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From the Editor

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Budget Games In Times of Fiscal Restraint

By Alison McChrystal Barnes

Our economic circumstances—after dot-com failures, general business losses, and government constraints in federal and most state-level budgets in 2001—create a climate for health and social services programs we have not seen in most of a decade. Money is suddenly tight, workers fear and experience layoffs, and governments engage in shell games to hide cuts in services that are likely to trigger an outcry from citizens.

It's a good time to remember that all the rules of government funding for health and social services seek to assure that the cost of care is predictable. Yes, of course, quality of care is essential. Predictability does not usually preclude quality. Rather, the search for predictability and fiscal constraint in an era of scant resources can at least temporarily interfere with reasonable quality of care by undercutting the volume of services. Typically, the volume of services is limited by placing new constraints on payments to providers or by excluding eligibility for groups of service recipients who are considered to be the least in need.

This brief tour of constrained services might serve as a template for understanding the services changes that might affect your client population. We are concerned here mostly with Medicaid waivers, although some dual eligibility and other matters arise in the context of financial need for elders with chronic disabilities and a government readjusting to more normally funded economic times.

Medicaid Waivers: A Little Context

Medicaid waivers allow for deviation from the federal guidelines governing health and health-related services to needy people. The fundamental Medicaid program, enacted by Congress in July 1965, includes a core package of benefits the state must offer in order to qualify for federal funds to match state dollars spent on health care for the poor. The match rate for states is based on the average per capita income in the state, so states with poorer populations overall can receive up to 80 percent federal money to just 20 percent of

state funds. The core services include (in part) inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility (SNF) care; home health care for people eligible for SNF services; physician care, and a small number of preventive or special diagnostic services. The state might also choose to provide so-called "optional" services, any of another 32 services, including nonskilled nursing home care, prescription drugs, vision services, prosthetic devices, and dental services. The federal guidelines set standards for the reliability and accountability of the state programs.

The state qualifies for federal Medicaid funds by creating a plan that shows how the state intends to fund and deliver the care on a continuing basis. The federal government requires that a state provide services in the amount, duration, and scope adequate to meet the objectives of the Medicaid program, which are to provide for the eligible poor all medically necessary care. Under the original rules, recipients had to be allowed to choose their health care providers (subject to the limitation that the provider had to agree to accept the Medicaid payment as full payment for the service), and each service was required to be available to all recipients throughout the state.

A state can provide to Medicaid recipients a variation in services from federal guidelines only with a waiver of the fundamental rules. The oldest waiver is the so-called 1915c waiver, originally called a 2176 waiver until its provisions were recodified. These waiver rules were enacted in the Omnibus Budget Reconciliation Act (OBRA) in 1981. Such a waiver gives states the option to use federal Medicaid funds to provide non-medical home care to elderly people at risk of institutionalization, an option not available under the basic program rules. Although hundreds of such waivers were granted over the years, some states had trouble qualifying because federal rules required them to show that providing the home care causes a reduction in the use of institutional care. This was impossible in states that lacked an adequate number of nursing home beds, because the so-called "cold bed" would be filled immediately by another person in need of care. Thus, while there might be a reduction in unmet need, there was no reduction in the volume of institutional care.

Other state choices, such as care for only a discrete population as a demonstration or because of special need, can be provided under Medicaid with a waiver of specific fundamental federal rules regarding "statewideness," the requirement that all services available to any recipient be available to all recipients in the state. Many waivers that allow Medicaid spending for home and community-based care waive both the provider choice and statewideness requirements so the state can test the effectiveness of a community-based service in a very limited area. The state avoids incurring the start-up difficulties of finding personnel and the exposure to costs that would arise if the program were implemented statewide.

To make waivers more widely available, Congress created the Frail Elderly program waiver in 1990 (called initially Section 4711 waivers for the section creating the authority in OBRA 1990, forming §1929 of the Social Security Act, and codified at 42 U.S.C. §1396d(a)(23)). Under these provisions, states can receive waivers to provide home and community-based care to "functionally disabled" persons aged 65 or older who receive SSI income payments or meet income and resource standards set by the state for prospective nursing home residents. The program costs are capped, reflecting the continuing concern that the government incrementally is undertaking financial responsibility for long-term care.

While the terms of the 4711 waiver seem very broad, services under such a waiver are in fact limited by very specific financial and physical or mental disability eligibility requirements. The amount available to the states caused many to forego the hassle of applying for so limited a sum.

Beginning in 1993, states received permission to enroll Medicaid recipients in managed health care under liberalized program rules amending the requirement of provider choice. Managed care had become prevalent in the private sector as a means of promoting cost-efficiency and potentially limiting the rapidly rising costs of Medicaid, which caused the states alarm for their budget balances. Medicaid managed care in fact provided the states some relief from rising costs, although those costs arose from a variety of sources other than inflation in the cost of health care. Thus, rising costs in the general economy or in related populations caused a change in the terms of care to the eligible population.

Waivers and Fiscal Constraints

States must balance their budgets, while legislators must respond to citizens' concerns about people who are old, poor, and frail or sick. In a time of shrinking services—whether economically or politically

dictated, or both—waivers might reallocate or limit existing services rather than providing the opportunities for care originally envisioned.

A newly created waiver program, the Health Insurance Flexibility and Accountability (HIFA) demonstration makes the point. States can seek a HIFA waiver in order to expand Medicaid and State Children's Health Insurance Program (SCHIP) benefits to eligible people of all ages with incomes up to 200 percent of the federal poverty level. This represents an expansion of some eligible populations and a contraction of others.[1]

However, states are not eligible to receive matching federal funds for this new coverage. Rather, the waiver gives them broad authority to constrict eligibility and require larger copayments from recipients who remain eligible. Thus, the funding for the waiver comes from current recipients, all of whom were formerly considered to be in need of their benefits.

Florida has received a new waiver in recent months, under initiatives of the Dept. of Health and Human Services (DHHS).[2] The state of Florida can adjust its upper payment limits to hospitals (other than state hospitals) that serve a large number of Medicaid patients. The permission reverses a plan formerly promoted by many states. States have, in recent years, engaged in strategic financial steps that netted payments from just such hospitals. Termed "voluntary contributions," or later, "provider taxes," the hospital and state agreed that the additional money would be offered in order to receive federal Medicaid matching funds that would then be available to cover hospital costs for care to Medicaid beneficiaries. Net gain: between 50 and 80 percent over unmatched funds, with the contributing hospital up for a share in proportion to the number of Medicaid patients served.

The effect of the waiver is not to expand the program to new and needed services, as waivers originally were conceived. Rather, it is a mechanism to allow the state to withdraw funds from hospitals from which it has encouraged or compelled contribution in the past. The state might find, in the new era of fiscal constraint, that the revenue deal for the hospitals is fiscally, or more likely ideologically, undesirable.

When is a waiver not a waiver? When the purposes are to reduce services to those currently receiving and relying on them, in order to limit the state's commitment to care; when access to care is restricted without a corresponding benefit in terms of finance or administration; when government seeks to support its fiscal needs by depriving those least capable of complaint. The recent history of Medicaid waivers shows that the impact of each one must be carefully analyzed. Florida has four more in the pipeline. What about your state?

Endnotes

1. The waiver program appears to undercut a number of federal initiatives of the 1990s. For example, federal mandates required the states to extend Medicaid coverage to a number of new populations, including so-called "dual eligibles," who are elders eligible for both Medicare and Medicaid. States are required to pay Medicare Part A deductibles and Part B premiums for elder Medicaid beneficiaries. Medicare becomes the primary payer for hospital costs, physician fees and other Medicare benefits. Medicaid, which has a broader package of benefits, pays for other needs, such as dentures and eyeglasses. States have implemented the program without enthusiasm or full effect. Without referring to "dual eligibles," the new waiver appears to threaten their benefits.

2. Florida has actually received three waivers, but two relate to expansion of services in more traditional ways. Under one, the state can provide more financial support to residents of nonmedical residential and related facilities, provided the individuals receive Optional State Supplement (OSS) payments. OSS payments are made at the state's discretion to persons receiving Supplemental Security Income (SSI) who move into the equivalent of assisted living.

   The other waiver funds a pilot program for 5,000 diabetic Medicaid recipients who will receive prescribed medications and supplies by mail. Without further information, it is difficult to determine whether the waiver provides a benefit to the recipients, or is intended to provide economic relief to the state.