TO: Interested Democratic Members and Staff

FROM: Andy Schneider, DPC, 6-4162 (Fax 6-0938)

RE: Options for Democratic Medicaid Alternative to a Block Grant

DATE: May 25, 1995

The purpose of this memo is to get a serious conversation started among Democrats as to how best to respond to the Republican attack on Medicaid.

The Republican Attack

It now appears that the FY96 Budget Resolution will require a reduction in Federal Medicaid outlays of between $174 (Senate) and $187 (House) billion over the next 7 years. The House Budget Committee report also specifies the conversion of the program from an individual entitlement to a block grant. The House Commerce Committee is under reconciliation instructions to report these changes by July 14.

The Republicans' message is:

(1) Medicaid spending is spiralling upward with no end in sight, and Congress can't balance the budget unless Medicaid costs are brought under control;

(2) The Medicaid "problem" cannot be solved in Washington; it will have to be done by the States and localities, which are closer to the people and more attuned to their needs.

(3) Under a block grant, States will have the flexibility to create innovative health care programs for their low-income citizens (and, by implication, stay under the Federal caps with no loss of coverage or access and no diminution in quality).

(4) The Republican budget plan will increase Medicaid spending, not cut it.

Democratic Options

This is a defining moment for Democrats. The Republicans are obviously not just trying to reduce Federal spending on Medicaid. Using the code words "block grants" and "flexibility," they are also trying to strip over 30 million Americans -- over half of whom are children -- of their entitlement to coverage for health and long-term care benefits. Once the entitlement is gone, States will be able to make the eligibility and benefits cuts necessary to handle huge reductions in Federal Medicaid funding and necessary to enable them to pull some or all of their own State dollars out of the program. .

Here is where Democrats can draw a clear, understandable line: reduce Federal spending on Medicaid but do not take basic health and long-term care coverage away from vulnerable Americans. The message: cut the deficit, but don't be mean-spririted about it. More specifically, do no harm to the elderly and to children.

The fact is that projected Federal Medicaid spending can be reduced without terminating the entitlement -- not by $187 billion over 7 years, perhaps -- but by significant amounts.

Here are four possible approaches, with differing levels of savings. Of course, there are numerous variations on these themes. NOTE: *The savings numbers are based on preliminary CBO estimates but were not prepared or reviewed by CBO and are <u>not</u> CBO estimates. Although the numbers are not precisely accurate, I believe that the orders of magnitude are right.*

Option #1. Repeal the Boren amendment for both hospitals and nursing facilities.. Repeal cost-based reimbursement for FQHCs. Repeal payment sufficiency requirements for pediatricians and obstetricians. Authorize use of managed care without waivers. Freeze DSH at FY 95 levels..

Total savings: about $18 billion over 7 years.

Option #2. Same as 1, but cut DSH payments by one third from CBO baseline.

Total savings: about $30 billion over 7 years.

Option #3. Same as 1, but impose an across-the-board 5 percent reduction in Federal matching payments (do not alter the matching formula itself).

Total savings: about $49 billion over 7 years.

Option #4. Same as 1, but impose a 5 percent per capita cap on acute care spending (non-DSH) for all eligibles.

Total savings: about $62 billion over 7 years.

Any of these options has several advantages:

- They preserve the existing acute and long-term care coverage for mothers and children, the elderly, and the disabled.
- They give the States far more flexibility than they now have with respect to payment of hospitals and nursing homes and with respect to use of managed care. (However, it is not possible to outbid the Republicans on flexibility, and none of these options does so).
- They generate scorable savings for deficit reduction, although not at the truly dangerous levels that the Republicans contemplate.
- Unlike block grants, these options do not invite divisive formula fights among the States (and their Democratic delegations), and they do not necessarily pit the high-DSH states against the low-DSH states.
- These options do not necessarily disturb the section 1115 waivers the Administration has already approved or is planning to approve.

- Finally, all of these options send a clear message: reduce the deficit, but don't go too far -- don't harm the elderly or children. This complements the Democratic message on Medicare and helps flush the Republicans out from behind their "flexibility" rhetoric.

During the debate on the budget resolution, Mr. Stenholm and Mr. Orton offered a substitute which, with respect to Medicaid, would have limited Federal payment growth to 8 percent in FY 96, 7 percent in FY 97 and FY 98, 6 percent in FY 99 and 2000, and 5 percent in FY 2001 and 2002, for a total savings of $135 billion over 7 years. The only way to achieve savings of this order of magnitude without block granting the program is to freeze per capita acute care payments at 1995 levels ($121 billion over 7 years) and freeze DSH payments at 1995 levels ($11 billion over 7 years).

Recommendation

The House Commerce Committee may begin hearings on Medicaid as soon as two weeks from now. If the official schedule holds, the Commerce Committee will report out Medicaid changes by the middle of July. Democrats need to make a decision fairly quickly as to whether they are going to offer an alternative to the Republican block grant, and if so, what it should look like.

Medicaid Block Grant Design Issues
(May 25, 1995)

If Medicaid is converted into a block grant that gives the States discretion as to whom to cover and what to cover them for, the following issues need to be addressed:

Eligibility

1.) May States establish eligibility criteria (standards or methodologies) that vary from county to county, or from community to community? For example:

o May a State operate an acute and/or long-term care benefits program only in its rural or suburban areas? Only in those counties or localities which agree to provide a specified level of matching funds? Only in those districts that voted in favor of the majority party in the State legislature?

2.) May States establish eligibility criteria that vary by race or ethnicity? By gender? By age? For example:

o May a State set more stringent eligibility criteria for Hispanics than for Whites? For children than for the eldelry?

3.) May States establish eligibility standards that vary by diagnosis or medical condition? For example:

o May a State deny payment for treatment of preexisting conditions?

o May a State exclude from coverage people with AIDS?

o Are their any medical underwriting techniques that States would be barred from using?

4.) May States establish eligibility criteria that require one or more years of residency? That require U.S. citizenship and do not cover legal aliens? For example:

o May a State exclude from coverage all migrant workers?

o May a State exclude from coverage some or all homeless individuals?

Benefits

5.) May States end coverage for acute care? If they must cover some acute care services, do they have to cover preventive care?

6.) May States end coverage for long-term care? If they must cover some long-term care services, do they have to cover home and community-based services that help avoid institutional placement?

7.) May States establish benefits packages that vary from county to county, or from community to community? For example:

o May a State operate an acute and/or long-term care benefits program that has a

richer benefits package in its rural or suburban areas than in its urban areas?

o May a State offer an acute and/or long-term care benefits program that has a richer benefits package in those counties or localities that are willing and/or able to contribute some of their own funds?

8.) May States establish benefits packages that vary by race or ethnicity? By gender? By age? By other category? For example:

o May a State offer a shallower package of acute care benefits to Hispanics than to Whites or African-Americans?

o May a State deny coverage to a woman with more than two children? To her third or subsequent child?

9.) May States deny coverage for abortions even where necessary to save the life of the mother? In cases of rape or incest?

10.) With respect to eligible individuals not enrolled in managed care plans, may States impose caps on the dollar amounts that they spend during a year? Over a lifetime? If so, may States vary such caps by race or ethnicity? By age? By gender? By other category?

Reimbursement

11.) If States elect to cover a particular service -- say, clinic services -- may they exclude a specified provider of such services -- say, a Federally-funded Community Health Center -- from reimbursement for such services, even if the provider is qualified to deliver the services? May States allow -- or direct -- managed care plans with which they contract for the particular covered service to exclude the specified provider? May States accomplish this exclusion indirectly by applying -- or allowing or directing managed care plans to apply -- excessively stringent participation requirements to the specified provider?

12.) May States pay their own facilities -- teaching hospitals, ICFs/MR, etc. -- more than they pay private facilities for the same services to the same individuals? May they use block grant funds to pay their own facilities far more than the costs of delivering the covered services?

13.) May States pay private managed care plans at rates that allow the plans to extract large percentages -- 20, 25, 30 percent or more -- of Medicaid revenues in the form of administrative or marketing expenses or profits?

14.) May States require some -- or all -- covered individuals to receive certain services -- or all their services -- from State-owned or operated facilities?

15.) If States offer eligible individuals a choice of managed care plans, may they require all those covered individuals who have not elected a managed care plan -- so-called "default" or "auto" enrollees -- to enroll in plans operated by or affiliated with State-owned or operated teaching facilities?

Fraud and Abuse

16.) May States use block grant funds to make payments to providers that have defrauded the Medicare or Medicaid programs? May States make payments to managed care plans or other fiscal intermediaries who in turn pay such providers?

17.) May States use block grant funds to make payments to providers that deliver poor quality care to Medicaid or Medicare eligibles or that abuse Medicaid or Medicare patients? May States make payments to managed care plans or other fiscal intermediaries who in turn pay such providers?

18.) May the State legislative or executive branch officials with responsibility for the Medicaid block grant dollars have direct or indirect financial interests in health care providers or managed care plans in the State?

Administration

19.) May States contract out or devolve parts or all of their block grant funds and administrative responsibilities to other entities? If so, are the Federal block grant substantive requirements (if any) enforceable against these other entities? For example:

o May a State turn its entire Medicaid program over to a private insurer or managed care plan or other private contractor? To the counties? To a State University?

o May a State privatize its survey and certification of nursing facilities?

20.) May the States use Federal Medicaid block grant dollars without reporting to the Federal government on a regular basis how those funds are being used and whether needed care is actually accessible to their low-income populations?

COVERAGE IMPLICATIONS OF MEDICAID CAPS

Status Quo

Under the status quo, state Medicaid programs must operate on a individual entitlement basis, but states still have substantial flexibility with respect to eligibility (and therefore coverage).

- Overall, 35% of Medicaid spending is for optional eligibility categories. Most of the spending for optional eligibility categories (26% out of the 35%) is for the aged and disabled adults.

- This 35% figure understates the true extent of optional eligibility, because even within a mandatory eligibility category, states have substantial discretion in setting the income level for eligibility.

- Conceptually, the fact that the federal government matches state Medicaid spending means that coverage is broader than it would be without federal matching payments. In a state with a 50% matching rate, the state is able to provide one dollar in coverage in exchange for only 50 cents of state spending.

  In theory, this coverage effect (relative to what coverage would be without federal matching payments) is highest in states with the highest federal matching rates.

The Effect of an Aggregate Cap or Block Grant

Aggregate Cap:

- Under an aggregate cap, the current federal/state matching arrangement would continue, but federal matching payments to a state would be capped at a predefined level. States would presumably have greater flexibility in determining eligibility, covered services, and provider payment levels. The expectation is that the cap is below (potential significantly below) projected spending levels.

- There is little reason to believe that states would respond by spending less

than the cap, since they could be doing that now if they wanted to.[1]

- It is highly unlikely, however, that states would maintain much spending above the cap (since to do so would require state spending without federal matching payments).

- An aggregate cap is neutral with respect to how a state attempts to keep spending below the level of the cap.

  - A dollar reduction in provider payments or benefits yields the same effect as a dollar reduction in coverage.

  - It is difficult to determine what mix of cuts states would use, though current practices might provide some indication. Currently, states are more likely to expand spending for optional services ($50 billion in FY93) than for optional eligibility categories ($38 billion in FY93).

Aggregate Block Grant:

- Under an aggregate block grant, states would receive a fixed sum of federal money, along with greater flexibility in determining eligibility, covered services, and provider payment levels.

- Effects will vary based on maintenance of effort requirements.

  - If states are required to maintain current effort in some way, then the effects of an aggregate block grant are likely to be similar to the effects of an aggregate cap.

  - If no maintenance of effort is required, then it is likely that many states would respond by spending less than they do today.

Per Capita Cap

- A per capita cap differs from an aggregate cap in that it is determined on a per enrollee basis. States would presumably have greater flexibility in determining covered services and provider payment levels, but not

[1]Some might argue that states could reduce spending with greater flexibility. It would seem unlikely that this is a large effect, particularly given the amount of spending today that is optional and the availability of waivers.

necessarily in determining eligibility.

- Like an aggregate cap, there is little reason to believe that states would respond by spending less than the cap, since they could be doing that now if they wanted to.

- Unlike an aggregate cap, a per capita cap is not neutral with respect to how a state attempts to keep spending below the level of the cap.

  - Assuming spending is projected to be above the cap, then a one dollar reduction in provider payments or covered services yields a dollar in state savings.

  - However, a dollar reduction in coverage yields less than a dollar in state savings (how much less depends on the state's matching rate).

- Though a per capita cap would lead primarily to reductions in covered services or provider payments, some reductions in coverage are possible.

  - If a state is unable (or unwilling) to hold per capita spending below the cap, then its matching rate is effectively changed.

  - For example, assume that per capita spending were projected to grow at 7% per year and a per capita cap growing at 5% per year were applied. If a state simply absorbed the full cut in federal spending, its federal matching would fall by about 12% after seven years (e.g., from 50% to 44%). The matching rate would continue to fall over time.

  - With a lower matching rate, states might reduce coverage somewhat.

  - The tighter the per capita cap, the more pronounced the effect on coverage. This is because with a tighter cap, states are less likely to be able to meet the cap through reductions in covered services or provider payment levels.

THE WHITE HOUSE

WASHINGTON

June 21,-1995

MEMORANDUM TO CAROL RASCO

FROM: Jennifer Klein J.K.

SUBJECT: Medicaid Per Capita Caps

You asked for a brief description of per capita caps to help answer some of the questions you've been getting. Attached please find a clear (though somewhat "wonkish") explanation as well as a copy of the testimony Bruce Vladeck gave yesterday at a Medicaid hearing. I think that his description of caps on page 10 provides a good answer to most questions.

Medicaid Per Capita Caps

Medicaid per capita caps limit the growth in Medicaid costs per recipient to some fixed amount, like medical inflation or the growth in gross domestic product. Caps operate by setting a fixed amount of Federal spending per recipient for each state, for each year. The total amount of Federal funding that a state receives is the product of the costs per recipient in the base year, the fixed growth rate per recipient and the number of recipients. For example, say a state has 100 Medicaid recipients in 1996 and a cost per recipient of $2,000 in 1995, the base year. If the per capita cap is 6%, then the state will receive in 1996: 100 times $2,000 times an increase of 6%. If the state had a recession, and there were twice as many recipients in 1996, then the federal payments would be twice as high. Per capita caps allow for fluctuations in enrollment, while limiting growth in expenditures due to factors such as excessive health care inflation.

Per capita caps are different than block grants. Block grants like those proposed by the Republicans in the House and Senate fix the total amount of federal spending in each state, for each year, without allowing for changes in recipient growth. Each state receives the amount determined by the formula, regardless of whether their Medicaid enrollment shrinks or grows. As a result, Medicaid financing is no longer linked to Medicaid coverage -- which, given the magnitude of the Republican cuts, will likely result in loss of coverage.