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An update on federal action from

The Center for Public Policy Priorities

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MEDICAID UPDATE

The Process As most readers know, Congress recently sent to the President a Budget Reconciliation Bill including sweeping provisions that would completely repeal the Medicaid program. Under this budget bill, Medicaid would be replaced with state administered block grant programs in which no state would be required to provide benefits beyond immunization and family planning. In his veto of that bill on December 7, the President indicated that he is determined to maintain Medicaid as a "national guarantee ," and to maintain national nursing home standards. The President has produced alternative bill language detailing his Medicaid proposal. The "Coalition" Budget Alternative produced by the conservative "Blue Dog" Congressional Democrats also contains alternative Medicaid language, which is generally close to the President's position (both retain Medicaid as an entitlement program), with a few important differences. As the President and Congressional leaders attempt to craft a budget compromise in the days and weeks to come, these 3 proposals indicate the range of possibilities for the budget that will ultimately be adopted.

This issue of *Washington Watch* summarizes major points of the Medicaid provisions of the vetoed budget bill and the administration proposal. Also provided is a brief description of some major differences between the President's Medicaid proposal and the Coalition alternative. We also provide another look at the relative merits of the very different approaches to funding Medicaid in the alternatives.

A Detailed side by side Comparison of the Medicaid provisions of the Administration and vetoed Budget Reconciliation Bill is available from the Center on request. Please FAX your request to (512) 320-0227, OR call us at (512) 320-0222 AFTER JAN. 1 (we will be closed 12/25-1/1). Or e-mail us at HN2960@handsnet.org.

DESCRIPTION OF CURRENT MEDICAID PROPOSALS

Budget Reconciliation Act - Vetoed by President

- **Medicaid Eliminated:** Repeals Title XIX (the federal Medicaid law) and replaces it with Title XX1, the Medi**grant** program.
- **No Mandatory Benefits:** Allows each state to define what benefits to provide; only child immunization and family planning are mandatory services.
- **No Entitlement:** Specifically states that no entitlement is created for any individual or provider. Requires state Medigrant programs to cover children under age 13 and pregnant women under 100% of the federal poverty level income; also requires state to cover some people with disabilities, but allows each state to define disability and set income limits for this group. All other groups whose coverage is mandatory under current Medicaid would be optional. However, though eligibility of these groups is mandatory, no specific benefits (other than child immunization and family planning) are required.
- **Nursing Facility Standards:** Retains nursing facility standards in current law, but eliminates any federal enforcement (all enforcement by states). Retains spousal impoverishment standards in **current federal law** (protections that allow spouse of Medicaid client in nursing home to retain some income and assets).
- **Financial Support From Adult Children:** States would be allowed to require financial support from adult children of parents in nursing homes if those adult children have incomes above the state median income (i.e., state could refuse Medigrant coverage to such parents).
- **Boren Amendment:** Repeals requirements that hospitals and nursing homes be paid "reasonable costs," and that Rural Health Clinics and Federal Health Centers be paid full costs.
- **Due Process Protections:** Individuals and providers could not sue states in federal court over Medigrant violations.

- **Spending Allocation:** Creates guidelines for allocation of Medigrant spending among 4 groups: low-income families (must include child or pregnant woman), low-income elderly, low-income disabled, and elderly receiving assistance with Medicare premiums only. **This is NOT an actual floor on spending. Only the RELATIVE SHARES of spending, and NOT THE TOTAL AMOUNT is mandated.**
- **Cost-Sharing Options:** Allows states to require cost sharing (co-payments, deductibles, and premiums) for most clients.
- **Basic Principles Repealed:** States are no longer required to ensure equal access to the program statewide. States may cover different benefits for different groups. States may limit client choice of provider in any way.

Administration Proposal

- **Entitlement Maintained:** Maintains entitlement to coverage for all mandatory groups entitled under current federal Medicaid law. Retains entitlement to all mandatory benefits covered under current law, and allows benefits optional under current law.
- **Spending Controls:** Reduces and controls program costs with a "per-capita cap": a cap on the amount by which Medicaid costs **per client** can grow each year. States would get federal matching funds for every enrolled entitled client -- thus ensuring a funding level that would respond to population growth, increased poverty, or economic downturns -- but growth in costs per client would be strictly limited.
- **Boren Amendment:** Repeals "Boren Amendment," which now requires that state Medicaid payments for hospitals and nursing homes be related to reasonable cost. This would allow states to cap these providers' cost increases without being sued (which creates concerns for many providers).
- **Nursing Facility Standards:** Retains all Nursing Home standards under current federal Medicaid law, including spousal impoverishment.
- **Home And Community-Based Services:** Home and community-based services to be treated as optional services; no waiver required.
- **Managed Care Options:** No waiver required for mandatory managed care programs. More than one choice of plan required in urban areas; more than one choice of provider required in rural areas. States could guarantee 6 months of eligibility for all managed care enrollees (not just to first-time enrollees, as under current law).
- **EPSDT:** Retains EPSDT as in current law. However, per-capita cap on kids' spending, and repeal of Boren likely to force some service reductions.
- **Provider Reimbursement:** Cost-based reimbursement for Federal Health Centers and Rural Health Clinics repealed, effective FY 1999 (remains mandatory benefit, however).

Major Differences Between Administration and Coalition Medicaid Provisions

Like the Administration proposal, the Coalition proposal would retain Medicaid entitlement, but impose a per-capita cap on cost increases. Some important differences between the 2 proposals are noted below.

- **EPSDT:** Retains preventive and diagnostic care components of children's Medicaid (EPSDT program). **However**, would replace current law guarantee that all medically necessary services are covered. Secretary of U.S. Department of Health and Human Services (USDHHS) would define what services must be covered for children.
- **Managed Care Options:** Prohibits mandatory managed care for SSI-eligible children, children in foster care, homeless persons, migrant farm workers, and American Indians (among others).
- **Boren Amendment and Provider Reimbursement:** Retains both the Boren Amendment and guaranteed Cost-based reimbursement for Federal Health Centers and Rural Health Clinics.
- **No Special Funds:** Unlike both Administration and Budget Bill, this proposal does not include special funds for states with high numbers of undocumented workers.

COMPARING THE DOLLAR IMPACTS OF THE PROPOSALS: APPLES AND ORANGES

Projected "Cuts" – "Savings" – "Spending Reductions"

As federal budget-watchers know by now, one of the disagreements between Congress and the Administration in the budget-balancing process has been over what the spending "baseline" should be; that is, what prediction about future government spending under current law should be used. In order to "score" the potential savings that would result from changing or eliminating government programs, you must first

decide how much you would have spent had the change never been made. The Congressional Budget Office (CBO) has predicted a higher level of spending under current law than the Office of Management and Budget (OMB - essentially the President's budget office), and therefore the CBO predicts that a larger dollar savings would be needed to balance the budget. The CBO has "scored" the vetoed Budget Reconciliation Act as reducing Medicaid spending by $163 Billion over 7 years, and the Coalition budget alternative as cutting spending by $85 Billion over the same period. The Administration's proposal is still being analyzed by the CBO as we go to press. The OMB has scored this plan as reducing costs by $54 Billion, but this number is, of course, not comparable to the CBO figures. Because of the higher CBO spending assumption, it is assumed that the CBO scoring of the administration plan will result in a larger number than OMB's, but how much larger is not clear.

Which Plan Would Give Texas More Medicaid Funding?

The vetoed Budget Reconciliation bill would have provided a fixed block grant of funding for Texas which would not grow if demand exceeded the dollars allotted to Texas. The 2 alternative proposals each would guarantee that funding would grow if the number of people qualifying for Medicaid grew, but would cap the year to year increase in cost per enrollee. Judging which approach is more beneficial for the state of Texas depends on the priorities of the judge. If your highest priorities are ensuring a medical safety net for the poorest and most vulnerable Texans, and minimizing cost-shift to city and county governments, the per-capita cap under the Administration and Coalition budgets would be a much better deal for Texas. On the other hand, if your top priority is being able to predict the exact number of state matching dollars that will be required for Medicaid, regardless of the number of Texans in need, then the block grant approach would be your choice.

The DSH Issues

Complicating the task of judging the adequacy of proposed block grant funding is the Disproportionate Share Hospital (DSH) reimbursement program, a lump-sum bonus payment program that is unrelated to payment for services to Medicaid clients (payments go to hospitals based on uncompensated care, Medicaid volume, and other publicly-subsidized care). The size of Texas' DSH program is capped permanently at $1.5 Billion per year, with Federal funding (based on the current matching funds rate) of about $958 million. In evaluating Medicaid proposals, Texas and other states are concerned not only about being able to continue to fund health care for many of the poorest of the uninsured, but also about avoiding an abrupt cut-off of DSH funds. Though DSH isn't needed to pay the bills for Medicaid clients, many Texas hospitals have come to rely on those funds, and would be "in the red" if DSH were to dry up overnight. DSH funds have made it possible for Texas' large urban public hospital districts to limit or avoid property tax increases.

It is important to recall that DSH has been frozen for several years, and to note that the elimination of DSH by Congress has been widely anticipated for several years. The best-case to be hoped for, then, may be a gradual phase-down of the program. The Administration proposal reduces Medicaid spending partly through an explicit down-sizing of DSH. Under the block grant proposal, continuation of DSH would be optional for states. Under a block grant, if growth in demand for client services grew faster than the annual growth factor for the grant (4% in the out-years), one of the first decisions the state would have to make would be whether to reduce direct client coverage, or whether to start shrinking the DSH funding to accommodate client need. Assuming that states would choose to maintain client services, the point at which a state would have to start shrinking the DSH program would come earlier than the point at which (even with no DSH program) there would not be enough money to maintain current-law Medicaid eligibility and services.

WOULD THE BLOCK GRANT FORCE PROGRAM CUTS?

- **Historical Rate of Growth in Demand for Federal Medicaid Funds Has Been Much Higher Than Block Grant Growth Rate.** Spending growth in federal funds (excluding DSH) for Texas Medicaid from 1994 to 1995 dropped sharply to less than 7% (see **Table 1**), and growth from 1995 to 1996 is projected to be under 8%. However, growth was substantially higher for the previous 6 years (averaging about 20% per year). National experts predict 11-12% average annual growth in Texas Medicaid under current law from 1994-2002.
- **Block Grant Growth Cap Drops from 9% to 4%.** Under the vetoed Budget proposal, Texas' Medigrant block grant allotment would be $54.9 Billion over 7 years. Texas would also get about $397 million in special payments to states with high numbers of undocumented aliens. The annual increase in the grant would taper to 4% in 2002 and out years (see **Table 2**).

- **Growth Rate of 9.4% or More Would Force Medicaid Program Cuts Before 2002.** As **Table 3** shows, this level of funding could maintain Texas current Medicaid programs **if** growth in demand for spending stays below 9.4% per year, but DSH would have to start shrinking in 2001. **Table 4** shows that 12.6% growth in client care costs would result in total care costs exceeding the block grant allotment in the year 2000, leaving no funds at all available for DSH. It can be safely said that this grant will not be adequate if Texas experiences a significant downturn in the state economy.
- **Growth at THHSC Projected Rate Would Create Shortfall in 2004.** Even at the low growth rate (6.33% in out years) assumed by the Texas Health and Human Service Commission (THHSC), the block grant would fall short in 2004 (**Table 5**).

Supporting a Medicaid Block Grant for Texas is a high-stakes Gamble. A block Grant would, at best, eliminate the chance for Texas to serve more of its 4 million uninsured citizens. At worst, it would require significant cut-backs in the coverage provided to nearly 3 million Texas Medicaid recipients today, and massive cost-shifts to local governments for health care provided to the uninsured.

Table 1: Texas' Historical Growth in Need for Federal Medicaid Dollars

	All Fed Funds	Increase from previous year	Fed Funds less DSH	Increase from previous year
1980	$627,555,916		$627,555,916	
1981	$751,038,764	19.68%	$751,038,764	19.68%
1982	$682,503,508	-9.13%	$682,503,508	-9.13%
1983	$809,937,782	18.67%	$809,937,782	18.67%
1984	$843,683,329	4.17%	$843,683,329	4.17%
1985	$875,460,229	3.77%	$875,460,229	3.77%
1986	$907,997,797	3.72%	$907,997,797	3.72%
1987	$1,142,032,909	25.77%	$1,134,651,999	24.96%
1988	$1,233,980,033	8.05%	$1,231,364,582	8.52%
1989	$1,421,413,492	15.19%	$1,418,557,449	15.20%
1990	$1,993,292,217	40.23%	$1,971,777,266	39.00%
1991	$2,698,950,959	35.40%	$2,484,145,425	25.99%
1992	$4,062,010,375	50.50%	$3,090,948,293	24.43%
1993	$4,720,620,438	16.21%	$3,745,624,438	21.18%
1994	$5,459,048,518	15.64%	$4,487,986,518	19.82%
1995	$5,734,172,843	5.04%	$4,776,647,843	6.43%

Table 2: Federal "Medigrant" Funds for Texas under Conference Budget

	Basic Grant	Growth	Undoc. $	Growth	Total Grant	Growth
1996	6,351,909,343		71,232,577		6,423,141,920	
1997	6,923,581,184	9.00%	76,463,047	7.34%	7,000,044,231	8.98%
1998	7,408,231,866	7.00%	79,747,424	4.30%	7,487,979,290	6.97%
1999	7,926,808,097	7.00%	83,247,797	4.39%	8,010,055,894	6.97%
2000	8,411,691,687	6.12%	86,732,819	4.19%	8,498,424,506	6.10%
2001	8,751,450,414	4.04%			8,751,450,414	2.98%
2002	9,101,508,431	4.00%			9,101,508,431	4.00%
7-year total	$54,875,181,022				$55,272,604,686	

Table 3: Block Grant Falls Short if Client Care Costs Grow at 9.35%
Either Care or DSH must Shrink in 2001

	Client Care Costs, Growth at 9.35%	Client Care Costs Plus DSH	Total Grant	Shortfall
1995	4,776,647,395	5,734,172,395		
1996	5,223,263,926	6,180,788,926	6,423,141,920	
1997	5,711,639,104	6,669,164,104	7,000,044,231	

1998	6,245,677,360	7,203,202,360	7,487,979,290	
1999	6,829,648,193	7,787,173,193	8,010,055,894	
2000	7,468,220,299	8,425,745,299	8,498,424,506	
2001	8,166,498,897	9,124,023,897	8,751,450,414	-372,573,483
2002	8,930,066,544	9,887,591,544	9,101,508,431	-$786,083,113
7-yr. total	$48,575,014,322	$55,277,689,322	$55,272,604,686	

Table 4: Block Grant Falls Short of Covering Client Care Costs Alone if Growth is at 12.6% Short of Funding for Care, Zero Available for DSH in 2000

	Client Care Costs, Growth at 12.6%	Client Care Costs Plus DSH	Total Grant	Shortfall
1995	4,776,647,395	5,734,172,395		
1996	5,378,504,967	6,336,029,967	6,423,141,920	
1997	6,056,196,593	7,013,721,593	7,000,044,231	-13,677,362
1998	6,819,277,363	7,776,802,363	7,487,979,290	-288,823,073
1999	7,678,506,311	8,636,031,311	8,010,055,894	-625,975,417
2000	8,645,998,106	9,603,523,106	8,498,424,506	-1,105,098,600
2001	9,735,393,868	10,692,918,868	8,751,450,414	-1,941,468,454
2002	10,962,053,495	11,919,578,495	9,101,508,431	-$2,818,070,064
7-yr. total	$55,275,930,702	$61,978,605,702	$55,272,604,686	

Table 5: Comparing Block Grant With THHSC Demand Projection After 2002

	Block Grant at 4% Growth	THHSC Costs at 6.33% Growth	Shortfall
2002	9,101,508,431	8,780,100,000	
2003	9,465,568,768	9,335,880,330	
2004	9,844,191,519	9,926,841,555	-82,650,036
2005	10,237,959,180	10,555,210,625	-317,251,446
2006	$10,647,477,547	$11,223,355,458	-$575,877,911

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