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FROM: Bob Greenstein, Richard Kogan
DATE: June 10, 1996

The Medicaid "Umbrella Payments"

Attached is an analysis of the "umbrella mechanism" in the Medicaid Restructuring Act, which is supposed to protect states against unanticipated increases in caseload. The bill is scheduled to be marked up in House Commerce this Thursday and Senate Finance next week.

The analysis shows that the umbrella in the Republican bill is not at all what the governors called for in February. Under the bill, dollars would follow people only to a very limited degree. The problems the governors sought to address when they designed the umbrella concept would remain largely unaddressed under the bill.

The umbrella mechanism would be seriously defective in two major ways. To begin with, the umbrella payments would cover only the first-year cost of unanticipated caseload increases. But most caseload increases will be long-lasting. For example, if caseload grew 1 percent faster than expected for six years, then by the sixth year a state would need six percent more money. Yet it would only receive one percent more money, a small fraction of what it would need. For this reasons, recession protection is incomplete, since recessions increase caseload for a number of years. Likewise, the phase-in of children age 13 through 18 would be covered only in small part; states will have an incentive to reject coverage of these poor children.

Second, access to umbrella payments would be inequitable, with some states getting umbrella payments to cover caseload increases that are already expected to occur, but others getting umbrella payments only if caseload exceeds current expectation by significant amounts.

CENTER ON BUDGET AND POLICY PRIORITIES

June 10, 1996

"Umbrella Payments" Under The Medicaid Restructuring Act of 1996

by Richard Kogan

The new Republican Medicaid proposal, the Medicaid Restructuring Act of 1996, would replace the current Medicaid program with federal block grant payments to states. States also could receive "umbrella payments" to protect them from "unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters."[1]

The idea behind "umbrella payments," as conceived by the governors last winter, is that if a state's Medicaid caseload exceeded expectations for any reason, umbrella payments would cover the federal government's share of the extra Medicaid costs. When the National Governors Association approved a Medicaid outline that included an umbrella payment mechanism in February, governors said it would assure that "federal dollars would follow beneficiaries."

The Medicaid Restructuring Act, however, falls far short of this goal. The umbrella mechanism in the bill is *not* what the governors recommended in February. Under the bill's umbrella provisions, state access to the umbrella fund would be largely unrelated to greater-than-expected caseloads. As a result, the distribution of umbrella payments among states would be highly inequitable, and many states would be denied umbrella payments in all but the most extreme cases.

In addition, the umbrella payments would cover *only the first-year cost* of extra caseload, not the continuing cost in years after that. As a result, even states that *did* have access to umbrella payments would generally be indemnified for only a small fraction of the cost of serving a greater-than-expected caseload. States would be left holding the bag for most of the costs that would result if their Medicaid caseloads climbed, which is precisely the result the governors sought to avoid.

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[1] The quote comes from the bill's Statement of Goals, Section 2002(b)(4).

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I. Access to Umbrella Payments Largely Unrelated to Extra Caseload

The bill's proponents describe its umbrella payment mechanism as protecting states against unanticipated caseload growth. Such descriptions, however, are not accurate. One key reason that the bill's umbrella mechanism does not provide such protection is that access to the umbrella fund would be largely unrelated to whether a state's caseload rose beyond projected levels. Instead, those states whose average Medicaid costs per beneficiary are currently high would have easy access to the umbrella fund, while states that now have low average costs per beneficiary would have little or no access to the fund.

In theory, a state would receive umbrella payments to cover the federal costs of extra caseload. Extra caseload is defined in the bill as reflecting the degree to which a state's actual caseload exceeds its anticipated caseload for a given fiscal year. That sounds like how an umbrella mechanism ought to work.

But there is a catch. The legislation has a very peculiar definition of "anticipated caseload." A state's "anticipated caseload" for a year is defined as (1) its actual caseload in the prior year, increased by (2) the growth rate between the prior year and the current year in the amount of federal block-grant funds the state receives, adjusted for inflation. This means the rate of growth in each state's federal block-grant funding level is the pivotal factor that determines whether the state has access to umbrella payments.

For example, under the legislation, Georgia's block grant funding would grow five percent between 2001 and 2002. If inflation in 2002 is three percent, as the Congressional Budget Office forecasts, the *adjusted* growth rate for Georgia's block grant funding level is two percent. To determine whether Georgia would qualify for umbrella payments, Georgia's actual caseload level in 2001 would be increased by two percent, since that is Georgia's adjusted block-grant growth rate. This yields an "anticipated" caseload for the state in 2002 that equals its caseload in 2001 plus two percent. If Georgia's *actual* caseload in 2002 proved greater than this "anticipated" caseload, Georgia would receive an amount from the federal government as an umbrella payment for each extra beneficiary.

This formula for determining whether a state can receive umbrella funds produces strange effects. Under the bill, the block-grant funding levels for states that now have high average Medicaid costs per beneficiary would generally grow slowly from year to year. By contrast, the block grant funding levels for states with below-average Medicaid costs per beneficiary would grow at a faster rate. This feature of the bill is designed to narrow modestly the cost differences between high-cost and low-cost states. This feature may also reflect recognition of the fact that some low-cost states have already instituted certain efficiencies to control Medicaid cost growth that some

high-cost states have yet to implement on a large scale. These high-cost states thus can reap future savings to slow the rate at which their Medicaid costs grow, while low-cost states that already have these savings in their "base" do not have similar opportunities to slow the rate at which their Medicaid costs climb.

Varying block grant growth rates in this manner, so that low-cost states are allowed to grow somewhat faster than high-cost states, seems reasonable enough. But the umbrella mechanism would undercut this feature of the bill and also render the distribution of umbrella funds among states highly inequitable. Under the bill's umbrella mechanism, states whose block-grant funding levels would grow slowly from year to year — that is, the high-cost states — would have ready access to the umbrella fund even if their caseloads grew very little. At the same time, states whose block-grant funding levels would grow more rapidly — i.e., states with low costs per beneficiary — would have little ability to get umbrella payments unless their caseloads grew unusually swiftly. Here is why this would occur.

- Suppose the block-grant funding level for a state with low average costs per beneficiary is scheduled to rise seven percent per year. If inflation remains at three percent per year as CBO forecasts, the state's *adjusted* block grant growth rate would be four percent. The state would get umbrella payments only if — and only to the extent that — its caseload rose more than four percent per year.

  Low-cost states such as California, Texas, Florida, and Virginia would be in this situation. According to Urban Institute forecasts, Medicaid caseload is projected to grow noticeably more slowly than that in each of these states.[2] For these states and others in the same position, caseloads would have to grow considerably faster than projected before the states could receive a dollar in umbrella payments.

- By contrast, the block grant funding level for some high-cost states would, after the first few years, increase less than three percent per year. If the inflation rate is three percent as forecast, the adjusted block-grant growth rate for these states would be *zero* (since the rate of inflation would exceed the rate of growth in the block-grant funding level for these states).[3] As a result, these states would get umbrella payments for *any* increase in

[2] Forecast developed by David Liska and John Holahan of the Urban Institute.

[3] The adjusted growth rate — the block-grant growth rate adjusted for inflation, which serves as the "umbrella threshold" — is not allowed to be smaller than zero. For high-cost states whose block-grant funding level grows more slowly than inflation, the umbrella threshold is zero by definition. For these states, the "anticipated caseload" for any year simply equals the state's actual caseload in the prior year.

caseload. States such as Massachusetts, Connecticut, New York, and New Jersey would be in this situation by 1998.

In summary, some states would receive umbrella payments for caseload growth that is already projected to occur, while other states would not receive umbrella payments even if caseload growth noticeably exceeded current projections.[4] This is inconsistent with the principles the governors adopted in February.

II. The Umbrella Covers Only the First-Year Costs of Unanticipated Caseload

Even if the problem just described did not exist — and states received umbrella payments whenever their caseloads grow faster than some objective forecast of anticipated caseload growth — states still would not receive umbrella payments sufficient to cover the costs of higher-than-anticipated caseloads. This is because the umbrella mechanism in the bill contains a second fundamental flaw — the umbrella payments would cover the cost of extra caseload *only in the first year*. Yet extra caseload usually lasts for a number of years, if not permanently.

This flaw stems from the fact that the amount of umbrella payments a state will receive depends on the state's annual caseload *growth rate*, rather than on its actual caseload *level*. A simple example illustrates the point:

- Suppose a recession sets in during 1997. A state's Medicaid caseload might consequently be four percent higher than would otherwise be the case in 1997, in 1998, and in 1999 (if not longer). Medicaid participation responds to changes in the unemployment rate, and recessions generally cause higher unemployment for a number of years after the economy stops contracting.

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[4] Extra caseload, and the attendant umbrella payments, would be calculated separately for each of eight groups of Medicaid beneficiaries: pregnant women, children, disabled persons, disabled-but-working persons, the elderly, two different sets of "qualified Medicare beneficiaries" (QMBs), and everyone else (basically AFDC adults). Dividing beneficiaries among groups creates data integrity problems but has two policy advantages. First, by making separate calculations for each group, umbrella payments can be pegged at appropriate levels — a state will receive higher umbrella payments on behalf of extra disabled beneficiaries (who tend to be quite expensive) than on behalf of extra child beneficiaries (who tend to be inexpensive). Second, because extra caseload in one group offsets caseload shortfalls in another group, the umbrella mechanism responds to unanticipated changes in case *mix* as well as in total caseload (although *net* umbrella payments cannot be negative). Unfortunately, for the reasons described in this paper, the umbrella fund responds inequitably and inadequately to unanticipated caseload growth.

- In 1997, the state's caseload growth rate would be higher than anticipated. Consequently, umbrella payments would cover the federal share of the extra Medicaid costs.

- But look ahead to 1998. The state's caseload *level* in 1998 would be four percent above caseload projections for that year because of the long-lasting effect of the recession. But the state's caseload *growth rate* from 1997 to 1998 would *not* be higher than anticipated. The extra growth would have occurred in 1997; in 1998, the caseload *level* would reflect the higher-than-anticipated level it reached the previous year, but the caseload would not still be growing at a faster-than-anticipated *rate*. Because the caseload growth rate would not be higher than anticipated in 1998, however, the state would get no umbrella payments in 1998. The umbrella payment the state received in 1997 would end after 1997, even through the extra caseload added in 1997 would still be present. The same phenomenon would recur in 1999.

  In short, the umbrella payments cover only the first year of extra caseload in a state even if the extra caseload lasts for many years.

A second example illustrates the extent to which umbrella payments could fall short of need. The table on the next page shows what would happen if the caseload in a particular state started at 100,000 and grew faster than expected by one percentage point per year for each of the six years from 1997 through 2002. In this example, the state's adjusted block-grant funding rate — which serves as the state's threshold for receiving umbrella funding — grows two percent per year (see line A in the table), but the state's actual caseload level grows three percent per year (as shown in line B).[5]

By 2002, the state's actual caseload would be 6,800 higher than what the block grant and the umbrella fund would cover (see line C). The umbrella payments however, would not cover 6,800 extra beneficiaries in 2002; these payments would cover only 1,200 additional beneficiaries (see line E).

The umbrella payments thus would be insufficient. They would cover only a fraction of the amount by which the state's actual caseload exceeded the caseload level assumed in the state's block grant. Put differently, extra caseload that lasts more than one year does *not* trigger umbrella funding for a state for any year after the first year. In still other words, if extra caseload is permanent, it will have a cumulative effect, with

[5] In this case, we are assuming that two percent per year is in fact a reasonable, objective forecast of expected caseload growth, and that the actual growth rate of three percent per year represents one percent per year of unanticipated caseload growth.

The Umbrella Does Not Provide Full Protection
(Hypothetical example: caseload in thousands)

Caseload	1996	1997	1998	1999	2000	2001	2002
A) Caseload growth assumed in the state's block grant funding level (2% per year in this example)	100.0	102.0	104.0	106.1	108.2	110.4	112.6
B) Actual Caseload growth of 3% per year	100.0	103.0	106.1	109.3	112.6	115.9	119.3
C) Caseload for which umbrella funding is needed (B minus A)		1.0	2.0	3.2	4.3	5.5	6.8
D) Caseload level above which umbrella payments actually are provided (prior year's actual caseload + 2%)		102.0	105.1	108.2	111.5	114.8	118.2
E) Actual Umbrella payments (B minus D)		1.0	1.0	1.1	1.1	1.1	1.2

*Figures may not add due to rounding.

each year's extra caseload added to the prior years' extra caseload. But the umbrella mechanism does not cover that cumulative effect.

This flaw in the design of the umbrella fund has significant policy implications. To cite one, it would make the option of phasing in Medicaid coverage for poor children aged 13 through 18 unattractive to states. Under current law, states are required to raise the age at which poor children are eligible for Medicaid one year at a time, until by 2002 all poor children through age 18 are eligible. The Medicaid Restructuring Act repeals this requirement, permitting states to choose whether to make such children eligible. If it had been designed properly, states could use the umbrella mechanism cover the costs of insuring these poor children. In practice, this approach would not work. As just explained, the umbrella mechanism would provide temporary funding for what, in this case, would be a permanent caseload increase.

By 2002, states electing to phase in Medicaid coverage for these children would have enrolled six additional age groups of children: first 13-year-olds, then 14-year-olds, etc. But in any given year, these states would receive umbrella payments on

behalf of only *one* additional age group, the group being newly enrolled. In 2002, such states would receive umbrella payments on behalf of their newly enrolled 18-year-olds. But they would not receive umbrella payments on behalf of poor children aged 13 through 17 because those caseload increases would have occurred in prior years.

Other Problems with the Umbrella Fund

The design of the umbrella fund in the new legislation also is flawed in other respects.

- **States would receive inadequate payments for Qualified Medicare Beneficiaries ("QMBs").** Under current law, *Medicaid* pays the cost of *Medicare* premiums, copayments, and deductibles incurred by Medicare beneficiaries who are poor or near-poor. The Medicaid Restructuring Act repeals this requirement, making continuation of this coverage a state option. If a state attempted to continue providing QMB benefits consistent with current law, however, it would not receive adequate umbrella payments if the number of QMBs exceeded the anticipated level. Under the bill, the amount of umbrella payments provided for extra QMBs would be based solely on the cost of Medicare premiums for these individuals. Medicare copayments and deductibles would be ignored. Yet premiums contribute *less than 30 percent* of total QMB costs, according to the Congressional Budget Office.

- **People with disabilities might not be covered by the umbrella fund.** Under the governors' proposal, states would have been allowed to develop their own definitions of disability, and the umbrella fund would have protected states if the number of disabled enrolles exceeded expectations. The Medicaid Restructuring Act stipulates that states can choose either to use the SSI definition of disability or to develop their own disability definition. But a state using its own disability definition would be ineligible for umbrella payments on behalf of disabled people.

  This restriction might encourage more states to use the SSI definition of disability. But in states that nevertheless chose to develop their own definition, disabled individuals would be placed at a disadvantage. If the number of such beneficiaries exceeded the anticipated level, these states would not receive federal umbrella payments on their behalf.

Conclusion

The umbrella payments would be of use to states with low average costs per beneficiary only if caseload growth or inflation exceeded current forecasts by large amounts. In addition, for *all* states — including high-cost states — any umbrella payments would cover only the first year of added costs, ignoring the continuation of such costs in subsequent years.

The umbrella funding mechanism in the Medicaid Restructuring Act is quite different from what the governors recommended. It does relatively little to protect states from increased costs over time that result from unanticipated growth in their Medicaid beneficiary populations.

Appendix

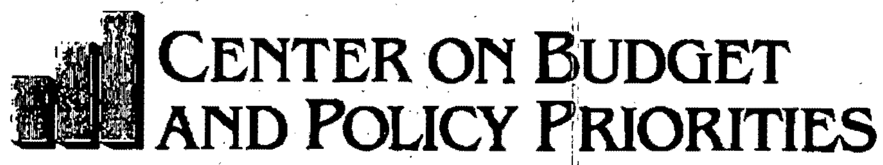
Adjusting for Inflation: A Solid Concept

To calculate a state's umbrella threshold — the growth rate above which umbrella payments are made — the state's block-grant growth rate is adjusted for inflation, as measured by *actual* percentage changes in the Consumer Price Index (CPI). Suppose a state's block-grant growth rate were five percent in 1998. If inflation were three percent, as CBO forecasts, the state would receive umbrella payments to the extent its caseload growth exceeded two percent. If inflation turns out to be four percent rather than three percent, the state would be protected. In this case, the state would receive umbrella payments to the extent its caseload growth exceeded one percent, rather than two percent. Higher inflation would mean a lower "umbrella threshold," which in turn would mean higher umbrella payments. Stated another way, higher-than-expected inflation means higher umbrella payments.

Using the umbrella mechanism to protect against higher inflation is desirable; it affords needed protection to states if CBO's inflation forecast proves to have been too low. Inflation protection of this type does not put the federal Treasury at risk; both CBO and OMB analyses show that higher inflation generally causes higher spending and higher revenues in almost equal amounts and hardly affects the deficit as a result.

At the same time, however, the umbrella mechanism fails to provide adequate protection against the permanent, cumulative costs of higher-than-expected inflation.[6] As a result, the protection it affords in this area is inadequate. And, as explained in Part I of this paper, states will not have equal access to umbrella payments to begin with. For example, states with low block-grant growth rates (generally the high-cost states) will have no protection against extra inflation because their umbrella threshold is already at the statutory minimum of zero.

[6] The design flaw discussed in Part II of this paper vitiates the inflation protection the umbrella formula is supposed to provide if inflation is higher than forecast. As explained, umbrella payments would increase if the actual inflation rate exceeds inflation forecasts. But the umbrella payments would not take into account the cumulative effect of inflation. If inflation were one percent higher than anticipated for four years in a row, by the fourth year prices would exceed the initial forecast for that year by approximately four percent. Yet a state would receive an umbrella payment for that year covering one percent extra costs due to higher-than-anticipated inflation, not four percent. The preceding three years of extra inflation, which would permanently increase the cost of medical care, would be reflected neither in the state's umbrella payment nor in its block grant allocation.



June 9, 1996

THE NEW MEDICAID PROPOSAL WOULD LEAD TO AN INEQUITABLE DISTRIBUTION OF FEDERAL FUNDS

by Cindy Mann, Steve Wilber, and Lily Hua

The new Republican Medicaid bill would replace the Medicaid program with a block grant. The Center on Budget and Policy Priorities has analyzed the proposed distribution of the block grant payments that would be made to states, along with the payments that states would receive under two relatively small supplemental funds for undocumented aliens and Native Americans.[1] This analysis considers the distribution of these payments using four different measures — federal Medicaid spending per state resident, per elderly resident, per poor resident and per Medicaid beneficiary. Under all four measures, the proposed allocation would result in an inequitable distribution of federal Medicaid funds among states.

Federal Medicaid Spending per State Resident

When the allocation of federal Medicaid funds to each state is analyzed with respect to state population, the distribution of funds proposed by the new bill appears very uneven.[2] Federal payments to eight states would be more than 25 percent *higher* than the national average payment per state resident, while payments to eight other states would be more than 25 percent *below* the national average. West Virginia and New York would receive more than *three* times the federal Medicaid funds per resident that Nevada, Virginia, and Colorado would get.

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[1] The funds analyzed here represent 95 percent of the federal dollars that would be distributed to states between 1997 and 2002, according to estimates provided by the Congressional Budget Office. The remaining federal dollars — $ 26 billion out of the $731 billion distributed over the six-year period — would be paid to states through an "umbrella" fund designed to cover a portion of the cost of caseload growth above anticipated levels. Although the umbrella payments are not considered in this analysis, because of the relatively small size of the fund, they would not materially change the distributions reported here.

[2] The General Accounting Office (GAO) has projected the year-by-year state allocations through fiscal year 2002 under the formulas for the block grant payments and the alien and Native American funds proposed in the bill. This analysis is based on the allocations reported by GAO for the year 2002 compared with state population projected for 2002 by the U.S. Census Bureau.

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Federal Medicaid Payments Per State Resident, 2002

States With the Highest Payments	Payment as Percent of National Average	Dollar Amount Per State Resident	States With the Lowest Payments	Payment as Percent of National Average	Dollar Amount Per State Resident
West Virginia	182%	$846	Florida	79%	$365
New York	177%	$821	Nebraska	77%	$357
Mississippi	151%	$701	Wyoming	75%	$350
Louisiana	141%	$654	Kansas	75%	$348
Maine	139%	$646	Maryland	73%	$337
Rhode Island	136%	$633	Washington	71%	$328
Tennessee	130%	$602	Utah	70%	$325
South Carolina	130%	$601	Idaho	70%	$324
Kentucky	125%	$583	Hawaii	59%	$274
Arkansas	124%	$575	Colorado	57%	$266
Massachusetts	121%	$559	Virginia	51%	$238
New Hampshire	118%	$549	Nevada	49%	$228

Federal Medicaid Payments per *Elderly* Resident

Medicaid spending for the elderly, including payments for long-term care, accounts for a large share of total Medicaid spending for most states. Nationally, in 1993, almost one-third of all Medicaid expenditures other than disproportionate share payments — 31.7 percent — were made on behalf of elderly individuals.[3] The distribution of federal Medicaid funds under the new Medicaid legislation would vary sharply among states when analyzed in terms of federal spending per elderly resident.[4]

Federal Medicaid grants per elderly resident would be more than 25 percent *below* the national average in eight states — Florida, Nevada, Virginia, Hawaii, Iowa,

[3] When disproportionate share payments are considered, spending on the elderly accounted for 27.4 percent of all Medicaid spending in 1993.

[4] For this analysis, the allocations reported by the GAO for 2000 are considered with respect to U.S. Census Bureau projections of elderly residents by state for 2000. Census estimates of elderly residents for 2002 are not available.

Nebraska, Colorado, and Kansas. By contrast, payments for ten states — Alaska, New York, West Virginia, Louisiana, Mississippi, New Hampshire, Tennessee, Maine, South Carolina and New Mexico — would be more than one quarter *higher than* the national average. Florida, a state with one of the fastest growing elderly populations, ranks at the bottom among states under this measure. Its payment per elderly resident would be $1,692, compared with payments for Alaska and New York of $8,361 and $5,990 per elderly resident, respectively.

Federal Medicaid Payments Per Elderly Resident, 2000

States With the Highest Payments			States With the Lowest Payments		
	Payment as Percent of National Average	Dollar Amount Per Elderly Resident		Payment as Percent of National Average	Dollar Amount Per Elderly Resident
Alaska	251%	$8,361	Maryland	84%	$2,803
New York	180%	$5,990	Delaware	80%	$2,675
West Virginia	155%	$5,151	Idaho	79%	$2,620
Louisiana	147%	$4,902	Oklahoma	77%	$2,552
Mississippi	146%	$4,845	Kansas	72%	$2,410
New Hampshire	133%	$4,438	Colorado	72%	$2,403
Tennessee	131%	$4,351	Nebraska	72%	$2,394
Maine	130%	$4,311	Iowa	68%	$2,253
South Carolina	128%	$4,250	Hawaii	67%	$2,244
New Mexico	127%	$4,232	Virginia	59%	$1,952
Rhode Island	121%	$4,039	Nevada	57%	$1,898
Vermont	119%	$3,967	Florida	51%	$1,692

Federal Medicaid Payments Per *Poor* Resident

When Medicaid block grant payments are analyzed to determine how much funds each state would receive per poor resident, the distribution continues to be highly skewed.[5] Federal payments would range from a high of $6,244 per poor resident in New Hampshire to a low of $1,919 per poor resident in Nevada. Federal

[5] The poor resident analysis is based on the GAO allocations for 2002 compared with the numbers of residents in poverty in 2002. The poverty numbers for 2002 are derived from the poverty rate for each state in 1992 - 1994 — as calculated based on Census data — applied to the Census population projections for 2002.

Medicaid payments per poor resident to New Hampshire, Rhode Island, Vermont, Massachusetts, Connecticut, Maine, and New York would be more than twice as large as payments per poor resident for Nevada, California, Oklahoma, Florida, Virginia, and Idaho.

Of the ten states that receive the lowest federal payment per poor resident, five states —California, Oklahoma, Louisiana, Texas, and New Mexico — are among the ten states in the country that have the highest poverty rates and the greatest need for federal assistance. California, which ranks second to the bottom in payments per poor resident, has one of the highest child poverty rates in the nation.

Federal Medicaid Payments Per Poor Resident, 2002

States With the Highest Payments			States With The Lowest Payments		
	Payment as Percent of National Average	Dollar Amount Per Poor Resident		Payment as Percent of National Average	Dollar Amount Per Poor Resident
New Hampshire	200%	$6,244	Washington	90%	$2,800
Rhode Island	180%	$5,602	Colorado	86%	$2,687
Vermont	179%	$5,582	Kansas	86%	$2,680
Massachusetts	176%	$5,484	New Mexico	84%	$2,630
Connecticut	171%	$5,330	Texas	84%	$2,604
Maine	162%	$5,046	Louisiana	82%	$2,566
New York	161%	$5,003	Idaho	78%	$2,420
North Dakota	144%	$4,489	Virginia	76%	$2,380
Delaware	142%	$4,420	Florida	73%	$2,268
Alaska	134%	$4,173	Oklahoma	72%	$2,245
West Virginia	129%	$4,031	California	70%	$2,193
New Jersey	128%	$4,000	Nevada	62%	$1,919

Federal Medicaid Payments Per Beneficiary

It is also possible to analyze the proposed distribution of federal Medicaid payments per Medicaid beneficiary under the new Republican bill based on state projections of beneficiary growth developed by the Urban Institute.[6] Once again, the

[6] These projections were developed by John Holahan and David Liska at the Urban Institute. The (continued...)

analysis shows the distribution of funds would be very uneven among states. Eight states — New Hampshire, North Dakota, Wisconsin, New York, Minnesota, South Dakota, Connecticut and Massachusetts — would receive more than $4,000 in federal funding per Medicaid beneficiary, while seven states — Virginia, California, Georgia, Washington, North Carolina, Hawaii and Florida — would receive less than $2,500 in federal dollars per Medicaid beneficiary. New Hampshire would receive more than *three* times the amount of federal dollars per beneficiary that Virginia would get.

Federal Medicaid Payments Per Beneficiary, 2002

States With the Highest Payments			States With the Lowest Payments		
	Payment as Percent of National Average	Dollar Amount Per Beneficiary		Payment as Percent of National Average	Dollar Amount Per Beneficiary
New Hampshire	194%	$5,860	Rhode Island	90%	$2,724
North Dakota	149%	$4,502	New Mexico	90%	$2,703
Wisconsin	147%	$4,430	Tennessee	87%	$2,626
New York	143%	$4,320	Vermont	86%	$2,590
Minnesota	143%	$4,313	Oregon	85%	$2,558
South Dakota	140%	$4,226	Florida	83%	$2,496
Connecticut	135%	$4,075	Hawaii	81%	$2,443
Massachusetts	134%	$4,051	North Carolina	80%	$2,420
Pennsylvania	131%	$3,944	Washington	77%	$2,324
Maine	128%	$3,856	Georgia	76%	$2,285
South Carolina	126%	$3,807	California	75%	$2,248
Utah	123%	$3,715	Virginia	64%	$1,925

The Rankings Among States Are Similar Under All Measures

A state that ranks low under one of these measures is likely to rank low under at least one of the other three measures. Thirteen states appear in the bottom group of states under at least two of the measures examined here. For example, California has the second lowest federal payment per poor resident and the second lowest federal payment per Medicaid beneficiary. The same eight states are among the states that receive the lowest payments under three of the four measures considered in this analysis. These states are Florida, Virginia, Kansas, Idaho, Colorado, Nevada,

[6] (...continued)
analysis here compares state beneficiary projections for 2002 with GAO's projected allocations for states in 2002.

Washington, and Hawaii. Two of these states — Florida and Virginia — fall to the bottom of the list under all four measures.

Similarly, some states consistently appear at the top of these rankings. Fourteen states receive the highest payments relative to other states on two of these measures, while seven states receive the highest payments relative to other states under three of the four measures. These seven states are New York, Maine, New Hampshire, West Virginia, Rhode Island, South Carolina, and Massachusetts. Three states — New York, Maine and New Hampshire — are among the states that receive the highest payments under all four measures.

Conclusion

The new Republican Medicaid bill calls for almost all of the $730 billion in federal Medicaid funds that would be spent over the next six years to be distributed to states according to a formula set forth in the bill. Allocations to states would be based on this formula; actual costs and enrollment, population shifts and changes in demographics would no longer determine how most federal Medicaid funds are distributed among states.

The measures analyzed here show that the allocation of federal block grant funds among states under the new Republican plan is inequitable. Part of the reason that allocations under a block grant follow this pattern is that the distribution reflects current differences in Medicaid expenditures among states. States have varying health care costs, and states have made different decisions about whom they will cover under the Medicaid program and the scope of benefits provided. These variations, however, take on a new meaning under a block grant funding structure. A block grant takes the current differences among states and freezes them into place without regard to the costs that states incur in the future and the decisions that states make in the years ahead regarding how they will provide health care coverage to vulnerable populations in their states. States whose health care costs rise or fall relative to other states, and states that choose to expand or contract health care coverage relative to other states, will remain locked into the distribution of federal Medicaid dollars proposed by this bill.

Because so many factors affect health care spending in states, it is virtually impossible for any block grant formula to assure a rational and equitable distribution of funds among states. The uneven distribution of hundreds of billions of federal Medicaid dollars frozen into place under the proposed legislation is likely to exacerbate the problems states experience as they assume greater fiscal and programmatic responsibility for the program.

Federal Medicaid Payments Per State Resident
Medicaid Restructuring Act of 1996

	Dollar Amount Per State Resident	Payment as % of National Avg
National Average	$464	100%
WEST VIRGINIA	846	182%
NEW YORK	821	177%
MISSISSIPPI	701	151%
LOUISIANA	654	141%
MAINE	646	139%
RHODE ISLAND	633	136%
TENNESSEE	602	130%
SOUTH CAROLINA	601	130%
KENTUCKY	583	125%
ARKANSAS	575	124%
MASSACHUSETTS	559	121%
NEW HAMPSHIRE	549	118%
NEW MEXICO	526	113%
VERMONT	525	113%
CONNECTICUT	517	111%
NORTH DAKOTA	503	108%
ALABAMA	495	107%
MONTANA	484	104%
PENNSYLVANIA	477	103%
TEXAS	476	103%
MICHIGAN	476	103%
OHIO	472	102%
MISSOURI	466	100%
SOUTH DAKOTA	460	99%
ARIZONA	453	98%
GEORGIA	452	97%
NORTH CAROLINA	449	97%
INDIANA	431	93%
MINNESOTA	427	92%
WISCONSIN	424	91%
OREGON	420	90%
OKLAHOMA	413	89%
ALASKA	409	88%
NEW JERSEY	404	87%
ILLINOIS	395	85%
DELAWARE	389	84%
CALIFORNIA	384	83%
IOWA	382	82%
FLORIDA	365	79%
NEBRASKA	357	77%
WYOMING	350	75%
KANSAS	348	75%
MARYLAND	337	73%
WASHINGTON	328	71%
UTAH	325	70%
IDAHO	324	70%
HAWAII	274	59%
COLORADO	266	57%
VIRGINIA	238	51%
NEVADA	228	49%

Federal Medicaid Payments Per Elderly Resident
Medicaid Restructuring Act of 1996

	Dollar Amount Per Elderly Resident	Payment as % of National Avg
National Average	$3,325	100%
ALASKA	8,361	251%
NEW YORK	5,990	180%
WEST VIRGINIA	5,151	155%
LOUISIANA	4,902	147%
MISSISSIPPI	4,845	146%
NEW HAMPSHIRE	4,438	133%
TENNESSEE	4,351	131%
MAINE	4,311	130%
SOUTH CAROLINA	4,250	128%
NEW MEXICO	4,232	127%
RHODE ISLAND	4,039	121%
VERMONT	3,967	119%
KENTUCKY	3,917	118%
GEORGIA	3,885	117%
MASSACHUSETTS	3,814	115%
TEXAS	3,793	114%
CONNECTICUT	3,464	104%
ARKANSAS	3,425	103%
MONTANA	3,413	103%
ALABAMA	3,373	101%
UTAH	3,353	101%
CALIFORNIA	3,347	101%
MINNESOTA	3,333	100%
OHIO	3,271	98%
NORTH DAKOTA	3,222	97%
NORTH CAROLINA	3,216	97%
WYOMING	3,136	94%
INDIANA	3,131	94%
SOUTH DAKOTA	3,095	93%
MISSOURI	3,048	92%
MICHIGAN	3,044	92%
WISCONSIN	2,974	89%
ILLINOIS	2,961	89%
ARIZONA	2,958	89%
WASHINGTON	2,936	88%
OREGON	2,907	87%
NEW JERSEY	2,895	87%
PENNSYLVANIA	2,826	85%
MARYLAND	2,803	84%
DELAWARE	2,675	80%
IDAHO	2,620	79%
OKLAHOMA	2,552	77%
KANSAS	2,410	72%
COLORADO	2,403	72%
NEBRASKA	2,394	72%
IOWA	2,253	68%
HAWAII	2,244	67%
VIRGINIA	1,952	59%
NEVADA	1,898	57%
FLORIDA	1,692	51%

Federal Medicaid Payments Per Poor Resident
Medicaid Restructuring Act of 1996

	Dollar Amount Per Poor Resident	Payment as % of National Avg
National Average	$3,117	100%
NEW HAMPSHIRE	6,244	200%
RHODE ISLAND	5,602	180%
VERMONT	5,582	179%
MASSACHUSETTS	5,484	176%
CONNECTICUT	5,330	171%
MAINE	5,046	162%
NEW YORK	5,003	161%
NORTH DAKOTA	4,489	144%
DELAWARE	4,420	142%
ALASKA	4,173	134%
WEST VIRGINIA	4,031	129%
NEW JERSEY	4,000	128%
WISCONSIN	3,924	126%
PENNSYLVANIA	3,818	122%
MONTANA	3,610	116%
NEBRASKA	3,606	116%
OREGON	3,586	115%
OHIO	3,579	115%
IOWA	3,540	114%
MINNESOTA	3,529	113%
TENNESSEE	3,522	113%
SOUTH CAROLINA	3,497	112%
UTAH	3,462	111%
INDIANA	3,422	110%
MICHIGAN	3,305	106%
ARKANSAS	3,265	105%
WYOMING	3,186	102%
MARYLAND	3,153	101%
SOUTH DAKOTA	3,151	101%
NORTH CAROLINA	3,035	97%
MISSISSIPPI	3,033	97%
GEORGIA	2,993	96%
KENTUCKY	2,987	96%
MISSOURI	2,951	95%
HAWAII	2,949	95%
ALABAMA	2,912	93%
ARIZONA	2,887	93%
ILLINOIS	2,845	91%
WASHINGTON	2,800	90%
COLORADO	2,687	86%
KANSAS	2,680	86%
NEW MEXICO	2,630	84%
TEXAS	2,604	84%
LOUISIANA	2,566	82%
IDAHO	2,420	78%
VIRGINIA	2,380	76%
FLORIDA	2,268	73%
OKLAHOMA	2,245	72%
CALIFORNIA	2,193	70%
NEVADA	1,919	62%

Federal Medicaid Payments Per Beneficiary
Medicaid Restructuring Act of 1996

	Dollar Amount Per Beneficiary	Payment as % of National Avg
National Average	$3,013	100%
NEW HAMPSHIRE	5,860	194%
NORTH DAKOTA	4,502	149%
WISCONSIN	4,430	147%
NEW YORK	4,320	143%
MINNESOTA	4,313	143%
SOUTH DAKOTA	4,226	140%
CONNECTICUT	4,075	135%
MASSACHUSETTS	4,051	134%
PENNSYLVANIA	3,944	131%
MAINE	3,856	128%
SOUTH CAROLINA	3,807	126%
UTAH	3,715	123%
MARYLAND	3,657	121%
ARKANSAS	3,616	120%
ALABAMA	3,403	113%
NEBRASKA	3,372	112%
NEW JERSEY	3,370	112%
MICHIGAN	3,354	111%
MONTANA	3,229	107%
NEVADA	3,223	107%
ARIZONA	3,204	106%
KANSAS	3,193	106%
IOWA	3,175	105%
INDIANA	3,165	105%
OHIO	3,164	105%
OKLAHOMA	3,155	105%
ALASKA	3,147	104%
WEST VIRGINIA	3,104	103%
LOUISIANA	3,018	100%
DELAWARE	3,008	100%
KENTUCKY	2,982	99%
COLORADO	2,945	98%
IDAHO	2,935	97%
MISSISSIPPI	2,917	97%
WYOMING	2,848	95%
TEXAS	2,846	94%
MISSOURI	2,745	91%
ILLINOIS	2,735	91%
RHODE ISLAND	2,724	90%
NEW MEXICO	2,703	90%
TENNESSEE	2,626	87%
VERMONT	2,590	86%
OREGON	2,558	85%
FLORIDA	2,496	83%
HAWAII	2,443	81%
NORTH CAROLINA	2,420	80%
WASHINGTON	2,324	77%
GEORGIA	2,285	76%
CALIFORNIA	2,248	76%
VIRGINIA	1,925	64%

STATE MEDICAID CHANGES IN FY 1996 – PROPOSED

States either have recently enacted or are considering a variety of changes to their Medicaid programs (summarized below).

HIGHLIGHTS:

- States are now focussing primarily upon reductions in coverage and provider reimbursements.
- States appear to be considering a few eligibility reductions and a few expansions (primarily from Medicaid funds saved elsewhere).

EXAMPLES OF REDUCTIONS AND COST CONTAINMENT EFFORTS:

ELIGIBILITY

- **Reduce eligibility**

  WV - narrow diagnosis and functional levels of behavioral health clients eligible for rehabilitation and clinic services, narrow Medicaid eligibility (unspecified) and postpone any eligibility expansions

  CT - reduce eligibility of poverty-level pregnant women, infants, and children

  PA - limit medically needy-only eligibility period

  VT - change income eligibility standard for medically needy program and pharmacy assistance programs to save funds

COVERAGE

- **Reduce/eliminate optional services**

  CA - eliminate (except for children under age 21 and persons in nursing homes) psychology, chiropractic, podiatry, independent rehabilitation centers, acupuncture, medical supplies, speech and audiology, and non-emergency transportation

  WV - limit number of prescriptions per recipient, cap number of reimbursable visits to physician's offices, limit services available during second six months of transitional Medicaid (welfare to work), determine essential services and narrow benefits provided

CT - eliminate (except for certain federally-mandated coverage groups) optional services including dental, vision, and other practitioner services, restructure non-emergency transportation for beneficiaries in nursing homes, methadone clinics and non-institutional clients not enrolled in managed care

PA - limit number of home health visits per year per beneficiary, eliminate transportation, child personal care services, eliminate or limit to certain children or adults DME, psychologists, PT, OT, speech therapists, optometrists, etc.

- **Require pre-authorization**

FL - require pre-authorization for home health, in-patient psychiatric hospital

VA - decrease threshold for DME pre-authorization

WV - require pre-authorization for inpatient hospital services

PA - require pre-authorization for chiropractor and podiatry services

- **Impose new/increased copays**

LA - for all allowable services/beneficiaries

VA - for non-emergency use of ERs

CA - for allowable services/beneficiaries, appeal Federal Court judgement requiring payment of Medicare copayments and deductibles for dual eligibles

WV - include comprehensive system of copayments

FL - impose new copayment and sliding scale dispensing fee per prescription

- **Increase use of generic drugs**

FL - promote generic drug usage

- **Impose new/increased utilization review (UR)**

VA - enhance prospective drug UR and apply to long-term care beneficiaries

WV- utilization review for inpatient psychiatric services

- **Impose new/additional managed care requirements**

  CA - increase enrollment in managed care

  WV - implement managed care and expand statewide

  CT - contract for purchase of pharmacy services for Medicaid beneficiaries

  FL - expand enrollment in HMOs and primary care case management, implement managed care for community mental health services

  PA - verify residence for HMO eligibility, phase in mandatory Medicaid managed care statewide beginning with AFDC, then SSI

  NC - encourage new HMOs

PROVIDER REIMBURSEMENT

- **Cap/reduce rates**

  FL - reduce increase in outpatient hospital rates, reduce operating cost component to eliminate incentive payments from nursing home per diem rates

  LA - cap maximum charges

  VA - percentage reduction in DME, study/adjust rates for specialized services by nursing homes

  CA - reduce drug costs to level paid by pharmacies, revise rates for medical supplies, reduce daily rates for "distinct part" nursing homes adjoining an acute care hospital

  NJ - eliminate reimbursement for bed hold days for nursing homes with less than 95% occupancy rates

  WV - reduce rates for lab/x-ray, DME, ambulatory surgery centers, pharmacy, inpatient psychiatric under age 21, personal care, physician services (due to copays), home health, review bundled rates for behavioral services/child care, develop bundled rates for behavioral services/adult residential

TX - selective contracting with certain hospitals for certain services to get lower rates

- Competitive bidding

FL - prepaid plans

- **Reduce DSH/uncompensated care reimbursements**

IN - reduce indigent care trust fund

CT - discontinue Hospital Assistance Program (in conjunction with phase-down of hospital gross receipts tax

VT - reduce DSH payments to hospitals

- **Cap/reduce funding by categories of care**

NY - reduce home care funding

WV - reduce case management funding, limit funding for behavioral services, basic living skills, and ICFs/MR

- **Change waivers**

WV - control growth of MR/DD waiver and reserve slots for deinstitutionalized persons, cap aged/disabled waiver program

FL - seek waivers to integrate acute and LTC, to create a managed care system for all LTC services, to use a new HCB waiver to decrease nursing home case load

PA - begin full-risk capitated model with community-based services and short-term nursing, double the number of slots in current HCB waiver for the elderly

MS - expand current 1915(b) waiver statewide

TX - expand current 1915(b) waiver

- **Impose/revise prospective payment/DRGs/RBRVS, prescription drug formulary**

VA - fully implement PPS for inpatient hospital services

WV - implement PPS/DRGs for inpatient hospital services, implement RBRVS, establish prescription drug formulary

ADMINISTRATIVE/OTHER

- **State decrease local government costs**

NY - assume part of local government costs if minimum FMAP increased from 50% to 60%

- **Other state cost reductions**

MA - reduce number of state cabinet departments

RI - RFP for redesign of entire state health care delivery system

- **Health education/prevention**

UT - fund health education centers and community health centers

CA - fund unwed and teen pregnancy prevention programs

CT - eliminate funding for Children's Health Initiative and reallocate funds to teen pregnancy prevention program

FL - additional funding for Alzheimer's disease respite care program, additional funding for school-based health insurance program for low-income families and health initiative for uninsured children under age 6

- **Medicaid savings dedicated to coverage expansion**

UT - for low-income and uninsured

- **New technology**

UT - additional funds for telemedicine

- **Other beneficiary issues**

  WV - provide incentives for citizens to purchase LTC insurance, use Medicaid savings elsewhere to fund special behavioral services for mentally ill and substance abusers who will lose benefits

  UT - increase nursing home personal needs allowance

- **Other provider issues**

  WV - no provider may simultaneously provide case management and direct behavioral health services to recipients, stiffen provider penalties for non-compliance, review medical malpractice liability standards

  SC - soliciting providers who will take partial capitation

Sources: Draft IHPP - 1996; survey of HCFA Regional Offices - May 1996

THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable federal guarantee of coverage for a defined benefit package
- Adequate and appropriately shared federal and state financing
- Beneficiary protections through quality standards and accountability

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, the House Commerce Republican bill would alter existing eligibility criteria thereby eliminating the guarantee of coverage for some currently-eligible groups. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal Poverty Level (FPL).**

- **offers each state the option of using either: 1)the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of current policy, which has a federal definition. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.

- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**

- **eliminates the current guarantee of transitional medical assistance for individuals losing cash assistance due to proposed time limits or other provisions in welfare reform.**

- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid. For example, it appears states may even have flexibility to restrict eligibility based on home ownership. Under current law, a home of any value does not affect a person's eligibility. Under the Republican bill, home owners could be found ineligible.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefit packages. There would be no "required" services for optional eligibility groups.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the "amount, duration, and scope" of benefits).** The Secretary does not have clear authority to affect states' decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.

- **Statewideness requirements would be eliminated.** States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain populations that tend to live in specific areas.

- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries). Alternatively, states could provide richer benefits to favorable groups.

- **"Treatment" under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services.** Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they would be optional services.

- **The Vaccines for Children Program is repealed, while making childhood immunization a** mandatory service. States are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.

- **Federal funding for abortion services would be permanently limited to instances of rape, incest, or where the life of the mother is in jeopardy.**

- **Family planning services are limited to "pre-pregnancy" family planning services and supplies.**

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in

federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** Beneficiaries could file a petition for certiorari before the Supreme Court of the United States, but only after all state appeal mechanisms are exhausted. Otherwise, only the Secretary of HHS would be able to sue in federal court on behalf of individuals. No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.

- Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns, and from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The base funding formula in the Republican bill has been seen before: it's the basic Medigrant II formula. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigrant II block grant formula. About 3 percent is attributable to the new umbrella fund.

The funding formula provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.

- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they may be forced either to raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to decrease total Medicaid funding and the state contribution required to generate the capped federal share of dollars spent on Medicaid. States have the incentive to withdraw large amounts of state Medicaid funding, making total cuts much larger than the proposed $72 billion in federal cuts.

- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year. Repealing these limitations would give states the incentive to use these schemes to reduce the state contribution to Medicaid even further.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.

- **The Republican bill does not include critical federal quality standards for institutions caring for people with mental retardation and developmental disabilities.** There are no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.

- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.

- **The Republican bill expands states' ability to impose cost sharing on Medicaid beneficiaries.** Unlike current law, which bars states from imposing co-payments on children or on pregnancy related services, the Republican bill would allow cost sharing for children and pregnant women for any service except preventive and primary services, as defined by the state. In addition, co-payments could be imposed for all other services to the elderly and disabled.

- **Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.**

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as "nursing home services." Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.

- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

- **The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries.** Assets, including the home, needed by survivors could be at risk of being claimed by the state.

THE IMPACT OF FLOORS AND CEILINGS IN THE MAY 21ST REPUBLICAN MEDICAID BILL

Summary: Most states are allocated their base grant amounts at the floor percentage, the ceiling percentage, or by a direct allocation (Louisiana) in the May 21st Republican Medicaid Bill:

Year	1997	1998	1999	2000	2001	2002
States receiving a floor percent	15	29	26	24	27	24
States receiving a ceiling percent	32	18	22	23	22	20
Special Allocation (Louisiana)	1	1	1	1	0	0
Total	48	48	49	48	49	44

Between 89 percent and 96 percent of the base grant total funds of $797 billion are allocated to states at either the floor percentage or the ceiling percentage. Very few states and less than 10 percent of the funds are actually computed through the needs based formula.

Floor percentages in the May 21st Republican Medicaid bill are 4.33 percent for each of the years between 1998 and 2002, or 3.5 percent for FY 1997, 3.0 percent for FY 1998, 2.5 percent for FY 1999, 2.25 percent for FY 2000, and 2.0 percent for 2001 and 2002.

Ceiling percentages are 9.0 percent for FY 1997, and either 6.41 percent or 7.22 percent in other years.

The Impact of Floors and Ceilings in the May 21st Republican Medicaid Bill

	Fiscal Year						
	1997	1998	1999	2000	2001	2002	Totals
Numbers of States Subject to Floors	16	28	26	24	27	24	
Numbers of States Subject to Ceilings	32	18	22	23	22	20	
Special Allocations (LA)	1	1	1	1	0	0	
Total Number of States Subject to Floors, Ceilings, Special Alloc.	48	48	49	48	49	44	
Money Subject to Floors, Ceilings and Special Allocations	$98.5	$104.3	$107.1	$111.9	$120.3	$116.1	$656.2
Money NOT Subject to Floors, Ceilings, Special Allocations	$6.8	$4.0	$6.4	$7.1	$4.4	$14.6	$43.3
Total Funds Allocated	$103.3	$108.3	$113.5	$119.0	$124.7	$130.7	$699.5
Percent Based on Floors and Ceilings	93.46%	96.28%	94.37%	94.03%	96.45%	88.84%	93.81%

Notes:

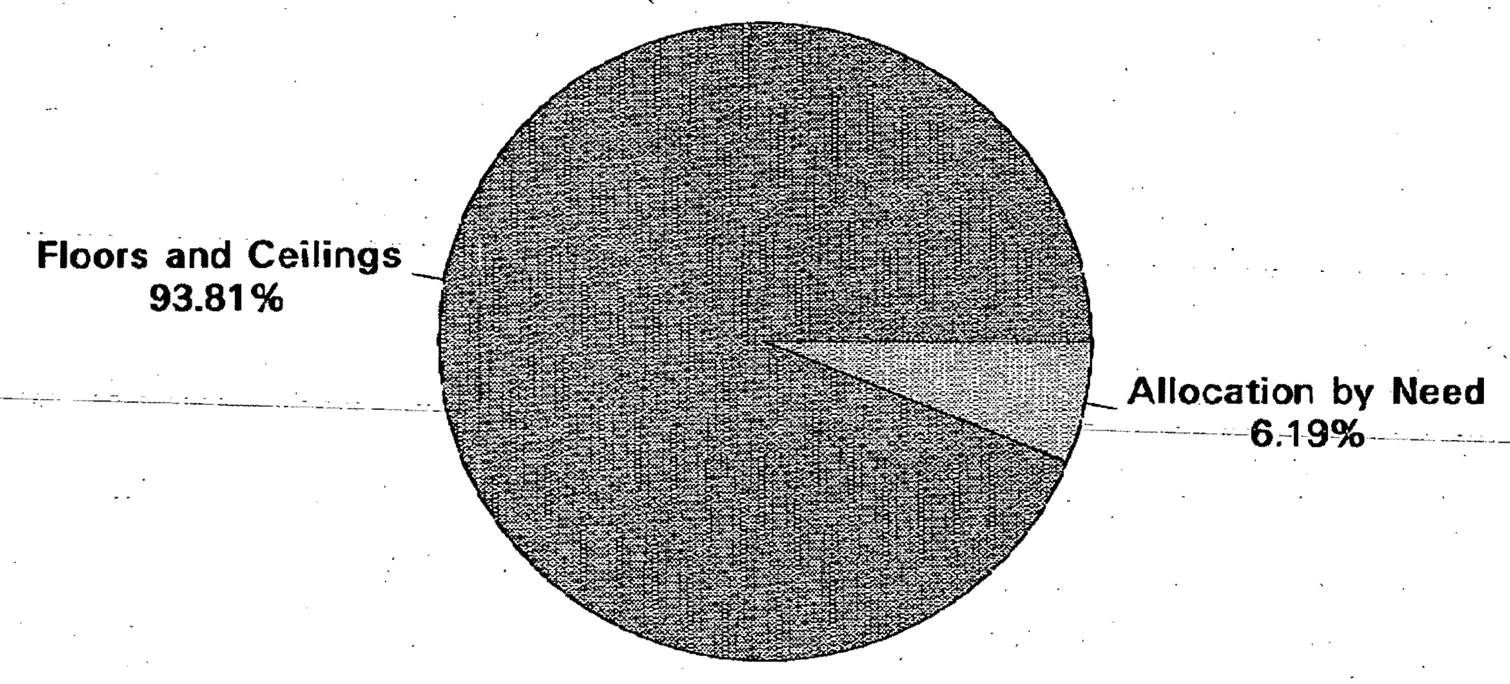
(1) Floors for each year are 4.33% for FY 1998-2002, or 3.5% for FY 1997, 3.0% for FY 1998, 2.5% for FY 1999, 2.25% for FY 2000, 2.0% for FY 2001, and 2.0% for FY 2002.

(2) Ceilings are 9.0% for FY 1997, 6.41% and 7.22% for other years.

(3) Source: GAO projections of "Rev. Medicaid Allocations, 7 Yr Funding $797 B, Const'd Program Need, Relative Ceilings (133/150), Floors (3.5, 3, 2.5, 2.25, 2)" Analysis by the U.S. Department of Health and Human Services.

Budget Allocations in the May 21st Republican Medicaid Bill

93.81 Percent of the Base Allocation is Subject to Floors or Ceilings



Base Allocation

Source: DHHS analysis based on legislative provisions in the 5/21 Republican Medicaid Bill.
Note: The "floors and ceilings" category includes the allocation for Louisiana and minimum of 0.24%.

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BUDGET ALLOCATIONS IN THE MAY 21ST REPUBLICAN MEDICAID BILL

93.81 Percent of the Base Allocation is Subject to Floors or Ceilings

- The "floors" for each year are 4.33 percent for FY 1998-2002, or 3.5 percent for FY 1997, 3.0 percent for FY 1998, 2.5 percent for FY 1999, 2.25 percent for FY 2000, and 2.0 percent for FY 2001 and 2002.
- The "ceilings" are 9.0 percent for FY 1997, 6.41 percent and 7.22 percent for other years.
- The 93.81 percent is the percent of the money allocated at either the floor or the ceiling for FY 1997-2002, or $656.2 billion of $699.5 billion ($699.5 billion is the base allocation minus FY 1996 and the amounts for the territories). FY 1996 is not included in this calculation as the floors and ceilings are limits on the increase from one year to the next, and FY 1996 is the beginning point for the calculations.
- Louisiana is given a specified allocation of $2.622 billion for FY 1996-2000. This amount is included as being within a floor or ceiling. In addition, the bill specifies that no states can receive less than 0.24 percent of the total base allocation for each year; states receiving the 0.24 percent are considered to be at a floor.

Source:

GAO projections of "Rev. Medicaid Allocations, 7 Yr. Funding $797 B, Const'd Program Need, Relative Ceilings (133/150), Floors (3.5, 3.0, 2.5, 2.25, 2). Analysis by the Department of Health and Human Services.

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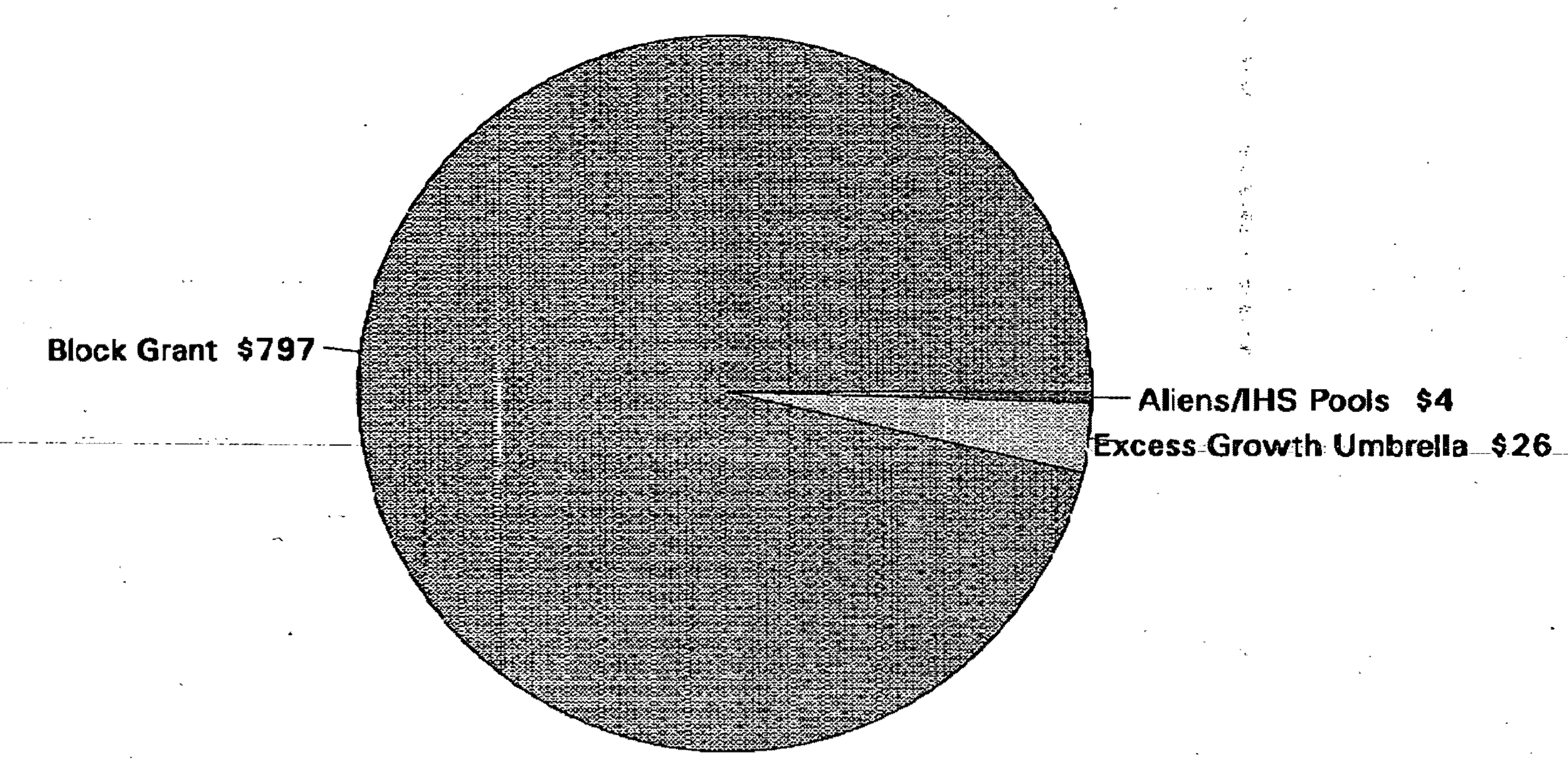
Budget Allocations in the May 21st Republican Medicaid Bill

96.3% Percent of the Total Allocation is the Block Grant

($ billions)



Total Allocation

Source: DHHS analysis based on legislative provisions of the 5/21 Republican Medicaid Bill.
Note: The "Aliens/IHS Pools" category includes the undocumented aliens and IHS pools.

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BUDGET ALLOCATIONS IN THE MAY 21ST REPUBLICAN MEDICAID BILL

96.3 Percent of the Total Allocation is the Block Grant

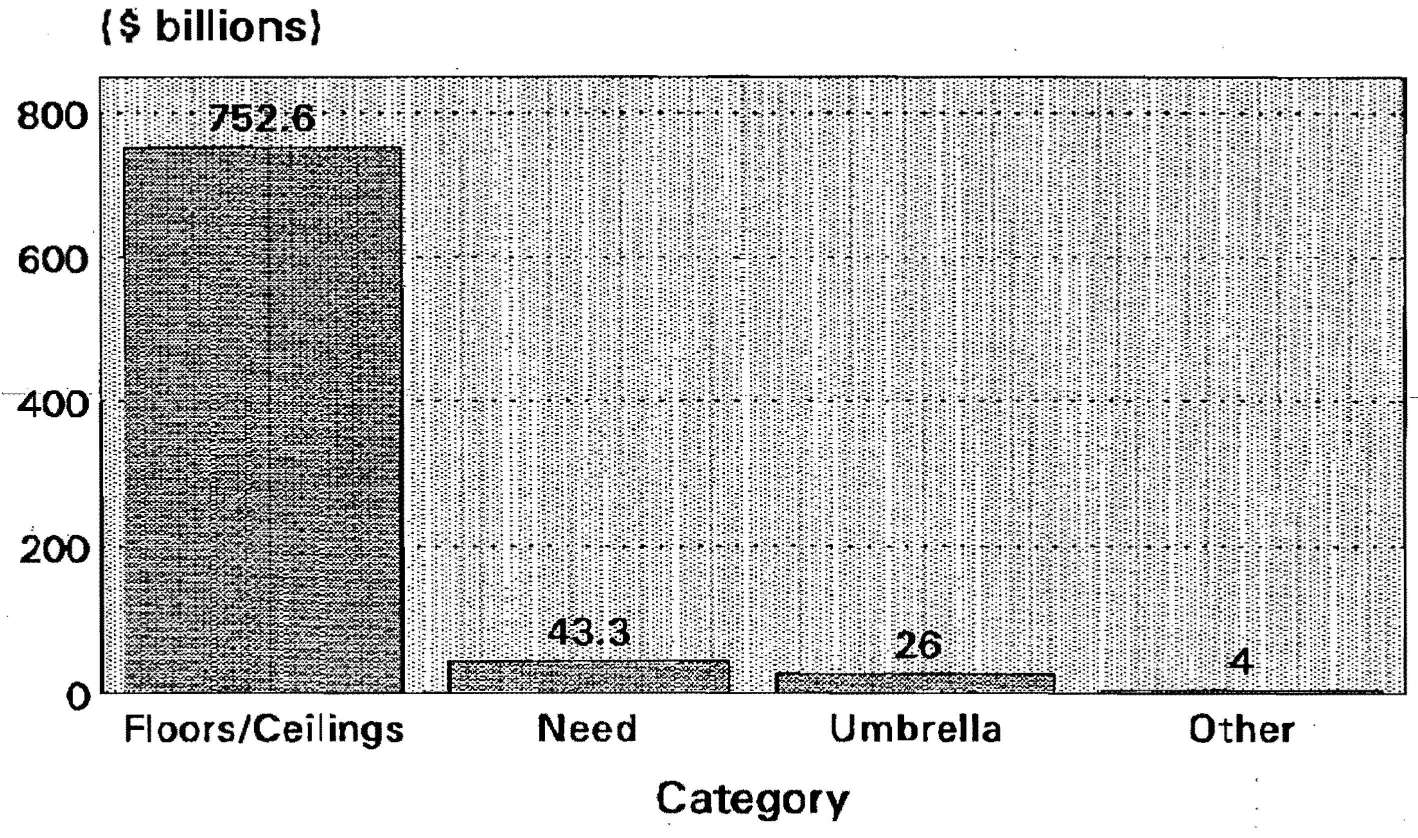
This figure contains the basic budget allocation specified in the legislation:

Block Grant (base allocation)	$797 billion
Excess Growth Umbrella Fund	$ 26 billion
Undocumented Alien Pool	$ 3.5 billion
Indian Health Service Pool	$ 0.5 billion
Total	$827 billion

Source:

GAO projections of "Rev. Medicaid Allocations, 7 Yr. Funding $797 B, Const'd Program Need, Relative Ceilings (133/150), Floors (3.5, 3.0, 2.5, 2.25, 2). Analysis by the Department of Health and Human Services.

The May 21st Republican Medicaid Bill Budget and Funding Allocations



Note: See accompanying writeup for an explanation of the categories.
Source: DHHS analysis based on legislative provisions of the 5/21 Republican Medicaid Bill.

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THE MAY 21ST REPUBLICAN MEDICAID BILL
BUDGET AND FUNDING ALLOCATIONS

(Numbers Presented are $ Billions)

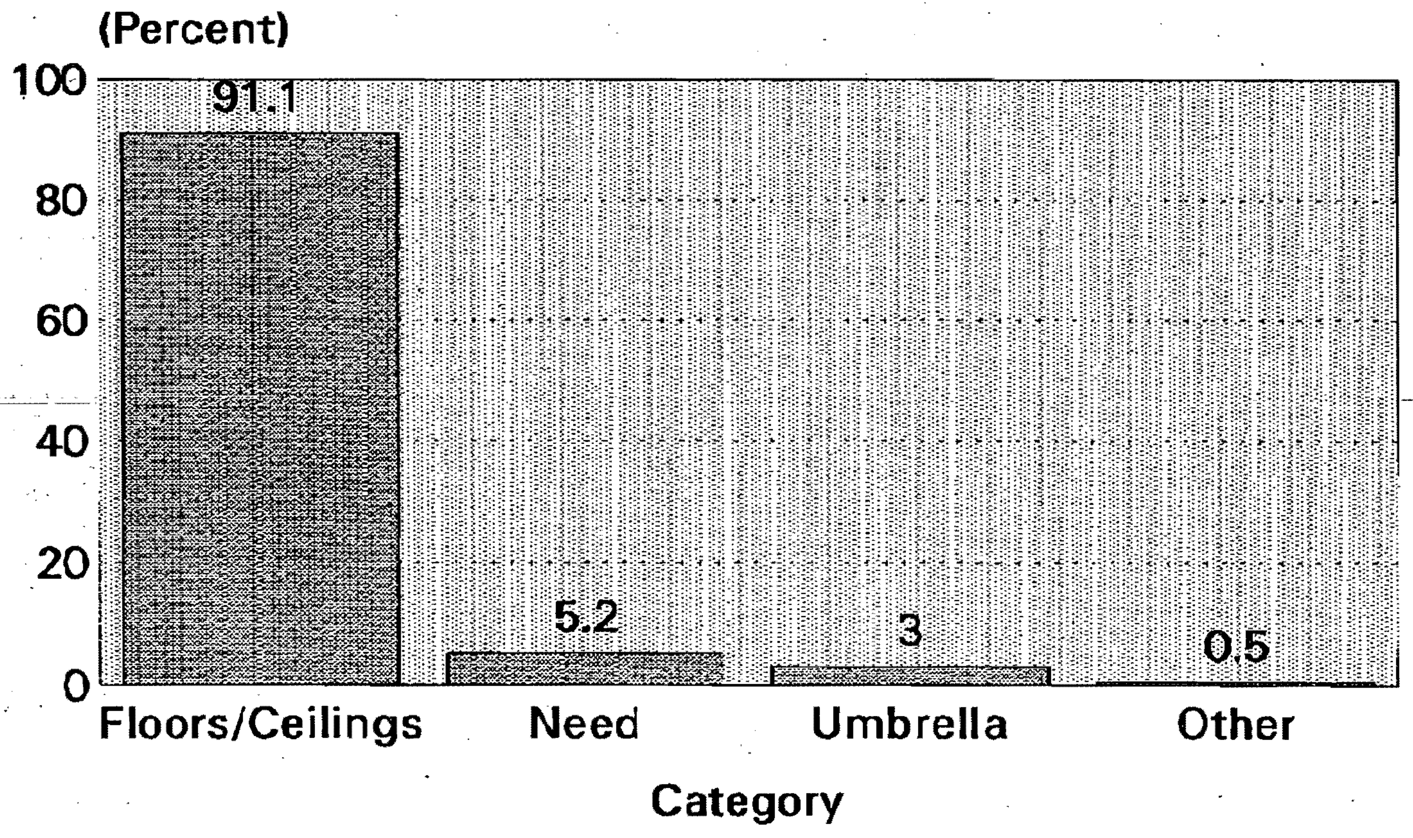
This figure takes the total amount for the bill and breaks it into four categories:

- "Floors/Ceilings" -- The amount subject to floors and ceilings ($656.2 billion + the allocation of $96.6 billion for FY 1996)
- "Need" -- the amount of the base grant not subject to floors and ceilings ($43.3 billion)
- "Umbrella" -- the amount estimated in the background information for the umbrella fund for excess enrollment ($25.1 billion)
- "Other" -- the amount allocated for the undocumented aliens pool ($3.5 billion), the Indian Health Service pool ($0.5 billion), and the additional direct allocations for Louisiana ($0.037 billion) and Nevada ($0.270 billion).

Source:

GAO projections of "Rev. Medicaid Allocations, 7 Yr. Funding $797 B, Const'd Program Need, Relative Ceilings (133/150), Floors (3.5, 3.0, 2.5, 2.25, 2). Analysis by the Department of Health and Human Services.

The May 21st Republican Medicaid Bill Budget and Funding Allocations



Note: See accompanying writeup for an explanation of the categories.
Source: DHHS analysis based on legislative provisions of the 5/21 Republican Medicaid Bill.

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THE MAY 21ST REPUBLICAN MEDICAID BILL
BUDGET AND FUNDING ALLOCATIONS

(Numbers Presented are Percentages)

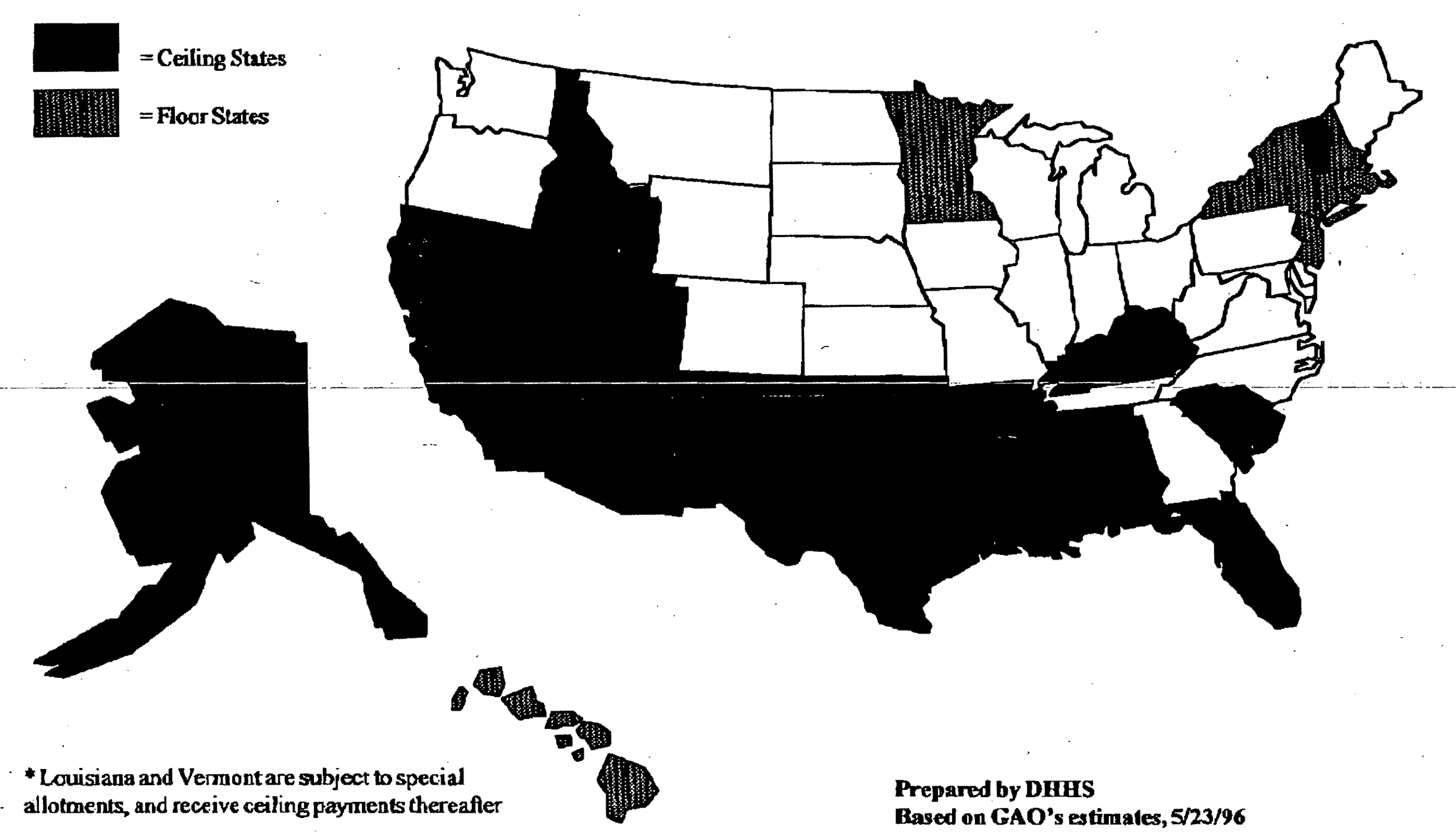
This figure takes the total amount for the bill and breaks it into four categories:

- "Floors/Ceilings" -- The amount subject to floors and ceilings ($656.2 billion + the allocation of $96.6 billion for FY 1996) -- 91.1 percent.
- "Need" -- the amount of the base grant not subject to floors and ceilings ($43.3 billion) -- 5.2 percent.
- "Umbrella" -- the amount estimated in the background information for the umbrella fund for excess enrollment ($25.1 billion) -- 3 percent.
- "Other" -- the amount allocated for the undocumented aliens pool ($3.5 billion), the Indian Health Service pool ($0.5 billion), and the additional direct allocations for Louisiana ($0.037 billion) and Nevada ($0.270 billion) -- 0.5 percent.

Source:

GAO projections of "Rev. Medicaid Allocations, 7 Yr. Funding $797 B, Const'd Program Need, Relative Ceilings (133/150), Floors (3.5, 3.0, 2.5, 2.25, 2). Analysis by the Department of Health and Human Services.

States at the Floor or Ceiling Every Year*, 1997-2002



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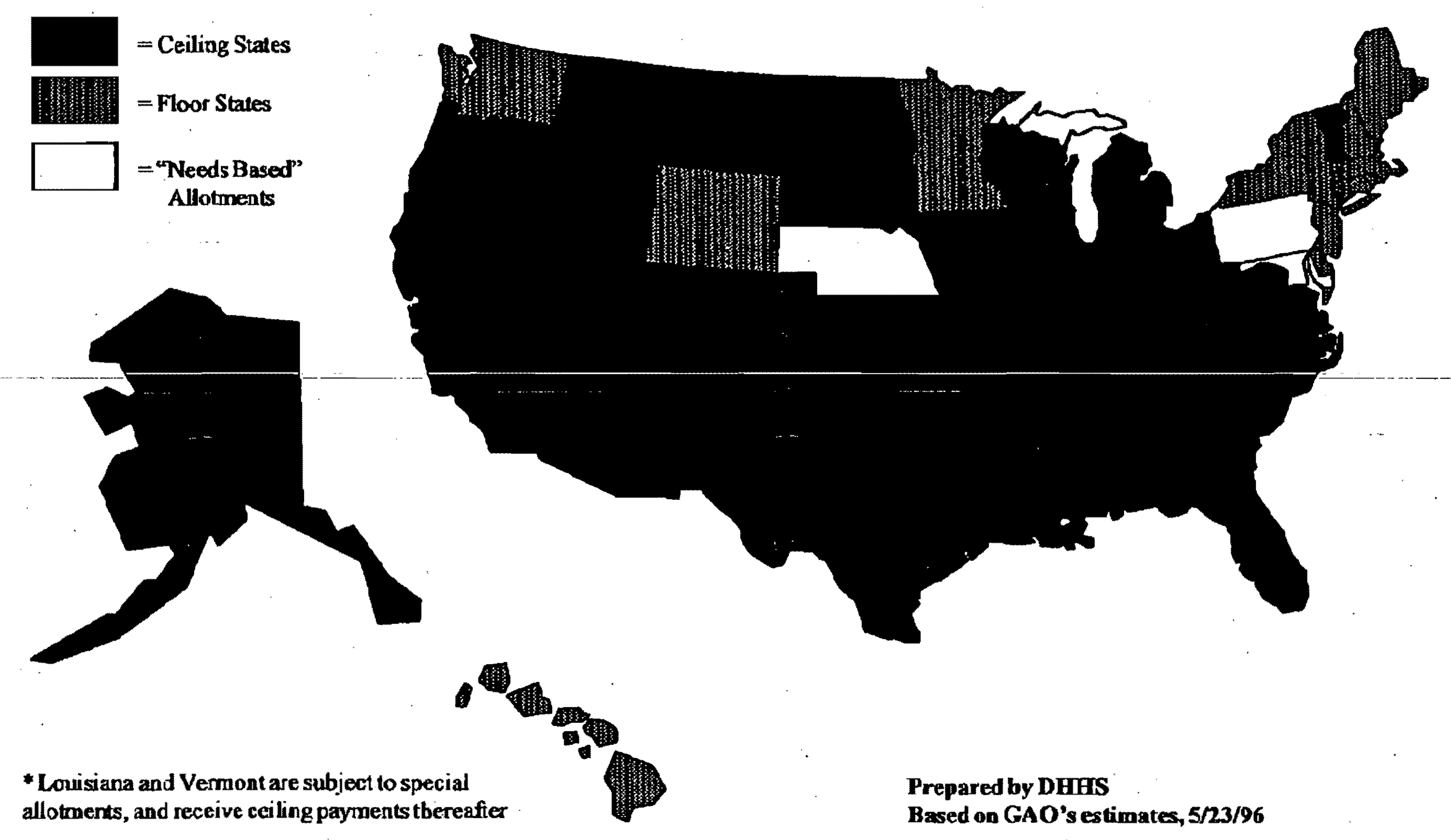
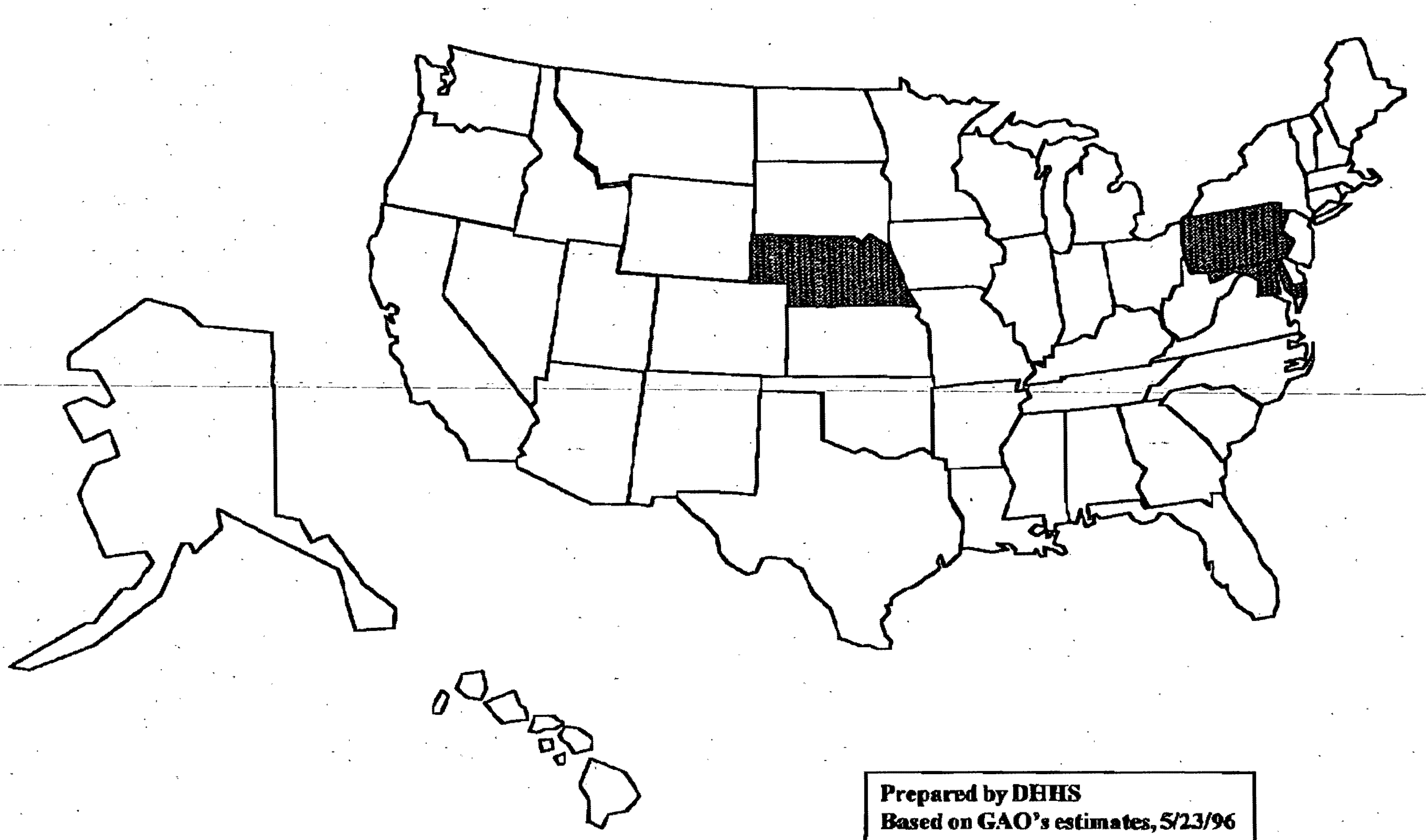
States at the Floor or Ceiling in 1997*

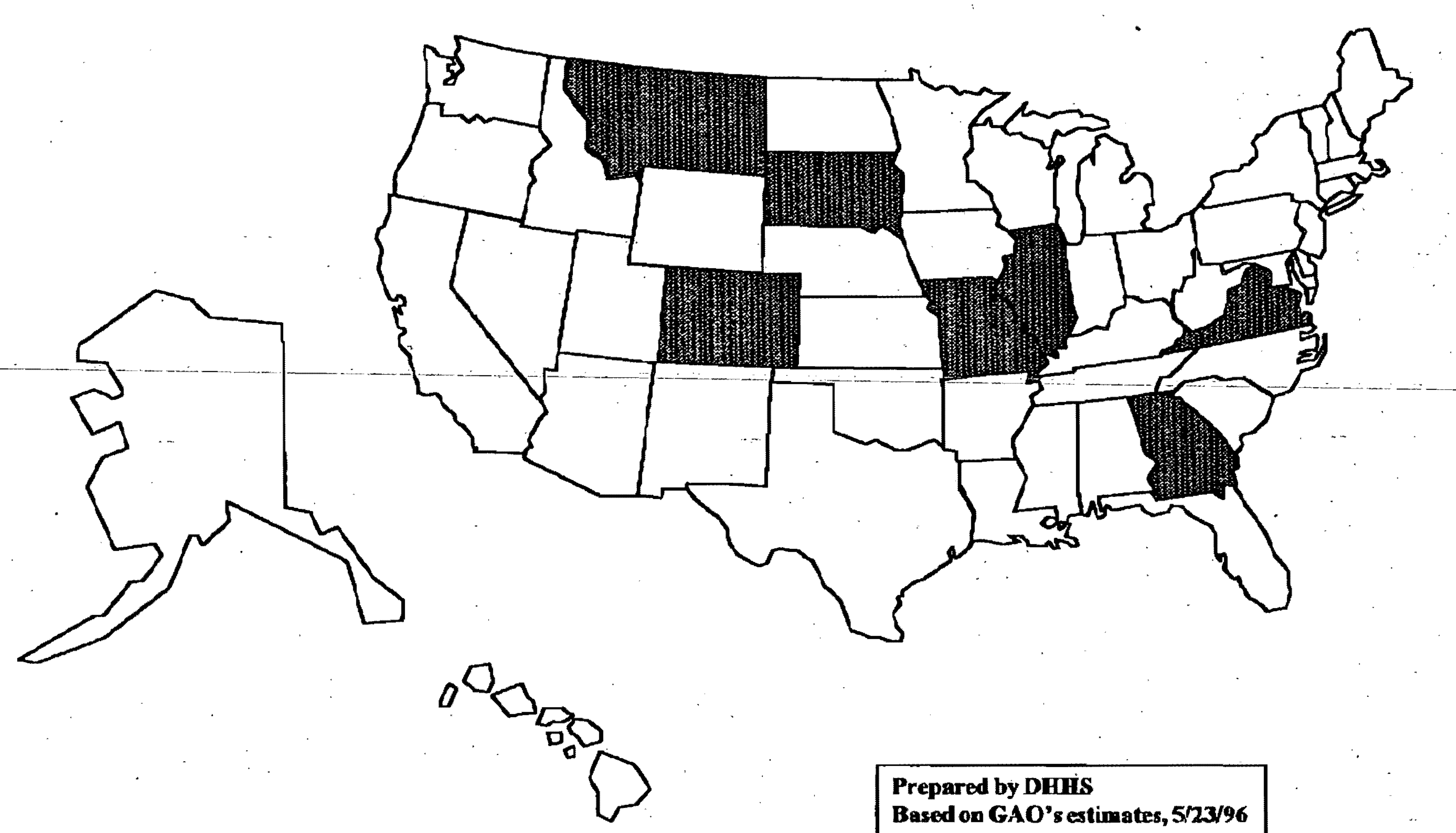


States Receiving Needs Based Allotments in 1997



Prepared by DHHS
Based on GAO's estimates, 5/23/96

States Receiving Needs Based Allotments in 2002



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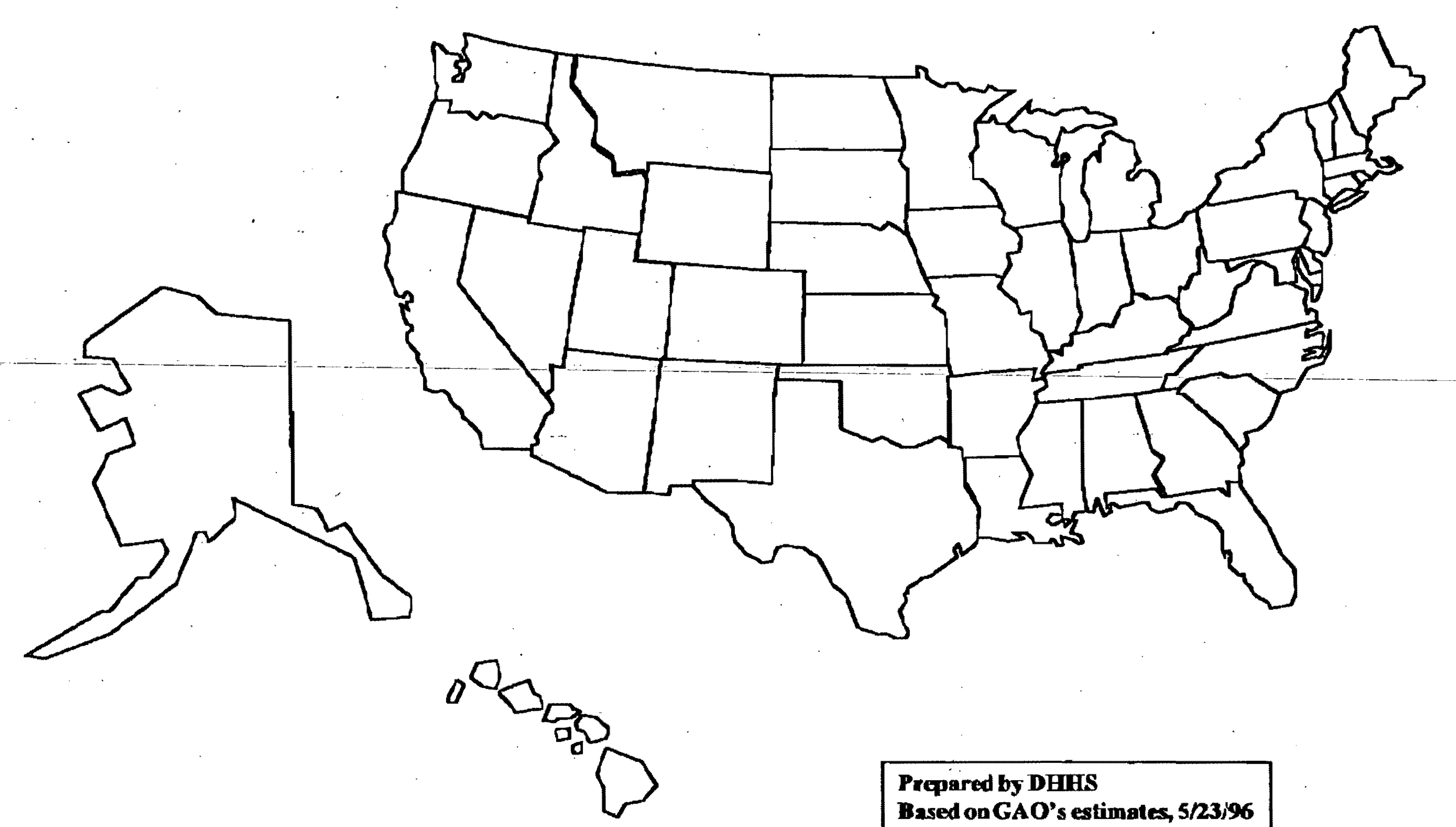
States Receiving Needs Based Allotments Every Year, 1997-2002



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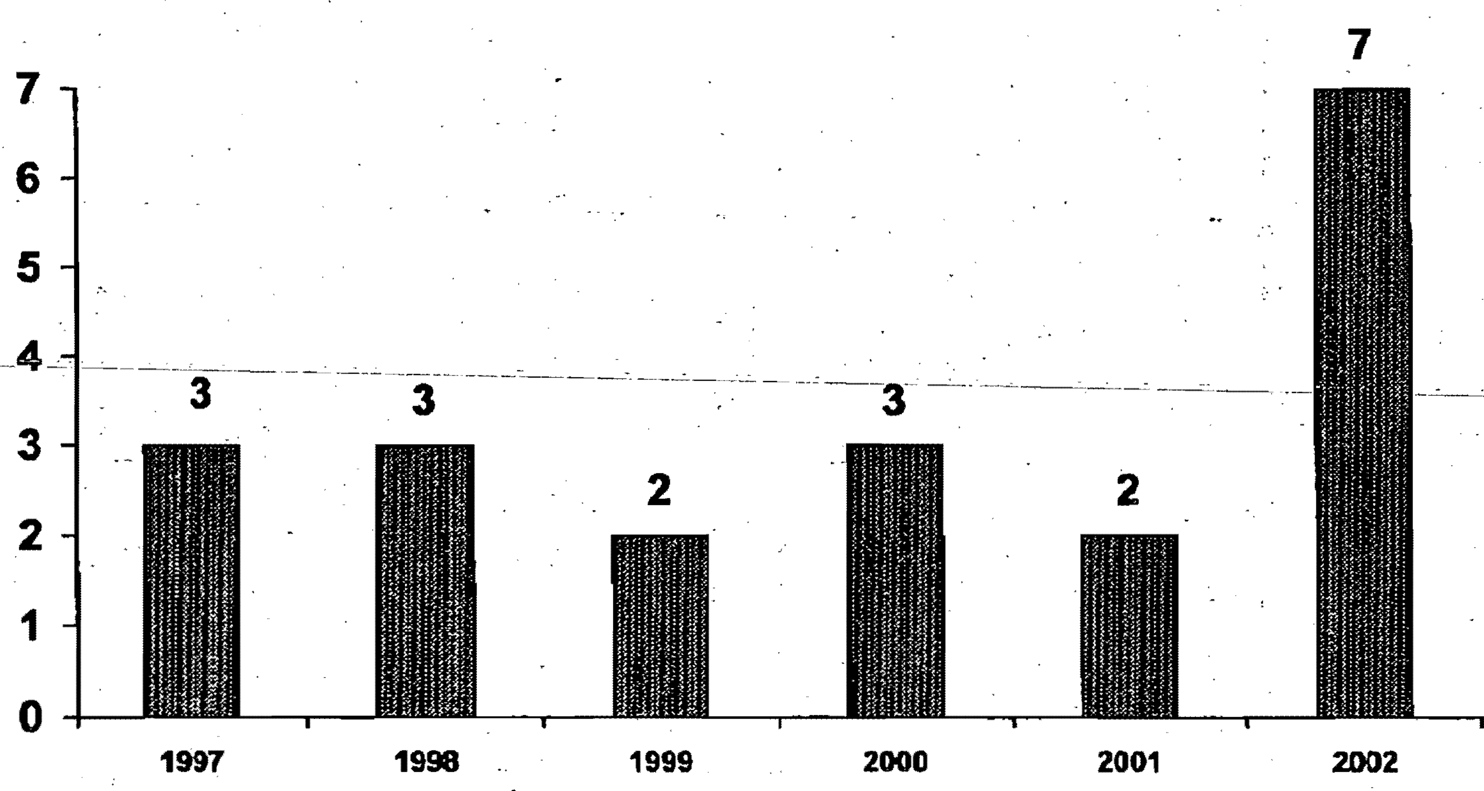
Number of States in each year receiving Needs Based Allotments, 1997-2002



Prepared by DHHS
Based on GAO's estimates, 5/23/96

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THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable federal guarantee of coverage for a defined benefit package
- Adequate and appropriately shared federal and state financing
- Beneficiary protections through quality standards and accountability

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, the House Commerce Republican bill would alter existing eligibility criteria thereby eliminating the guarantee of coverage for some currently-eligible groups. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal Poverty Level (FPL).**

- **offers each state the option of using either: 1)the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of current policy, which has a federal definition. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.

- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**

- **eliminates the current guarantee of transitional medical assistance for individuals losing cash assistance due to proposed time limits or other provisions in welfare reform.**

- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid. For example, it appears states may even have flexibility to restrict eligibility based on home ownership. Under current law, a home of any value does not affect a person's eligibility. Under the Republican bill, home owners could be found ineligible.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefit packages. There would be no "required" services for optional eligibility groups.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the "amount, duration, and scope" of benefits).** The Secretary does not have clear authority to affect states' decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.

- **Statewideness requirements would be eliminated.** States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain populations that tend to live in specific areas.

- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries). Alternatively, states could provide richer benefits to favorable groups.

- **"Treatment" under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services.** Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they would be optional services.

- **The Vaccines for Children Program is repealed,** while making childhood immunization a mandatory service. States are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.

- **Federal funding for abortion services would be permanently limited to instances of rape, incest, or where the life of the mother is in jeopardy.**

- **Family planning services are limited to "pre-pregnancy" family planning services and supplies.**

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in

federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** Beneficiaries could file a petition for certiorari before the Supreme Court of the United States, but only after all state appeal mechanisms are exhausted. Otherwise, only the Secretary of HHS would be able to sue in federal court on behalf of individuals. No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.

- Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns. and from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The base funding formula in the Republican bill has been seen before: it's the basic Medigrant II formula. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigrant II block grant formula. About 3 percent is attributable to the new umbrella fund.

The funding formula provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.

- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they may be forced either to raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to decrease total Medicaid funding and the state contribution required to generate the capped federal share of dollars spent on Medicaid. States have the incentive to withdraw large amounts of state Medicaid funding, making total cuts much larger than the proposed $72 billion in federal cuts.

- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year. Repealing these limitations would give states the incentive to use these schemes to reduce the state contribution to Medicaid even further.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.

- **The Republican bill does not include critical federal quality standards for institutions caring for people with mental retardation and developmental disabilities.** There are no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.

- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.

- **The Republican bill expands states' ability to impose cost sharing on Medicaid beneficiaries.** Unlike current law, which bars states from imposing co-payments on children or on pregnancy related services, the Republican bill would allow cost sharing for children and pregnant women for any service except preventive and primary services, as defined by the state. In addition, co-payments could be imposed for all other services to the elderly and disabled.

- **Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.**

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as "nursing home services." Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.

- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

- **The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries.** Assets, including the home, needed by survivors could be at risk of being claimed by the state.