The Kaiser Commission on

THE FUTURE OF MEDICAID

Medicaid: The Health and Long-Term Care Safety Net

Diane Rowland, Sc.D.

Senior Vice President
Henry J. Kaiser Foundation

and

Executive Director of the
Kaiser Commission on the Future of Medicaid

Testimony before the

Committee on Finance
United States Senate

Hearing on "Medicaid: Historical Perspective"

June 29, 1995

1450 G Street, N.W., Suite 250, Washington, D.C. 20005
tel (202) 347-5270 • fax (202) 347-5274

Thank you Mr. Chairman and members of the Committee for this opportunity to provide a historical perspective on the Medicaid program and the role it plays in financing health and long-term care services for low-income Americans. I am Diane Rowland, Senior Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission on the Future of Medicaid is a fourteen member bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Commission and discuss Medicaid's role as a safety net for the health and long-term care needs of 36 million low-income Americans.

The Structure and Role of Medicaid

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has been on the front lines in meeting the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for one in ten Americans. In its thirty years, Medicaid has enabled millions of low-income Americans to gain access to needed health services. It has helped to close the gaps in care between the poor and non-poor, eased financial burdens, and provided a safety net for the most needy Americans. It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans.

Medicaid's role as a health insurer and safety net for vulnerable Americans is visible throughout the health care system. Medicaid finances care for one in four American children, pays for one-third of the nation's births, assists 60 percent of people living in poverty, pays for half of all nursing home care, and accounts for 13 percent of all U.S. health care spending. It is the source of insurance for 13 percent of the non-elderly population and supplements Medicare by paying premiums and cost sharing for one in ten elderly and disabled Medicare beneficiaries. Its funding is the major source of federal financial assistance to the states, accounting for 40 percent of all federal-grant-in-aid payments to states.

Authorized under Title XIX of the Social Security Act in 1965, Medicaid is a means-tested entitlement program that is jointly financed by the federal and state governments. States elect to participate in Medicaid and federal requirements and state choices determine Medicaid's structure. States design and operate the program within federal guidelines that determine the population groups and services for which the federal government will match state expenditures. Some eligibility groups and services are required, but others are left to state option. The federal government pays 50 to 79 percent of program expenditures, depending on the state's per capita income.

To be eligible for federal matching payments, the federal statute requires states participating in Medicaid to cover certain low-income groups, most notably recipients of cash assistance under the Aid to Families with Dependent Children (AFDC) program and low-income pregnant women and young children, and to provide basic benefits, including hospital and physician services. In addition to these basic coverage and benefit requirements, states have the option to cover other low-income groups who are not receiving cash assistance and to provide

more comprehensive benefits, such as prescription drug coverage or dental care, and still receive federal matching funds. Because the states make very different decisions regarding program design, there is substantial variation across states in who is covered, what benefits are offered, how services are delivered, and how much is spent for care.

In reality, Medicaid is four separate programs, configured and operated somewhat differently in each of the fifty states and the District of Columbia. For 16 million children and 7 million adults in low-income families, Medicaid is a health insurance program with comprehensive benefits and little or no cost-sharing. For nearly 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid has multiple roles. It is a long-term care program for home-and community-based services and the dominant source of public financing for nursing home care. In addition, Medicaid is a supplementary insurance program to Medicare paying Medicare's premiums and cost-sharing requirements and covering additional services, most notably prescription drugs and long-term care, for low-income Medicare beneficiaries. Finally, Medicaid is a health insurance program for low-income disabled adults who do not have Medicare coverage.

From the perspective of who is served, Medicaid is predominantly a program assisting low-income families, but from the perspective of how Medicaid dollars are spent, Medicaid is predominately a program serving the low-income aged and disabled population. As shown in Figure 1, adults and children in low-income families make up nearly three-fourths of beneficiaries, but account for only 27 percent of spending. In contrast, the elderly and disabled account for 27 percent of beneficiaries and the majority (59 percent) of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings.

The use of services under Medicaid reflects the differing needs of the low-income population served by Medicaid and state coverage choices. The key services that Medicaid programs must cover are physician and hospital services, laboratory and x-ray services, nursing facility services for persons over age 21, prenatal care, family planning, and screening and treatment for children (EPSDT). The primary optional services that states elect to cover are intermediate care facilities for the mentally retarded, prescription drugs, vision care and eyeglasses, dental care, and clinic services.

As shown in Figure 2, acute care spending under Medicaid accounts for 46 percent of program spending, HMO and Medicare premium payments for 5 percent and long-term care for 35 percent with the remaining 14 percent of spending for payments for disproportionate share hospitals (DSH). DSH payments are a recent component of Medicaid spending directed at hospitals with high volumes of care to the low-income population and do not directly relate to expenditures for specific population groups.

The elderly and disabled use the bulk of long-term care services and account for half of acute care spending. Because they use more services and the services they use are more expensive, the cost to Medicaid to cover aged and disabled beneficiaries is substantially higher than the cost for children and adults in low-income families. As shown in Figure 3, the average per enrollee Medicaid cost in 1993 for a child was $955 and for a non-aged adult was $1,717 compared to $7,216 per disabled beneficiary and $8,704 per elderly beneficiary. With over an eight-fold difference between the cost of a child and elderly beneficiary, the cost of any state's Medicaid program is largely determined by the mix of beneficiaries covered by the program.

The Cost of Medicaid

Medicaid is an expensive program because it provides health insurance coverage and long-term care financing for many of the nation's poorest and most disabled individuals. Its benefits are comprehensive with little or no cost-sharing because most Medicaid beneficiaries have incomes that are significantly below the federal poverty line of $14,800 per year for a family of four. They have neither the income nor the resources to pay for care on their own. By providing comprehensive benefits, Medicaid helps to overcome the financial barriers that can impede access to needed services.

Medicaid provides a safety net for individuals with the most catastrophic of illnesses -- chronic illnesses for children that leave them disabled for a lifetime, mental illness and retardation that requires intensive care in the community or in an institutional setting, and long-term nursing home care for the aged and disabled. Medicaid's average cost for a pregnant women or child without complex medical needs is often substantially lower than a comparable private health insurance premium whereas the average cost for a severely retarded individual on Medicaid can exceed $50,000 per year, an expense not covered by most private insurance.

Medicaid has become a major budgetary commitment for both the federal and state governments. In recent years, Medicaid expenditures have escalated rapidly, more than doubling from $51 billion in 1988 to $125 billion in 1993. It is projected that total federal and state spending for Medicaid will exceed $158 billion this year and grow to $308 billion by 2002. The federal share, roughly 56 percent of total expenditures, is projected to grow from $90 billion in 1995 to $177 billion in 2002. Federal expenditures for Medicaid now account for 6 percent of the

federal budget while state Medicaid funds account for 13 percent of state spending.

Historical rates of growth for Medicaid have been more moderate than increases in private health care spending, but in the late 1980s and early 1990s, the costs for Medicaid soared with annual rates of increase in excess of 25 percent between 1990 and 1992. The excessive growth rates during this period were attributable to several factors, including a national recession and growth in the number of people eligible for Medicaid, inflation in health care spending, and states' use of statutory loopholes to leverage federal dollars.

Spurred by federal requirements to increase coverage of pregnant women and children, state efforts to cover more low-income uninsured, and court-required expansions in coverage of the disabled, enrollment increased from 22 million in 1988 to 32 million in 1993. As shown in Figure 4, low-income children constituted the largest portion of the growth in Medicaid enrollment, but the numbers of disabled individuals covered by the program also increased substantially. However, as shown in Figure 5, coverage of additional children with their low per capita costs played a relatively minor role in Medicaid's rapid growth during the 1990s.

The major factor contributing to this sudden escalation in program spending was that some states generated additional federal dollars from Medicaid by using provider taxes and donations and disproportionate share hospital (DSH) payments as alternative financing strategies to increase the base payments that had to be matched by the federal government. The federal share of DSH payments alone grew from $800 million in 1990 to 10.1 billion in 1992. As shown in Figure 6, state efforts to maximize federal Medicaid funding had the most pronounced effect on increases in Medicaid spending between 1991 and 1992, when over half of the annual increase in Medicaid spending was attributable to rapid growth in Federal DSH payments to states. By 1993,

DSH payments accounted for 14 percent of total Medicaid spending.

The use of special financing techniques to generate additional federal financing varied significantly across states. Disproportionate share hospital (DSH) payments were intended to be used to compensate hospitals with a high volume of low-income patients, but were used in some states to increase the share of federal payments to the state. The states that used DSH financing heavily include Alabama, Kansas, Louisiana, Missouri, New Hampshire, New Jersey, South Carolina, and Texas. In each of these states, DSH payments represented more than 20 percent of total Medicaid expenditures.

With legislation enacted in 1991 and implemented in 1993 to restrict state use of tax and donation financing strategies and curb the growth in DSH payments, the annual rate of growth in Medicaid spending has now dropped back to historical levels. The changes in the provider tax provisions and the cap on DSH payments have clearly closed some of the mechanisms used by states to increase federal Medicaid payments. From 1992 to 1993, the program grew by 11 percent and future projections assume an annual growth rate of about 10 percent. Future increases are expected to be mostly driven by inflation and enrollment growth due to increases in the number of people in poverty and expanded coverage of children below poverty.

Given the size and scope of Medicaid, sustaining an annual spending increase of 10 percent requires a substantial commitment of new funds each year. With budgetary pressure and the desire to reduce spending at both the federal and state level, restraining the annual increases in Medicaid spending has taken on new urgency. How expenditures for the program are shared and managed between the federal and state governments is at the heart of the policy debate over Medicaid's future.

Forces Shaping Medicaid's Future

Today, the Medicaid program fills many diverse roles as it provides federal funding to states to match their expenditures for coverage of their indigent and elderly and disabled populations. From the state's perspective, it is the source of federal rules and mandates that require states to cover specific populations and benefits and that constrain state flexibility in setting provider payment rates and in adopting broad scale use of managed care. Yet, the matching funds provided by the federal government through Medicaid also enable states to improve the services they provide to their low-income population, to respond to changes in the economy that affect the number of poor and uninsured in each state, to accommodate population growth, and to undertake health and long-term care reform at the state level.

The Medicaid program's current structure as an entitlement for low-income, elderly, and disabled Americans and as an entitlement to states for open-ended federal matching funds for individuals and services that fall within federal guidelines provides a safety net for both states and their low-income residents. It, however, offers limited fiscal control for the federal government because federal spending levels are largely determined by state choices over who is covered and how much is paid for services.

The tensions between the federal government and state governments over the structure and financing of Medicaid have notably increased in recent years. Federal mandates requiring coverage of more low-income children and pregnant women, providing assistance with Medicare cost-sharing and premiums for low-income aged and disabled Medicare beneficiaries, and protecting income for spouses of nursing home residents combined with requirements for reasonable cost payments to hospitals, nursing homes, and community health centers have limited

state discretion over program spending and imposed new costs. States, struggling to finance care for an expanded population and to limit the increases necessary to pay for that care from already strapped state budgets, have employed a variety of methods to maximize federal funding. The resulting pressures underscore today's debate over financing and flexibility.

The Pressure on Medicaid from the Uninsured Population

Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in America's uninsured population. As shown in Figure 7, fifty-eight percent of all Americans living in poverty and 82 percent of all poverty-level pregnant women and young children are now covered by Medicaid. If the growth in Medicaid over the last five years had not offset the decline in employer-based insurance for working families, an additional nine million Americans would be uninsured today, increasing the percent of non-elderly Americans without insurance from 18 to 22 percent.

Today, 41 million Americans, two-thirds of whom have incomes below 200 percent of the federal poverty level, are uninsured. But, Medicaid as it is currently structured is limited in its ability to broaden coverage of the uninsured. Medicaid is a means-tested entitlement program. Only persons who meet stringent and state-specific income and assets limits and who fall into particular "categories," such as people receiving cash assistance or low-income children and pregnant women, are eligible. Despite recent extensions of coverage to poor children and pregnant women, millions of uninsured low-income Americans, most notably poor single individuals and childless couples, remain beyond the program's reach.

As a result, many states have sought waivers from the federal Medicaid eligibility requirements in order to use Medicaid as a building block in their state health care reform efforts.

With waivers, federal matching funds can be used to help pay the cost of insuring low-income individuals who are not in Medicaid's traditional coverage categories. As shown in Figure 8, twelve states now have federal waivers of Medicaid law (known as Section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional low-income uninsured people and to use managed care to restructure the delivery and financing of services. With the growing budgetary pressures on states, many states are turning to 1115 waivers as a way to gain broader flexibility over their Medicaid programs.

Potential for Savings from Managed Care

Low levels of participation in Medicaid by private physicians, heavy reliance by program beneficiaries on care in clinics and hospital emergency and outpatient departments, and concerns about both the cost and quality of care under the fee-for-service medical care system have led many states to turn to managed care as a model to coordinate care and help control costs for the Medicaid population . Medicaid managed care enrollment has grown steadily in the last decade from 800,000 enrollees in 1983 to 7.8 million in 1994, as shown in Figure 9. Today, 23 percent of Medicaid beneficiaries, predominantly poor children and their parents, are enrolled in managed care. More than half of Medicaid managed care enrollees are in Health Maintenance Organizations (HMOs) or similar organizations that provide a full range of services for a fixed capitation payment per enrollee.

Managed care has the potential to improve the delivery of care by integrating and coordinating services to enrollees and promoting early intervention and primary care to reduce hospitalizations and reliance on emergency rooms as a site of care. Capitated managed care systems also offer the potential to constrain Medicaid costs and make spending more predictable

by setting a fixed payment per enrollee and putting the health plan at risk for delivering needed services.

Managed care is not, however, an instant solution to Medicaid's access and cost problems. Managed care works most effectively if the enrolled population is stable and can receive ongoing preventive and primary care, but a program such as Medicaid which determines eligibility on the basis of income has significant eligibility turnover because people lose coverage due to fluctuations in income and employment. As a public program, Medicaid also operates under budget constraints that have often resulted in substandard provider payment rates. In a capitated managed care arrangement where the incentive is to keep utilization low, substandard payment rates could discourage participation by mainstream plans and compromise quality and access.

Moreover, significant savings for the overall Medicaid program cannot be achieved if enrollment of Medicaid in managed care focuses only on low-income families. As shown in Figure 10, only 23 percent of overall program spending is related to acute care services for low-income children and adults. Even if managed care is able to achieve the savings of 5 to 15 percent over fee-for-service reported in the literature, these savings on care for low-income families would result in a 1 to 2 percent savings for the overall program. Achieving significant overall program savings from managed care will be difficult without enrolling the costly disabled and elderly populations. Most Medicaid dollars are spent on services to the elderly and disabled, but the experience with these populations in managed care is limited and the potential for savings is unknown.

The extent to which states will be able to achieve savings from managed care is also highly dependent on the current configuration of their Medicaid programs. States that have a heavier

share of their Medicaid dollars in long-term care services will be less able to achieve significant savings than those with a larger share of spending in acute care services where managed care has its greatest potential for savings. As shown in Figure 11, there is substantial variation across states in the level of spending related to acute versus long-term care services.

Pressure on Medicaid from Low-Income Medicare Beneficiaries

In recent years, Medicaid has also been pressed to expand the assistance offered to low-income Medicare beneficiaries. Today, nearly 4 million low-income disabled and elderly Medicare beneficiaries rely on Medicaid to pay the premium and cost-sharing obligations under Medicare and provide benefits that Medicare does not cover, most notably prescription drugs and long-term care. In 1995, Medicare's Part B premium is $533.20 per year and cost-sharing requirements are $716 for a hospital stay, a $100 deductible for physician services, and 20 percent cost-sharing for physician and other medical care.

In essence, Medicaid makes Medicare work for the low-income elderly and disabled by reducing their financial barriers to care under Medicare. However, providing this coverage to the dual beneficiaries of Medicare and Medicaid imposes financial obligations on state Medicaid programs. Increases in Medicare's obligations on beneficiaries translates to higher Medicaid costs to finance these payments, but states have no control over the level of Medicare premiums and cost-sharing. Many states argue it should be the responsibility of the federal government, not Medicaid, to pick up the additional cost to low-income beneficiaries when costs to Medicare beneficiaries increase.

In addition to its role supplementing Medicare, Medicaid is also under pressure because it provides the only public source of financing for long-term institutional care for individuals with

severe physical and cognitive limitations. Medicaid pays for half of all nursing home care and about 20 percent of long-term home and community-based care. In the absence of adequate private financing alternatives, setting appropriate limits on Medicaid's availability to help families and individuals with long-term care will continue to be a source of tension in program policy and spending.

Challenges for Medicaid's Future

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Today, Medicaid continues to play a critical role in providing acute and long-term care services to our nation's most vulnerable people, but its widening safety net responsibilities and spending growth are straining both federal and state budgets. The most critical issue facing Medicaid today is how this safety net program can best be structured to meet the needs of low-income Americans at the most reasonable cost to the federal and state governments.

As it enters its thirtieth year, Medicaid is at a critical juncture. In its role as a medical safety net, Medicaid is today financing care for over 36 million of the poorest, sickest, and most disabled Americans at a cost of over $159 billion to federal and state governments. But, Medicaid has been a victim of its own success. While Medicaid was broadening its reach in providing health insurance to the poor and becoming the mainstay of financing for long-term care, spending was rising rapidly, raising new questions about the ability of the federal and state governments to sustain such growth.

Today, the Congress is proposing to curb federal Medicaid spending to realize savings of $184 billion from projected federal spending between 1996 and 2002. This would amount to an 18 percent reduction in federal support for Medicaid over this period. As shown in Figure 12, the growth limits would have a wedge effect with the largest share of the reductions occurring in the last two years.

In addition, proposals are being discussed that would dramatically alter the program structure and beneficiary protections by replacing the current entitlement program with a block grant to the states. Instead of guaranteeing insurance coverage, protection for nursing home residents, and federal financing for all individuals who meet Medicaid's eligibility criteria, a block grant would provide states with federal funds and the flexibility to decide how those funds can be used. Under the proposals being discussed, states would gain discretion over the scope and design of the program, but lose unrestricted federal matching payments because federal payments to the states would be capped. The full impact of such proposals is highly dependent on the level of cuts in federal funding, the degree of flexibility given to individual states, and ultimately on the decisions made by individual states which are difficult to predict.

The reduction in federal Medicaid spending coupled with the proposed end to the entitlement nature of Medicaid are likely to result in significant changes in the scope of coverage of the poor and the way in which their care is organized and financed. Because states have differing economic situations and the current Medicaid program varies in size and scope across the states, the impact of the changes is difficult to predict, but would certainly affect states differently. As shown in Figures 13 and 14, states have different patterns of Medicaid expenditures per poor person as well as very different growth rates in expenditures per

beneficiary. A block grant with a federal rate of increase limit on funding would fix these differences in place and make it difficult for states to accommodate future growth in the program.

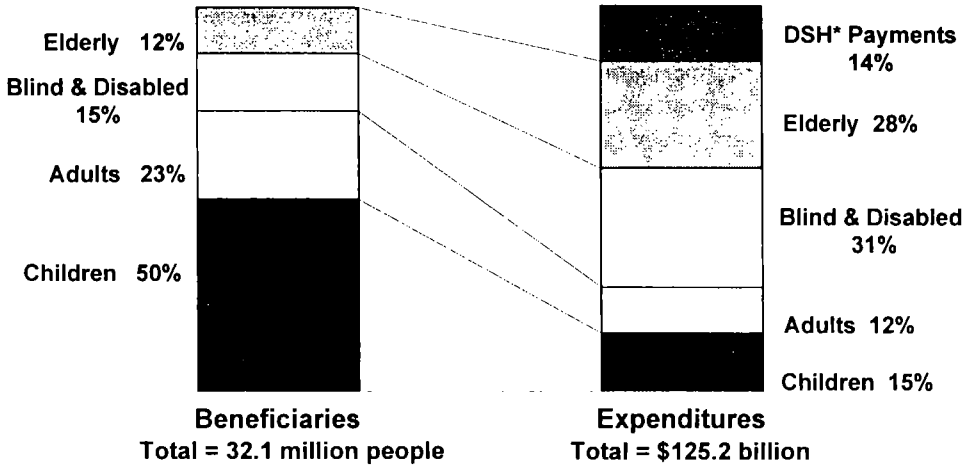
The outcome of the policy debate over Medicaid's future is obviously of great import to the states, the low-income people who now rely on Medicaid for health and long-term care services, and the providers that serve them. There are no simple solutions to reducing the cost of providing care to the over 36 million Americans who now depend on Medicaid or the millions more who are uninsured and fall just beyond its reach.

The policy dilemma at both the federal and state levels is how to restrain the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program in ensuring access to essential health services for the needy. In implementing solutions to meet the crises of today, it is important not to undo the progress Medicaid has made in providing health care for tens of millions of low-income and elderly and disabled Americans.

Thank you for the opportunity to testify today. I welcome your questions.

Figure 1

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1993



* Disproportionate share hospital

SOURCE: Urban Institute analysis of HCFA data, 1994

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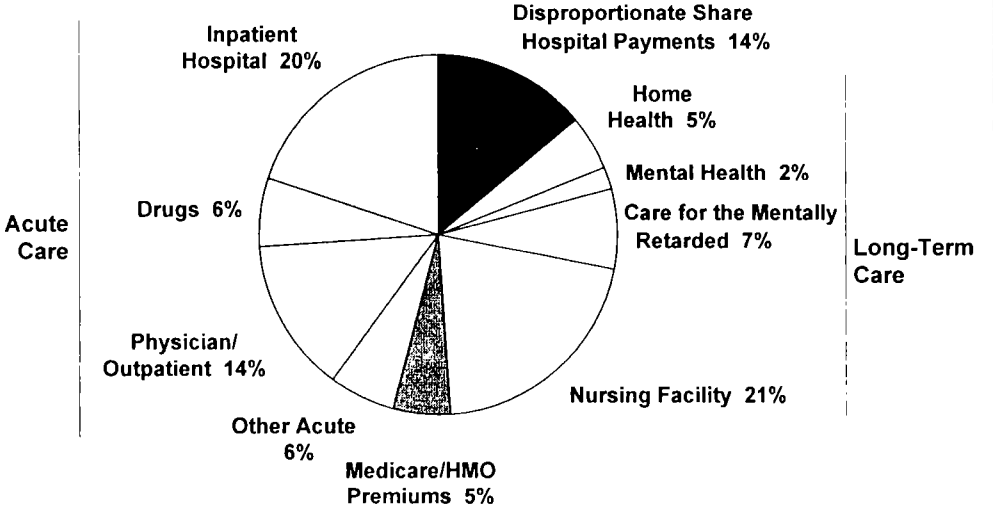
Figure 2

Medicaid Expenditures by Type of Service, 1993



Total = $125.2 billion

SOURCE: Urban Institute analysis of HCFA data, 1994.

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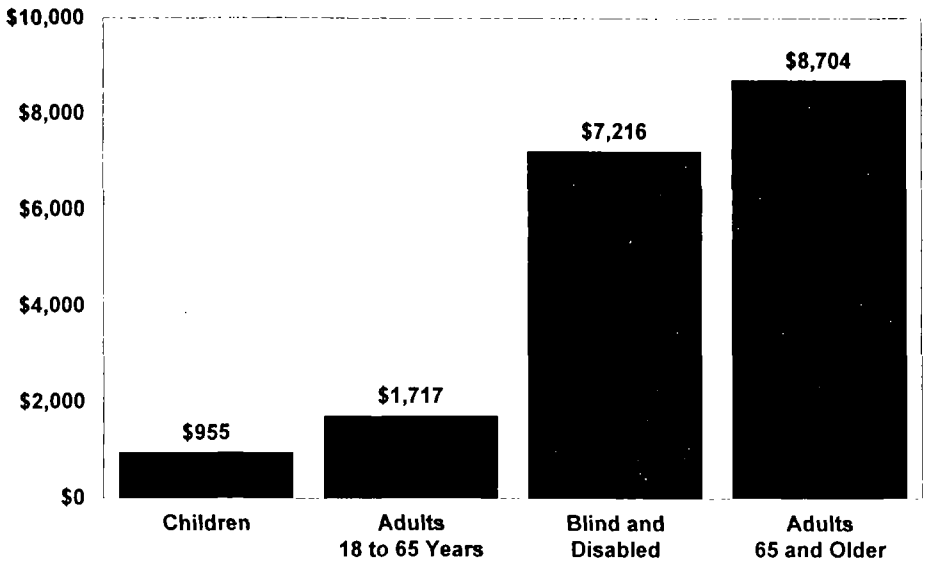
Figure 3

Medicaid Expenditures Per Enrollee, 1993



Note The totals per enrollee do not include disproportionate share payments to hospitals.
SOURCE: Winterbottom, Liska, and Obermaier, 1994

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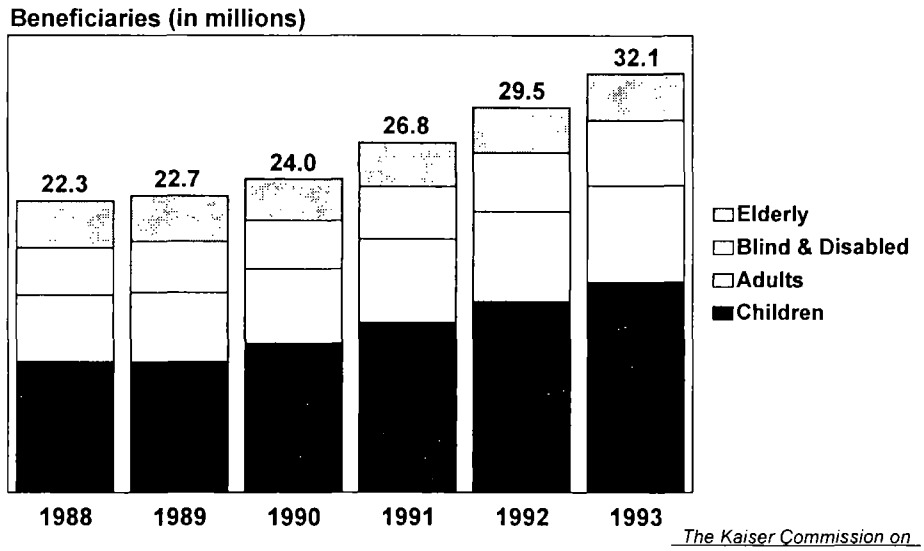
Figure 4

Medicaid Beneficiary Growth by Enrollment Group, 1988-1993



SOURCE: Urban Institute analysis of HCFA data, 1994.

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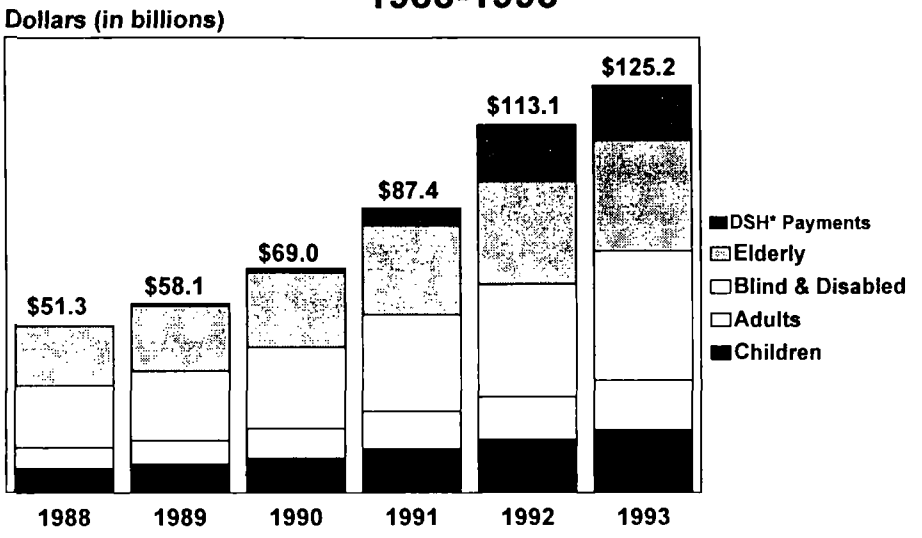
Figure 5

Medicaid Spending by Enrollment Group, 1988-1993



* Disproportionate share hospital

SOURCE: Urban Institute analysis of HFCA data, 1994.

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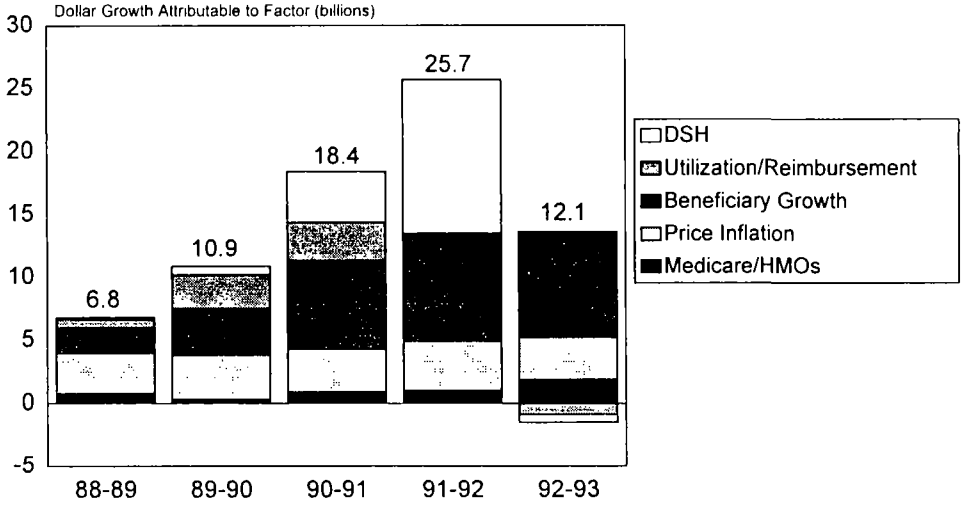
Figure 6

Decomposition of Medicaid Expenditures by Year and Growth Factor



Source. The Urban Institute calculations based on HCFA 64 data, 1995.

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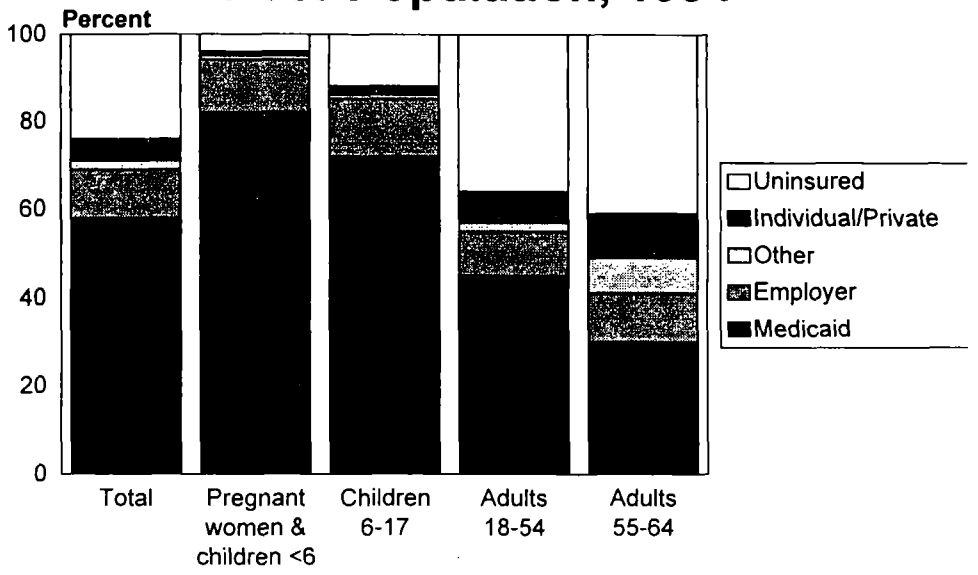
Figure 7

Insurance Coverage of the Poor Population, 1994



SOURCE Urban Institute estimates, 1994

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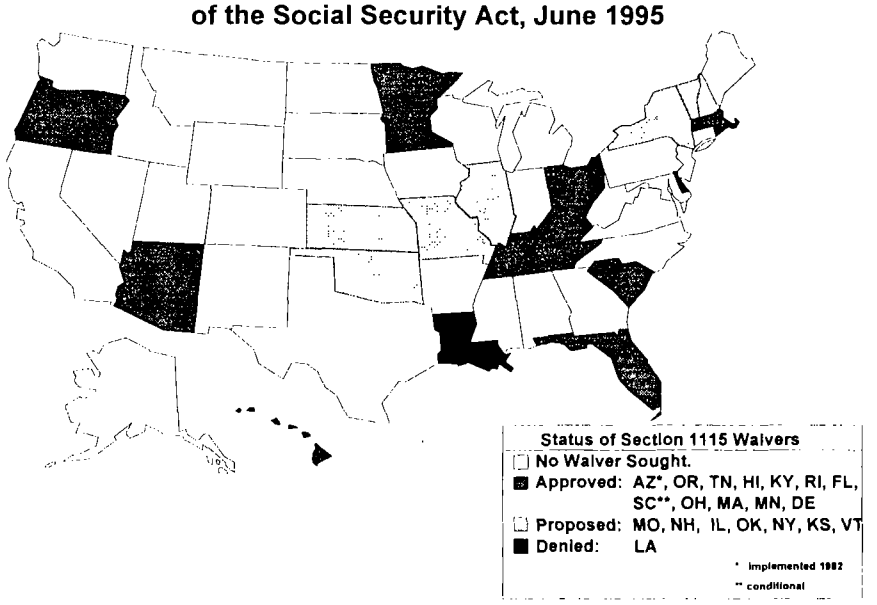
Figure 8

Statewide Medicaid Demonstrations Under Section 1115 of the Social Security Act, June 1995



SOURCE: The George Washington University Center for Health Policy Research, 1995.

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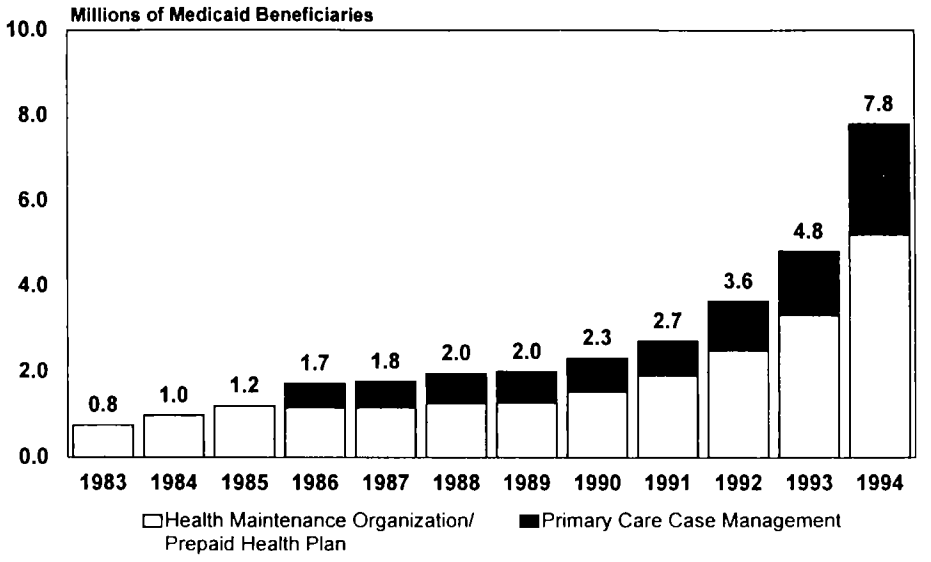
Figure 9

Growth in Medicaid Managed Care Enrollment, 1983-1994



SOURCE: Health Care Financing Administration, 1992 and Health Care Financing Administration, 1994.

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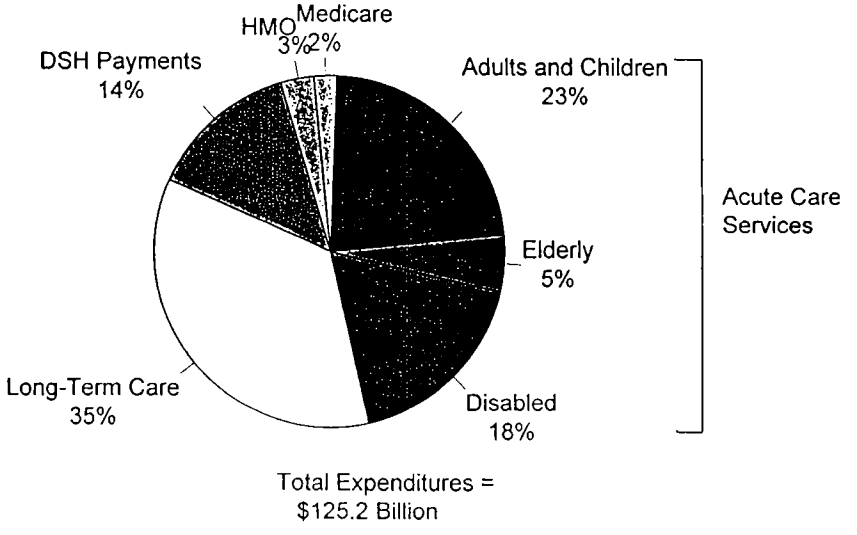
Figure 10

Medicaid Spending by Service, 1993



Total Expenditures = $125.2 Billion

Note: 'HMO' represents payments for Medicaid beneficiaries enrolled in managed care. 'Medicare' represents payments for Medicare Part B premiums and co-payments for low-income elderly.

SOURCE: The Urban Institute analysis of HCFA data.

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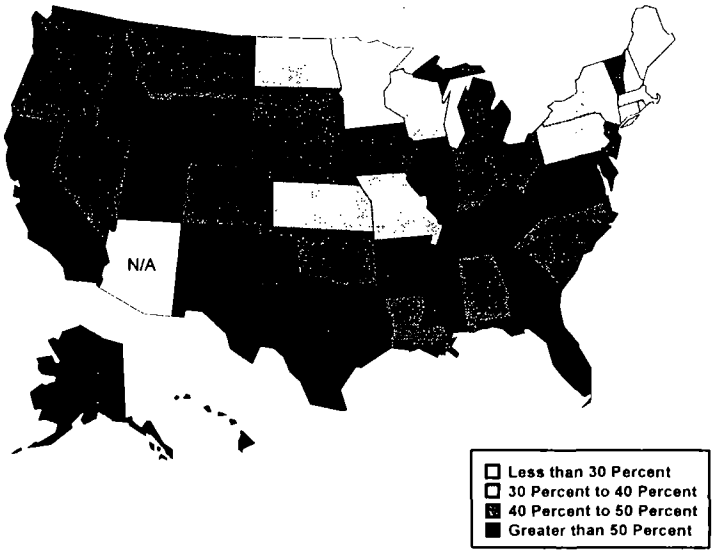
Figure 11

Medicaid Acute Care Spending as a Percent of Total Medicaid Spending, 1993



SOURCE: Urban Institute analysis of HCFA data, 1994

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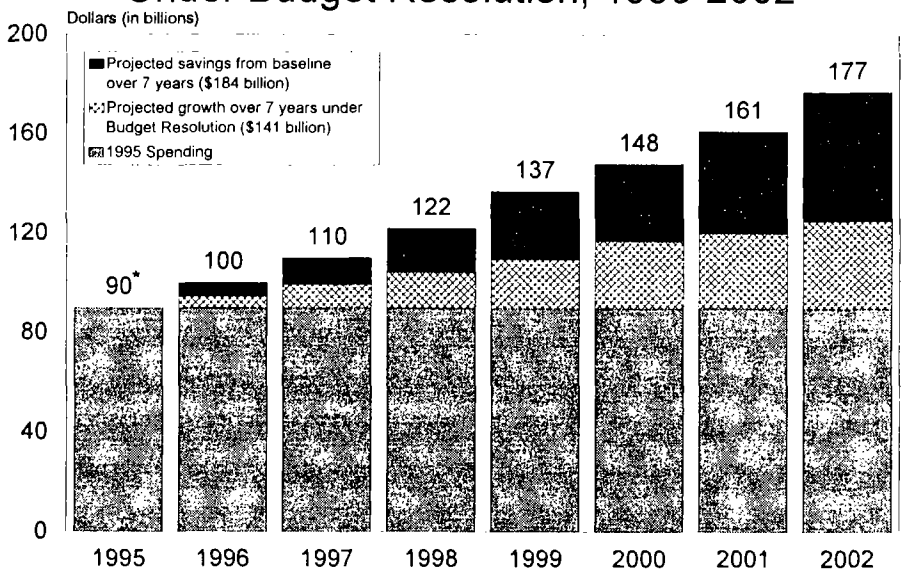
Figure 12

Projected Federal Medicaid Spending Under Budget Resolution, 1996-2002



* The 1995 Budget Resolution uses an estimate of $89 billion for 1995 spending
Source CBO 1995, 1995 Budget Resolution.

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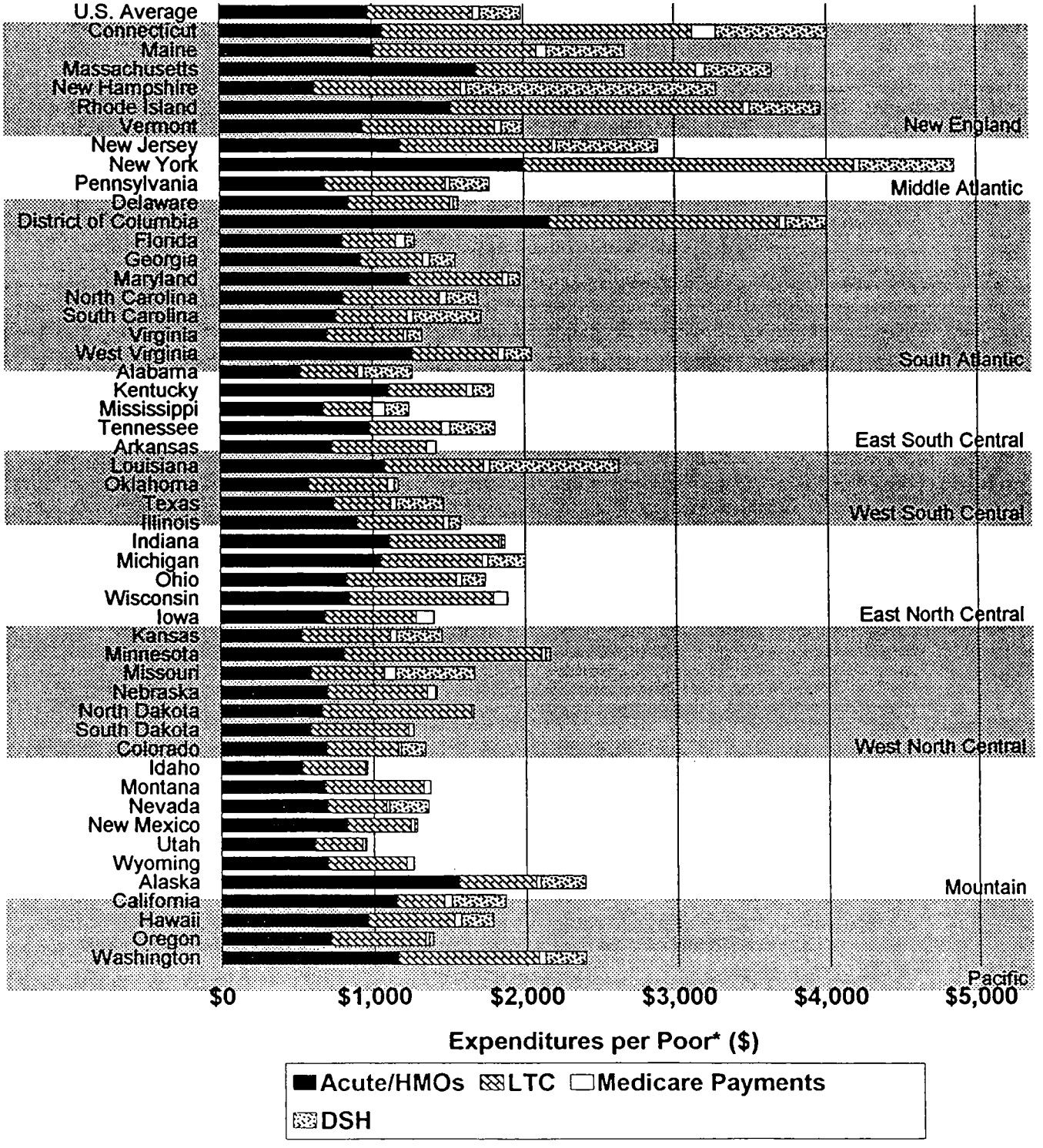
Figure 13

Medicaid Expenditures per Poor* Person

By state, census region, and type of service, 1993

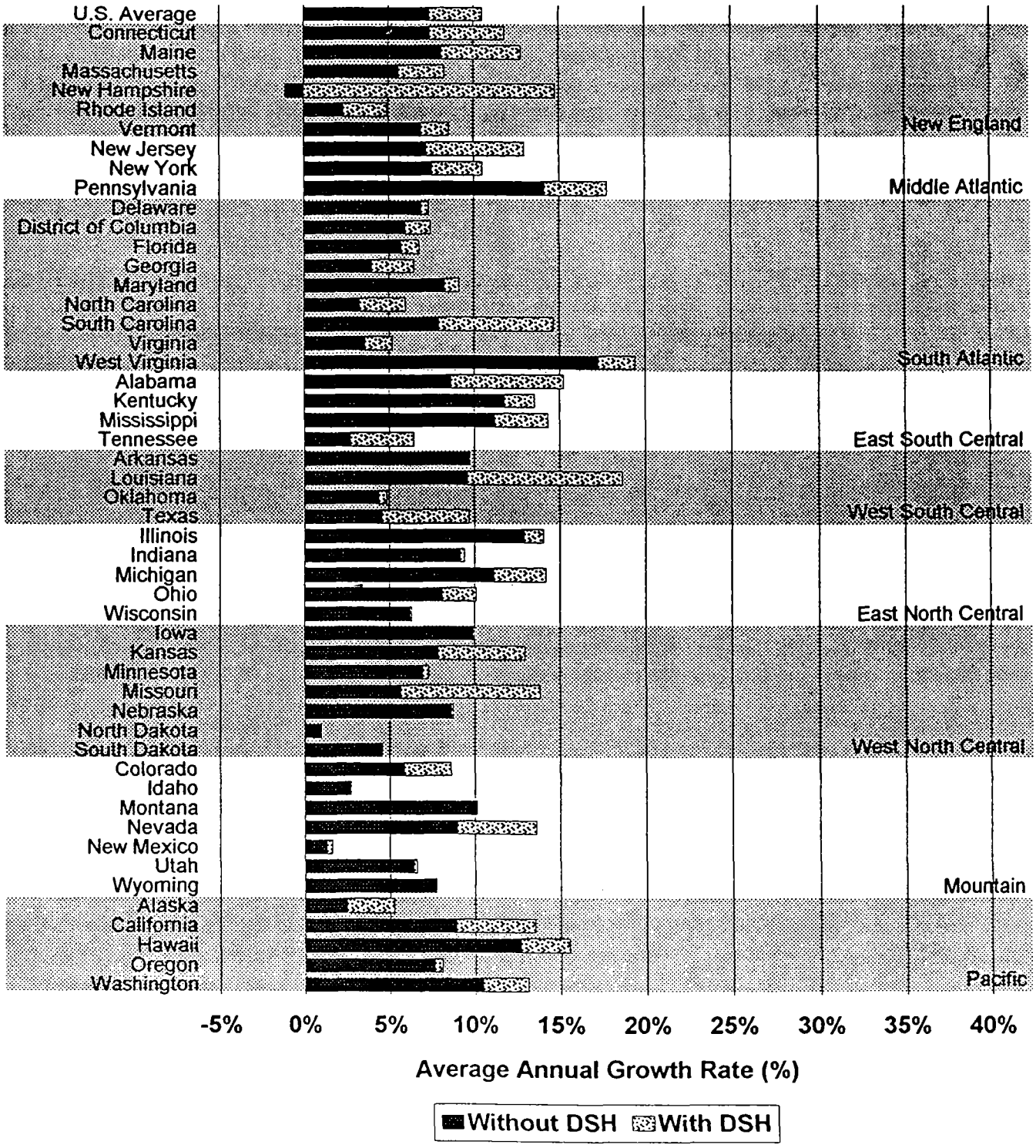


SOURCE: The Urban Institute, prepared for the Kaiser Commission on the Future of Medicaid. Based on the HCFA 64 and the 1991-1993 March Current Population Surveys. 1993 population numbers are estimated. Expenditures do not include Arizona, U.S. Territories, accounting adjustments, or administrative costs. *Poor defined as the number of individuals below 150% of poverty.

Figure 14

Growth in Medicaid Expenditures per Beneficiary

With and w/out disproportionate share payments (DSH), 1988-93



SOURCE: The Urban Institute, prepared for the Kaiser Commission on the Future of Medicaid. Based on the HCFA 64 and HCFA 2082. Does not include Arizona, U.S. Territories, accounting adjustments, or administrative costs.

PER CAPITA CAP VERSUS A BLOCK GRANT

Question:

Why does the Administration support a per capita expenditure cap instead of a block grant for Medicaid?

Answer:

- **We recognize that the growth in Medicaid should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage.**
- **The President has proposed a per capita limit on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but not force States to reduce coverage in difficult times.**
- **Unlike a fixed block grant, per capita spending limits allow Federal spending to adjust to changes in enrollment which may be due to economic conditions and individual needs.**

Prepared by OLIGA, 7/7/95.

STATES' ABILITY TO LIVE WITHIN BLOCK GRANTS

Question:

Since states are able to expand coverage by achieving savings in the Medicaid program, why can't states live within block grants by simply taking the savings and not expanding coverage?

Answer:

- **There are three reasons why states' 1115 demonstration experience does not translate into an ability to live within a Medicaid block grant. They are:**
  - **1115 demonstrations allow states to test innovative delivery systems without risking coverage if the savings do not materialize. Under the budget neutrality agreement, states may use any savings that can be generated by the innovation for purposes consistent with the goals of the Medicaid program. However, if for some reason a state cannot achieve the savings that it anticipates, it can continue to cover the current Medicaid recipients at current payment levels. Thus, the federal government, states and beneficiaries are protected from unexpected Medicaid costs. Under a block grant the state receives a fixed federal payment that does not increase if states cannot manage the program within the cap. This leaves states and beneficiaries at risk.**
  - **Most 1115 demonstrations offer to test innovative delivery systems for part of the program, not the full Medicaid program. Capping the growth of expenditures for the elderly and persons with disabilities, or for long-term care, may not be feasible without harming recipients.**
  - **The proposals discussed by the Republicans suggest that the magnitude of reduction in federal Medicaid payments under a block grant would be large. Speaker Gingrich and Representative Kasich have suggested a 5% cap on Medicaid expenditures, while Senator Gregg has recommended a 4% cap. Both of these growth caps are only slightly higher than recipient growth.**
- **The Kaiser Commission on the Future of Medicaid projected the impact of a 5 percent cap on Federal Medicaid payments to States. Such a proposal would:**
  - **have varying affects on States;**

- reduce overall Federal payments over $166 billion between 1996 and 2002.
+ The percentage losses in Federal payments range from 2 percent ($89 million) in New Hampshire to almost 24 percent ($3.3 billion) in West Virginia.

o The Kaiser Commission concluded that the required reductions in Medicaid spending are "not achievable simply by enrolling people in managed care, controlling utilization, reducing provider payment rates, or eliminating optional services." "States would most likely have to reduce enrollment in order to achieve these savings."

Prepared by OLIGA, 6/16/95.

VARIATIONS IN STATES GROWTH RATES

Question:

Some States grow at much faster rates. How would the President's proposal and the Budget Resolution takes this into account?

Answer:

- President's proposal includes a per person limit as a means of slowing the growth in Medicaid spending.
- A per person limit takes into account those states (e.g. sunbelt states) which have faster growing Medicaid populations.
- Whereas, the Congressional Budget Resolution does not include the assumptions about the method to be employed in cutting Medicaid $182 billion.
- If Congress decides to design a block grant similar to the one proposed in the House Budget Resolution, state variations will be completely disregarded and Federal funds will be distributed to all states at the same rate.
- Clearly, the House Budget approach will place considerable financial pressure on some states while moderating the effect or providing a possible windfall to some other states.

Prepared by OLIGA, 7/7/95.

BLOCK GRANT WITH STRINGS

Question:

What types of strings or standards for States would you suggest if a block grant was established for the Medicaid program?

Answer:

- **The President has proposed some changes to the Medicaid program. However, the President did not propose modifying the entitlement nature for this program. A Block Grant proposal would threaten coverage and that's the President's bottom line.**

Prepared by OLIGA, 7/7/95.

BUDGET RESOLUTION IMPACT ON DEMONSTRATION PROGRAMS

Question:

What would happen to Statewide health reform demonstration programs under the Budget Resolution? Would any of these programs survive under a four percent growth rate?

Answer:

- **We work very closely with States to develop budget projections for Statewide demonstration programs, and none of the ten approved programs could survive under a four percent annual growth rate.**

  -- **Most demonstration States choose to project program spending on a per capita basis in order to protect themselves from unexpected increases in Medicaid enrollment. The Budget Resolution uses an aggregate limit that puts States at risk for enrollment, inflation and utilization increases -- and uses an unrealistically low growth rate.**

  -- **Two States have used an aggregate budget projection, but these States have agreed to annual growth rates that are above the Budget Resolution.**

  -- **We consider national trends and State experience when developing our budget neutrality agreements, but the Budget Resolution considers neither of these factors. This proposal does not adjust for State experience (either high or low growth), and it falls far below the current national projections of 9.3 percent average year to year growth from 1996 through 2000.**

Prepared by OLIGA, 7/7/95.

GROWTH TRENDS IN MEDICAID

Question:

What have been the trends on growth in the Medicaid program and how do they compare to your projections? In addition, what about the projected and actual growth of DSH payments over the years? What do these trends mean?

Answer:

- For FY 1992 to FY 1995, Federal Medicaid outlays have grown an average of approximately 9 percent annually.
- We project that this annual growth rate will continue through FY 2000.
- This annual rate of growth is significantly lower than Medicaid experienced in the early 90's, when the annual average was over 25 percent.
- Much of the high growth in the early 90's was the result of States using tax and donation arrangements to leverage Medicaid funding, primarily for increased DSH payments.
- Since FY 1993, the growth rate declined significantly and stabilized due, in part, to several interacting factors:
  - limits on the State's ability to use tax and donation arrangements;
  - limits on DSH expenditures;
  - an improving economy and a general slowdown in the rate of health care price inflation;
  - no eligibility mandates since FY 1990; and the
  - aggressive use of managed care and utilization management by States.
- Between FY 1989 and 1992, Federal and State DSH spending grew from $.5 billion to about $17 billion. It remained at approximately this level in FY 1993 and FY 1994.
- The current baseline assumes DSH will grow at an average of just under 7 percent per year between FY 1994 and FY 2000.
  - This growth rate is about the same as inpatient hospital spending and reflects an assumption that States will continue to spend less than their full DSH allotments because of current restrictions on taxes and donations and DSH.

Prepared by OACT, 6/16/95.

MEDICAID AGGREGATE GROWTH PROJECTIONS

Question:

What are the aggregate projections of Medicaid growth? How much is driven by growth in enrollment?

Answer:

- **Aggregate Federal Medicaid outlays (including administration costs) are expected to grow from $88 billion in FY 1995 to $138 billion in FY 2000, an average annual growth rate of about 9 percent.**

- **Over the same period, Medicaid recipients are projected to grow from 36 million to nearly 44 million, or an average increase of just under 4 percent per year.**

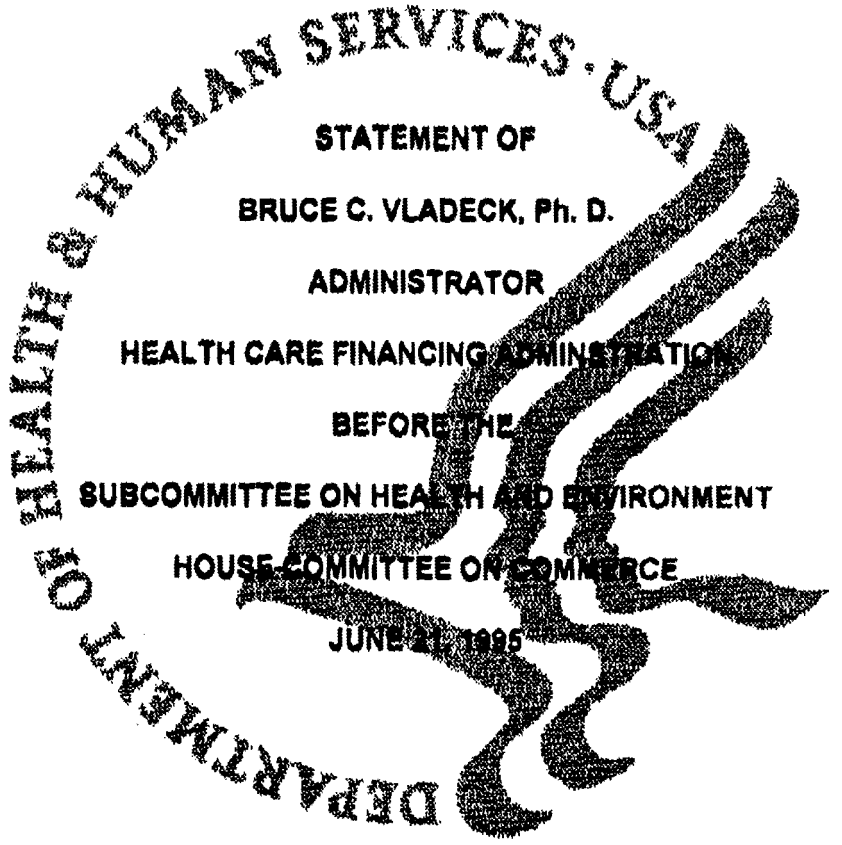
  - **Aapproximately 9 million aged or disabled and 24 million AFDC-type adults and children.**

  - **The elderly and disabled comprised a little over a quarter of the Medicaid population but accounted for nearly $70 billion or 70 percent of Federal and State vendor costs (excluding DSH, capitation payments).**

  - **Conversely, AFDC adults and children comprised over 70 percent of the Medicaid population but only accounted for $30 billion or 30 percent of vendor costs.**

  - **About 1.6 million individuals use nursing facility services in the course of a year and 75 thousand individuals use mental hospitals. However, we do not capture how many individuals are mentally ill.**

Prepared by OACT, 6/16/95.



STATEMENT OF

BRUCE C. VLADECK, Ph. D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

HOUSE COMMITTEE ON COMMERCE

JUNE 27, 1995

HCFA
MEDICARE · MEDICAID

We continue our efforts to control growth in program spending. The substantial program growth of the late 1980s and early 1990s was largely driven by States' use of provider taxes, voluntary donations and disproportionate share hospital (DSH) payments to leverage Federal matching dollars. Fortunately, because of our work and Congress's efforts -- through this Committee and others -- the worst abuses have been tempered.

Today, we project that year-to-year expenditure growth in the Medicaid program will average 9.3 percent through 2000. Because enrollment growth has driven much of the spending increases in Medicaid, our per capita growth rates are much lower. We estimate that Medicaid's annual per capita growth will average 5.4 percent through 2000.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. We believe that this can best be achieved within the current Federal-State partnership. The

Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities and children are Medicaid-eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise, buying-power and technical assistance to achieve program goals.

The President's proposal seeks $54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care models a program option.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be enhanced further. Finally, we are evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment and other provider payment requirements.

Beyond increasing State flexibility, we know that Medicaid cost-containment must be continued. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the House budget proposal would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the House spending cut -- $187 billion over seven years -- is too big to absorb through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither whole-scale use of

managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the House proposal. As the attached chart (Chart 4) demonstrates, Medicaid enrollment growth projections edge very close to the proposed spending limits on block grants. As you know, medical inflation influences public health care spending as well as private spending. Inflation, added to anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the House proposal. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the block grant proposal.

To maintain current coverage levels, the House budget proposal would force States to either absorb a large cost-shift from the Federal government, causing the proportion of State to Federal dollars invested in a State's Medicaid program to increase as States are forced to adjust to lost Federal matching payments. The Urban Institute concludes that if States chose to fill the gap, States would, on average, have to increase their spending by 39 percent to make up for the loss of Federal funds. However, in the current fiscal climate, few States may be able to devote new State dollars to their Medicaid program.

There are fundamental differences between the President's plan and the House budget resolution. We rely on per capita limits to allow for changes in enrollment, while the House proposal is based on an aggregate cap and therefore does not provide room for enrollment growth. In addition, we believe that the States and Congress can realize meaningful savings and additional flexibility without resorting to a block grant.

Conclusion

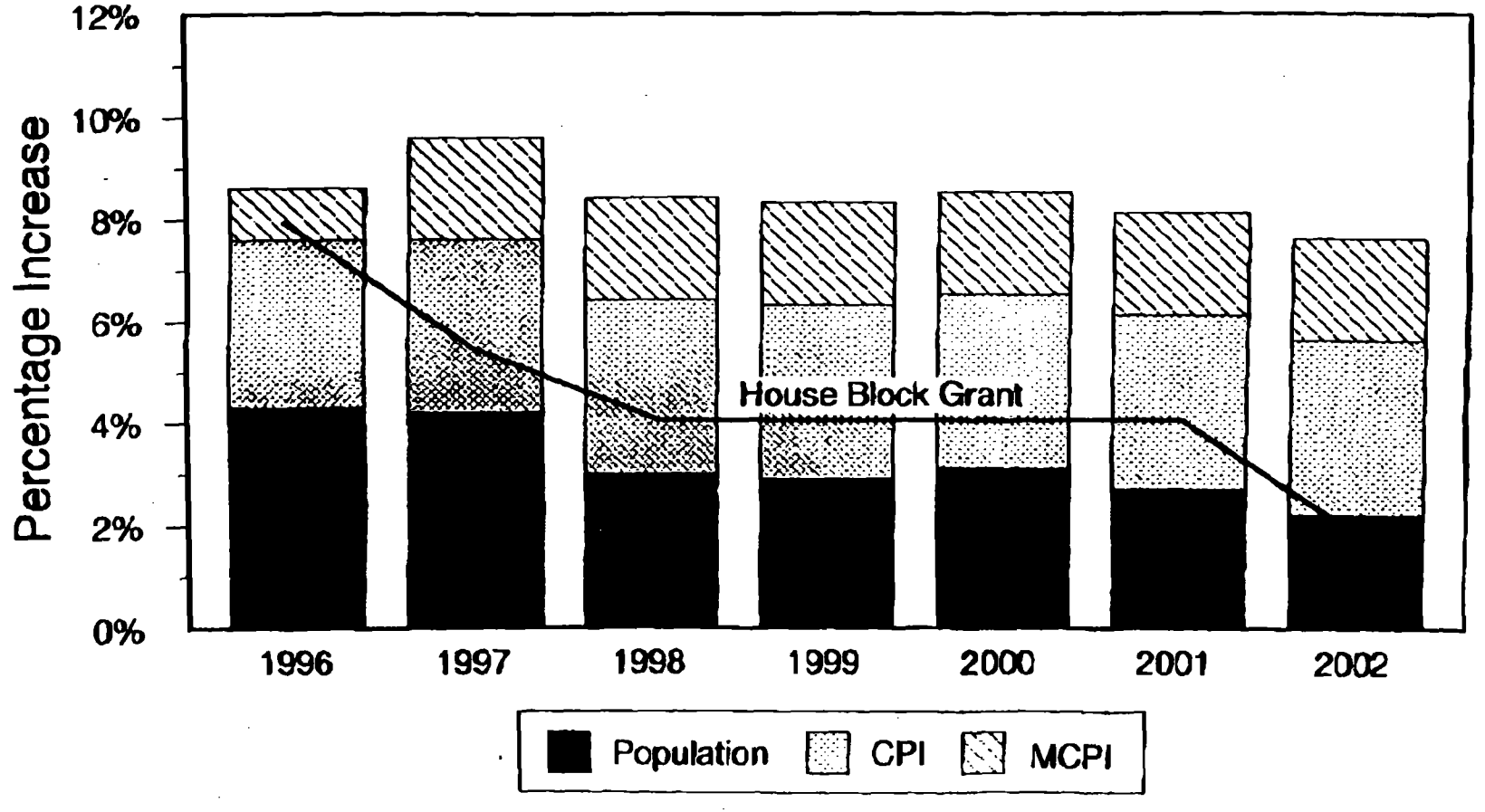
The Medicaid program has a substantial history of success -- together, the Federal government and the States have provided an essential safety net for children, seniors, nursing home residents, the disabled, and other vulnerable Americans.

We are committed to maintaining and building upon Medicaid's successes in order to better serve our beneficiaries. We believe this can best be achieved by making the changes that we know will help both the Federal government and the States control costs and maintain coverage for the Americans we serve today.

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002

All Beneficiaries



P34 AS6190

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

7/24/95

LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 2115

FILE NO: 0

Total Page(s): 16

TO: Legislative Liaison Officer - See Distribution below:

FROM: Janet FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Testimony on Innovations in the Medicaid program.

URGENT

DEADLINE: 3:00 p.m. Tuesday, July 25,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Hearing is before the House Commerce Committee on Wednesday, July 26th. HCFA Administrator Vladeck is the witness.

URGENT

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RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 2115
FILE NO: 0

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter.

Please include the LRM number shown above, and the subject shown below.

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_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Testimony on innovations in the Medicaid program.

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

Testimony of

Bruce C. Vladeck

Administrator

Health Care Financing Administration

Before the

Subcommittee on Health and Environment

Committee on Commerce

United States House of Representatives

July 26, 1995

D-R-A-F-T 7/22/95

Mr. Chairman and Members of the Committee:

I am pleased to be here this morning to discuss innovations in the Medicaid program. Since its inception in 1965, Medicaid has provided a flexible framework for Federal and State efforts to provide health coverage to low-income Americans. Through a Federal-State partnership, the Medicaid program has fostered substantial innovation in both health financing mechanisms and delivery systems for the diverse populations that Medicaid serves.

Background

Medicaid provides health coverage for 36.1 million Americans -- children, senior citizens, individuals with disabilities and others -- through a partnership between the Federal government and the States which provides States with substantial flexibility regarding eligibility, benefits, payment rates, and delivery systems.

Medicaid covers a broad range of services, from well-child care for low-income children and prenatal care for pregnant women to long term care for the elderly. It also provides a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

More than seventy percent of all Medicaid enrollees are mothers and children in low-income families. However, while mothers and

children account for the great majority of Medicaid enrollees, senior citizens and people with disabilities account for most Medicaid spending. Nearly seventy percent of Medicaid spending purchases services for this population (Chart 1).

Programmatic Flexibility

Medicaid provides States with great leeway to decide who to cover through the Medicaid programs, what benefits are included in the program, and how these services are delivered. The Federal-State partnership also provides States with ample flexibility to develop program management initiatives and respond to dramatic changes in their citizens' health status or coverage needs. In fact, to speak of the Medicaid program is almost a misnomer. The States and Territories have created 56 different Medicaid programs, each one tailored to fit the needs, the delivery systems, and the circumstances of its State.

Eligibility and Benefits

States largely determine who is eligible for Medicaid. The largest group of Medicaid enrollees are families who receive cash assistance from the Aid to Families with Dependent Children (AFDC) program. Since the States define their own AFDC eligibility standards, they simultaneously govern Medicaid eligibility.

Similarly, while Federal law requires States to extend

eligibility to several mandatory groups -- pregnant women, infants and children up to age six in families with incomes below 133 percent of the poverty level, children up to age 13 in families with incomes below the poverty level, and (in most States) individuals who are eligible for the Supplemental Security Income (SSI) program -- States may use additional options provided by statute to extend coverage beyond these parameters. For example, States may extend eligibility to institutionalized aged and disabled persons by covering individuals with high medical expenses -- the "medically needy". Thirty-four States have expanded coverage for pregnant women and children beyond Federal minimum guidelines, while several States have liberalized financial eligibility standards to cover additional low- and moderate-income women, children and senior citizens.

States are also free to cover additional Medicaid services beyond the ten services required in law. 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. As Chart 2 illustrates, in 1993 only 43.5 percent of Medicaid

service payments (excluding disproportionate share hospital (DSH) payments) was spent on mandatory services provided to mandatorily eligible individuals. The balance, over 56 percent, was spent by States on optional services and populations they have chosen to cover.

States also have broad freedom to establish payment rates. Beyond current restrictions on payments to hospitals and nursing homes, States have developed pioneering approaches to paying providers. For example, States have enhanced payments to primary care physicians who decrease emergency room utilization among their Medicaid patients. Similarly, States have developed methodologies for adjusting payments to nursing homes based on the health status and complexity of their patients needs.

Program Initiatives

States also have significant autonomy in day-to-day operations of their Medicaid programs. This freedom enables States to pursue management initiatives that respond to their particular administrative or programmatic concerns, rather than following a Federally-prescribed process.

For example, Massachusetts is pursuing a number of innovative quality improvement initiatives in Medicaid managed care. Massachusetts' asthma management program engages Medicaid-contracting health maintenance organizations (HMOs) in the

State's efforts to measure and improve plans' effectiveness in managing asthma care for Medicaid enrollees. Similarly, the Massachusetts Health Care Purchaser Group will, in time, buy coverage for public and private enrollees as a single block while making purchasing decisions on cost and quality criteria.

In addition, numerous States have creatively responded to the statute's drug utilization review (DUR) requirements. The DUR process reviews prescriptions for appropriateness, medical necessity and cost-effectiveness in order to ensure that patients receive the drugs they need, avoid adverse drug reactions, combat fraud, waste and abuse, and lower drug spending. Innovative State strategies include on-line, point-of-sale systems that provide pharmacists with electronic access to information on the appropriateness of a particular prescription. This process may include screening a prescription against the beneficiary's diagnosis and other prescriptions they may be taking. These systems also enables States to profile physicians' prescription patterns, pay pharmacy claims electronically at the time of dispensing, and verify Medicaid eligibility.

I have also witnessed first-hand the responsiveness and State-level flexibility that is possible within the Medicaid program. In the mid- and late 1980's, before I came to the Health Care Financing Administration (HCFA), I was involved with helping New York respond to an acute public health crisis that demanded a

creative response -- the AIDS epidemic. While many AIDS patients' health services are covered by Medicaid, some of these patients had difficulties obtaining services they needed. New York State, the City government, and the provider community responded by developing several programs that emphasized care coordination, heightened criteria for participating providers and increased availability of services for HIV and AIDS patients.

For example, hospitals that are designated AIDS centers must meet clinical standards of excellence and provide case management services for patients with AIDS and HIV-related conditions that coordinate care beyond the hospital's walls. In return, they receive increased Medicaid reimbursement. Related initiatives use a similar approach for primary care providers, home care and long term care for these patients.

New York had the freedom it needed to develop this innovative approach to the AIDS crisis because this flexibility is built into the Medicaid program. No waivers were required, and New York could adapt financing and service delivery programs quickly -- and be sure of the Federal share of funding -- in responding to the AIDS epidemic.

Managed Care and Home and Community-Based Services

Recently, States have re-designed their Medicaid programs in response to changes in the health care system. This has led to a

substantial increase in Medicaid managed care enrollment and enhanced availability of home and community-based services and other care for disabled populations.

States have developed managed care programs to target a number of State-specific priorities. A sample of Medicaid managed care arrangements includes: Alabama's program to enhance prenatal services for high-risk pregnant women; KenPAC, Kentucky's program that pioneered managed fee-for-service systems; and capitated mental health and substance abuse services in Massachusetts and Utah. States have used program waivers and voluntary managed care enrollment to increase Medicaid enrollees' access to services while controlling Medicaid costs. By June of last year, 23 percent of all Medicaid enrollees participated in managed care programs -- and this year's enrollment figures should be significantly higher.

Home and community based services programs also allow States to manage elderly and disabled individuals' care efficiently. Every State operates a home and community based services program -- in addition to the disabled and elderly, States are also serving people with HIV/AIDS, traumatic brain injury patients, and medically fragile children through these programs.

States have also enhanced their Medicaid programs by developing targeted case management programs for Medicaid beneficiaries.

Under these programs, States coordinate a range of social, educational, housing, and other social services in addition to medical care. States may choose to deliver these services to a particular segment of the Medicaid population, such as mentally retarded or developmentally disabled individuals, people with HIV/AIDS, high-risk pregnant women and the mentally ill. States define the target group, provider qualifications, payment rates, and any limits on the scope of services.

Demonstration Programs

States and the Federal government have also been deeply engaged in developing Statewide demonstration programs. This Administration is particularly committed to providing States with ample flexibility to test new approaches to covering low-income populations and delivering health services under section 1115 of the Social Security Act.

Historically, States had sought demonstration authority to test relatively narrow changes, such as changes to the Medicaid benefit package, payment methodologies or eligibility requirements for a defined group of beneficiaries or services. Since 1993, States have begun to develop broad, Statewide reform programs under this demonstration authority. To date, we have approved ten Statewide health reform demonstrations, and we are working with States on several additional proposals.

These States will experiment with innovative financing and delivery systems on a broad scale. For example, Florida intends to develop a ground-breaking health alliance system that will broker private health coverage for low-income and uninsured Floridians through a community purchasing network, while Hawaii has created a seamless system of insurance coverage for more than 95 percent of its population through a combination of Medicaid expansions and a requirement that employers provide health insurance to their employees.

States also continue to develop smaller-scale demonstration programs under 1115 demonstration authority. HCFA has approved twenty-four smaller, more targeted demonstrations since January 1993. Some of these demonstrations provide preventive services to low-income children, extend coverage of family planning services beyond the sixty-day postpartum limit, and establish alternative delivery systems in sub-state geographic areas.

Balancing Innovation and Federal Responsibility

Statewide health reform demonstrations are particularly complex examples of State innovation. Through these programs, States can re-allocate their projected expenditures over the next five years to cover additional low-income, uninsured residents, restructure their delivery systems or test other new ideas. These broad-based changes therefore create an immense challenge to both the States and the federal government, because they require a large

number of policy decisions and create a host of administrative and implementation issues that must be addressed. To ensure that these demonstrations are successful, States and the Federal government must work together as partners. Because we have worked with a number of States as they designed and implemented their demonstration programs, we are better able to foster new State innovations by building upon experiences with other States.

We must also balance our commitment to State flexibility within demonstration programs with our responsibility to Medicaid beneficiaries and American taxpayers. We need to ensure that Medicaid beneficiaries receive high quality services and maintain access to health services. We also need to protect Medicaid's fiscal integrity and insure that Federal dollars are well spent in these programs. We not only foster State innovation by supporting these demonstration programs -- we also ensure that broader public interests are protected.

We have similar responsibilities in the regular Medicaid program. HCFA provides monitoring and oversight to ensure that Medicaid beneficiaries and taxpayers are well-served by State programs. We also provide significant technical assistance to help States work through program management problems and develop new administrative initiatives.

Block Grants and Flexibility

Proposals before Congress to block grant the Medicaid program will actually rob States of much of the flexibility they have under the current Medicaid program. While block grants purport to provide States with unlimited freedom to experiment within their Medicaid programs, the $182 billion cut in Medicaid spending required by the Budget Resolution will severely restrict States' abilities to maintain coverage for current populations and respond to developing health needs, much less pursue innovations.

To maintain current coverage levels, States would have to raise taxes and devote a greater proportion of State dollars to the Medicaid program. The Urban Institute's analysis indicates that if States try to make up for lost Federal funds, they would, on average, have to increase their projected Medicaid spending by 39 percent. Some States, of course, would face even greater cuts in Federal matching payments. As Chart 3 demonstrates, the proposed Federal spending limits would grow at a rate that is only slightly higher than enrollment projections, thus leaving little room for increases in the cost of providing health care. To live within these caps, States would be forced to cut Medicaid eligibility and covered services. While States may have additional freedom under a block grant mechanism, they would have to use this freedom to cut their Medicaid programs in order to absorb significant decreases in Federal Medicaid spending. Innovation, under these circumstances, would be nearly

impossible, while creative responses to new public health challenges -- such as New York's AIDS program I described earlier -- would also be very difficult.

Our experience with Statewide health reform demonstrations indicates how innovations would be threatened within a block grant environment. States have been able to restructure their Medicaid delivery systems and cover additional low-income residents through these demonstrations. However, State spending in these programs has been limited by baseline spending projections under current law, not to the more restrictive confines of the Budget Resolution. Many of these programs could not be sustained if these Medicaid proposals were enacted and further innovation would be stifled.

In contrast, the President's proposals for enhancing State flexibility -- which go beyond even the latitude that is available through the current program -- will further support State innovation. For example, we want to give States more flexibility to develop Medicaid managed care programs by making managed care a program option, rather than requiring States to obtain waivers from HCFA. Similarly, we are evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment.

We intend to build upon States' current flexibility to

dramatically reorganize their Medicaid programs through demonstration programs or Medicaid managed care initiatives, develop new management strategies, add additional benefits or make optional categories of individuals eligible for Medicaid. This freedom is available within Medicaid today, because this program was designed as a partnership between the Federal government and the States -- with the States having much of the decision-making power.

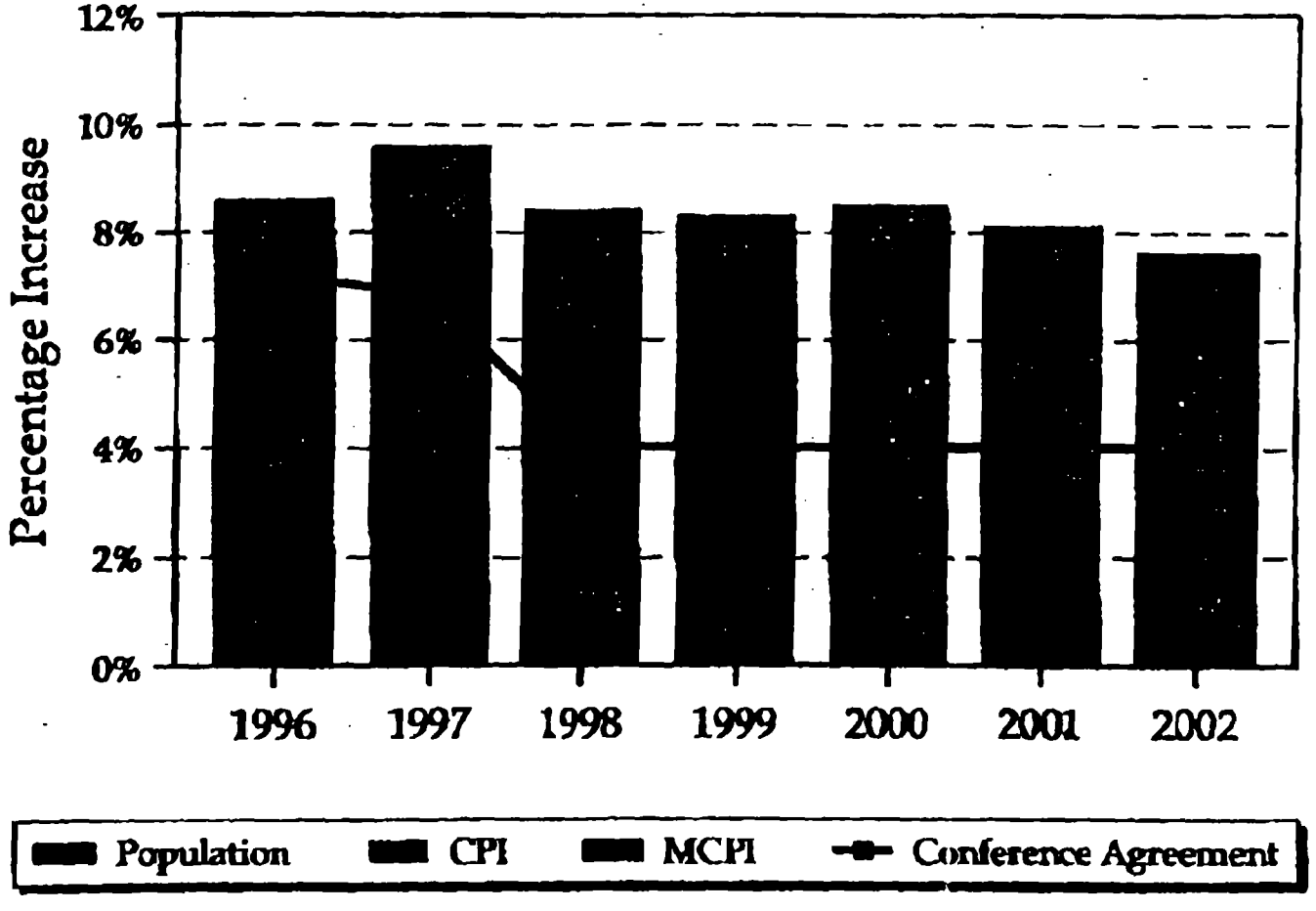
Conclusion

Medicaid has a long history of innovation. States have always been free to design their Medicaid programs to respond to their specific needs. The Clinton Administration has demonstrated its commitment to enhancing State flexibility. We know that States will face new problems in the years ahead, and we believe that the Administration's proposed program structure can enable them to meet these challenges.

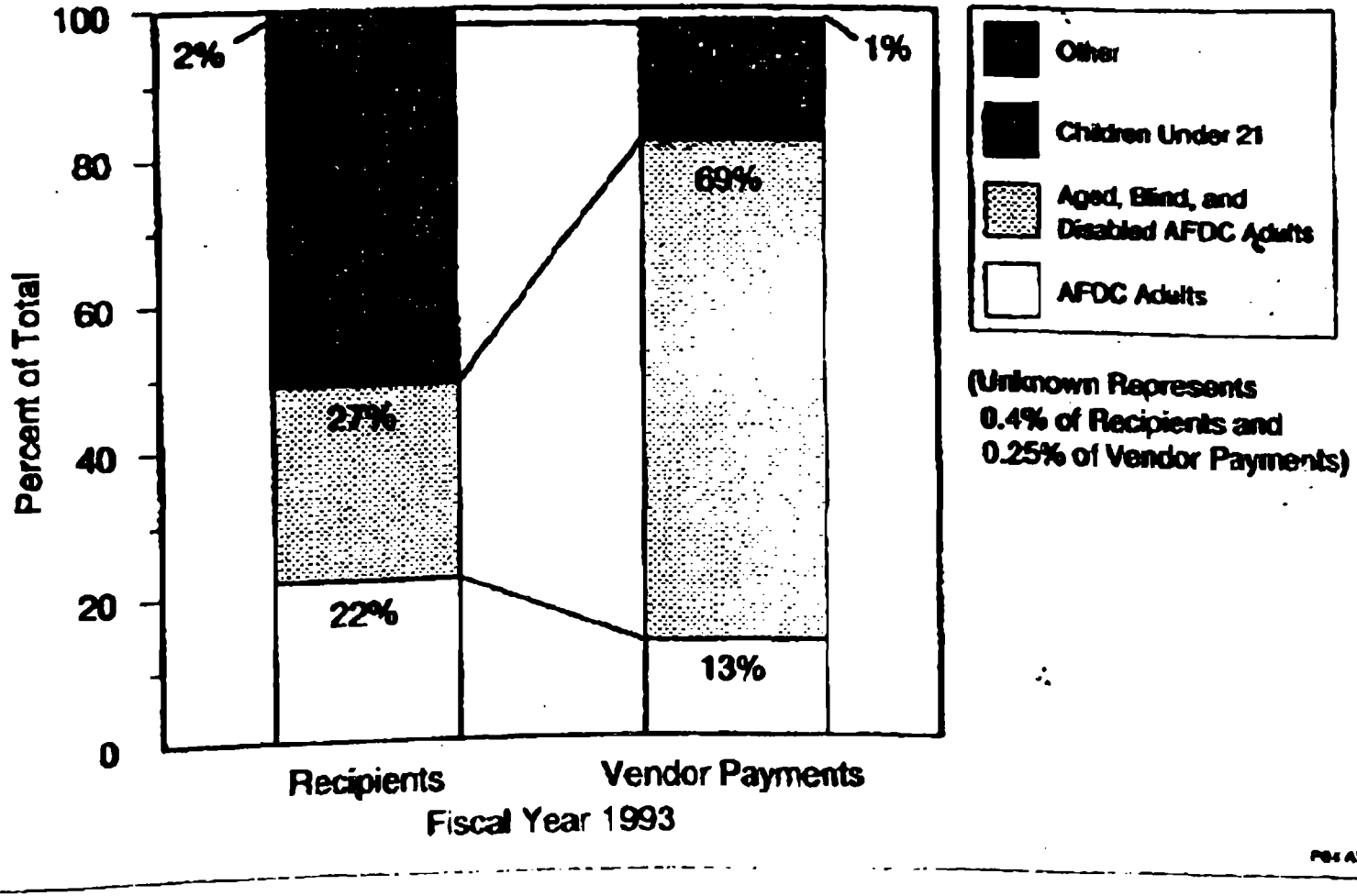
In contrast, proposals that narrowly limit Federal participation within the Medicaid partnership threaten the balance between State flexibility and broader Federal interests, while restricted Federal matching payments would inhibit States' abilities to cover their low-income populations, develop new approaches within their programs, and respond to the challenges ahead.

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002 for All Beneficiaries



Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility



Total Expenditures for Mandatory and Optional Medicaid Services and Populations: FY 1993

(Dollars in Millions)

Mandatory People	47,885	23,681	71,566
Optional People	12,052	26,358	38,409
TOTAL	59,936	50,039	109,975

As A Percent of Total

Mandatory People	43.5%	21.5%	65.1%
Optional People	11.0%	24.0%	34.9%
TOTAL	54.5%	45.5%	100.0%

Excludes DSH, collections and adjustments

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
OFFICE OF HEALTH LEGISLATION

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200 Independence Avenue, SW
Washington, D.C. 20201

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REMARKS:

Testimony of

Bruce C. Vladeck

Administrator

Health Care Financing Administration

Before the

Committee on Finance

U.S. Senate

July 12, 1995

Mr. Chairman and Members of the Committee:

I welcome the opportunity to be here this morning to discuss State flexibility under the current Medicaid program and this Administration's efforts in expanding and assisting States in using that flexibility. The Medicaid program was conceived as a Federal/State partnership, and this Administration has made major strides in strengthening the relationship. Nonetheless, we recognize the need for additional work to build on this partnership.

Introduction

Before beginning our discussion about State flexibility, I would like to highlight some essential facts about the Medicaid program.

First, Medicaid's spending growth has moderated. A widespread myth holds that Medicaid is growing out of control, far faster than other parts of the health care sector. Chart 1 shows the contrary. In fact, the growth in Medicaid spending on a per person basis has not exceeded the growth in private health insurance since the period between 1989 and 1992. At that time, States used provider taxes combined with disproportionate share hospital payments as a means of increasing Federal matching funds.

Second, the lion's share of Medicaid spending is devoted to the aged and disabled. As chart 2 indicates, the aged and disabled represent 30 percent of Medicaid recipients and account for 70 percent of the spending.

Third, Medicaid is a critical safety net for a wide variety of populations with very diverse health needs. State Medicaid programs cover prenatal care for low and moderate-income pregnant women, health care for children, and long-term care for low-income senior citizens. They also provide a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries. For many of these populations, whose disabling conditions or medical costs preclude them from purchasing insurance, Medicaid is the only system of care.

Chart 3 shows how Medicaid coverage increased between 1989 and 1994 while employer-based insurance declined. Medicaid brings an important stability to the health care marketplace by offsetting losses in private insurance coverage. Although different populations are involved, Medicaid coverage increases have leveled the overall percent of uninsured and thereby maintained an essential balance in the cost shift to the private sector.

State Flexibility Under Current Law

Medicaid was enacted in 1965 to provide access to coverage for low-income Americans. Medicaid represented a consolidation of several Federal grant programs administered by the States. The nation's most vulnerable populations -- low-income senior citizens, individuals with disabilities, and children -- are Medicaid eligible in every State.

Nevertheless, the current Medicaid program is actually 56 different programs. The States have tailored their programs to meet the varying specific needs of their individual populations. The diversity across States' Medicaid programs is a direct result of the inherent flexibility of the program.

The States' Medicaid programs are dynamic. In partnership with HCFA, States are continuing to find innovative ways to improve health care delivery, enhance access, and control rising health care costs.

Flexibility in Coverage

The original Medicaid statute only required States' Medicaid programs to provide a set of five core benefits, including inpatient hospital services, outpatient services, physician services, laboratory and x-ray services, and skilled nursing home services. States could also cover any of ten optional benefits.

Over the past 30 years, Congress has added seven services to the list of required benefits and has expanded the list of optional benefits that States may offer to include 30 services.

States use their flexibility to cover optional services to customize their Medicaid programs to serve the special needs of their vulnerable populations. For example, Utah provides 28 optional benefits to its Medicaid beneficiaries while Delaware offers 15

optional benefits. A few benefits, such as prescription drugs and clinic services, are offered by almost all the States. On average, the States cover about 24 optional benefits. Only 44 percent of Medicaid spending in 1993 was for mandatory services provided to mandatorily eligible individuals. Chart 4 shows that over 50 percent of the total Medicaid spending was for optional services and populations elected by the States.

Flexibility in Determining Eligibility

States have significant flexibility in determining who is eligible for their Medicaid programs. The largest portion of the caseload are those on the Aid to Families with Dependent Children (AFDC) program. The eligibility standards for this program are directly determined by States.

States may also extend Medicaid coverage to low-income families above the Federal minimum guidelines and to individuals with large medical expenses. The States use this flexibility to make their institutionalized aged and disabled populations eligible for Medicaid.

Medicaid statute requires States to cover pregnant women and children under age 6 up to 133 percent of the Federal poverty guideline. In addition, States must also phase-in coverage for all other children over age six born after September 30, 1983. Thirty-three States use Medicaid flexibility to expand coverage for pregnant women and children with family incomes beyond the Federal minimum guidelines. Twenty-seven of those States

cover pregnant women and infants to at least 185 percent of the Federal poverty guidelines.

In addition, States have further flexibility to liberalize financial eligibility criteria for certain high-priority populations under the authority of section 1902(r)(2) of the Social Security Act. Under this provision, States are able to apply more liberal financial eligibility standards by disregarding certain income and/or assets.

Several States have used the authority of section 1902(r)(2) as a means of expanding eligibility for children beyond 185 percent of the Federal poverty level and accelerating the phase-in coverage for children below the poverty level. For example, both Delaware and West Virginia have used the 1902(r)(2) authority to cover all children under age 19 up to the Federal poverty level.

Flexibility in Service Delivery and Financing

States have additional flexibility to design their Medicaid programs through various program and research waivers.

Managed Care Programs

Under freedom-of-choice waivers, States can establish primary care case management programs, require Medicaid beneficiaries to choose among managed care plans, and selectively contract with hospitals, nursing facilities, or other providers. States use this

flexibility to target coordinated and comprehensive managed care systems to their high-risk populations and to purchase services in a cost-effective manner.

States are taking full advantage of the flexibility to design managed care programs for their Medicaid populations. Thirty-nine States now operate 75 managed care programs covering 8 million Medicaid eligible individuals.

States have also developed managed care programs to target a number of specific priorities. For example, the Kansas Primary Care Network (PCN), which was established in 1984, was one of the first managed care programs to provide physician case management to beneficiaries. Under this program, the State assigns each Medicaid beneficiary in the seven most populous counties to a physician case manager. The case manager is responsible for managing all of the recipient's health care. Over 30 percent of the State's Medicaid eligibles are now enrolled in this PCN program. HCFA reviews have shown the program to be cost effective as well as providing better access to services for the participating Medicaid beneficiaries.

Similarly, Florida has developed MediPass, an extensive primary care case management program. The State pays MediPass primary care providers a $3 per member per month case management fee to coordinate care for their MediPass enrollees. These providers manage many of their patients' health needs, including specialty referrals, but continue to be paid on a fee-for-service basis for the health care services they provide.

Utah has developed a ground-breaking prepaid mental health program for Medicaid beneficiaries. The State contracts with three community mental health centers to provide inpatient and outpatient psychiatric and related physician services. The first year results indicate that contractors were able to reduce utilization of inpatient psychiatric services while increasing the percentage of eligibles served in their catchment areas.

Home and Community Based Services Programs

Home and community based services waivers give States the ability to establish home and community based care programs that provide services to beneficiaries in the community setting rather than in nursing homes and hospitals. Home and community based services programs allow States to manage care provided to the elderly and disabled populations in an efficient manner while increasing the consumer's satisfaction with the services provided.

States have made extensive use of this authority as well. Over 205 programs are now operating. Every state is currently serving developmentally disabled and aged individuals under a home and community based services program. States are also serving people with HIV/AIDS, those with traumatic head injury, and medically fragile children.

HCFA is actively involved in encouraging and assisting States in using this flexibility. Recently, Alaska officials requested HCFA assistance in developing their home and community based services program. Our staff went to Alaska and helped the State

design four home and community based services programs to meet the unique needs of its citizens. The programs were quickly reviewed and approved. Other States are also increasingly seeing HCFA as a partner in the development of their programs.

Service Delivery and Financing Demonstrations

Medicaid's research and demonstration authority, section 1115, gives States much broader opportunities to develop and test new and innovative ideas. States can use this authority to develop sub-state and statewide demonstrations of new approaches to health care financing and delivery.

This Administration has approved ten statewide section 1115 demonstrations. Several additional States have submitted proposals that are currently being reviewed. No previous Administration had been willing to give States a comparable degree of flexibility as the Clinton Administration. We have actively encouraged States to develop innovative reform demonstrations including managed care approaches working with the private sector and public health providers.

One of the first acts of this Administration was to approve the Oregon Reform Demonstration. The Oregon request, which was the first approval of a statewide demonstration in 10 years, had been denied by the previous Administration.

Since that point, innovative reform proposals have been approved in Hawaii, Tennessee,

Rhode Island, Kentucky, Florida, Ohio, Massachusetts, Minnesota, and Delaware. These States are experimenting with new ways of financing and delivering essential health care. For example, Delaware has created seamless coverage for those below the Federal poverty level. Rhode Island is testing the effectiveness of extending family planning benefits and contracting with an FQHC-based managed care system.

In addition, the Administration has approved twenty-three smaller, more targeted section 1115 demonstrations. Some of these demonstrations provide preventive services to children, test extended family planning services, and establish alternative delivery systems.

For example, under the Iowa Drug Utilization Review Program, the State conducts on-line prospective drug utilization review. There are 250 pharmacies participating in the project either as randomized control or experimental entities.

Further, the multi-State Nursing Home Case-Mix and Quality Demonstration which is operating in Kansas, Maine, Mississippi, New York, South Dakota, and Texas, will test a combined Medicare and Medicaid nursing home payment and quality monitoring system. This system will significantly enhance the quality assurance process in nursing facilities.

Flexibility in Program Administration

States have considerable flexibility in establishing provider participation criteria. Certification requirements for institutions such as hospitals and intermediate care facilities for the mentally retarded, physician qualification requirements, and requirements for other providers are determined primarily by the States.

Similarly, States have latitude in setting provider payment rates. Although the Boren Amendment and Medicare accounting principles provide general lower and upper bounds with respect to payments for hospitals and nursing homes, States have significant flexibility to establish payment rates for these providers. States have still greater flexibility for other classes of providers.

Another area in which States have flexibility is targeted case management. States use the Medicaid program to coordinate not only medical services but a range of social, educational, housing, or other services for Medicaid beneficiaries. States have the ability to use case management for as many segments of the Medicaid population as they believe would benefit from such coordination.

For example, States have established programs to coordinate the service needs of mentally retarded individuals, the mentally ill, individuals with HIV/AIDs, high-risk pregnant women, and at-risk children. In each case, the State is afforded the flexibility to define the level of service coordination provided, the target group, provider

qualifications, level of payment, and any limits on the scope of services. This has enabled States to develop individualized plans of care for their most vulnerable citizens that weave together a tapestry of support from the diverse threads of Federal, State, local, and private resources.

With HCFA cooperation and assistance, many States are collaborating with various health-related and community organizations to design and implement programs that meet a comprehensive range of health needs of children. Because children's health is frequently affected by a number of socioeconomic conditions such as poverty, substance abuse, and fragmented health resources, no single agency or program can address all of their needs. Increasingly, communities are using public/private arrangements to develop integrated services networks. These networks disseminate information and serve as referral links between women and children in the community and the State's Medicaid, Maternal & Child Health, Women Infants & Children, and primary care programs.

Further, States have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

-- Introducing magnetic-strip cards to provide immediate access to information about eligibility and third-party liability; and

-- Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. The President proposes a combination of policies to expand State flexibility and reduce the growth of Federal Medicaid spending. This combination includes expanding managed care, reducing and better targeting Federal payments for hospitals that serve a high proportion of low-income people, and limiting the growth in Federal Medicaid payments to States for each beneficiary. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. This improvement can best occur within the current Federal-State partnership. The Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities, and children are Medicaid eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise and assistance to achieve program goals.

The President's proposal seeks $54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best

achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care a program option that States could elect without extensive Federal review.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be further enhanced. HCFA supports the NGA recommendations to repeal requirements for payment rates to obstetricians/pediatricians and to replace the HMO enrollment provisions called the "75/25 rule" (which requires HMOs to maintain at least 25 percent private enrollment) with more outcome-based quality assurance methods. We support provisions that would allow managed care entities to better serve rural areas. We are also evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment.

We recognize that the growth in Medicaid should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force

them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the reductions required in the conference agreement on the budget resolution would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the spending cut -- $182 billion over seven years -- is too big to be absorbed through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither wholesale use of managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the conference agreement. As Chart 5 demonstrates, The Congressional Budget Office's (CBO) projections of Medicaid enrollment growth alone edge very close to the

proposed spending limits in the budget resolution. As you know, medical inflation impacts public health care spending as well as private spending. Inflation, added to CBO's anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the budget resolution. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the budget resolution.

The President's plan and the budget resolution are fundamentally different. We rely on per capita limits to allow for changes in enrollment, while the budget resolution cuts spending to the point that any unexpected change in enrollment would shift considerable cost to the States or force a reduction in coverage. We fear that States may be forced to reduce coverage, thereby adding to the number of uninsured at an alarming rate. The States and Congress can realize meaningful savings and additional flexibility without completely dismantling the Medicaid program.

Conclusion

The Medicaid program affords States a considerable amount of flexibility in the design of their individual programs. The Clinton Administration has worked with States to further increase flexibility and permit States' use of innovative means of service delivery and cost containment.

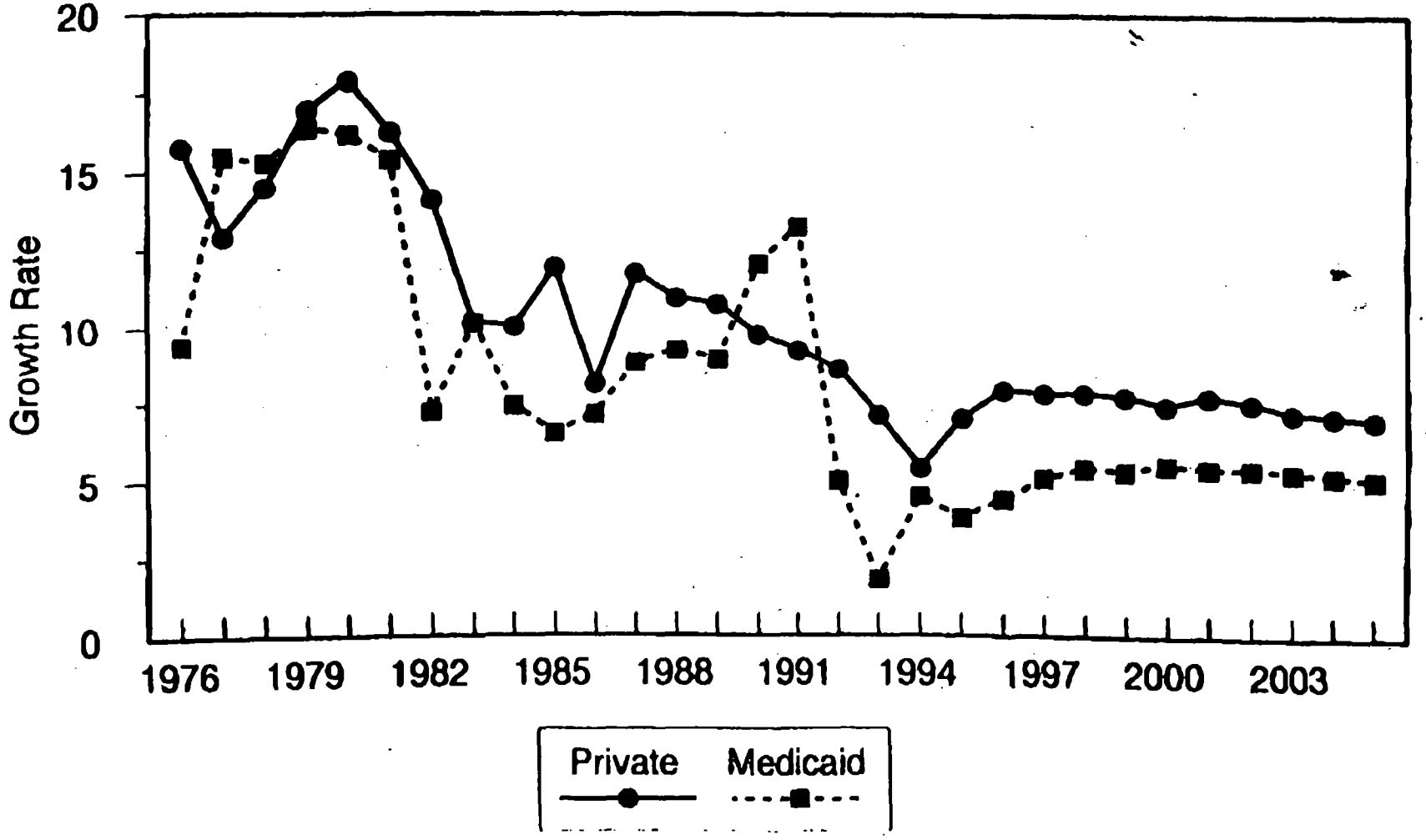
We believe that the President's plan is the right way to improve the Medicaid program. Flexibility can be achieved within the current program, without taking apart the structure of this program that has served as a critical safety net for populations without many alternatives.

Rather than simply block granting the program which, given the loss of Federal funds, may reduce flexibility for many States, we propose a more targeted approach; building upon the inherent program flexibility while also protecting coverage for the nations most vulnerable populations. We want to work with Congress to improve this program in ways that increase State flexibility, control costs and better serve beneficiaries, as the President has proposed.

Chart 1

Annual Percent Increase in Medicaid Expenditures per Enrollee vs. Private Health Insurance

1976-2005



*Private health expenditures per insured person & Medicaid Expenditures per recipient

Source: HCFA/OACT

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Chart 2

Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility

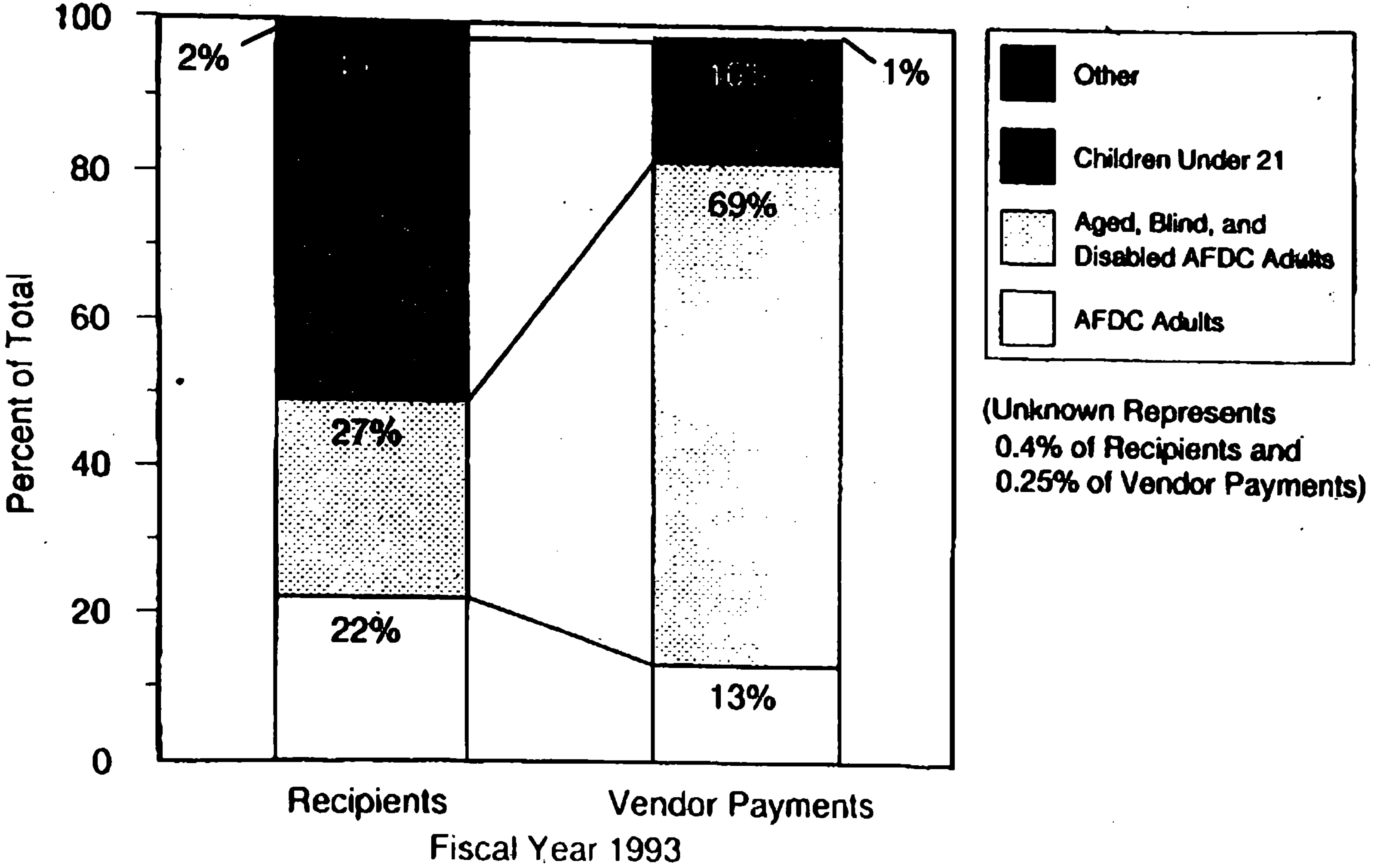
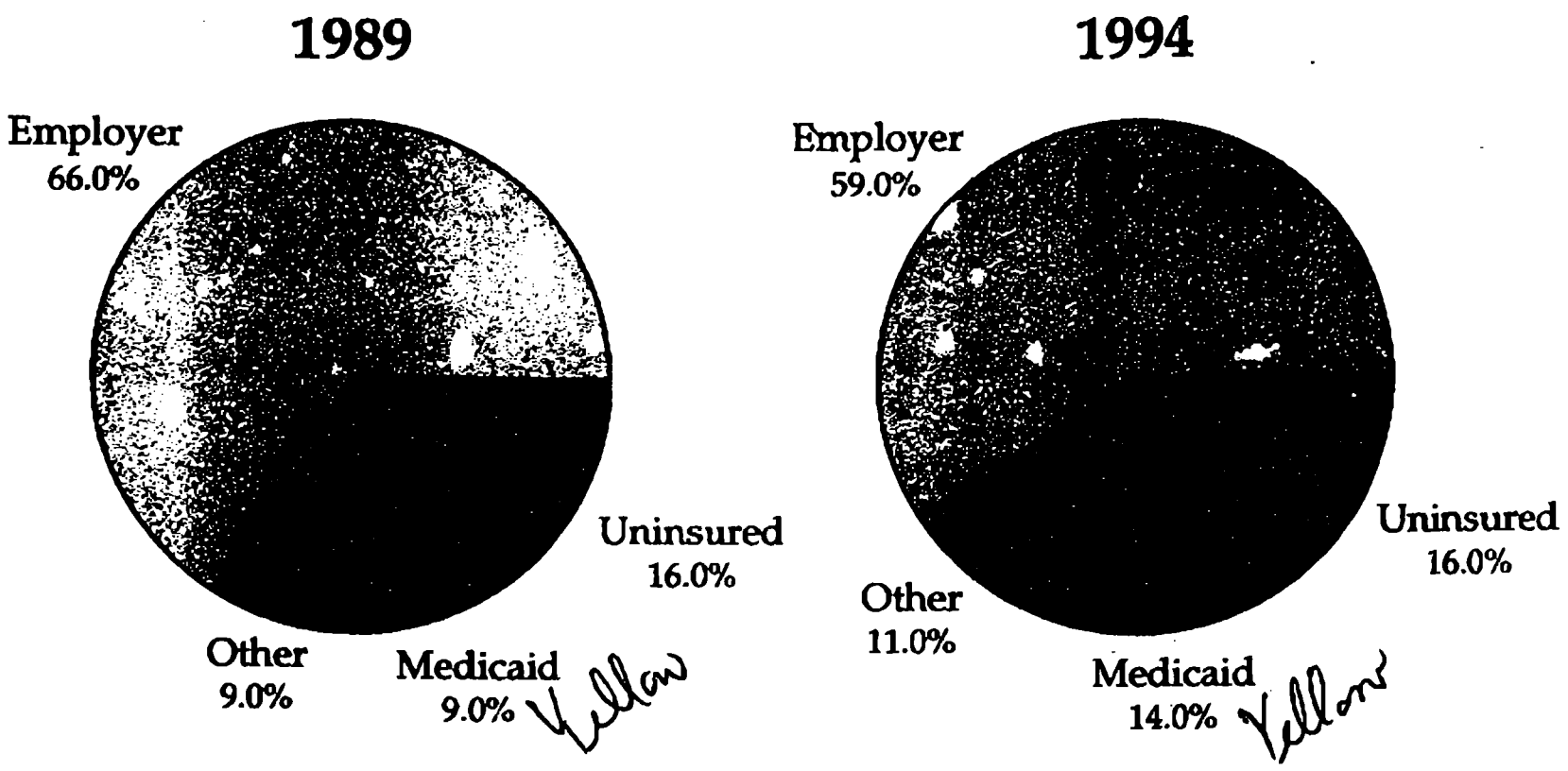


Chart 3

Medicaid is a Critical Safety Net



SOURCE: HCFA, Office of the Actuary and Urban Institute, 1995.

Chart 4

Total Expenditures for Mandatory and Optional Medicaid Services and Populations: FY 1993

(Dollars in Millions)

	Mandatory Services	Optional Services	
Mandatory People	47,885	23,681	71,566
Optional People	12,052	26,358	38,409
TOTAL	59,936	50,039	109,975

As A Percent of Total

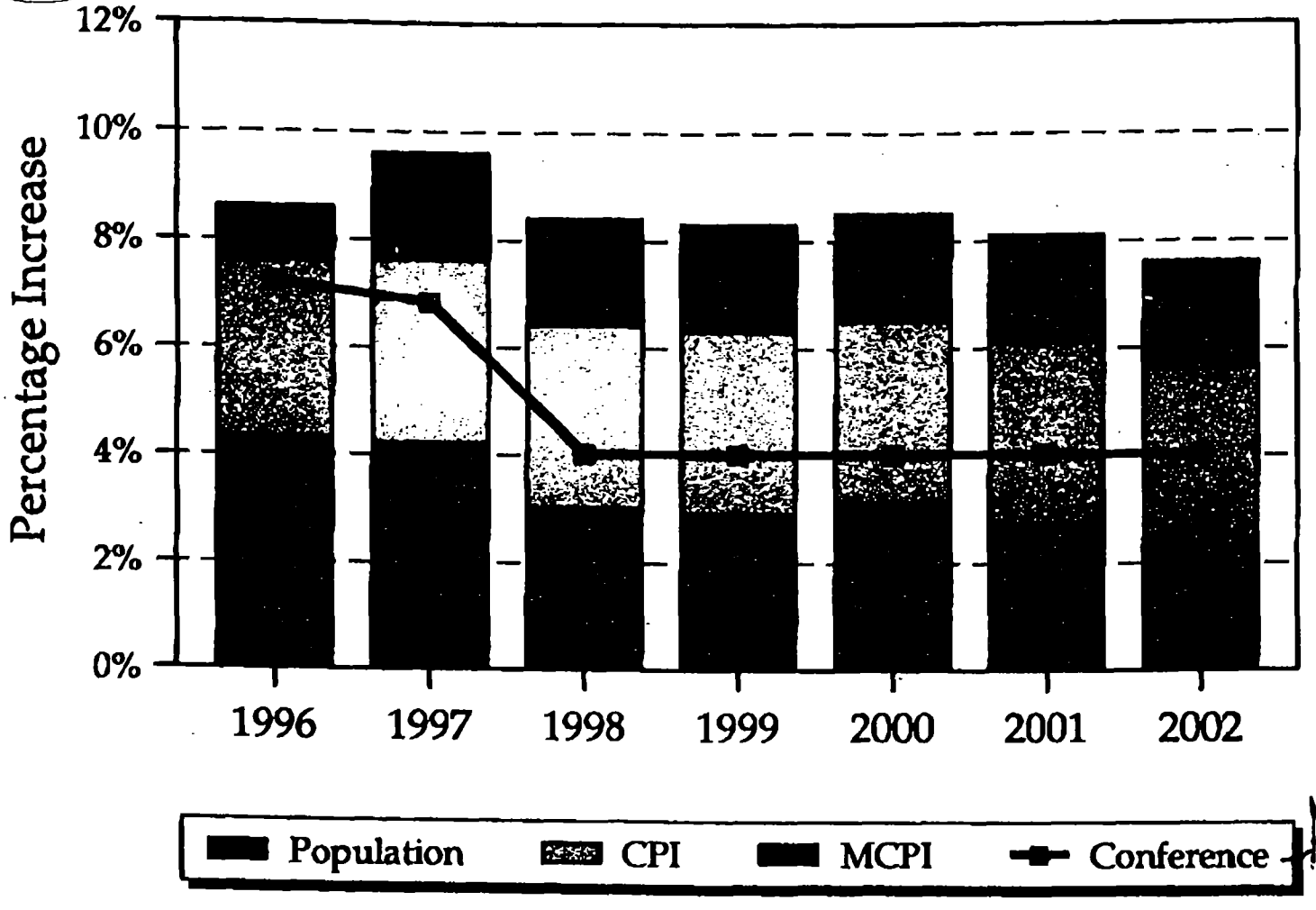
	Mandatory Services	Optional Services	
Mandatory People	43.5%	21.5%	65.1%
Optional People	11.0%	24.0%	34.9%
TOTAL	54.5%	45.5%	100.0%

Excludes DSH, collections and adjustments

Chart 5

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002 for All Beneficiaries



Agreement