IMMEDIATE ASSISTANCE TO THE MEDICAID PROGRAM

Rapidly rising Medicaid costs are breaking states' budgets. Without changes in federal law and regulation to allow cost containment in some Medicaid programs, increased flexibility in financing and implementing programs, and financial assistance from the federal government, many states cannot afford to stay in compliance with federal laws and millions of people stand to loose important services.

Governors know that, once adopted and implemented, national health reform may change or replace the current Medicaid program. However, until health reforms are in place, states must have cooperation and assistance from the federal government.

Through the National Governors' Association, governors sent President Clinton a list of recommendations for changes in federal laws and policies to improve access and contain costs in the Medicaid program. From that rather lengthy list, the governors recommend several priorities for immediate action by the President, the Congress and the U.S. Department of Health and Human Services (HHS). Action on the following priorities can have a positive impact on state Medicaid budgets and accomplish overall cost containment without limiting access or reducing quality of services:

1. NO CAPS FOR FEDERAL SPENDING ON MEDICAID ENTITLEMENTS UNTIL ANOTHER HEALTH FINANCING SYSTEM IS IN PLACE.

   Federal caps on medical entitlements will not cut health care costs or reduce people's need for health services. Such caps will shift costs to state and local governments that they simply cannot afford. Capping federal Medicaid entitlements will result in a loss of services for millions of people and will shift additional costs to people with private insurance.

2. GIVE GREATER LEEWAY IN CONTAINING THE COST OF HEALTH SERVICES AND LONG TERM CARE THROUGH ISSUING RULES FOR THE BOREN AMENDMENT.

   The Boren Amendment was intended originally to allow states to contain costs for hospital and nursing home services. Because no rules were issued to guide states in implementing the law, hospitals and nursing homes sued states, and courts have interpreted the law in a manner that drives up health care costs significantly. HHS needs to issue rules for the Boren Amendment as soon as possible. In addition, legislative revisions need to be reviewed and strongly considered.

3. ALLOW STATES TO MANAGE COSTS IN THE EPSDT PROGRAM THROUGH PROVIDING SERVICES WITHIN THEIR STATE MEDICAID PLAN AND SELECTING LESS COSTLY ALTERNATIVES FOR DIAGNOSIS AND TREATMENT WITHOUT RISKING QUALITY.

Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. HHS needs to issue rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

4. PROVIDE FAIRNESS AND FLEXIBILITY IN THE DISPROPORTIONATE SHARE PROGRAM THROUGH RULES AND LAWS THAT WILL:

A. Modify the interpretation of the statute to allow for growth in low-DSH states without penalizing high-DSH states.

B. Ease restrictions on how states raise matching funds for the disproportionate share program.

C. Give states flexibility to use disproportionate share funds in whatever way best fits the needs in serving Medicaid-eligible and other medically indigent people in their state.

When caps were set for spending on the disproportionate share program, some states share in the program was frozen at rates below the maximum spending level set for each state. Fairness requires that these low-DSH states be allowed to move up to the level of the cap for states without penalizing high-DSH states that are already at or near the cap.

Different revenue-raising measures are chosen by different states, and the federal government should not dictate to state governments how they raise their matching funds for the Medicaid program.

By allowing states to spend disproportionate share funds in whatever way will serve the most Medicaid-eligible and other medically indigent people in each state, the disproportionate share funds can be used to cover the unmet needs of the greatest number of people. The federal government can give states flexibility in using disproportinate share funds without increasing demands on the federal budget, and the flexibility will allow each state to make the best use of these dollars.

The governors recognize the Administration is already proceeding on these and other issues relating to provider taxes and disproportionate share. We applaud this work.

5. PROVIDE WAIVERS TO ENCOURAGE OR PROVIDE INCENTIVES TO STATES TO USE OF IN-HOME AND COMMUNITY SERVICES FOR ELDERLY AND DISABLED PEOPLE AS A MEANS OF CONTAINING LONG TERM CARE COSTS AND PROVING THE MOST APPROPRIATE SERVICES.

Medicaid laws and regulations favor institutional care by paying for services when a person is in a hospital or nursing home that would not be paid for if the person lived at home or in a community-based program. More people can be served for less money in non-institutional settings, and in-home and community services allow people to gain or maintain greater independence. HHS needs to expedite waivers that allow states to serve people outside of hospitals or nursing homes and to develop incentives for states to contain costs through increasing in-home and community services when this is in the best interest of the person served.

6. RECOGNIZE THE STATES' FINANCIAL CRISES IN FUNDING MEDICAID SERVICES AND RAISE THE FEDERAL GOVERNMENT'S PORTION OF THE MEDICAID MATCH RATE UNTIL A HEALTH REFORM PLAN IS IN PLACE.

States' budgets cannot continue to cover the escalating costs of the Medicaid program. By temporarily increasing the federal portion of the Medicaid match, the federal government will assist states as they provide federally mandated Medicaid until comprehensive health reform can be implemented. If federal budget constraints preclude this option, we urge increased flexibility in Medicaid programs and mandate relief.

7. EXPEDITE THE WAIVER PROCESS SO STATES CAN IMPLEMENT MANAGED CARE SYSTEMS, COMPREHENSIVE DEMONSTRATION PROJECTS, AND LIMITED MEDICAID SERVICES IN SCHOOL-LINKED CLINICS.

Delays in getting waivers from HCFA have curtailed states' efforts to implement managed care as a means of cost containment and improved access. Waivers also have been delayed or denied for large demonstration projects attempting to set up comprehensive, integrated health care systems in states. School-linked clinics can offer improved access to health services at relatively low costs, and these clinics need to be Medicaid approved even if they do not offer the full range of services available in Medicaid community primary care clinics. HHS needs to respond quickly to waiver requests and to favor requests that will improve access to health care and contain costs.