

THE ADMINISTRATION'S PROPOSAL FOR MEDICAID: BLOCK GRANTS REVISITED

On January 31st, HHS Secretary Tommy Thompson outlined the Administration's plans to do away with Medicaid and SCHIP (State Children's Health Insurance Program) as we know them. The proposal angles the carrot of more state flexibility, with additional federal funding to assist in tight budget times, but only if states agree to a capped allotment – effectively a block grant for Medicaid and SCHIP.

1. What is the option being offered to states?

The proposal offers states additional federal money for seven out of the next ten years. But the proposal puts states in a bind – if they accept the additional federal funding, they must also agree to accept a capped annual federal “allotment,” in effect a block grant and effectively repay advanced federal funds in later years (after the Bush Administration and most current Governors will be out of office). States not choosing the block grant would continue to administer Medicaid and SCHIP subject to existing rules and without additional federal funding.

2. Will Congressional approval be required?

According to Secretary Thompson, the proposal requires legislative approval.

3. What is HHS proposing?

Initial details are limited to a press release, press briefing by HHS Secretary Tommy Thompson, and statements in the President's FY 2004 budget.¹ More information may not be available until legislative language is submitted to Congress. However, from Secretary Thompson's initial statement, we know one indication to the thrust of the proposal: “We need to bring the same clear-eyed spirit of innovation to Medicaid that we brought to welfare.”

HHS' proposal would provide states participating in the block grant with an additional \$3.25 billion in FY 2004. For the first seven years, a total of \$12.7 billion in additional federal funds would be available. It is unclear whether the entire amount will be available if not all states participate. In contrast, a proposal in the Senate to increase the federal Medicaid FMAP (the federal share of Medicaid costs) would provide states with \$10 billion dollars through June 2005; a House FMAP proposal would provide states with \$8 billion over 12 months.²

Secretary Thompson said the proposal will be budget neutral for the federal government over ten years. Since HHS would offer states additional money in years one through seven, it would seem that a decrease in federal spending would have to occur in years eight through ten. Thus, should their current fiscal woes prove to be persistent (or recurring), states opting for the quick fix being offered

¹ See <http://www.hhs.gov/budget/docbudget.htm>.

² See S.138, sponsored by Senators Rockefeller, Snowe and Collins; the House bill, sponsored by Representatives King and Sherrod Brown is called the State Fiscal Relief Act but has not been introduced in the 108th Congress.

OTHER OFFICES

by the Administration could find themselves in even more dire straits in a few years. Compounding this problem is the fact that the decreased federal funding will coincide almost exactly with the rising population of aging baby boomers for whom increased healthcare costs can be assured. Of course, this Administration will not be in office at that time.

4. What would states have to do to get federal assistance?

States would have to agree to accept two block grants– one for acute care and one for long term care. A state would be foreclosed from getting federal matching funds for any expenditure that exceeded its allotment. In contrast, Congressional FMAP proposals would not require states to alter administration of their Medicaid/SCHIP programs or pay back federal funding in subsequent years.

5. How does this differ from current Medicaid and SCHIP spending?

Currently, states receive federal “matching” funds for all of their Medicaid and SCHIP expenditures through four funding streams – Medicaid services, SCHIP services, DSH (Disproportionate Share Hospitals) payments and management/administrative expenses. These four streams would be merged into two – acute care and long term care. Currently, no Medicaid funding other than DSH is capped. SCHIP allotments are capped and administrative expenses cannot exceed 10% of the state’s SCHIP budget.

In this new proposal, states would receive capped allotments for both acute and long term care and would have the ability to transfer up to 10% of the funds between the two. States could use up to 15% of the funds for management/administrative expenses.

6. What is wrong with a cap?

One of the major problems with a capped allotment is that it precludes Medicaid from responding to the ebbs and flows of the economy and healthcare costs. Medicaid is a counter-cyclical program – as the economy weakens and people lose jobs, they can turn to Medicaid for health insurance. With a capped allotment, a state will not receive additional money as it enrolls more individuals. Thus, just when the stresses on Medicaid are greatest, states will have less money to spend per enrollee.

The cap also destroys Medicaid’s role as an entitlement program. It is this entitlement that makes Medicaid insurance, that gives beneficiaries the right to obtain needed services in a timely manner. Couched in “flexibility,” the Administration’s proposal would destroy this individual right. Moreover, flexibility has already failed as a magic bullet. Over the past decade, state flexibility has been greatly enhanced, through the use of waivers, to allow mandatory managed care and other cost containment initiatives. However, Medicaid spending has nevertheless increased. Other factors, largely beyond state control, are at the root of the spending increases – the aging of the population, health care price inflation, and increases in the number of people who are unemployed or have disabilities.

7. How would HHS determine the allotments?

The initial allotments would be based on states’ FY 2002 Medicaid and SCHIP spending and increase yearly according to an undisclosed formula. It is unknown whether this formula will account for the differences between a state’s Medicaid FMAP and its enhanced SCHIP rates.

According to the President's FY 2004 budget, states taking the capped allotment would have a "maintenance of effort" (MOE) requirement – they must continue to spend at least the same amount on Medicaid/SCHIP as they do in FY 2002. The MOE requirement will increase annually by a trend rate. Yet the MOE requirement does not seem to be a "match" requirement. States could thus reduce Medicaid spending by counting other healthcare spending towards its MOE.

According to HHS, Medicaid spending is increasing at an average rate of 9% per year. It is unclear whether HHS' allotments will fluctuate if actual growth exceeds 9% per year. Under the proposal, HHS anticipates providing states with a FY 2004 FMAP increase of approximately 2%. In years 2-7, states would also anticipate getting increased federal funding above projected Medicaid spending growth. In years 8-10, however, states would get less than projected Medicaid spending growth.

8. How could states change benefit packages?

Mandatory populations and benefits. According to Secretary Thompson, CMS would preserve comprehensive benefits for "mandatory" groups. There is, however, no definition of "comprehensive." Under current law, states are mandated to provide only certain services³; the rest are optional (e.g. prescription drugs, hospice care, dental and vision care). And since HHS has built this proposal on the SCHIP model – where states can use either the statutorily defined benefit package or a Secretary-approved benefit package – "comprehensive" could turn out to be whatever the Secretary will approve.

Optional populations and benefits. Over 11 million beneficiaries are "optional" and 66% of spending on Medicaid services are for optional services or optional beneficiaries (particularly used by people with disabilities and the elderly) States that take the block grant would have carte blanche to design benefit packages and eligibility. A state could have different eligibility levels for different geographic areas in the state. Different benefits could be offered to different populations. In short, this block grant proposal would, for optional populations and optional services, do away with the current Medicaid requirements that benefits be comparable among recipients and of sufficient amount, duration and scope to serve their intended purpose.

9. How could states change cost-sharing?

According to Secretary Thompson, states would have complete discretion to determine cost-sharing, including co-pays, deductibles and premiums, for all optional beneficiaries. This marks a dramatic change from current law, which specifically prohibits cost-sharing for children in the Medicaid program, limits co-payments to amounts that are "nominal," and limits cost-sharing for families and children receiving coverage through SCHIP. Without any limitations on co-pays, cost-sharing and premiums, the new proposal would allow states to price coverage above the means of low-income individuals, thereby creating the illusion of decreased demand.

10. How would this proposal affect care for current Medicaid recipients with disabilities?

³ These are: physician services; laboratory and x-ray services; in-patient hospital services; outpatient hospital services, federally qualified health center and rural health clinic services; EPSDT (early and periodic screening, diagnosis and testing), nursing facility services for individuals over age 21, family planning services & supplies; pregnancy related services; nurse midwife services; certified nurse practitioner services; and home health care services (for individuals entitled to nursing facility care).

Over 1.5 million individuals with disabilities are now Medicaid “optional” beneficiaries. This includes individuals with disabilities who have incomes above SSI eligibility levels, individuals eligible for Medicaid through home and community based waivers, certain working individuals with disabilities, and the medically needy. Over 66% of Medicaid spending on people with disabilities is optional.

The benefits used by individuals with disabilities vary. As noted by the Kaiser Family Foundation, children with disabilities may need specialty care, home-based care, medical equipment, and, in some cases, institutional care; working individuals with disabilities may need personal attendants, prescription drugs, and other supportive services to remain independent; and frail elderly individuals may require home health care or nursing home care. Under this proposal, however, states would have unfettered discretion to define both eligibility and benefits, so that the coverage needed by individuals with disabilities will not be guaranteed.

The President’s budget includes a number of new proposals under the New Freedom Initiative that could positively affect the lives of individuals with disabilities without creating a Medicaid block grant.⁴ But because the New Freedom Initiative is built on traditional Medicaid coverage, it is unclear how many states would pursue that option when tempted by the HHS proposal to offer them additional federal funding with virtually no oversight.

11. How would this proposal affect elderly individuals currently receiving Medicaid?

Over 56% of elderly individuals – over two million individuals – receiving Medicaid are “optional” beneficiaries. These individuals include those residing in nursing homes, the medically needy, and other elderly individuals ineligible for SSI or only receiving State Supplemental Payments.

Eighty-three percent of spending on elderly Medicaid beneficiaries is optional. Yet many of the services included in the Medicaid program, particularly costly long-term institutional care, are generally not covered by private insurers or Medicare. If a state were to model benefits on a plan received by state employees – who generally do not need long-term care – the benefit package would likely shortchange elderly individuals.

12. How would this proposal affect children and their parents currently receiving Medicaid or SCHIP?

The proposal would merge children’s Medicaid and SCHIP coverage into one acute care block grant. All SCHIP enrollees – over 4 million children since 1997 – as well as many children currently covered by Medicaid could be affected by this proposal. In addition, 3.7 million parents receive Medicaid as “optional” beneficiaries.

Further, Medicaid currently requires EPSDT (early and periodic screening, diagnosis and treatment) services for all children. States opting for the block grant could eliminate the protections of EPSDT for “optional” children. It is also unclear whether EPSDT would be part of the “comprehensive” benefit package HHS would require for mandatory populations.

⁴ CMS is proposing three demonstration programs promoting at-home care as an alternative to institutionalization. CMS also seeks to initiate a program to address the shortages of community direct care workers. Another demonstration proposal would have CMS paying the entire first year of Medicaid services for individuals moving from institutions to at-home care. After the first year, states will begin paying their Medicaid match. *See* <http://www.hhs.gov/budget/docbudget.htm>

13. How would this proposal affect women currently receiving Medicaid?

Medicaid plays a crucial role in insuring more than 23 million low-income women. Over 33% of women with incomes below 100% of the federal poverty level (FPL) receive Medicaid. Medicaid pays for 40% of all births in the US and is the largest public source of family planning funding. States receive 90% federal match for family planning services. Under the block grant, family planning services would likely not receive this higher match, thereby eliminating an incentive that states currently have to provide these services.

“Optional” Medicaid women who could be affected include pregnant women with incomes above 133% of the poverty line, parents, and women covered under the Breast and Cervical Cancer Treatment program. Under current Medicaid law, states may not impose co-pays on pregnancy and family planning services and must provide all pregnancy related services. The block grant option would allow states to impose co-pays on, as well as restrict, these services.

14. How would this proposal affect immigrants receiving Medicaid/SCHIP?

To the extent that immigrants receiving Medicaid are “optional” beneficiaries, they too could be affected by states’ restructuring of their Medicaid programs. Unless the proposal is accompanied by revisions to immigrant eligibility restrictions enacted in 1996 – revisions which this Administration has not previously supported – most immigrants will remain ineligible for Medicaid for the first five years after entry into the U.S. (unless they are within exempted categories such as asylees, refugees, Cuban/Haitian entrants).

15. How would the block grant proposal affect funding for hospitals?

Currently, hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the Disproportionate Share Hospital (DSH) program. While states already have flexibility to design their DSH programs – determining which hospitals are DSH, how much funding to distribute, etc. – the DSH payments were designed to provide a designated funding stream to hospitals that serve as “safety net” providers. In many states the DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. More than 10% of all Medicaid funding is through DSH, amounting to more than \$15.8 billion in 2001.

Under the Administration’s proposal, designated DSH funding would be eliminated. Hospitals would have to compete with all other providers to obtain compensation from a state’s acute and long term care allotments.

16. How would this proposal affect the number of uninsured Americans?

There are currently over 41 million uninsured individuals in this country and that number is rising. While the Administration says that its proposal will allow states to cover more individuals, including those ineligible for Medicaid (e.g. childless adults), the funding mechanism it employs is more likely in the long run to produce the opposite result. While the proposal offers up-front money to financially strapped states, many of those states will need that money just to continue current coverage. Yet in years 8-10, states will receive less federal funding, likely causing them to reduce coverage and further swell the ranks of the uninsured. In addition, by allowing states to increase cost-sharing without any constraints, the proposal may well lead to a Medicaid program that many of the most

needy cannot afford, thereby in that critical way mirroring the private insurance model that the Administration seems to so admire.

Further, the history of recent “expansions” through CMS’ waiver process illustrates that states, even with less than absolute discretion, have sometimes diluted their benefit packages so much that the resulting product cannot legitimately be described as insurance. For example, Utah recently received a waiver that reduces benefits to existing Medicaid recipients in order to offer childless adults limited to access to primary care, without any coverage for specialists or in-patient hospitalization to treat any ailments that the primary care provider might discover.

17. What comes next?

As the Administration recognizes, this proposal will require legislative approval. Separately from the Administration’s proposal, the House Energy and Commerce committee has scheduled hearings to examine Medicaid. It will be important for Senators and Representatives to be educated about:

- the benefits of the current structure of Medicaid and SCHIP;
- the need for the federal government to accept its responsibility for dual eligibles by adopting a comprehensive Medicare prescription drug plan and otherwise remedying the current situation in which the states are essentially forced to use their precious Medicaid dollars to subsidize the Medicare program; and,
- the need for immediate financial assistance to the states – without the poison pill of a capped allotment— to meet the increased demand for Medicaid and SCHIP caused by our sickly economy.