" eligibles -- there are at least 12 statutory categories of individuals that the States may cover with the assistance of Federal Medicaid matching funds. These "optional" eligibles range from aged or disabled individuals with high nursing home, prescription drug, or other medical expenses (the "medically needy") to pregnant women and infants with incomes between 133 and 185 percent of poverty.

**Benefits.** In order to receive Federal Medicaid matching funds, States must cover a specified set of services for the "mandatory" eligibles (although they have some discretion in limiting the amount, duration, or scope of those services). However, there are at least 15 types of services that States may cover and for which they may obtain Federal Medicaid matching funds. These "optional" services range from prescription drugs to clinic services to case management services to hospice care. States may also cover home and community-based services under "section 1915(c)" waivers.

**Provider Payment.** For most types of practitioners, including physicians, as well as many other provider categories, such as clinical labs, States have essentially complete discretion in determining Medicaid payment rates. One exception is the physicians serving children or pregnant women; States must show that their rates are sufficient to enlist enough of these providers so that care and services are available to Medicaid beneficiaries at least to the extent that they are available to the general population in the area. (Other exceptions on payment discretion are described below).

**Managed Care.** States have the option of offering Medicaid beneficiaries the choice of enrolling in managed care organizations (MCOs) rather than receiving care on a fee-for-service basis; however, in order to receive Federal matching funds, States may only contract with MCOs that also serve some privately-sponsored enrollees. In addition, States have the option, under a "section 1915(b)" waiver, of restricting Medicaid beneficiaries to a choice among primary care case management (PCCM) programs, if the restriction does not substantially impair access to services of adequate quality where medically necessary (as of June 30, 1995, according to HCFA, States had enrolled over 3.6 million Medicaid beneficiaries in PCCMs under these waivers).

**Waivers.** States have the option of using Federal Medicaid funds to cover acute care benefits exclusively through managed care organizations. However, States need waivers of certain Federal requirements in order to do so. The Secretary of HHS has exercised her authority under section 1115 of the Social Security Act to grant such "statewide Medicaid demonstration" waivers to 15 States. (See discussion of section 1115 Medicaid waivers elsewhere in this Briefing Book).

**Current Law: Flexibility States Do Not Have.** While States have what CBO has described as "significant flexibility" under Medicaid, they do not have unlimited flexibility. There are a number of areas in which the States do not have as much managerial discretion as many of them would like. Among the most contentious are:

**Boren Amendment.** This requires States to pay hospitals and nursing homes for inpatient services delivered to Medicaid beneficiaries using rates that are "reasonable and adequate." (See separate discussion elsewhere in this Briefing Book).

**FQHCs/RHCs.** Under current law, State Medicaid programs must cover services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), and they must pay those entities 100 percent of their reasonable cost of delivering these services to Medicaid patients. This payment floor has been waived under the terms of some section 1115 Medicaid waivers. (See separate discussions of FQHCs and RHCs, and section 1115 waivers, elsewhere in this Briefing Book).

**EPSDT.** All children eligible for Medicaid are entitled to have payment made on their behalf for early and periodic screening, diagnostic, and treatment (EPSDT) services. The "T" or "treatment" element of the EPDST benefit includes all necessary health care services to correct physical or mental illnesses or conditions discovered during an EPSDT screening, whether those services are otherwise covered under the State's Medicaid program for other populations. (See discussion of Medicaid coverage of children elsewhere in this Briefing Book).

**Managed Care.** Except in the case of a section 1115 Medicaid demonstration waiver, States may not require Medicaid beneficiaries to enroll in managed care organizations that serve only Medicaid patients. States are also required to reimburse all managed care organizations with which they contract to enroll Medicaid beneficiaries using capitation rates that are set on an "actuarially sound basis." (See discussions of Managed Care and of section 1115 Waivers elsewhere in this Briefing Book).

**QMBs and Dual Eligibles.** Under current law, States cannot require Medicare beneficiaries for whom Medicaid pays premiums and deductibles and coinsurance (known as QMBs), or Medicare beneficiaries for whom Medicaid also pays for prescription drugs and nursing home care (known Dual Eligibles), to enroll in managed care organizations (MCOs) to receive hospital, physician, and other services covered by Medicare. (See discussion elsewhere in this Briefing Book).

**Most Recent Republican Proposal.** Under both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1791), the States would have received virtually unlimited flexibility in designing and administering their block grant programs (including all 5 issues above) in exchange for a State-specific cap on the Federal government's financial exposure for the costs of health and long-term care services for low-income Americans.

## MANAGED CARE

A sea change is taking place in the way in which Medicaid pays for physician, hospital, and other acute care. Historically, Medicaid, like Medicare and private employer health plans, paid for such care largely on a fee-for-service basis. Medicaid is now in transition toward paying for acute care largely through managed care organizations (MCOs), reimbursing them on a prepaid, capitated basis (a fixed amount per enrollee per month). As of July 1, 1995, 3.3 million Medicaid beneficiaries were enrolled in 158 health maintenance organizations (a type of MCO that assumes full financial risk for the services contracted); this represented an increase of 630,000, or 23 percent, in the number of Medicaid enrollees in just one year. Medicaid beneficiary enrollment in MCOs will continue to increase over the next few years as States seek cost savings (through reductions in use of emergency rooms and hospital care) and, in the view of the States and managed care advocates, improved access and quality for beneficiaries.

The implications of this sea change are profound. MCOs face dramatically different financial incentives than do fee-for-service providers. In fee-for-service, hospitals and physicians can maximize net revenue by increasing the number of services delivered; under prepayment, providers can maximize net revenue by reducing the amount of care delivered. Medicaid beneficiaries who are required to enroll in MCOs are at risk for restricted access and lower quality care if the primary objective of the MCOs, knowing that their enrollees are "locked in," is to maximize net revenue by withholding the delivery of services, especially costly ones. In the absence of effective oversight, MCOs will continue to receive a monthly capitation payment from the State for each Medicaid enrollee regardless of the level of services actually provided.

From the Federal government's standpoint, the transition to managed care raises a host of fiscal integrity issues. In a largely fee-for-service system, Medicaid payments are disbursed by the States among a relatively large number of participating hospitals and physicians and other providers. In a largely managed care environment, Medicaid payments are channelled through a relatively small number of plans under what are often multi-year, multi-million dollar contracts with the States. The Federal government, which finances on average 57 percent of the cost of Medicaid, has the majority financial stake in these contracts. (No information is available as to how many Federal Medicaid matching dollars are paying for managed care).

Unquestionably, the shift from fee-for-service to managed care does provide States with more predictability as to their Medicaid expenditures. However, whether there are significant long-term savings to be had for either the States or the Federal government is still at issue. In April, 1995, CBO staff estimated that Federal savings from requiring the enrollment of all Medicaid beneficiaries in managed care would be only \$2.5 billion over a 7-year period. Whether CBO would provide a comparable estimate for this policy in 1997 is uncertain.

**History.** States have been contracting with managed care plans to deliver services to Medicaid beneficiaries since 1967, shortly after Medicaid was enacted. The first State to attempt to expand managed care enrollment on a systematic basis was California. In the early 1970's, during Governor Ronald Reagan's administration, the State entered into numerous contracts with MCOs (then called prepaid health plans, or PHPs), many of which were formed solely for the purpose of marketing to Medicaid beneficiaries. The General Accounting Office and other investigators documented marketing abuses, instances of underservicing and poor quality care, and profiteering and diversion of Federal health care funds.

These abuses prompted the Congress, in 1976, to enact minimum Federal requirements for State Medicaid contracts with managed care plans (P.L. 94-460). Among other things, these requirements specified that no more than 50 percent of a plan's enrollees could be Medicaid or Medicare-eligible (new plans were given 3 years to enroll sufficient commercial patients to meet this requirement): The purpose of this requirement was to stop the flow of Federal Medicaid funds to plans serving exclusively Medicaid eligibles, several of which had been closely associated with the most serious abuses. In addition, Federal Medicaid matching funds could generally only be paid to those managed care plans that were Federally qualified HMOs under Title XIII of the Public Health Service Act.

In 1981, at the urging of the Reagan Administration, the Congress relaxed these minimum Federal requirements (OBRA '81, P.L. 97-35). States were allowed to use Federal Medicaid funds to contract with managed care plans other than Federally-qualified HMOs, if the State determined the plan had the capacity to provide covered services. The 50 percent Medicare/Medicaid enrollment limitation was raised to 75 percent (the 3-year grace period continued to apply to all new plans); this requirement is now known as the "75-25 rule." Medicaid beneficiaries were given the right to disenroll from a managed care plan without cause upon one month's notice, enabling them to protect themselves against underservicing or poor quality care. Finally, the Secretary was given authority to grant "section 1915(b)" waivers to States to allow them to require beneficiaries to enroll in primary care case management (PCCM) plans.

**Current Law.** The current Federal minimum requirements governing the use of Federal matching funds by States in contracting with managed care plans are found at section 1903(m) of the Social Security Act. Implementing regulations are found at 42 C.F.R. 434.20 - 434.80 and 447.361 (upper limit on capitation rate).

The current law right of Medicaid beneficiaries to obtain covered services from any provider that elects (and is qualified to) to participate in the program -- the so-called "freedom of choice" of provider -- is set forth at section 1902(a)(23) of the Social Security Act. Implementing regulations are at 42 C.F.R. 431.51.

The Secretary has two separate authorities for waiving some or all of these requirements:

- Section 1915(b) of the Act (42 C.F.R. 430.25, 431.55) authorizes the Secretary to enable States to restrict beneficiary freedom of choice by limiting them to enrollment in managed care plans; however, these plans must meet the 1903(m) requirements, including the "75-25 rule."
- Section 1115 of the Act authorizes the Secretary to grant waivers to enable States to carry out broad Medicaid "demonstrations;" these include waivers of the "75-25 rule," the voluntary one-month disenrollment requirement, and the beneficiary "freedom of choice" provision. Under these waivers, States are mandating enrollment into managed care plans serving only Medicaid eligibles.

**Implementation.** While virtually all States are moving to increase Medicaid beneficiary enrollment in managed care, some States are much farther along than others. The accompanying table shows total Medicaid beneficiary enrollment by State, as of July 30, 1995, in MCOs that assume full financial risk for all covered acute care services. These figures do not include beneficiaries enrolled in mental health or dental managed care plans, or beneficiaries enrolled in primary care case management plans and other MCOs that assume financial risk only for some acute care services. Medicaid enrollment in these MCOs in 1995 varied widely as a percentage of total Medicaid recipients that year, from as low as 0 percent in Alabama to as high as 77 percent in Hawaii.

The recent rapid expansion of Medicaid beneficiary enrollment in managed care has not been without its problems. Over the past five years, the press has reported instances of marketing fraud (Illinois, Maryland, New York, Tennessee, Virginia); denial of covered, medically necessary services for which States contracted (Florida, New York, Ohio); failure to reimburse non-plan hospitals (and their ER physicians) for emergency care provided to plan enrollees (Florida, Ohio); and profiteering or excessive administrative costs (Florida, Ohio, Pennsylvania) on the part of MCOs serving exclusively Medicaid patients.

**Most Recent Republican Proposal.** In both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507/S. 1795), the current Federal statutory rules relating to Medicaid managed care contracting and enrollment would be repealed. Under the Republican block grant, States would have virtually unlimited discretion in contracting with MCOs and enrolling beneficiaries in them. The States would be subject to only two requirements in buying managed care with Federal block grant funds: (1) managed care plans at full financial risk would have to meet State solvency standards applicable to private HMOs, and (2) States would have to disclose to the public the amounts of capitation payments made to MCOs (unless State law treats this information as proprietary). All other issues, ranging from plan qualifications to capitation rates to marketing and enrollment practices, would be left to the sole discretion of the States.

**MEDICAID MANAGED CARE  
(FY 1995)**

State	Managed Care Plans	Medicaid Enrollees in Full Risk Acute Care Managed Care Plans	Total Medicaid Eligible	Acute Care Full Risk Managed Care Enrollees as % of Total Medicaid Eligibles
Alabama	1	0	539,251	0%
Alaska	none reported	none reported	68,117	0%
Arizona	15	337,213	493,893	68%
Arkansas	1	0	353,370	0%
California	48	704,568	5,016,645	14%
Colorado	7	40,175	293,723	14%
Connecticut	none reported	none reported	380,327	0%
Delaware	1	6,593	78,555	8%
District of Columbia	5	2,661	138,444	2%
Florida	27	432,754	1,735,141	25%
Georgia	3	0	1,147,443	0%
Hawaii	7	153,879	200,000	77%
Idaho	1	0	115,014	0%
Illinois	5	142,268	1,551,948	9%
Indiana	2	35,000	558,020	6%
Iowa	6	25,150	304,304	8%
Kansas	1	0	255,702	0%
Kentucky	1	0	640,930	0%
Louisiana	1	0	785,388	0%
Maine	1	0	153,180	0%
Maryland	7	119,691	414,261	29%
Massachusetts	17	73,930	727,506	10%
Michigan	18	265,300	1,168,435	23%
Minnesota	11	140,527	473,420	30%
Mississippi	1	0	519,697	0%
Missouri	5	31,713	695,458	5%
Montana	1	0	98,708	0%
Nebraska	none reported	none reported	168,383	0%
Nevada	5	0	105,233	0%
New Hampshire	2	10,985	96,954	11%
New Jersey	9	93,893	789,666	12%
New Mexico	1	0	286,763	0%
New York	48	583,914	3,035,477	19%
North Carolina	3	132,419	1,084,337	12%
North Dakota	1	0	61,383	0%
Ohio	14	211,680	1,532,547	14%
Oklahoma	none reported	none reported	393,613	0%
Oregon	36	246,877	451,959	55%
Pennsylvania	9	461,542	1,230,193	38%
Rhode Island	5	60,479	135,230	45%
South Carolina	3	29	495,500	less than 1%
South Dakota	1	0	74,077	0%
Tennessee	12	803,265	1,466,194	55%
Texas	2	0	2,561,957	0%
Utah	7	39,664	160,408	25%
Vermont	none reported	none reported	99,693	0%
Virginia	5	54,202	681,313	8%
Washington	30	361,463	639,256	57%
West Virginia	1	0	388,667	0%
Wisconsin	15	141,272	460,016	31%
Wyoming	none reported	none reported	51,374	0%
<b>Total:</b>	<b>402</b>	<b>5,713,106</b>	<b>35,357,073</b>	<b>16%</b>

SOURCE: "Medicaid Managed Care Enrollment Report," Office of Managed Care, HCFA, (July 30, 1995).  
Data on Medicaid recipients for FY 1995 as reported by States to HCFA.

## PROVIDER TAXES

This issue goes to the basic financing structure of the Medicaid program. States that elect to participate in Medicaid are entitled to receive Federal matching funds for State (or local) dollars spent on covered populations and services. In counting State dollars for purposes of qualifying for Federal matching, may the States use revenues received from taxes (or assessments or fees) imposed on hospitals, nursing homes, physicians, or other providers? The answer in Federal Medicaid law is yes, but only if the taxes meet certain minimum Federal standards designed to assure that the taxes are not subterfuges to draw down Federal dollars without any real State (or local) fiscal effort.

**History.** Until January 1, 1992, the date on which Federal minimum standards enacted in 1991 began to take effect in any State, there were no restrictions on the use of revenues from provider taxes (or donations) by States to claim Federal Medicaid matching funds. In the late 1980's, many States began to use revenues from provider taxes (or donations) as a bootstrap financing technique to generate Federal Medicaid matching payments to help balance their budgets. Between fiscal year 1990 and fiscal year 1993, the percentage of State Medicaid spending coming from provider taxes (or donations) rose from 5.8 percent to 21.1 percent.

Although the details of these provider tax (and donation) schemes varied from State to State, they shared a common dynamic. Hospitals, nursing homes, or other providers either "donated" funds to State Medicaid programs or agreed to be taxed or subjected to fees or assessments, with the revenues earmarked for Medicaid. The States would use these revenues to make expenditures that would qualify for Federal Medicaid matching funds. The States would then use the Federal matching funds to make payments to the providers to hold them harmless for the costs of their "donations" or taxes or fees or assessments (in the case of hospitals, this was commonly done using "disproportionate share" or "DSH" hospital payment adjustments). Both the States and the providers were better off — at the Federal government's expense.

Consider the following example. A State with a Federal Medicaid matching rate of 57 percent (the national average) imposes a \$43 licensing fee on a hospital, with the revenues earmarked for Medicaid. It then pays that hospital an additional \$100 in "disproportionate share" (DSH) payment adjustments. The State claims, and the Federal government makes a matching payment of, \$57 in connection with this \$100 expenditure. The State has incurred no net cost (it received \$43 from the hospital and \$57 from the Federal government). The hospital has gained \$57. And the Federal government has paid out \$57. If the hospital is a State-owned or -operated hospital, the \$57 can then be folded into the State general budget and used, among other things, for other State Medicaid spending that would in turn qualify for additional Federal matching payments.

**Current Law.** The Federal provider tax requirements are found at section 1903(w) of the Social Security Act. They were enacted in the the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). Detailed implementing regulations have been issued, 42 C.F.R. 433.50 - 433.74.

The basic thrust of the current Federal statute is to reduce, on a dollar for dollar basis, the amount of Federal Medicaid matching funds paid out to a State by the amount of revenues received by a State (or locality) from provider taxes (or donations) that do not meet certain minimum requirements. In the case of provider taxes, which the statute defines as a tax (or licensing fee, assessment, or other mandatory payment) 85 percent or more of the burden of which falls on health care providers, those requirements are:

- (1) the tax must be "broad-based" (generally, it must cover at least all non-Federal, non-public providers in a class, such as hospitals, nursing homes, etc., and it must be imposed uniformly on every provider in the class); and
- (2) the State must not have in effect a "hold harmless" provision with respect to the tax (generally, the State or locality provides, directly or indirectly, a payment or offset that holds the provider harmless for any portion of the cost of the tax).

The statute gives the Secretary the authority to waive the "broad-based" requirement if the State can show that the net impact of the tax and related Medicaid spending is "generally redistributive."

There is no limit on the amount of revenues a State may receive from legitimate provider taxes in order to finance its share of Medicaid (such a limit was enacted in 1991 and was effective January 1, 1992, but expired effective October 1, 1995).

**Implementation.** As the accompanying table indicates, during FY 1995, 34 States and the District of Columbia reported receiving revenues from provider taxes or donations (no information was available with respect to 5 States). On average, about 8 percent of all State Medicaid spending was raised from provider taxes or donations, according to reports by the States. However, there is considerable variation among the States in the degree of reliance on this revenue source. In 6 States (Colorado, Georgia, Kentucky, Missouri, Ohio, and West Virginia), revenues from provider taxes and donations accounted for more than 20 percent of all State Medicaid spending; 11 States (Alaska, Arizona, California, Delaware, Idaho, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, and Wyoming) reported no revenues from these sources at all.

As of September, 1996, HCFA had approved 6 different provider taxes in 5 States (Minnesota, Louisiana, Montana, Ohio, and Virginia); these affected hospitals(2), nursing homes (2), physicians (1), and intermediate care facilities for the mentally retarded (ICFs/MR)(1). As of that date, HCFA was reviewing requests for waivers of the Federal requirements with respect to 38 different provider taxes from 18

States. In addition, 6 States had received notices from HCFA that their provider taxes clearly violated the Federal statute (Hawaii, Illinois, Louisiana, Maine, New York, and Tennessee).

**Most Recent Republican Legislative Proposal.** Under the Republican Medicaid block grant contained in the budget reconciliation bill (H.R. 2491) vetoed by the President on December 6, 1995, the current Federal provider tax rules would simply have been repealed. The 1996 version of the Republican Medicaid block grant, as reported out by the House Commerce and Senate Finance Committees (H.R. 3734, S. 1795), would have authorized the Secretary of HHS, effective 2 years after enactment, to waive the current Federal provider tax and donation standards for tax or donation schemes used by any State "if the Secretary determines that the waiver would not financially undermine the program under this title and would not otherwise be abusive" (sec. 1512(i)) of block grant authorization). The fiscal and political pressures on the Secretary in the exercise of such waiver authority are likely to be enormous.

**MEDICAID PROVIDER TAXES FY 1995**  
(Dollars in thousands)

State	Total Provider Tax Revenues	Total State Expenditures	Tax Revenues as % State Expenditures
Alabama	27,148	589,382	5%
Alaska	0	157,366	0%
Arizona	0	559,794	0%
Arkansas	20,452	330,206	6%
California	0	8,982,938	0%
Colorado	259,861	728,519	36%
Connecticut	225,168	1,276,020	18%
Delaware	0	173,207	0%
District of Columbia	3,011	407,360	1%
Florida	206,096	2,711,912	8%
Georgia	494,942	1,368,196	36%
Hawaii	127	380,117	less than 1%
Idaho	0	112,442	0%
Illinois	564,729	3,122,606	18%
Indiana	unknown	793,427	unknown
Iowa	2,270	449,883	1%
Kansas	2,542	597,254	less than 1%
Kentucky	173,095	667,652	26%
Louisiana	72,570	1,162,269	6%
Maine	unknown	355,406	unknown
Maryland	504	126,011	less than 1%
Massachusetts	318,393	2,547,117	13%
Michigan	5,847	2,325,517	less than 1%
Minnesota	257,733	1,331,223	19%
Mississippi	12,294	342,819	4%
Missouri	373,265	1,140,761	33%
Montana	12,831	109,994	12%
Nebraska	8,212	269,057	3%
Nevada	23,744	233,681	10%
New Hampshire	unknown	426,317	unknown
New Jersey	0	2,771,366	0%
New Mexico	0	216,526	0%
New York	1,201,820	12,428,580	10%
North Carolina	0	1,422,710	0%
North Dakota	0	97,456	0%
Ohio	576,192	2,546,968	23%
Oklahoma	5,504	372,484	1%
Oregon	379	589,413	less than 1%
Pennsylvania	5,560	3,518,128	less than 1%
Rhode Island	16,157	455,106	4%
South Carolina	29,947	611,619	5%
South Dakota	0	100,420	0%
Tennessee	130,028	1,166,372	11%
Texas	2,223	3,356,264	less than 1%
Utah	unknown	162,927	unknown
Vermont	27,163	138,856	20%
Virginia	unknown	1,050,218	unknown
Washington	30,586	1,451,836	2%
West Virginia	115,823	338,991	34%
Wisconsin	18,205	1,032,475	2%
Wyoming	0	63,704	0%
<b>Total:</b>	<b>5,224,421</b>	<b>67,670,872</b>	<b>8%</b>

SOURCE: Data reported by the States to the Health Care Financing Administration.

## QUALIFIED MEDICARE BENEFICIARIES (QMBs) AND "DUAL ELIGIBLES"

Of the estimated 37 million Medicaid beneficiaries in 1996, about 5 million were also eligible for Medicare. For these low-income aged or disabled Americans, Medicaid makes their Medicare coverage effective, in one of two ways. For roughly 2.5 million of them -- known as "Qualified Medicare Beneficiaries," or QMBs -- Medicaid pays the monthly Medicare premiums, as well as the Medicare deductibles and coinsurance. For the remaining 2.4 million or so -- known as "Dual Eligibles" -- Medicaid not only pays their Medicare premiums and deductibles and coinsurance requirements, but it also "wraps around" their Medicare benefit by covering outpatient prescription drugs, nursing home care, and other services that Medicare does not cover. According to CBO, the Federal Government in 1995 spent about \$1.9 billion in Medicaid matching funds for Medicare Part B premiums alone for QMBs and Dual Eligibles (there is no information on total Federal Medicaid spending for either of these populations).

Because these aged and disabled Americans are entitled to coverage under both Medicare and Medicaid, changes in Medicare will affect State Medicaid programs. For example, if the Federal government, for budgetary reasons, increases the Medicare Part B premium, then the amount which States must spend for premium subsidies for both QMBs and Dual Eligibles will increase (of course, Federal Medicaid matching funds for these premium costs will rise correspondingly, offsetting the Federal Medicare Part B savings to some extent). Similarly, changes in State Medicaid policies will affect the viability of these beneficiaries' Medicare coverage. For example, States may wish to require aged and disabled residents, including Medicare beneficiaries, to enroll in managed care organizations (MCOs) for Medicaid-covered services. However, under Medicare law, these aged and disabled beneficiaries are entitled to freedom of choice of provider and may not be forced to enroll in an MCO to receive any Medicare-covered services. One State -- Minnesota -- has received a waiver of current law under section 1115 of the Social Security Act to require Dual Eligibles to enroll in MCOs that are responsible for delivering both acute and long-term care services to this population.

**History.** There have been Dual Eligibles since the enactment of both the Medicare and Medicaid programs in 1965 (P.L. 89-97). In that original enactment, States electing to participate in Medicaid were required to pay the costs of Dual Eligibles' Medicare Part A deductibles and, on an income-related basis, the costs of Medicare Part B deductibles and cost-sharing. These State expenditures, known as the Medicare "buy-in," were eligible for Federal matching funds at the State's normal matching rate. (From the standpoint of the States, it made fiscal sense to "buy in," i.e., help low-income elderly enroll in Medicare Part B by paying their monthly premium, because the States' Medicaid programs would then not have to pay for physician or other services covered by Medicare. Effective in 1970, costs of services for which Medicare would have paid did not because the Medicaid beneficiary was not enrolled in Medicare Part B were no longer eligible for Federal Medicaid matching funds).

In the mid-1980's, as Medicare premiums and other cost-sharing requirements were raised for budgetary reasons, the Congress took steps to protect low-income Medicare beneficiaries from the financial burden of increasing premiums, deductibles, and coinsurance. In many States, Medicaid eligibility standards for the elderly and disabled were so low that they excluded many individuals with incomes below the Federal poverty level. In OBRA '86 (P.L. 99-509), Congress gave States the option of using Federal Medicaid matching funds to provide Medicaid coverage (either full benefits or just assistance with Medicare premiums and cost-sharing) to low-income elderly or disabled individuals with incomes up to the Federal poverty level and resources up to twice the level permitted under the Supplemental Security Income (SSI) program. In the Medicare Catastrophic Act of 1988 (P.L. 100-360), the Congress required States to cover Medicare premiums and cost-sharing for QMBs with incomes up to 100 percent of poverty and resources no greater than 200 percent of the SSI level; this coverage requirement, which was phased in from 85 percent of poverty to 100 percent over 4 years, survived the repeal of the Medicare catastrophic coverage program in 1989 (P.L. 101-234).

Finally, in OBRA '90 (P.L. 101-508), Congress raised the Medicare Part B premium and accelerated the phase-in of coverage for QMBs by one year, to January 1, 1991. In that same legislation, Congress also required States to pay the Part B premiums (but not deductibles or coinsurance) for Medicare beneficiaries with incomes between 100 and 120 percent of the Federal poverty level, and resources at or below twice the SSI level; this requirement was fully phased in as of January 1, 1995.

**Current Law.** QMBs are defined in section 1905(p) of the Social Security Act. The requirement that States cover their Medicare premiums and cost-sharing expenses is set forth at section 1902(a)(10)(E).

**Medicare Premium and Cost-Sharing Requirements.** Premiums for Medicare Part B, which covers physician and other medical services, are \$42.50 per month in 1996. (Most elderly automatically qualify for Medicare Part A, which covers hospital care; the small number who do not must pay a monthly premium of \$289 in 1996 to enroll). The Medicare hospital deductible under Part A is \$736 in 1996; the Part B deductible is \$100. The Part B coinsurance requirement is 20 percent of Medicare's approved payment for the physician or other covered medical service.

**QMBs.** QMBs are elderly or disabled individuals who are entitled to Medicare Part A coverage, whose family income is at or below 100 percent of the Federal poverty line (\$7,740 for a single individual and \$10,360 for a couple in 1996), and whose resources (other than a home and certain other items) do not exceed 200 percent of the SSI resource standard (\$4,000 for an individual and \$6,000 for a couple in 1996).

QMBs are entitled to Medicaid payment for their Medicare premiums and cost-sharing, including Part B monthly premiums (and in a limited number of cases, Part A premiums), deductibles under both Part A and Part B, and coinsurance under Part A

and Part B, and coinsurance and deductibles charged by Medicare Health Maintenance Organizations and Competitive Medical Plans (States have the option of paying the Medicare HMO or CMP enrollment premiums).

Specified Low-income Medicare Beneficiaries (SLIMBs) must meet the same requirements as QMBs except that their incomes may range up to 120 percent of poverty (\$9,288 for a single individual and \$12,432 for a couple in 1996). SLIMBs are entitled only to Medicaid payment of their Medicare Part B premiums.

**Dual Eligibles.** These are aged and disabled Americans eligible for both Medicare and Medicaid, commonly because they qualify for Medicaid coverage due to the receipt of cash assistance under the SSI program in most States. (Some Medicare beneficiaries may also qualify for Medicaid as "medically needy" by incurring large medical costs for services not covered by Medicare). The Dual Eligibles are entitled to coverage not just for Medicare premiums and cost-sharing, as in the case of QMBs, but also for the other benefits covered under the State's Medicaid program, including nursing home care and prescription drugs.

**Coverage of Coinsurance and Deductibles.** Because State Medicaid programs commonly pay less than Medicare does for physician and other services that both Medicare and Medicaid cover, there is an issue as to how much assistance QMBs are entitled to receive with respect to coinsurance and deductibles. For example, if Medicare recognizes \$50 as the appropriate payment for a physician visit, and if the beneficiary has met her \$100 deductible, Medicare will pay 80 percent, or \$40, and the beneficiary must pay the 20 percent coinsurance, or \$10. Under HCFA's interpretation of current law, if the State only pays \$30 for the physician visit under Medicaid, then the QMB is entitled to no assistance with the \$10 coinsurance charge, because the actual Medicare payment (\$40) exceeds the Medicaid payment rate (\$30). However, Federal courts have disagreed with HCFA and the States. As of July, 1995, 4 circuit courts of appeals had ruled that States must pay the full Medicare cost-sharing expenses of QMBs, regardless of the State's Medicaid payment rate for the service in question; in this example, the State would have to pay the \$10 co-insurance requirement.

**Managed Care.** While States may, under waivers from the Secretary, require Medicaid eligibles to enroll in managed care organizations (MCOs), neither the States nor the Secretary have any legal authority to require Medicare beneficiaries to enroll in a Medicaid MCO in order to receive hospital, physician, or other services covered by Medicare. Medicare beneficiaries are free to choose whether to enroll in an MCO or not; if they choose to do so, Medicare will make capitation payments on the beneficiary's behalf to that MCO only if it meets Medicare standards. The potential for conflict between the beneficiary's Medicare rights and the State's Medicaid policy interest is obvious. For example, at least one State now pays for Medicaid-covered services for this population (including Medicare premiums and cost-sharing) only through Medicaid MCOs, effectively forcing Medicare beneficiaries to enroll in Medicaid MCOs if they want Medicaid assistance with their monthly Medicare premiums.

**Implementation.** The accompanying table provides the numbers of Medicare beneficiaries (both QMBs and Dual Eligibles) on whose behalf each State reported paying Medicare premiums (both Part B and Part A) in July, 1996, as well as the amount of Federal Medicaid matching funds paid to each State during FY 1995 in connection with the costs of the monthly Medicare premiums (both Part B and Part A). Data regarding the number of QMBs (or the number of Dual Eligibles) on a State-by-State basis is unavailable.

**Most Recent Republican Proposal.** Both the 1995 and the 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795) would have repealed the individual entitlement to coverage for both QMBs and Dual Eligibles (the Medicare entitlement of these individuals would not have been affected by the block grant, although the Republican Medicare proposals would have raised premiums and cost-sharing obligations).

With respect to QMBs, the 1996 version claimed to "guarantee" coverage of Medicare premiums and cost-sharing by requiring States to make payment for these costs. However, no individual Medicare beneficiary was given a right to this coverage, and all Medicare beneficiaries were expressly prohibited from enforcing this "guarantee" in Federal court. In addition, the Republican bill would have allowed States to make no payments toward the coinsurance requirements of a QMB, leaving the QMB to pay the entire coinsurance amount, if the State's payment rate for the service is less than the Medicare payment rate.

With respect to Dual Eligibles, the 1996 version purported to "guarantee" coverage for a so-called "guaranteed benefit package" to elderly individuals meeting SSI income and resource standards. However, no Medicare beneficiary had an individual entitlement to Medicaid coverage; States were given complete discretion in limiting the amount, duration, or scope of any of these "guaranteed benefits" (i.e., 1 month of nursing home care per year); and Medicare beneficiaries were expressly prohibited from enforcing any of these "guarantees" in Federal court.

The 1996 version also included a free-standing authority for a so-called "Integration Demonstration Project" which would have authorized the Secretary of HHS to waive any requirements of Medicare as well as the new Medicaid block grant in order to enable up to 10 States to implement "innovative programs" for individuals dually eligible for benefits under both programs. To obtain a waiver, a State would have had to demonstrate budget neutrality with respect to Federal Medicare and block grant funds. States would not have been authorized to require beneficiaries to participate.

## QMBS AND DUAL ELIGIBLES

(Dollars In thousands)

State	Dual Eligibles and QMBs (July, 1996)	Federal Medicaid Matching Funds for Medicare Premlums (FY 1995)
Alabama	120,399	\$53,171
Alaska	6,659	\$2,413
Arizona	47,393	\$16,915
Arkansas	79,549	\$39,337
California	768,907	\$264,880
Colorado	49,651	\$12,325
Connecticut	50,226	\$18,817
Delaware	7,735	\$2,739
District of Columbia	14,195	\$8,398
Florida	290,838	\$150,981
Georgia	165,210	\$66,380
Hawaii	17,905	\$9,768
Idaho	13,835	\$5,121
Illinois	144,330	\$45,140
Indiana	75,930	\$21,528
Iowa	50,031	\$17,849
Kansas	37,064	\$12,153
Kentucky	103,705	\$44,607
Louisiana	114,917	\$57,998
Maine	31,063	\$594
Maryland	59,882	\$27,454
Massachusetts	132,575	\$48,826
Michigan	131,263	\$45,789
Minnesota	55,989	\$9,826
Mississippi	104,036	\$65,641
Missouri	76,883	\$25,157
Montana	11,638	\$5,428
Nebraska	16,986	\$5,446
Nevada	15,711	\$4,885
New Hampshire	5,878	\$1,576
New Jersey	131,292	\$41,393
New Mexico	32,346	\$13,787
New York	342,539	\$90,068
North Carolina	197,039	\$83,784
North Dakota	5,751	\$2,177
Ohio	172,316	\$54,171
Oklahoma	61,723	\$34,600
Oregon	47,600	\$12,926
Pennsylvania	170,790	\$68,149
Rhode Island	16,780	\$6,411
South Carolina	98,817	\$39,905
South Dakota	12,661	\$6,321
Tennessee	157,602	\$72,992
Texas	327,827	\$186,254
Utah	14,387	\$5,386
Vermont	12,863	\$4,666
Virginia	107,457	\$30,964
Washington	76,885	\$21,473
West Virginia	42,377	\$23,536
Wisconsin	78,661	\$32,185
Wyoming	5,548	\$1,862
<b>Total:</b>	<b>4,913,644</b>	<b>\$1,870,981</b>

SOURCE: Information reported by the States to the Health Care Financing Administration

## SECTION 1115 MEDICAID WAIVERS

As of October 30, 1996, one fifth of the States were operating part or all of their Medicaid programs under so-called "section 1115 waivers." Granted by the Secretary of HHS, these "demonstration" waivers excuse States from compliance with specified requirements in the Federal Medicaid statute in order to enable the States to change the delivery of services under their Medicaid programs while continuing to receive Federal matching funds. More specifically, nearly all of the recently-granted section 1115 Medicaid waivers allow States to require beneficiaries to enroll in managed care organizations (MCOs) that serve only Medicaid eligibles. Several of these waivers have also resulted in expansion of health care coverage (paid for in part with Federal Medicaid matching funds) to populations not covered under current Medicaid law.

**History.** The "section 1115" waiver authority with respect to Medicaid has been in place since the enactment of the Medicaid program in 1965. However, this authority was not used to implement comprehensive, Statewide changes in Medicaid programs until 1982, when Arizona, which had not participated in the Medicaid program up to that point, received a section 1115 waiver to enable it to receive Federal Medicaid matching funds to implement a program of acute care coverage with no significant fee-for-service component. (Arizona continues to operate its Medicaid program under this 1115 waiver, which was subsequently extended to bring in Federal matching funds for long-term care services). Beginning with the approval of the Oregon "rationing" demonstration in 1993, the section 1115 waiver authority has been used to enable an additional 14 States to make comprehensive, Statewide changes in the delivery of services and eligibility under their programs.

**Current Law.** Section 1115(a) of the Social Security Act gives the Secretary of HHS authority to waive compliance with certain sections of the Medicaid statute to enable States to carry out demonstration projects if the project is "likely to assist in promoting the objectives of" the Medicaid statute. These "demonstration" waivers are required to be budget neutral (from the Federal government's standpoint) over their 5-year terms and generally are subject to a formal, independent evaluation.

In addition to section 1115, the Secretary of HHS has two other significant Medicaid waiver authorities: "section 1915(b)" waivers enable States to require beneficiaries to enroll in managed care plans, and "section 1915(c)" waivers enable States to offer home- and community-based services to individuals at risk of nursing home care. Under "section 1915(b)" waivers, States cannot require beneficiaries to enroll in managed care plans that serve only Medicaid eligibles, and they cannot expand eligibility beyond the categories allowed under current law; under section 1115 waivers, they can do so.

**Implementation.** Overall, the 10 States operating section 1115 statewide Medicaid waivers as of September 1, 1996, covered about 2.9 million beneficiaries, or about 8%

of the estimated 36.8 million Medicaid beneficiaries that fiscal year. In FY 1995, Federal Medicaid payments for these demonstrations (which were operational in only 6 of these States that year) totalled \$4.4 billion, or just under 5 percent of the \$89.1 billion in Federal Medicaid outlays nationwide in FY 1995. The accompanying table shows the numbers of individuals covered and the amounts of Federal funds received, by State, during FY 1995.

**Operational States.** The following 10 States were, as of October 30, 1996, operating statewide Medicaid demonstrations under section 1115 waivers: Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. (California received a section 1115 Medicaid waiver to enable Los Angeles County to restructure its hospital and clinic system).

**Approved but Not Operational States.** Florida, Illinois, Kentucky, Maryland, Massachusetts, and Illinois had received section 1115 waivers as of October 30, 1996, but were not operational as of that date.

**Waiver Applications Under Review.** As of October 30, 1996, the Secretary of HHS was reviewing applications for section 1115 Medicaid demonstration waivers from the following States: Alabama, Georgia, Kansas, Louisiana, Missouri, New Hampshire, New York, Texas, and Utah.

**Main Features of Approved Waivers.** While each section 1115 waiver has its own set of terms and conditions negotiated by the State with the Department of HHS, the Office of Management and Budget, and the White House, the operational (as of 10/1/96) waivers have certain features in common:

- They all maintain the current individual entitlement, the currently required eligibility categories, and the current Federal-State matching arrangements.
- Most of these waivers affect only acute care services, not nursing home or other long-term care services (the two exceptions are Arizona, which receives Federal long-term care matching funds under its 1115 waiver, and Minnesota waiver, which involves the integration of acute and long-term care services for individuals dually eligible for Medicare and Medicaid).
- Almost all of these waivers retain the current law minimum benefits package for current Medicaid eligibles (the major exception is the Oregon waiver, which is testing the denial of coverage of medical treatments for conditions with a "prioritization" ranking below a State-specified "line"). However, some of these waivers provide for a narrower benefit package or increased cost-sharing for those newly eligible under the waiver (so-called "expansion" eligibles).
- These waivers all allow States to require enrollment in managed care plans that serve primarily or exclusively Medicaid enrollees.

- The majority of these waivers allow States to use Federal Medicaid funds to purchase care for individuals not eligible under the current Medicaid statute (Delaware, Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, Vermont). As of September 1, 1996, health care coverage was extended through these waivers to about 564,000 individuals not otherwise eligible for Medicaid.
- Several of these waivers allow States to maintain current and/or projected levels of Federal matching funds for payments to "disproportionate share" (DSH) hospitals while at the same time allowing them to redirect these payments.

**Most Recent Republican Proposal.** Both the 1995 and the 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507, S. 1795) would have repealed the current Federal Medicaid statute, Title XIX of the Social Security Act, in its entirety. Although the Republican proposal technically did not amend section 1115, the Secretary's waiver authority under that section would have been rendered moot, since there would be no more requirements under Title XIX to waive. All States, whether operating under section 1115 or not, would have been entitled to Federal block grant funds. In theory, they could choose to keep operating their section 1115 demonstration within the confines of the block grant, but the amount of Federal funds available to them would have been determined by the statutory block grant formula, not by the current terms of their waivers.

After it became clear that Republicans would not succeed in their efforts to repeal Medicaid during the 104th Congress, individual Republicans made efforts to enact legislation requiring the Secretary of HHS to approve State-specific section 1115 Medicaid waiver applications from Michigan (H.R. 3507) and Wisconsin (H.R. 3562). Although H.R. 3562 did pass the House, neither bill was enacted.

**Section 1115 Welfare Waivers.** Section 1115 of the Social Security also authorizes the Secretary of HHS to waive provisions of the Aid to Families with Dependent Children (AFDC) program to enable States to carry out demonstrations. As of September 26, 1996, 43 States had received one or more section 1115 welfare waivers, including each of the 10 operational section 1115 Medicaid waiver States other than Rhode Island.

In some of the States with section 1115 welfare waivers, additional Medicaid-specific policy changes have been incorporated into the waivers. The most significant of these is the expansion of transitional Medicaid coverage for families losing cash assistance due to earnings; the section 1115 welfare waivers of 15 States include expansions in this "welfare to work" transitional Medicaid benefit, usually by extending the duration of coverage from the current 12 months to 18 or 24 months (Arizona, California, Connecticut, Delaware, Florida, Maine, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, Pennsylvania, South Carolina, Tennessee, and Virginia).

**OPERATIONAL SECTION 1115 MEDICAID DEMONSTRATION WAIVERS**  
(September 1, 1996)

<b>State</b>	<b>Traditional Eligibles (as of 9/1/96)</b>	<b>Expansion Eligibles (as of 9/1/96)</b>	<b>Federal Waiver Matching Payments (FY 1995) (millions of dollars)</b>	<b>Federal Waiver Payments as Percent of Total Federal Matching (FY 1995)</b>
Arizona	480,024		\$ 1,080.8	97%
Delaware	54,990	4,000		
Hawaii	90,000	45,000	\$ 162.9	48%
Minnesota	142,200	86,000	\$ 7.5	3%
Ohio	295,861			
Oklahoma	125,133			
Oregon	255,742	108,207	\$ 904.0	94%
Rhode Island	68,943	2,424	\$ 39.9	7%
Tennessee	849,933	315,099	\$ 2,220.1	99%
Vermont		3,088		
<b>Total</b>	<b>2,362,826</b>	<b>563,818</b>	<b>\$ 4,414.9</b>	