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

11-Jan-1996 03:18pm

TO: Paul J. Weinstein, Jr
TO: Christopher C. Jennings

FROM: Daniel J. Chenok
Office of Mgmt and Budget, OIRA

CC: Sally Katzen

SUBJECT: Medicaid, IDEA, and Unfunded Mandates

Sally Katzen asked me to forward to attached note to you, to inform you about the status of a particular issue involving Medicaid's relationship to payment for services provided to disabled children under the Individuals with Disabilities in Education Act (IDEA). Please let me know if you have any questions. The issue is not likely to come up in the Medicaid/Mandates hearing that has been rescheduled for Jan. 18, but given the potential tie-in we thought this was important for you to know.

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

05-Jan-1996 05:43pm

TO: (See Below)

FROM: Daniel J. Chenok
Office of Mgmt and Budget, OIRA

SUBJECT: Medicaid and ED/IDEA mandates issue

The complications on this issue have grown with further coversations and research. After you read this note, let me know if you want us to do anything more than follow the issue and keep you updated as appropriate.

This issue may be especially important in light of the upcoming Shays hearing on Medicaid and unfunded mandates, at which Vladeck

will testify. (Note: we just received the testimony and will comment to LR. We will let you know of any big issues; if you want info on it whether or not there are "big issues" just say the word -- on a quick scan he does not raise the ED/IDEA tie-in at all, and the testimony appears generally sound.)

The bottom line from today's research: due to the arcanities of the UM law, a proposal like "Eliminate Medicaid funds for ED/IDEA payments" may not be subject to the law, even if the real-world effect reduces the amount of Federal money to provide the same level of services.

1. The Administration is not committed to, or in explicit favor of, eliminating the EPSDT provision in Medicaid, which provides Federal reimbursement for health care services to poor disabled children under IDEA in many (though by no means all) schools and school districts (it is a local decision as to whether the Medicaid funds should be used to fund the IDEA services).

2. Even if EPSDT elimination were part of the Administration proposal, and this were to reduce total Federal funds available for the State share of ED's IDEA program, that action may not trigger the UM law's coverage threshold. This is not because of the amount of funds involved -- some $550 million annually would be lost to States -- but because of the way the law defines an unfunded mandate:

-- Grant programs like IDEA are covered only if their annual appropriation exceeds $500 million, which is true for IDEA, and if the funds are provided "under entitlement authority". The IDEA law does indicate that States are "entitled" to their payment, but OMB has always scored this as a discretionary grant program and OMB's GC has pushed removing the ?e-word? when IDEA is reauthorized.

-- The UM law speaks of effects "under the program". The law does not mention indirect effects that would occur if funds from a second program were used to pay for the "mandate" program.

3. On the other hand, Jim Martin thinks that all such programs are included (he has said as much in the past), and if the Administration tried to argue the definitional issue to avoid the UM law's requirements, Martin may get the NGA riled up to charge that real costs are being obfuscated by technicalities.

4. The Medicaid per-capita cap itself, which is the cornerstone of the Admin's Medicaid proposal, is a much bigger issue (among other bigger issues) and has been criticized as a mandate. The Governors will oppose this if it is associated with too many requirements that they would have to fund as a result of the cap on Federal payments. Vladeck's testimony refutes this charge.

5. If Medicaid is block-granted, it does not appear to be subject to UM -- block granting does not appear to be covered by the UM Act.

Distribution:

TO: Sally Katzen

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OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

URGENT

FROM: Bob Pellicci -- 395-4871

DATE: 1/16/96 **TIME:** 10 am

Pages sent (including transmittal sheet): 16

COMMENTS: Copy of Vladeck's testimony for 1/18 hearing. Please give me your comments by COB today. thanks

TO: Jennifer Klein

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

DRAFT 1/5/95

Testimony of

Bruce C. Vladeck

Administrator

Health Care Financing Administration

Before the

House Committee on Government Reform and Oversight,

Subcommittee on Human Resources

and Intergovernmental Relations

January 18, 1996

DRAFT 1/5/95

Introduction

Medicaid provides health coverage for 36.1 million Americans -- children, pregnant women, senior citizens, individuals with disabilities and others -- through a partnership between the Federal government and the States that provides States with substantial flexibility in designing their Medicaid programs.

Under the current program structure, States and the Federal government have been working to implement more flexibility in the Medicaid program. HCFA has used current demonstration authority to enable States to pursue a number of innovative approaches to provide health coverage to populations and to redesign provider delivery systems.

Furthermore, the President has proposed important new reforms that will maintain coverage of vulnerable populations, increase control of Medicaid costs, contribute savings to the Federal budget, and provide States with additional programmatic flexibility.

In fact, Medicaid program spending has grown less rapidly than spending in the private sector on a per person basis, except for the period between 1989 and 1992 (Chart 1)[1]. Combined efforts by

[1]The higher growth rates during this time were caused by several factors, including a national recession, States' use of statutory loopholes to increase Federal payments without

the Executive Branch, Congress and the States have kept program costs under control while maintaining the Medicaid program as an important source -- often the only source -- of coverage for low-income Americans. This Administration's new proposals to control spending continue this commitment to guaranteeing these individuals access to a meaningful benefits package. The President's proposal does not shift Federal responsibilities to the States, it is not an unfunded mandate, and it provides significant increases in States' flexibility to manage their Medicaid programs.

Medicaid is a Critical Safety Net

Medicaid is the primary source of coverage for Americans with diverse health care needs. It covers preventive care for low-and moderate-income pregnant women and children and long-term care for low-income senior citizens and persons with disabilities. It also provides a variety of rehabilitative services and adaptive technologies for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

Benefits

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increases in medical services, and increased provider payments.

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Generally, Medicaid acute-care coverage mirrors the employer-based coverage available to most Americans, but for senior citizens and individuals with disabilities Medicaid also provides long-term care benefits that are rarely available or affordable through other sources. Because Medicaid covers these services, the program ultimately helps a large number of working American families care for their chronically ill family members. Indeed, 68 percent of all nursing home residents rely on Medicaid to help pay for some of their care.

Many senior citizens have complex health problems or need long-term care. In 1993, spending on all services for elderly and disabled individuals constituted approximately 70 percent of all Medicaid spending, excluding payments to disproportionate share hospitals (DSH). Approximately half of these dollars was spent on long term care in nursing homes. Without Federal Medicaid funding, the costs of caring for many of these individuals -- the elderly, chronically ill, disabled and mentally ill -- would fall entirely on States, local communities and families. The remaining thirty percent of Medicaid spending pays for care -- primarily hospital and physician services -- of low-income adults and children (Chart 2).

It is important to note that States are free to cover additional populations and services beyond those required under Federal

guidelines. A few optional benefits, such as prescription drugs and clinic services, are covered by almost all of the States. States can choose to offer a wide variety of other medical services, and they can and do change their benefit packages.

States use flexibility in eligibility and coverage of services to customize their Medicaid programs to meet their specific needs. In 1993, only 38 percent of Medicaid service payments was spent on mandatory services provided to mandatorily eligible individuals. States spent nearly 50 percent of their Medicaid funds on optional services and populations they have chosen to cover, while another 13 percent was devoted to disproportionate share hospital payments.

Americans who qualify for Medicaid are guaranteed financing for their essential health services. National standards for coverage of vulnerable populations apply in all States. States provide a full range of services to beneficiaries, from childhood immunizations to nursing home care. Within these parameters, Medicaid has had substantial success serving diverse low-income populations.

Financial Partnership

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Medicaid is a voluntary program designed by Congress to be administered by States with matching Federal funding at rates that range from 50 to 80 percent depending on State per capita income. Today, all 50 States, the Territories, and the District of Columbia have chosen to participate in the Medicaid program and to enter into a financial partnership with the Federal government.

States have used the broad flexibility inherent in the Federal-State relationship to create many optional eligibility, coverage, and financing policies that meet the diverse needs of their people and the State's own financial circumstances.

More importantly, this relationship provides State Medicaid programs with the financial backing of the Federal government. The flow of Federal funds under the current Medicaid entitlement program protects States and beneficiaries during economic downturns and natural disasters, such as earthquakes or hurricanes. When States increase enrollment, the Federal government automatically shares the responsibility of additional costs. The combination of Federal financial participation and an individual entitlement guarantees that the Federal government will consistently share the cost of providing medical care to low-income children, elderly, pregnant women, and individuals with disabilities. Federal financial assistance is provided

regardless of changes in program enrollment or in a State's economic situation. The Federal/State partnership inherent in the Medicaid program guarantees the commitment of Federal funds.

Block Grant

The Conference Agreement would curtail Federal financial responsibility by converting Medicaid into a capped block grant formula, throwing the Federal/State partnership out of balance. The new MediGrant program would end the Federal/State commitment to providing a basic health care safety net for low-and middle-income individuals and families. It would also be seriously underfunded.

The MediGrant proposal would constrain increases in Federal Medicaid spending far below the rate of inflation and the rate of growth in the number of elderly, disabled and low-income people who will need help from the program. Federal Medicaid payments would be an aggregate, fixed amount in law, totally disconnected from State funding needs. This would underfund the Federal-State partnership and leave States with no protection from enrollment changes. States with growing populations would be at greater financial risk. The arbitrary limits particularly threaten States with rapidly aging populations, since the block grant

amounts would not change to reflect the increasing number of high-cost beneficiaries in a State.

Exacerbating the underfunding problem, the Republican block grant formula creates an overwhelming incentive for States to reduce their contributions to Medicaid. The formula would lower the amount of State expenditures required to receive Federal matching funds. State spending beyond the block grant amount would not be matched at all. The Urban Institute has estimated total Medicaid spending reductions - Federal and State - could exceed $400 billion over seven years.

While both Federal and State support for low-income individuals and families would be dramatically reduced under the Conference agreement, the medical needs of this population would not go away. The cost of caring for the uninsured and low-income Americans would fall to local-level public health care systems and, through cost-shifting, to the privately insured and their employers. Worse, millions of needy people would have to forgo care altogether.

The Republican plan would also eliminate the individual entitlement to health care under Medicaid. Vestiges of statutory language guaranteeing coverage for some people are undermined by a lack of definitions for eligibility criteria and a specified

set of meaningful health benefits. The set-asides in the Republican plan offer little protection for vulnerable populations. They really mean that the four designated sub-populations would receive only constant proportions of shrinking budget totals.

In addition, the Republican block grant does not provide any assurance that Federal and State tax dollars will be appropriately spent. The Conference Agreement contains no Federal enforcement provisions to guard against waste or abuse of American Federal tax dollars. The taxpayers deserve appropriate Federal standards and oversight in the Medicaid program.

The President's Proposal

The Administration opposes the Republican Medicaid proposal as excessive, harmful and unnecessary. The President has proposed an alternative approach that would protect health care access and high quality of care while providing States with additional flexibility in their programs and controlling costs and yielding savings for deficit reduction.

The President's Medicaid per capita cap proposal would continue the shared Federal-State financial partnership and maintain the entitlement to a meaningful set of health benefits for low-income

children, pregnant women, seniors, and individuals with disabilities.

States would receive Federal matching funds up to per person spending limits for any current or new enrollees. This plan would maintain the Federal financial commitment even if States have to expand enrollment. Under a period of economic recession, increased enrollment in a State would automatically result in additional Federal funds for States. Under a per capita approach, Federal dollars would be specifically linked to the number and casemix of enrollees. The Center on Budget and Policy Priorities estimates that a recession, depending on its severity, could increase Medicaid costs due to increased enrollment by between $8 billion and $29 billion. Under the per capita approach, Federal funds would automatically be available to match State spending for each new enrollee.

Cost Shift -- Opponents of the President's plan charge that the per capita cap would result in a cost-shift from the Federal government to the States. That accusation is wrong. The President's proposal provides new State flexibility under the current partnership, not new mandates. The President's proposal maintains the Federal/State financial partnership and the Federal government's financial commitment to the States and to beneficiaries -- which is the heart of the Medicaid program.

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Under the per capita cap, States would continue to receive Federal matching funds for individuals States need to enroll in the Medicaid program. Federal matching funds would increase as the States' population expands and enrollment grows. Federal matching funds under the per capita cap proposal would be dynamic and responsive to States needs.

It is the block grant that would shift costs and leave States at risk -- particularly in the event of economic downturns. Under a block grant, Federal matching funds do not change -- regardless of changes in the size of the States' Medicaid populations.

Unfunded Mandate -- Opponents charge that the per capita cap proposal is an "unfunded mandate" on the States. This accusation is also wrong. In fact, under A per capita cap methodology, Federal funding would expand as the States' needs expand and enrollment grows. The per capita cap would reduce Federal spending without putting the States at undue financial risk.

However, the Republicans' block grant proposal would underfund the Federal/State partnership, leaving the States with no protection from enrollment changes. States with growing populations would be at greater financial risk. The block grant methodology does not reflect the number of high-cost

beneficiaries in a State. Consequently, the arbitrary limits particularly threaten States with rapidly aging populations.

Flexibility -- Opponents also charge that the per capita cap proposal does not provide enough State flexibility. The President's proposal enhances State flexibility -- but not to the point of jeopardizing beneficiary access to services or their quality of care. The President's proposal is designed to provide States increased flexibility to manage their Medicaid programs. At the same time it retains the beneficiary entitlement to benefits.

The President's proposal incorporates many flexibility changes States have been advocating through the National Governors Association, the State Medicaid Directors Association, the American Public Welfare Association and other groups. These changes would provide States greater flexibility to design and operate their programs, thereby permitting them to improve program management to help meet the Federal per capita payment limits. These flexibility provisions could also produce savings independent of the Federal payment limits in cases where State spending is projected to be under the per person growth limits.

The President's proposal provides:

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Greater State control over program efficiency and costs:

- Eligibility simplification and expansion would provide States the option of covering individuals with incomes up to 150 percent of poverty, ~~or expanding overall coverage by 30 percent, subject to a budget neutrality adjustment.~~

- States would be able to require enrollment in managed care without waivers.

- States would be able to continue innovations in provider payment methods without Federal requirements regarding hospital and nursing home payments.

- States would no longer have to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on a cost basis.

- States would have greater control over long-term care costs because they would be able to implement home and community-based services programs without Federal waivers.

- States would have more latitude to target disproportionate share payments to certain hospitals and other providers.

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Enhance flexibility for States to establish managed care networks:

- States would be able to establish provider networks (including primary care case management (PCCM) programs) without needing waivers.

- States would be able to contract with capitated health plans without regard to Federal enrollment requirements (i.e., the current rule requiring Medicaid capitated plans to have 25 percent commercial enrollment would be repealed).

- States would be able to restrict Medicaid beneficiaries in a rural area to a single HMO if only one HMO were available.

State relief from administrative requirements regarding provider qualifications and long-term care services:

- Federal minimum qualifications for providers who serve pregnant women and children would be removed.

- States would no longer be subject to annual reporting requirements for obstetric and pediatric care.

- States would no longer have to conduct duplicative annual resident assessments for mentally ill and mentally retarded nursing home residents.

- Federal restrictions on training sites for nurse aides would be relaxed.

These flexibility provisions would augment current State authority within Medicaid's Federal-State partnership. This enhanced State flexibility, combined with a per capita cap funding mechanism, would preserve the safety net Medicaid provides while containing costs.

Conclusion

Can savings be achieved in Medicaid? Of course, as long as they are at a moderate level that protects the vulnerable populations who depend on Medicaid. The Administration's per capita cap proposal would do just that within the context of continuing the entitlement to meaningful benefits and providing substantial new flexibility to the States.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: Jon Klein

FAX NO.: 456 2878

FROM: Jug Tolu

DATE:

PAGES INCLUDING THIS COVER SHEET: 4

COMMENTS:

Jon - Testimony for Wednesday -
Thoughts ??

Today or Tuesday -

Have a super weekend -

Jug

2233 Wisconsin Avenue, NW Suite 525 Washington DC 20007
202-687-0880 202-687-3110 *facsimile*

Mr. Chairman, members of the Committee, it is a pleasure to appear before you to discuss proposed changes to the Medicaid program--our nation's critical health and long-term care safety net for poor families, people with disabilities and the elderly. Based on better than twenty years of health policy research, my views, in summary, are as follows:

- Legislative change to reduce requirements on states regarding service delivery and provider payment can enhance Medicaid's efficiency and generate savings in pursuing the program's fundamental purpose: health insurance protection for vulnerable populations. This is the approach taken in the Administration's Medicaid proposal.

- In contrast, the Conference Agreement and subsequent Republican proposals that would eliminate the entitlement and dramatically reduce federal funds would not provide flexibility in pursuit of a goal; rather, they would abandon the insurance guarantee that defines the Medicaid program.

- Block grants with limited funds put states willing to sustain coverage at greatest risk. Under these proposals, coverage can be sustained only if states increase spending to offset federal reductions. If, instead, states spend the minimum needed to draw down their allocation of federal funds, insurance is even more severely undermined.

Medicaid is a voluntary federal/state partnership. The Medicaid program is a federal state partnership. Under the program, the federal government makes matching funds available to states to operate medical assistance programs consistent with federal guidelines. State participation is voluntary; guidelines aim to assure the intended use of federal funds.

Most important, these guidelines define Medicaid as an insurance program--that is, they define the population that must or may be insured and specify the health and long-term care benefits that must or may be covered. People who satisfy Medicaid eligibility criteria have a legally enforceable right to coverage for a defined set of benefits. That means that Medicaid beneficiaries, like people with private insurance, know what services will be paid for when they get sick.

States can decide whether or not they wish to participate in the Medicaid program. But if they choose to participate, they are choosing to provide meaningful insurance protection to a defined population.

Legislation to reduce Medicaid spending must preserve Medicaid as an insurance program. The Administration's Medicaid proposal preserves Medicaid's insurance protections, while promoting greater efficiency in their pursuit. The proposal would provide states flexibility in service delivery, specifically with respect to managed care and negotiation of provider payment. On managed care, the proposal would eliminate the requirement that states seek federal waivers in order to contract for managed care for their beneficiaries. This change would make it easier for states to expand the use of managed care, just as private employers are doing. On provider payment, the proposal would eliminate the so-called Boren amendment requirements which impede states' ability to limit payments to hospitals and nursing homes.

This change will make it easier for states to negotiate with providers in setting rates.

Both managed care and provider payment changes will facilitate state efforts to provide insurance protection at lower cost. The Administration further promotes these results with the additional action of establishing a limit on the rate of growth in federal payments per beneficiary enrolled in the program. The per capita cap, as it is called, has three fundamental characteristics:

- First, by focusing on expenditures per beneficiary, rather than total expenditures, it encourages states to focus on efficiency in coverage--not eliminating coverage--in slowing cost growth.

Why not unfunded mandate?

- Second, by allowing federal funds to increase as the number of beneficiaries increases, it sustains the health insurance safety net and protects states against increased demands for coverage that comes with economic recession, from which no state is immune.

- Third, by establishing a growth rate for federal funds that recognizes inflation, it protects states and beneficiaries against the erosion of purchasing power as prices rise, thereby sustaining the value of insurance protection.

In sum, flexibility and the per capita cap combine to promote efficiency in achieving the well-established and widely recognized goal of the Medicaid program--insurance protection for vulnerable populations.

Block grants that eliminate entitlements do not promote efficient insurance protection; they eliminate insurance coverage. The Conference Agreement repealed the Medicaid program and replaced it with a block grant that eliminates fundamental insurance guarantees, provides states insufficient funds to cover the population eligible under current law, and leaves states at risk for recession and price increases. This is not a proposal to promote flexibility or efficiency; it is an abdication of federal responsibility to protect the nation's most vulnerable populations.

The Conference Agreement would eliminate the fundamental elements of Medicaid as insurance--legally enforceable national criteria for who is covered for what benefits. At the same time, it would dramatically reduce (by 17 percent over seven years; over 28 percent in 2002) the federal funds available to provide that protection. In other words, states would have neither the obligation nor the ability to sustain current insurance coverage.

Under the Conference Agreement, federal funds for the Medigrant program would increase an average 4.8 percent per year from 1996-2002. This growth rate is well below the 6 percent per year needed to keep pace with estimated beneficiary growth (about 3 percent per year) and general inflation (about 3 percent per year). Looked at another way, if states were to retain coverage provided under current law, they would have to constrain expenditure growth per beneficiary to 1.3 percent--less than half the rate of general price inflation.

okay?

To achieve this goal, the Agreement provides no flexibilities in service delivery beyond

those in the Administration proposal; nor is it clear that any such flexibilities exist. Rather, it allows states the safety valve that undermines the program's fundamental purpose--the ability to eliminatecoverage . That means that poor families, people with disabilities and senior citizens would lose essential health and long-term care protection.

The Conference Agreement's threat to coverage goes beyond its reduction in federal dollars. By changing the matching formula and other current Medicaid provisions, it allows states to substitute the limited pool of federal funds for expenditure of state dollars. The Urban Institute estimates that if states reduce their spending to the minimum needed to draw down their allowed federal payments, total spending on medical assistance would fall an additional 8 percent beyond the 17 percent reduction in federal funds--a total of 25.4 percent from 1996-2002 and 35.3% in 2002 alone.

No amount of flexibility can sustain coverage in light of such expenditure reductions. Coverage could be sustained only if states were actually to increase their spending, in order to offset federal reductions. Rather than enhancing states' ability to manage their programs, the major thrust of the Conference Agreement is to leave states holding the fiscal bag for protecting vulnerable Americans.