

MEMORANDUM

January 29, 1996

TO: Alice Rivlin, Carol Rasco, Laura Tyson, Gene Sperling, Nancy-Ann Min, George Stephanopoulos, Marcia Hale, Emily Bromberg, Jennifer Klein

FR: Chris Jennings

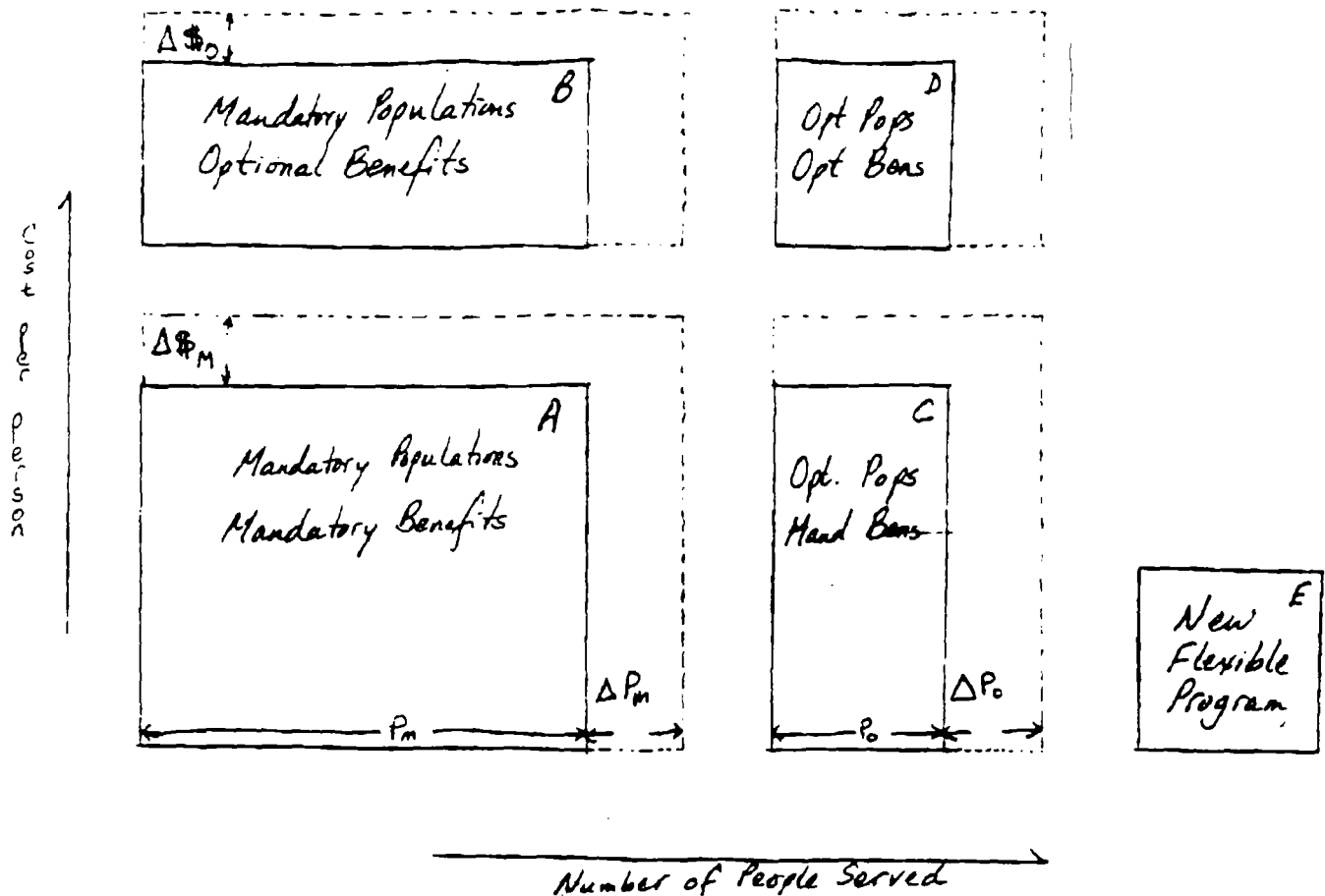
RE: Medicaid Flexibility Issues

Attached is the updated list of outstanding major flexibility issues that we have been reviewing for possible consideration in our Medicaid package. It is important to point out that they fall far short of the Republican's wish list and still may not be sufficient for the Democratic Governors.

Having said this, most of these issues push the outside limits for our Democratic base, and we need to carefully consider the political ramifications prior to integrating them into our package.

Also attached is a copy of a document that Governor Romer proposed to Leon Panetta. It outlines some additional modifications to the per capita cap he believes we should consider to reach out to Republicans.

We will use these documents for our 4:00 meeting today. If you have any questions prior to the meeting or believe an issue is missing or should be missing please feel free to call me at 456-5560.



Notes on the Chart:

The sum of the size of the boxes A, B, C, and D represents the cost of serving the current Medicaid population. The area of each box is the number of people served times the average cost of serving each person.

While only one set of boxes is drawn, it would be sensible to draw a set for each eligibility category. In that case, the size of the boxes would vary dramatically across categories.

The relative size of the boxes varies by state.

The dotted lines extending to the right of each box represent growth in the number of people enrolled from one year to the next. On the left is the change in mandatory populations, while on the right is the change in optional populations.

The dotted lines extending above each box represent an increase in the average cost per person enrolled from one year to the next. On the bottom is the change in cost for mandatory benefits, while on the top is the change in cost for optional benefits.

The sum of the size of the dotted-line boxes is the cost of the program in the subsequent year.

Box E represents a new program serving people and covering services at the option of the state.

Current Law

Matching funds are available based upon the size of the boxes. These funds grow and shrink as the number of people and the cost per person change.

Benefits for people in all categories, with limited exceptions, must be identical.

Per capita structure outlined by Democratic Governors

Matching funds are available for all costs attributable to increases in enrollment.

Matching funds are only available up to a capped growth amount per person enrolled. That is, if a state's per capita costs grow faster than the cap, the costs above the cap are not eligible for matching funds.

If enrollment declines, available matching funds decline in proportion.

While states may eliminate optional categories of enrollment, they lose the matching funds associated with the people they drop from the program.

If a state keeps its growth in spending per person below the cap, the savings may be diverted to a new program. This is the case even if per-person spending is reduced because the state has eliminated optional benefits.

The benefits for people in boxes C and D can differ from those for people in boxes A and B, which can all differ from the benefits for people in box E. Some amount of variation in benefits will also be permitted within each of these boxes.

The people served by the new program (box E) must be below a certain federally-defined income standard.

Additional funding flexibility some Governors may want:

The federal matching amount based upon the total area of boxes in the base year is a floor that a state can never fall below in future years. Historical DSH payments are also considered part of the base below which the state can never fall.

All eligible populations bring with them matching funds. The mandatory populations must be served, but the optional populations generate matching funds whether the dollars are spent on them or on people in the new program. That is, all of the funds that have historically been in boxes C and D are matchable whether they are spent on optional populations, or people served by a new program.

The state has complete flexibility regarding who it serves in the new program (box E).

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

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

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

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

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

Federal Entitlement/Right of Action

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

Pending Proposals

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

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

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

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

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

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

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

Counsel are meeting Tuesday to better develop these options.

Comments

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

Benefits

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

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

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

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

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

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

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

• **Governors Concerns -**

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

Pending Proposals

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

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

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

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

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

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

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

Comments:

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

Congressional consultation required.

Eligibility

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

Pending Proposals

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

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

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

Comments:

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

Congressional consultation required.

Federal Financing

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

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

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

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

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

Pending Proposals

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

Congressional consultation required.

January 25, 1996

MEMORANDUM FOR LEON PANETTA

CC: PAT GRIFFIN
MARCIA HALE
CAROL RASCO
ALICE RIVLIN
LAURA TYSON

FROM: Emily Bromberg
Intergovernmental Affairs

Chris Jennings
Domestic Policy

SUBJECT: Governors and Medicaid

Yesterday, Governors Romer, Miller, and Chiles met with Governors Thompson, Engler, and Leavitt on Medicaid. After the bipartisan Governors meeting, this group met with twenty Democratic and Republican Senators brought together by Senators Chafee and Breaux. The perception of both of these meetings varies among Governors and among staff who attended. What is clear from their reports is that the real details that ultimately will make the difference between a Medicaid deal coming together or falling apart were neither discussed nor bridged between the two sides. The Republican rhetoric in both meetings was that the Governors are not far apart and can quickly solve the Medicaid problem. Some Democratic Governors were encouraged by this. Governor Thompson did state that he believes that Governors should no longer wait for the principals to cut a budget deal, but should move ahead with a Governors agreement on Medicaid, as well as on welfare reform and employment and training.

On our bottom line essentials for any deal:

- Per capita cap financing mechanism: There was not a significant amount of discussion on this issue in the Governors only meeting. It is still unclear whether Republican Governors understand what Democrats mean by a per capita cap, and it appears that for Republican Governors, the real issue is money and not structure. Democrats believe that Republican Governors might accept a per capita cap if it produced (along with DSH savings) dollars equal to the amount allocated to them in the Republican conference report and if it had few or no strings. It is unclear whether we can achieve our savings goal and generate the funds necessary to accomplish this. Opinion among Democrats varies as to whether we can really win on per capita cap without giving up our principles on benefit and entitlement issues.

It is worth noting that in the Governors' meeting on the Hill, both Leavitt and Engler

stated that they had not agreed to a per capita cap approach.

- Enforcement of eligibility through the Federal courts: Reports indicate that Governors reached no agreement. Democratic Governors would like to find a middle ground on this issue. We, along with HHS, have set up a legal advisory group to examine our options in this area.
- Federally defined benefits package: Reports indicate that there is bipartisan support for mandatory benefits for mandatory populations. However, Senator Breaux and others indicated a desire to have the Governors redefine a national minimum mandatory benefits package. It is unclear how Democratic or Republican Governors would define this.

The Governors will return on Thursday February 1st. The Chafee/Breaux group asked that they return on Thursday with a Medicaid agreement. While Republican Governors agreed, Democratic Governors stated that there were still major differences but that a report on their progress would be possible on Thursday.

All Democratic Governors agree that Thompson's goal is to get a Medicaid agreement among the bipartisan negotiating team before the NGA meeting, and then bring that policy to all the Governors at NGA. The Democrats now believe that Thompson wants agreement on a complete Medicaid package, not simply state flexibility. It is becoming increasingly difficult for Democratic Governors to resist striking a deal. They are tempted by Republican offers of state flexibility and are constantly assaulted by Republican charges that they are unable to cut a deal because they are too connected to the White House.

MEDICAID OPTIONS

1. Ride Out the Week With No Major Announcements.
 - Work with Governors and their staffs, as well as Hill, to ensure that they fully understand our position and are prepared to draw lines in the sand if necessary for the Thursday Governors' meeting, the Friday Hill meeting, and subsequent NGA meetings during the annual meeting.
 - Use Leon's AHA address to highlight important Medicaid distinctions.
 - Highlight the letters from the advocates and providers criticizing the Republican plan, which are likely to be released this upcoming week.
2. Have the President outline his vision of Medicaid restructuring -- perhaps in his radio address right before formal NGA meetings commence. Three options for the President:
 - A. Release his Medicaid flexibility package pretty much as it currently stands, but highlight its important provisions that have always been high priorities of the Governors.
 - B. Highlight his entire Medicaid restructuring proposal, including the per capita cap and flexibility provisions.
 - C. Outline a new version of his flexibility provisions, which go as far (or almost as far) as the Democratic Governors want to go, in order to give them something they feel most comfortable defending.

The President's Medicaid Plan: Effect on States

The President's plan for Medicaid:

- **Guarantees Coverage:** The President's plan ensures that the low-income elderly, nursing home residents, pregnant women, children, and people with disabilities continue to receive health coverage.
- **Increases State Flexibility:** States would have significantly enhanced flexibility in how to manage their Medicaid program and pay for services. The Boren Amendment would be repealed. States would be permitted to require enrollment in a choice of managed care plans or delivery systems, or provide home and community-based care at their option without a Federal waiver. The President's plan accomplishes most of the objectives put forth by the National Governor's Association in January of 1995.
- **Controls Medicaid Spending without Putting States at Financial Risk:** The President proposes a "per capita cap". This policy limits Federal spending without ending the Federal commitment to share in the risk of an aging population, recession, or increasing number of uninsured children. The Federal government will match state spending up to a limit that is adjusted for enrollment. When spending growth per beneficiary increases at a rate higher than the index proposed in the policy, Federal payments are limited. Otherwise, Federal payments are the same as under current law.
- **Reduces Disproportionate Share Payments but Increases State Control:** The President's plan changes the current Disproportionate Share (DSH) program in two ways. First, Federal DSH payments are gradually reduced and then frozen at their levels in 1998 for subsequent years. Supplemental pools for states with high numbers of undocumented persons and with high levels of uncompensated care and Medicaid shortfalls will ease this transition. Second, states are given more latitude in choosing which providers are eligible for DSH payments. States will submit annual reports to the Secretary on who gets the funds, how much the providers receive, and how the funding is easing the problems in their states.

Why States Benefit from the President's Plan:

- **Federal Spending Reductions Are Not Large:** The President's plan reduces Federal Medicaid spending by \$54 billion over seven years -- a third of the Republicans' plan of \$163 billion in cuts.
- **All States Fare Better Under the President's Plan than the Republicans' Plan:** Every single state gets more Federal funding under the President's plan than under the Republicans' plan.

NOTE: The attached table shows US DHHS estimates based on a preliminary Urban Institute December baseline. It will be revised before January to reflect incoming data for 1995 and the changes in the CBO economic assumptions. THE ESTIMATES PRESENTED IN THE TABLE WILL CHANGE.

Estimates of the Effects of the President's Medicaid Plan on States, 1996 - 2002
(Fiscal years, Dollars in Millions)

States	Savings			Comparison of Spending		
	Baseline	Proposal	Savings	Proposal	Republicans	Difference
Total	952,994	899,276	(53,719)	899,276	790,003	(109,272)
Alabama	14,221	13,442	(779)	13,442	12,864	(578)
Alaska	1,944	2,225	282	2,225	1,660	(565)
Arizona	14,359	13,679	(680)	13,679	11,658	(2,021)
Arkansas	9,672	9,869	197	9,869	8,574	(1,295)
California	81,852	86,149	(5,703)	86,149	80,310	(5,839)
Colorado	7,118	6,887	(231)	6,887	6,367	(520)
Connecticut	13,723	13,073	(650)	13,073	11,094	(1,980)
Delaware	1,859	2,167	308	2,167	1,720	(447)
District of Columbia	5,145	5,168	23	5,168	3,802	(1,366)
Florida	39,369	37,280	(2,090)	37,280	33,045	(4,234)
Georgia	27,451	25,393	(2,059)	25,393	20,348	(5,044)
Hawaii	2,982	2,801	(182)	2,801	2,450	(351)
Idaho	2,706	2,703	(3)	2,703	2,448	(254)
Illinois	35,050	33,307	(1,743)	33,307	29,056	(4,250)
Indiana	20,803	19,990	(813)	19,990	16,069	(3,921)
Iowa	8,250	7,951	(299)	7,951	6,874	(1,077)
Kansas	6,989	6,457	(532)	6,457	5,874	(584)
Kentucky	15,888	15,600	(289)	15,600	13,374	(2,225)
Louisiana	33,752	28,896	(4,856)	28,896	18,818	(10,078)
Maine	6,904	6,270	(634)	6,270	5,264	(1,006)
Maryland	13,691	13,158	(532)	13,158	11,266	(1,892)
Massachusetts	26,156	24,508	(1,648)	24,508	21,815	(2,693)
Michigan	34,117	31,072	(3,045)	31,072	28,518	(2,554)
Minnesota	17,930	16,990	(941)	16,990	13,602	(3,388)
Mississippi	12,973	11,791	(1,182)	11,791	11,100	(691)
Missouri	15,835	15,344	(491)	15,344	15,338	(7)
Montana	3,264	3,187	(77)	3,187	2,603	(584)
Nebraska	4,798	4,531	(267)	4,531	3,682	(868)
Nevada	2,415	2,682	266	2,682	2,539	(143)
New Hampshire	4,336	3,687	(649)	3,687	2,542	(1,145)
New Jersey	26,510	25,213	(1,298)	25,213	21,775	(3,437)
New Mexico	6,511	6,226	(286)	6,226	5,605	(621)
New York	119,880	112,975	(6,905)	112,975	98,331	(14,643)
North Carolina	26,621	25,600	(1,021)	25,600	21,298	(4,302)
North Dakota	2,255	2,225	(30)	2,225	1,985	(240)
Ohio	37,962	35,277	(2,684)	35,277	33,200	(2,077)
Oklahoma	8,321	8,222	(98)	8,222	8,016	(206)
Oregon	9,876	9,515	(361)	9,515	8,982	(533)
Pennsylvania	41,820	39,776	(2,044)	39,776	36,174	(3,602)
Rhode Island	4,975	4,423	(552)	4,423	4,138	(285)
South Carolina	15,703	14,520	(1,183)	14,520	13,741	(780)
South Dakota	2,422	2,320	(102)	2,320	2,163	(157)
Tennessee	20,949	20,949	(0)	20,949	20,739	(210)
Texas	67,978	62,724	(5,254)	62,724	55,273	(7,452)
Utah	4,761	4,651	(110)	4,651	4,103	(548)
Vermont	2,138	2,071	(67)	2,071	1,919	(152)
Virginia	11,760	11,637	(124)	11,637	9,835	(1,802)
Washington	17,176	16,153	(1,023)	16,153	13,405	(2,748)
West Virginia	12,866	12,111	(755)	12,111	9,521	(2,591)
Wisconsin	15,643	15,116	(527)	15,116	14,069	(1,046)
Wyoming	1,315	1,315	(0)	1,315	1,077	(238)

US DHHS estimates based on the Urban Institute's December 1 baseline.

Note: The savings do not total the savings from the CBO baseline because of the differences in the Urban Institute & CBO baselines.

Savings include a 33% offset for the per capita cap savings.

DSH reduction: percent reduction from 1995 DSH spending (same reduction after 1998)

Supplemental payments: \$3.5 billion undocumented pool; \$3.5 billion pool for states with high uncompensated care & Medicaid shortfall; transition pool

The President's Medicaid Plan: Effect on States

Guarantees Coverage: The President's plan ensures that the low-income elderly, nursing home residents, pregnant women, children, and people with disabilities continue to receive health coverage.

The Republican plan would end guaranteed coverage for the 36 million Americans currently insured by Medicaid. By 2002, nearly 8 million children, elderly and people with disabilities could be without the health care coverage now provided by Medicaid.

Provides for Unprecedented State Flexibility: States are given significantly greater flexibility in the administration of their Medicaid programs. The President's plan is extremely responsive to the flexibility objectives put forth by the National Governor's Association in January of 1995. The Boren Amendment would be repealed. States would be permitted to establish managed care plans as well as home- and community-based care options without Federal waivers.

While the Republican block grant would allow states to administer their program without virtually any national minimum standards, it comes at a cost -- a loss of over \$100 billion relative to the President's plan over seven years.

Controls Medicaid Spending without Putting States at Financial Risk: The President proposes a "per capita cap". This policy limits spending without ending the Federal commitment to share in the risk of an economic downturn or other unexpected events that increase costs. The Federal government will match state spending up to a limit that is adjusted for enrollment. When spending growth per person increases at a rate higher than the proposed index, Federal payments are limited.

The Republican plan ends the Federal role as a partner in states' health care spending for seniors, children and people with disabilities. States would be 100 percent at risk for unexpected increases in costs associated with recessions or an aging population.

Reduces Disproportionate Share Payments but Increases State Control: The President's plan changes the current Disproportionate Share (DSH) program in two ways. First, Federal DSH payments are gradually reduced and then frozen at their levels in 1998 for subsequent years. Supplemental pools for states with high numbers of undocumented persons and with high levels of uncompensated care and Medicaid shortfalls will ease this transition. Second, states are given more latitude in choosing which providers are eligible for DSH payments. States will submit annual reports to the Secretary on who gets the funds, how much the providers receive, and how the funding is easing the problems in their states.

The Republicans end the DSH program, increasing the already-severe financing problems of inner city, public and rural hospitals which care for uninsured and Medicaid patients.

Why States Benefit from the President's Plan:

- **Federal Spending Reductions Are Not Large:** The President's plan reduces Federal Medicaid spending by \$54 billion over seven years -- a responsible reduction that can be managed by states.

The Republicans' plan takes \$163 billion in Federal Medicaid funding from the states, leaving them with the same health care problems but less support in addressing them. Since the cut is too large to be absorbed through efficiency alone, states will be forced to shift the costs onto providers, reduce coverage for their citizens or increase their state spending.

- **All States Fare Better Under the President's Plan than the Republican Plan:** Every single state gets more Federal funding under the President's plan than under the Republican plan. More importantly, Federal spending to states would increase if states were faced with a recession or some other unforeseen event that causes enrollment to increase.

The Republicans cannot reduce Federal spending by \$163 billion without hurting states -- and hurting some states more than others. In fact, while most states get similar percentage reductions under the President's plan, the Republican plan takes up to 45 percent from some states and actually gives money to others.

Jen

FYI, but not

for distribution.

DR

FAX TRANSMISSION

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

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Portland, ME 04101

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(6 PAGES)

MEMORANDUM

TO: DIANE ROWLAND

FROM: Trish Riley

DATE: December 14, 1995

Thanks for your help at our Medicaid Summit on Wednesday! I'm sorry you had to leave, as we really did focus in the afternoon. Enclosed is a draft final report. As it turned out, the Governors' negotiating group stayed in town and we were able to get this information to them in time for their deliberations. So, it may not be great writing, but it was timely!

The participants were very supportive of a Kaiser Work Group, especially if we coordinate it with the work and resources of the Commission. They are eager to convene, but advise that we not create one group. Rather, we should convene experts around topics and not everyone is expert in everything! They felt we need to wait to see what Congress does before selecting topics. Finally, they think much more research needs doing and hope for the opportunity to advise the Commission on our research agenda.

I'm pleased to report their enthusiastic support even after a day of tough discussion.

Thanks again for your support. I look forward very much to making the Kaiser Work Group a reality!

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NATIONAL ACADEMY FOR STATE HEALTH POLICY **Proposals from Summit on Medicaid Restructuring 12-13-95**

Medicaid proposals from both Congress and the Administration assume reduced growth in federal spending and significant increased state flexibility. Both proposals eliminate the Boren amendment, repeal special FQHC payment rules and permit states to expand managed care and home care without waivers. The Academy convened state executive and legislative leaders to propose additional areas of flexibility needed which will allow states to operate with less growth in federal Medicaid funding and improve the quality of health services. We recommend five specific additional tools that will allow states to continue to serve eligibles in ways that are cost effective and that accommodate decreased growth in federal spending. These additional tools will improve the states' flexibility to deliver more appropriate services to residents and produce better health outcomes.

States need flexibility to offer their residents an understandable, cost effective, common sense way of obtaining health and long term care services but they cannot make reforms precipitously. States will engage in a public process and submit proposals for debate in state legislatures before changes can be implemented. Changes as complex as those proposed would benefit from a transition period (18-24 months) to ensure thoughtful decision making and time to respond to the implications of combined changes in Medicaid, Medicare and welfare reform.

States need additional flexibility to:

1. Design a benefit package rather than a set of services and eliminate "provider" entitlement.

Problem:

Today Medicaid reimburses a list of services and must provide the same list of services to all those eligible. Services are defined by providers - hospital, nursing facility, physician or clinic for example - making the program a guaranteed entitlement for providers rather than a beneficiary-sensitive set of benefits. Because different population groups served by Medicaid have different needs, states seek the flexibility to construct different, more appropriate benefits to meet beneficiary need and to focus on outcomes and improving and maintaining health status, not on delivering a number of units of specific services. For example, states may wish to subsidize health insurance for low income eligibles transitioning from welfare to work or to provide a limited pharmacy benefit to certain beneficiaries eligible for Medicare and Medicaid or cover care in less costly assisted living settings than in a nursing facility.

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Proposed solution:

Eliminate current Medicaid provisions mandating statewideness and comparability of the scope and duration of services and eliminate the list of services. Replace that list with language which assures that each state shall provide for making medical assistance available to each eligible group and including at least primary care, preventive care and long term care appropriate to the needs of eligible groups. States may establish variable benefit packages for these groups, or subsets of these groups, based on state priorities established through a public involvement process. Benefit packages may vary according to the types of primary, preventive and long term care appropriate to covered populations.

States must document that resources for covered groups are allocated based on findings and priorities derived from a public process.

2. Eliminate categorical eligibility systems

Problem:

The current Medicaid eligibility system is complex and confusing, with extensive mandatory and optional eligibility categories. Eliminating the tie between cash assistance and Medicaid eligibility will require a new approach to eligibility determination. Today, eligibility requirements work against the goal of continuity of care as beneficiaries go on and off Medicaid if their incomes change even slightly month to month. Guaranteed eligibility can be provided only through waivers and for beneficiaries enrolled in managed care; persons who spend resources on nursing facility care can become Medicaid eligible, but those who spend for home care generally cannot. A low income person with need for care may not qualify for coverage without a predetermined categorical eligibility that makes a person of similar need eligible. Such inconsistencies make eligibility confusing for beneficiaries and costly for states to administer. A simplified and streamlined process would also make it easier states to identify and collect third party liability obligations.

Proposed solution:

Phase out the current system of categorical eligibility and replace it with a simplified, income-based process. Current categorical eligibles could be "grandfathered" in as states move to replace categorical eligibility determination with a simplified, income-based process.

3. Develop more premium-based options/cost sharing.

Problem:

Current Medicaid eligibility creates a "cliff effect": beneficiaries receive every service for which they present a medical necessity until a day when they receive additional income or change living arrangements. At that point they receive no services. Similarly Medicaid pays

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for total nursing home care but pays nothing for less costly assisted living, even though residents in both settings may have similar levels of disability. States seek flexibility to create positive incentives for use of appropriate benefits and to facilitate the transition from welfare to work by creating premium structures that allow beneficiaries to cost share based upon their incomes and capacity to pay. States may wish to subsidize insurance costs for low income workers transitioning off Medicaid or create incentives to develop affordable and appropriate private long term care insurance. This flexibility could also be used to encourage small employers to offer insurance by offering employers tax credits and providing workers who meet the gross income threshold to afford their share of the premium.

Finally, states should have the flexibility to develop a range of benefit packages which include incentives through the use of income sensitive cost sharing options for specific benefits, providers or delivery systems.

Proposed solution:

Allow states to create comprehensive approaches to cost-sharing and develop income-based and sensitive premiums for certain groups of Medicaid eligibles as determined through a public process.

4. Integration for dually eligible Medicaid and Medicare beneficiaries.

Problem:

Today more than 5 million elderly and disabled persons qualify for both Medicare and Medicaid. States pay for Medicare cost sharing (premiums, deductibles, co-payments) and for long term care for this population, yet cannot effectively manage care or costs because they have no control over the delivery of Medicare services. It is particularly difficult for states to enroll dually eligible persons in managed care, since Medicaid and Medicare managed care rules are inconsistent. The current federal-state bifurcation of responsibility also provides little incentive to states to save money through managed care, since savings are likely to accrue to Medicare as inappropriate hospitalization use is reduced. Dual eligibility also creates expensive administrative burdens, such as the process of identifying and paying “cross-over” claims.

Proposed Solution:

The Secretary of Health and Human Services should be given new authority to approve state demonstration projects for dually eligible persons. Subject to federal approval would be any aspect of the proposed demonstration project that requires a waiver of Medicare law. Not subject to federal approval would be any aspect of the program involving Medicaid activities not otherwise subject to federal review. The demonstration should include at least the following characteristics:

The Secretary should be able to grant states greater flexibility to oversee Medicare

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expenditures for dually eligible persons, and ability to unify Medicare and Medicaid systems and procedures for dually eligible persons. Permissible state activities should include but not be limited to administration of Medicare funds, execution of unified Medicare/Medicaid contracts with managed care organizations, development and oversight of unified Medicare/Medicaid quality improvement systems, and implementation of unified enrollment and disenrollment procedures;

The Secretary should be able to authorize network lock-in of Medicare benefits in dual eligibility managed care demonstrations for up to the same period of time allowed in Medicare managed care plans (1 year in the most recent reconciliation bill), provided that an appropriate appeal system exists to disenroll for cause;

Demonstration programs eligible for approval should be those that propose benefits equal to or greater than the benefits required by the Medicare program, a quality improvement system likely to result in services of comparable or greater quality to those available in the Medicare program, and costs to the federal government that are no greater under the demonstration than they would be absent the demonstration; and

If demonstration programs are successful, they should be eligible for permanent authorization without time restrictions and without requirements to phase down the programs.

5. Develop more outcome, performance approaches to replace prescriptive federal regulations.

Problem:

The current system relies heavily on process and paper standards which require extensive data collection but do not necessarily assure quality.

Proposed solution:

Allow states to propose measures, which would be approved by HCFA, to replace federal regulations and standards with beneficiary satisfaction and outcome measures. Federal standards would remain in effect until new methods were proposed by a state which are based on outcomes, client satisfaction and performance. Some state measures might be built on public health measures (rates of childhood illness, mortality rates); others could use NCQA and HEDIS indicators as benchmarks. Measures would be developed that are appropriate to each population served.

**THE NATIONAL ACADEMY FOR STATE HEALTH POLICY'S
SUMMIT MEETING: RESTRUCTURING MEDICAID**

The following individuals participated in a day-long discussion on Wednesday, December 13th, and assisted the Academy frame these proposals. States represented include diverse opinion about how best to restructure Medicaid.

Bruce Bullen
Commissioner
MA Division of Medical Assistance

Pat Butler (CO)
Pew Fellow
University of Michigan

Barbara DeBuono
Commissioner
NY Department of Health

Pam Dickson
Director, Health Care Reform
NJ Department of Health

Tom Hamilton
Director
WI Bureau of Long Term Support

Michael Hogan
Director
OH Department of Mental Health

Paula Hollinger
MD State Senate

Barbara Matula
Director
NC Division of Medical Assistance

John McDonough
Chair, Committee on Health Care
MA State Legislature

David Murday
USC, Institute of Public Affairs
Former SC Legislative Staff

Ernesto Scorsone
KY State Legislature

Garth Splinter
OK Health Care Authority

Jean Thorne
Federal Policy Coordinator
OR Office of the Governor

Jim Verdier
Assistant Secretary
IN Medicaid Policy & Planning

Martin Wasserman
Secretary
MD Department of Health and
Mental Hygiene

John Woolley
Management Analyst
WA Aging & Adult Services

1. CURRENT MEDICAID PROGRAM

Formula: Medicaid costs are shared by the Federal and state governments through a matching formula.

Spending & Growth: The Congressional Budget Office (CBO) projects that:

Federal Spending	1996 to 2002:
-------------------------	----------------------

- | | |
|------------------------------------|---------------|
| ○ Total: | \$924 billion |
| ○ Benefits and Administration: | \$837 billion |
| ○ Disproportionate Share Payments: | \$87 billion |

Average Growth Rates:	1996 to 2002:
------------------------------	----------------------

- | | |
|---|------|
| ○ Total Spending: | 10% |
| ○ Spending per person: | 6.9% |
| ○ Enrollment: | 3.0% |
| ○ 3.8% enrollment growth for aged beneficiaries; | |
| ○ 4.8% enrollment growth for disabled beneficiaries; | |
| ○ 2.0% enrollment growth for adult beneficiaries; and | |
| ○ 2.5% enrollment growth for children. | |

Comparison to other types of growth (on a per capita basis from CBO December baseline, for 1996-2002):

General Economic Growth	1996 to 2002:
--------------------------------	----------------------

- | | |
|-----------------------------|------|
| Nominal GDP per capita: | 4.1% |
| Consumer Price Index (CPI): | 3.3% |

Health Care	
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- | | |
|------------------------------------|---------------------|
| Private Health Insurance Spending: | 7.1% (February CBO) |
| Medical Inflation (MCPI): | 5.2% (February CBO) |

- | | |
|---------------------------------|-------|
| Medicare Spending: Current Law: | 7.9 % |
|---------------------------------|-------|

MEDICAID PAYMENT STATISTICS

FISCAL YEAR 1994

STATE	MEDICAID EXPENDITURES (MILLIONS)	MEDICAID DSH PAYMENTS (MILLIONS)	FED MATCH PERCENTAGE
ALL JURISDICTIONS	\$137,609	\$16,890	%
ALABAMA	1,777	417	71.22
ALASKA	287	17	50.00
AMERICAN SAMOA	10	0	50.00
ARIZONA	1,702	106	65.90
ARKANSAS	1,066	3	74.46
CALIFORNIA	14,587	2,009	50.00
COLORADO	1,111	106	54.30
CONNECTICUT	2,304	409	50.00
DELAWARE	279	6	50.00
DISTRICT OF COLUMBIA	786	53	50.00
FLORIDA	5,195	285	54.78
GEORGIA	3,219	355	62.47
GUAM	7	0	50.00
HAWAII	457	30	50.00
IDAHO	309	0	70.92
ILLINOIS	5,148	300	50.00
INDIANA	2,464	295	63.19
IOWA	1,044	6	63.33
KANSAS	974	165	59.52
KENTUCKY	1,835	67	70.91
LOUISIANA	4,195	1,326	73.49
MAINE	910	165	61.96
MARYLAND	2,240	151	50.00
MASSACHUSETTS	4,363	541	50.00
MICHIGAN	4,975	615	56.37
MINNESOTA	2,469	44	54.65
MISSISSIPPI	1,310	158	78.85
MISSOURI	2,520	713	60.64
MONTANA	328	0	71.05
N. MARIANA ISLANDS	2	0	50.00
NEBRASKA	613	9	61.98
NEVADA	381	74	50.31
NEW HAMPSHIRE	953	380	50.00
NEW JERSEY	4,777	1,034	50.00
NEW MEXICO	681	8	74.17
NEW YORK	21,473	2,507	50.00
NORTH CAROLINA	3,111	390	65.14
NORTH DAKOTA	272	1	71.13
OHIO	5,519	498	60.83
OKLAHOMA	1,052	24	70.39
OREGON	1,108	21	61.12
PENNSYLVANIA	6,918	817	55.61
PUERTO RICO	221	0	50.00
RHODE ISLAND	784	95	53.87
SOUTH CAROLINA	1,854	481	71.08
SOUTH DAKOTA	288	0	69.50
TENNESSEE	2,671	108	67.15
TEXAS	8,144	1,513	64.18
UTAH	507	5	74.35
VERMONT	288	19	59.55
VIRGIN ISLANDS	7	0	50.00
VIRGINIA	1,849	140	50.00
WASHINGTON	2,572	309	54.24
WEST VIRGINIA	1,242	103	75.72
WISCONSIN	2,300	12	60.47
WYOMING	152	0	65.63

Medicaid Per Capita Spending

State	1994 Per Capita Spending			
	Adults	Children	Aged	Disabled
AK	\$ 3,543	\$ 2,463	\$ 9,822	\$ 10,926
AL	\$ 2,606	\$ 1,036	\$ 5,330	\$ 3,924
AR	\$ 1,903	\$ 1,878	\$ 6,394	\$ 5,317
AZ	\$ 1,710	\$ 1,120	\$ 18,952	\$ 8,055
CA	\$ 1,653	\$ 1,059	\$ 4,218	\$ 4,699
CO	\$ 2,706	\$ 1,568	\$ 7,848	\$ 7,594
CT	\$ 2,093	\$ 1,624	\$ 19,235	\$ 15,838
DC	\$ 2,371	\$ 2,249	\$ 16,415	\$ 13,381
DE	\$ 2,352	\$ 1,588	\$ 11,643	\$ 11,094
FL	\$ 1,283	\$ 1,470	\$ 7,697	\$ 5,939
GA	\$ 3,387	\$ 1,326	\$ 5,526	\$ 6,008
HI	\$ 3,279	\$ 2,128	\$ 9,152	\$ 8,876
IA	\$ 2,372	\$ 1,730	\$ 7,809	\$ 9,120
ID	\$ 2,712	\$ 1,147	\$ 9,740	\$ 8,475
IL	\$ 1,722	\$ 1,336	\$ 8,485	\$ 8,421
IN	\$ 3,960	\$ 2,070	\$ 13,219	\$ 12,560
KS	\$ 2,948	\$ 1,915	\$ 11,016	\$ 11,657
KY	\$ 2,469	\$ 1,430	\$ 6,747	\$ 5,011
LA	\$ 3,383	\$ 1,984	\$ 6,459	\$ 7,870
MA	\$ 2,324	\$ 2,654	\$ 14,320	\$ 9,740
MD	\$ 3,086	\$ 1,994	\$ 12,782	\$ 8,967
ME	\$ 2,014	\$ 1,853	\$ 13,186	\$ 8,339
MI	\$ 2,335	\$ 1,463	\$ 12,260	\$ 7,675
MN	\$ 1,228	\$ 887	\$ 10,885	\$ 8,512
MO	\$ 1,619	\$ 1,134	\$ 6,960	\$ 6,628
MS	\$ 2,194	\$ 1,065	\$ 4,306	\$ 3,696
MT	\$ 2,627	\$ 1,583	\$ 15,391	\$ 9,547
NC	\$ 2,479	\$ 1,473	\$ 6,175	\$ 8,484
ND	\$ 2,098	\$ 1,640	\$ 11,500	\$ 13,329
NE	\$ 2,562	\$ 1,909	\$ 11,051	\$ 9,440
NH	\$ 1,928	\$ 1,925	\$ 13,345	\$ 14,126
NJ	\$ 3,599	\$ 1,483	\$ 13,830	\$ 11,800
NM	\$ 2,596	\$ 1,690	\$ 6,448	\$ 7,199
NV	\$ 3,470	\$ 1,773	\$ 7,660	\$ 9,726
NY	\$ 3,093	\$ 2,305	\$ 18,143	\$ 14,974
OH	\$ 1,770	\$ 1,227	\$ 13,037	\$ 8,812
OK	\$ 1,670	\$ 1,566	\$ 6,063	\$ 6,551
OR	\$ 2,415	\$ 2,185	\$ 8,500	\$ 9,823
PA	\$ 1,779	\$ 1,570	\$ 14,304	\$ 6,694
RI	\$ 1,901	\$ 2,064	\$ 10,111	\$ 17,663
SC	\$ 2,680	\$ 1,382	\$ 4,617	\$ 6,312
SD	\$ 2,534	\$ 1,482	\$ 11,062	\$ 9,717
TN	\$ 1,014	\$ 876	\$ 9,850	\$ 4,857
TX	\$ 3,005	\$ 1,312	\$ 5,946	\$ 7,521
UT	\$ 3,643	\$ 1,688	\$ 9,744	\$ 9,953
VA	\$ 2,203	\$ 1,119	\$ 6,480	\$ 6,226
VT	\$ 2,082	\$ 986	\$ 8,835	\$ 8,343
WA	\$ 2,538	\$ 1,390	\$ 10,437	\$ 9,646
WI	\$ 1,780	\$ 1,633	\$ 13,326	\$ 7,961
WV	\$ 2,703	\$ 1,729	\$ 11,104	\$ 6,854
WY	\$ 3,360	\$ 1,570	\$ 11,944	\$ 10,313

2. FINANCING: Formula

A “per capita cap” is a policy that limits Federal Medicaid spending growth on a per person basis. The Federal payments under this policy automatically adjust to a state’s enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in the costs for that population.

- Per person spending levels are estimated using a base year of 1995. Certain spending items, such as payments for Medicare premiums and cost-sharing and Disproportionate Share Hospital payments, will be excluded from the spending limit.
- Future year spending limits will be calculated by applying an index to the base year spending per group (estimated separately for non-disabled children, non-disabled adults, disabled and elderly).
- States will receive Federal matching funds up to this indexed spending per person for any current or new enrollee.
- The maximum total amount of Federal matching funds for a given state will depend upon the number and mix of people in the program.
- Protection from recession. Under a period of economic recession, increased enrollment in a state will automatically result in additional federal funds for states. Under a per capita approach, federal dollars will be specifically linked to the number and casemix of enrollees. The Center on Budget and Policy Priorities estimates that Medicaid costs due to increased enrollment could increase between \$8 billion and \$29 billion over seven years depending on the intensity (mild or severe) of the recession.
- Protection from inflation. The Center on Budget and Policy Priorities also estimates that if inflation were just 1 percentage point higher than CBO projects for the next seven years, then total Medicaid costs would be \$65 billion higher over seven years. A per capita approach that uses an index linked to inflation will allow federal funds to match changing state needs in such a situation.

2. FINANCING: Formula

Formula: The proposed formula retains the current Federal matching structure, but Federal spending growth per beneficiary is limited through a per capita cap. The limit is calculated by:

1. **Calculating the 1995 Federal and state spending per beneficiary**, by beneficiary group, for each state. The four groups are: adults; children; aged; and disabled. Calculating the limit by group allows it to adapt to changes in the type of beneficiaries enrolled in a state;
2. **Multiplying the 1995 spending per beneficiary by an "index"**, which would be set in the legislation. The index is a factor that is based on some measure of inflation such as the CPI or nominal gross domestic product growth per person. This is used to allow the future year spending per person to keep up with inflation.
3. **Multiplying the indexed spending per beneficiary by the number of beneficiaries in that year.** The limit is the total spending amount that the Federal government will match. By multiplying the indexed spending per beneficiary by the number of beneficiaries in each group, the limit increases or decreases depending on total enrollment and enrollment mix in that year. These group-specific limits would then be summed for the state; and
4. **Multiplying the cap by the Federal matching rate (FMAP).** Once the limit is determined, it is multiplied by the FMAP to determine the maximum Federal spending.

2. FINANCING: Formula: Example of How the Formula Adjusts to Changes in Enrollment

- To give an example of how the formula works, say that a state spends the following amount per person in the base year:

Aged	\$9,000
Disabled	\$8,000
Adults	\$2,000
Children	\$1,000

- If today we predict that enrollment in a state is 12,000 the year 2000, then:

	Enrollment		Base Spending/ Person		Cumulative Index (5 years of 6.5%)	Per Capita Limit	Total Limit
Aged	1,000	x	\$9,000	x	1.37 =	\$12,330	\$12.3 million
Disabled	2,000	x	\$8,000	x	1.37 =	\$10,960	\$21.9 million
Adults	3,000	x	\$2,000	x	1.37 =	\$2,740	\$8.2 million
Children	6,000	x	\$1,000	x	1.37 =	\$1,370	\$8.2 million
Total	12,000						\$50.6 million

Assuming an FMAP of 50%, the state may receive up to \$25.3 million in Federal funds.

- However, if state's actual aged population grows faster than expected:

	Enrollment		Base Spending/ Person		Cumulative Index (5 years of 6.5%)	Per Capita Limit	Total Limit
Aged	1,500	x	\$9,000	x	1.37 =	\$12,330	\$18.5 million
Disabled	2,000	x	\$8,000	x	1.37 =	\$10,960	\$21.9 million
Adults	3,000	x	\$2,000	x	1.37 =	\$2,740	\$8.2 million
Children	6,000	x	\$1,000	x	1.37 =	\$1,370	\$8.2 million
Total	12,500						\$56.8 million

Now, the state may receive up to \$28.4 million -- \$3 million more than it would have received with the original assumptions.

2. FINANCING: Formula: Example of How States Can Expand Enrollment

- Using the same example, assume that the state managed spending per person below the cap. The state could, at its option, use the extra room under the limit to expand coverage.

	Enrollment	Actual Spending/Person	Per Capita Limit	Per Capita Savings	Total Difference
Aged	1,500	\$10,995	\$12,330	-\$1,335	-\$2 million
Disabled	2,000	\$9,960	\$10,960	-\$1,000	-\$2 million
Adults	3,000	\$2,740	\$2,740	0	0
Children	6,000	\$1,370	\$1,370	0	0
Subtotal					-\$4 million
New eligibles	2,000	\$2,000			+\$4 million

- Alternatively, the state could simply keep the savings.

2. FINANCING: Disproportionate Share Payments

Disproportionate Share Hospital payment reductions: There are two options that have been discussed to reduce and retarget payment for Disproportionate Share Hospitals (DSH):

- **Reduce Current Allotments:** One option keeps the current distribution of DSH payments by state, but reduces those allotments. This reduction is larger for states whose DSH payments are a larger percentage of their non-DSH spending.
*handwritten: less than 5% : 10% reduction
5-40% : 35% reduction
more than 40% : 75% reduction*
- **Reallocate Spending Based on Need:** A second option phases out current allotments and replaces them over time with a needs-based formula.

3. PROGRAM DESIGN AND FLEXIBILITY: Eligibility

1. **The proposal maintains the Federal entitlement.**

The proposal maintains the Federal entitlement for coverage for all mandatory Medicaid categories.

When a state chooses to cover an optional category, the state creates an entitlement to coverage for all people in that category.

States that have gone beyond the Federal mandates can scale back coverage at their option.

2. **The proposal provides Federal matching funds for eligibility increases and changing case mix -- and provides an opportunity for Federal matching for states to add new categories in a budget neutral manner**

Federal matching funds will automatically increase for increased enrollment within existing eligibility categories.

If States are able to contain spending below their per capita cap for some categories, they may increase per capita spending for other categories.

In addition, under a new option, if they are able to manage costs below their per capita limits, they may add new eligibility groups up to 150 percent of the poverty level so long as expansions do not result in net additional spending.

3. PROGRAM DESIGN AND FLEXIBILITY: Benefits

1. **Mandatory benefits remain mandatory benefits.**
2. **States have increased flexibility on additional benefits.**

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

States will identify additional areas of flexibility on optional benefits.

- targeting optional
- reducing mandatory

3. PROGRAM DESIGN AND FLEXIBILITY: State Flexibility

1. States will have new flexibility to use managed care.

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

Administratively burdensome requirements for managed care programs, including Federal contract approvals, annual quality reviews and the 75/25 enrollment composition rule will be eliminated.

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

States will be able to require HMO enrollees to make nominal copayments.

2. States will have greater ability to establish provider payment rates.

Boren Amendment - The Boren Amendment will be repealed, so States will establish hospital and nursing home payment rates.

FQHCs and RHCs - States will no longer be required to pay non-IHS FQHCs and RHCs on a cost basis beginning in FY 1999.

Other Providers - Federal standards for payments to obstetricians and pediatricians will be repealed.

Private Insurance - States will no longer be required to enroll individuals in private insurance in certain situations, and to pay the private insurance rates and copayments. States will have the option to continue purchasing group insurance and negotiate their own rates.

Nurse-Aide Training - States will be able to conduct nurse-aide training in certain rural nursing homes.

4. CONCLUSION

- **Financing:** The Federal government continues to share in state financial risk in Medicaid:
 - Federal funds will automatically follow increased eligibles, changing case mix;
 - Federal funds will automatically adapt to changing economic situations.
- **Program design:** Responds to many of our long-standing requests for Medicaid flexibility.
 - Flexibility in how to deliver service (e.g, managed care);
 - Flexibility in how to pay for services, protection from provider lawsuits (Boren).

MEDICAID: STATUS OF MAJOR ISSUES IN NEGOTIATIONS

- I. **Increasing Support for a Per Capita Cap:** With the exception of the Republican Conference bill, every major balanced budget proposal (yours, the Daschle, the Coalition and the Breaux/Chafee plan) now assumes a Medicaid per capita cap. Moreover, on January 5th, the Republican Governors indicated to the Democrats that they would accept a per capita financing approach to pay for the costs of both the mandatory and optional populations. Lastly, the CBO has now indicated that they will "score" a per capita approach.
- II. **Opportunity for Unprecedented State Flexibility:** If there is no final deal on Medicaid, the Governors will lose out on ridding themselves of some of their biggest headaches, including: the Boren Amendment, the requirement to go through a waiver process to establish managed care, the 75/25 managed care requirement, the cost-based reimbursement requirement for community health centers. As will be discussed below, we can are willing to do even more. However, if we go too far, we may well lose the great majority of our Democrats on the Hill.

III. Enforcement of Entitlement

Republicans want: To eliminate the right of action in Federal court to enforce the individual entitlement -- both eligibility and benefits. They would substitute a state administrative and court appeals process. From all reports, this is the Republicans' number one priority.

Our current and possible fall-back position: We do not believe an entitlement exists without Federal court enforcement of Medicaid eligibility. (Otherwise there would be 50 separate court systems defining eligibility differently.) However, Governor Chiles has suggested making a distinction between the enforcement of eligibility and benefits. Since most cases involve benefit disputes, Chiles believes it is worth exploring having the eligibility disputes heard at the Federal level, but individual benefits' disputes heard at state level. We are working on such an option. The Democratic Governors are pleased with this development, but they do not believe it will be sufficient to appease the Republican Governors.

IV. Benefits

Republicans want: To have complete autonomy in defining their own benefit package (with the exception of immunizations to children and limited family planning). In so doing, they would also eliminate the requirements that both mandatory and optional benefits be comparable among eligibility groups and across regions (the so-called "comparability and statewideness" provisions).

Our current and possible fall-back position: We believe there needs to be a nationally defined, minimum benefit. Without a Federally-defined benefit package, the entitlement nature of the program is called into question.

We do not believe the current core benefit package should be altered significantly since it is a relatively modest package. To address legitimate state flexibility concerns, however, we believe that we should take the position that comparability and statewideness requirements should be removed for optional services provided to optional recipients. Moreover, we believe that these requirements could also be removed for some optional services for mandatory populations, e.g., for personal care services. We would like to work with the Governors to determine what other benefits could be removed from this category.

The mandatory benefit that creates the greatest frustration for Governors is **EPSDT**. Many Governors believe that the comparability requirements force them to offer benefits they provide under EPSDT to the rest of their population. We believe we should clarify in the statute that this is not the case. If it is necessary to go further in this area, you may want to consider that the treatment part of this requirement be provided only consistent with the benefits provided to the rest of the Medicaid population under the state plan amendments. (In the alternative, you could preserve the treatments currently provided for a certain age group, e.g., 0–6.)

Finally, on the issue of **cost-sharing**, we believe the statute should be changed to permit states to impose nominal copayments on managed care plans. Going beyond nominal copayments does not appear to be a high priority of the Governors since it does not seem practical, appears to the providers as a back-door reimbursement cut, and may lead to additional access to provider problems.

V. Eligibility

Republicans want: To limit mandatory coverage to pregnant women, children under 13 (they therefore stop the phase-in of all children through age 17), and the disabled (as defined by the state.) No other populations would be guaranteed coverage.

Our current and possible fall-back position: We maintain current eligibility requirements because we do not want to go backwards in terms of coverage. For example, between 2–3 million children who would otherwise be guaranteed Medicaid coverage could well be dropped from the program as the result of the elimination of the mandatory phase-in through age 17. While we oppose dropping major categories of eligibles, we do believe we could make eligibility optional for a number of "grandfathered" groups that are currently mandatory.

VI. Federal Financing/Medicaid Formula

Republicans want: Changes in current Federal matching formula (FMAP) that has the effect of lowering the amount of dollars a state must spend to draw down a given level of Federal funds. This approach would lower total Federal/state funds spent on Medicaid across the states. In addition, in order to justify much lower Federal dollars to the states, the Republicans back-end the cuts.

Our current and possible fall-back position: Oppose FMAP changes, but would support a base-closure model commission to address formula inequities. Moreover, the savings from our DSH cuts (and our lower cuts in general) could be used to establish pools of dollars to help certain states who need "transitional" assistance.

January 15, 1996

Note to Carol Rasco

From: Jack Ebeler

Jennifer Klein asked that I follow-up on our conference call on Friday and send you the welfare reform language on the definition of disability as it relates to alcoholism and drug abuse.

Sec. 9604 of the Coalition welfare reform plan amends section 1614(a)(3) to provide that "an individual shall not be considered to be disabled for purposes of this title [title XVI - SSI] if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled."

cc: Jennifer Klein

MEDICAID: KEY ISSUES FOR DISCUSSION WITH GOVERNORS

Essential Program Elements. We believe we must provide significant flexibility to states while retaining the individual entitlement to a set of defined benefits and maintaining the federal-state financial partnership and restraining the rate of growth through a per capita cap.

We also believe that cuts in Medicaid should come as close as possible to the \$54 billion target that the President has outlined. The Republican cuts in Medicaid are excessive and totally unacceptable as they would reduce allowable growth rates to 70% below CBO's projection of the private sector per person growth rate (Republican growth rate: 2.2%, Administration: 5.5%, private sector: 7.1%).

The three elements that are essential to the Administration are:

1. **Federal Medicaid entitlement must be retained.** This requires a definition of mandatory beneficiaries and benefits, and enforcement of the entitlement through federal courts.
 - Mandatory beneficiaries: must include low-income pregnant women, children, elderly and disabled Medicare beneficiaries, and post-welfare reform AFDC and SSI recipients, including those transitioning from welfare to work.
 - Mandatory benefits: must include a federally required benefit package (some specifics can be negotiated as long as it remains comparable to the basic mandatory benefits under current law).
 - Right of action: the Federal entitlement requires that individuals ultimately have a right of action in federal court to enforce their eligibility under Medicaid.
2. **Federal financial partnership must be preserved.** The federal matching structure, coupled with a new per capita cap to limit the rate of increase in spending, will allow the federal government to maintain its guaranteed financial partnership with states and allow states to respond to changing economic and demographic realities.
3. **Meaningful flexibility to states must be assured.** Within this structure, states must be given unprecedented flexibility to operate their Medicaid programs, organize their delivery systems through managed care and other innovative arrangements, and pay providers.

Significant Flexibility Proposed. We have proposed a number of provisions to make the Medicaid program more flexible. We have already addressed about two-thirds of the issues raised by the National Governor's Association (NGA) over the past several years, and our flexibility proposals go beyond the provisions in the Coalition bill. To take just a few examples (attached is a document comparing Governors' concerns to our policy responses), these include:

- Allowing states to have greater flexibility to implement managed programs without obtaining waivers from HCFA;
- Repealing the Boren Amendment for hospitals and nursing homes; and
- Eliminating cost-based reimbursement for federally qualified health centers and rural health centers.

Flexibility Proposals Contained in the Alternative Medicaid Proposal

NGA Medicaid Proposals	Alternative Proposal
<u>Structure:</u>	
o Impose no unilateral caps for federal spending on Medicaid entitlement.	Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. Entities eligible for DSH payments would be expanded to include FQHCs, RHCs and other outpatient providers. The alternative proposal would also include new payments to a number of States with high numbers of undocumented immigrants and high levels of uncompensated care.
<u>Eligibility:</u>	
o Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)	Addressed. To allow for eligibility simplification and eligibility expansion, States would have the option of covering individuals up to 150 percent of poverty, or expanding overall coverage by 30 percent, as long as the expansion is "budget neutral" (subject to CBO scoring). Current coverage would be maintained.
o Allow States that have expanded coverage for pregnant women and infant beyond the mandatory level to reduce income eligibility to as low as the mandatory level. (NGA '93)	NEW - Include
o Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)	Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.

<u>Provider Payment:</u>	
o Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95) .	Addressed. Boren amendment is repealed for hospitals and nursing homes
o Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs following a two-year transition
o Allow greater flexibility in imposing beneficiary co-payments. (NGA '93)	New -- Allow States to establish nominal co-payments for HMO enrollees.
o Provider Qualifications	
• Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93)	Included
• Repeal the annual reporting requirements for OB and pediatric care. (NGA '93)	Included
<u>Benefits:</u>	
o States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers (subject to CBO scoring).
o Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)	Affirms current law that personal care services can be delivered by providers other than home health agencies.

<u>Delivery Systems:</u>	
o Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
• States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95) • Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95,) • Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93)	Included. Included. Included.
o Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)	Addressed. Managed care and home and community-based care no longer require waivers.
<u>Quality:</u>	
o OBRA '87 Nursing home reform modifications:	Addressed.
• Eliminate restrictions on training sites for nurse aides (NGA '93) • Eliminate PASARR. (NGA '93, NGA '95)	Eliminates prohibition on providing nurse-aide training in rural nursing homes. Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.

o OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93) .	Affirms current law to allow the targeting of state enforcement resources.
<u>Administrative:</u>	
o Technical disallowances -- prohibit Federal disallowances for "technical" issues that do no harm to beneficiaries. (NGA '93, NGA '95)	New- HCFA's disallowance authority would be modified to enable it to avoid imposing excessive disallowances that are not commensurate to the size of the State's violation.

ADDITIONAL NEGOTIATING OPTIONS

Negotiating options are available within the framework of the core policy of preserving the federal Medicaid entitlement to meaningful benefits, enforceable through the federal courts, and with financing assured through a continued federal and state partnership.

Key issues raised by Governors	Negotiating Options
Simplify Medicaid eligibility	1) Eligibility simplification can be pursued in which some currently mandatory Medicaid coverage groups that are now classified as "grandfathered" groups could be made optional. 2) Resolve Medicaid eligibility requirements in light of welfare reform. If receipt of cash remains a viable Medicaid link, need to address Medicaid for those for whom cash benefits are terminated due to time limits; these individuals in transition from welfare programs could be a required Medicaid coverage group for a defined period (as are certain individuals in transition from welfare to work) or an optional group.
Provide greater flexibility in what benefits states provide to beneficiaries	1) Redefine mandatory benefits: mandatory benefits could be redefined (including EPSDT -- child health screening, diagnosis and treatment) so long as the core benefit provisions remain -- including such basic benefits as inpatient hospital, physician services, family planning, diagnostic services, and nursing home and home health services. (However, it is politically difficult to drop other services, such as nurse midwife services) 2) Enhance state flexibility in making available optional services. Substantial new flexibility could be given to states in making optional services available to certain groups, by revising current constraints about amount duration and scope, comparability of those services among groups, and statewideness of the coverage and benefits.

Key issues raised by Governors	Negotiating Options
Protect states from lawsuits - especially in federal court.	1) Eligibility: Must maintain the current law requirements under which individuals have a right of action in federal court regarding eligibility. However, it could be made explicit that a state administrative process must be exhausted prior to filing in court on eligibility-related claims. 2) Benefits: For factual disputes regarding an individual's benefits, deductibles, and copayments (not involving a challenge to a policy), a health plan or HMO process and a state administrative process could be required, with <u>appeal only to state courts</u> of competent jurisdiction (after exhaustion of administrative remedies), unless the claim exceeded certain threshold amounts. 3) Provider payment: New statutory language could accompany the repeal of the Boren amendment to state that the Congress intends that there be no privately enforceable right of action by providers against a state for payment rates under section 1902.
Financing alternatives could be considered	1) Block grant: the administration cannot accept any fixed block or formula grant, even with population and economic adjusters. 2) Could begin to consider variable caps based on costs in the state (higher growth rates for low cost states); there is political uncertainty over the distributional impact of such a proposal. 3) The disproportionate share policy (DSH) cut and remaining payment policy could be negotiated: the administration could phase to the Coalition plan, which includes a targeted DSH policy (and substantial redistributions among the states). 4) Some type of pooled funding could be established for federally qualified health centers and rural health centers. Additional "transitional" and/or "hold-harmless" funding pools can also be negotiated to deal with state impact of the plan.

ISSUES IN REFORMING ENTITLEMENT PROGRAMS

AFDC

- Essential Program Elements. A reformed AFDC program must have tough work requirements, time limits, and increased State flexibility. It should also retain certain features of current law: It should provide a guarantee of assistance to all individuals who meet certain criteria. Its funding mechanism should respond automatically to changes in economic and demographic conditions. It should give States strong incentives to share in program financing and to match Federal funds, but allow flexibility in setting income eligibility and benefit levels. Individuals in like circumstances should be treated equally.
- Administration Position. The conference report on welfare reform converts AFDC and related programs into a capped block grant. The block grant fails to address many of the essential elements of the current program. The Administration supports the Coalition proposal, which replaces AFDC with a conditional time-limited entitlement and provides an automatic response to countercyclical increases in need while increasing State flexibility.
- Potential Fallback Position. If a cash assistance block grant were to be enacted, several modifications and more adequate protections for states and children would be needed. These would include a much more responsive countercyclical mechanism triggered by changes in child poverty, continued effective State financial participation, objective State-defined eligibility criteria, and guarantees of equitable treatment for families in like circumstances. Also needed would be: stronger performance bonuses, lower block grant transfer provisions, greater flexibility in setting family caps, vouchers for children of teen mothers denied cash assistance, guaranteed Medicaid eligibility for cash recipients, individual responsibility contracts, and higher time-limit exemptions.

Child Care

- Essential Program Elements. Current child care programs provide a guarantee for all AFDC recipients required to work or who are moving off welfare into work. Capped amounts are also provided for low-income families at-risk of going on to welfare. Federal and State governments share in program financing.
- Administration Position. The Conference report block grants three mandatory child care programs -- two of which are open-ended -- and increases Federal funding by \$1.8 billion over 7 years -- too little to meet the child care needs of those required to work. The Administration supports the Coalition bill, which maintains the child care guarantee for AFDC recipients required to work and those transitioning off welfare for work.
- Potential Fallback Position. If the new child care block grant were to be enacted, we would need an additional \$3-\$4 billion in Federal funds above the Conference level, which would be matched by States (as the Conference currently requires). Lower funding add-ons are possible if more realistic work requirements are established. Current law health and safety protections, which are dropped in the conference report, should be restored.

Food Stamps

- Essential Program Elements. The current Food Stamps program automatically responds to increases in need for assistance. It serves as the national uniform safety net for nutrition.
- Administration Position. HR 4 would allow States that met certain conditions to elect a Food Stamps block grant. It would impose a spending cap on the program that, while adjusting for some elements, would not preserve the program's ability to respond to changing circumstances (such as erosion of wages). It also permits States unprecedented authority to change the structure and rules of the national program. The Administration has no such proposals and is opposed to any proposal which would undermine this universal safety net program's ability to respond to increased need
- Potential Fallback Position. None.

Child Protection Services and Training Programs

- Essential Program Elements. The four foster care and adoption assistance services, training, and administration programs are open-ended entitlements to States and allow States to respond automatically to increases in need for services.
- Administration Position. The Conference block grants four currently open-ended foster care and adoption assistance programs for placement services, training, and administration. The bill also repeals the Family Preservation & Support and Independent Living programs. These provisions reduce funding by \$0.4 billion. The Administration would maintain current law in each of these programs. The Administration opposes block granting and capping the open-ended programs because of rising abuse and neglect problems. Caseloads could also potentially increase due to dramatic changes elsewhere in the social safety net, which make cuts in child welfare programs especially dangerous.
- Potential Fallback Position. None.

Child Nutrition

- Essential Program Elements. The child nutrition program ensures that millions of children get nutritious meals in schools and other settings.
- Administration Position. HR 4 would allow one state in each of the seven USDA regions to run a school block grant demonstration for five years. States that adopt this block grant would not be required to serve all needy students. The Administration is opposed to block granting these important nutrition programs nationwide.
- Potential Fallback Position. If a child nutrition/school lunch block grant demonstration were enacted, the Administration would prefer considerably reducing the number of States. Only minor changes would be needed in the structure of the demonstrations.

MEDICAID

- Essential Program Elements.
 - **Federal Medicaid entitlement must be retained:** this requires a definition of mandatory beneficiaries and benefits, and enforcement of the entitlement through Federal courts:
 - Mandatory beneficiaries: must include AFDC and SSI recipients -- post welfare reform, low-income pregnant women, children, and elderly and disabled Medicare beneficiaries, as well as individuals transitioning from welfare to work and other post-welfare transitions.
 - Mandatory benefits: must include a Federally-required benefit package that could be negotiated so long as it remains comparable to the basic mandatory benefits under current law.
 - Right of action: the Federal entitlement requires that individuals ultimately have a right of action in federal court to enforce their eligibility to Medicaid.
 - **Federal financial partnership must be preserved:** The Federal matching structure, coupled with a new per capita cap to limit the rate of increase in spending, is the mechanism through which the Federal government would maintain its guaranteed financial partnership with states as they respond to changing economic and demographic realities in their state.
 - **Meaningful flexibility to States must be assured:** Within this structure, States must be given unprecedented flexibility in how to operate their Medicaid programs, organize their delivery systems through managed care and other innovative arrangements, and pay providers.
- Administration Position: The conference position does not preserve the Federal Medicaid entitlement to meaningful benefits or enforcement through the Federal courts. The block grant structure fails to preserve the Federal financial partnership through economic and demographic changes.
- Potential Fallback Position.
 - **Medicaid entitlement:**
 - Beneficiaries: Eligibility simplification can be pursued in which some currently mandatory Medicaid coverage groups that are now classified as “grandfathered” could be made optional.

- **Benefits:**

- Mandatory benefits could be redefined so long as the core benefit provisions remain -- including such basic benefits as inpatient hospital, physician services, family planning, diagnostic services, nursing home and home health services, and child health screening, diagnosis and treatment (EPSDT).
- Substantial new state flexibility could be negotiated in how states make available optional benefits -- this would lessen current law constraints for optional benefits about comparability of benefits among groups and statewideness.

- **Enforcement:**

- Eligibility: there is no viable option to maintaining the individual's right of action in Federal court regarding their entitlement to Medicaid. However, it could be made explicit that a state administrative process must be exhausted prior to court-filing.
- Benefits: For disputes regarding benefits, deductibles, and copayments, a health plan or HMO process, and a state administrative process, could be required, with appeal only to state courts, unless the claim exceeded certain threshold amounts.

-- **Federal financing:** The administration cannot accept any fixed block or formula grant proposal, other than revision in the current formula cap on DSH.

- The administration could begin to consider variable caps based on state costs, but there is a great deal of uncertainty about the distributional impact of such a proposal.
- The disproportionate share (DSH) cut and remaining payment policy could be negotiated.
- Transitional and/or hold-harmless pools can be negotiated, as well as pooled funding for federally qualified health centers and rural health centers.

Flexibility Proposals Contained in the Alternative Medicaid Proposal

*Administrative
Proposal as
released*

NGA Medicaid Proposals	Alternative Proposal
<u>Structure:</u>	
o Impose no unilateral caps for federal spending on Medicaid entitlement.	Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. Entities eligible for DSH payments would be expanded to include FQHCs, RHCs and other outpatient providers. The alternative proposal would also include new payments to a number of States with high numbers of undocumented immigrants and high levels of uncompensated care.
<u>Eligibility:</u>	
o Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)	Addressed. To allow for eligibility simplification and eligibility expansion, States would have the option of covering individuals up to 150 percent of poverty, or expanding overall coverage by 30 percent, as long as the expansion is "budget neutral" (subject to CBO scoring). Current coverage would be maintained.
o Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)	Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.

<u>Provider Payment:</u>	
o Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95) .	Addressed. Boren amendment is repealed for hospitals and nursing homes
o Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs following a two-year transition
o Provider Qualifications	
● Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93)	Included
● Repeal the annual reporting requirements for OB and pediatric care. (NGA '93)	Included
<u>Services:</u>	
o States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers (subject to CBO scoring).
o Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)	Affirms current law that personal care services can be delivered by providers other than home health agencies.

<u>Delivery Systems:</u>	
o Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
• States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95) • Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95,) • Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93)	Included. Included. Included.
o Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)	Addressed. Managed care and home and community-based care no longer require waivers.
<u>Quality:</u>	
o OBRA '87 Nursing home reform modifications:	Addressed.
• Eliminate restrictions on training sites for nurse aides. (NGA '93) • Eliminate PASARR. (NGA '93, NGA '95)	Eliminates prohibition on providing nurse-aide training in rural nursing homes. Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.

o OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93)

Affirms current law to allow the targeting of state enforcement resources

~~Confidential~~

DISCUSSION DRAFT ONLY

BOREN-STYLE CLAIMS

Issue

Notwithstanding the repeal of the Boren amendment in the Administration's proposed amendments to Title 19, would Sec. 1902(a)(30)(A) provide an alternative cause of action for providers seeking essentially the same relief?

Existing law

In Wilder v. Virginia Hospital Ass'n, 496 U.S. 498 (1990), the Supreme Court ruled that providers of health care in the Medicaid program could sue states pursuant to Sec. 1983 to compel compensation for services rendered in accord with the "reasonable rate" standard established in 42 U.S.C. Sec. 1902(a)(13)(A) (popularly known as the Boren amendment). The Court ruled that the language of that provision was sufficient in its clarity and in its mandatory nature to establish an enforceable right. Two years later, in Suter v. Artist M., 112 S.Ct. 1360 (1992), the Court, without reversing Wilder, held that one of the 16 listed state plan requirements under the Adoption Assistance and Child Welfare Act of 1980 was not sufficiently precise to support a private right of action. The Court stressed the importance of "examining exactly what is required of States" under the statute, and found that the only unambiguous requirement of that Act was that "a State have a plan approved by the Secretary which contains the 16 listed features." The features themselves, however, were deemed to be too general to create a privately enforceable right. Such "generalized dut[ies are]...to be enforced not by private individuals, but by the Secretary." There is substantial confusion in the courts about how to harmonize the two decisions, which have been widely criticized as inconsistent.

The Administration's Medicaid proposal would explicitly repeal the Boren amendment, but would leave in place another, long-standing subsection of Sec. 1902(a) that states as follows:

A State plan for medical assistance must... (30)(A) provide such methods and procedures relating to the... payment for care and services available under the plan... as may be necessary to... assure that payments are... sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Governors have questioned whether providers might be able to rely on this provision to secure essentially the same kind of relief as was sought by the provider plaintiffs in Wilder.

December 29, 1995

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2/24/14

DISCUSSION DRAFT ONLY

Possible resolution

Immediately following the provision repealing the Boren amendment, new statutory language could be drafted for inclusion in the Administration's proposal that would state that Congress intends that there be no privately enforceable right of action by providers against a State for the establishment of compensation rates that comply with the standards set forth in this section, i.e. Sec. 1902(a).

ISSUES IN REFORMING ENTITLEMENT PROGRAMS

AFDC

- Essential Program Elements. A reformed AFDC program must have tough work requirements, time limits, and increased State flexibility. It should also retain certain features of current law: It should provide a guarantee of assistance to all individuals who meet certain criteria. Its funding mechanism should respond automatically to changes in economic and demographic conditions. It should give States strong incentives to share in program financing and to match Federal funds, but allow flexibility in setting income eligibility and benefit levels. Individuals in like circumstances should be treated equally.
- Administration Position. The conference report on welfare reform converts AFDC and related programs into a capped block grant. The block grant fails to address many of the essential elements of the current program. The Administration supports the Coalition proposal, which replaces AFDC with a conditional time-limited entitlement and provides an automatic response to countercyclical increases in need while increasing State flexibility.
- Potential Fallback Position. If a cash assistance block grant were to be enacted, several modifications and more adequate protections for states and children would be needed. These would include a much more responsive countercyclical mechanism triggered by changes in child poverty, continued effective State financial participation, objective State-defined eligibility criteria, and guarantees of equitable treatment for families in like circumstances. Also needed would be: stronger performance bonuses, lower block grant transfer provisions, greater flexibility in setting family caps, vouchers for children of teen mothers denied cash assistance, guaranteed Medicaid eligibility for cash recipients, individual responsibility contracts, and higher time-limit exemptions.

Child Care

- Essential Program Elements. Current child care programs provide a guarantee for all AFDC recipients required to work or who are moving off welfare into work. Capped amounts are also provided for low-income families at-risk of going on to welfare. Federal and State governments share in program financing.
- Administration Position. The Conference report block grants three mandatory child care programs -- two of which are open-ended -- and increases Federal funding by \$1.8 billion over 7 years -- too little to meet the child care needs of those required to work. The Administration supports the Coalition bill, which maintains the child care guarantee for AFDC recipients required to work and those transitioning off welfare for work.
- Potential Fallback Position. If the new child care block grant were to be enacted, we would need an additional \$3-\$4 billion in Federal funds above the Conference level, which would be matched by States (as the Conference currently requires). Lower funding add-ons are possible if more realistic work requirements are established. Current law health and safety protections, which are dropped in the conference report, should be restored.

Food Stamps

- Essential Program Elements. The current Food Stamps program automatically responds to increases in need for assistance. It serves as the national uniform safety net for nutrition.
- Administration Position. HR 4 would allow States that met certain conditions to elect a Food Stamps block grant. It would impose a spending cap on the program that, while adjusting for some elements, would not preserve the program's ability to respond to changing circumstances (such as erosion of wages). It also permits States unprecedented authority to change the structure and rules of the national program. The Administration has no such proposals and is opposed to any proposal which would undermine this universal safety net program's ability to respond to increased need
- Potential Fallback Position. None.

Child Protection Services and Training Programs

- Essential Program Elements. The four foster care and adoption assistance services, training, and administration programs are open-ended entitlements to States and allow States to respond automatically to increases in need for services.
- Administration Position. The Conference block grants four currently open-ended foster care and adoption assistance programs for placement services, training, and administration. The bill also repeals the Family Preservation & Support and Independent Living programs. These provisions reduce funding by \$0.4 billion. The Administration would maintain current law in each of these programs. The Administration opposes block granting and capping the open-ended programs because of rising abuse and neglect problems. Caseloads could also potentially increase due to dramatic changes elsewhere in the social safety net, which make cuts in child welfare programs especially dangerous.
- Potential Fallback Position. None.

Child Nutrition

- Essential Program Elements. The child nutrition program ensures that millions of children get nutritious meals in schools and other settings.
- Administration Position. HR 4 would allow one state in each of the seven USDA regions to run a school block grant demonstration for five years. States that adopt this block grant would not be required to serve all needy students. The Administration is opposed to block granting these important nutrition programs nationwide.
- Potential Fallback Position. If a child nutrition/school lunch block grant demonstration were enacted, the Administration would prefer considerably reducing the number of States. Only minor changes would be needed in the structure of the demonstrations.

MEDICAID

- **Essential Program Elements.**

- **Federal Medicaid entitlement must be retained:** this requires a definition of mandatory beneficiaries and benefits, and enforcement of the entitlement through Federal courts:
 - Mandatory beneficiaries: must include AFDC and SSI recipients -- post welfare reform, low-income pregnant women, children, and elderly and disabled Medicare beneficiaries, as well as individuals transitioning from welfare to work and other post-welfare transitions.
 - Mandatory benefits: must include a Federally-required benefit package that could be negotiated so long as it remains comparable to the basic mandatory benefits under current law.
 - Right of action: the Federal entitlement requires that individuals ultimately have a right of action in federal court to enforce their eligibility to Medicaid.
- **Federal financial partnership must be preserved:** The Federal matching structure, coupled with a new per capita cap to limit the rate of increase in spending, is the mechanism through which the Federal government would maintain its guaranteed financial partnership with states as they respond to changing economic and demographic realities in their state.
- **Meaningful flexibility to States must be assured:** Within this structure, States must be given unprecedented flexibility in how to operate their Medicaid programs, organize their delivery systems through managed care and other innovative arrangements, and pay providers.

- **Administration Position:** The conference position does not preserve the Federal Medicaid entitlement to meaningful benefits or enforcement through the Federal courts. The block grant structure fails to preserve the Federal financial partnership through economic and demographic changes.

- **Potential Fallback Position.**

- **Medicaid entitlement:**
 - Beneficiaries: Eligibility simplification can be pursued in which some currently mandatory Medicaid coverage groups that are now classified as “grandfathered” could be made optional.

- **Benefits:**

- Mandatory benefits could be redefined so long as the core benefit provisions remain -- including such basic benefits as inpatient hospital, physician services, family planning, diagnostic services, nursing home and home health services, and child health screening, diagnosis and treatment (EPSDT).
- Substantial new state flexibility could be negotiated in how states make available optional benefits -- this would lessen current law constraints for optional benefits about comparability of benefits among groups and statewideness.

- **Enforcement:**

- Eligibility: there is no viable option to maintaining the individual's right of action in Federal court regarding their entitlement to Medicaid. However, it could be made explicit that a state administrative process must be exhausted prior to court-filing.
- Benefits: For disputes regarding benefits, deductibles, and copayments, a health plan or HMO process, and a state administrative process, could be required, with appeal only to state courts, unless the claim exceeded certain threshold amounts.

-- **Federal financing:** The administration cannot accept any fixed block or formula grant proposal, other than revision in the current formula cap on DSH.

- The administration could begin to consider variable caps based on state costs, but there is a great deal of uncertainty about the distributional impact of such a proposal.
- The disproportionate share (DSH) cut and remaining payment policy could be negotiated.
- Transitional and/or hold-harmless pools can be negotiated, as well as pooled funding for federally qualified health centers and rural health centers.

DRAFT

MEDICAID STATE FLEXIBILITY

The Alternative Medicaid Reform Proposal dramatically increases State flexibility in Medicaid program administration. At the same time, it achieves Federal Medicaid savings through the use of per capita caps which protect States against eligible population growth due to demographic changes, economic downturns, and other uncontrollable events. Finally, the level of savings proposed by the alternative is substantially less than a third of what the Republicans are seeking. Thus, States would have the flexibility to tailor their Medicaid programs to meet local needs without the substantial funding losses and financial risks inherent in the Republican block grant proposals.

The State flexibility of the alternative plan is illustrated by the fact that many of the Medicaid flexibility proposals requested by the States over the past several years are included explicitly in the plan. The following chart reflects items requested by the NGA in its 1993 summary of State Recommendations for Statutory Change and its Medicaid Policy adopted in January 1995.

Provisions in the alternative plan should be considered preliminary.

November 28, 1995

Flexibility Proposals Contained in the Alternative Medicaid Proposal

NGA Medicaid Proposals	Alternative Proposal
1. Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95)	Included.
Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95,)	Included.
Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93)	Included.
2. OBRA '87 Nursing home reform modifications:	Addressed.
Eliminate restrictions on training sites for nurse aides. (NGA '93)	Eliminates prohibition on providing nurse-aide training in rural nursing homes.
Eliminate PASARR. (NGA '93, NGA '95)	Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.
3. States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers (subject to CBO scoring).
4. Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs following a two-year transition.

5. Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95)	Addressed. Boren amendment is repealed for hospitals and nursing homes.
6. Provider Qualifications	Addressed.
• Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93)	Included.
• Repeal the annual reporting requirements for OB and pediatric care. (NGA '93)	Included.
7. Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)	Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.
8. Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)	Addressed. Managed care and home and community-based care no longer require waivers.
9. Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)	Addressed. To allow for eligibility simplification and eligibility expansion, States would have the option of covering individuals up to 150 percent of poverty, or expanding overall coverage by 30 percent, as long as the expansion is "budget neutral" (subject to CBO scoring). Current coverage would be maintained.
10. Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)	Affirms current law that personal care services can be delivered by providers other than home health agencies.

11. OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93)	Affirms current law to allow the targeting of state enforcement resources.
12. Impose no unilateral caps for federal spending on Medicaid entitlement.	Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. Entities eligible for DSH payments would be expanded to include FQHCs, RHCs and other outpatient providers. The alternative proposal would also include new payments to a number of States with high numbers of undocumented immigrants and high levels of uncompensated care.

October 29, 1995

MEMORANDUM

TO: Files

FR: Sara Rosenbaum

RE: Analysis of the Administration's draft legislative excerpt pertaining to Medicaid

The attached memorandum analyzes the Administration's draft legislative language pertaining to Medicaid (fax date of 10/26/95)

Overall Approach

The Administration proposes to retain the existing Medicaid program in lieu of replacing Medicaid with a new program as is the case under both the House and Senate reconciliation legislation. In retaining the program, however, the Administration proposes significant changes in federal financial participation in state programs, treatment of disproportionate share payment hospitals, federally qualified health centers and other providers of medical assistance, eligibility standards, state options to use both voluntary and mandatory managed care arrangements, and state options with respect to coverage of home and community care services.

The amendments proposed by the Administration would become effective for quarters on and after October 1, 1996.

Federal Payments to States

Current Law: Under current law the federal government reimburses states for expenditures made on behalf of eligible individuals for the provision of medical assistance by participating providers. The federal government also reimburses states for a range of administrative activities. States are entitled to reimbursement for medical assistance in accordance with a formula that ranges from 50 to 83 percent of each state dollar spent. Certain medical assistance services (family planning services and supplies) are reimbursed at a higher rate. Federal reimbursement for administrative costs is at 50 percent of state expenditures; certain administrative expenditures are reimbursed at a higher rate. Federal reimbursement rises with state spending, that is, as the number of eligible persons increases and as costs rise, federal reimbursement rates remain constant at the state's federal financial participation formula. Thus, for example, if per capita spending on the elderly rises 10 percent in a year, federal contributions will increase by 10 percent as well.

Federal contributions are made by categories of medical assistance, without distinction as to the type of beneficiary for whom the claim for reimbursement is made. For example, if a state spends \$50 million on prescribed drugs, the federal contribution is based on the state's expenditure for all beneficiaries rather than for specific sub-categories of beneficiaries.

Administration Proposal: The Administration proposes to place a per beneficiary growth rate limitation on federal contributions to state expenditures for most classes of services and administrative activities. Under the new system, beneficiaries would be divided into four eligibility groups: non-disabled children; non-disabled adults under age 65, non-disabled adults ages 65 and older; and disabled beneficiaries of any age.¹

Beginning in FY 1997 and in each succeeding year, the total federal payment would be

¹ The draft bill provides no definition of disability, nor does it provide a mechanism for distinguishing between non-disabled elderly adults and disabled elderly adults.

made in an aggregate amount equal to the sum of the federal payment limits established for each of the four groups described above. For each group the annual aggregated limit would be the product of the per beneficiary base rate² for the group multiplied successively by (a) the allowable growth multipliers for FY 1996³ and each succeeding fiscal year through the current fiscal year, (b) the number of full year equivalent members of the group in the current fiscal year⁴, and (c) the state's federal medical assistance percentage. States operating under waivers would have the option of using an alternative methodology for calculating limits.⁵

Under this payment system, no aggregate overall limit would be placed on federal participation in the total number of beneficiaries that a state could enroll.⁶ However, federal payments per beneficiary would be limited by an annual growth factor, and upper federal contribution limits for different categories of eligibles would be established as a means of curbing major increases in coverage for one or more sub-groups (in accordance with new options described below) which are achieved by cutting back base-year coverage for another group.

Federal payments for medical assistance for a fiscal year would be made prospectively in advance of each quarter of the fiscal year for each of the four groups, based on the number of beneficiaries within each eligibility grouping.⁷

² The "per beneficiary base rate" for each group equals total federal payments to the state for the group in FY 1995 divided by the total number of full-year equivalent individuals in the group in FY 1995 plus the total federal payment made for administrative costs in FY 1995 divided by the total number of individuals enrolled in the state's plan in FY 1995.

³ The allowable growth rate multiplier for a fiscal year is 1 plus the average annual change in the nominal GDP for the 5 consecutive 12-month periods ending on June 30 of the preceding fiscal year.

⁴ I assume that payments would be made on the basis of an estimation of the number of members in the beneficiary group, since it would be impossible to know how many individuals in fact were members of the group until after the end of the fiscal year.) Payments would also include adjustments for prior quarters.

⁵ Under the alternative only expenditures on traditional eligibles would be included in the four groups; payments for each group would be assumed to bear the same ratio to the amount actually paid with respect to the group as the total federal medical assistance paid to the state bears to the sum of the medical assistance payments to all four groups.

⁶ But the quality control provisions would be amended to penalize states for "erroneous" enrollment of individuals in each group. The term "erroneous" appears to apply to individuals who are not eligible for assistance rather than eligibles who are misclassified into a particular group. Several exceptions are made to the erroneous enrollment provision, including errors made by the Social Security Administration, technical errors, enrollment of presumptively eligible persons, and enrollment based on misinformation.

⁷ The draft bill does not say so, but I assume that the prospective payments are based on *estimates* only since the state has no way of knowing until after the fact how many beneficiaries it served nor the proportion of the total served that fell into each grouping. This is particularly true in light of the fact that, as noted, there is no definition of a disabled individual.

In calculating the federal payments subject to these per beneficiary limits, the following federal payments would not be included: federal DSH payments, cost-sharing payments for QMBs, IHS facility payments, fraud and abuse administration payments and payments for vaccines for children.

Federal enhanced matching rates for certain medical assistance and administration expenditures also would be eliminated.

Federal Eligibility Rules

Current Law: Federal financial participation is available for medical assistance payments on behalf of certain categories of low income persons. At their option states may extend coverage to pregnant women, children under age 19 or elderly or disabled individuals in accordance with financial eligibility criteria determined by the state. Under this option, states may extend coverage to groups with incomes at whatever level the state determines appropriate.

Administration Proposal: States would have the option to extend eligibility to any individual whose income does not exceed 150 percent of the federal poverty level, as well as to individuals in new categories defined by the state, whose enrollment does not result in an increase of more than 30 percent in total program enrollment.⁸ The existing state option to extend coverage to additional pregnant women, children under 19 and elderly and disabled persons would be capped at 150 percent of the federal poverty level.

Individuals from these new optional groups apparently would be assigned to one of the four eligibility groupings described above. For example, if the state created a new category of poor working adults without health insurance, these adults would be added to the non-disabled adult category. However, expenditures by a state for these new optional members of the non-disabled adult group would not be eligible for federal financial participation. As a result, while expenditures for additional numbers of traditional eligibles (mandatory or optional) are not subject to federal contribution limits other than the per beneficiary cap, new optional eligibles do not qualify for FFP.⁹

⁸The 30 percent limit on enrollment of new optional eligibles may apply to both new categories of optional persons. It is difficult to tell from the manner in which the language is drafted exactly what is meant.

⁹It may not be clear whether additional eligibles fall into a traditional group or new optional group. For example, if welfare reform eliminates the AFDC program, are low income women and children who formerly would have been eligible because of their receipt of AFDC benefits to be considered traditional eligibles or new optionals? Since the cap applies only to new optionals and not to traditional eligibles, it will be important for states to limit the number of persons classified as "new optionals" in order to avoid reaching the cap on new eligibles. This may prove difficult to do. Moreover, since there is no FFP for "new optionals" this means that misclassification of eligibles as "new optional eligibles" within any single group will lead to fewer resources to cover all individuals within the group. For example, would women who used to receive AFDC but who no longer do so because of welfare reform be considered a "new optional" category of former AFDC recipients or "traditional eligibles" under federal Medicaid law? If they are treated as a new group rather than a traditional group, there will be no FFP. The new eligibles will have to

Additionally, Section 1115 of the Social Security Act would be amended to eliminate the Secretary's authority to waive Section 1902 with respect to eligibility requirements.

Treatment of Disproportionate Share Payment Hospitals, Federally Qualified Health Centers and Rural Health Clinics

Current Law: States must establish a system for paying hospitals that treat a "disproportionate share" of Medicare and Medicaid beneficiaries and low income persons. In addition, current law includes a formula for ensuring that at a minimum facilities whose Medicare, Medicaid and low income patients exceed a certain percentage of their total inpatient population. Federally qualified health centers and rural health clinics are entitled to payment for the reasonable cost of furnishing services to Medicaid enrollees. Additionally, FQHC and RHC services constitute a mandatory service for categorically needy persons.

Administration Proposal: States would have the option to make disproportionate share hospital payments and (at state option) payments to FQHCs and rural health clinics. The federal DSH payment standard would be repealed, as would cost-based reimbursement methodologies for FQHCs and RHCs. However, FQHC and RHC services would remain a mandatory benefit for categorically needy persons. Federal DSH payment amounts would be limited to one-third of the amount of federal DSH funds allocated to the state for FY 1995, adjusted by the GDP for each succeeding fiscal year.

Treatment of Managed Care

Current Law: States may offer enrollment in federally qualified or state licensed HMOs or HIOs on a voluntary basis to Medicaid beneficiaries. In addition, states may obtain waivers of federal freedom of choice requirements under Section 1915 or Section 1115 of the Social Security Act in order to mandate enrollment in managed care arrangements. If states desire to use full-risk contractors (on either a mandatory or voluntary basis) that do not meet federal requirements for HMOs or HIOs waivers must be obtained under Section 1115. Risk arrangements involving 2 or fewer services do not have to meet federal standards. States wishing to guarantee enrollment for up to 6 months may do so in the case of individuals enrolled in federally qualified or state licensed HMOs and HIOs and selected other plans.

Administration Proposal: 1. **Voluntary enrollment in managed care.** States would have the option to offer enrollment on a voluntary basis in "primary care case management" systems without obtaining federal waivers. So long as enrollment was voluntary states could contract with

share whatever resources are available for the "non-disabled adult" group without the benefit of new FFP. Classification of the 30,000 as "traditional eligibles" however, will yield additional FFP in accordance with the per beneficiary growth cap.

full-risk managed care entities that do not meet federal HMO/HIO requirements. Primary care¹⁰ case management systems are defined as a physician, a physician group practice or any "entity employing or having other arrangements with physicians who provide case management services". "Entities" meeting this definition that would be exempt from risk contracting standards could include PPOs, PHOs, ISNs and other full risk arrangements that do not operate as federally qualified or state licensed HMOs or HIOs and thus are not subject to federal standards.

Primary care case management providers and entities participating in voluntary systems would have to meet new requirements including reasonable and adequate hours of operation, reasonable geographic access, and the inclusion of sufficient providers to ensure prompt services without compromising the quality of care. Entities would be prohibited from discriminating on the basis of health status or service requirements in enrollment, reenrollment or disenrollment.

2. Mandatory enrollment in managed care systems. In order to mandate enrollment in primary care case management systems states would continue to be required to obtain waivers. States would be required to permit individuals to choose between at least two entities or case management providers. States would be required to permit individuals to change plans without cause at least once every six months and for cause at any time.

3. Federal HMO/HIO qualifications. The federal HMO/HIO standards would be amended to eliminate the 75/25 rule. Additionally Secretarial approval of contracts involving more than \$100,000 is eliminated as a requirement.

4. Quality and access in managed care. In the case of any managed care contracting, states would be required to implement a quality improvement strategy which includes access standards, procedures for monitoring performance, and collection and analysis of encounter data. States would be required to determine that entities can demonstrate the capacity to deliver covered services to enrolled persons.

5. Lock-in. It appears that the draft would extend the six-month lock in option to other classes of managed care plans, but it is difficult to tell.

Home and Community Based Care

Current Law: States may obtain federal waivers in order to extend coverage for home and community based care services to individuals who would require institutionalization in the absence of such services. Home and community based services include items and services not normally considered medical assistance for purpose of federal financial participation. Persons receiving home and community services may be treated as eligible in accordance with higher standards for

¹⁰The term primary care includes all health care services customarily provided by or under the supervision of and all laboratory services customarily provided by or through a general practitioner, a family practice physician, an internist, an ob/gyn specialist or a pediatrician.

the disregard of post-eligibility income.

Administration Proposal: The Administration proposes to make home and community care a state option, including provision of services, expanded services and the use of more liberal income eligibility rules.

Note: Since this would be a new category of optional disabled eligibles, this group might be limited by the new 150 percent of poverty rule.

Payment for Private Insurance

Current law: Under certain circumstances states must pay for private insurance premiums for certain groups of individuals.

Administration Proposal: The private insurance payment mandate is repealed. It is unclear whether states would still have the option to pay for such insurance with federal funds when they elect to do so.

Nurse Supervised Clinics

Current law: Payment can be made for services of clinics only if services are supervised by a physicians.

Administration Proposal: The Administration proposes to cover clinic services in the case of clinics supervised by a nurse practitioner.

IMD Services

Current law: Persons ages 21 through 64 are ineligible for Medicaid when admitted as patients to an IMD.

Administration proposal: The restriction on eligibility for adults in IMDs would be eliminated

Provider Participation and Payment

Current Law: Payments to providers. Section 1902(a)(13) requires payment at cost-based rates for several groups of providers including hospitals, nursing facilities, hospices, rural health clinic and federally qualified health centers, ICFs and home and community care.

Participation of obstetricians and pediatricians. Special payment rules apply to obstetric and pediatric services. Additionally, limitations are placed on the participation by obstetricians and pediatricians in state Medicaid programs to ensure that participating physicians have a means

of securing hospital admissions.

State health agency agreements. Additionally, state Medicaid agencies must maintain interagency relationships with state health agencies and pay agencies for services furnished to Medicaid beneficiaries.

Administration Proposal: Provider payments. The Administration proposes to replace the current cost-based system with a provision requiring states to make payments that are "adequate to secure sufficient participation of qualified providers" so that eligible persons have reasonable access to services meeting quality and safety standards.

Payment to obstetric and pediatric providers. Special rules pertaining to participating of obstetrical and pediatric providers and payment levels to such providers would be repealed.

State health agency agreements. The proposal also would repeal the interagency requirements pertaining to state health agencies.