## 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 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 (but not necessarily all rights) 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 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 their 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.

**[NOTE: The following issues should be raised only if the decision has been made to put significant new issues on the table.]**

**Additional Concerns Raised by Governors.** We know that you have also had discussions with Republican Governors on other issues, and we think that we can address some of their concerns. These issues include:

- More benefit flexibility

  New proposal: (1) Redefine some currently mandatory benefits, including EPSDT (child health screening, diagnosis and treatment), but leave core benefits in place (such as inpatient hospital, physician services, nursing home and home health services); (2) Give states flexibility to make optional services available only to certain groups ("comparability") or in certain areas of the state ("statewideness").

- Relief from federal lawsuits

  New proposal: As Governor Chiles has suggested, apply different rules to eligibility claims and benefit claims. Eligibility claims could be heard in federal court after exhausting a state administrative process. Certain factual individual benefit claims could be heard only in state court after participation in a state or plan-sponsored administrative process (unless the claim exceeded a certain dollar amount).

- More provider payment changes

  New proposal: Add statutory language (that would accompany the repeal of the Boren amendment) stating that Congress intends that there be no privately enforceable right of action by providers against a state to challenge payment rates.

- Additional eligibility changes

  New proposal: Make certain limited coverage groups optional that are currently mandatory (e.g., widows deemed to be eligible).

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
### OFFICE OF HEALTH POLICY

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# MEDICAID - CORE POLICY

Substantive Medicaid negotiations cannot proceed without first securing agreement on the fundamental policy issue at the core of the debate -- preserving the federal Medicaid entitlement to meaningful benefits, enforceable through federal courts, and backed with a guarantee of federal financing.

- **Federal entitlement:** requires a definition of mandatory beneficiaries, benefits to which they are entitled, and enforcement of the entitlement.

  -- Mandatory beneficiaries: must include individuals receiving cash assistance under AFDC and SSI after enactment of welfare reform, individuals in certain defined transitional status as they leave those cash programs, and the specific income-related groups covered under current law Medicaid (pregnant women, children, and certain low-income elderly and disabled Medicare beneficiaries). States would retain additional options beyond these required groups, and eligibility groups could be simplified as well.

  -- Mandatory benefits: must include a federally-required benefit package that could be negotiated so long as it remains comparable to the basic mandatory benefit package defined under current law. States could be given additional flexibility beyond current law in how they make available certain optional services.

  -- 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 commitment and partnership:** the federal financing commitment to states must be maintained if the entitlement is to remain viable. That requires that a block grant, or any other type of cap on total federal funding, even with adjustments, be rejected. The federal matching structure, coupled with a new per capita cap, 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.

Within this structure, states can and should be given unprecedented new flexibility in how to operate their Medicaid programs, organize their delivery systems through managed care and other innovative arrangements, and pay providers.

# MEDICAID - NEGOTIATING OPTIONS

Certain negotiating options are available within the framework of the core policy of preserving the federal Medicaid entitlement to meaningful benefits, enforceable through federal courts, and backed with a guarantee of federal financing.

## Federal entitlement

### Beneficiaries

- The Administration's initial plan retains current law mandatory and optional eligibility groups -- and adds a new option for states to cover individuals with income up to 150 percent of the federal poverty level, subject to a budget neutrality adjuster.

- Negotiating options:

  -- Need to resolve Medicaid eligibility requirements in light of welfare reform -- in particular 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.

  -- Eligibility simplification: some currently mandatory Medicaid coverage groups that are "grandfathered" groups could be made optional. These are groups that have maintained their coverage status as mandatory when federal policy changes have been enacted in the past. The issue is whether it is politically viable to cease requiring coverage of these groups.

### Benefits

- The Administration's plan maintains the current mandatory and optional Medicaid benefit structure, with one exception. It allows states the option to cover home and community-based services without having to get a waiver from HCFA.

- Negotiating options:

  -- Redefine mandatory benefits: the current list of 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, and nursing home and home health services. The issue is whether it is politically viable to shorten the list and exclude currently mandatory benefits such as nurse-midwife services.

-- Enhance state flexibility in making available optional services: currently, when states provide optional services (as all do) they are still subject to certain constraints about comparability of those services among groups, and statewideness of the coverage and benefits. Substantial new flexibility could be negotiated in how states make those optionals services available to certain groups.

Enforcement - right of action

- The President's plan maintains the current law requirements under which individuals have a right of action in federal court regarding eligibility and benefits.

- Negotiating options:

  -- There is no viable option to maintaining the individual's right of action in federal court regarding their entitlement to Medicaid.

  -- However, it may be possible to negotiate with Democratic governors some changes, leading to the following outcome:

     - Eligibility: It could be made explicit that a state administrative process must be exhausted prior to filing in court on eligibility-related claims.

     - Benefits: For disputes regarding benefits, deductibles, and copayments, a health plan or HMO process (for those in such plans) and a state administrative process could be required, with appeal only to state courts of competent jurisdiction, unless the claim exceeded certain threshold amounts.

     - 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.

**Federal financing**

- The Administration's plan includes a per capita cap, coupled with reductions in disproportionate share hospital (DSH) payments.

- Negotiating options:

  -- The administration cannot accept any fixed block or formula grant proposal, even with population and economic formula adjusters.

-- We could begin to consider whether the per capita cap should eventually include movement to variable caps based on costs in the state (higher growth rates for low cost states); given the uncertainty over such a proposal, this would be best left to a major study, report, and recommendation for future action.

-- The disproportionate share policy (DSH) cut and remaining payment policy could be negotiated in any number of ways:

- The administration could phase to the Coalition plan, which includes a much better targeted DSH policy (and substantial redistributions among the states).

- Some type of pooled funding could be established for federally qualified health centers and rural health centers, especially if states are given broader flexibility in coverage and payment for such providers.

- Flexibility should be retained to develop "transitional" and/or "hold-harmless" funding pools to deal with state impact of the Administration's plan.

## Flexibility Proposals Contained in the Alternative Medicaid Proposal

| NGA Medicaid Proposals | Alternative Proposal |
|---|---|
| Structure: | |
| 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.<br><br>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. |
| Eligibility: | |
| 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. |

| | |
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| Provider Payment: | |
| 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<br>• 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 |
| Benefits: | |
| 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. |

| | |
|---|---|
| Delivery Systems: | |
| 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) | 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. |
| 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. |
| Quality: | |
| o 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. |

| | |
|---|---|
| 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. |
| Administrative: | |
| 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. |

## 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 must also retain certain features of current law: It must provide a guarantee of assistance to all individuals who meet certain State- and Federally-defined 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 must 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 almost of all 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 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, higher work program funding, 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 also impose a 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). 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 (Mandatory)*

- 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 December 28, 1995

## MEDICAID ELIGIBILITY

Issue 1: **How to maintain appropriate linkage of eligibility between cash welfare and Medicaid?**

Background: Under current law, people who receive AFDC or SSI also receive Medicaid. The welfare reform conference bill includes a draft provision that would break this link and leave the matter to State decisions. This means that a potentially significant number of individuals could lose Medicaid eligibility, even if some of them are retained on welfare rolls by the States.

Recommended policy: Insist that this provision be stripped from the welfare bill. This step would mean that *those individuals eligible for the new welfare program[1] under this bill would automatically be eligible for Medicaid.* Of course, since individuals in some groups now on welfare would presumably lose eligibility for welfare, these individuals would lose Medicaid eligibility as well. Beneficiaries that receive cash welfare in the new system, however, would be assured of Medicaid as a concomitant.

Issue 2: **How to give States more flexibility in determining which groups are eligible for Medicaid?**

A related but separate question relates to how to give the States more flexibility in connection with Medicaid eligibility. More flexibility is relevant regardless of whether welfare reform passes, since an extensive list of mandatory eligibility groups remains in Medicaid.

Background: Current law provides for 31 separate mandatory eligibility groups. The major groups are recipients of AFDC and SSI, poverty-level pregnant women and children, and those groups in which the individuals would qualify for cash assistance but for some special rules. In addition, a number of the mandatory Medicaid groups are "grandfathered" -- that is, Congress mandated continuation of Medicaid eligibility for those who lost AFDC or SSI benefits because of some Congressionally mandated improvement, such as an increase in Social Security benefits.

Recommended policy: Retaining the mandatory character of "major" eligibility groups -- cash welfare recipients; those in transition from welfare, including those exceeding the time limit for receipt of cash benefits; pregnant women, infants, and children; and Qualified Medicare Beneficiaries and related groups -- while making other groups, including the "grandfathered" groups, optional. The attached list shows the mandatory groups in the new system and those that are now mandatory but would become optional. (The appendix shows the full list of currently mandatory groups.)

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[1] Or the SSI program, except where specifically prohibited elsewhere in the bill, such as substance abusers or certain disabled children.

## NEW MANDATORY GROUPS

### FAMILIES WITH CHILDREN

Welfare clients

- Recipients of ongoing, general purpose cash welfare benefits (including those who would receive a benefit except for administrative reasons such as recoupment of overpayments). Note: this group would not include those receiving one-time grants, nor those with grants for single purposes, such as utility expenses or child care.

- Families that lose cash welfare benefits because of transitions parallel to those in current law due to moving into employment or gaining new or additional child or spousal support, for limited periods of time.

- Families that lose cash welfare benefits as a result of exceeding the time limit for receipt of cash benefits permitted under the welfare reform bill, either the 60 month limit on Federal assistance or a shorter limit adopted at State option.

- Families that would receive benefits except for State-elected interruptions in benefits (for instance, States may restrict benefits for some individuals to no more than six months a year).

- Families that are participating in welfare-related job programs (e.g., Welfare Supplementation), without which they would qualify for cash benefits.

Poverty level pregnant women and children

- All pregnant women and children up to their sixth birthdays in families with income below 133 percent of the Federal poverty level.

- Children born after September 30, 1983, in families with income below 100 percent of poverty and with assets not in excess of a State-defined level at least as generous as AFDC asset levels.

- All pregnant women during the post partum period if they establish eligibility and receive services during their pregnancy.

- Children born to mothers eligible for Medicaid on the date of birth for one year after birth (or to the end of an inpatient episode if the child's first birthday occurs during that episode), provided the mother would have remained eligible if she were still pregnant.

- Children who age out of eligibility during a hospital stay.

Children adopted or in foster care:

- Children who are adopted under Federally subsidized adoption assistance agreements or receive foster care payments.

**AGED, BLIND, AND DISABLED**

- Recipients of SSI payments. Most States must cover all SSI recipients. In twelve States, however, different standards apply. These are States that chose in 1972, when the SSI program was set up, to use different eligibility criteria for Medicaid from those used for SSI population. The same rules would be maintained in Medicaid, applicable to those who are covered by SSI according to the new, post-reform rules in that program.

- Qualified Medicare beneficiaries. (QMBs) Persons who (a) are enrolled in Medicare Part A, (b) whose income does not exceed 100 percent of Federal poverty lines, and (c) whose resources do not exceed 200 percent of SSI limits. Benefits are limited to Medicare cost sharing: premiums for Medicare Parts B (and A, if the person does not qualify for it without paying the premium), deductibles and coinsurance.

- Selected low income beneficiaries. (SLMBs) Persons who would be QMBs except that their incomes are 110 percent of poverty, phased in to 120 percent by 1995. The Medicaid benefit for SLMBs consists only of Medicaid payment of the Part B premium, no other cost sharing.

- "Qualified severely impaired individuals". Disabled people (1) who formerly received SSI benefits,(2) who work despite their medical impairments, but (3) whose level of earnings, though substantial, is less than the cash, medical, and other benefits they would receive if they did not work.

- Qualified disabled and working individuals (QDWIs). Persons who(1) formerly received Social Security Disability benefits,(2) still have their disabling medical condition,(3) are entitled to Medicare Part A,(4)have income no higher than 200 percent of the Federal poverty line,(5)have resources no higher than twice the amount allowed under SSI,(6) are not otherwise eligible for Medicaid. The Medicaid benefit for these individuals is limited to receive cost sharing amounts for Medicare Part A (premiums, deductibles, coinsurance). States impose a sliding scale, income-related premium for persons with income between 150-200 percent of poverty.

## PRESENT MANDATORY GROUPS THAT WOULD BECOME OPTIONAL

**AGED, BLIND, AND DISABLED**

"Grandfathered" groups -- those who received (or could have received) cash assistance from their State in December 1973 and who lost (or would have lost) cash and/or medical benefits when SSI

replaced State aid programs for the aged, blind and disabled, including:

- Recipients of mandatory State supplemental cash payments
- Certain "essential" spouses.
- Certain medically needy individuals in institutions
- Blind and disabled assistance recipients who were unable to meet the SSI eligibility criteria for blindness or disability

Groups "grandfathered" when they lose SSI because of a change in Social Security benefits.

- Disabled widows and widowers who lost SSI benefits because of 1983 changes in the actuarial formula used to compute the amount of their Social Security benefit.
- Disabled widows and widowers who lose SSI benefits at age 60 when they become entitled for early widow's or widower's benefits under Social Security.
- Disabled children who lose SSI because of increases in Social Security benefits they receive that are based on a parent's entitlement to Social Security.

Certain recipients of veterans' pensions. AFDC and SSI applicants are required to apply for any other cash benefits to which they may be entitled. However this requirement is set aside for veterans who would otherwise be ineligible for SSI solely because of improvements in VA pensions enacted in 1979 and who live in States where medically needy coverage is not available These veterans may decline to accept the increased VA amount in order to keep SSI and, with it, Medicaid

**EITHER**

Former recipients of cash assistance from AFDC, SSI, or a State Supplemental Payment (SSP) program whose incomes now exceed eligibility thresholds because of cost of living adjustments (COLAs) in their Social Security benefits, but who meet all other eligibility requirements for one of the cash programs, including:

- people who actually lost cash benefits due to a COLA;
- those who lost cash assistance for some other reason but who could qualify currently if that part of their Social Security benefits attributable to past COLAs is disregarded;
- those who would have lost AFDC or SSI if they had applied for and been receiving it when the COLA was provided;

- those who would have qualified for AFDC or SSI if they had not been in a medical institution when the COLA was effected.

## OTHERS

Recipients of Refugee Cash Assistance.

G DIRECTOR TONSELIG PR2

## APPENDIX

## CURRENT MANDATORY GROUPS

* = Mandatory status of this group or an analogous one would be retained.

### FAMILIES WITH CHILDREN

Cash recipients

- *Recipients of Aid to Families with Dependent Children (AFDC)

AFDC-like families that do not receive an AFDC payment

- *Families that would receive AFDC except that State has withheld the payment in order to recoup AFDC overpayments made to the family in previous months.

- *Families that qualify for an AFDC payment of less than $10, the minimum amount that AFDC will pay

Certain families terminated from AFDC:

- *Families that lost AFDC because of earnings from employment.

- *Families that lose AFDC because of increased hours of or earnings from employment

- *Families that lose AFDC due to the onset of or increase in receipt of child (and/or spousal) support payments under title IV-D.

- *Families that are ineligible for AFDC because of eligibility restrictions that are forbidden in Medicaid

AFDC-like families that do not receive an AFDC payment

- *"Qualified family members" -- persons in two parent families in which the principal bread winner is unemployed and who would receive an AFDC payment that month except that the State has elected to restrict AFDC eligibility for two parent to no more than six months out of a year.

- *Families that participate in a "Work Supplementation" program which States can implement under AFDC, which subsidizes employment, and without the earnings from which the participants would qualify for AFDC.

Poverty level pregnant women and children

- *All pregnant women and children up to their sixth birthdays in families with income below 133 percent of the Federal poverty level

- *Children born after September 30, 1983, in families with income below 100 percent of poverty and with assets not in excess of a State-defined level at least as generous as AFDC asset levels

- *All pregnant women during the post partum period if they establish eligibility and receive services during their pregnancy.

- *Children born to mothers eligible for Medicaid on the date of birth for one year after birth (or to the end of an inpatient episode if the child's first birthday occurs during that episode), provided the mother would have remained eligible if she were still pregnant.

- *Children who age out of eligibility during a hospital stay.

Children adopted or in foster care:

- *Children who are adopted under Federally subsidized adoption assistance agreements or receive foster care payments.

**AGED, BLIND, AND DISABLED**

- *Recipients of SSI payments. Most States must cover all SSI recipients. In nine States, however, different standards apply. These are States that chose in 1972, when the SSI program was set up, to use different eligibility criteria for Medicaid from those used for SSI population.

- *Qualified Medicare beneficiaries. (QMBs)

- *Selected low income beneficiaries. (SLMBs)

- *"Qualified severely impaired individuals".

- *Qualified disabled and working individuals. (QDWIs)

"Grandfathered" groups -- those who received (or could have received) cash assistance from their State in December 1973 and who lost (or would have lost) cash and or medical benefits when SSI replaced State aid programs for the aged, blind and disabled, including:

- Recipients of mandatory State supplemental cash payments.

- Certain "essential" spouses.

- Certain medically needy individuals in institutions

- Blind and disabled assistance recipients who were unable to meet the SSI eligibility criteria for blindness or disability.

Groups "grandfathered" when they lose SSI because of a change in Social Security benefits.

- Disabled widows and widowers who lost SSI benefits because of 1983 changes in the actuarial formula used to compute the amount of their Social Security benefit.

- Disabled widows and widowers who lose SSI benefits at age 60 when they become entitled for early widow's or widower's benefits under Social Security.

- Disabled children who lose SSI because of increases in Social Security benefits they receive that are based on a parent's entitlement to Social Security.

Certain recipients of veterans' pensions. AFDC and SSI applicants are required to apply for any other cash benefits to which they may be entitled. However this requirement is set aside for veterans who would otherwise be ineligible for SSI solely because of improvements in VA pensions enacted in 1979 and who live in States where medically needy coverage is not available. These veterans may decline to accept the increased VA amount in order to keep SSI and, with it, Medicaid.

**EITHER**

Former recipients of cash assistance from AFDC, SSI, or a State Supplemental Payment (SSP) program whose incomes now exceed eligibility thresholds because of cost of living adjustments (COLAs) in their Social Security benefits, but who meet all other eligibility requirements for one of the cash programs, including:

- people who actually lost cash benefits due to a COLA;

- those who lost cash assistance for some other reason but who could qualify currently if that part of their Social Security benefits attributable to past COLAs is disregarded;

- those who would have lost AFDC or SSI if they had applied for and been receiving it when the COLA was provided;

- those who would have qualified for AFDC or SSI if they had not been in a medical institution when the COLA was effected.

**OTHERS**

Recipients of Refugee Cash Assistance.

- **Transition**

States are reacting strongly against any immediate savings in Medicaid legislation. They emphasize that it will require 18 to 24 months to enact and implement programmatic changes associated with spending reductions. That means, essentially, holding states harmless for two years.

- **Eligibility**

First priority should be given to coverage of the poverty population. States would prefer to get away from categorical restrictions and to have instead an income-based eligibility system. We recommend, however, that the statute hold as mandatory the following groups **under the poverty level**: children through age 18, the SSI population, QMBs. In addition, we recommend that coverage be mandatory for anyone states make eligible for welfare.

In addition to mandatory coverage we would give states the option of covering any adult under the poverty level or allow them to limit this new coverage to adults who are "caretakers" of minor children. This approach requires a budget neutrality mechanism--e.g. the one in the President's bill.

In addition, all the optional coverage groups would remain eligible for federal matching funds, including nursing home residents covered either under the state's medically needy program or the state's 300% of SSI rule.

With these recommendations, we would be giving states the option **not** to cover Medicare premiums for seniors with incomes between 100%-120% of poverty and flexibility to cover low income people without categorical restrictions. (Note, the latter flexibility is already in your proposal.)

- **Financial Eligibility Standards**

(1) Simplified income eligibility. States complain about calculating disregards for earned income and child care to determine eligiblity for working people. To eliminate disregards would contract eligibility for the working poor, most likely to be moving off welfare. An alternative that would provide administrative simplification would be to set a higher income standard for the working poor. New York sets it at 120%.

(2) Deeming. States also want the right to deem income of parents of institutionalized disabled children and of adult children of nursing home residents in determining eligibility and requiring ongoing contributions to the cost of care. These are areas in which flexibility would reverse thirty years of social policy and could potentially impoverish the parents of disabled children, as well as adult

children of nursing home residents who themselves may be elderly. These provisions penalize family members who live in the same state, ignoring family members who live elsewhere.

(3) Legal aliens. Undoubedly the issue of coverage of legal aliens will come up. Republicans retained coverage. That's the right thing to do.

- **Benefits**

In addition to a desire to narrow specific benefit requirements, states object to what they describe as **providers'** entitlement to payment--a result of the specific listing of providers able to receive payment within the current Medicaid statute. We recommend addressing this issue by replacing provider specifications with the approach used in the Health Security Act: coverage of services of health professionals and institutions (including but not limited to hospitals and nursing homes) that provide primary, preventive, acute and long-term care services.

Another way to respond to states' concerns that providers feel they have an entitlement to Medicaid is, rather than changing the benefit package, to eliminate the providers' private right of action.

Cost sharing: States' focus here is on allowing sliding scale premiums--in essence, allowing people above poverty to buy into Medicaid. This is largely a budget neutrality issue, not a cost-sharing issue. It's O.K.; as long as you constrain it.

- **Dual eligibles**

States are seeking control over the Medicare dollars associated with dual eligibles. To give them that control would enable states to use only the Medicare dollars--limiting additional Medicaid funds--to provide low income seniors the full range of services. That would mean limiting significantly restricted benefits, in other words making these seniors eligible for Medicaid, not Medicare. **To do this would be to repeal Medicare for low income seniors.**

States see federalization of coverage for low income seniors--at a minimum, for QMBs--as a partial way to deal with their concerns. Although federalization poses a dollar problem, some easing of state fiscal responsibilities might help on this issue. Probably the greatest area of interest is help with Part B premiums.

On specific benefits, the most obvious contentious area is the scope of EPSDT. Keeping the screening and referral is important, but you may have to give on requiring treatment beyond what's covered in the state plan.

Consistent with this action would be to allow states to offer different benefit packages for adults and children within the optional benefits. That would mean allowing states to offer vision or dental benefits to children and not to adults. The concept of differential benefit packages could be applied more broadly to allow states to provide limited benefits, like prescription drug

Sec. wld convene process
Comparability -- need shield in federal law

coverage, to seniors, who already have Medicare. (Note: States are here emphasizing the categorical nature of the Medicaid program, while elsewhere they claim to want to eliminate it.)

- **Other issues**

The Administration proposal already gives total flexibility in provider payment, substantial flexibility on managed care. You should not give more flexibility on nursing home standards and spousal impoverishment.

## MAJOR ISSUES

- Provider payment rates

  In addition to Boren, there is an "equal access" requirement. CDF suggests including increasing states' freedom to determine provider reimbursement rates by amending 1902(a)(30)(A)'s equal access requirement -- permit states to assure "equal access" using methods other than payment levels.

- EPSDT

  - CDF: Under the Administration's bill, states have the right, without waivers, to hold managed care plans responsible for furnishing the full range of EPSDT services, without further risk to the state. States could have the additional option to contract outside managed care plans with experienced providers to furnish all "outlier" services to special needs children, or to require managed care plans to enter into such contracts without riks to the state. EPSDT administrative requirements could be streamlined and reporting made less burdensome and more effective.

  - Sarah, Judy, Diane: May have to give up on treatment beyond what is covered in the state plan.

- Private right of action

  - Jack: Separating benefits from eligibility?

NOTE: Provision allowing Medicaid expansion if total number of new beneficiaries does not exceed 30% of previous caseload seems strange.

# FAX TRANSMITTAL

| | | |
|---|---|---|
| TO: | Chris Jennings, Jennifer Klein | |
| ORGANIZATION: | White House | |
| Telephone Number: | Fax Number: 456-7431 | # of Pages (including cover sheet) 11 |
| FROM: | Stan Dorn, Gregg Haifley, Jim Weill | |
| | CHILDREN'S DEFENSE FUND HEALTH DIVISION | |
| Telephone Number: (202) 662-3595 FAX Number: (202) 662-3560 | Administrative Assistant: Lauren Becker (202) 662-3551 | Date: Time: AM PM |
| Comments: | | |

**Please call 662-3595 or 662-3551 if you did not receive all of this fax transmission.**

**MEMORANDUM**

**To:** Chris Jennings, Jennifer Klein

**From:** Stan Dorn, Gregg Haifley, Jim Weill

**Subject:** Medicaid

**Date:** December 21, 1995

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

We remain deeply grateful to the President and the rest of the White House and HHS staff for the Administration's strong defense of the Medicaid entitlement and the Administration's proposal, which keeps intact the essential safeguards of Title XIX, including guarantees of eligibility and benefits, especially EPSDT's guarantee of necessary care for children, and cost-sharing protections. We are working hard to support the President's current Medicaid plan. We have letters en route to House members and Democratic Governors (attached) and worked hard this week to get all Democratic Senators on the Murray letter. We have also been actively working the Hill and the press on both the per capita cap and the Medicaid pieces buried in the welfare bill -- see the enclosed fact sheets. Please let us know how else we can help.

We also want to expand on what we said to you last week about our concerns. We agree that, with new fiscal pressures on states under per capita caps, states will need more flexibility to manage Medicaid efficiently, without denying essential services to children and families. We support the President's proposal to give states increased leeway to set provider payment rates, even for obstetrical and pediatric care. We support the basic concept of the Administration's proposal to let states implement managed care without waivers, although we believe additional safeguards are needed to protect children and families. In fact, it is possible to go farther in giving states the ability to determine provider payment rates and manage their overall health care purchasing systems, as described in the enclosed document.

Within EPSDT, states could receive additional freedom to manage their purchase of health care, without undercutting the program. Under the Administration's bill, states have the right, without waivers, to hold managed care plans responsible for furnishing the full range of EPSDT services, without further risk to the state. States could have the additional option to contract outside managed care plans with experienced providers to furnish all "outlier" services to special needs children, or to require managed care plans to enter into such contracts, all without risk to the state. EPSDT administrative requirements could be streamlined and reporting made less burdensome and more effective.

However, EPSDT's guarantee of medically necessary care for children must not be repealed or weakened. There's just no reason for children to lose current guarantees of essential health care in the face of the evidence that EPSDT been neither expensive nor burdensome. Children should not be singled out as the only group in the entire Medicare and Medicaid debate to lose coverage of current, essential benefits. Even moderate House Republicans recognized the long-term,

preventive benefits of EPSDT in the sign-on letter they sent to Chairman Bliley last summer. We support the President's current stance of granting states additional managerial flexibility without abandoning guarantees of essential health care for vulnerable children and families.

As we mentioned to Jennifer in the first part of our telephone conversation, we believe that one significant change in the bill is needed to safeguard essential health care for children. The absence of any income link in Section 11311's second option permits the diversion of capped Medicaid funds away from low-income children and families towards those who do not need help or do not need it nearly as badly. Under this section, states could use Medicaid funds to prop up state budgets or recruit employers from other states. The enclosed sheet explains this issue and recommends an approach that would prevent abuses while promoting state flexibility.

It should be possible to craft a Medicaid compromise that grants states necessary flexibility without denying children and families essential health care. We look forward to continuing to work with you to make sure that any Medicaid proposal signed into law meets these objectives, which we all share. Again, we deeply appreciate the support of the President and the Administration staff for the underlying Medicaid entitlement and for children's coverage in the program, and we will do all we can to support you in making those decisions hold.

**DRAFT -- Additional state flexibility**

1. Increase states' freedom to determine provider reimbursement rates. Amend Section 1902(a)(30)(A)'s "equal access" requirement now governing reimbursement rates. Permit states to assure "equal access" using methods other than payment levels.

2. Permit states to employ a market-based approach to Medicaid purchasing, using their leverage as large purchasers to lower provider payment levels.

   a. Allow states to use selective contracting, without waivers. Maintain current standards for access and services. To further protect beneficiaries, in states exercising this option, let beneficiaries use non-contracting providers where necessary to preserve reasonable access to covered services or in emergencies.

   b. Permit states to join together to conduct competitive bidding or selective contracting, without waivers. States could do so either through multi-state agreements or through IICFA.

   c. Let states increase their leverage to bargain for reduced prices with the following options:

      i. Let public employees, small business and others "buy in" to Medicaid, without cost to the state or the federal government;

      ii. Authorize states to purchase jointly Medicaid benefits and any other health benefits purchased by the state or through a broad purchasing cooperative, letting states require contracting providers to serve all such groups;

      iii. Let states disregard traditional fee for service reimbursements in setting new payment levels, including capitation, provided that access and quality are protected. In determining actuarial soundness of capitated rates, permit states to consider managed care utilization and market factors.

   d. Permit states to use the private sector, contractual enforcement tool of automatic partial withholds of capitated payments until plans have shown substantial compliance with key contractual requirements chosen by the state (e.g., one primary care visit).

3. Increase states' freedom to control program administration.

   a. Let states spend their capped DSH funds to furnish health coverage to low-income people who otherwise would be uninsured, if essential health care infrastructure is not thereby endangered.

   b. Let states use the bill's targeted funding for undocumented immigrants to cover prenatal care, not just emergency care (including labor and delivery). California and other states now use state funds for prenatal care for such immigrants.

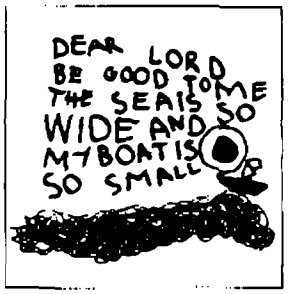
# AVOIDING THE DIVERSION OF CAPPED MEDICAID FUNDS TO HIGHER-INCOME PEOPLE

Under Section 11311 of the Administration's Medicaid proposal, states may use their capped Medicaid funds to cover, not just current Medicaid beneficiaries, but also two additional groups: low-income beneficiaries with incomes up to 150% of the federal poverty line; or any other group, no matter how high their income or how little their need for aid, so long as the new group numbers less than 30% of the total, previous Medicaid population.

The latter, open-ended provision could help states fund useful insurance expansions or could let states abuse the program by diverting scarce dollars to non-needy groups. For example, states could extend Medicaid coverage to state workers and retirees. This would substitute Medicaid funds for current state spending, allowing redirection of state funds to other state interests. In effect, Medicaid could subsidize state construction of roads and prisons, state tax breaks or state budget balancing. Similarly, Medicaid could be used to attract employers from other states with the promise of state-furnished health coverage for their employees, regardless of income. Such uses of capped Medicaid funding would come at the expense of children and other current beneficiaries. They could also undermine the integrity of the program in much the same way as did past state "creative financing" techniques that produced illusory state matching funds.

Even the Republican block grant plan permits Medicaid funds to be used only to cover households at or below 275% of poverty. This provision of the Administration bill, by contrast, would allow a state to have no income limit for these beneficiaries.

A slight change in this provision would prevent these abuses while still permitting very broad state flexibility, the purpose of this section. States should be allowed to use capped Medicaid funds to cover additional beneficiaries, but the additional groups would have to be based on income, not on extraneous factors. States could provide eligibility up to any defined income level. However, if that income level is above 150% of poverty, the total number of new beneficiaries should not be allowed to exceed 30% of the previous Medicaid caseload. Basing expanded coverage on need would be consistent with the Administration's policy, in granting statewide Medicaid waivers, that eligibility expansions should be based on beneficiary income.




Children's Defense Fund

December 22, 1995

Dear Representative:

I am writing to emphasize the importance of preserving the current guarantees of essential health services that the Medicaid program provides to children, pregnant women, and parents and to support the concept of a per capita cap as a means to preserve those guarantees. A block grant in Medicaid is unacceptable. Restructuring Medicaid through a per capita cap would contribute to discipline in federal budgeting without balancing the budget on the backs of children, pregnant women, and parents by stripping them of guaranteed health coverage and benefits.

A strong Medicaid program is essential to this nation's health. Medicaid covers one in four children and one in three births. More than half of the children covered by Medicaid are from working families. And Medicaid's importance as the essential source of health coverage for children is growing, as more than 1 percent of children each year lose employer-based insurance coverage.

Preservation of Medicaid as a guaranteed source of health coverage for children and pregnant women through a per capita cap financing structure will ensure that Medicaid reforms do not compound today's insurance crisis, which already leaves more than ten million children uninsured. A per capita cap would also give states the essential federal financing partner they need to respond to changing economic and demographic conditions which can increase the number of children and families needing Medicaid.

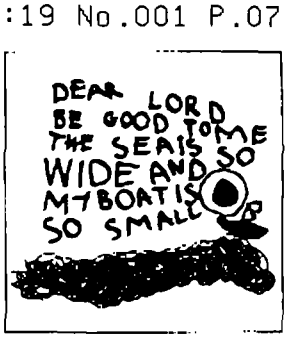
Many recent statements and letters from hundreds of groups have opposed Medicaid block grants and supported per capita caps, including: 1) a letter to the President last week signed by 35 national groups supporting per capita caps; 2) a letter opposing Medicaid block grants signed by more than 250 organizations concerned about the health of America's children and families; 3) the enclosed set of recommendations to preserve Medicaid guarantees of eligibility, benefits, and access for children and pregnant women signed by more than 150 organizations that focus on maternal and child health; 4) a statement signed by thirteen national children's health provider organizations recommending preservation of the Medicaid guarantees of coverage and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits for children; and 5) a letter this week to President Clinton signed by all forty-six Senate Democrats supporting per capita caps.

There is broad support for preserving the essential guarantees of the Medicaid program and overwhelming opposition to the block granting of Medicaid. I want to encourage your support of the per capita cap approach to Medicaid reform and offer to assist in any way I can.

Sincerely yours,

Marian Wright Edelman

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510




Children's Defense Fund

December 22, 1995

Dear Governor:

The Children's Defense Fund is writing to ask you to continue to do everything you can in the crucial days and weeks ahead to protect children's access to essential health care by preserving guaranteed coverage through Medicaid. We are deeply grateful that the Democratic Governors have given children the support they so desperately need on this issue.

For the same reasons, it is essential to preserve the basic guarantees in the AFDC, child protection, food stamps, and child nutrition programs, rather than block granting any of these programs. While reforms are needed and state flexibility can and should be enhanced, it is essential to preserve the assurance that children who need help to stay housed, clothed, fed, and safe from abuse and neglect will be able to get the supports they need. We hope you will work to preserve these guarantees as well.

We are enclosing a set of letters showing the breadth of the opposition to a Medicaid block grant and the widespread support for the Medicaid entitlement and per capita caps, including: a letter from 35 national groups to the President last week; a letter opposing block grants endorsed by more than 250 organizations concerned about the health of America's children and families; a set of recommendations to preserve the Medicaid guarantees of eligibility, benefits and access for children and pregnant women signed by more than 150 organizations that focus on maternal and child health; and a letter to President Clinton signed by all forty-six Senate Democrats supporting the per capita cap approach. The American Medical Association and the American Academy of Pediatrics also have endorsed Medicaid's guarantee of coverage to qualified children and families.

Medicaid covers one in four American children, guaranteeing millions of low-income parents that, if their children qualify, they can obtain essential cost-saving preventive care and necessary treatment for illness. If the Medicaid entitlement is repealed, children's access to health care would depend on the shifting winds of politics in each state capital.

The most effective way to secure the guarantee for children while protecting legitimate state interests is to preserve the present structure of Medicaid eligibility and benefits coupled with the President's per capita cap proposal. Not only does it provide states with much more federal Medicaid funding than would the Congressional block grant, but the President's proposal preserves Medicaid's guarantee of health coverage for qualified children and families. States would receive increased flexibility through repeal of the Boren Amendment and other restrictions on states' ability to control payment levels for providers. The proposal would also increase flexibility by permitting managed care without waivers.

25 E Street, NW
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Telephone 202 628 8787
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Under the President's proposal, total federal funding in a state would expand automatically when caseloads rise, helping states meet increased needs for assistance during periods of recession or population growth. Medicaid would remain a state-federal partnership, with the federal government sharing risks with each state. If Medicaid instead is repealed and replaced by block grants, a state would receive no additional federal assistance when recession or unexpected population growth or other demographic change occurs.

Thank you for your important part in this effort to protect America's children. Please continue your essential work to help give every child a healthy start, a head start, a fair start, a safe start, and a moral start. If we can assist you in any way, we hope you will not hesitate to call.

Sincerely yours,

James D. Weill
General Counsel

Stan Dorn
Director, Health Division

# THE BUDGET RECONCILIATION BILL DESTROYS THE MEDICAID PROGRAM, DEPRIVING LOW-INCOME CHILDREN OF HEALTH CARE PROTECTION

**Basic facts about health coverage for children**

- We are the only developed country not guaranteeing health coverage for all of its people. Our infant mortality rate remains the highest in the developed world. A Cuban or Sri Lankan baby is more likely to survive past his or her first birthday than is an African-American baby.

- More than 10 million children are now uninsured, and an additional 1% of American children lose employment-based coverage each year. If current trends continue, less than half of all American children will have employment-based coverage in the year 2000.

- Medicaid now covers health care for 17 million children, or 1 in 4 American children, including one-third of children under age three. While children comprise more than half of all Medicaid beneficiaries, children represent less than 25% of Medicaid costs.

**The Republican proposal eliminates the guarantee of health coverage for <u>every</u> poor child.**

- The Republican budget proposal would repeal Medicaid's guarantee of necessary health coverage for children. Whether poor children receive necessary health care would depend on the shifting economic fortunes and political winds in each state. The proposal also eliminates the Vaccines for Children Program.

- During the next seven years, the Republican budget proposal would reduce projected federal Medicaid spending by $163 billion, with the cuts rising to 28% in the seventh year. The proposal also would permit states to make even deeper cuts in their spending of state Medicaid dollars, allowing reductions in combined state and federal spending of $420 billion, or 35% in the seventh year. The federal reduction alone is more than 10 times the size of any Medicaid cut ever signed into law by any President, Democrat or Republican.

- While the Republican plan purports to protect eligibility for poor children through age 12, it is an empty gesture. No child would be assured coverage of <u>any</u> health care need, except immunizations. As one Republican Senator said on the floor, a state could provide only aspirin.

- If these cuts fall equally on children and other groups of beneficiaries, roughly 6 million children would be denied coverage in the year 2002 alone -- more children than live in the states of Massachusetts, Connecticut, Rhode Island, New Hampshire, Vermont, Maine, Wisconsin, Iowa and Kansas combined.

**The President's proposal preserves current guarantees of comprehensive health coverage for poor children.**

- The President's plan would preserve Medicaid's guarantee of health coverage for children and families. Every child on Medicaid would retain guaranteed coverage of check-ups, immunizations and all necessary treatment of medical conditions. The President would preserve current law coverage for children, including completing the phase-in of coverage of all poor children by the start of the next century. The proposal also preserves the Vaccines for Children Program.

- The President's plan would cut federal Medicaid spending by $54 billion, less than one-third the size of the Republican cut. This reduction would be accomplished without eliminating current guarantees of essential health care.

- The President would achieve savings by capping the growth of federal funding per beneficiary. If a state goes into recession and more children qualify for Medicaid, states would receive more federal funds to cover the additional children in need.

December 21, 1995

**WELFARE CONFERENCE BILL ENDS GUARANTEE OF HEALTH COVERAGE FOR AMERICA'S NEEDIEST CHILDREN AND PARENTS**

Current Medicaid law guarantees health coverage to children and parents receiving AFDC. Both the House and Senate welfare reform bills continued the guarantee of Medicaid coverage to cash assistance recipients and provided that poor children and families thrown off AFDC because of new rules (e.g., time limits on benefits) would still get Medicaid. But the new conference version of the welfare reform bill abruptly changes course, ending the guarantee of health coverage for millions of America's poorest children and parents in both groups. Not only does section 114 of the conference version of the bill delete any requirement of Medicaid coverage for children and parents **denied AFDC** by the new welfare-related restrictions, it ends the current law guarantee that children and their parents **receiving AFDC** get Medicaid. Nothing in any prior version of the welfare bills took this drastic step of singling out some of the country's poorest parents and children for elimination of guaranteed health coverage. In the median state, cash assistance recipients live on less than $380 a month for a family of three. Among these desperately poor cash assistance recipients and families denied all cash aid, 4.6 million parents and 1.6 million children over age 12 would lose guaranteed health coverage.

Under the new provision, states could deny Medicaid coverage to anyone unprotected by other sections of the Medicaid statute. Thus, states could deny coverage for poor children over age 12 and all poor parents (except those who are pregnant), no matter what the age of their children. These children and families will lose guaranteed health coverage even if no other Medicaid bill passes the Congress.

# FAX TRANSMITTAL

| | | |
|---|---|---|
| TO: | Jennifer Klein | |
| ORGANIZATION: | White House | |
| Telephone Number: 456-2599 | Fax Number: 456-2878 | # of Pages (including cover sheet) 4 |
| FROM: | Gregg Haifley | |
| | CHILDREN'S DEFENSE FUND HEALTH DIVISION | |
| Telephone Number: (202) 662-3541 FAX Number: (202) 662-3560 | | Date: 12/15/95 Time: AM PM |
| Comments: Jennifer: Attached is info regarding EPSDT. | | |

**Please call 662-3541 if you did not receive all of this fax transmission.**

November 20, 1995

Maintaining the EPSDT benefits package is essential to the health of America's children.

In the context of ongoing budget discussions and efforts to maintain Medicaid as an entitlement program, some have suggested giving states flexibility to reduce children's Early and Periodic Screening, Diagnosis and Treatment benefit package. This would be harmful to the health of children and the nation. This memo outlines some of the reasons why it would be a terrible mistake to dilute the current EPSDT provisions of the Medicaid program.

EPSDT currently covers screenings to identify physical, mental, dental, vision and hearing problems. Services required after a problem is diagnosed include physician and hospital care, eyeglasses, dental services, and hearing aids, and such other health care as is necessary to correct or ameliorate defects, illnesses and conditions discovered by the screening services, whether or not such services are otherwise covered for Medicaid-eligible adults.

Investments in children's health are, of course, among the best investments a society can make. This country already underinvests in child health, even though children's health costs are very low (1993 Medicaid expenditures for all covered children under age 21 were $1,065 per child) and the benefits of good health care for children flow for decades.

One proposal under discussion would continue to require states to cover children for screenings, immunizations, eyeglasses, dental services and hearing aids. Otherwise, children would only be guaranteed those treatment services (most significantly inpatient hospital, physician, certain clinic and family planning services) required to be provided by states to all recipients without regard to EPSDT. Under this proposal other treatment services necessary to address physical or mental conditions would not have to be provided unless a state opted for coverage. These services include: prescribed drugs; home health care; physical, speech and other therapy; and prosthetic devices like crutches and wheelchairs.

In the absence of EPSDT's special treatment requirement, children will lose essential services, with the sickest and most disabled children suffering the greatest cuts.

1. **Through EPSDT, children receive, as of right, many developmentally crucial services that are currently optional for adults and are not covered by many states, including:**

- physical therapy - 10 states do not cover.
- speech therapy - 13 states do not cover.
- rehabilitative services - 7 states do not cover.
- respiratory care services - 40 states do not cover.
- psychologists' services - 29 states do not cover.

The denial of these services to children would be devastating. And there is little reason to believe that states would continue these services for children if they became optional. Before such treatment became required for children, states generally left children and adults alike uncovered for many optional services.

2. **These optional services are even more likely to disappear under the per capita cap because the political pressures will be greater than ever to cut services in order to raise reimbursement rates to the more powerful provider groups.** Given the constraints of the per capita cap, the best way for providers of mandatory services to get fee hikes may well be to knock out optional services.

3. **Several states currently impose amount, duration, or scope limitations on mandatory services provided to adults (EPSDT does not permit these types of limitations on medically necessary services for children).** For example, according to the 1993 Medicaid Resource Book (House Energy & Commerce Committee Print 103-A), Alabama limits inpatient hospital services to 14 days per year, and 6 other states have yearly limits ranging from 15 to 30 days. Physician visits in a hospital are limited in Alabama to 14 per year. Office visits to physicians are severely limited in six states, with limits ranging from 12 visits a year (Georgia and Kansas) to 25/year (Arkansas). Other states limit the number of prescriptions covered per month. While most children never hit such service limits, the limits are devastating to the sickest and most disabled children.

4. **There is a particularly perversity to requiring states to aggressively screen and diagnose children's illnesses and conditions, but then letting states refuse to treat them,** even withholding such typical services as physical therapy, prescription drugs, and wheelchairs.

5. **Reducing children to the basic mandatory package applies an adult-oriented package to the needs of children.** As all the studies show, children's need for services is different than that of adults. Children need and use more preventive care (check-ups, screenings, vaccinations). Children are less frequent utilizers than adults of routine, non-preventive care, (e.g., physician and hospital care). But a small number of children need a lot of extensive and intensive care -- rehabilitation, home health, prolonged hospitalization, etc. In a sense, children use more of the very "front end" and "back end" of the system; adults use more of the middle. A mandatory benefits package that emphasizes the middle disadvantages children and structures the program around adult needs.

6. **Letting states deny the more expensive services to the relatively few very ill and disabled children who need them creates a serious prospect of a "race to the bottom."** The nearly one million disabled children for whom Medicaid is a lifeline include many who would need the services some states would eliminate if given the option. While families are unlikely to move for routine care, families whose children have great medical needs may well move to a state that covers rehabilitation or extensive therapies from one that does not. States may "race to the bottom" to avoid having to care for such children.

7. **Because relatively few children are utilizers of these more expensive services, on the other hand, the amount that can be saved by states is very small, in the broader Medicaid context.**

8. **As the White House and the minority in Congress struggle to maintain health coverage for America's elderly and for poor children and adults, it would be wholly inappropriate for children to be singled out for benefit cuts.** The entire set of health entitlements (in Medicare as well as Medicaid, and for civil service employees and retirees) will suffer constraints on spending, but to our knowledge no group other than children is facing a proposal for a significant reduction in covered services. Coming on top of the vastly disproportionate cuts children are suffering in the areas of income, nutrition, education and other programs, a substantial benefits package cut in Medicaid would represent another unjustified and unshared sacrifice.

**Staff Summary of Medicaid Discussions**
**Thursday, December 22, 1995**
**11:00 A.M.**

## ELIGIBILITY

### A. GUARANTEED COVERAGE GROUPS

1. Pregnant women to 133% of poverty
2. Children under age 6 to 133% of poverty
3. Children under age 13 to 100% of poverty
4. Persons with Disabilities — income to 100% of SSI (≈ 80% of poverty); functional impairment defined by state [unresolved]
5. Elderly (65+) — income to 100% of SSI (≈ 80% of poverty); functional impairment = need for institutional care
6. Qualified Medicare Beneficiaries and related groups
7. Adults from AFDC Program-Related Groups - States must choose from among the following options.
   - Continue serving individuals who would qualify under current AFDC rules; or
   - states are encouraged to develop work programs to develop AFDC when they do so they may establish a single eligibility system for both medical assistance and the new AFDC program.

Under current law a mandatory coverage for children is being phased in annually. That phase-in is not complete. It remains unresolved whether the phase-in should be included in the reformed program.

### B. OPTIONAL COVERAGE GROUPS

In additions to the above categories, states would be free to provide health care to any other group of individuals or families. States would have complete freedom to define the eligibility standards for this population.

### C. ASSETS STANDARDS

Persons with disabilities and the elderly would also be required to meet both an income and assets standard. The following are some principles to guide that standard.

1. The federal government should establish the asset limit. States could establish more restrictive limits, if they so choose.
2. Federal spousal impoverishment standards would apply.
3. Federal estate recovery standards would apply.
4. For eligibility purposes, the state may consider the maximum amount assets for the three years prior to application. If assets were divested during that period, the burden of proof is on the applicant and not the state to show that those assets were not divested to obtain nursing home coverage.

No diagnosis discrim,
no lifetime maximum,
no annual limit

C. RIGHT OF ACTION

The states must be held accountable for the operation of the program. There are however, at least two strategies by which the accountability can be enforced.

Option 1: The state is accountable to the federal government through the state plan. This agreement is enforced through state administrative action and the state courts. The state is also accountable to individuals classes. This relationship is outlined as follows.

a) States must offer individuals (or classes) a private right of action in state court as a condition of participation in the program. This would follow some state administrative appeal process. Once all state judicial remedies are exhausted, individuals may appeal to the U.S. Supreme Court.

b) Independent of any state judicial remedy, the Secretary of HHS may bring action in federal courts on behalf of individuals (or classes).

Option 2: The state is accountable to the federal government though the state plan, enforced through administrative action by the Secretary of HHS and the federal courts. The state is also accountable to individuals (or class). This may be enforced through a right of action in federal courts.

**BENEFITS**

The current Medicaid program includes ten mandatory benefits which must be offered to all beneficiaries and 34 benefits that may be offered to beneficiaries at state option. This proposal maintains this listing of benefits but makes them available as follows.

A. GUARANTEED COVERAGE GROUPS

States must offer to each beneficiary in the guaranteed coverage groups all of the benefits that are mandatory in the current program with the following conditions. States may offer any of the optional benefits to this population.

1. States have complete authority to define amount, duration and scope of services
2. States have complete authority to establish payment rates for providers.
3. The OBRA '89 provisions that expand mandatory benefits for children should be modified.

B. OPTIONAL COVERAGE GROUPS

For these coverage groups, there are no mandatory benefits and all benefits are at state option.

1. States define amount, duration and scope of services.
2. States establish payment rates for providers.

**FINANCING**

Discussion of financing should take into account the following principles.

1. Base expenditures should reflect a state's recent spending patterns.
2. A relationship between the state and federal government should be maintained.
3. Increases in the base, over the next seven years, should reflect changes in eligible populations (e.g. children, mothers, disabled and the elderly)

4. The financing system should address economic fluctuations among states to protect them against disproportionate variations in the economic cycle.
5. States should not be penalized financially if changes are made in mandatory populations as a result of program restructuring under welfare reform.

States are willing to engage in a process to develop a specific mechanism to address these principles.

## FEDERAL FUNDS AND SAVINGS FROM BASELINE

It is acknowledged that the final savings from baseline in this proposal will be somewhere between 51 billion and 133 billion.

## PROGRAM FLEXIBILITY

While there is considerable agreement among participants concerning program flexibility. The details of such changes are still under discussion.

## EFFECTIVE DATE AND TRANSITION

Under discussion.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 46 - I-95

Subject: The Medicaid Program and Current Efforts to Achieve its Restructuring

Presented by: P. John Seward, MD, Chair

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This report discusses the current Medicaid program, the Medicaid Transformation Act of 1995 recently passed by Congress, AMA policy with respect to Medicaid and AMA advocacy activities regarding the restructuring of the Medicaid program. This report is submitted for the information of the House of Delegates.

## THE CURRENT MEDICAID PROGRAM

### General

Medicaid (Title XIX of the federal Social Security Act) is a program through which the federal government grants funds to participating states to furnish medical assistance on behalf of the eligible needy (42 U.S.C. § 1396, et seq., known as the "Medicaid Act.") Medicaid is a means-tested entitlement program that pays for health care and long-term care on behalf of low-income persons who are aged, blind, disabled or members of families with a pregnant woman or children. The federal government has an open-ended commitment to match each state's expenditures for covered items and services furnished to Medicaid beneficiaries.

### Eligibility

The Medicaid Act defines over fifty distinct population groups that may qualify under the program. Federal law requires states to cover certain population groups called "categorically needy" because of their relationship to the categories of public assistance under the federal Social Security Act; other groups may be covered at a state's option.

- **Families, Pregnant Women and Children** - States must provide Medicaid to:

  Families receiving benefits under the Aid to Families with Dependent Children (AFDC) program and to AFDC-related groups not actually receiving cash payments. For example, states must provide Medicaid for twelve months to certain families who have lost AFDC because of increased earnings or hours of work. States are permitted to provide coverage to additional AFDC-related groups.

  Pregnant women and children under age 6 in families with household incomes under 133 percent of the federal poverty level. At their option, states may extend coverage to pregnant women and children up to age 1 in families with incomes below 185 percent of the federal poverty level.

Children under age 19 born after September 30, 1983 to families with incomes below the federal poverty level.

- **Aged and Disabled Persons** - States generally are required to cover aged and disabled persons who receive benefits under the Supplemental Security Program (SSI). Twelve states are permitted to use more restrictive eligibility standards for Medicaid than those for SSI if the state's standards were in place on January 1, 1972. States using more restrictive income standards must allow applicants to deduct incurred medical expenses from income before determining eligibility. This process is know as "spend-down."

States must continue Medicaid coverage for certain groups of individuals who have lost SSI eligibility. The "qualified severally impaired" are disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. Medicaid must be continued if such an individual needs continued medical assistance for employment and the individual's earnings are not sufficient to provide the equivalent of SSI, Medicaid and attendant care benefits the individual would qualify for in the absence of earnings. States must continue Medicaid coverage for those persons who have lost SSI because of a cost-of-living adjustment in their Social Security benefits.

- **Medicare Beneficiaries** - States must cover:

"Qualified Medicare Beneficiaries (QMBs)": These are aged and disabled Medicare beneficiaries with incomes below 100 percent of the federal poverty level and resources not more than twice the amount allowable under the SSI program. States must pay Medicare premiums and cost-sharing charges for these individuals.

"Specified Low-Income Medicare Beneficiaries (SLMBs)": These are aged and disabled Medicare beneficiaries whose incomes do not exceed 110% of the federal poverty line in 1993 and 1994 and 120% of the federal poverty line in subsequent years. Their resources cannot be more than twice the amount allowable under the SSI program. States must pay Medicare Part B premiums (but not deductible or co-insurance charges) for these individuals.

"Qualified Disabled and Working Individuals (QDWIs)": These are persons who are disabled but employed, who are entitled to Medicare Par A through enrollment under the Social Security Act. Their income must not exceed 200 percent of the federal poverty level, their resources must not exceed twice the SSI resource standard, and they must not be otherwise eligible for Medicaid. States must pay all or part of their Medicare Part A premiums for these individuals.

At their option, states may provide full Medicaid benefits, rather than just paying Medicare premiums and cost-sharing, to Medicare beneficiaries who meet a state-established income standard that is no higher than the federal poverty level.

- **Persons Receiving Long-Term Care** - States may provide Medicaid for persons receiving long-term care in a nursing home or a community-based program if they meet a special income standard no higher than 300 percent of the basic SSI benefit that would be payable to a person living at home. At their option, states also may provide Medicaid to other persons who are in nursing homes or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community. Current law requires people to spend their income and assets down to eligibility standards before becoming eligible for Medicaid. The law contains spousal impoverishment protections which allow the community (noninstitutionalized) spouse to keep a certain amount of the couple's income and resources.

- **Medically Needy Persons** - States are permitted to provide Medicaid coverage to "medically needy" persons. These are people who meet the categorical standards for Medicaid (i.e., pregnant women, children, aged, blind, or disabled individuals) but do not meet the applicable income and resource requirements. Individuals may qualify for Medicaid by incurring medical expenses to "spend down" to a state's medically needy standard. A state may set its medically needy standard at any income level up to 133 percent of the maximum payment for a similar family under the state's AFDC program. Over half the states have exercised their option of covering the medically needy.

- **Other Individuals** - In addition to the categorically needy and the medically needy, states may cover individuals not associated with the public assistance titles of the Medicaid Act, such as individuals receiving general assistance under a state program; however, they will not receive federal funds for these individuals.

Benefits and Cost Sharing

A state's Medicaid plan must offer the categorically needy (those individuals the state is required to cover) the following services: inpatient and outpatient hospital services; rural health clinic services; federally qualified health center and other ambulatory services provided in Community Health Centers, Migrant Health Centers, and Health Care for the Homeless programs; other laboratory and X-ray services; nursing facility services for individuals 21 or older; early and periodic screening, diagnosis and treatment for individuals under age 21; family planning services for individuals of child-bearing age; physicians' services, including dentists' services that qualify as physicians' services; home health services for individuals entitled to receive skilled nursing facility services; nurse-midwife, pediatric nurse practitioner, and family nurse practitioner services; and transportation to receive medical care.

States are permitted to offer the categorically needy any number of the optional services covered in the federal Medicaid law. Some of the most commonly covered services are prescription drugs and care in intermediate care facilities for the mentally retarded.

States that cover the medically needy may offer more restricted benefits to the medically needy than to the categorically needy; however, states must cover at least the following: prenatal care and delivery services; ambulatory services for individuals under age 18 and

individuals entitled to institutional services; and home health services for individuals entitled to care in nursing facilities.

Without specific waivers from HCFA, states must allow Medicaid beneficiaries free choice among participating providers and must provide equality of care for all individuals within a specified eligibility group. States are permitted to impose nominal fees, premiums, copayments or other charges on certain Medicaid services and recipients; however, charges may not be imposed on services provided to individuals under age 18; services related to pregnancy; family planning services; emergency services; health maintenance organization services to certain enrollees; and hospice services.

Federal Funding

Each state is entitled to federal reimbursement for its Medicaid expenditures based on the amount spent by the state and the state's federal medical assistance percentage (FMAP). The FMAP is a statutory formula designed to give a higher matching rate to states with lower per capita incomes relative to the national average. Matching rates for Medicaid services range from 50 percent to 83 percent and are determined annually.

Reimbursement

A variety of the provisions of the Medicaid Act are designed to ensure that state programs are adequately funded, that they offer sufficient and timely payment to providers, and that they assure the quality of medical services. For example, a state plan must:

- provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan...as may be necessary...to assure that payments are consistent with efficiency, economy, and quality of care and 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 (42 U.S.C. § 1396a(a)(30), referred to as the "equal access" provision and interpreted by the courts as requiring consideration of equal access, efficiency, economy and quality of care when reimbursement rates are being set); and

- provide for payment...of the hospital services, nursing facility services and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates...which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access...to inpatient hospital services of adequate quality (42 U.S.C. § 1396a(a)(13)(A), referred to as the Boren Amendment).

Delivery Systems

Most Medicaid beneficiaries currently receive services from providers who are reimbursed on a fee-for-service basis. Today, approximately 25 percent of all Medicaid beneficiaries are enrolled in some type of managed care plan. States may not require Medicaid beneficiaries to enroll in a managed care plan unless the state has obtained a waiver. Two basic types of waivers are program waivers (Section 1915(b)) and demonstration waivers (Section 1115(a)).

A Section 1915(b) waiver allows a state to waive the provision in the Social Security Act that requires that Medicaid recipients have freedom to choose their providers. States also seek Section 1915(b) waivers to avoid the requirements of a uniform statewide operation ("statewideness") for Medicaid recipients and identical benefits for different categories of beneficiaries ("comparability"). A state that enters into a managed care agreement (other than a voluntary prepaid plan) that operates in only part of the state or that affects only certain categories of beneficiaries, must seek a Section 1915(b) waiver from HCFA in order to continue to receive federal funding for its Medicaid program. Currently, over 40 states hold Section 1915(b) waivers, many of which have been used to implement a wide variety of primary care case management (PCCM) programs.

Section 1115(a) of the Social Security Act specifies conditions under which the Secretary of Health and Human Services (HHS) may waive compliance with a variety of requirements of the Medicaid Act to allow states to conduct experimental, pilot or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of Medicaid. The intended purpose of Section 1115(a) waivers is to test the effectiveness of a certain program or to investigate a new approach to delivering or financing services to Medicaid recipients. A state that requires a Medicaid beneficiary to enroll in a single prepaid plan for a specific period of time must obtain a Section 1115(a) waiver. In addition, states seeking to expand Medicaid eligibility to cover a segment of the state's uninsured population must also secure a demonstration waiver. Currently, twelve states and the District of Columbia hold Section 1115(a) waivers.

Provider Standards

States must have standards and procedures for determining the eligibility of providers of services to participate in the Medicaid program. Federal law specifies standards and certification procedures for institutional providers (including hospitals, nursing facilities and intermediate care facilities for the mentally retarded), health maintenance organizations and certain other providers including rural health clinics. For most other non-institutional providers, state licensure laws govern qualification for program providers. States generally follow their own procedures for certifying practitioners and other noninstitutional providers.

Drug Rebate Program

Under the drug rebate program enacted in the Omnibus Budget Reconciliation Act of 1990

(OBRA 90), in order for federal Medicaid payment to be available for prescription drugs, a manufacturer must have entered into a rebate agreement with the Secretary of HHS. The law requires a manufacturer to provide each state with a quarterly rebate amount for the products of the manufacturer that the state has purchased on behalf of Medicaid recipients. Amounts of such rebates are based on the average manufacturer price for a drug and the lowest price available from the manufacturer to any wholesaler, retailer, nonprofit entity or governmental entity within the United States. Covered outpatient drugs dispensed under Medicaid managed care arrangements or by certain hospitals are not subject to rebate requirements.

## THE IMPETUS FOR RESTRUCTURING MEDICAID

For years, state leaders have called for significantly greater flexibility in designing and administering Medicaid programs that meet their needs, goals and budgetary constraints. Traditionally, they have viewed federal requirements relating to Medicaid as bureaucratic and inefficient, particularly with regard to mandates for expanded coverage that increase costs and provisions that require them to procure formal waivers in order to implement mandatory managed care, add additional uninsureds to the Medicaid program, prioritize covered benefits, create alternative long term care systems or implement other measures designed to control costs. Medicaid programs are consuming an increasing portion of state budgets. Because of this, many state leaders are willing to accept fewer federal Medicaid funds in exchange for increased flexibility and relief from federal mandates and regulation. This call for flexibility from the states dovetails with Congress' efforts to achieve a balanced budget by the year 2002.

## THE MEDICAID TRANSFORMATION ACT OF 1995

### General

In an effort to achieve its goal of achieving a balanced budget by the year 2002, Congress recently passed the Balanced Budget Act of 1995 (H.R. 2491). As this report was being finalized, it was expected that the President would veto the entire budget proposal. Title VII of the Balanced Budget Act is "The Medicaid Transformation Act of 1995" (referred to herein as the "MediGrant Act.") The MediGrant Act would replace the current Medicaid program with a program that would provide block grants to the states. Under the MediGrant Act, states would be able to cover low income individuals and families with incomes below 275% of the federal poverty level ($34,623 for a family of three in 1995). The individual entitlement to Medicaid would be eliminated. The MediGrant Act would reduce projected Medicaid spending by $163.4 billion over a seven year period, according to estimates prepared by the Congressional Budget Office. The $163.4 billion in projected reductions is less than the $182 billion in reductions in Medicaid spending called for in the original budget resolution. Over the period from 1996 through 2002, federal spending would increase at an average rate of 5.2 percent per year--from $97.1 billion in 1996 to $127.4 billion in 2002-- rather than the 10% annual increases projected under the current system.

Eligibility

States would be required to cover all pregnant women and children under the age of 13 whose family income does not exceed the poverty line applicable to a family of the size involved, as well as disabled individuals who meet state-defined disability, income and resource standards. States also would be required to devote specified minimum percentages of total program spending to services for each of three groups: low income elderly, low income blind and disabled, and low income families (families with incomes below 185% of poverty that include a pregnant woman or child). For each group, the minimum percentage to be spent would be set equal to 85 percent of the average percentage of the state's Medicaid spending during fiscal year (FY) 1992 through FY 1994 devoted to mandatory services for members of that group who were required to be covered under federal Medicaid law. The percentage would be set at 75 percent for states that covered only mandatory services during the base period. For the elderly, there would be an additional set-aside for Medicare premium assistance, again based on the percentage of the state's spending that went for such assistance to individuals required to be covered in the base period. The minimum Medicare premium assistance percentage would be equal to 90 percent of the average percentage of the state's spending for Medicare premiums during FY 1993 through FY 1995 for individuals whose coverage for such assistance was required under Medicaid.

In computing the base period spending percentages, payments to disproportionate share hospitals would not be treated as payments for mandatory services. A state would be allowed to provide for a lower percentage of expenditures than the minimum set-asides if it certifies to the Secretary of HHS that the health care needs and the performance goals relating to the respective low income population could be met without the expenditure of the percentages otherwise required.

The MediGrant Act provides for earmarked funding of federally-qualified health centers and rural health clinics. States would be required to spend an amount equal to at least 85% of the average amount spent on rural health clinic services and federally-qualified health center services provided to Medicaid eligible low income individuals in FY 1992 through FY 1994. A state may be granted a waiver from this requirement if the state certifies to the Secretary of HHS that the state can service its low income population in medically underserved rural areas without meeting the 85% spending requirement.

States would be required to cover immunizations for children eligible for any medical assistance under the MediGrant plan according to a schedule established by the state health department. Pre-pregnancy family planning services and supplies also would be covered.

Benefits and Cost Sharing

States would have unprecedented flexibility to determine other eligibility standards, covered benefits and delivery systems. States would not be required:

- to provide medical assistance for any particular items or services;

- to provide for any payments with respect to any specific health care providers or any level of payment for any services;
- to provide for the same medical assistance in all geographical areas;
- to provide any individual eligible for medical assistance with the freedom to choose the institution, agency or person to provide the item or service.

A MediGrant plan would be able to impose cost-sharing (including copayments, deductibles, coinsurance and other charges for the provision of health care services) to discourage the inappropriate use of emergency medical services. States also would be allowed to impose premiums and cost-sharing differentially in order to encourage the use of primary and preventive care and discourage unnecessary and less economical care. In the case of a pregnant woman or a child who is a member of a family eligible for medical assistance under the MediGrant plan with an income below 100 percent of the poverty line, the plan would not be allowed to impose: (1) any premium, or (2) any cost-sharing with respect to primary and preventive care services for children or pregnant women unless the cost-sharing was nominal.

Federal Funding

The federal government would no longer have an open-ended commitment to match each state's expenditures for items and services furnished to Medicaid beneficiaries. MediGrants would be distributed to the states through a needs-based formula. The formula would determine state allocations based upon factors including the size of each state's poverty population; the weighted share of the elderly, disabled and other recipients within that population; the cost of providing health care in each state; and the national average spending per resident in poverty. As a result of the MediGrant formula, the state's annual growth rates would be based on each state's calculated expenditure need. The MediGrant funding formula establishes a growth rate floor of not less than 3.5% in FY 1997, 3.0% in FY 1998, and 2.0% thereafter. The formula also establishes a growth rate ceiling of 9.0% in FY 1997 and 5.33% thereafter. A higher ceiling of 7% is made available to the ten states with the lowest per capita medical assistance expenditures, starting in FY 1998. The MediGrant Act includes a special funding rule for Louisiana, New Hampshire, Nevada and Nebraska.

At the state's option, the federal matching rate would be: the old FMAP, the lesser of the new FMAP or the old FMAP plus 10 percentage points, or 60 percent. The new matching rate would be determined under a formula which takes into account states' total taxable resources. States would be permitted to carry-over unused federal funds into future years, although states would be required to match these funds. MediGrant dollars could only be expended only for medical assistance and medically-related services for eligible individuals.

The MediGrant Act provides for a $3.5 billion national fund in FY 1996 through FY 2002 for emergency medical care services provided to illegal aliens. The 15 states determined by the Immigrant and Naturalization Service to have the nation's largest illegal alien populations would be recipients of this fund, based on their proportion of illegal aliens.

Reimbursement

The Boren Amendment and other federal payment rules would be eliminated. States would determine provider payment rates. Before the beginning of each contract year, a state would be required to provide a process for public notice and comment on the amounts of capitation payments to capitated health care organizations and information regarding the use of actuarial science with respect to those capitation payments.

Delivery Systems

States would no longer be required to secure waivers in order to restrict beneficiaries' choice of providers or to mandate that beneficiaries be placed in a managed care delivery systems. States would be free to contract with managed care plans or individual providers on a capitated or other basis, to contract for case management services or coordination of medical assistance, or to set capitation rates on the basis of competition or negotiation.

The Secretary of HHS would be required to conduct demonstration projects providing integrated service delivery and financing for chronically-ill elderly and disabled beneficiaries under Medicare and Medicaid. Each state, or a coalition of states, desiring to conduct such a demonstration would be required to submit an application to the Secretary; however, a state could not require an individual to participate in the demonstration project.

Provider Standards

Sates would determine qualifications for participating providers. Federal nursing home standards would be retained, with minor modifications, and the state enforcement of the federal standards would be strengthened. States with state law requirements for nursing facilities that are equivalent to or stricter than current federal law requirements could apply to the Secretary of HHS for a waiver. The MediGrant Act also retains current law protections against the impoverishment of spouses of institutionalized recipients. Community spouses would be protected from having to liquidate all assets to meet the costs of nursing care. States would be prohibited from requiring an adult child of moderate means to contribute to the cost of nursing facility and other long-term care services for the child's institutionalized parents.

Drug Rebate Program

The drug rebate program enacted in OBRA 90 would be retained. Supplemental rebates would be prohibited.

State Plans

As a condition of receiving funding, each state would be required to submit to the Secretary of HHS a MediGrant plan meeting the applicable requirements of the MediGrant Act. The Secretary of HHS would review and approve or disapprove state MediGrant plans and plan amendments. A state would be required to develop its MediGrant plan through a public

process, establishing advisory committees for consultation in the development, revision and monitoring of the plan. States would be required to develop strategic objectives and performance goals for their MediGrant programs and to revise them at least every three years. Specific goals and objectives for childhood immunizations and reductions in infant mortality and morbidity also would be required.

States would have to audit their expenditures under their MediGrant plans and to report on program activities and performance annually. The Secretary of HHS could conduct verification audits. Independent evaluations of each state's program would be required at least every three years.

States would be required to have in place fraud prevention programs. Whenever a provider was terminated, suspended, sanctioned or prohibited from participating under a state's plan, the state agency would be required to notify the Secretary of HHS and, in the case of a physician, the state medical licensing board. Each MediGrant plan also would be required to provide for a state MediGrant fraud control unit and to provide for the recovery of MediGrant funds from third party payors.

The Secretary of HHS would be able to withhold funding for a state out of compliance with the law or its MediGrant plan. An individual complaint process would be created through which an individual could register complaints with the Secretary of HHS against a state for noncompliance. The Secretary of HHS would be permitted to compel a state under federal law to comply with the provisions of the MediGrant Act; however, no other cause of action could be filed under federal law against a state.

MediGrant Task Force

The conference agreement on the MediGrant Act does not include a provision which was contained in the House Medicaid proposal calling for the establishment of a MediGrant Task Force; however, the conferees indicated their intent that the Secretary of HHS establish this task force. The conferees also indicated their intent that the MediGrant Task Force consist of six members appointed by the chair of the National Governors' Association (NGA) and six members appointed by the vice chair of the NGA. The MediGrant Task Force would be assisted by an advisory group composed of one representative from each of a number of organizations in the health care industry, including the AMA. The conferees indicated that the MediGrant Task Force and advisory group would develop models for states to use in developing strategic objectives and performance goals; suggested methodologies for measuring and verifying the objectives or goals; an assessment of the usefulness to states of quality assurance safeguards, utilization data sets, and accreditation programs used in the private sector; and designs and methodologies for providing for independent evaluations. Further, it was the expectation of the conferees that the MediGrant Task Force would develop recommendations by which states could respond to needs of the chronically mentally ill. States may, but would not be required to, adopt any of the specific objectives or goals suggested by the MediGrant Task Force.

## AMA ADVOCACY EFFORTS REGARDING MEDICAID

Throughout the AMA's advocacy efforts, the emphasis has been on ensuring that under any restructuring Medicaid maintains its function as a safety net by providing reasonable access to quality health care services for the nation's most vulnerable populations. Therefore, the AMA has not endorsed The Medicaid Transformation Act of 1995 submitted to the President, and has publicly applauded lowering the level of reductions in Medicaid funding pursuant to the Act. This is consistent with amended Resolution 228 (A-95), adopted at the 1995 Annual Meeting, which states: That the American Medical Association seek to assure that any restructuring of Medicaid, including block grants, preserve the safety net function of Medicaid. The AMA believes there needs to be an appropriate balance between states' interests in securing increased flexibility in light of fewer federal funds for Medicaid and the very real needs of the people the Medicaid program is intended to serve, most of whom have no other means of access to health care coverage.

The AMA provided input early and often to Congressional leadership regarding how best to achieve the restructuring of Medicaid. The AMA's proposal "Transforming Medicare," which was furnished to Congressional leadership, contained the AMA's proposal to transform Medicaid. The "Transforming Medicaid" proposal, which was based on existing AMA policy, also served as the basis for testimony the AMA gave to the House Commerce and the Senate Finance Committees.

In addition, the AMA and the American Dental Association jointly sent a letter to the Congressional authorizing committees and the House and Senate leadership detailing the elements the AMA believes must exist under any restructuring of the Medicaid program. This letter also was sent to all state medical societies and national specialty organizations as a model for their communications with their Congressional delegations and governors regarding Medicaid reform. The AMA took a neutral position on shifting Medicaid to a block grant program--a concept which Congressional leadership indicated was nonnegotiable--in order for the AMA to play a proactive role in the debate regarding how to restructure Medicaid. The AMA has worked to assist specific state medical societies in lobbying key members of Congress on issues relating to the funding formula, which will impact each state differently.

In keeping with AMA policy, Congressional testimony and other advocacy efforts have called for certain principles to apply regardless of the mechanism for restructuring the Medicaid program. For example, Policy 290.997, AMA Policy Compendium, states: The AMA believes that greater equity should be provided in the Medicaid program, through adopting of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.

Based on this policy, the AMA has called for income-based eligibility with a national floor.

The AMA believes that states should provide Medicaid coverage to those whose incomes fall below a federal eligibility requirement, set at, or at some percentage of, the federal poverty level. While the existing categorical requirements structure should be eliminated, states also should be required to maintain current efforts in covering children, pregnant women and dual Medicaid-Medicare eligibles. The AMA also has called for the establishment of basic standards of uniform minimum adequate benefits for Medicaid recipients.

Policy 165.895 provides that: The AMA will: (1) continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront...(4) fight for adequate funding for federal health care programs, in particular, Medicare and Medicaid; that AMA further advocate for long term reform of those programs which insures their effectiveness and fiscal soundness and against reimbursement reductions which promote cost shifting, diminish access and reduce the quality of care for beneficiaries." Policy 165.989 states: "...Delivery and payment mechanisms in the Medicaid program should be subject to "test of performance" criteria to ensure that they are sufficient to guarantee appropriate access to quality and cost-effective care."

In keeping with these policies, the AMA has advocated for standards that states must meet to ensure that beneficiaries have access to an adequate set of quality health care services. The AMA believes that access standards must include guidelines for adequate provider reimbursement levels, which have a demonstrated link to beneficiaries' access to medical care. The AMA also has promoted quality improvement, patient empowerment and market competition in the Medicaid program, to be achieved through various mechanisms including medical savings accounts and vouchers; provider-sponsored networks; choice of health delivery systems, including managed care, traditional fee-for-service, and benefit payment schedule, where available, within a defined contribution framework; quality improvement systems and quality performance measures; and standards for health plans contracting to cover Medicaid beneficiaries. In order to ensure that as states assume more control over Medicaid they are accountable for policies that affect Medicaid beneficiaries and providers, the AMA also has called for requirements for public notice and input regarding state Medicaid policies.

Another issue of concern in any Medicaid restructuring is the impact on long term care. Medicaid currently is the largest payor of long term care costs in the United States. The long term care component of Medicaid consumes 35% of Medicaid spending, and Medicaid pays for 52% of all nursing home expenditures. Currently, few Americans purchase long term care insurance. Instead, even middle-income Americans who require long term care often access Medicaid to cover their costs by sheltering and disposing of their assets and thus "spending down" for Medicaid coverage.

Policy 280.993 states: The AMA supports the following policy positions regarding long term care: (1) LTC should be available through a combination of public and private programs. Primary reliance should be placed on development of affordable and appropriate LTC insurance - both individually purchased and employer-based. Public financing should continue to be made available for those unable to provide for their own LTC...(3) Consumer

participation in private sector LTC insurance arrangements should be encouraged through a variety of modifications to the tax law. These changes should include mechanisms to encourage individuals to purchase LTC insurance, as well as for employers to offer such policies as part of employee benefit packages. In addition, Policy 280.990 states: The AMA believes that a program to finance long-term care (LTC) should: (4) create tax incentives to allow individuals to deduct the cost of LTC coverage from income tax, treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (5) authorize a tax deduction or credit to encourage family care giving.

Based on these policies, the AMA has called for the federal and state governments to establish incentives and mechanisms for individuals to plan for their long term care costs. States should phase-in rules to allow individuals an opportunity to purchase long term care insurance and establish a spend down "offset" for individuals who purchase such insurance.

Currently, waivers are required for states to shift long term care from costly institutional care to community-based and home-based approaches. The AMA has advocated for Congress to eliminate waiver requirements for states to implement long term care projects that utilize case management approaches, emphasize community-based or home-based care or use Medicaid funds to facilitate the purchase of long term care insurance.

Further, the AMA has called for the study of potential alternative methods of financing long term care including, but not limited to, the use of the following devices: MSAs; long term care insurance, including the possibility of Medicaid-funded stop loss coverage and tax incentives for employers to provide and individuals to purchase such insurance; and tax incentives for family care giving.

## THE FUTURE OF MEDICAID

As exemplified by some of the programs for which Section 1115(a) waivers have been granted, when given broad flexibility, states sometimes place budgetary concerns over those of patient access and choice, reasonable provider reimbursement and solvency of participating entities. The result is that beneficiaries' access to quality medical care suffers. The Board of Trustees believes that state flexibility must be tempered by the need for accountability standards designed to ensure that state programs fulfill Medicaid's objective of improving access to quality medical care. Such standards also are critical to assuring that state Medicaid programs will have provider participation sufficient to meet beneficiaries' needs, without resorting to coercive approaches to securing that participation. Moreover, for states that move their Medicaid populations into managed care systems in hopes of achieving savings, safeguards are necessary to ensure that Medicaid beneficiaries are treated fairly and receive high quality care.

As noted above, the President maintains that he will veto the Balanced Budget Act of 1995, including The Medicaid Transformation Act of 1995. At this time, it is impossible to predict the results of subsequent Congressional actions and any ensuing negotiations between Congress

and the Administration regarding the balanced budget, Medicare and Medicaid. Thus, it is uncertain when or whether Medicaid will be shifted to a block grant system, what the level of funding will be and how much flexibility states will be granted. It is possible that negotiations between Congress and the Administration could result in lesser reductions in projected Medicaid spending over the seven year period than the $163.4 billion in reductions scored by CBO for the MediGrant Act. The AMA will continue to support efforts to lower the level of reductions in Medicaid funding.

## AMA ASSISTANCE TO STATE MEDICAL SOCIETIES

Because of the potential "devolution" of the Medicaid program to the states through block grants, a significant burden may be placed on state medical societies seeking to influence and respond to the Medicaid reform process. In 1994, prompted by the increased need for Federation involvement in addressing the changes taking place in state Medicaid programs, the AMA's Division of State Legislation organized a special working group of the State Health Reform Action Group (SHRAG) to address Medicaid managed care issues and, in particular, Section 1115(a) waivers. The AMA will continue its efforts through the SHRAG to assist state medical societies faced with the development and implementation of state MediGrant or reformed Medicaid programs.

## CONCLUSION

Regardless of the outcome of the reform process, the Board remains committed to ensuring that the Medicaid program maintain its role as a safety net for the nation's poorest and most vulnerable populations by providing reasonable access to quality health care services. The AMA will continue to work to bring necessary reforms to the Medicaid program in any way that will not compromise the health of patients.

# Supporters of the Entitlement and the Per Capita Cap and as Outlined by the President

## Balanced Budget Proposals

President Clinton
Senator Daschle
Democratic Coalition
Breaux/Chafee Bipartisan Plan

## Democrats Unified

| | |
|---|---|
| All Democratic Senators | (signed a letter to the President) |
| Virtually All House Democrats | (through House Democratic Leadership) |
| Democratic Governors | (DGA policy) |

## Providers and Other Advocacy Organizations

AARP
AIDS Action Council
Alzheimer's Association
American Academy of Pediatrics
American College of Physicians
American Hospital Association
American Health Care Association (Nursing Homes)
American Civil Liberties Union
Catholic Charities USA
Child Welfare League of America
Children's Defense Fund
Families USA
March of Dimes
National Association of Children's Hospitals
National Association of Home Care
National Association of Public Hospitals
National Citizens' Coalition of Nursing Home Reform
National Council of Senior Citizens
Older Women's League
Women's Legal Defense Fund

## Medicaid

1. Entitlement or Block Grant: Should Medicaid be maintained as an individual entitlement to a set of defined mandatory benefits for a statutorily defined group of beneficiaries?

2. Magnitude of Reductions: What rate of growth in Medicaid spending is adequate to provide access and quality of health services to beneficiaries and adequately compensate providers?

   - If the entitlement is maintained, how should the reductions be distributed between the two main categories of Medicaid spending (i.e., between spending on benefits and spending on disproportionate share hospital payments)?

   - If the entitlement is maintained, should current law eligibility and benefits requirements be maintained?

3. State Flexibility: To what extent can federal standards for provider payments, service delivery, eligibility, and beneficiary cost sharing be relaxed while continuing to ensure beneficiary access to quality health care ?

4. Financial protections for beneficiaries and their families:

   - Should we change the provisions that protect the children of Medicaid beneficiaries from being forced to contribute to the cost of nursing home care?

   - Should all current protections against spousal impoverishment be maintained?

5. 1115 Waiver States: Should states that have received 1115 demonstration waivers receive special treatment?

6. Nursing Homes: Should all current federal nursing homes standards and enforcement responsibilities be maintained?

7. Abortion: Should restrictions on Medicaid payment for abortions be included as part of permanent law?

8. Immunizations: Should the Vaccines for Children program be maintained?

## Medicare

1. Magnitude of Reductions: What is the appropriate level and mix of Medicare cuts that still ensure beneficiary access and quality and maintains adequate compensation for providers?

   - Should the Part B premium be held to the 25% level, or should it be raised to 31.5% or some other level?

   - Should the Part B premium paid by beneficiaries be related to their income? If so, what portion of the premium should higher income beneficiaries pay?

   - Should we levy the Hospital Insurance (HI) tax on the remaining state and local government retirees (and their employers) who qualify for Medicare without having paid into the Part A Trust Fund?

   - What is the proper allocation of Medicare reductions across various provider groups (e.g., hospitals, skilled nursing facilities, doctors)?

   - Should savings in Medicare fee-for-service spending come from across-the-board reductions or from program reengineering (i.e., competitive bidding, selective contracting)?

   - Should savings in the Medicare program come only from specified policies, or should there be an arbitrary cap enforced by a "fail safe" or "look back" mechanism?

2. Should new preventive care benefits be added to the Medicare program?

3. Managed Care/New Medicare choices: How should an expanded Medicare managed care option be structured so as to minimize adverse beneficiary risk selections (causing healthy beneficiaries to leave traditional Medicare) and adverse provider selection (creating incentives for providers to leave traditional Medicare)?

   - What new arrangements should be included? Should private fee-for-service plans, association plans, and MSA's be allowed?

   - How should the new system, including Provider Service Networks, be regulated (i.e., state v. federal regulation, relaxation of antitrust laws)?

   - Should Medigap plans also be incorporated into the beneficiary choice process so remaining in or returning to fee-for-service Medicaid remains a real option for older and sicker beneficiaries?

   - What should be the payment mechanism for managed care plans? (i.e., Should payments continue to be linked to fee-for-service rates?)

4. Other issues:

- Should current law prohibitions on physician self-referral and provisions regulating quality in lab testing be changed?

- Should federal medical malpractice reforms that preempt state medical liability laws be adopted as par of reconciliation?

There may be some eligibility categories and methodology provisions that could be dropped or simplified to allow states greater flexibility. For example:

- States could have the option to return to a lower income standard for pregnant women and children, so long as the mandatory minimums are met (no lock-in)

- States could have the option of covering all pregnant women who meet the income requirements (no requirement that the pregnant woman would qualify for AFDC if the child were born) (some increased cost involved)

- If Medicaid and AFDC are decoupled, could drop a number of provisions. For example:

  - requirement that persons who would qualify for AFDC but for $10 minimum benefit rule must be covered

  - requirement that family who would receive AFDC but for work supplementation program must be covered

  - requirement that AFDC family members must be covered when parent is sanctioned

  - requirement that families who would receive AFDC but for an overpayment must be covered

  - requirement that families who are denied AFDC for reasons that are inapplicable under Medicaid must be covered

  - requirement that people who would be eligible for AFDC but for 1972 SS benefit increase must be covered

- Transitional Medicaid *(ignoring, for the moment, the larger set of issues regarding how to capture AFDC and transitional AFDC families onto Medicaid if AFDC is repealed)*

  - could allow (state option) states to continue transitional assistance for up to 12 months for both groups of transitional recipients

  - could eliminate the requirement for quarterly reporting for the earnings people during the second 6-month period

  - could limit the requirement that states notify families of the possible second six months of transitional Medicaid benefits twice during the first

six months to once during the initial six-month period

- Allow states to waive asset requirements for all families with children under 100% of the poverty level (some increased cost involved)
- Drop requirement that people who would be eligible for SSI but for 1972 SS benefit increase must be covered // provision for AFDC
- Drop requirement that blind individuals be examined by a specialist (leave to state discretion)
- Drop three mandatory categories of grandfathered Medicaid recipients relative to 1973 standards; make categories optional

Identify areas where requirements/standards could be maintained but states allowed flexibility in terms of how the requirements/standards would be achieved. For example,

- Standards having to do with staff, institutions, cooperative arrangements and other standards to assure high quality care -- replace with outcome measures?? (1396a(a)(22)
- Maintain requirement that states take all reasonable measures to secure third party liability, but drop specific review and process requirements 1396a(a)(25)
- Maintain utilization review and screening requirements, but drop specific directives as to how these review shall be conducted 1396a(a)(30)
- Maintain requirement for state to review the appropriate level of care, but drop the specific directives on how the review shall be conducted 1396a(a)(33)
- maintain requirement of disclosure of ownership, but leave the method and means to states 1396a(a)(38)
- maintain the requirement for outstationing and simplified applications, but drop the language specifying sites 1396a(a)(55) - applying outside of welfare office
- maintain HIV children waiver, but reframe provisions to allow states to show they are meeting specified goals ?? 1396n(e)(1)(A)

Ask Tim ←

- maintain option for presumptive eligibility for pregnant women, but drop detailed conditions and requirements for implementation 1396r-1(a)

Other

- Drop dissemination of state law reqruiement 1396a(a)(58)
- Drop provision relating to maintenace of AFDC benefit levels 1396a(c)

Benefits

- Allow states to cover benefits retroactively (up to 3 months) at state option

Leave off initially

EPSDT

Drop Reporting

Grant funds like DSH

Elig.

Deeming ~~over~~ people eligible for other programs e.g. food stamps and if don't have a card we look ~~at~~ at gross income

→ Look at 30^70 - what does this mean? Needs definition.

**DRAFT**
**12/14/95**

Each state is eligible each year for federal matching funds up to the per capita amount of the base year times the number of people eligible in the given year times an inflation factor[4] times the federal match rate.[5]

The guarantee of services for this population is by the federal government. All possible efforts will be made to ensure that enforcement of this guarantee occurs through administrative processes at the state level. However, at the end of the day, as a federal guarantee, it will be enforceable in federal courts.[6]

The total federal exposure for this portion of the Medicaid program is uncapped. That is, during economic cycles or natural calamities, when the number of people eligible grows, the federal match available to serve eligibles grows without constraint. Similarly, the state obligation to appropriate funds to cover the mandated services for this group is unlimited so long as the state participates in this program.

A long list of flexibility provisions would be enacted to streamline administration of this program.

States would also have available to them additional funds that can be drawn down using a matching formula. Matchable funds would be any amount spent on a broad range of services for people up to a modest income (such as 275% FPL as in the reconciliation bill). Federal standards for the use of these funds would be limited to making sure the dollars are spent on health-related services, making sure the dollars go to low-income families, and making sure the state match is real.

The base amount for the MediFlex portion (like that name?) would be base year total Medicaid expenditures less the amount for the core described above.[7] For most states, this would be a sizable portion of their program. The more a state has invested in expansions and options in the past, the more that state would have in its base.

For each year, each state would have a hard cap on its total core plus MediFlex expenditures. This cap would be designed to grow parallel to the expected growth by state under a per capita cap. That is, the expected growth rate for the MediFlex portion of the program would be comparable for all states.[8]

For each year, there would be a hard cap for the total federal expenditures for all states. This would generate a clear CBO score.

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If it does not, we need to see if we have the data available to compute a true base. This area needs exploration, since the mandatory/optional split on services is an awkward one.

[4] The definition of the inflation factor has not been discussed.

[5] This formula presents an opportunity to generate greater equity among states. If this is desired, a factor can be added that causes the variation among states in per capita amounts to decline over time. I have specified that formula elsewhere if anyone is interested.

[6] States are very interested in creative options to address this issue.

[7] How DSH fits in this (or in the core portion) is a very difficult issue I have not yet examined.

[8] This assumption could be relaxed if there were a desire to have the size of this portion of the program converge around a more neutral number, such as a flat amount per person in poverty.

DRAFT
12/14/95

Dynamics:

Federal Medicaid cost growth would become fully predictable. For the first time in its history, the program would have a defined cap.

States would be rewarded for efficiencies. Any savings a state generates in its core program automatically becomes part of its MediFlex program allowing those dollars to be spent on that state's priorities.

States would be able to experiment with many models for delivering services and covering different subsets of their population. For core populations, these experiments would have to be within the context of the federal guarantee. For other populations, states could form their own, appropriate delivery systems without federal oversight.

**DRAFT**
**12/14/95**

Notes to my friends on the concept paper.

The dynamics of this option are interesting and I hope you will consider them.

First, the size of the flexible portion of the program shrinks during economic downturns (because the size of the core grows, and the total is fixed). Since this is the portion devoted to the higher-income low-income, it is the portion that goes to a population with more political clout than the average Medicaid recipient. There will be strong political pressure to prevent this from shrinking during a recession. Therefore, it is likely that the program will retain its counter-cyclical features because it will likely develop a UI-like component with the federal government stepping in to increase the size of the program during a recession.

Second, the flexible portion is the playground for Republican Governors. I may not like all of their plans for this portion, but it will be nice to have them lobbying to increase the size of a program that serves low-income people.

Third, a large portion of the flexible portion will be money currently spent on elders in nursing homes. They will have the political power to keep that money in the system.

Finally, this structure retains a clear federal entitlement. If we keep that unambiguously in the law, it forms a barrier against gutting the program that I think we all fear under a block grant.