WHITE HOUSE BRIEFING DOCUMENT ON MEDICARE AND MEDICAID FOR PEOPLE WITH DISABILITIES

DRAFT
December 13, 1995

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Contents Page

MEDICARE AND MEDICAID FOR PEOPLE WITH DISABILITIES

- Medicare and Medicaid provide critical health care services and long-term supports to people with disabilities of all ages:

  - Medicaid serves more than 6 million people with disabilities.

  - Medicare serves 4 million people under age 65 with disabilities.

- Total federal and state Medicaid payments for people with disabilities totaled approximately $53 billion in fiscal year 1995.

- Medicare payments for people eligible for Medicare because of a disability totaled $19 billion in fiscal year 1995. Medicare spends billions more on services for elderly people with disabilities.

MEDICAID AND PEOPLE WITH DISABILITIES: WHO MEDICAID COVERS

- Medicaid is the primary insurer of people with disabilities because people with disabilities are often unable to buy private health insurance because of high costs, pre-existing condition exclusions and other restrictions on coverage.

- People with disabilities are more likely to be low-income, use more health and long-term care services, and incur higher health costs than people without disabilities.

- Medicaid covers people with disabilities if they:

  - Are disabled and poor enough to qualify for SSI

  - Are impoverished by medical expenses in some states

  - Meet State criteria for home and community-based care in some States

  - Are poor and elderly
    (Medicaid pays for their Medicare premiums and cost sharing)

MEDICAID SERVICES FOR PEOPLE WITH DISABILITIES

- All states cover a minimum set of services, including:

  - Hospital and physician services
  - Nursing home services
  - Institutions caring for people with mental retardation (ICFs/MR)

- States have the option of covering many services that people with disabilities need, including:

  - Prescription drugs
  - Physical, occupational and speech therapy, and other rehabilitation services
  - Assistive devices and equipment, such as wheelchairs and communication devices
  - Home and community-based care

  These services have become increasingly critical to people with disabilities, enabling many to participate fully in family life, live in communities, attend school, and for some, work.

MEDICARE COVERAGE FOR PEOPLE WITH DISABILITIES

- Medicare covers people with disabilities if they:
  - Receive Social Security disability benefits (after a waiting period of two years)
  - Have a kidney failure
  - Are adult disabled children of individuals receiving Social Security benefits, if the parent has died and was the sole source of support for the child
  - Are elderly
- People with disabilities on Medicare qualify for the same services as other Medicare beneficiaries, including hospital services, physician services, laboratory services, skilled nursing facilities, home health care, and durable medical equipment.

CHILDREN WITH DISABILITIES

- Medicaid serves over 913,000 children with disabilities, according to the Department of Health and Human Services.

- Children may experience a range of disabling conditions, such as mental retardation, severe speech and language problems, developmental delays, cerebral palsy, cystic fibrosis, and seizure disorders.

CHILDREN WITH DISABILITIES: HOW THEY QUALIFY FOR MEDICAID

- Medicaid covers children with disabilities if:
  - The family's income is low enough to meet AFDC guidelines
  - The child is disabled and poor enough to qualify for Supplemental Security Income (SSI)
  - The child qualifies for a state home and community-based waiver program, based on the nature of the disability, family income, or the need for certain services
  - A family qualifies for a "medically needy" program offered in many states for families with large medical expenditures but incomes that are too high to qualify for Medicaid under normal circumstances.
    - Medical costs for a child with a disability can easily impoverish a middle class family.

CHILDREN WITH DISABILITIES: MEDICAID SERVICES

- At a State's option, Medicaid can provide children with disabilities services and supports, including:

    - Basic health services
    - Special therapies
    - Long-term care services
    - Family training and support
    - Special education and related services such as_____
    - Home modifications

- Under the Medicaid Early and Periodic Diagnosis, Screening and Treatment Program (EPSDT), states must cover all needed treatment identified under a child's EPSDT screening -- regardless of whether the state Medicaid program would otherwise cover the services.

CHILDREN WITH DISABILITIES: A MEDICAID CASE STORY

Tommy is a 13-year old boy with cerebral palsy. He uses a wheelchair to get around and a communication board to speak. Medicaid paid for his wheelchair and communication board, and helps cover the cost of maintaining them. Tommy also receives Medicaid-financed physical therapy, once a month, and his physical therapist works with his parents so they can help Tommy with his daily exercises.

Both Tommy's parents work, but their employers do not provide health insurance that covers people with severe disabilities such as Tommy's because of the very high cost of such insurance.

Medicaid enables Tommy's family to live together in their community. Because Medicaid provides the acute and long-term supports that he needs, Tommy can go to school. [PUBLIC??] Without these Medicaid supports, Tommy might be relegated to a segregated, institutional setting. Instead, Tommy is now in high school and expects to make the honor roll this year, has been elected Vice President of the student council, and serves as a reporter for the school newspaper.

CHILDREN WITH DISABILITIES: MEDICAID SERVICES COORDINATE WITH OTHER SERVICES

- Medicaid enables schools to provide needed services to disabled children in home and school-based settings, and funds school health programs, early intervention programs for disabled infants and toddlers, and maternal and child health programs.

- Medicaid provides health coverage that makes it possible for many disabled children to be legally adopted by families. Without Medicaid, some adoptive parents would be unable to get needed health care coverage for their disabled children.

PEOPLE WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (MR/DD)

- Medicaid provides health coverage for approximately 734,000 adults, aged 21-64, with mental retardation or other developmental disabilities (MR/DD).

- While the MR/DD population is not a large segment of all Medicaid users, MR/DD spending accounts for 10% of all Medicaid spending or $__ billion [CHECK].

- Many of these individuals also receive some health coverage under Medicare as “adult disabled children" of Medicare beneficiaries.

MEDICAID SERVICES FOR PEOPLE WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

- Medicaid acute and long-term care services enable people with MR/DD to live in their homes and communities, as well as in institutions. Medicaid enables many people with MR/DD to take care of themselves and their homes, get around in their communities, and work.

- **Acute Health Services.** Medicaid provides acute health services to people with MR/DD, including doctor and hospital care, physical therapy, eyeglasses and dental care, and assistive technology and equipment like communication devices and wheelchairs.

MEDICAID SERVICES FOR PEOPLE WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

- **Long-Term Care Services.** Medicaid provides long-term care to people with MR/DD, including:

  1. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR): 120,000 people receive 24-hour services in ICFs/MR at a cost of about $9 billion. ICFs/MR are federally regulated and monitored group living situations, ranging from 4 to over 500 individuals.

  2. Home and Community-Based Supports: Over 122,000 people receive home and community-based supports under Medicaid waiver programs, at a cost of approximately $3 billion.

  3. Other Medicaid Long-Term Care Services: These include personal care, clinic and rehabilitation services, supported living, supported employment, and case management.

WORKING-AGE ADULTS WITH DISABILITIES

- Medicaid covers health services and long-term supports for approximately 3.2 million adults with disabilities other than MR/DD.
    - 1.4 million disabled individuals under age 65 receive both Medicare and Medicaid (e.g., poor people who are eligible for Medicare because of a disability).
- Vital services for this population include: physician and hospital services, home health care, personal care, therapies, assistive devices and equipment, nursing home care, and prescription drugs.
- Under current law, many people with disabilities are able to work and earn some income while still receiving Medicaid coverage, so that they people do not have to choose between health care coverage and employment.

PEOPLE WITH HIV AND AIDS

- Most people with AIDS are "medically uninsurable," meaning their medical condition prevents them from obtaining health insurance. [CHECK]

- Medicaid is the single largest source of health care financing for people with AIDS, providing coverage for:

    - nearly 50% of adults with HIV
    - more than 90% of children with HIV
    - 60% of people with AIDS

- Medicaid covers hospital stays, physician visits, home health care, respite care, and in most states also the prescription drugs which people with AIDS need. [CHECK]

- Medicaid spends an estimated $4 billion annually for the care of people with HIV/AIDS, nearly four times the total amount spent on the Ryan White CARE Act.

ELDERLY PEOPLE WITH DISABILITIES

- Medicaid provides a safety net for over 4 million low- and middle-income elderly individuals, many with disabilities, and their families:

  - **Nursing Home Care.** [Medicaid covers nursing home care for???] 1.6 million older Americans, at a combined federal and state cost of $28 billion in 1994.

    - Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Medicaid covers 68% of nursing home residents and over 50% of nursing home costs.

    - Nursing home care costs average $38,000 per year.

  - **Home and Community-Based Care.** Over 1 million people received home and community-based care, at a combined federal and state cost of $8.4 billion in 1994.

  - **Prescription drug coverage.** Medicaid paid approximately $505 per elderly beneficiary for prescription drugs in 1994.

ELDERLY PEOPLE WITH DISABILITIES

- Medicaid covers Medicare premiums, deductibles, and copayments for people with incomes below 100% of poverty (known as "Qualified Medicare Beneficiaries") and premiums for people with incomes between 100% and 120% of poverty.

  - 5.4 million people had their Medicare premiums, deductibles, and copayments covered by Medicaid in 1995

- Medicare provides acute and long-term care services, such as home health care, for elderly people with disabilities. The elderly often experience disabilities such as Alzheimer's, broken hips, and _____ [other examples?].

QUA _ITY S' 'ANDAR)S

- To be reimbursed by Medicaid, nursing homes must comply with strict federal quality standards. These standards -- signed into law by President Reagan -- require facilities to provide all needed services, limit the use of physical and chemical restraints, and ensure that nurse aides are trained and qualified.

  - Since these standards have been in place, there has been a:

    - 50% reduction in dehydration among residents,
    - 31% reduction in hospitalization rates, and
    - 25% reduction in the use of physical restraints.
      [Sources: Research Triangle Institute and HCFA.]

- Since 1971, to be reimbursed by Medicaid, institutions caring for the mentally retarded have had to comply with federal Medicaid quality standards. Because of these standards, people with mental retardation can live in safe, healthy institutions rather than in the deplorable conditions of the past.

THE REPUBLICAN BUDGET AND QUALITY STANDARDS

The Republican reconciliation bill:

- **Repeals federal enforcement of nursing home quality standards.**

  - States would define and enforce nursing home standards.
  - The federal government would have no way to ensure that states enforce these standards.
  - States could even turn over their standard setting and enforcement responsibilities to private organizations, with no federal review.
  - Budget constraints, combined with the elimination of federal standards and monitoring, could threaten quality of care.

- **Repeals entirely federal standards for institutions caring for people with mental retardation and developmental disabilities.** [CHECK]

  - In addition, it does not require states to assure even the most basic rights, such as protection from abuse and neglect. States do not have quality standards for these institutions in place today.

SPOUSAL IMPOVERISHMENT PROTECTIONS

- Medicaid protects spouses of nursing home residents from having to become impoverished in order for their spouse to qualify for Medicaid. States must let spouses keep income equal to 150% of the national poverty level -- about $15,000 per year. States must also allow spouses to keep a minimum amount of the couple's assets -- ranging from $15,000 to $75,000 -- in addition to their house and car.

- Since this law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of the spouses are women.

- Initially, Republicans repealed these protections. In response to criticism that spouses could be forced to use all their income and assets to pay for nursing home care, Republicans modified their plans. But the protections in their reconciliation bill are hollow:

  - They repeal all current protections from liens, allowing states to impose liens on the homes and family farms of Medicaid recipients and their families. [CHECK]

  - They make it more difficult for the federal government to ensure that states protect spouses, and repeal the right of individuals to sue states to enforce spousal protections.

HOME AND COMMUNITY-BASED CARE

- People with disabilities of all ages, and their family members, often prefer to receive services and supports at home and in the community so that they can participate more fully in family and community life. Medicaid financing has adapted to this change in our society over the past 15 years.

- The Medicaid home and community-based waiver program allows states to design programs that provide home and community care to people who would otherwise need to be in an institution, as long as the cost of the care does not exceed the cost of institutional care.

- 49 states operate a total of over 200 home and community-based waiver programs, using Medicaid dollars to provide a range of supports to certain people eligible for Medicaid, such as adults with mental retardation, the frail elderly, or people with HIV/AIDS. Waivers may also be designed to serve people in targeted areas within a state (e.g., certain counties).

- In addition to waiver programs, states provide home and community-based care to people with disabilities by offering optional Medicaid services like personal care services or case management.

IMPACT OF THE REPUBLICAN MEDICAID PLAN ON PEOPLE WITH DISABILITIES

Under the Republican reconciliation bill's proposal to block grant Medicaid and cut it by $163 billion over seven years:

- 1.3 million people with disabilities could be denied coverage in 2002.
- Coverage for the disabled is *not* guaranteed, despite claims by some Republicans.
  - The bill guarantees that [POOR??] people with disabilities will be covered by Medicaid, but each state would define eligible disabilities and the level of services provided.
  - Because the federal cuts reach 28% in 2002, states will be forced to reduce significantly Medicaid eligibility and benefits for disabled individuals.

IMPACT OF THE REPUBLICAN MEDICAID CUTS ON PEOPLE WITH DISABILITIES

- The deep funding cuts could force States to eliminate coverage for many services important to people with disabilities:
  - People with disabilities would no longer be guaranteed coverage of even the minimum set of services now covered by all states (known as "mandatory services"), such as doctor and hospital care.
  - Coverage of "optional services" such as prescription drugs, assistive devices and equipment, home and community-based supports (such as personal assistance services), and home modifications, could be eliminated.
- Children and other people with disabilities who tend to have less political power may fare especially poorly in securing funding from each state's inadequate block grant.

IMPACT OF THE REPUBLICAN MEDICAID CUTS

- Families of children with severe disabilities might be forced to impoverish themselves paying for their children's medical care. Parents might have to give up jobs to stay home to care for their children.

- Adults with MR/DD who live independently in community settings with Medicaid supports might be forced to enter state institutions or return to the homes of their aging parents, who would have to provide care formerly covered by Medicaid.

  - Under a Medicaid block grant, home and community-based care may lose funding to large state institutions, which tend to have strong state political support.

- Working age people with disabilities might be forced to give up their job in order to qualify for Medicaid benefits.

- People with AIDS would likely be unable to secure adequate funding under a block grant and might lose coverage of many critical services, including coverage of prescription drugs, and home health and hospice services.

IMPACT OF THE REPUBLICAN MEDICAID CUTS ON PEOPLE WITH DISABILITIES

- Costs would increase significantly for elderly people with disabilities:

  - Medicare premiums would increase dramatically, disproportionately affecting people with disabilities who already pay high out-of-pocket costs, are less likely to have private insurance, and are more likely to be poor.

    - The Republican Medicare plan increases premiums by $20 a month in 2002, compared with the President's plan [CHECK].

  - Medicaid would no longer guarantee coverage of Medicare premiums, deductibles, and copayments for low-income Medicare beneficiaries. The Republican Medicaid plan sets aside *less than half* of the funding needed to cover premiums for low-income Medicare beneficiaries in 2002, and does not set aside any funding for their deductibles and copayments.

THE PRESIDENT'S BALANCED BUDGET PLAN PROTECTS PEOPLE WITH DISABILITIES

- The President's Medicaid plan includes savings of $54 billion over seven years -- less than one-third of the Republican $163 billion cut.

- The President's plan limits the growth in federal Medicaid payments to States on a per person basis, so that states do not need to reduce coverage to achieve savings.

- The President's plan guarantees coverage to people currently eligible for Medicaid, including the disabled. Under the Republican plan, 1.3 million people with disabilities would lose coverage in 2002.

- The President's plan also maintains current benefits ~~mandatory services~~ for people on Medicaid. The Republican plan would leave states free to decide not to cover any service.

- The President's plan protects quality of care in nursing homes and other facilities, and ensures that spouses of nursing home residents are not driven into poverty by the costs of nursing home care.

THE WHITE HOUSE
WASHINGTON

OFFICE OF THE FIRST LADY

TO John Spiegel

FROM Jennifer Klein

FAX # 401-7321

PHONE #

OF PAGES (including cover)

COMMENTS This needs one more look over. I've also attached Pauline's questions. Call with questions. This is not a rush.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

03-Jan-1996 01:48pm

TO: Jennifer L. Klein

FROM: Pauline M. Abernathy
National Economic Council

SUBJECT: Disabilities briefing document

Attached is the revised disabilities briefing document. It really is quite good. It incorporates your, HHS's, and Diana's comments. There are still a few question marks in the text. In addition, I have the following comments:

the case study is still phony -- shouldn't we get a real one?

the bullet on medicaid and schools is still somewhat eliptical and I don't know enough to fix it. I think the woman who works on this for Mike Smith at ED is on furlough.

I changed the 1.3 million people losing coverage to "hundreds of thousands" people with disabilities. Could we do this until we have a hard number?

Did we decide the GOP proposal guarantees coverage to people who are both disabled and below the federal poverty line?

Is $53 billion [more than] one third of total Medicaid spending?

I added some items from Diana and Bob Williams' email, including that current federal law guarantees coverage of disabled kids who are adopted, that the number of people with MR/DD in homes and community care has nearly doubled, and I more directly compared the share of Medicaid recipients who are disabled to the share of Medicaid spending for people with disabilities.

Let me know what you think. I think it makes sense to have this in shape so that it is ready to go, if possible. I know both John S and Ruth K are not furloughed.

A PC Data File is attached. Use PCT SAD to download to your PC

WHITE HOUSE BRIEFING DOCUMENT ON MEDICARE AND MEDICAID FOR PEOPLE WITH DISABILITIES

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January 2, 1996

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MEDICARE AND MEDICAID FOR PEOPLE WITH DISABILITIES

- Medicare and Medicaid provide critical health care services and long-term supports to people with disabilities of all ages.

  ⇒ Medicaid serves more than 6 million people with disabilities.

  ⇒ Medicare serves 4 million people under age 65 with disabilities, and millions more elderly with disabilities.

- People with disabilities are more likely to be low-income, use more health and long-term care services, and incur higher health costs than people without disabilities.

- Medicaid is the primary insurer of people with disabilities because people with disabilities often are unable to buy private health insurance because of high costs, pre-existing condition exclusions and other restrictions on coverage.

  ⇒ While people with disabilities represent about 16% of Medicaid beneficiaries, they account for **[more than?]** *one-third* of total Medicaid payments or approximately $53 billion in fiscal year 1995.

MEDICAID ELIGIBILITY AND PEOPLE WITH DISABILITIES

- The primary ways people with disabilities qualify for Medicaid are if they:

  - Are disabled and poor enough to qualify for SSI

  - Have a family income low enough to meet AFDC guidelines

  - Are poor and Medicare beneficiaries
    (Medicaid pays for their Medicare premiums, deductibles, and copays)

  - Qualify for a State home and community-based waiver program, based on the nature of the disability, family income, or the need for certain services

  - Qualify for a "medically needy" program offered in many States for families with large medical expenditures but incomes that are too high to qualify for Medicaid under normal circumstances.

    ⇒ Medical costs for a child or adult with a disability can easily impoverish a middle class family.

MEDICAID SERVICES FOR PEOPLE WITH DISABILITIES

- All states cover a minimum set of services, including:

  ⇒ Hospital and physician services
  ⇒ Nursing home services

- States have the option of covering many services that people with disabilities need, including:

  ⇒ Prescription drugs
  ⇒ Physical, occupational and speech therapy, and other rehabilitation services
  ⇒ Assistive devices and equipment, such as wheelchairs and communication devices
  ⇒ Home and community-based care and other personal care
  ⇒ Institutions caring for people with mental retardation (ICFs/MR)

  Many of these optional services have become increasingly critical to people with disabilities, enabling many to participate fully in family life, live in communities, attend school, and for some, work.

MEDICARE COVERAGE FOR PEOPLE WITH DISABILITIES

- Medicare covers people with disabilities if they:

  - Receive Social Security disability benefits
    (after a waiting period of two years)
  - Have kidney failure
  - Are adult disabled children of individuals receiving Social Security benefits, if the parent has died and was the sole source of support for the child
  - Are elderly

- People with disabilities on Medicare qualify for the same services as other Medicare beneficiaries, including hospital services, physician services, laboratory services, skilled nursing facilities, home health care, and durable medical equipment.

- Medicare payments for people eligible for Medicare because of a disability (who are generally under age 65) totaled $19 billion in fiscal year 1995. Medicare spends billions more on services for elderly people with disabilities.

CHILDREN WITH DISABILITIES

- Medicaid serves over 913,000 children with disabilities, according to the Department of Health and Human Services.

- Children may experience a range of disabling conditions, such as mental retardation, blindness, severe speech and language problems, developmental delays, cerebral palsy, cystic fibrosis, and seizure disorders.

CHILDREN WITH DISABILITIES: MEDICAID SERVICES

- Medicaid provides children with disabilities with basic health services, and at the State's option, may also provide other services and supports, including:

  - ⇒ Long-term care services
  - ⇒ Family training and support
  - ⇒ Home modifications
  - ⇒ Special therapies
  - ⇒ Special education, treatments, and equipment

- Under the Medicaid Early and Periodic Diagnosis, Screening and Treatment Program (EPSDT), states must cover all needed treatment identified under a child's EPSDT screening -- regardless of whether the state Medicaid program would otherwise cover the services.

CHILDREN WITH DISABILITIES: A MEDICAID CASE STORY

Tommy is a 13-year old boy with cerebral palsy. He uses a wheelchair to get around and a communication board to speak. Medicaid paid for his wheelchair and communication board, and helps cover the cost of maintaining them. Tommy also receives Medicaid-financed physical therapy, once a month, and his physical therapist works with his parents so they can help Tommy with his daily exercises.

Both Tommy's parents work, but their employers do not provide health insurance that covers people with severe disabilities such as Tommy's because of the very high cost of such insurance.

Medicaid enables Tommy's family to live together in their community. Because Medicaid provides the acute and long-term supports that he needs, Tommy can go to his local public school. Without these Medicaid supports, Tommy might be relegated to a segregated, institutional setting. Instead, Tommy is now in high school and expects to make the honor roll this year, has been elected Vice President of the student council, and serves as a reporter for the school newspaper.

CHILDREN WITH DISABILITIES: MEDICAID SERVICES COORDINATE WITH OTHER SERVICES

- Medicaid enables schools to provide needed services to disabled children in home and school-based settings, and funds school health programs, early intervention programs for disabled infants and toddlers, and maternal and child health programs.

- Medicaid also provides health coverage that makes it possible for many disabled children to be legally adopted by families.

  ⇒ Federal Medicaid law guarantees Medicaid coverage for children with disabilities in adoptive homes. Without Medicaid, many adoptive parents would be unable to get needed health care coverage for their disabled children.

PEOPLE WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (MR/DD)

- Medicaid provides health coverage for approximately 734,000 adults, aged 21-64, with mental retardation or other developmental disabilities (MR/DD).

- While only 1% of all Medicaid recipients are people with MR/DD, spending on institutional and community care for people with MR/DD accounts for more than 10% of all Medicaid spending, or approximately $16 billion in fiscal year 1995.

- Many of these individuals also receive some health coverage under Medicare as “adult disabled children" of Medicare beneficiaries.

MEDICAID SERVICES FOR PEOPLE WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

- Medicaid provides people with MR/DD with both acute and long-term care services.

- These Medicaid services enable people with MR/DD to live in their homes and communities, as well as in institutions.

  ⇒ They enable many people with MR/DD to take care of themselves and their homes, get around in their communities, and work.

- **Acute Health Services.** Medicaid provides acute health services to people with MR/DD, including doctor and hospital care, physical therapy, eye glasses and dental care, and assistive technology and equipment like communication devices and wheelchairs.

MEDICAID SERVICES FOR PEOPLE WITH MR/DD

- **Long-Term Care Services.** Medicaid provides long-term care to people with MR/DD, including:

  1. **Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):** 120,000 people receive 24-hour services in ICFs/MR at a cost of about $9 billion. ICFs/MR are federally regulated and monitored group living situations, ranging from 4 to over 500 individuals.

  2. **Home and Community-Based Supports:** Over 122,000 people receive home and community-based supports under Medicaid waiver programs, at a cost of approximately $3 billion.

     ⇒ Since 1992, the number of people served in homes and communities nearly doubled from 62,000 to more than 122,000.

  3. **Other Medicaid Long-Term Care Services:** These include personal care, clinic and rehabilitation services, supported living, supported employment, and case management.

WORKING-AGE ADULTS WITH DISABILITIES

- Medicaid covers health services and long-term supports for approximately 3.2 million adults with disabilities other than MR/DD.

  - 1.4 million disabled individuals under age 65 receive both Medicare and Medicaid (e.g., poor people who are eligible for Medicare because of a disability).

- Vital services for this population include: physician and hospital services, home health care, personal care, therapies, assistive devices and equipment, nursing home care, and prescription drugs.

⇒ Under current law, many people with disabilities are able to work and earn some income while still receiving Medicaid coverage, so that they do not have to choose between health care coverage and employment.

PEOPLE WITH HIV AND AIDS

- Many people with HIV/AIDS are "medically uninsurable," meaning their medical condition prevents them from obtaining health insurance.

- Medicaid is the single largest source of health care financing for people with HIV/AIDS, providing coverage for:

  ⇒ nearly 50% of adults with HIV
  ⇒ more than 90% of children with HIV
  ⇒ 60% of people with AIDS

- Medicaid covers hospital stays, physician visits, home health care, respite care, and in most States also the prescription drugs which people with AIDS need.

- Medicaid spends an estimated $4 billion annually for the care of people with HIV/AIDS, nearly four times the total amount spent on the Ryan White CARE Act.

ELDERLY PEOPLE WITH DISABILITIES

- Medicaid provides a safety net for over 4 million low- and middle-income elderly individuals, many with disabilities, and their families:

  - **Nursing Home Care.** Medicaid pays for nursing home care for 1.6 million Americans, at a combined Federal and State cost of $28 billion in 1994.

    ⇒ Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Medicaid covers 68% of nursing home residents and over 50% of nursing home costs.

    ⇒ Nursing home care costs average $38,000 per year.

  - **Home and Community-Based Care.** Over 1 million people received home and community-based care, at a combined Federal and State cost of $8 billion in 1994.

  - **Prescription Drug Coverage.** Medicaid paid approximately $585 per elderly beneficiary for prescription drugs in 1994.

ELDERLY PEOPLE WITH DISABILITIES

- Medicare provides acute and long-term care services, such as home health care, for elderly people with disabilities. The elderly often experience disabilities such as Alzheimer's, strokes, heart attacks, high blood pressure, and broken hips.

- Medicaid covers Medicare premiums, deductibles, and copayments for people with incomes below 100% of poverty (known as "Qualified Medicare Beneficiaries") and premiums for people with incomes between 100% and 120% of poverty.

  ⇒ 5.4 million people -- many of whom are disabled -- had their Medicare premiums, deductibles, and copayments covered by Medicaid in fiscal year 1995.

  ⇒ This assistance with Medicare premiums and cost-sharing ensures that poor disabled people can afford to participate in the Medicare Part B program.

HOME AND COMMUNITY-BASED CARE

- People with disabilities of all ages and their family often prefer to receive services at home and in the community so that they can participate more fully in family and community life. Medicaid financing has adapted to this change in our society over the past 15 years.

- The Medicaid home and community-based waiver program allows States to design programs that provide home and community care to people who would otherwise need to be in an institution, as long as the cost of the care does not exceed the cost of institutional care.

- 49 States operate a total of over 200 home and community-based waiver programs, using Medicaid dollars to provide a range of supports to certain people eligible for Medicaid, such as adults with mental retardation, the frail elderly, and people with HIV/AIDS. Waivers may also be designed to serve people in targeted areas within a state (e.g., certain counties).

- In addition to waiver programs, States provide home and community-based care to people with disabilities by offering optional Medicaid services such as personal care services or case management.

NURSING HOME QUALITY STANDARDS

- To be reimbursed by Medicaid, nursing homes must comply with strict federal quality standards. These standards -- signed into law by President Reagan -- require facilities to provide all needed services, limit the use of physical and chemical restraints, and ensure that nurse aides are trained and qualified.

- Since these standards have been in place, there has been a:

  ⇒ 50% reduction in dehydration among residents,

  ⇒ 31% reduction in hospitalization rates, and

  ⇒ 25% reduction in the use of physical restraints.

[Sources: Research Triangle Institute and HCFA.]

THE REPUBLICAN BUDGET AND NURSING HOME QUALITY STANDARDS

- The Republican Reconciliation Bill *repeals* federal enforcement of nursing home quality standards and some key standards.

  ⇒ States would define and enforce nursing home standards. The Federal government would have no way to ensure that States enforce them.

  ⇒ States could even turn over their standard setting and enforcement responsibilities to private organizations, with no federal review.

  ⇒ It repeals the federal requirement that nursing homes provide services to "attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident." Thus, residents could be denied rehabilitative services needed to improve their ability to function.

- While States may want to maintain the quality of nursing homes, inadequate resources combined with the elimination of federal standards and monitoring may lead them to fail to set and enforce quality standards that will protect disabled people in nursing homes.

QUALITY STANDARDS FOR ICF/MRs

- Since 1971, to be reimbursed by Medicaid, institutions caring for the mentally retarded (ICF/MRs) have had to comply with federal Medicaid quality standards.

  ⇒ Prior to adoption of these standards, people with MR/DD were routinely subject to abuse and lacked even minimally safe and sanitary living conditions.

- The Republican Reconciliation Bill *entirely repeals* federal standards for institutions caring for people with mental retardation and developmental disabilities (ICF/MRs).

  ⇒ It does not require States to assure even the most basic rights, such as protection from abuse and neglect.

  ⇒ States do not have their own quality standards for these institutions in place today.

SPOUSAL IMPOVERISHMENT PROTECTIONS

- Medicaid currently protects spouses of nursing home residents from having to become impoverished in order for their spouse to qualify for Medicaid.

  ⇒ States must let spouses keep income equal to 150% of the national poverty level -- about $15,000 per year.

  ⇒ States must let spouses keep a minimum amount of the couple's assets -- ranging from $15,000 to $75,000 -- in addition to their house and car.

- Since this law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of the spouses are women.

THE REPUBLICAN BUDGET AND SPOUSAL IMPOVERISHMENT PROTECTIONS

- Initially, Republicans repealed the federal spousal impoverishment protections.

- In response to criticism that spouses could be forced to use all their income and assets to pay for nursing home care, Republicans modified their plans. But the protections in their Reconciliation Bill are hollow:

  ⇒ They repeal the Medicaid guarantee to nursing home coverage. Spouses of people denied coverage will not be protected from impoverishment from nursing home costs that average $38,000 per year.

  ⇒ Even the spouses of people covered by Medicaid could be charged by the nursing home for services no longer covered by Medicaid. **?**

  ⇒ Republicans make it more difficult for the federal government to ensure that States enforce the protections for spouses.

  ⇒ They repeal the right of individuals to seek redress in Federal court to enforce spousal protections not being provided by the State.

FINANCIAL PROTECTIONS FOR FAMILIES OF PEOPLE WITH DISABILITIES

- The Republican Reconciliation Bill repeals the current protections for homes and family farms:

  ⇒ States could count their value in determining Medicaid eligibility, forcing people to sell their homes or family farm in order to qualify for Medicaid -- even while a spouse or child is still living there.

  ⇒ They repeal all current protections from liens, allowing States to impose liens on the homes and family farms of Medicaid recipients and their families.

  ⇒ States could reduce Medicaid benefits based on the value of people's homes or farm.

- The Republican Reconciliation Bill allows States to provide minimal nursing home benefits under Medicaid, leaving families to pay for items no longer covered by Medicaid. It also repeals current protections against discrimination by nursing homes, allowing nursing homes to charge large up-front payments for admittance.

IMPACT OF THE REPUBLICAN MEDICAID PLAN ON PEOPLE WITH DISABILITIES

The latest Republican Medicaid proposal eliminates the Medicaid guarantee to meaningful health coverage, block grants the program, and cuts it by $117 billion over seven years. Under this proposal:

- Coverage for the disabled is *not* guaranteed, despite claims by some Republicans.

  - The bill guarantees that some people with disabilities will be covered by Medicaid, but each State would define the eligible disabilities and the level of services provided.

  - Because the Federal Medicaid cuts would reach 26% by 2002, States would almost certainly be forced to reduce significantly Medicaid eligibility and benefits for disabled individuals, who account for **[more than]** one-third of all Medicaid spending.

- Hundreds of thousands **[#]** of children and adults with disabilities could be denied meaningful health coverage by 2002.

IMPACT OF THE REPUBLICAN MEDICAID CUTS ON PEOPLE WITH DISABILITIES

- The elimination of the Medicaid guarantee to a meaningful benefits package combined with the deep funding cuts could force States to eliminate coverage of many services important to people with disabilities:

  ⇒ People with disabilities would no longer be guaranteed coverage of even the minimum set of services now covered by all States, such as doctor and hospital care.

  ⇒ Coverage of "optional services" such as prescription drugs, assistive devices and equipment, home and community-based supports (such as personal assistance services), and home modifications, could be eliminated.

- Children and other people with disabilities who tend to have less political power may fare especially poorly in securing funding from each State's inadequate block grant.

IMPACT OF THE REPUBLICAN MEDICAID CUTS

- Families of children with severe disabilities might be forced to impoverish themselves paying for their children's medical care. Parents might have to give up jobs to stay home to care for their children.

- Adults with MR/DD who live independently in community settings with Medicaid supports might be forced to enter State institutions or return to the homes of their aging parents, who would have to provide care formerly covered by Medicaid.

  ⇒ Under a Medicaid block grant, home and community-based care may lose funding to large State institutions, which tend to have strong State political support.

- Working age people with disabilities might be forced to give up their jobs in order to qualify for Medicaid benefits.

- People with AIDS would likely be unable to secure adequate funding under a block grant and might lose coverage of many critical services, including coverage of prescription drugs, and home health and hospice services.

IMPACT OF THE REPUBLICAN CUTS

- Elderly people with disabilities would face significantly higher costs:

  - Medicare premiums would increase dramatically, disproportionately affecting people with disabilities who already pay high out-of-pocket costs, are less likely to have private insurance, and are more likely to be poor.

    ⇒ The Republican Medicare plan increases premiums by $12 a month or $143 a year in 2002 compared with the President's plan.

  - Medicaid would no longer guarantee coverage of Medicare premiums, deductibles, and copayments for low-income Medicare beneficiaries.

    ⇒ The Republican Medicaid plan sets aside *less than half* of the funding needed to cover premiums for low-income Medicare beneficiaries, and does not set aside *any funding* for their deductibles and copayments.

THE PRESIDENT'S BALANCED BUDGET PLAN PROTECTS PEOPLE WITH DISABILITIES

- The President's Medicaid plan includes savings of $54 billion over seven years -- *less than half* of the Republican $117 billion cut.

- The President's plan limits the growth in federal Medicaid payments to States on a per person basis, so that States do not need to reduce coverage to achieve savings.

- The President's plan guarantees coverage to people currently eligible for Medicaid, including the disabled. Under the Republican plan, hundreds of thousands **[#]** of people with disabilities could be denied meaningful health coverage by 2002.

- The President's plan also maintains current services for people on Medicaid. The Republican plan would allow States to eliminate coverage of any service.

- The President's plan protects quality of care in nursing homes and other facilities, and ensures that spouses of nursing home residents are not driven into poverty by the costs of nursing home care.

Called MCAID.d20

EXECUTIVE OFFICE OF THE PRESIDENT

21-Dec-1995 04:55pm

TO: Jennifer L. Klein

FROM: Pauline M. Abernathy
National Economic Council

CC: Jason S. Goldberg
CC: Aaron J. Rappaport

SUBJECT: medicaid issue briefs attached

attached are the medicaid issue briefs. this is their status:

Done (edits in from Jen Klein-$117 billion figure may need to be changed):

medicaid overall
guarantee
QMBs (in Aaron's Medicare packet)
flexibility

Still in Need of Work but in the attached document directly after the above:

nursing home quality
overall financial protections

There are others in the document, but they are a lower priority.

I will complete these documents when I get back, but if they are needed before then you now have them and know where things stand. I'm sorry I didn't have time to finish everything before I left.

December 21, 1995

TO: Jen Klein

FROM: John Spiegel

SUBJECT: Document Updates/changes

I got a similar package from Pauline and Aaron yesterday. I sent them some changes already. I'm faxing one issue paper to you that I sent to them (Trust Fund Solvency). Otherwise, I've marked up what I can given what we know. This material reflects the best we can do on numbers given that we don't have all of the details on the latest Repub offer. We could probably do some comparisons based on the conference agreement or the conference agreement adjusted for baseline changes, or other (cpi) changes. However, that would be out of date and the Repubs would say the comparison is unfair because it's not their latest offer.

I sent new pages back to Aaron and Pauline today also.

Sorry this was late. Give me a call if I can clarify anything.

The stuff I'm faxing is really messy. I'll be glad to walk you thru it.

John

SAVING AND SPENDING

Overall Savings

The President's proposal secures the Trust Fund through responsible and genuine reform. The President's plan would achieve $124 billion in savings -- securing the Medicare Trust Fund through 2011 -- as strong as or stronger than it has been in 14 of the last 20 years.

The Republican proposal represents a radical restructuring of Medicare. The Republican plan cuts [$200] billion from Medicare -- far greater than any other cut in history.

- According to the Americans Hospital Association and 40 state hospital associations, these deep cuts will "jeopardize the ability of hospitals and health care systems to deliver quality health care, not just to Americans who rely on Medicare and Medicaid, but to all Americans."

The Republican cuts will also lead to a massive cost-shift onto the private sector. Updating a study conducted by VHI-Lewin, the Department of Health and Human Services estimates that Medicare and Medicaid cuts could add [$85] billion in additional costs onto the private sector, as health care providers hike the bills they charge privately insured individuals to compensate for Medicare cuts. [CAN WE USE THIS ANALYSIS?]

Spending

The President's proposal maintains spending growth near the private sector rate. The President's plan would hold the Medicare per person program growth to [6.3%], just slightly below the private sector growth rate of 7.1%.

Republican plan imposes unrealistic constraints on spending, enforced by an arbitary budget cap. The Republican plan cuts the permissible growth rate to [4.7%], more than [30%] below the private sector rate. *By 2002, Republican proposals will provide [$1,400] less in spending for an elderly couple compared to the President's proposal -- while increasing premiums $600 per year.*

Budget Cap

The President's plan relies on specific policy changes to achieve savings, not an aggregate budget cap. The President's proposal achieves its savings through specific policy changes that improve efficiency and cut costs, not through the implementation of a rigid budget cap.

The Republican savings rely on a rigid budget cap that limits Medicare spending irrespective of the actual health care costs or needs in the future.

PREMIUMS

Part B Premiums

The President's proposal does not increase Part B premiums beyond the rate set under the current law. The President's proposal maintains Part B premiums at the current law rate: 25% of program costs.

Republicans increase premiums. The Republican plan raises premiums to 31.5% of program costs -- increasing costs $264 above the President's proposal for an elderly couple next year alone, and [$1,700] more for an elderly couple over seven years

HHS Check

INCOME RELATED

Means-Testing of Premiums

The President's proposal does not raise premiums beyond current law for any beneficiary.

The Republican proposal adopts means-testing proposals that would encourage healthy beneficiaries to leave the traditional fee-for-service program. The Republican proposal increases premiums for high-income beneficiaries, encouraging many to leave the traditional fee-for-service program. Because these beneficiaries are often in good health, their disenrollment will weaken the traditional program and increase costs for those beneficiaries remaining in the program.

Premium payments for low-income Beneficiaries

The President's proposal protects financial safeguards for low-income beneficiareis. Under current law, Medicaid pays premiums for everyone falling below 120% of the poverty line and deductibles and copayments as well for those falling below 100% of that line. The President's proposal maintains that protection.

The Republican proposal effectively eliminates the safety net for low-income beneficiaries -- who would no longer be guaranteed coverage of their premiums, deductibles, and copayments. As a result, many would be forced to leave the traditional program and enroll in managed care plans that require little or no cost-sharing – that is, assuming one exists in their area.

CBO estimates GOP premiums would be $84.60 in 2002. This estimates program under is at least $12/mo higher than the President's plan. This means $140 more in premiums in 2002.

MAINTAINING A STRONG FEE-FOR-SERVICE PROGRAM

checking

Spending on Fee-For-Service

The President's proposal maintains equitable funding levels for the fee-for-service program, with comparable spending increases for the fee-for-service and private health care options. [Check]

The Republican proposal underfunds the fee-for-service program in some years. The Republican proposal constrains the spending growth rate in 1996 to 6% per year, while allowing spending on the private plans to grow by 8% per year -- 33% higher.

HHS

Private Plan Options

The President's plan expands the range of private options available, while also ensuring that the fee-for-service program remains structurally sound. The President's plan would expand beneficiary choice among health care plans and delivery system options that gaurantee high quality care for reasonable costs. However, the plan rejects health care options, such as Medical Savings Accounts, that could segment Medicare into pools of sick and healthy beneficiaries and undermine the traditional fee-for-service program.

The Republican proposal establishes new options -- such as Medical Savings Accounts -- that would leave the traditional fee-for-service program with the sickest beneficiaries and a dwindling amount of resources.

Balance Billing

The President's proposal ensures that doctors don't have additional incentives to leave the fee-for-service program. The President's proposal imposes the same restrictions on physicians in private health care plans as those in the fee-for-service program. Providers associated with both programs would be prohibited from "balance billing" -- charging beneficiaries beyond what Medicare pays for medical services.

The Republican proposal gives doctors additional incentives to leave the traditional fee-for-service program by allowing them to balance bill in the new private plans.. Physicians may see the opportunity to balance bill in these private plans as a way of compensating for the deep cuts they will suffer under the Republican proposal.

Cash-Rebates

The President's proposal follows current law in prohibiting private plans from using cash rebates to attract new enrollees. Cash rebates are prone to abuse and can be used as a marketing tool to draw only the healthiest beneficiaries into the private health crae plans -- leaving the traditional fee-for-service program with the sicker and more costly beneficiaries.

The Republican proposal rejects current law and allows private health care plans to market their policies using cash rebates.

TRUST FUND SOLVENCY

CURRENT LAW:

Medicare consists of two parts: Part A Hospital Insurance and Part B Supplemental Medical Insurance.

Medicare Part A covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

- **Payroll tax funds Part A.** Part A is financed by the Hospital Insurance (HI) payroll tax, a 1.45 percent tax on earnings paid both by employer and by employee (for a combined payroll tax rate of 2.9 percent). Income from the payroll tax goes directly into the Part A Trust Fund. All Hospital Insurance benefits and administrative costs are paid from this trust fund.

- **Trust Fund solvent until 2002.** According to the 1995 Medicare Trust Fund Trustees Report, the Part A Trust Fund is projected to be exhausted in the fourth quarter of calendar year 2002 (the first quarter of fiscal year 2003). This is the ninth time in the last twenty-~~five~~ years that the Trust Fund has been projected to be insolvent in seven years or less. ~~(CHECK)~~

Medicare Part B covers physician and other outpatient services. Part B is funded by premiums paid by beneficiaries and by general revenues. Specifically, for 1996, 25% of the cost of Part B is funded by beneficiary premiums; the remaining 75% comes from the general tax fund. Medicare Part B cannot become insolvent.

PRESIDENT'S PROPOSAL:

Part A. The President's Plan strengthens Medicare Part A, securing the trust fund until 2011. The Plan proposes two changes that reduce projected Part A outlays by $150 billion between 1996 and 2002.

- **Spending reduction.** The President's Plan reduces outlays by $89 billion by enacting specific policy changes to reduce Part A spending. These policy proposals, alone, would extend the Part A Trust Fund until about January 2007.

- **Transfer of non-hospital home health services.** The President's plan also saves another $61 billion in Part A spending by shifting certain home health costs not related to hospital stays from Part A to Part B. This transfer, combined with the Part A savings proposals, would extend the Part A Trust Fund until October 2011.

Part B. The President's proposal achieves approximately $ ~~billion~~ in additional savings by extending current law, which sets premiums at 25% of program costs. [Besides premium increases, are there any other cuts in Part B? How do we account for the full $124 billion in total cuts?]

→ Physician and other Part B provider cuts.

~$30 B Total in Part B cuts

See other document (attached)

not enough info to verify these #s.

REPUBLICAN PROPOSAL:

HHS

Part A. The Republican proposal cuts [$130] billion from Part A spending -- [$41] billion more than the President's proposal.

Part B. The ~~President's~~ Republican proposal makes two significant changes to Part B.

- **Raises premiums.** The proposal ~~raises premiums by~~ saves approximately [$57] billion by increasing Part B premiums from 25% to 31.5% of program costs and by raising Part B premium for higher-income beneficiaries. (See ____ for more information). The Republican plan then transfers these additional revenues from the Part B program to the Part A Trust Fund -- extending the life of the fund for another undetermined number of years. [CHECK]

HHS

I think it's determined - we just don't like to say it.

- **Additional cuts.** The Republican proposal makes an additional $80 billion in cuts from Part B payments from ___. These cuts have nothing to do with the Part A Trust Fund and do not extend the solvency of that fund any additional years. [What are the additional cuts that are necessary to reach the Republican's total of $200 or so billion? How is this number broken out?]

cutting provider payments + other policy changes.

can't verify

ANALYSIS:

The President's proposal secures the Trust Fund without excessive cuts. The President's proposal achieves $124 billion in savings, securing the Trust Fund through 2011 and leaving it as strong or stronger than it has been in 18 of the last 20 years. Moreover, it achieves that goal without increasing premiums beyond current law. By contrast, the Republican proposal cuts $140 billion farther. It cuts $40 billion more from the Part A Trust Fund, raises premiums by $57 billion, and cuts $80 billion from Part B spending that does nothing to strengthen the Trust Fund.

HHS

The Republican proposal requires duplicative payment for Part A coverage. The Republican proposal to use a Part B premium surcharge to bail out the Part A Trust Fund has troubling implications. This provision is akin to establishing a premium for Part A. Transferring the surcharge to Part A means that beneficiaries would pay twice for their Part A coverage -- once through a payroll contribution and again with their Part B surcharge.

This is a good number

Sent last night. Has new #'s today 12/21

TRUST FUND SOLVENCY

CURRENT LAW:

Medicare consists of two parts: Part A Hospital Insurance and Part B Supplemental Medical Insurance.

Medicare Part A covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

1.45 employee
1.45 employer

- **Payroll tax funds Part A.** Part A is financed by the Hospital Insurance (HI) payroll tax, a 1.45 percent tax on earnings paid both by employer and by employee (for a combined payroll tax rate of 2.9 percent). Income from the payroll tax goes directly into the Part A Trust Fund. All Hospital Insurance benefits and administrative costs are paid from this trust fund.

- **Trust Fund solvent until 2002.** According to the 1995 Medicare Trust Fund Trustees Report, the Part A Trust Fund is projected to be exhausted in the fourth quarter of calendar year 2002 (the first quarter of fiscal year 2003). This is the ninth time in the last twenty ~~fifty~~ years that the Trust Fund has been projected to be insolvent in seven years or less. ~~[illegible]~~ current law calls for

Medicare Part B covers physician and other outpatient services. Part B is funded by premiums paid by beneficiaries and by general revenues. ~~Specifically, for 1996~~, 25% of the cost of Part B is funded by beneficiary premiums; the remaining 75% ~~comes~~ coming from the general tax fund. Medicare Part B cannot become insolvent. However, due to an estimating error by CBO, current premiums are set in statute at about 31.5% of costs.

PRESIDENT'S PROPOSAL:

Part A. The President's Plan strengthens Medicare Part A, securing the trust fund until 2011. The Plan proposes two changes that reduce projected Part A outlays by $150 billion between 1996 and 2002.

- **Spending reduction.** The President's Plan reduces outlays by $89 billion by enacting specific policy changes to reduce Part A spending. These policy proposals, alone, would extend the Part A Trust Fund until about January 2007.

- **Transfer of non-hospital home health services.** The President's plan also saves another $61billion in Part A spending by shifting certain home health costs not related to hospital stays from Part A to Part B. This transfer, combined with the Part A savings proposals, would extend the Part A Trust Fund until October 2011.

Part B. The President's proposal achieves approximately $[illegible] billion in additional savings. ~~by extending current law, which sets premiums at 25% of program costs.~~ [Besides premium increases, are there any other cuts in Part B? How do we account for the full $124 billion in total cuts?] Of this amount, $[illegible] 10.6 TEN POINT SIX comes from extension of the Pt B premium at 25% of program costs. The rest comes from refining physician payments, and other provisions and Medicare secondary payer extension.

over 32 billion Part B

REPUBLICAN PROPOSAL:

Part A. The Republican proposal cuts [$130] billion from Part A spending -- [$41] billion more than the President's proposal.

Part B. The President's proposal makes two significant changes to Part B.

- **Raises premiums.** The proposal raises premiums by approximately [$67] billion by increasing Part B premiums from 25% to 31.5% of program costs and by raising Part B premium for higher-income beneficiaries. (See ___ for more information). The Republican plan then transfers these additional revenues from the Part B program to the Part A Trust Fund -- extending the life of the fund for another undetermined number of years. [CHECK]

- **Additional cuts.** The Republican proposal makes an additional $___ billion in cuts from Part B payments from ___. These cuts have nothing to do with the Part A Trust Fund and do not extend the solvency of that fund any additional years. ~~[What are the additional cuts that are necessary to reach the Republican's total of $200 or so billion? How is this number broken out?]~~

ANALYSIS:

The President's proposal secures the Trust Fund without excessive cuts. The President's proposal achieves $124 billion in savings, securing the Trust Fund through 2011 and leaving it as strong or stronger than it has been in 16 of the last 20 years. Moreover, it achieves that goal without increasing premiums beyond current law. By contrast, the Republican proposal cuts $46 billion farther. It cuts $___ billion more from the Part A Trust Fund, raises premiums by $67 billion, and cuts $60 billion from Part B spending that does nothing to stregnthen the Trust Fund.

The Republican proposal requires duplicative payment for Part A coverage. The Republican proposal to use a Part B premium surcharge to bail out the Part A Trust Fund has troubling implications. This provision is akin to establishing a premium for Part A. Transferring the surcharge to Part A means that beneficiaries would pay twice for their Part A coverage -- once through a payroll contribution and again with their Part B surcharge.

MEDICARE BUDGET "CAP"
December 13, 1995

CURRENT LAW:

Under current law, Medicare spending reflects numerous factors, including the need for medical services by eligible beneficiaries and the cost of those health care services in any given year. Spending is not constrained by any budget limit or "cap," which would limit spending regardless of anticipated medical needs, growth in beneficiary population, or health care costs.

PRESIDENT'S PROPOSAL: The Administration's proposal offers specific policy changes to achieve savings in the Medicare program. Following current law, it does not adopt a budget "cap" as an enforcement mechanism to limit Medicare spending.

REPUBLICAN PROPOSAL:

The Republican Plan imposes a "budget cap" that constrains fee-for-service spending in Medicare. This enforcement mechanism follows a 5-step process:

- First, the overall spending allocation is set for the Medicare system as a whole.

- Second, the spending allocation for the private health care plans (MedicarePlus plans) is calculated. This allocation is determined, in part, by the per capita growth rate permitted for the MedicarePlus plans. This number is set by statute and equals about 8% in 1996 (compared to a projected growth rate in the fee-for-service program of 6%). [~~CHECK: Is this accurate?~~]. Since the MedicarePlus growth rate represents a per person (per capita) growth rate, the actual allocation for the MedicarePlus plans depends also on the number of beneficiaries who choose the private plans; the greater the participation in these plans, the greater the spending allocation on the MedicarePlus system.

- Third, the allocation for the fee-for-service program is calculated by subtracting the allocation for the MedicarePlus plans from the total spending allocation for the Medicare system as a whole. The fee-for-service allocation is subdivided into nine smaller allocations according to a legislatively-created formula. These allocations impose spending limits on the nine separate fee-for-service sectors identified in the Republican proposal: inpatient hospital, home health, extended care, hospice, physicians, hospital outpatient, DME, diagnostic tests, and other.

- Fourth, projected spending in each of the nine fee-for-service sectors is compared to the sector's allocation. If spending is projected to be greater than a sector's allocation, the Republican proposal reduces payments to that sector by an appropriate amount.

- Fifth, after the year has ended, the actual spending on the total fee-for-service

Budget caps pose a particular threat to the traditional fee-for-service program.

- **Budget caps establish unequal treatment of fee-for-service and managed care.** The Republican budget caps constrain spending in the fee-for-service plans far more than the managed care plans in some years -- 6% vs. 8% in 1996.

- **Budget caps may exacerbate the negative effects of certain Republican proposals.** One of the central features of the Republican plan is the introduction of Medical Savings Accounts. These plans increase spending on healthy beneficiaries, who will likely receive from Medicare a voucher that exceeds what the beneficiary would have cost in the traditional fee-for-service plan. CBO predicts that the participation rate in these plans will be low, costing the system only about $5 billion. However, if more beneficiaries join MSAs, spending on these private plans could increase dramatically. Because of the budget cap, this increase will have to be offset with additional cuts in the fee-for-service allocation. In short, to the extent the private plans succeed in attracting beneficiaries, they will leave the traditional program with fewer dollars and a pool of beneficiaries that is, on average, sicker and more costly than before.

Impact on Low-Income Medicare Beneficiaries. Under current law, Medicaid pays for the Medicare premiums of low-income Medicare beneficiaries. The Republicans' higher Medicare premiums would increase costs for those States that wish to continue to cover Medicare premiums for low-income elderly and disabled Medicare beneficiaries. However, because the Republican ~~Medigrant~~ (Medicaid block grant) provides States with ~~$163~~ billion less funding over 7 years than under current law, many States may be forced to cut back their coverage of these poor Medicare beneficiaries' premiums. ~~The higher premiums increase the probability that States will be forced to do so.~~ (For more information, see the separate explanation of "Medicaid Coverage of Poor Medicare Beneficiaries' Premiums, Deductibles, and Copayments.")

De Facto Premium for the Part A Program. The Republican proposal to transfer ~~all~~ of the ~~receipts~~ from the Part B premiums to the Part A Trust Fund effectively establishes a premium for the Part A. Transferring premium receipts to the Part A program means that beneficiaries effectively pay twice for their Part A coverage; once through their payroll contributions and again through their premiums.

Budget Gimmicks. By allowing the share of program costs financed by premiums to fall after 2002, the Republican proposal would allow a future Congress to claim savings by extending the 31.5% policy after 2002. By permanently extending the 25% policy, the President's proposal does not play baseline games.

What about discussion of set aside for premiums?

Can't do without actual difference between 25% & input premium #

MEDICAID COVERAGE OF POOR MEDICARE BENEFICIARIES' PREMIUMS, DEDUCTIBLES, AND COPAYMENTS

December 5, 1995

CURRENT LAW: Medicaid pays all Medicare premiums, coinsurance, and deductibles for people below 100% percent of poverty (known as "qualified Medicare beneficiaries or "QMBs"). Medicaid also covers Medicare premiums for people between 100-120% of poverty (known as "SLIMBs"). The poverty line for an elderly person living alone is currently $7,470, and out-of-pocket Medicare costs will average $1,375 in 1996 [CHECK]. In 1995, 5.4 million very low-income elderly and disabled people have their Medicare premiums, deductibles, and copayments covered by Medicaid.

Medicaid coverage of Medicare premiums, deductibles, and copayments ensures that poor elderly and disabled people can afford to participate in the Medicare Part B program and do not become uninsured.

PRESIDENT'S PROPOSAL: Retains current law.

REPUBLICAN PROPOSAL:

Deductibles and Copayments. The reconciliation bill completely eliminates the requirement that States cover Medicare coinsurance and deductibles for poor elderly and disabled people under Medicaid.

Premiums. The bill sets aside some money within the Medicaid block grant for Medicare premiums. The set-aside equals 90% of the average percentage of mandated State spending on premiums from FY1993 to FY1995. This amount turns out to be less than half of what States would be required to spend under current law on poor Medicare beneficiaries' premiums in 2002. States would decide whom to cover.

ANALYSIS:

Inadequate Set-Aside for Premiums. While the reconciliation bill sets aside 90% of the average percentage of mandated State spending on premiums from FY1993 to FY1995, this amount turns out to be *less than half* of what would be needed under current law to cover poor Medicare beneficiaries' premiums in 2002. Thus, under the block grant States will be forced to reduce the level of assistance with premiums, restrict eligibility for the assistance, or pay for the premiums with State funds, or a combination of the three. HHS estimates that 950,000 poor elderly and disabled people could lose funding for their Medicare premiums in 2002 -- at the same time that the reconciliation bill increases these premiums.

No Set-Aside for Copayments and Deductibles. ~~Medicaid currently covers Medicare copayments and deductibles for more than 5 million poor elderly and disabled people.~~ The reconciliation bill eliminates the requirement that States cover poor beneficiaries' copayments and deductibles, and does not set aside *any* funds for this purpose. States could voluntarily continue to cover poor beneficiaries' copayments and deductibles, but with the reductions in federal Medicaid assistance to States reaching 26% in 2002, ~~many of the more than 9 million~~ poor people now receiving assistance with their copayments and deductibles ~~may~~ could lose it.

Impact on Enrollment in Fee-for-Service Plans. Under the Republican proposal, poor Medicare beneficiaries who lose Medicaid coverage of their premiums, deductibles, and copayments may be forced to leave the Medicare fee-for-service plan and enroll in a managed care plan that does not require cost-sharing -- if one exists in their area. These poor Medicare beneficiaries would effectively lose their choice of plan.

- **MSA's offer benefits to a select few -- at a cost to everyone else.** Because Medicare's payments to MSAs healthy beneficiaries will be more than what the traditional fee-for-service program would have spent on these individuals, MSA plans typically increase Medicare spending. For that reason, the Congressional Budget Office estimates that MSAs will raise Medicare costs by nearly $5 billion over seven years, while VHI-Lewin projects MSAs will increase costs by $15-20 billion over that same period. Moreover, because of the way the Republican "fail-safe" mechanism is structured, the increased costs due to MSAs would have to be offset by further cuts in the traditional fee-for-service program. As a result, the fee-for-service system would be left with fewer dollars to spend on a sicker and more costly pool of beneficiaries.

- **Risk Adjustment will not remedy the problem.** The principal way to limit this kind of segmentation is to adjust payments to MSAs so that contributions more accurately reflect the low health care costs of these healthy enrollees. However, no reliable risk adjustment method is available today. While the capacity exists to adjust plan payments for factors which are broadly associated with higher costs, such as age, sex, and welfare status, we do not have well developed mechanisms to adjust for health status differences within these broad age, sex, or welfare groups. While HHS is planning to test potential improvements in risk adjustment methods, no breakthrough seems imminent. Until a reliable risk adjustment is available, the introduction of MSAs into the Medicare system is unwise.

The President's proposal expands choice while protecting the traditional fee-for-service medicine. While both proposals expand the range of private health care options, the President's proposal extends critical beneficiary safeguards to the new private plans -- making these choices real choices. The Republican proposal does not, leaving beneficiaries -- and ultimately the Medicare system as a whole -- vulnerable.

- Current law protects beneficiaries in the fee-for-service program from being charged extra for medical treatment (a practice referred to as "balance billing"). The President's proposal maintains these protections for beneficiaries who join private health care plans.

- The Republican proposal, by comparison, witholds this protection from beneficiaries in MSAs and private fee-for-service plans -- leaving these beneficiaries financially vulnerable.

- This feature also exacerbates the division of Medicare into distinct programs for the healthy and sick programs. Only the healthiest beneficiaries will risk the potential liability in the new private plans. Those expecting significant medical bills will be more likely to stay behind in the traditional fee-for-service program. (For additional details on "balance billing," and related issues see "Financial Protection of Beneficiaries" and "Quality Standards").

Why is this section here?

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

19-Dec-1995 03:19pm

TO: Jennifer L. Klein
TO: Pauline M. Abernathy

FROM: Diana M. Fortuna
Domestic Policy Council

CC: Christopher C. Jennings

SUBJECT: New disability stats from Bob Williams

Assuming we have a more leisurely time to revise the disability document, here are some interesting stats I have never seen before from Bob Williams. I have an email in to him asking where numbers came from and why he is doing this, and also telling him to talk to Robyn Stone.

Possibilities include:

o change in # kids in institutions in last 30 years;

o increase in number of people served in the community while President has been in office.

Bob also has statistics on how the rate at which states have closed institutions has increased greatly since 1992 (15 a year, vs 4 a year pre-1992). It is very much on his agenda to reduce sharply the number of people with disabilities in institutions. There is a very vocal but small pro-institution lobby, as you probably know.

There is also an interesting comparison on the higher cost of serving MR/DD kids in ICF/MRs vs. community settings. Doesn't this argue that states have some room in managing under the per capita cap to save money by deinstitutionalizing? (unless it's the cheaper ones who have moved to the community, while expensive benes remain in institutions.

Bob also said the expected growth rate for community based services is 26%, which is the average over the past 4 years. I told him that sustaining that growth rate might be difficult under likely constraints to be imposed on the proggram, unless savings came from deinstitutionalization.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

19-Dec-1995 02:55pm

TO: judy_heumann
TO: howard_moses
TO: fortuna_d
TO: Ann Rosewater

FROM: Bob Williams

SUBJECT: Medicaid and Disability Talking Points

Ann: Sorry this took a day longer than I expected to get to you. It is the first in a series of pieces I will be forwarding on to you.

Here are some major points which I believe need to be both understood and then communicated by those in the Administration and particularly those of us at HHS with regard to Medicaid and its everyday impact on Americans with disabilities and their families:

o Medicaid touches and affects the lives of six million Americans with varing types and levels of disabilities more profoundly and personally than anything else we do at HHS or throughout the Federal Government.

o Medicaid is helping to keep increasing numbers of children with disabilities and other chronic health conditions at home with their families and in the public schools where they belong.

In 1994 the number of children and youth in state institutions (4,001) fell below 5% of the highest total number of 91,592 in 1965. Medicaid, together with IDEA and SSI, is largely responsible for this shift.

In 1990, the total children with "disabling conditions" in substitute care was 52,000. While it costs on average $6000 each year to support a special needs child in a natural home, it costs $65,000 in an institutional setting. Since 1980, a Federal law has made kids with disabilities in adoptive homes automatically eligible for Medicaid (4e SSA).

o Medicaid enables hundreds of thousands of people with disabilities of all ages to get up in the morning, bathe, eat, go to school or work and then to bed each night: All the things most others take for granted.

o Medicaid provides critical access to health insurance and personal assistance for employed persons with disabilities who might otherwise be denied coverage because of preexisting conditions and thus have to give up working.

o Medicaid is a vital safety net for Americans with disabilities and their families as it is for other vulnerable individuals. But, it has also become the key to increased independence, productivity and personal responsibility for thousands of these persons.

o People with disabilities, birth to age sixty five, make up fifteen to sixteen percent of those on Medicaid. Roughly, forty nine billion dollars of Medicaid services are provided to people with disabilities, birth to age sixty four annually.

o HOWEVER EXPENDITURES ON BEHALF OF THESE INDIVIDUALS ACCOUNTED FOR 39 PERCENT OF ALL MEDICAID SPENDING IN 1993. THIS IS THE LARGEST PERCENTAGE OF MEDICAID FUNDS SPENT ON ANY ONE GROUP.

o AROUND FOURTEEN BILLION DOLLARS OF THIS ARE SPENT ON PROVIDING SPECIALIZED SERVICES TO PEOPLE WITH DEVELOPMENTAL DISABILITIES (PRIMARILY THROUGH THE ICF-MR AND VARIOUS COMMUNITY BASED SERVICES WAIVERS) EVEN THOUGH SUCH INDIVIDUALS MAKE UP ONLY ABOUT FIVE PERCENT OF PEOPLE ON MEDICAID.

o About nine billion continues to be spent on both institutional and group home ICF-MRs. The average 1992 costs of average 1992 costs of these facilities were as follows:

Large ICF/MR (Institutions & Large Private ICFs/MR): $57,088

Small ICFs/MR (15 Bed or Less Public, Private): $54,065

o Expenditures for the ICF-MR program, therefore, continued to make up about fifty eight percent of all Medicaid dollars spent on specialized services for people with developmental disabilities nationwide.

o THE GOOD NEWS IS THAT TIMES ARE CHANGING.

o Forty two percent of DD Medicaid funds are now spent by States on optional services and waiver programs designed to maximize the personal independence, productivity and community participation of these individuals.

o Moreover, the average 1992 costs of such home and community based services are proving to be significantly less costly on a per capita basis than those provided by the ICF-MR program:

Home and Community based services Waivers	$24,440
Community Living Services Arrangements	$11,038

o The expected expenditure growth rate for DD Federal Medicaid Institutional and Home and Community based services are:

Institutional (including 16+ Beds ICFs/MR):	6.9%
COMMUNITY:	26.4%
TOTAL (Both DD Instituional & DD Community):	12.9%*

*(Assume average of growth over last 4 years, 1988-92)

O DUE TO INCREASED FLEXIBILITY IN GRANTING SUCH WAIVERS UNDER THE CLINTON ADMINISTRATION, THE NUMBER OF PEOPLE SERVED IN HOMES AND COMMUNITIES INCREASED FROM 62,462 IN 1992 TO 122,075 IN 1994. AS A RESULT, EVERY STATE NOW UTILIZES THE HCBS WAIVER PROGRAMS.

o In 1992-1994, States closed a total of 45 state institutions (or 15 per year) compared with an average of less than 4 per year in the previous 20 years, and less than 6 in the previous decade.

o In 1994 for the first time ever in the United States:
  -- In 23 states the average number of persons per residential setting was less than 4.0 persons.
  -- Half of all states (25) served more than half of their residential services recipients in homes of 6 or fewer persons; and;
  -- Four-fifths of all states (41) served more than half of all residential service recipients in settings of 15 or fewer residents.

RFC-822-headers:
Received: from gatekeeper.eop.gov by PMDF.EOP.GOV (PMDF V5.0-4 #6879)
 id <01HYZSQZWRGW003XCD@PMDF.EOP.GOV> for fortuna_d@a1.eop.gov; Tue,
 19 Dec 1995 14:02:05 -0400 (EDT)
Received: from [158.71.1.12] by gatekeeper.eop.gov;
 (5.65v3.2/1.1.8.2/17Oct95-0424PM) id AA00997; Tue, 19 Dec 1995 14:10:40 -0500
Received: by vines12.acf.dhhs.gov; Tue, 19 Dec 1995 14:02:27 -0500 (EST)
X-Priority: 3 (Normal)

UCPA
UNITED
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ASSOCIATIONS
Advancing the independence of people with disabilities

MEMORANDUM

TO: **Diana Fortuna**
Office of Domestic Policy

FROM: Allan I. Bergman
Deputy Director, Community Services Division
Director, State-Federal Relations

RE: Impact of Medicaid Per-Capita Cap and State Aggregate Cap on Optional Long Term Service for Persons with Disabilities

DATE: December 14, 1995

I appreciated the opportunity to talk with you today re: our concerns over the potential negative impact of the aggregate state cap on future funding of long term services for persons with disabilities. In addition, there are a number of problems in current Medicaid law which continue to be a barrier to an agenda of choice and empowerment and a preference for family, home and community supports for children and adults with disabilities. Similar issues apply to people who are elderly.

The Presidents Plan:
As we discussed, the President's plan for a per-capita cap funding formula and an aggregate annual state cap on federal matching funds creates many problems in the name of maintaining the "entitlement". If the President's plan goes forward, then all of the issues addressed in the list of problems (attached) in current law must be solved. (The President's bill has solved #2) In addition, the following amendment, at a minimum, must be made to the President's proposal"

> The State must be required to maintain proportional effort ($$) on long term services and supports in relation to the state's total Medicaid budget. We must protect this base of financial resources from the competition of the nursing homes, managed care companies, hospital associations and medical associations who will be vigorously lobbying for resources for the entitled/mandatory services for acute care, home health care and nursing home care. The optional services of ICF/MR, H-CBS, personal care, targeted case management, etc. will be major targets for their attack.

1660 L STREET, NW SUITE 700 WASHINGTON, DC 20036-5602
800 USA.5UCP 202.776.0406 TDD 202.973.7197 FAX 202 776.0414

In this regard, I am enclosing some materials several of us drafted earlier this year recognizing that the future growth of federal Medicaid matching funds would be capped each year, which dramatically changes the political decision making process in the states. I also am enclosing a brand new publication, *You Choose* for your careful review for the need to amend Title XIX to contain a family, home, community, independence, self sufficiency, independence and community inclusion. As I stated to you, if there is a "compromise", we do not expect another opportunity to address Medicaid statutory authority anytime soon. Let's make this Real Medicaid Reform.

not attached

I am anxious to talk with you in greater detail and to meet with you, Chris Jennings, Nancy Ann Min and any other folks as soon as possible. Thanks for your help.

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Encl:

MAJOR POLICY PROBLEMS IN CURRENT MEDICAID LAW IMPACTING LONG TERM SERVICES AND SUPPORTS

1. Institutional Bias

Problem: Medicaid is based on an institutional bias where home and community-based services (H-CBS) are defined as "alternatives" to institutional care. In 1993, 78% of all Medicaid long term care dollars still was spent on institutional care.

Solution: Decouple eligibility for Medicaid home and community-based services from eligibility for institutional care.

2. Secretarial Waiver Process

Problem: The Medicaid home and community based "waiver" is a cumbersome process requiring periodic Secretarial approval. The program has demonstrated its success since its inception in 1981.

Solution: Convert the Secretarial waiver authority from H-CBS to a Medicaid targeted optional state plan coverage.

3. Multiple Funding Streams

Problem: Medicaid long term services are funded under multiple Medicaid programs with overlapping rules resulting in inefficient use of resources; e.g. ICF/MRs, H-CBS waivers; personal care, targeted case management; rehabilitation, clinic services.

Solution: Create Secretarial authority for the states to request approval to consolidate into a single funding stream all existing institutional and community-based services of funding for long term services and supports to designated segments of the Medicaid population.

4. Supported Employment

Problem: The Medicaid H-CBS waiver only allows persons formerly institionalized to receive supported employment services thus precluding the use of Medicaid funds to promote the increased independence and self-sufficiency of most people with developmental disabilities.

Solution: Authorize the use of H-CBS funding for supported employment services for any person receiving H-CBS regardless of their prior institutional status.

5. Alternative Uses of Funds

Problem: Medicaid financing is based on provider reimbursement for the provision of a state plan service and does not allow alternative payment methods.

Solution: Authorize states to have greater discretion in the use of Medicaid funds for long term services and supports including direct cash payments to consumers and their families, use vouchers, sponsor and certify "preferred community services organizations" that are authorized to furnish needed services and supports on a wrap around basis, and establish fixed sum consumer/family budgets which allow individuals and families to exercise greater control over how public dollars are used to meet their unique needs.

6. Public Participation

Problem: Medicaid law does not require public participation in the plan development process.

Solution: Require states to provide assurances that they have solicited and obtained public participation in the development of their H-CBS and long term services and support plans.

7. Long Range Planning

Problem: Medicaid requires no planning and provides no incentives for states to expand resources for H-CBS.

Solution: Provide states a state plan option to move resources and people from institutions to H-CBS by providing a financial incentive for them to do this.

UCPA/AB: December 8, 1995

cc Jen Klein
Ruth Katz

Talking Points

Vulnerability of People with Mental Retardation/Developmental Disabilities Under a Per Capita Cap

- **Financing Issues**

Under the per capita cap proposal advanced by the Clinton Administration, the effects of constraining the growth in Medicaid expenditures is likely to fall primarily on individuals in need of long term care services in general and people with mental retardation and related developmental disabilities in particular. The average base year per capita cost of serving all people with disabilities is likely to range from $3,900 in Alabama to about $17,500 in Connecticut, with a nationwide average of roughly $8,200 per recipient, per annum. Federal financial participation (FFP) would not be capped with respect to newly eligible Medicaid recipients under the Administration's proposal (i.e., utilization would remain open-ended). However, a very high proportion of individuals in need of LTC services already will be entitled to receive Medicaid acute care services at the time they are in need of long term services/supports. In other words, the cost of their Medicaid services already will be included in the baseline (i.e., for acute care services only). The fiscal equation facing the state officials will be this: every time LTS is provided to an additional Medicaid-eligible individual, the problems the state faces in staying within its disability per capita spending cap will be exacerbated.

Let's examine the way in which this situation would play out for the typical candidate for long term MR/DD services:

- The individual is a young adult who has been on a waiting list for community residential and daytime habilitation/training services over three-five years;
- He/she is entitled to receive SSI-benefits (and has been since turning 18) and, therefore, is categorically eligible for Medicaid benefits;
- The current costs of the acute care Medicaid benefits the individual receives is between $3,000 - $5,000 (i.e., the amount typical for recipients of specialized MR/DD waiver services); and
- The state's only existing mechanism for providing the community day/residential services the individual requires is its existing specialized Medicaid MR/DD waiver program.

If the state adds the subject individual to its HCB waiver program after the per capita caps go into effect, it will increase the Medicaid costs of this individual from $3,000 - $5,000 to $33,000 - $35,000 annually, on average. In order to stay within its per capita cap, a state would have to substantially lower its average per capita expenditures on behalf of other disabled recipients of Medicaid services. Given these

dynamics, it seems virtually certain that a state would be very, very cautious in adding further recipients of LTS. The death rate among elderly recipients would permit a certain nature level of turnover (albiet no where near the level necessary to offset the burgeoning demand for LTC services). By contrast, the typical turnover percentage in specialized MR/DD services (ICFs/MR and HCB waiver programs) is much, much lower (usually ranging between 2-3%).

Administrative Issues

In order to consolidate responsibility and accountability for the management of publicly-funded long term services for people with mental retardation and other developmental disabilities, many states have shifted authority for determining how Medicaid funds should be deployed on behalf of this population from the single state Medicaid agency to the state MR/DD agency (i.e., the agency charged under state law with providing institutional and community-based long term services to this population). As the states' reliance on Medicaid dollars to finance MR/DD services (which currently excesses 70% of total MR/DD services in most states) has grown in recent years, such consolidations of fiscal and programmatic responsibilities have become an essential element in the successful efforts in many states to shift individuals from high-cost institutional settings to lower cost home and community-based settings. Since 1982, the states collectively have reduced the number of people served in state-operated ICFs/MR from 107,000 to under 60,000. Meanwhile, the number of individuals served in Medicaid-financed home and community-based waiver programs has increased by more than 150,000. Because the average annual per capita cost of ICF/MR services, nationwide, is more than double the cost of HCB services ($75,000 vs. $30,000), states have been able to address the growing backlog in unmet needs (as represented by the estimated 181,000 persons nationally who are on waiting lists for services).

Because the proposed cap on average per capita costs would be calculated on the basis of all Medicaid recipients with disabilities (approximately 6 million persons, versus the roughly 300,000 who receive MR/DD long term services/supports), states would be forced to modify their current administrative arrangements in order to ensure that expenditures are managed around the central objective of holding expenditures within the aggregate disability-wide expenditure cap. The net effect would be to shift fiscal control back to the single state Medicaid agency in many states and thereby thwart future efforts to move MR/DD long term service expenditures as well as the recipients of such assistance from institutional to more cost-effective home and community-based services. Waiting lists, predictably, would grow even longer and the longstanding efforts in many states to move toward more economical home and community-based service systems would be thwarted.

Statutory Constraints on Promoting More Cost-Effective Services

The Clinton Administration's Medicaid proposals would convert the existing HCB waiver authority into a state plan coverage, thus affording states somewhat greater

assurance of continuity in administering such services as part of is Medicaid program. But the states would be left with all of the other statutory constraints which makes it more difficult than it needs to be to transition service systems from costly institutionally-oriented models to truly community-centered approaches. For example, in the area long term supports for people with developmental disabilities, the most critical barrier to resolutely embracing a community-based approach to services is the lack of cohesive policies governing the operation of HCB waiver services and ICFs/MR. ICFs/MR operate under a distinctive set of federally-defined policies (including detailed federally-prescribed standards), while each state is given broad leeway in designing HCB waiver policies that fit its own unique situation. The lack of coherence in these policies makes it difficult for states to develop single stream funding arrangements that would facilitate the transition of people with developmental disabilities to community service models that are in keeping with current thinking in the field and which, on average, are more economical to provide.

Other statutory provisions that would be carried over under the Clinton Medicaid proposal are:

- the outmoded linkage between eligibility for HCB services and the institutional needs test (thus preventing states from tightening institutional admission criteria without simultaneously limiting eligibility for HCB services);

- the absence of any latitude to move away from vendor payment systems and substitute other payment approaches (capitated payments; vouchers; etc.) where such arrangements might prove to be highly cost-effective alternatives and afford consumers and their families much greater range of choice and control; and;

- the failure to address the constraints to applying managed care principles to the organization, financing and delivery of long term services [N.B., The new flexibility states would be afforded in this area under the Administration's bill would be limited to acute health care services.]

Ultimately, the capacity of states to complete the transition to home and community-based long term service systems for people with developmental disabilities is tied to their ability to collapse funding on behalf of this population into a single financing stream. The reform proposals thus far advanced by the Clinton Administration fall far short of this goal.