CRS Report for Congress
Received through the CRS Web

Medicaid: 105th Congress

February 4, 1998

Melvina Ford and Richard Price
Specialists in Social Legislation
Jennifer Neisner
Analyst in Social Legislation
Education and Public Welfare Division

Medicaid: 105th Congress

Summary

Medicaid is a joint federal-state matching, open-ended entitlement program that pays for medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Through the use of special income standards, states may provide Medicaid to certain non-poor persons who are in nursing facilities or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community. Within federal guidelines, each state designs and administers its own program. Total program outlays in FY1997 were $167.6 billion. Federal outlays were $95.6 billion; state outlays were approximately $72.1 billion. The federal government shares in a state's Medicaid costs by means of a statutory formula based on the state's per capita income. Adjusted annually, federal matching rates currently range from 50% to 79% of a state's expenditures for Medicaid items and services. Overall, the federal government pays for about 57% of all Medicaid costs.

Two major factors have prompted Congress to consider fundamental restructuring of the Medicaid program in recent years. First, Medicaid has been one of the fastest growing items in federal and state budgets. Second, many state Governors said their federal-state Medicaid partnership was being eroded by increases in federal requirements regarding eligibility, benefits, and reimbursement to providers. The 104th Congress considered but did not enact proposals for Medicaid reform. The proposals considered by the 104th Congress would have transformed the program into a capped block grant to states and reduced program funding to the states by approximately $72 billion over 6 years.

The 105th Congress made important changes to the Medicaid program though H.R. 2015, the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). BBA 97 is less far-reaching in its reform of the Medicaid program than proposals considered in the 104th Congress, leaving the program's existing structure largely intact. The Act achieves net Medicaid savings of about $13 billion between FY1998 and FY2002, largely from reductions in supplemental payments to hospitals that serve a disproportionate share of Medicaid and low-income patients. The new law significantly increases the flexibility that states have to manage their Medicaid programs. In particular, it gives states the option of requiring most beneficiaries to enroll in managed care plans without seeking a federal waiver and replaces federal financial requirements imposed by the Boren amendments with a public notice process for setting payment rates for institutional services. Spending items in the Act include Medicaid coverage for additional children, and increased assistance for low-income people to pay Medicare Part B premiums.

As part of his FY1999 budget, President Clinton proposes giving states additional funds to find and cover uninsured children by expanding Medicaid outreach funds and making it easier to grant immediate coverage to children who have not yet enrolled. The budget also proposes to streamline the Medicaid application process by simplifying eligibility; to allow states to provide Medicaid

coverage to legal immigrant children; and to reduce the federal share of state administrative costs.

Contents

List of Tables

Medicaid: 105th Congress

Overview

Medicaid is a joint federal-state matching, open-ended, entitlement program that pays for medically necessary health care services provided to eligible beneficiaries by qualified providers. Eligible Medicaid beneficiaries must be both *categorically* and *financially* eligible. Generally, Medicaid eligibility is limited to low-income children and women, low-income people with disabilities and low-income elderly persons. Through the use of special optional income standards, states can extend coverage to certain non-poor persons. For some groups, age and income requirements for Medicaid eligibility are mandated by federal law, but for others the state may decide who is eligible.

Medicaid covers one quarter of the Nation's children. Of the 42.4 million people who were enrolled in Medicaid in FY1996, nearly 21 million were children under age 21. An additional 9.6 million people were adults in families with children. Together, these adults and children comprised 74% of the Medicaid population and accounted for 26% of total benefit costs. The elderly and disabled made up 26% of the population but accounted for 72% of total benefit costs. Much of the spending for elderly and disabled recipients is for long-term care. Medicaid is a major source of public support for nursing home care and a range of home care services. It is also the largest payer of services, both institutional and community-based, needed by persons with mental retardation and developmental disabilities. In FY1996, over $50 billion, or 41% of Medicaid spending for services, was for long-term care. In addition to nursing home and other long-term care services, Medicaid is the country's largest single purchaser of maternity care.

Within broad federal guidelines, each state designs and administers its Medicaid program. Federal law requires that states offer certain services including hospital, physician, nursing facility, and laboratory and x-ray services. States have the option of offering other services such as prescription drugs, dental care, or eyeglasses. Each state determines what services it will provide, and what it will pay for services. Considerable variation exists in terms of persons covered, types and amounts of services offered, and payments for services. The variation among states is so great that some speak of Medicaid as 51 separate programs. To control costs, states are increasingly delivering services to their Medicaid populations through managed care. Approximately 40% of the Medicaid caseload was enrolled in some form of managed care in 1996, up from 12% in 1992.

At the federal level, Medicaid is administered by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). Federal law requires that each state operate its Medicaid program through a single state agency. Usually this is the state human resource or welfare agency, the health

department, or a combination of the two. The single state agency sets policies, certifies providers, pays for services, and oversees eligibility determinations. Each state's Medicaid policies are set forth in a Medicaid state plan that is subject to approval by the Secretary of HHS.

The federal government reimburses states for their Medicaid expenditures by means of a statutory formula designed to give a higher matching rate to states with lower per capita incomes. Matching rates for services range from 50% to 79% and are adjusted annually. Matching rates for administrative costs are generally 50%, though rates ranging from 75% to 90% are available for certain management and control activities. For Puerto Rico and other outlying areas, the federal share of all costs is 50% with a maximum dollar limit placed on the amount each area can receive. Overall, the federal government pays about 57% of total Medicaid program expenditures.

In FY1997, total program outlays were $167.6 billion. Federal outlays were $95.6 billion; state outlays were approximately $72.1 billion. Under the Medicaid provisions of the BBA, the Congressional Budget Office (CBO) estimates that there will be a net reduction of $13 billion in federal Medicaid expenditures between FY1998-FY2002. As of January 1998, CBO projects annual average Medicaid growth of 6.7% through 2003. CBO estimates that FY1998 federal Medicaid expenditures will be $99 billion and total expenditures will be $170 billion.

Table 1. Medicaid Outlays, FY1988-2003*
($ in billions)

Fiscal year	Federal	State[a]	Total	Annual % change
1988	$30.5	$23.7	$54.1	—
1989	34.6	26.6	61.2	13.2%
1990	41.1	31.1	72.2	17.8%
1991	52.5	41.9	94.5	30.9%
1992	67.8	50.3	118.2	25.1%
1993	75.8	56.2	132.0	11.7%
1994	82.0	61.8	143.8	8.2%
1995	89.1	67.2	156.3	8.6%
1996	91.3	68.3	159.6	2.1%
1997	95.6	72.1	167.6	5.0%
1998	*100.5*	*75.8*	*176.3*	*5.2%*
1999	*108.4*	*81.8*	*190.2*	*7.9%*
2000	*115.0*	*86.8*	*201.8*	*6.1%*

Fiscal year	Federal	State[a]	Total	Annual % change
2001	*122.6*	*92.5*	*215.1*	*6.6%*
2002	*130.9*	*98.7*	*229.6*	*6.8%*
2003	*140.7*	*106.2*	*246.9*	*7.5%*

Source: Office of Management and Budget, Dept. of the Treasury Financial Management Service, and Congressional Budget Office..

* FY1998-FY2003 figures based on Congressional Budget Office projections, January 1998.

[a] State outlays are based on percentage estimates furnished by the HCFA, Office of the Actuary.

Two major factors prompted the 104th Congress to consider fundamental restructuring of the Medicaid program. First, Medicaid had been one of the fastest growing items in federal and state budgets. (Note the annual percent change in the table above.) Second, many state Governors said their federal-state Medicaid partnership was being eroded by increasing federal requirements that the states regarded as unfunded mandates.

Due to a combination of factors including enrollment increases, health care inflation, and creative state financing practices, federal Medicaid outlays rose dramatically from FY1989 to FY1992, increasing at an average annual rate of over 25%. Some states said Medicaid was the largest single item in their budgets, using resources that states wanted to put into education or other state programs. Although outlay growth slowed to 12% in FY1993 and to 8% in FY1994, lawmakers saw the reduction of Medicaid growth as an essential part of reducing the federal deficit and providing relief to states.

The 104th Congress considered fundamental reform of the Medicaid program, not only because of the growth rate of Medicaid spending but also because of the relationship between the federal and state governments in administering and financing the program. Beginning in the mid-1980s, Congress gradually added to the federal requirements regarding eligibility, benefits, and reimbursement to providers. The population required to be served was expanded to include pregnant women, children, and Medicare beneficiaries with incomes substantially higher than those of other Medicaid recipients. New and more extensive standards for nursing home care were established by federal legislation. "Boren amendments" established federal payment requirements for state reimbursement to hospitals and nursing homes. In addition, states pointed to an unnecessarily complex and cumbersome process they were required to go through in order to serve more of their population through managed care and to expand coverage to populations not otherwise eligible for Medicaid. States have asked for more flexibility and fewer federal constraints. The proposals considered by the 104th Congress would have transformed the program into a capped block grant and reduced federal funding to the states by approximately $72 billion over 6 years.

Although no Medicaid reform legislation was enacted by the 104th Congress, there was general agreement that measures to reduce Medicaid growth and increase state flexibility were needed.

Medicaid in the 105th Congress

In the 105th Congress, President Clinton's FY1998 budget, the concurrent budget resolution for FY1998, and H.R. 2015, BBA 97, passed by Congress on July 31, 1997 all echoed the sense of the 104th Congress regarding Medicaid, this time, however, without major structural reforms, and with much smaller reductions in program spending. BBA 97 (P.L. 105-33), signed into law August 5, 1997, reduces program growth and increases state flexibility.

The President released a plan in February 1997 that included proposals for savings through a per capita cap on federal funds and a reduction in payments to hospitals that serve a disproportionate number of Medicaid and low-income patients, offset by various spending initiatives. The National Governors Association (NGA) asked for flexibility that the Governors believed would result in Medicaid savings without a per capita cap. The concurrent budget resolution assumed lower disproportionate share hospital (DSH) payments and rejected a cap on federal funding for Medicaid, incorporating instead an increase in state Medicaid flexibility.

P.L. 105-33 is estimated to result in Medicaid savings of about $13 billion between FY1998-FY2002, largely through reductions in payments to DSHs. The law adopts many of the flexibility provisions that were recommended by the President and by the NGA. These provisions allow states to require managed care enrollment without obtaining waivers, ease some other managed care requirements, and repeal or modify some of the current provider payment rules. The law eliminates or modifies some existing administrative requirements and codifies quality assurance requirements for managed care. It adds new Medicaid benefits for children, disabled workers, and Medicare beneficiaries who receive some Medicaid benefits. This report describes the major savings provision and the new spending provisions, then discusses other items in the Medicaid portion of P.L. 105-33.

Reduction in Payments to Disproportionate Share Hospitals (DSH)

Since 1981, states have been required to make supplemental payments to hospitals that serve a disproportionate number of Medicaid recipients and low-income patients. These payments are referred to as DSH payments. Each state determines which hospitals receive DSH payments and the payment amounts to each. States that contract with health maintenance organizations (HMOs) or other prepaid capitated managed care providers may include DSH expenses in the payment rates to contractors. The DSH adjustment was intended to offset the costs to hospitals of treating unsponsored low-income patients, and to protect access to care for vulnerable populations. However, studies have shown that only a portion of DSH expenditures benefit low-income people or reduce uncompensated care.

Federal Medicaid DSH payments were $10 billion in 1995. By statute, DSH payments in the national aggregate, as well as in each state, are permitted to equal up to 12% of total Medicaid spending applicable to a fiscal year, excluding administrative costs. The 12% limit is being phased in through the use of state-specific DSH allotments (limits on federal matching payments) for each federal fiscal year. States with DSH payments at 12% of their costs or more (classified by HCFA as "high" DSH states) have a fixed allotment and cannot increase their DSH payments until the fixed amount is less than 12% of the state's Medicaid spending. States with DSH payments below 12% of their Medicaid costs (classified as "low" DSH states) can receive allotments increasing their DSH adjustments up to the 12% limit.

The BBA lowers DSH allotments by imposing freezes and making graduated proportional reductions. It establishes additional caps on the state DSH allotments for fiscal years beginning in 1998 and specifies those caps for 1998 to 2002 as shown in **Table 2**.

Table 2. DSH Allotment
(in millions of dollars)

State or District	FY1998	FY1999	FY2000	FY2001	FY2002
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1085	1068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	23	23	23
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	16	16	16
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379

State or District	FY1998	FY1999	FY2000	FY2001	FY2002
Montana	0	0	0	0	0
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	5	5	5
New York	1512	1482	1436	1361	1285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0	0	0

Source: P.L. 105-33.

Thereafter, the DSH allotments for a state will be equal to the allotment for the preceding fiscal year increased by the percentage change in the medical care component of the consumer price index for all urban consumers as estimated by the Secretary for the previous fiscal year, subject to a ceiling of 12% of the total amount of expenditures under the state plan for medical assistance during the fiscal year.

P.L. 105-33 imposes a new cap on DSH payments to institutions for mental disease (IMDs — facilities that are largely long-term care mental hospitals). Medicaid law prohibits federal financial participation for services provided to individuals between the ages of 21 and 65 who are in IMDs. Mental health services to these individuals have traditionally been considered a state and local responsibility. These facilities may be reimbursed for services provided to patients under age 21 or age 65 or over and they are also eligible for DSH payments. There was concern that state Medicaid programs were using DSH payments to IMDs to pay for some of the costs of providing institutional services for those persons between the

ages of 21 and 65 that Medicaid is prohibited from covering.[1] The provisions in BBA 97 limit DSH payments to IMDs and other mental health facilities to the lesser of the amount of such payments made in 1995 or a specific percentage of the state's DSH allotment for the current fiscal year. For FY1998-FY2000, federal IMD DSH payments may not exceed the lesser of (1) a state's total DSH spending in 1995 for such facilities[2] or (2) the same percentage of DSH expenditures their IMD spending represented in 1995. For FY2001 and beyond, IMD DSH payments may not exceed the lesser of (1) a state's total DSH spending in 1995 for such facilities; (2) the same percentage of DSH expenditures their IMD spending represented in 1995; or (3) 50% of DSH payments in 2001, 40% in 2002, and 33% for succeeding years. The provision does not apply to DSH payments made under payment arrangements in effect on July 1, 1997.

The law also requires states to develop a methodology and submit to the Secretary a description of the methodology to be used by the state for prioritizing payments to DSHs, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. Finally, the law requires states to pay disproportionate share adjustments on behalf of individuals in managed care entities directly to the hospitals rather than to the managed care entities and not to include such payments in the capitation rate.[3]

Managed Care

A major flexibility measure involves states' use of managed care organizations for delivering services to Medicaid beneficiaries. Under prior law, states had to obtain waivers of certain Medicaid provisions to require that Medicaid beneficiaries get their services through managed care organizations. P.L. 105-33 eliminates the need for waivers that many states have complained are unnecessarily complex and time-consuming.

As states increasingly move to provide services through managed care arrangements and Congress seeks to ease state requirements with respect to managed care, lawmakers have also been looking at the quality of managed care services. The Act includes managed care provisions that establish standards for quality and solvency, and provide protections for beneficiaries.

To control costs and quality of care, states are increasingly delivering services to their Medicaid populations through HMOs and other managed care arrangements such as primary care case management (PCCM). Managed care organizations (MCOs) provide or arrange for a defined set of benefits in exchange for a fixed monthly premium called a capitation payment. Under such arrangements,

---

[1]U.S. General Accounting Office. *Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals*. GAO/HEHS-98-52, January, 1998. Washington, 1998.

[2]FY1995 DSH payments to IMDs are defined in the law as those reported by the state on HCFA Form 64 no later than January 1, 1997.

[3]For further information, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

beneficiaries have a regular source of coordinated care and states have predictable, controlled spending per beneficiary. This is in contrast to the traditional fee-for-service arrangements used by Medicaid beneficiaries where Medicaid pays for each service used. Under PCCM, a Medicaid beneficiary has a primary care provider that provides or arranges for all covered services. The primary care case manager is paid a small monthly "management" fee in addition to fees for any health care services that the case manager provides directly to a beneficiary.

A state may offer MCO services on a voluntary basis. However, to mandate that a beneficiary enroll in an MCO, or to limit MCO services to a specific population or geographic area, a state had to first obtain a waiver of certain provisions of Medicaid law. These renewable waivers, as authorized under section 1915(b) of Medicaid law, are initially good for 2 years. (The 1915(b) waiver is more restrictive than the Section 1115(a) waiver under which a state can undertake a statewide demonstration program that may include mandatory managed care.)

P.L. 105-33 eliminates the need for the 1915(b) waiver process and permits states to require that individuals enroll with managed care entities. Managed care entities are defined to include both MCOs and PCCMs. The new law establishes a statutory definition of PCCM, adds it as a covered service, and sets contractual requirements for both PCCM and MCOs. The Act prohibits states from requiring children with special health care needs and certain Medicaid-eligible Medicare beneficiaries to enroll with managed care entities. Additionally, it stipulates that Native Americans/Alaskan Natives may only be required to enroll in a participating Indian Health, urban Indian, or tribally operated managed care entity. The new law requires that beneficiaries have a choice between at least two plans or two primary care providers, and establishes special rules for beneficiaries living in rural areas.

The Act adds measures intended to safeguard the quality of care provided under managed care arrangements. For example, managed care entities must provide information on providers, enrollee rights and responsibilities, grievance and appeal procedures, and covered items and services to enrollees and potential enrollees. States must, on an annual basis, provide individuals required to enroll with managed care entities with a list identifying the managed care entities available and comparative information about each entity's benefits and cost-sharing, service area, and quality and performance. PCCM contracts must provide that hours of operation are reasonable and adequate, including 24-hour availability of information, referral, and treatment with respect to medical emergencies; that a sufficient number of providers are employed to meet the needs of enrollees; and that individuals aren't discriminated against in enrollment, disenrollment, or reenrollment based on health status or need for care. Managed care entities are required to provide assurances of adequate capacity; to establish internal grievance procedures; and to comply with the mental health parity and maternity length-of-stay requirements enacted by the Mental Health Parity Act of 1996 and the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204).

Among other changes to Medicaid managed care arrangements, P.L. 105-33 eliminates the current law provision that requires MCOs to have no more than 75% of their enrollment be Medicaid and Medicare beneficiaries and raises the threshold for federal review of managed care contracts from $100,000 to $1 million. The Act

eliminates the current law prohibition on cost-sharing for services furnished by HMOs.

As more states deliver Medicaid benefits through managed care arrangements, there is also heightened interest in assuring that MCOs are solvent and that states have quality standards that must be met, and sufficient data to monitor the quality of care provided under managed care. The new law sets requirements for quality and access, solvency, and consumer protections. It requires a state entering into contracts with MCOs to establish a quality assurance program, consistent with standards that the Secretary would establish and monitor. State quality assurance programs would be required to include (1) standards that ensure covered services are available within reasonable timeframes and that ensure adequate access to primary care and specialized services, (2) procedures for monitoring and evaluating quality of care that includes submitting quality assurance data using requirements for entities with Medicare contracts or other requirements as approved by the Secretary and, (3) examination of other aspects of care and services directly related to the improvement of quality of care (including grievance procedures and marketing and information standards). The Act requires MCOs to obtain an annual external independent review of the quality outcomes and timeliness of, and access to, the services included in the organization's contract with the state. MCOs must make results of the reviews available to participating providers, enrollees and potential enrollees.

The Act requires Medicaid MCOs to meet the same solvency standards set by the states for private HMOs not participating in Medicaid, or have state licensure or certification as a risk-bearing entity. This requirement would not apply under the following circumstances:

- The organization does not provide inpatient and physician services;
- The organization is a public entity;
- The organization is a federally qualified health center; or
- The organization's solvency is guaranteed by the state.

P.L. 105-33 applies a "prudent layperson" standard to whether a Medicaid MCO would have to pay for services provided to an enrollee in an emergency room. The provisions defines emergency service for the enrollee as service needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is defined as one manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy (and in case of a pregnant woman, her health or that of her unborn child), (b) serious impairment to bodily functions or, (c) serious dysfunction of any bodily organ or part. The Act also includes a ban on so-called "gag rules," prohibiting interference with physician advice to enrollees.

The Act contains provisions that protect Medicaid beneficiaries against false or misleading HMO marketing materials and practices, and includes several provisions to protect beneficiaries and providers. These include requiring managed care entities to make assurances that enrollees will not be held liable for the entity's debts in the event of insolvency, balanced billing limitation requirements, prohibiting entities

from discriminating against providers, and establishing sanctions for entities that fail to comply with program rules.

Payment Methodology

Traditionally, each state has established its provider payment methodologies and rates. Legislation enacted in the 1980s, however, added federal requirements for reimbursing certain providers. Among the most important of these are the so-called Boren amendments and provisions requiring cost-based reimbursement to federally qualified health centers (FQHCs) and rural health clinics (RHCs). P.L. 105-33 amends these payment methodologies and others as well.

Repeal of Boren Amendments. Prior to enactment of the Boren amendments, states used Medicare cost-based reimbursement methods for paying institutional providers. In response to concerns about the growth of spending to these providers, and criticism that cost-based reimbursement provided few incentives for providers to perform efficiently, Congress enacted the Boren amendments in the 1980s. The amendments directed that payment rates be "reasonable and adequate" to cover the cost of "efficiently and economically operated" facilities. Subsequently, a number of courts found that state systems failed to meet the test of "reasonableness" and some states have had to increase payments to these providers. The NGA has repeatedly asked for relief from the Boren amendment.

P.L. 105-33 repeals the Boren amendment and establishes a public notice and comment process for setting reimbursement methodology and rates for hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR). Some facilities and their trade associations have been concerned that with repeal of the Boren amendments, states would lower their payments to rates under which the facilities would be strained to provide specified levels of quality service. Under the new provision, each state will be required to publish proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates. The public will have an opportunity for review and comment on the proposed rates. Final rates are to be published with the underlying methodologies and justifications for the rates. The provision applies to payment for services furnished on or after April 1, 1998. The bill requires the Secretary to study the effect of states' rate-setting methods on access to, and quality and safety of, services and report to Congress within 4 years of enactment.

Federally Qualified Health Centers and Rural Health Clinics. Prior law required that states' payments for ambulatory services provided by FQHCs and RHCs must be equal to 100% of the facilities' reasonable costs for providing the services. If an FQHC entered into a contract with an HMO that contracts with a state Medicaid program, the HMO were required to pay the FQHC 100% of reasonable costs and the state's capitation payment to the HMO had to reflect the 100% rate that was due to the FQHC.

The law defines FQHC as a center that receives, or meets the requirements to receive, a certain grant under the Public Health Service Act. In addition, an entity is an FQHC if, based on the recommendation of the Health Resources Services

Administration (HRSA) within the Public Health Service, the Secretary determines that the entity meets the requirement for receiving such a grant.

Under P.L. 105-33, the requirement to pay a percentage of FQHC and RHC costs will be phased out over 6 fiscal years. States are required to pay 100% of costs for services furnished during FY1998 and FY1999; 95% of costs for services furnished during FY2000; 90% for services furnished during FY2001; 85% for services furnished during FY2002; and 70% for services furnished during FY2003. For services furnished on or after October 1, 2003, no required payment percentage will apply.

To ease the transition from cost-based payment rates, the new law specifies two special payment rules that would be applicable during FY1998-FY2002. In the case of a contract between an FQHC or RHC and a managed care organization, the managed care organization will have to pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States will be required to make supplemental payments to the FQHcs and RHCs. Such payments will be equal to the difference between the contracted amounts and the cost-based amount.

P.L. 105-33 amends the definition of FQHC to exclude from coverage an entity that is owned, controlled, or operated by another entity.

Reimbursement to Obstetricians and Pediatricians. To assure the availability of obstetrical and pediatric services to Medicaid beneficiaries, the Medicaid law required states to assure adequate payment levels for services furnished by these providers and to provide annual reports on their payment rates for the services. The BBA repeals these requirements.

Treatment of State Taxes Imposed on Hospitals. States may not claim for federal matching payments state spending generated from provider-related donations or health care taxes that are not broad based. Health care provider-specific taxes are not considered broad-based and, thus, may not be used to claim federal matching payment for Medicaid spending. The effect of this provision is that if a state imposes taxes on hospitals, it must tax all hospitals in the state including charity hospitals that receive no revenues from Medicaid, insurers, or individuals. P.L. 105-33 amends the definition of the term "broad-based health care related tax" to specify that taxes that exclude hospitals which are exempt from taxation under Section 501(a) of the Internal Revenue code and do not accept Medicare and/or Medicaid reimbursement would qualify for federal matching payments if used as state Medicaid spending. The provision also prohibits states from claiming federal matching payments for state spending generated from health care taxes applied to these facilities.

This provision is important to Shriners Hospitals for Children. These hospitals provide specialized care, free of charge, to children under age 18 who have orthopedic or burn conditions. In many cases Medicaid coverage may be unavailable for such care because it is not *medically* necessary.

Medicare Cost-Sharing. State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare (dual eligibles) and for qualified Medicare beneficiaries

(QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards. The amount of required payment has been the subject of some controversy. State Medicaid programs frequently have lower payment rates for services than the rate that would be paid under Medicare. Program guidelines permit states to either (1) pay the full Medicare deductible and coinsurance amounts or (2) pay cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers for the full Medicare allowable rates for services provided to QMBs and dually eligible individuals. P.L. 105-33 clarifies that a state Medicaid program is not required to pay Medicare cost-sharing expenses if the Medicare payment for the service exceeds the amount that the state Medicaid program would have paid for the service to a recipient who was not a QMB. Under the new law, the Medicare payment plus the state's Medicaid payment, if any, will be considered payment in full. The QMB will not be liable for payment to a managed care entity or other provider.

Eligibility

State Option of Continuous Eligibility for 12 Months. Generally, Medicaid coverage can be provided only to individuals who continue to meet all the requirements for eligibility. For some individuals, or families, income fluctuations result in frequent interruptions in eligibility status. Medicaid law includes exceptions that provide for continuous eligibility for pregnant women and infants regardless of changes in income. A pregnant recipient continues to be eligible for Medicaid until 60 days after the pregnancy ends; a child born to a Medicaid recipient remains eligible for 1 year so long as the child is a member of the mother's household and the mother remains eligible for Medicaid or would remain eligible if pregnant. P.L. 105-33 gives states the option of providing a full 12 months of eligibility for a child who is determined eligible for Medicaid

Option to Accelerate the Expansion of Eligibility. OBRA90 mandated that states phase in Medicaid coverage to children living in households with incomes not over 100% of the federal poverty level who were born after September 30, 1983, until all children up to age 19 are covered. P.L. 105-33 permits states to accelerate the expansion of eligibility to all children in poverty-level households through age 18.

Payment of Home-Health Related Medicare Part B Premium Amount for Certain Low-Income Individuals. Prior law required states to pay Medicaid Part B premiums for Medicare beneficiaries who had incomes up to 120% of the official poverty line. The BBA includes Medicare provisions that increase monthly premium payments as a result of the transfer of certain home health visits from Part A to Part B. Under the Act, states will be required to pay Part B premiums for beneficiaries with incomes up to 135% of poverty. For Medicare beneficiaries with incomes between 135% and 175% of poverty, state Medicaid programs will be required to cover that portion of the Medicare Part B premium attributable to the transfer of home health visits. These new state requirements apply to premiums payable between January 1998 and December 2002.

The federal government will pay 100% of the costs associated with expanding Medicare Part B premium assistance from 120% to 135%, as well as the extra premium cost attributable to the home health transfer for persons between 135% and 175%. The Act establishes a capped allotment to states to cover these costs. The Secretary will be required to provide for allocations to states based on the sum of (1) a state's number of Medicare beneficiaries with incomes between 135% and 175% of poverty and (2) twice the number of Medicare beneficiaries with incomes between 120% and 135% of poverty, relative to the sum for all eligible states. Total amounts available for allocations are $200 million for FY1998, $250 million for FY1999, $300 million for FY2000, $350 million for FY2001, and $400 million for FY2002. The federal medical assistance percentage (FMAP) for each participating state would be 100% up to the state's allocation. If a state exceeded its allocation, the FMAP for any "excess" assistance would be zero.

During a calendar year, a state will allow all qualifying individuals to apply for assistance. For receipt of premium assistance, the state will select individuals in the order in which they apply, up to the number the state has estimated will use, but not exceed, the state's allocation for Part B premium assistance. Although this provision of BBA 97 does not establish an entitlement for individuals, an individual selected by the state to receive assistance for a month is entitled to assistance for the remainder of the year so long as the individual continued to be a qualifying individual. However, an individual selected to receive assistance at any time during a year is not entitled to continued assistance for any succeeding year.

Coverage for Disabled Working Individuals. Currently, states must continue Medicaid coverage for "qualified severely impaired individuals under the age of 65." These are disabled and blind individuals whose earnings reach or exceed the supplemental security income (SSI) benefit standards. (The current law threshold for earnings is $1,053 per month.) This special eligibility status applies as long as the individual (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing or obtaining employment if Medicaid eligibility were to end; and (4) has earnings that are not sufficient to provide a reasonable equivalent of benefits from SSI, state supplementary payments (if provided), Medicaid, and publicly funded attendant care that would have been available in the absence of those earnings. To implement the fourth criterion, the Social Security Administration compares an individual's gross earnings to a "threshold" amount that represents average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's state of residence.

Under P.L. 105-33, states have the option of creating a new eligibility category for disabled SSI beneficiaries with incomes up to 250% of poverty. Beneficiaries can "buy into" Medicaid by paying a sliding scale premium based on the individual's income as determined by the state.

Aliens. The Personal Responsibility and Work Opportunities Act (PRWORA, P.L. 104-193), established significant restrictions on the eligibility of legal aliens for needs-based public assistance. Under PRWORA, legal immigrants arriving in the United States after August 22,1996 are ineligible for Medicaid benefits for 5 years. Coverage of such persons after the 5-year ban is a state option. States are required

to provide Medicaid coverage to legal immigrants who resided in the country and were receiving benefits on August 22,1996. States are also required to provide coverage to: refugees for the first 5 years after entry into the United States; asylees for the first 5 years after asylum is granted; individuals whose deportation is being withheld by the Immigration and Naturalization Service for the first 5 years after grant of deportation withholding; lawful permanent aliens after they have been credited with 40 quarters of coverage under Social Security; and honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children. Qualified aliens and non-qualified aliens who meet the financial and categorical eligibility requirements for Medicaid may receive emergency Medicaid services. BBA 97 modifies these restrictions somewhat. BBA 97 requires states to provide Medicaid coverage to legal immigrants who resided in the country on August 22, 1996 and who become disabled in the future and extends the period that states must provide coverage to refugees, asylees, and individuals whose deportation has been withheld from 5 to 7 years.[4]

Medicaid Eligibility for SSI Children. P.L. 104-193 included several provisions that changed the SSI program with respect to disabled children. The law established a new definition of disability for children, which resulted in making approximately 100,000 children who formerly received SSI ineligible for benefits. These children also would have lost Medicaid eligibility. BBA 97 reinstates Medicaid eligibility for those children who lost coverage as a result of the new disability definition.

Programs of All-Inclusive Care for the Elderly (PACE)

The Omnibus Budget Reconciliation Act of 1986 required the Secretary of HHS to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All-Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, On Lok, serving frail elderly, could be replicated across the country. The Omnibus Budget Reconciliation Act of 1990 expanded the number of organizations eligible for waivers to 15. P.L. 105-33 permits states to offer PACE as an optional benefit. States will be allowed to limit the number of persons enrolled in PACE programs.

Administration

P.L. 105-33 includes a number of measures that would change or eliminate requirements that some states have found burdensome. Among these are repeal of the requirement that states identify cases in which it would be cost-effective to enroll a Medicaid-eligible individual in a private insurance plan and, as a condition of eligibility, require the individual to enroll in the plan. Instead, states will have the option of identifying cases and purchasing private insurance for Medicaid-eligible

---

[4]For further information, see CRS Report 96-617, *Alien Eligibility for Public Assistance*, by Joyce C. Vialet and Larry M. Eig.

individuals. States will no longer be required to submit annual reports on their payment rates for obstetricians and pediatricians. Inspection of care requirements with respect to patients in ICFs/MR and mental hospitals will be eliminated in favor of other requirements that many regard as duplicative. States are allowed to establish remedies to deter noncompliance and correct deficiencies in ICFs/MR. More changes are discussed below.

1115 Waiver Renewals. Under Section 1115 of the Social Security Act, a state may obtain waivers of compliance with a broad range of Medicaid requirements in order to conduct an experimental, pilot or demonstration project that is likely to promote the objectives of Medicaid. In the absence of established conditions for these projects, each request receives individual consideration from HCFA. In the past, 1115 waivers have been granted for research purposes, to test a program improvement or investigate an issue of interest to HCFA. Except for the Arizona Health Care Cost Containment System which operates a medical assistance program as a demonstration project, projects generally run for a limited period of 3 to 5 years and are not renewable. Recently, more states are using the 1115 waiver authority to completely revamp their Medicaid programs and the delivery of health care to their state residents.

P.L. 105-33 provides a mechanism for extension of a state-wide comprehensive 1115 waiver project for up to 3 years. Slightly over a year before a waiver project is due to expire, the chief executive officer of a state may submit to the Secretary a written request for extension for up to 3 years. Such a request will be deemed to have been granted if the Secretary does not respond within 6 months. Generally, extension of a project will be on the same terms and conditions that applied to the project before the extension.

Federal Payments

Funding for Emergency Health Services Furnished to Undocumented Aliens. State Medicaid programs are required to cover emergency services furnished to undocumented aliens who otherwise meet Medicaid eligibility standards. Some states, especially border states, say they bear a disproportionate burden for this type of costs. To help defray the costs of emergency services to undocumented aliens, P.L. 105-33 makes $25 million available for grants to the 12 states with the highest number of undocumented aliens for each of the FY1998-FY2001. For each year, the Secretary would compute allotments based on a state's share of undocumented aliens relative to the undocumented aliens in all states. Numbers of undocumented aliens would be based on estimates prepared by the Statistics Division of the Immigration and Naturalization Services as of October 1992.

Federal Payment to the District of Columbia and Alaska. Under Medicaid law, the District of Columbia is treated as a state. States are required to pay at least 40% of the non-federal share of Medicaid expenditures. A state, by law, can require local jurisdictions to share Medicaid costs instead of bearing the entire nonfederal share. The District's federal Medicaid matching rate is 50%, i.e., 50% of total Medicaid expenditures (100% of the nonfederal share). Under agreements reached between the District of Columbia, the District of Columbia Financial Responsibility and Management Assistance Authority (Authority, commonly known as the control

board), and the Office of Management and Budget, the District's federal Medicaid matching rate was to be increased to 70%. The provision would reduce the District's share of Medicaid costs to 30%, the maximum amount that the District, as a local government, could be required to contribute if it were located within a state with a federal matching rate of 50%. P.L. 105-33 increases the federal share of the District's Medicaid costs to 70%. The Act also includes a provision that increases Alaska's federal Medicaid matching rate to 59.8% for FY1998-FY2000.

Federal Payment Cap for Puerto Rico. For Puerto Rico and the territories, the federal Medicaid matching rate is 50% up to statutory limits that are specified in section 1108 of the Social Security Act. Beginning with FY1994, the federal Medicaid limit increases annually by the percentage increase in the medical care component of the consumer price index for all urban consumers, rounded to the nearest $100,000 for Puerto Rico and rounded to the nearest $10,000 for the other outlying areas. For FY1998, BBA 97 would increase the federal Medicaid funding limits to these islands over current law amounts by $30 million for Puerto Rico, $750,000 each for the Virgin Islands and Guam, and $500,000 each for American Samoa and the Northern Mariana Islands. For FY1999 and after, the islands would be allowed the amount certified for the preceding year increased as under current law.

FY1999 Budget

President Clinton's FY1999 budget, which was released February 2, 1998, proposes giving states additional funds to find and cover uninsured children by expanding Medicaid outreach funds and making it easier to grant immediate coverage to children who have not yet enrolled. Over 5 years, the proposal is expected to cost $900 million in new federal spending. The budget also proposes to streamline the Medicaid application process; allow states to provide Medicaid coverage to legal immigrant children; and reduce the federal share of state administrative costs. The budget proposes to reduce overall federal Medicaid spending by $210 million in FY1999.

Increase Outreach Fund. Under P.L. 104-193, $500 million was made available to states over a 3 year period to identify and enroll children and parents who lost eligibility for welfare under the law, but may still be eligible for Medicaid.[5] The

---

[5]Prior to the enactment of the P.L. 104-193, states were required to provide Medicaid to all persons receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. P.L. 104-193 repealed the AFDC program, replacing it with the block grant program Temporary Assistance for Needy Families (TANF). Unlike AFDC, TANF eligibility does not confer automatic Medicaid eligibility. However, the new law preserves Medicaid entitlement for individuals who meet the requirements for the AFDC program that were in their state on July 16, 1996, even if they do not qualify for assistance under TANF. States are required to use the eligibility determination process already in place for AFDC and Medicaid, including the same income and resource standards and other rules formerly used to determine if a family's income and composition made them eligible for AFDC and Medicaid. States are allowed to modify their "pre-reform" AFDC income and resource standards as follows: (1) states may lower their income eligibility standards, but not below those it used on May 1, 1988; (2) states may increase their income and resource standards

(continued...)

President's FY1999 budget proposes to increase the size of this fund; to allow states use the fund and to receive a 90% matching rate for most outreach activities for all uninsured children, not just children whose parents are no longer eligible for welfare; and to make the fund available to states beyond 2002, the year it is scheduled to sunset.

Expand Qualified Entities for Presumptive Eligibility. Current law allows certain entities, such as Medicaid providers and eligibility workers for Head Start and child care, to enroll children into Medicaid on the presumption that they are eligible (presumptive eligibility). The presumptive eligibility period begins when a qualified entity determines, based on preliminary information, that the child's family income is below the applicable income eligibility level for the state Medicaid program, and ends when a formal determination is made. The Administration proposes expanding the category of qualified entities who can make the presumptive eligibility decisions to include organizations such as public schools, child care resource and referral centers, child support enforcement agencies, and eligibility workers for the new State Children's Health Insurance Program (S-CHIP). This proposal is expected to cost $570 million over 5 years.

Simplify Enrollment. The budget proposes to streamline the Medicaid application process by simplifying eligibility and encouraging states to use mail-in applications to determine eligibility.

Cover Immigrant Children. Under current law, states can provide Medicaid coverage to legal immigrant children who entered the country before August 22, 1996, the date P.L. 104-193 was enacted, but children who entered the country after that date are ineligible for benefits for 5 years. The President's budget would allow states to disregard the 5 year ban for children who enter the country after August 22, 1996. Under the proposal, states could provide health coverage to legal alien children through Medicaid or through S-CHIP.

Reduce FMAP for Administrative Costs. The federal government pays 50% of most administrative costs associated with the Medicaid program. The Administration's budget would reduce the FMAP for administrative costs from 50% to 47%. This proposal is designed to offset expected cost increases as states begin to charge Medicaid for administrative costs that were formerly charged to the AFDC program and are now included in TANF block grants.

Prior to the enactment of the welfare reform law in 1996, states charged most of the common costs of administering AFDC, Medicaid, and Food Stamps to the AFDC program, because the reimbursement policy was the same for all three programs (states received 50% of administrative costs). However, P.L. 104-103 altered that by replacing the open-ended AFDC program with the capped TANF program. Administrative expenses were included in TANF's funding base. Because administrative expenses have been rising since the enactment of the new law, a

---

[5](...continued)
up to the percentage increase in the Consumer Price Index (CPI); (3) states may use *less* restrictive income and resource standards than those in effect on July 16, 1996.

number of states requested permission from the Administration to charge administrative costs to the Medicaid and Food Stamps programs (which are still open-ended) rather than to TANF (which is capped). Such a change is estimated to cost $3 billion over 5 years. The Administration's proposal to reduce Medicaid's FMAP for administrative expenses from 50% to 47% is designed to allow states to shift costs to Medicaid and Food Stamps without greatly increasing federal outlays.