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## WELFARE AS AN ENTITLEMENT

### QUESTION:

What is the Administration's position on the welfare entitlement?

### ANSWER:

- ▶ This Administration supports reforming welfare the right way, through a reform plan that is strong on work and family responsibility, but does not punish children.
- ▶ Our preference has always been a conditional entitlement - it is in our own legislation, it was in the Daschle bill which we endorsed, and it's still our preference.
- ▶ What we have to have is a basic safety net for children. That's why protecting foster care and child welfare programs is very important, and why we want to maintain a basic nutritional safety net through food stamps. We also need to have protections for states and poor families in case of recession, and we're pleased that the NGA proposal includes a contingency fund for states, which when combined with adequate maintenance of effort will ensure that states have the resources they need to require work and protect children.
- ▶ In addition, we believe help should not be given out on a first-come, first-served basis; a lottery; or, worse yet, based on some bureaucratic process which determines when money is available and when it is not.

## DIFFERENCE BETWEEN HEALTH AND WELFARE ENTITLEMENT

### QUESTION:

Why does the Administration defend a guarantee of health benefits for the poor, but drop its insistence that welfare also remain an entitlement?

### ANSWER:

- ▶ Our preference has always been a conditional entitlement - it is in our own legislation, it was in the Daschle bill which we endorsed, and it's still our preference.
- ▶ What we have to have is basic safety net for children. That's why protecting foster care and child welfare programs is very important, and why we want to maintain a basic nutritional safety net through food stamps. We also need to have protections for states and poor families in case of recession, and we're pleased that the NGA proposal includes a contingency fund for states, which when combined with adequate maintenance of effort will ensure that states have the resources they need to require work and protect children.
- ▶ Having said that, welfare and Medicaid are fundamentally different programs, with vastly different goals for reform.
- ▶ Nearly everyone agrees that our welfare system is broken and must be fixed. Under welfare reform, our primary goals are to move people from welfare to work, promote parental responsibility, and protect children. That's why we've insisted at a minimum on a contingency fund that will protect states and families in times of recession and a requirement that states continue to invest in a work-oriented welfare system. Ensuring equitable treatment, as in the NGA proposal, may be one way to ensure these fundamental protections.
- ▶ Medicaid, by contrast, is a program that already meets its primary goal: providing basic health insurance to the poor and disabled. Our main objective in Medicaid reform is containing costs and making sure states have flexibility in administration. Our proposals must be designed to meet those goals, while still guaranteeing health care coverage to the most vulnerable among us.

**VETO OF WELFARE CONFERENCE BILL****QUESTION:**

The President has listed welfare reform as one of his main priorities over the past three years. If welfare reform is so important to this president, why did he veto the bill Congress sent him?

**ANSWER:**

- ▶ The President is determined to enact national welfare reform this year, and he has consistently urged Congress to send him a bipartisan bill that would get the job done. Instead, Congress sent him extreme legislation that would have done little to move people from welfare to work and made unnecessary cuts to programs serving disabled, abused, and hungry children. The Administration will continue to work with the governors and Congress to craft a bill that is tough on work and responsibility and protects children. Remember too that this President has already given 37 states the flexibility to impose time limits, require work, and strengthen child support enforcement -- that's more than any President in history.

## WHY ISN'T THE SENATE BILL GOOD ENOUGH?

### QUESTION:

Why isn't the Senate bill good enough for the President now when it was good enough last fall?

### ANSWER:

- ▶ Last fall the President welcomed the Senate welfare bill as a promising starting point that, with additional work, could lead to a true welfare reform bill. He noted that "despite the progress we've made, our work isn't done yet... We'll be working hard to build on the bipartisan progress we've made..."
- ▶ Rather than building on the Senate effort, however, the welfare reform conferees took a step backward, producing a bill that made deep and unnecessary cuts in assistance for disabled children, legal immigrants and children at risk of abuse or neglect. The conference agreement also eliminated the guarantee of medical coverage for families on welfare and failed to give States the resources they will need to move recipients into the workforce while maintaining the safety net for poor children.
- ▶ The President very much hopes that Congress takes this opportunity to build on the Governors' proposal, in a bipartisan manner, to craft a welfare reform bill we can all support.

## ADMINISTRATION SUPPORT

### QUESTION:

In his speech to the NGA, President Clinton seemed to imply that he would endorse this proposal now that additional child care resources have been put in. Would you recommend to the President that he sign this if it were passed by Congress?

### ANSWER:

- ▶ President Clinton and I applaud the bipartisan work of the Governors in developing the NGA proposal. However, it's premature to make any recommendations at this point on the NGA proposal. We still need to see the details of the proposal in order to evaluate whether or not the proposal meets the President's requirements for real reform.
- ▶ We are very pleased to see that the proposal calls for an additional \$4 billion in new federal funds for child care, that the contingency fund is increased by \$1 billion and it includes a food stamp trigger, and that there is recognition that state eligibility criteria have to be equitable and objective. The proposal also makes the work requirements more feasible and less costly for states, creates a separate funding stream for the performance bonus, permits mothers with pre-school age children to work part-time, encourages parental responsibility through ten parent provisions and strong child support enforcement measures, and makes the family cap a state option.
- ▶ However, the NGA resolution still needs improvement in several important areas. The Administration continues to have serious concerns about NGA provisions for child welfare, food stamps, school lunch, and child care health and safety standards. We also have a concern about the potential for states to withdraw substantial sums from programs serving low-income children and their families and changing the basis of the federal/state partnership. And we're concerned about protections for individual families from arbitrary bureaucratic actions. We'll continue to work with the governors and Congress to resolve these issues and create a real, bipartisan welfare reform bill that gets the job done.

## OVERALL GOALS

### QUESTION:

What does the President want in a welfare reform bill?

### ANSWER:

- ▶ As the President has clearly stated, he wants welfare reform that requires work, promotes parental responsibility, and protects children.

### FOLLOW-UP QUESTION:

What exactly does that mean? Would the President veto a bill that block-grants food stamps or doesn't have 80 percent maintenance of effort for states?

### ANSWER:

- ▶ As the President has said, welfare reform must be tough on work -- not on kids. The NGA proposal has made substantial progress towards real reform by including provisions that the Administration has called for from the start: a performance bonus to reward states for moving people from welfare to work; resources for child care; conditional assistance for teenagers; a contingency fund to help protect states against an economic downturn; and all of the tough child support enforcement provisions proposed by the Administration last year. The NGA proposal also eliminates the punitive provisions in the Conference bill -- such as the mandatory family cap. Building on the strengths of the NGA proposal, we'll continue to work with the governors and Congress to get real, bipartisan welfare reform enacted this year.

## STRENGTHS OF NGA PROPOSAL

### QUESTION:

The unanimous support the NGA proposal received from governors indicates that it must have some positive value. What do you think are the principal strengths of the NGA proposal?

### ANSWER:

The primary strength of the NGA agreement is that it begins to address the resource needs of states in implementing rigorous national reform. For example:

- ▶ The proposal provides \$4 billion in new federal money for child care.
- ▶ The work requirements are more feasible and less costly -- the number of hours required in work activities is reduced from 35 to 25 (from the Senate bill) and job readiness and job search are included as work activities.
- ▶ The performance bonus is a separate funding stream rather than a set-aside from the block grant, as in the Senate bill.
- ▶ The contingency fund is increased by \$1 billion and includes a trigger based on the number of children receiving food stamps.
- ▶ NGA recognized to a limited degree the notion that state eligibility criteria should be equitable and objective.
- ▶ The proposal allows mothers with pre-school age children to work part-time.
- ▶ The family cap is truly optional for states.

## OBJECTIONS TO NGA PROPOSAL

### QUESTION:

What are your main objections to the NGA proposal and why?

### ANSWER:

- ▶ Overall, the NGA proposal is a substantial improvement over the flawed Conference bill, which the President vetoed. The NGA proposal improves on the conference bill by providing more child care funding, a better contingency fund, a substantial performance bonus for states, an optional family cap for states, and protections for disabled children. In addition, it takes the Administration's approach of requiring unmarried minor parents to live at home and stay in school in order to receive assistance, and it contains all of the tough Administration-backed child support enforcement provisions.
- ▶ However, we are concerned about the effect of the NGA proposal on the federal-state partnership in this area. The Administration continues to have serious concerns about the optional child welfare and food stamp block grants in the NGA proposal. In addition, the proposal would also block grant administrative costs for school lunches. As we've said from the start, real welfare reform must promote work and protect children, not be used as a cover for budget cuts at the expense of our poorest children. It must also require accountability of states, so we prefer the Senate bill's approach on maintenance of effort. We'll continue to work with the governors and Congress to resolve these issues and enact real bipartisan welfare reform that gets the job done.

### BACKGROUND:

It is important that welfare reform maintain a federal-state partnership. This partnership is severely weakened by the NGA proposal.

- ▶ Compared to current law, the NGA proposal allows states to dramatically reduce -- by approximately \$58 billion -- the resources it commits to poor families and children. It ends the federal-state matching structure of welfare programs, which is how this partnership is maintained under current law.

- ▶ ~~Unlike~~ the Senate bill, it allows states to transfer 30 percent of the cash assistance block grant for services other than assistance for needy families (e.g. the social services block grant). The transferability provision might force poor families to compete with other, more politically powerful constituencies for cash assistance block grant dollars.
- ▶ ~~Unlike~~ the Senate bill, the NGA proposal does not require states to maintain 100 percent of their FY 1994 spending to draw down contingency fund dollars.
- ▶ ~~In the event~~ of a national economic downturn, even a \$2 billion contingency fund might be exhausted quite rapidly. During the last recession, for example, AFDC benefit payments rose from \$17.2 billion in 1989 to \$21.9 billion in 1992 -- \$4.7 billion over 3 years. A provision should be added to the bill allowing States to draw down matching dollars during a national recession even if the \$2 billion in the contingency fund had been expended.
- ▶ It does not require a State match or even a maintenance of the FY 1994 level of State effort to draw down the new \$4 billion pool of federal funding for child care.
- ▶ It allows states to establish a Food Stamp block grant, effectively ending the federal-state partnership for nutrition assistance. If many states took advantage of this option, the nation's nutritional safety net could be seriously undermined.
- ▶ The maintenance of effort standard is set at 75 percent, as opposed to 80 percent in the Senate bill and 90 percent in the Breaux amendment supported by the Administration. In addition, the definition of spending that counts toward the maintenance of effort standard is too broad -- states can count spending on child welfare, juvenile justice, and other sources if they had previously drawn down Emergency Assistance funds for such purposes.
- ▶ The proposal makes no provision for federal oversight of state plans or program audits within federal guidelines to ensure accountability for federal taxpayers.

The NGA proposal does not provide adequate protections for children.

- ▶ The NGA proposal does not provide adequate protections for children. The proposal would give states the option to block grant foster care, adoption assistance, and independent living assistance which could jeopardize the guarantee of assistance for abused and neglected children.

- ▶ The proposal would not preserve **medical assistance coverage** for those currently eligible, especially mothers (non-pregnant) and teenage children.
- ▶ It does not include provisions **protecting the health and safety of children in child care.**
- ▶ The proposal provides no **child care guarantees** to individuals who are participating in work or training programs or those who have left welfare for work.
- ▶ The proposal does not guarantee individual protections. It explicitly ends the **individual entitlement** to assistance.
- ▶ The proposal neither supports nor opposes the immigrant provision included in the underlying Conference bill.

## MEDICAID LINK

### QUESTION:

What is the NGA proposals' position in terms of Medicaid coverage for welfare recipients? Where does the Administration stand on severing the link between Medicaid and AFDC?

### ANSWER:

- The governors' proposal would end the guaranteed Medicaid coverage for some poor women and children now categorically eligible (i.e. receiving assistance). It would also repeal the phase-in of mandatory Medicaid coverage for poor children 13 and older. It would also eliminate the guarantee of a transitional year of health coverage when parents are leaving welfare for work. These provisions are fundamentally counterproductive, since many poor women now choose welfare over work simply because they or their children need health care. And they retreat on our commitment to health coverage for vulnerable Americans.
- ▶ The Administration believes that providing poor families and children access to the health care they need is critical to successfully moving people from welfare to work. We support the Senate bill's approach, which would maintain Medicaid coverage for poor families making the transition to self-sufficiency.

### BACKGROUND:

The NGA proposals could weaken the link between cash assistance and Medicaid.

- ▶ States would have to "guarantee" Medicaid, either by continuing the current AFDC rules for Medicaid, or by providing Medicaid automatically to cash assistance recipients eligible under the new AFDC rules.
- ▶ However, this "guarantee," like all of the other eligibility "guarantees" in the NGA proposal would be neither a legally enforceable entitlement nor a promise of a specific and meaningful package of benefits. Cash assistance recipients could find themselves with inadequate benefits and no alternatives.

## BUDGETARY IMPACT

## QUESTION

A preliminary estimate by CBO suggests that the NGA proposal would save about \$40 billion over seven years—about the same as the Administration's most recent plan. Given that, what is standing in the way of agreement on a welfare bill?

## ANSWER:

- ▶ Welfare reform is not, as you know, primarily a question of Federal budget savings. The goal of a welfare reform bill must be to help families move from welfare to work while maintaining the safety net for poor children. The Administration has a number of very serious concerns about the NGA proposal that are separate from the issue of the budgetary impact.
- ▶ It is important that welfare reform maintain a federal-state partnership. This partnership is severely weakened by the NGA proposal.
- ▶ Compared to current law, the NGA proposal allows states to dramatically reduce the resources it commits to poor families and children. It ends the federal-state matching structure of welfare programs, which is how this partnership is maintained under current law.
- ▶ Unlike the Senate bill, it allows states to transfer 30 percent of the cash assistance block grant to services other than assistance for needy families (e.g. the social services block grant). A transferability provision might force poor families to compete with other, more politically powerful constituencies for cash assistance block grant dollars.
- ▶ Unlike the Senate bill, the NGA proposal does not require states to maintain 100 percent of their 1994 spending to draw down contingency fund dollars.
- ▶ In the event of a national economic downturn, even a \$2 billion contingency fund might be exhausted quite rapidly. During the last recession, for example, AFDC benefit payments rose from \$7.2 billion in 1989 to \$21.9 billion in 1992 — \$4.7 billion over 3 years. A provision could be added to the bill allowing States to draw down matching dollars during a recession even if the \$2 billion in the contingency fund had been expended.
- ▶ It does not require a State match or even a full maintenance of the FY 1994 level of State spending to draw down the new \$4 billion pool of federal funding for child care.
- ▶ We believe these problems can be addressed in Congress in the same spirit of bipartisanship displayed by the Governors.

## POVERTY IMPACT

### QUESTION:

The Administration has produced estimates of the impact of House and Senate welfare bills on poverty. An Administration study last November found that the Senate welfare bill would push 1.2 million children below the poverty line and the House welfare bill would push 2.1 million children below the poverty line. How many children would the NGA Proposal push into poverty? When can the Administration provide such an answer?

### ANSWER:

We will not be able to conduct this analysis until all of the details on the NGA proposal -- particularly the legislative language -- are provided. Producing an accurate analysis of the effect of the proposal on the number of children in poverty will take time, but we would be pleased to work with OMB to develop a revised analysis as soon as sufficient details are available.

## CONTINGENCY FUND

### QUESTION:

The Governors' proposal adds \$1 billion to the contingency fund and makes it available to States with rising food stamp caseloads, as well as those with high unemployment. Isn't that enough? What more could be needed?

### ANSWER:

- ▶ We are very pleased that the NGA proposal would add \$1 billion to the contingency fund and include a trigger based on food stamp receipt, which is preferable to the unemployment rate as a measure of economic need among low-income families. Both of these steps would represent improvements to the contingency fund in the conference agreement.
- ▶ The NGA proposal, unfortunately, would also eliminate the requirement that States meet their full 1994 level of effort in order to be eligible for the contingency fund. This would allow a State to draw down additional Federal dollars while actually reducing its own contribution to the family assistance program.
- ▶ We also have to consider whether the NGA agreement fully enables states to deal with a national economic downturn. For example, during the last recession, benefit payments rose from \$17.2 billion in 1989 to \$21.9 billion in 1992 -- \$4.7 billion over 3 years.
- ▶ We need to have a full bipartisan discussion involving the Administration, the Congress, and the governors to assess the potential demands on a contingency fund in various circumstances. None of us want a scenario in which states are forced to drop families from the rolls during recessions, when need would be the greatest.

## CHILD CARE FUNDING

### QUESTION:

How much child care funding is enough?

### ANSWER:

- ▶ We are very pleased to see the NGA proposal build on the substantial progress made in the Senate bill with respect to child care resources. The NGA proposal to provide an additional \$4 billion for child care is essential if states are to meet their work participation requirements and -- equally important -- to maintain their child care commitments to low-income working families.
- ▶ The Governors would also improve the child care provisions in the conference agreement by adopting the Senate's state option to permit mothers with children under six to participate in work programs part-time (20 hours per week) -- similar to the work experience of most mothers with preschool children.
- ▶ While these additional resources are critically important, it must be kept in mind that long waiting lists for child care exist in most states and communities, and the lack of child care is often cited as a major barrier to participation in work and training programs. It is therefore also important that states maintain their own contribution to child care and match the additional federal funds.

## QUALITY OF CHILD CARE

### QUESTION:

Do you have concerns about the changes in quality funding and health and safety in this proposal, given that so many more children (especially young children) will be entering child care due to welfare reform?

### ANSWER:

- ▶ We were very pleased that the Senate bill passed last September retained existing quality protections for children in child care. Unfortunately, the NGA proposal would eliminate these basic health and safety provisions and would reduce the targeted funds for quality.
- ▶ These vital protections were developed with the bipartisan support of the NGA in 1990, and enjoyed overwhelming support in the Congress. They are not federal standards, but basic protections set by the states to provide for the prevention and control of infectious diseases (including immunizations), building and premises safety, and minimum health and safety training for child care providers.
- ▶ The NGA proposal also would reduce funds designated to improve the quality of care. States use these funds to conduct criminal background checks, train providers, license programs, and provide consumer education to parents. The proposal undermines current state efforts to improve child care services by drastically reducing the funds available for this purpose.

## WORK PROGRAM

### QUESTION:

Does the NGA proposal require recipients to go to work? Does it provide states with the resources needed to move recipients from welfare to work?

### ANSWER:

- ▶ The Governors suggested a number of modifications to the work requirements in the welfare reform conference agreement, including (1) counting those who have left welfare for employment as participating for purposes of the work requirement; (2) reducing the required hours of participation to 25 after 1999; (3) giving States the option of limiting the hours to 20 for parents of children under 6; and (4) allowing job search and job readiness to count as work activities for up to 12 weeks (up from 4 weeks in the conference bill).
- ▶ The Administration supports each of these recommendations.
- ▶ The effect, however, of counting those who have left welfare for work (while leaving the participation rates unchanged from the conference report) is to reduce the number of recipients enrolled in work activities, relative to both the conference report and the Senate bill.
- ▶ This problem can be addressed by making relatively modest changes to the work requirements in the proposal; we look forward to bipartisan discussions on this issue.

### BACKGROUND:

- ▶ We think publicly attacking the work program in the NGA proposal as "weak" will lead the debate in the wrong direction. Our concerns about the relatively small number of recipients in work activities (workfare and subsidized employment) can be better addressed through consultation with Republican staff.

## CHILD WELFARE

### QUESTION:

Child welfare systems around the nation are a mess. The number of reports of abuse is rising. The number of children in foster care is rising. The NGA proposal makes important changes by reducing red tape and giving states the flexibility they need to improve their systems. Why does the Administration continue to insist on maintaining the status quo in this area?

### ANSWER:

- ▶ The Administration strongly supports the Senate bill's approach to maintain current services in this area. It is true that child welfare systems in the states are in trouble, but we are concerned the governors' proposal might not improve the system. There are several reasons for our concerns.
- ▶ Abused and neglected children in need of foster care and adoption are one of our most vulnerable populations. In light of this, we are very concerned about substantial changes in the child protection safety net at a time of dramatic change in the welfare and Medicaid systems. Under the governors' proposal, it is unclear how the individual guarantee to foster care and adoption assistance benefits would be maintained if states choose to convert funds to a capped entitlement block grant. States might have difficulty serving their children when caseloads grow unexpectedly in a particular year but block grant levels remain fixed.
- ▶ Second, the governors' proposal is silent concerning enforcement of national minimum standards now in place to protect children in the child welfare system. Weakening these protections will not help states solve the problems facing their child welfare systems.
- ▶ Third, the governors' proposal may cost the federal government considerably more than current law. Under the optional capped entitlement for adoption and foster care maintenance, states may be expected to choose whichever option would maximize the Federal funds flowing to them. CBO's preliminary analysis indicated that this provision could cost up to \$2 billion.

- ▶ Fourth, prevention efforts are likely to suffer. In a system that includes no targeted prevention or independent living funding, crisis-driven decision-making often depletes these efforts. States will have to respond to immediate protection needs, and longer term needs of children and families may be deferred.
- ▶ Finally, this proposal would eliminate the national leadership in child welfare research and innovation. The child protection block grant proposal would completely eliminate national funding for research on child abuse and neglect and child welfare services, federal funds to test innovative practices, and federal efforts to provide technical assistance to states and communities regarding what works in this field.

## ILLEGITIMACY AND TEEN PREGNANCY

### QUESTION:

Some people claim that the NGA proposal would fail to reduce out-of-wedlock and teen births, because it would continue to give assistance to teen mothers. How do you respond to that?

### ANSWER:

- ▶ We believe that denying assistance to teen mothers just doesn't make sense. Our approach to welfare reform, like the governors' approach, would take strong action to address the problem of teen pregnancy, but would not give up on teenage parents and their children. We would require teen mothers to live at home with their parents, identify their child's father, finish high school, and work in order to become good role models and providers for their children.
- ▶ The governors' proposal also makes the family cap optional for states -- unlike the Conference bill, which mandated a family cap unless the state legislatures voted to opt out of it. We believe that states should have more flexibility, not less under welfare reform, and that they shouldn't be constrained by conservative mandates.
- ▶ However, the governors' proposal contains an "illegitimacy ratio," which would give states a financial incentive linked to abortion rates. While the Administration believes that we must reduce out-of-wedlock childbearing, we do not support the use of an "illegitimacy ratio." Welfare reform should not become entangled in the politics of abortion.

**SUPPLEMENTAL SECURITY INCOME****QUESTION:**

What does the Administration think of NGA's approach to children with disabilities under the SSI program?

**ANSWER:**

- ▶ I would defer to my colleague, Dr. Shirley Chater, in this area. However, I will say that we were pleased to see that the NGA proposal follows the Senate-passed bill for making the changes to SSI children, with one modification--an effective date of January 1, 1998 rather than 1997.
- ▶ As you know, the Administration, particularly the Social Security Administration which administers this program, is supportive of making changes in the SSI program to tighten eligibility standards.
- ▶ We believe that we should retain full cash benefits for all eligible children and we should tighten eligibility for children now on the rolls. However, children found ineligible should not lose benefits until January 1998.
- ▶ Based on the information we have to date about the NGA proposal, we believe that these principles are retained.

## IMMIGRANTS

### QUESTION:

What does the Administration plan to do to cut back on the amount of welfare going to immigrants?

### ANSWER:

- ▶ We strongly believe that sponsors must be responsible for those immigrants they agree to sponsor, and that the current definition of which immigrants are eligible for the major welfare programs needs to be tightened. We oppose arbitrary bans on eligibility.
- ▶ Therefore we have proposed to increase the sponsor deeming period under SSI, AFDC, and Food Stamps to until the sponsored immigrant becomes a naturalized citizen, and to make the affidavit of support signed by sponsors legally binding.
- ▶ We also have proposed to limit immigrant eligibility for SSI, AFDC, Food Stamps and Medicaid to specific immigration statuses listed in statute, rather than base such eligibility on the currently vague reference to immigrants "permanently residing in the U.S. under color of law" --or PRUCOL.
- ▶ These policies strike a reasonable balance between ensuring that legal immigrants are self-sufficient, while maintaining family reunification as the foundation of our immigration policy and making sure that legal immigrants who are truly in need are not left without a federal safety net.

### BACKGROUND:

- ▶ We oppose deeming under Medicaid because: (1) there would be adverse public health impacts, and (2) there is no practical way for sponsors to meet this obligation, because individual health insurance policies are often unavailable, and when available are usually unaffordable for all but the wealthiest individuals.
- ▶ Expanding deeming and eligibility rules beyond the major welfare programs would require nurses, teachers, and other service providers to become immigration enforcement agents, which we oppose. It would also impose disproportionately large administrative costs and burdens on discretionary-funded programs (such as maternal and child health block grants, headstart, public health clinics, etc.)

## IMMIGRANT ELIGIBILITY

### QUESTION:

The Administration's recommendations on tightening immigrant eligibility do not go far enough; how much further are you willing to go to prevent the abuse of our welfare system by immigrants?

### ANSWER:

- ▶ The Administration opposes any broad, categorical denial of public benefits to *legal immigrants*, such as that proposed by the welfare bill vetoed by the President (H.R. 4).
- ▶ At the same time, we believe sponsors should be held responsible and we strongly endorse extending the deeming period for SSI, AFDC, and Food Stamps and making the affidavit of support legally binding.
- ▶ The National Governors Association supported our approach in their October 10, 1995 letter to welfare conferees, stating that "Although we can support deeming requirements for some programs and changes to make the affidavit of support enforceable, we oppose federal restrictions on aid that shifts costs to states" (see attachment). The NGA's most recent policy is neutral on the immigration provisions of H.R. 4.
- ▶ We are convinced that strengthening the deeming rules and making the affidavit of support legally binding--as we have proposed--is the right policy; it not only requires sponsors to meet their responsibilities, but also ensures that legal immigrants who are truly in need are not left without a federal safety net.

### BACKGROUND:

- ▶ Our deeming proposal would also allow state and local programs of cash assistance to follow the same deeming rules as the federal programs. In the context of seeking additional budget savings, the Administration might be willing to consider other ways to realize this goal, such as making the new deeming rules apply to current recipients. The Administration has never supported such an approach because we do not think it is fair to apply new deeming rules to immigrants who have complied with all the current immigration and program eligibility rules and are receiving assistance.

## CUBAN/HAITIAN ENTRANTS

### QUESTION:

What do you recommend doing about the eligibility of Cuban/Haitian entrants for federal benefits?

### ANSWER:

- ▶ The Administration has consistently supported allowing Cuban/Haitian entrants to remain eligible for federal assistance, and we continue to take that position.
- ▶ As you may know, H.R. 4 would have denied federal assistance to Cuban/Haitian entrants.
- ▶ We believe that H.R. 4 would merely result in shifting the costs of assistance for Cuban/Haitian entrants from the federal government to local governments and communities.
- ▶ Such a policy would essentially have the federal government walk away from its immigration responsibilities; and we cannot support that.

### BACKGROUND:

- ▶ Under current law (known as "Fascell/Stone," Section 501 of the Refugee Education Assistance Act of 1980), Cuban and Haitian entrants are eligible for public benefits on the same basis as refugees.

## CHILD SUPPORT ENFORCEMENT

### QUESTION:

There are studies that show that \$48 billion in child support could be collected from parents who do not live with their children. Yet last year, the child support enforcement program only collected \$11 billion in child support. What should be done to ensure that all parents support their children?

### ANSWER:

- ▶ Since taking office, President Clinton has taken strong steps to improve our nation's child support enforcement system.
- ▶ These efforts are working. The Clinton Administration has collected unprecedented amounts of child support. From 1992 to 1995, collections grew by nearly 40 percent. In 1995, the federal-state child support enforcement system collected a record \$11 billion from non-custodial parents, up from \$8 billion in FY 1992. In addition, paternity establishment rose by more than 40 percent from 1992 to 1995.
- ▶ The NCA proposal contains all of the President's proposals to further improve child support collections: streamlined paternity establishment, employer reporting of new hires, uniform interstate child support laws, computerized statewide collections, and tough new penalties such as driver's license revocation.
- The tough child support enforcement measures the President has proposed would send a strong signal about the responsibility of both parents to the children they bring into the world.

## NEED FOR FEDERAL PROTECTIONS

### QUESTION:

If most States already have the Model Administrative Procedure Act or other procedures in place, why is there a need to establish by federal statute further requirements?

### ANSWER:

- ▶ It is true that most states accord basic procedural protection to their citizens through legislation like the Model Administrative Procedure Act or similar means. Thus, the most important safeguard the legislation can provide is to require that state plans contain objective criteria that provide for fair and equitable treatment of all applicants and recipients.

## CONSTITUTIONAL DUE PROCESS PROTECTIONS

### QUESTION:

Aren't Due Process protections assured by the Constitution? Why do we need to put more procedural requirements into the welfare statute?

### ANSWER:

- ▶ Yes, to a certain extent the Constitution does provide safeguards.
- ▶ However, with new legislation totally restructuring the statutory underpinnings of the welfare system, there may be years of litigation before the exact parameters of Due Process protections under the Constitution are adequately redefined and universally recognized.
- ▶ Objective criteria providing for fair and equitable treatment will be the cornerstone of protection against arbitrariness and discrimination in individual cases.

## MINIMUM REQUISITES OF A FAIR AND EQUITABLE PROGRAM

### QUESTION:

What are the minimum requisites of a fair and equitable program?

### ANSWER:

- ▶ Foremost is the requirement for objective criteria, under which families with similar needs are treated similarly, regardless of where in the state they apply for assistance.
- ▶ Families forced to resort to public assistance, as courts have noted through the years, may face "brutal need." Denial, or even delay, in granting assistance may pose a risk of the most dire consequences.
- ▶ Eligibility decisions should be made fairly and promptly.

## WHY INCLUDE IN STATE PLAN REQUIREMENTS?

### QUESTION:

Why is it important that these criteria be included as state plan requirements?

### ANSWER:

- ▶ It is the federal government's responsibility to assure some uniformity, at least with regard to fundamental protections, throughout the country.
- ▶ In addition, to assure a better understanding of the policies and procedures states choose to implement, plans should be submitted in a standardized format, prescribed by the federal government.
- ▶ The federal government, ultimately, is funding a substantial portion of these programs.
- ▶ It is reasonable and prudent to design a system where the federal government maintains some oversight responsibility to ensure that states' programs fulfill the purpose and goals established by Congress.

## WHY PROCEDURAL PROTECTIONS ARE ESSENTIAL

### QUESTION:

What are the ultimate goals to be served by a public assistance program, and why are procedural protections essential to fulfill such goals?

### ANSWER:

- ▶ Families must be permitted to live in dignity while seeking to achieve the goal of independence and self-sufficiency.
- ▶ Recipients of welfare are among our most disadvantaged and defenseless citizens. They should not be further deprived of their own humanity by being subjected to arbitrary and discriminatory treatment.
- ▶ It is fundamental to the overall achievement of the purpose and objectives of these new welfare proposals that assistance be made available in a fair and equitable manner.
- ▶ Ours is a society founded upon principles of Due Process and Equal Protection. We espouse and should adhere to the highest standards of equity and fair treatment, regardless of an individual's stature in society or economic circumstances.
- ▶ We can easily afford to build minimal protections into our bureaucratic systems; we can ill-afford to neglect our weakest and most needy, and, especially, the very children who represent our future.

## BLOCK GRANTS AS A FUNDING MECHANISM

### QUESTION:

As a funding mechanism, what are the disadvantages to block grants? Can they be fixed?

### ANSWER:

- ▶ The Administration supports a funding mechanism that will not put children and states at risk down the road and that enables states to succeed in moving people from welfare to work. For example, one major concern about block grants is that during a recession states may run out of money before the end of the year. This means states would be forced to turn people away from their program or cut back on their work programs. While not as effective as the current state match structure in responding to the needs of states, combining block grants with adequate contingency fund provisions could somewhat alleviate this problem. However, the Administration has found that the most of the welfare proposals -- including the NGA proposal -- do not have sufficient contingency fund provisions. As a result, we have made several recommendations in this area.
- ▶ While the Administration supports proposals that significantly increase state flexibility, we also want to ensure accountability for achieving national goals. One problem with the current structure of the block grants is that they contain few provisions that allow the federal government to understand how the block grant dollars are spent and what is being achieved. This makes it difficult to be accountable to federal and state tax payers. To ensure accountability for federal funds, the Administration supports a provision which would require a program specific audit within federal guidelines.

## RACE TO THE BOTTOM

### QUESTION:

Why don't you trust the states to do the right thing? Do you believe there will be a race to the bottom?

### ANSWER:

- ▶ This is not a matter of trust. The Governors and State Legislators are elected officials who all seek to best serve the residents of their states. I am concerned because this legislation would create a funding mechanism that would provide greater rewards for states who reduce welfare spending, and penalize states who might otherwise increase benefits.
- ▶ At the same time that welfare legislation would encourage states to reduce benefits by changing the funding mechanisms, states will be under extraordinary budgetary pressure from all quarters. Public safety, education, medical assistance, and tax reforms are high priorities in states around the country.

- ▶ States may reduce benefits out of fear of becoming a welfare magnet, even though most research concludes that welfare magnet effects are minimal, if they exist at all. In fact, several states, including California, Connecticut, Illinois, and Wisconsin, have already proposed two-tier benefit structures to deter immigration into their states.
- ▶ In addition to the impact on welfare spending that could occur simply by shifting from the current federal/state partnership to a block grant funding mechanism, the NGA plan would give states substantial discretion to shift even the federal portion of assistance out of cash assistance programs. We believe that under the NGA plan, states could reduce their own spending on welfare and welfare-to-work programs by up to \$28 billion over seven years. On top of that, they give states the option to shift \$30 billion of the federal funds intended for use on these programs to spending on other social service programs. This \$30 billion could be used to supplant current state spending on social services, freeing up state dollars for any other purpose, such as education, prisons, roads, football stadiums, or tax cuts.

## NATIONAL REFORM VS. WAIVERS

### QUESTION:

The Clinton Administration has stressed its record on granting states welfare reform waivers. Why can't we just forget about national reform and allow each state to design its own system?

### ANSWER:

- ▶ There are several important reasons for a federal role in reform. First, there has been widespread agreement that issues in the SSI program need to be fixed. Likewise, there is a need for federal involvement in strengthening a child support enforcement system. There is a need to tighten the immigrant provisions across programs -- from funding deeming requirements to holding sponsors more accountable for those immigrants they sponsor. Within the Social Security Act there is a need to legislate more state flexibility. And finally, we need to authorize more federal child care funding to move people from welfare to work.
- ▶ We agree that the federal government does not have the answers to every problem, and that states and localities should have the flexibility to design welfare reform strategies that respond to local circumstances. But while we are committed to state flexibility in welfare reform, a federal/state partnership is important in the following areas: achieving the national reform objectives of work, responsibility and accountability; ensuring funding stability over time and protecting states and individuals against economic downturns; and preserving basic protections for needy Americans and their children.

## WAIVERS

### QUESTION:

Several Republican governors have complained that the Clinton Administration is holding up reform by refusing to grant states waivers. How do you respond?

### ANSWER:

- ▶ The Clinton Administration has granted an unprecedented number of state waivers, under both welfare and health care reform. In the last three years, we've approved 65 health care and welfare reform waivers; in contrast, the previous Administration granted waivers to only 11 states in four years. Our record on state flexibility is consistent and clear, and we're working hard with the states to approve these pending waiver requests.

### BACKGROUND:

- ▶ Our total of 65 waivers includes: 12 statewide Medicaid waivers and 53 welfare reform demonstration projects in 37 states. In contrast, the previous Administration granted 11 total waivers in four years: zero health care waivers and only 11 welfare reform waivers.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION  
FLORIDA PROPOSAL**

**QUESTION:**

What is the status of pending waiver request from Florida?

**ANSWER:**

- ▶ HHS received Florida's request for waivers to implement the Family Responsibility Act demonstration on October 4, 1996.
- ▶ On January 22, 1996, we sent the State a list of issues and questions resulting from a Federal review of the proposal.
- ▶ We are waiting to hear back from the State.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION****ILLINOIS PROPOSAL****QUESTION:**

What is ~~the~~ status of pending waiver request from Illinois?

**ANSWER:**

- ▶ HHS received Illinois' request for waivers to implement the Six-Month Paternity Establishment demonstration on July 18, 1995.
- ▶ We ~~have~~ had numerous conference calls with the State to ~~resolve~~ issues.
- ▶ We ~~sent~~ the State draft terms and conditions of approval on ~~February~~ 13, 1996.
- ▶ We ~~are~~ waiting to hear back from the State.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION  
IOWA PROPOSAL**

**QUESTION:**

What is the status of pending waiver request from Iowa?

**ANSWER:**

- ▶ HHS received Iowa's request for waivers to implement the Family Investment Plan demonstration on December 14, 1995.
- ▶ HHS is preparing a list of issues and questions resulting from federal review of the application to send to the State.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION  
KANSAS PROPOSAL**

**QUESTION:**

What is the status of pending waiver request from Kansas?

**ANSWER:**

- ▶ HHS received Kansas' request for waivers to implement the Actively Creating Tomorrow for Families Demonstration on July 26, 1994.
- ▶ HHS sent the Kansas Department of Social and Rehabilitation Services (SRS) a list of issues and questions September 19, 1994 which result from a federal review of the application and initial discussions with SRS.
- ▶ We reached agreement with Kansas on draft terms and conditions in April of 1994, but the State decided to place their request on hold at that time.
- ▶ We stand ready to issue a prompt decision on their application upon their request that we move forward.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION  
OKLAHOMA PROPOSAL**

**QUESTION:**

What is the status of pending waiver request from Oklahoma?

**ANSWER:**

- ▶ HHS received Oklahoma's request for waivers to implement the Welfare Self-Sufficiency Initiative on October 27, 1995.
- ▶ On January 26, 1996, we sent the State a list of issues and questions resulting from a Federal review of the proposal.
- ▶ We are waiting to hear back from the State.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION****TEXAS PROPOSAL****QUESTION:**

What is the status of pending waiver request from Texas?

**ANSWER:**

- ▶ HHS received the Texas request for waivers to implement the Achieving Change for Texans demonstration on October 6, 1995.
- ▶ On January 16, 1996, HHS sent Texas an analysis paper discussing issues of concern to us and clarifications we needed to better understand the State's proposal.
- ▶ Texas responded to our issues paper with answers to our questions on February 1, 1996 and we conducted a teleconference with State officials of the State on February 21, 1996 to discuss remaining issues.
- ▶ Our discussions with State staff suggest that we should be able to mutually resolve these issues and soon begin to develop draft terms and conditions.
- ▶ State officials expressed a desire to receive a final decision on their request by April 1st. It is our objective to work with the State to meet that deadline.

**STATUS OF PENDING WELFARE REFORM DEMONSTRATION  
UTAH PROPOSAL**

**QUESTION:**

What is the status of pending waiver request from Utah?

**ANSWER:**

- ▶ Utah's "Single Parent Employment Demonstration" (SPED) was approved on January 31, 1995.
- ▶ HHS received Utah's request for waivers to amend the SPED project on February 7, 1996.
- ▶ The application is currently under review.

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## FIVE-YEAR TIME LIMIT

### QUESTION:

I understand that HHS estimates that a five-year time limit would deny assistance to 2.8 million children. Are you aware of this estimate? And if yes, how can you possibly support a five-year time limit?

### ANSWER:

- ▶ First, let's be clear about what that number is. My department was asked to estimate the number of children who would eventually be affected by a five-year time limit, using **current behavioral assumptions** about the **current AFDC caseload**. That is a strictly numerical exercise, and the answer is approximately 2.8 million children, using the revised CBO baseline. (That is slightly less than our previously released estimate of 3.3 million.)
- ▶ However, that number probably will not accurately reflect what would happen when a five-year time limit is combined with other welfare reforms, such as increased child care, a part-time work option for young mothers, and a performance bonus to reward states for moving welfare recipients into public sector jobs.
- ▶ As you know, every major welfare reform bill now has a five-year time limit -- including the Daschle bill, the Democratic alternative in the House of Representatives, the Administration's bill, and the NGA proposal. Like a lot of proposals, the devil's in the details. We support combining a five-year time limit with other provisions designed to protect children, such as vouchers for children whose parents reach the time limit, and an adequate hardship exemption policy.

### BACKGROUND:

You may also want to mention the importance of the EITC, as a way to keep the 70 percent of welfare recipients who now leave the rolls in less than two years off welfare permanently. If pressed on protections for children, you may want to say more on the importance of maintaining the child welfare system.

## POTUS ACCEPTANCE OF SENATE WELFARE BILL

### QUESTION:

Would the President accept the Senate welfare bill if Congress sent it to him?

### ANSWER:

- ▶ As you know, Senator, the Senate bill was certainly a strong improvement over the flawed House bill. It included many provisions that the Administration called for from the start: personal responsibility contracts for recipients; requirements that states continue to invest their own funds in a work-oriented welfare system; and all of the tough child support enforcement provisions proposed by the Administration last year. The Senate bill also eliminated the punitive provisions in the House bill -- such as the ban on aid to teen mothers and the mandatory family cap. In addition, unlike the House bill, the Senate bill preserved the national commitment to child welfare and child nutrition programs -- ensuring that children are protected no matter where they live.
  
- ▶ But, the Administration wants to go forwards, not backwards on welfare reform -- that means crafting a truly bipartisan welfare-reform bill that will end welfare as we know it. The NGA resolution has made some improvements over the Senate bill that we're pleased with, particularly in the areas of child care funding, the performance bonus, the contingency fund, and provisions for fair and equitable treatment of recipients. We're optimistic that it can be done.

## EXEMPTION FOR HARDSHIP CASES

### QUESTION:

If even a 20 percent caseload exemption for hardship cases would deny assistance to 2.8 million children, how can you support such a policy?

### ANSWER:

- ▶ First, let me note that we prefer an exemption policy based on certain hardship categories, such as battered women, women with a disability, and women caring for a disabled child. We believe this is a better approach than exempting a set percentage of the caseload.
- ▶ However, we are willing to work with Congress on developing an alternative policy. We support the 20 percent exemption passed by the Senate and supported by the NGA as an alternative to the 15 percent exemption in the conference bill. This is also an area that could be amended by Congress in future years.

## CHILD CARE -- STATE MATCH AND MOE

**QUESTION:** How does the NGA proposal address state maintenance of effort and matching funds for child care? How will this impact the adequacy of child care services?

**ANSWER:**

- ▶ The governors clearly recognized the importance of child care to the success of welfare reform, and we applaud them for proposing to add \$ 4 billion to the conference agreement in this critical area. However, we understand that the NGA does not intend to apply to **these additional funds** the Senate and conference bill requirements that states maintain 100 percent of their 1994 child care funding and match at FMAP if they are to receive new federal mandatory child care funds. As a result, we are concerned that in the extreme instance a state may simply use these additional federal funds to replace current state spending for child care -- rather than using the funds for the additional child care services that will help more families move from welfare to work.
  
- ▶ While additional child care resources are extremely important, we believe that final welfare reform legislation should incorporate the child care maintenance of effort and matching provisions contained in the Senate and conference bills.

## HOW DOES CHILD PROTECTION BLOCK GRANT WORK?

**QUESTION:** How would the NGA's proposed child protection block grant actually work?

**ANSWER:**

- ▶ As you know, the NGA welfare reform proposal is a general one, and we too have many questions about how its child protection provisions actually would work. Would abused and neglected children be fully protected? Would children who have been abused, neglected or abandoned remain fully entitled to foster care or adoption assistance? Would states improve upon the less than satisfactory manner in which they have administered child protection programs to date? Would promising new prevention efforts be continued or would funds be channeled to immediate crises?
  
- ▶ We simply do not believe that we should take risks with the lives and well-being of our nation's most vulnerable children at the same time that we are making major changes in the welfare system.

## OPTIONAL FOOD STAMP BLOCK GRANT

### QUESTION:

The NGA proposal has an optional Food Stamp block grant for states -- How do you feel about that?

### ANSWER:

- ▶ As you know, my department doesn't run the Food Stamp program, and I would defer to Secretary Glickman to answer this question in greater detail. However, I can state that the Administration is opposed to an optional Food Stamp block grant for several reasons. This program serves as the ultimate nutritional safety net for our poorest children, and block-granting it would eliminate the program's ability to respond to economic changes, end national eligibility and benefit standards, and ultimately divert support away from food assistance.
  
- ▶ The Administration agrees that we can and should find savings under food stamps -- and we have proposed \$20.6 billion in savings under our seven-year budget proposal. But we believe that block-granting food stamps would do little to reward work, and would simply make many poor children hungry.

## CHILD SUPPORT SERVICES FOR NATIVE AMERICAN POPULATIONS

### QUESTION:

What is the Office of Child Support Enforcement doing to target the special needs of the Native American populations needing child support services?

### ANSWER:

- ▶ The delivery of child support enforcement services under title IV-D of the Social Security Act lies with the states and their local political instrumentalities. However, on most Indian reservations the jurisdiction of state law is limited, constraining state attempts to provide child support services on Tribal lands.
- ▶ In response, the Office of Child Support Enforcement (OCSE) actively encourages states and Tribes to cooperate in resolving jurisdictional barriers in order to address the long-standing problem of inadequate support enforcement services for Native Americans. Our Regional Offices work with representatives of the states and Tribes to design cooperative agreements aimed at providing support services on Tribal lands and some progress can be reported.
- ▶ In 1994, the Navajo Nation and the State of New Mexico signed a cooperative agreement for the opening of two child support offices on Tribal lands, and Tribal members have been hired and trained to staff each office. The Navajo Nation Council of the Navajo Nation shortly thereafter enacted a comprehensive child support enforcement statute designed to conform to title IV-D requirements.
- ▶ In addition, a staff position was been added to OCSE to function as a liaison responsible for building relationships with the broader Native American community and for strengthening the links between the child support community and Native American populations needing program services. The specialist, working closely with our Regional Offices and State programs will be invaluable in establishing systemic responses critical for a proactive approach to child support enforcement.
- ▶ While we believe that current authority to for cooperative arrangements between states and federally-recognized Indian Tribes can work to ensure the support rights of Native American children are protected, we would be happy to work with the Congress on this issue.

BACKGROUND INFORMATION

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MEDICAID

**SUMMARY OF THE PRESIDENT'S PLAN  
FOR STATE FLEXIBILITY**

## MEDICAID SAVINGS PROPOSALS

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The President's Medicaid proposal would reform Medicaid rather than repeal it, guaranteeing health and long-term care coverage for all Medicaid recipients. It will save an estimated \$59 billion over seven years in a responsible way by limiting spending growth per beneficiary (a "per capita cap") and reducing and retargeting Medicaid Disproportionate Share Hospital (DSH) payments to hospitals that serve large numbers of Medicaid and uninsured patients. The plan also offers states considerably more flexibility to design the payment and delivery systems.

- **Per Capita Cap (\$38 billion):** A per capita cap maintains the current matching structure but limits the growth in Medicaid spending on a per person basis. Each state's limit would be calculated based on 1995 spending per beneficiary by group (aged, disabled, adults and children). The spending per beneficiary in the base year would be multiplied by an "index", to update the base-year spending for inflation. This index averages 5.1 percent between 1995 and 2000. Beginning in 1997, the number of full-year equivalent beneficiaries in each state would be multiplied by the limit on the spending per beneficiary to determine the maximum amount of spending that the Federal government will match. Medicare-related Medicaid spending, DSH Payments, and certain administrative expenditures (e.g., fraud and abuse control) would be excluded from the limits.
- **Disproportionate Share Hospital Payments Changes (net \$29 billion):** DSH payments would be reduced and retargeted. The current (1995) Federal payments to states would be phased out, with a 25 percent reduction in 1997, 50 percent reduction in 1998, and 75 percent reduction in 1999. Three new programs would be created to better target the funding.
  - **Targeted DSH Program:** The current DSH program would be gradually replaced by a new, more targeted program. Funding from a fixed Federal pool would be allotted to states on the basis of their share of low-income days for eligible hospitals. This is defined as the state's percent of the nation's inpatient days and outpatient visits for uninsured and Medicaid patients. States would still contribute to the program through matching payments (using the current matching rates). States would use the funds for hospitals that serve a high number of uninsured and Medicaid patients, and would have the flexibility to cover additional hospitals that they deem needy.
  - **Undocumented Persons Pool:** A \$3.5 billion pool to help the 15 states with the largest numbers of undocumented persons would be created. This 100 percent Federal pool would be in effect from 1997 to 2001, and would be allocated to states in proportion to their share of the nation's undocumented persons. It would be used by states for emergency care for undocumented persons.
  - **Federally Qualified Health Centers and Rural Health Clinics Pool:** As part of the proposed changes to promote state flexibility, the mandate for states to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) on a cost basis would be repealed. To ease the change in funding for these facilities, a program would be created with \$500 million in Federal funds in each year beginning in 1997.
  - **Transition Pool:** For 1997 through 1999, \$3.5 billion in Federal funds would be available to enable a smooth transition to the reformed Medicaid program.

**Detailed Description of the Medicaid Financing Reform, January 26, 1996**

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**PER CAPITA CAP:**

- Base Year:** 1995
- Excluded expenditures:** DSH, Medicare premiums and cost sharing; certain administrative expenditures (survey & certification; fraud and abuse); and Indian Health program expenditures.
- Groups:** Full-year equivalent aged; disabled; children; adults (excluding beneficiaries eligible only as QMBs or SLMBs)
- Index:** Five-year historical average of nominal gross domestic product growth per capita plus an additive factor to yield:

<u>Year:</u>	<u>Index:</u>	<u>Nominal GDP +:</u>
1996	6.5%	+ 2.7%
1997	6.1%	+ 2.0%
1998	5.8%	+ 1.5%
1999	5.1%	+ 1.0%
2000	4.5%	+ 0.5%
2001	4.4%	+ 0.5%
2002	4.5%	+ 0.5%
Avg.	5.1%	

- 1115 Waiver Treatment:** Included in the per capita cap. States that have implemented demonstrations in 1995 have an option for how they would treat their new eligibles; both options are budget neutral.

**DISPROPORTIONATE SHARE REFORM:**

*Financing:*

- Federal Payment Limits:** Current (1995) Federal DSH payments are phased out by 2000, and a new DSH program is phased in by 2000. The transition occurs in 25 percent increments. This yields Federal payment limits of:

<u>Year:</u>	<u>Federal Limit:</u>
1997	\$9.3 billion
1998	\$7.9 billion
1999	\$6.4 billion
2000	\$5.0 billion
2001	\$4.5 billion
2002	\$4.0 billion

**State Allotments:**

**Transition:** Between 1997 and 1999, each state's allotment, or limit on Federal matching payments, would be the sum of the phased-out current payments and phased-in new allotment. In 1997, this amount is equal to 75% of the FY 1995 Federal DSH payments to the state plus 25% of the FY 2000 state allotment. In 1998, the amount is equal to 50% of the FY 1995 Federal DSH payments to the state plus 50% of the FY 2000 state allotment. And in 1999, the amount is equal to 25% of the FY 1995 Federal DSH payments and 75% of the FY 2000 state allotment. By 2000, the allotments is based solely on the allotment formula of the new DSH program.

**New Program:** In 2000 and subsequent years, the states' allotments will be based on their share of low-income patient days for a core set of providers. A "low-income patient day" is defined either an inpatient day or a day with one or more outpatient visits for uninsured and Medicaid patients. These days are summed for a core set of providers, described below, in each state. Each state's allotment is determined by multiplying the total Federal limit in the year by the state's proportion the nation's low-income patient days.

**Program Design:  
Transition Period:**

Before fiscal year 2000, the current laws regarding DSH (with the exception of the allotment structure) are continued. Beginning on October 1, 1999, the new program rules, described below, would begin. However, states would have the option to implement the new rules earlier.

**Optional Program:**

Beginning in fiscal year 2000, the DSH program would be made optional. States that choose to participate could do so through the current state plan amendment process and would have an additional requirement to produce an annual report describing which providers in their state received funds, and how much they received.

**Eligible Providers:**

A "core provider" is a hospital whose low-income utilization rate exceeds 25%; or a children's hospital whose low-income utilization rate exceeds 25% or whose Medicaid inpatient utilization rate exceeds 20% or is 1 standard deviation above the mean for receiving Medicaid payments in the state. States also have the option of designating other hospitals that serve a disproportionate number of low-income patients with special needs.

**Provider Payments:** States must pay core providers and have the option of paying additional providers that meet the standard described above. Limits on maximum payments to facilities are retained, as are rules about proportionality of payments.

**POOLS:** Three fixed pools of Federal funds are designated for payments to specific states and providers to help them transition from the current to the new Medicaid program.

### 1. UNDOCUMENTED POOL

**Financing:** A temporary pool for states with high numbers of undocumented persons is created to pay for emergency health services. No state matching payments would be required. Maximum Federal spending is limited to the following amounts:

<u>Year:</u>	<u>Federal Limit:</u>
1997	\$700 million
1998	\$700 million
1999	\$700 million
2000	\$700 million
2001	\$700 million
<b>Total:</b>	<b>\$3.5 billion</b>

**State Allotments:** The 15 states with the highest number of undocumented persons, according to Immigration and Naturalization Service data (October 1992), are eligible. Each state gets an allotment from the pool according to its share of the number of undocumented persons in the 15 states.

**Annual Report:** States receiving the funds shall submit a report within 90 days of the end of the fiscal year that describes which providers received how much funding and other such information that assures that services provided with this funding are consistent with current law.

### 2. POOL FOR FEDERALLY-QUALIFIED HEALTH CENTERS & RURAL HEALTH CLINICS

**Financing:** A pool for supplemental payments to federally-qualified health centers (FQHCs) and rural health clinics (RHCs) is created. Maximum Federal spending is limited to the following amounts:

<u>Year:</u>	<u>Federal Limit:</u>
1997	\$500 million
1998	\$500 million
1999	\$500 million
2000	\$500 million
2001	\$500 million
2002	\$500 million
<b>Total:</b>	<b>\$3.0 billion</b>

**Design:**

The Secretary of the Department of Health and Human Services shall determine eligibility, payment methodology and payment allocation to qualifying facilities. No state matching payments would be required.

**3. TRANSITION POOL:**

**Financing:**

A pool for payments to states to assist in the transition from the current Medicaid program to the new per capita cap and DSH programs is created. Maximum Federal spending is limited to the following amounts:

<u>Year:</u>	<u>Federal Limit:</u>
1997	\$1.5 billion
1998	\$1.5 billion
1999	\$500 million
<b>Total:</b>	<b>\$3.5 billion</b>

**Design:**

The Secretary of the Department of Health and Human Services shall determine eligibility, payment methodology and payment allocation to qualifying states.

# EXAMPLES OF FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PLAN

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## OVERVIEW

### I. IMPLEMENTING MANAGED CARE

- Repeal of Requirement for Federal Waivers for Managed Care
- Repeal of Managed Care Contracting Rules
- Elimination of Requirement for Federal Review of HMO Contracts over \$100,000

### II. FLEXIBILITY IN PROGRAM PAYMENT

- Repeal of the Boren Amendment
- Elimination of Special Requirements for Obstetricians and Pediatricians

### III. FLEXIBILITY IN PROGRAM BENEFITS

- Elimination of Requirement for Federal Waivers for Home and Community-Based Waivers
- Enabling States to Require Nominal Copayments for HMO Enrollees

### IV. FLEXIBILITY IN PROGRAM ELIGIBILITY

- Income Levels for Infants and Pregnant Women

### V. FLEXIBILITY IN STATE ADMINISTRATION

- Reforming Medicaid Eligibility Quality Control (MEQC)
- Revise and Simplify Medicaid Management Information System Requirements
- Provider Qualifications for Obstetricians and Pediatricians
- Elimination of Requirements to Pay for Private Health Insurance
- Elimination of Personnel Requirements
- Elimination of Requirements for Cooperative Agreements
- Elimination of Requirements for Preadmission Screening and Annual Resident Review (PASARR)

# EXAMPLES OF STATE FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PROPOSAL

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## I. IMPLEMENTING MANAGED CARE

### REPEAL OF REQUIREMENT FOR FEDERAL WAIVERS FOR MANAGED CARE

#### Administration Proposal:

The Administration's proposal would allow states to implement managed care programs without the need for Federal waivers. States could implement managed care programs with a state plan amendment.

- 43 States will no longer need to apply for waivers or waiver renewals. These States have initiated 162 requests -- either initial waivers or renewals -- over the last three years.
- States can implement managed care by submitting state plan amendments.
- This simplified process will save states the considerable administrative burden associated with preparing freedom-of-choice waiver requests.

#### Background:

Currently, states must apply for Federal waiver approval to implement Medicaid managed care programs. Waiver requests are administratively burdensome and repetitive -- freedom-of-choice waivers must be renewed every two years. States generally spend three to six months preparing freedom-of-choice waiver requests, although this effort varies widely depending on the scope and complexity of the program. All but five states with freedom of choice waivers have more than one such waiver, each of which requires separate processing. HCFA's review and approval process must be completed within 90 days; however, this time period may be extended substantially if the State must provide additional information. See attached table for affected states.

**FREEDOM OF CHOICE WAIVER ACTIVITY**  
(1993-1996)

State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers
Alabama	2	Kentucky	4	North Dakota	3
Alaska		Louisiana	2	Ohio	3
Arizona		Maine	3	Oklahoma	1
Arkansas	5	Maryland	3	Oregon	3
California	18	Massachusetts	3	Pennsylvania	7
Colorado	5	Michigan	5	Rhode Island	
Connecticut	1	Minnesota	2	South Carolina	2
Delaware		Mississippi	4	South Dakota	3
D.C.	2	Missouri	4	Tennessee	
Florida	4	Montana	2	Texas	7
Georgia	5	Nebraska	2	Utah	3
Hawaii		Nevada	1	Vermont	
Idaho	2	New Hampshire		Virginia	3
Illinois		New Jersey	1	Washington	14
Indiana	2	New Mexico	3	West Virginia	5
Iowa	4	New York	8	Wisconsin	4
Kansas	2	North Carolina	5	Wyoming	1
<b>TOTAL</b>					<b>162</b>

The numbers indicated include approved and pending new waivers, renewals, and modifications.

## REPEAL OF MANAGED CARE CONTRACTING RULES

### Administration Proposal

Under the Administration proposal, States will be able to contract with Medicaid-only managed care plans. States will also be able to enroll Medicaid beneficiaries into managed care plans for up to six months at a time. Some States -- Hawaii and Rhode Island -- have developed demonstration programs in order to implement managed care programs with these features.

- States will no longer need to apply for demonstration authority to receive waivers of these statutory provisions.
- States will be able to contract with a broader range of managed care entities.
- Six-month lock-in provisions will attract more managed care plans to contract with Medicaid programs.

### Background

Currently, Medicaid managed care plans must maintain a commercial enrollment base of twenty-five percent. This requirement -- the "75/25 rule" -- prohibits States from contracting with Medicaid-only managed care plans. In addition, Medicaid beneficiaries must be able to disenroll from most managed care plans on a month-to-month basis, thus disrupting enrollment stability.

If these provisions were repealed, the programmatic elements (but not eligibility expansions) of some demonstration programs (Hawaii and Rhode Island) could be operated without demonstration waivers. Other demonstration States, such as Oregon, require more complicated waivers of Medicaid law and would therefore still need waiver authority to operate their demonstration programs.

## ELIMINATION OF REQUIREMENT FOR FEDERAL REVIEW OF HMO CONTRACTS OVER \$100,000

### Administration Proposal:

Under the Administration's proposal, states will no longer need to seek Secretarial approval for HMO Contracts over \$100,000.

- All States with pre-paid managed care programs will avoid unnecessary and duplicative Federal oversight of their contracting and rate-setting procedures.
- This new flexibility will save states time and effort.

### **Background:**

Currently, states must obtain HCFA's approval of all contracts with HMOs that exceed \$100,000 in expenditures. This prior approval requirement represents an unnecessary double-check on the state's contracting and rate-setting procedures. HCFA approval generally takes between two and forty-five days.

See attached chart for state-by-state contract numbers.

**FEDERAL APPROVAL OF MANAGED CARE CONTRACTS**  
Annual Estimate

STATE	NUMBER OF CONTRACTS	STATE	NUMBER OF CONTRACTS	STATE	NUMBER OF CONTRACTS
Alabama	0	Kentucky	0	Ohio	14
Alaska	0	Louisiana	0	Oklahoma	12
Arizona	7	Maine	0 (6-8 next year)	Oregon	36
Arkansas	0	Maryland	6	Pennsylvania	9
California	16	Massachusetts	11	Puerto Rico	2
Colorado	7	Michigan	12	Rhode Island	5
Connecticut	11	Minnesota	9	South Carolina	0
Delaware	4	Mississippi	0	South Dakota	0
D.C.	4	Missouri	6	Tennessee	12
Florida	30	Montana	2	Texas	1 (8 next year)
Georgia	0	Nebraska	7	Utah	5
Hawaii	5	Nevada	0 (4 next year)	Vermont	0
Idaho	0	New Hampshire	3	Virginia	10
Illinois	7	New Jersey	25	Washington	30
Indiana	2	New Mexico	0	West Virginia	0
Iowa	8	New York	130	Wisconsin	11
Kansas	6	North Carolina	1	Wyoming	0
		North Dakota	0	<b>ESTIMATED TOTAL</b>	<b>466</b>

## **II. FLEXIBILITY IN PROGRAM PAYMENT**

### **REPEAL OF THE BOREN AMENDMENT**

#### **Administration Proposal:**

The Boren Amendment will be repealed, and replaced with a process for notifying the public about facility rates. Thus, states can establish hospital and nursing home payment rates without federal requirements.

- States will have flexibility to negotiate payment rates with providers.
- States would no longer be required to submit assurances of the adequacy of their payment rates to HHS.
- States will no longer face costly law suits from providers demanding higher payments.

#### **Background:**

Under current requirements, states are required to assure that payment rates for institutional facilities are reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated facility.

Since 1984, plaintiffs have filed at least 173 cases alleging that States have failed to comply with the Boren Amendment. Under the Administration's proposal, these suits would not be possible.

## **ELIMINATION OF SPECIAL PAYMENT REQUIREMENTS FOR OBSTETRICIANS AND PEDIATRICIANS**

### **Administration Proposal:**

The current burdensome requirements for data collection to document that states are meeting special payment rate requirements for obstetricians and pediatricians will be repealed.

- States will no longer have to collect and submit data on payment rates for obstetrical and pediatric services.
- States will no longer have to submit state plan amendments for the Ob/Peds information that can range from 30 pages to over 300 pages in size.

### **Background**

States are required to report the following information by April 1 of each year:

- payment rates for obstetrical and pediatric services for the coming year;
- data to document that the states' rates are sufficient to ensure access to these services is comparable to the access enjoyed by the general population;
- data that document that payment rates to HMOs take into account fee-for service payment rates for ob/ped services;
- data on the average statewide payment rates.

The data collection and analysis required to fulfill these requirements involve, on average, at least 5 people in each state Medicaid agency. In addition, staff from State licensing boards and provider offices are called upon to help states review and define data. Preparation of the final report alone takes, on average, 2 weeks. State plan amendments for the Ob/Peds information range from 30 pages to over 300 pages in size depending on the state.

### **III. FLEXIBILITY IN PROGRAM BENEFITS**

#### **ELIMINATION OF REQUIREMENT FOR FEDERAL WAIVERS FOR HOME AND COMMUNITY BASED SERVICES PROGRAMS**

##### **Administration Proposal:**

States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

- 49 States with a total of 517 home and community-based waiver programs will no longer need to obtain federal approval and renewal authority.
- States can provide tailored home and community-based services simply by submitting a state plan amendment.
- This simplification will save states approximately 6 months preparing new and renewal home and community-based waiver requests.

##### **Background:**

Currently, states must apply for Federal waiver approval to provide home and community-based services to elderly and disabled Medicaid beneficiaries. Waiver requests are administratively burdensome and repetitive because initial waiver approvals only last three years and must be renewed every five years. States spend approximately 180 hours to prepare each new and renewal home and community-based waiver request and approximately forty hours preparing an amendment to approved waivers. All 49 states with HCBS waivers have more than one such waiver, with separate processing requirements for each.

.See attached chart for affected states.

**HOME AND COMMUNITY-BASED WAIVER ACTIVITY  
(1993-1996)**

STATE	1915(C)HOME AND COMMUNITY-BASED WAIVERERS	STATE	1915(C) HOME AND COMMUNITY-BASED WAIVERS	STATE	1915(C)HOME AND COMMUNITY-BASED WAIVERS
Alabama	12	Kentucky	6	North Dakota	4
Alaska	12	Louisiana	12	Ohio	13
Arizona		Maine	12	Oklahoma	9
Arkansas	10	Maryland	8	Oregon	2
California	10	Massachusetts	3	Pennsylvania	14
Colorado	18	Michigan	12	Rhode Island	6
Connecticut	7	Minnesota	17	South Carolina	13
Delaware	7	Mississippi	6	South Dakota	8
D.C.		Missouri	11	Tennessee	15
Florida	17	Montana	5	Texas	22
Georgia	7	Nebraska	12	Utah	7
Hawaii	4	Nevada	9	Vermont	7
Idaho	4	New Hampshire	7	Virginia	7
Illinois	15	New Jersey	18	Washington	16
Indiana	24	New Mexico	4	West Virginia	3
Iowa	23	New York	15	Wisconsin	16
Kansas	7	North Carolina	13	Wyoming	8
				<b>TOTAL</b>	<b>517</b>

The numbers indicated include approved and pending new waivers, renewals, and modifications.

## **ENABLING STATES TO REQUIRE HEALTH MAINTENANCE ORGANIZATION ENROLLEES TO MAKE NOMINAL COPAYMENTS**

### **Administration Proposal:**

The Administration's proposal would allow States and health plans to require nominal copayments from Medicaid beneficiaries who are enrolled in HMOs to the extent that copayments could be imposed if the beneficiary were not enrolled in an HMO. For example, states could not require children to make copayments, nor charge copayments for pregnancy-related services or emergency services.

- o States and health plans would have the flexibility to control unnecessary utilization better,
- o States could reduce their capitation payments based on plans' anticipated copayment revenues, and
- o Plans would still be required to provide services, regardless of enrollees' ability to make a copayment.

### **Background:**

Currently, states cannot require categorically-eligible Medicaid beneficiaries who enroll in HMOs to make any type of cost-sharing payment, including copayments. This restriction prohibits States and Medicaid-contracting health plans from using all available tools to control unnecessary utilization of and payment for services. States currently have the ability to impose nominal copayments in the fee-for-service portion of the Medicaid program.

## **IV. FLEXIBILITY IN PROGRAM ELIGIBILITY**

### **INCOME LEVEL FOR INFANTS AND PREGNANT WOMEN**

#### **Administration Proposal:**

The 33 States that choose to cover pregnant women and infants above the minimum 133% of the Federal Poverty Level (FPL) will be given the option to lower this income eligibility threshold back to the minimum level. Currently, once a State chooses to expand Medicaid coverage to include populations at an income level above 133% FPL, they are prohibited from lowering the income threshold back to 133% FPL.

#### **Background**

States that used a percentage of poverty for eligibility level for pregnant women and infants that was above the minimum percentage required before OBRA 89 are currently prohibited from reducing that percentage.

The attached chart shows the 33 states that could take advantage of this provision today.

## INCOME AND ELIGIBILITY LEVELS: INFANTS AND PREGNANT WOMEN

The 33 highlighted states could take advantage of this provision

STATE	PERCENT OF POVERTY	STATE	PERCENT OF POVERTY	STATE	PERCENT OF POVERTY
Alabama	133	Kentucky	185	North Dakota	133
Alaska	133	Louisiana	133	Ohio	133
Arizona	140	Maine	185	Oklahoma	150
Arkansas	133	Maryland	185	Oregon	133
California	200*	Massachusetts	185	Pennsylvania	185
Colorado	133	Michigan	185	Rhode Island	250**
Connecticut	185	Minnesota	275*	South Carolina	185
Delaware	185	Mississippi	185	South Dakota	133
D.C.	185	Missouri	185	Tennessee	185
Florida	185	Montana	133	Texas	185
Georgia	185	Nebraska	150	Utah	133
Hawaii	300**	Nevada	133	Vermont	225*
Idaho	133	New Hampshire	185	Virginia	133
Illinois	133	New Jersey	185	Washington	200*
Indiana	150	New Mexico	185	West Virginia	150
Iowa	185	New York	185	Wisconsin	185
Kansas	150	North Carolina	185	Wyoming	133

\* States with effective income levels above the nominal statutory maximum use the authority in section 1902(r)(2) to disregard higher than usual amounts of income.

\*\* States using higher income level as part of demonstration under section 1115.

## V. FLEXIBILITY IN STATE ADMINISTRATION

### REFORMING MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

#### Administration Proposal:

The Administration's proposal reduces the complex accounting and individualized cost accounting currently required under MEQC, by requiring that states address only the numbers of ineligible and the average cost per ineligible in the appropriate group.

- o Details of spending on each ineligible case will not have to be documented, and
- o Disallowances will not be distorted and excessively inflated when the ineligible sample includes a very few very high cost cases.

All states will benefit from this reduction in individualized tracking. Though only a few States have excessive error rates (the national average has hovered around 2 percent for several years), all states are currently required to go through the entire determination, adjudication, cost accounting process every six months.

#### Background:

Federal matching funds are disallowed to the extent that a State makes excessive errors in determining ineligible persons to be eligible for Medicaid or understates the amount of medical bill that a person must be responsible for before becoming eligible. "Excessive" means erroneous payments in excess of 3 percent of total payments. In certain circumstances, disallowances may be waived (e.g., if excessive errors are explained by events beyond the State's control).

## REVISE AND SIMPLIFY MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REQUIREMENTS

### Administration proposal:

States would have new flexibility to design, structure, and operate their Medicaid Management Information Systems within general federal parameters rather than being required to comply with the detailed systems design requirements and planning documentation requirements in effect today.

- All states will be able to operate MMIS systems that are more tailored to State circumstances and thus more cost-effective.
- The Secretary will retain appropriate oversight authority and the ability to enforce general Federal parameters, but the States will not be hamstrung by a Medicaid equivalent of "mandatory sentencing."
- Because current financial penalties for non-compliance will be repealed, HCFA's on-site reviews of State MMIS systems would be less frequent and less intrusive. States would no longer need to dedicate several staff members to month-long preparations for these reviews.

### Background:

Currently, as a requirement for federal administrative matching, all States must operate a Medicaid Management Information System that meets highly detailed Federal requirements. Compliance is continuously and rigorously monitored. Non-compliance results in financial penalties, which are elaborated in considerable statutory detail.

## PROVIDER QUALIFICATIONS FOR OBSTETRICIANS AND PEDIATRICIANS

### Administration Proposal:

The administration proposal would eliminate the detailed minimum provider qualifications that specify requirements that must be met by physicians serving pregnant women and children.

The requirements that would be eliminated are difficult for practitioners in large urban and underserved rural states to meet. This proposal would make state licensure requirements the only qualification requirements practitioners serving pregnant women and children would have to meet.

### Background:

Section 1903(I) establishes provider qualifications for physicians serving pregnant women and children. Physicians must be certified in family practice or pediatrics, affiliated with an FQHC, have admitting privileges at a hospital participating in a State plan, a member of the National Health Service Corps, or certified by the Secretary as qualified to provide physicians' services to pregnant women.

Implications of the current policy are significant.

- New York estimated that only 1/3 of its physician provider population would remain eligible to treat pregnant women and children.
- Rural states e.g., Montana have indicated that the only source of physician care in some counties is from physicians who do not meet one of the qualifications.
- New Mexico conducted a quick review of disciplinary actions under licensure and found that all of the involved physicians met the Medicaid standards.
- The AMA estimates that approximately one third of the nation's physicians are not board certified.

## ELIMINATION OF REQUIREMENTS TO PAY FOR PRIVATE HEALTH INSURANCE

### Administration proposal:

The current Federal requirements in this area would be repealed. States will have the option to purchase health insurance for their Medicaid population under flexible terms of negotiation with insurers. States will be free to negotiate benefit packages, premiums, and cost sharing rates (deductible and co-payments). States would continue to have the option to continue such "buy-out" kinds of programs -- particularly cost-effective "buy-out" arrangements.

### Background:

Currently, states must pay premiums and all other cost-sharing obligations for a private insurance plan for Medicaid eligibles when this strategy provides cost-effective coverage.

Free of federal restrictions, states should be able to do a better job of restraining costs by moving people into private insurance. This is because Federal requirements require states to consider all cost-sharing related to private insurance. Because private plan deductibles and coinsurance amounts typically exceed the Medicaid rate for the same services, this requirement restricts the number of cases where a "buy-out" would be cost-effective. Also, the requirement is virtually impossible for states to administer since every plan may have different payment rules.

## ELIMINATION OF PERSONNEL REQUIREMENTS

### Administration proposal:

Prescriptive Federal personnel standards and requirements that currently must be met by states would be replaced with a simple requirement that states provide methods of administration which are necessary for the proper and efficient operation of the plan. The detailed state plan requirements and documentation currently required would be eliminated.

### Background:

Federal statute and regulations mandate in some detail that states must provide methods of administration for the establishment and maintenance of merit system-based personnel standards, and states must use professional medical personnel for administration and supervision. Many of these federal requirements are duplicative of state requirements and processes. States are required to provide considerable documentation for this portion of their state plan.

## ELIMINATION OF REQUIREMENT FOR COOPERATIVE AGREEMENTS

### Administration Proposal:

The current requirements for entering into cooperative agreements with numerous other state agencies would be repealed. Also repealed would be any requirements that states provide documentation, as a part of their state plan, that the agreements are in place and current.

The repeal of these requirements would alleviate considerable administrative burden for states, and would allow flexibility to pursue management of Medicaid within the circumstances within each state's administrative practices and circumstances.

### Background:

Section 1902(a) requires that a State Plan must "provide for entering into cooperative arrangements" with other State agencies. Some States have interpreted this to mean they must submit state plan amendments with the actual agreements every time an agreement is established or there is a change to an existing agreement. The requirement, however, is for states only to indicate in their State plan that agreements exist and identify which agencies the agreements are with. States are not required to submit the actual agreements.

## ELIMINATION OF REQUIREMENTS FOR PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)

### Administration proposal:

Replace the requirement for an annual resident review for all residents, with a requirement that States conduct an annual resident review on an exception basis. Under the Administration proposal, reviews would be conducted only when the NF resident assessment indicates a significant change in the physical or mental condition of the resident.

This would provide considerable administrative flexibility to focus scarce resources on those residents whose condition indicates there is a need for additional intervention and assessment. This proposal relieves the states of burdensome, costly, annual reviews of every resident which duplicate, in large part, the required evaluations and add little value to meeting the needs of residents.

### Background:

States are required to perform resident assessments promptly after admission, after a significant change in physical or mental condition and no less often than annually thereafter for all mentally retarded or mentally ill individuals residing in facilities.

Although each state administers their reviews differently, the state of Washington can be looked to as a case example. In 1991, Washington conducted 400 annual resident reviews at a cost of \$750,000. Under the administration's proposal, the State of Washington's burden would be reduced significantly because duplicative reviews would be eliminated. However, the actual reduction cannot be quantified.

## MEDICAID STATE FLEXIBILITY

The Alternative Medicaid Reform Proposal dramatically increases State flexibility in Medicaid program administration. At the same time, it achieves Federal Medicaid savings through the use of per capita caps which protect States against eligible population growth due to demographic changes, economic downturns, and other uncontrollable events. Finally, the level of savings proposed by the alternative is substantially less than a third of what the Republicans are seeking. Thus, States would have the flexibility to tailor their Medicaid programs to meet local needs without the substantial funding losses and financial risks inherent in the Republican block grant proposals.

The State flexibility of the alternative plan is illustrated by the fact that many of the Medicaid flexibility proposals requested by the States over the past several years are included explicitly in the plan. The following chart reflects items requested by the NGA in its 1993 summary of State Recommendations for Statutory Change and its Medicaid Policy adopted in January 1995.

Provisions in the alternative plan should be considered preliminary.

## Flexibility Proposals Contained in the Alternative Medicaid Proposal

NGA Medicaid Proposals	Alternative Proposal
<u>Structure:</u>	
<p>o Impose no unilateral caps for federal spending on Medicaid entitlement.</p>	<p>Addressed. In contrast with the Republican block grant proposal, the alternative per capita proposal provides States with protections for enrollment increases due to population changes and economic conditions. Disproportionate share payments (DSH) would be reduced and restructured. Entities eligible for DSH payments would be expanded to include FQHCs, RHCs and other outpatient providers.</p> <p>The alternative proposal would also include new payments to a number of States with high numbers of undocumented immigrants and high levels of uncompensated care.</p>
<u>Eligibility:</u>	
<p>o Simplify eligibility by collapsing existing categories and optional groups where appropriate. (NGA '93)</p>	<p>Addressed. To allow for eligibility simplification and eligibility expansion, States would have the option of covering individuals up to 150 percent of poverty, as long as the expansion is "budget neutral." Current coverage would be maintained.</p>
<p>o Allow States that have expanded coverage for pregnant women and infant beyond the mandatory level to reduce income eligibility to as low as the mandatory level. (NGA '93)</p>	<p>Included</p>
<p>o Allow states to pay Medicaid rates for those services provided to recipients for whom the state has purchased cost-effective group health insurance. (NGA '93)</p>	<p>Addressed. States will have the option to purchase group health insurance and pay Medicaid rates.</p>

<u>Provider Payment:</u>	
o Give states greater leeway in containing the cost of hospital and long-term care through the Boren Amendment. (NGA '93, NGA '95)	Addressed. Boren amendment is repealed for hospitals and nursing homes
o Promote cost control and efficiency -- i.e., encourage states to continue innovations in provider payment methods. (NGA '95)	Addressed. Permits States to implement managed care programs without waivers and eliminates cost-based reimbursement for FQHCs/RHCs following a two-year transition
o Allow greater flexibility in imposing beneficiary co-payments. (NGA '93)	Addressed. Allows States to establish nominal co-payments for HMO enrollees.
<u>o Provider Qualifications</u> <ul style="list-style-type: none"> <li>• Repeal provision establishing minimum qualifications for physicians who serve pregnant women and children. (NGA '93)</li> <li>• Repeal the annual reporting requirements for OB and pediatric care. (NGA '93)</li> </ul>	<p>Included.</p> <p>Included.</p>
<u>Benefits:</u>	
o States should have the ability to turn home and community based waivers into permanent state plan amendments once the waiver has been proven effective. (NGA '93, NGA '95)	Addressed. States may establish home and community-based services without waivers.
o Personal care should be an optional service that can be delivered or provided by other providers besides home health agencies. (NGA '93)	Affirms current law that personal care services can be delivered by providers other than home health agencies.

<u>Delivery Systems:</u>	
o Allow states greater flexibility to establish managed care networks:	Addressed. States may implement managed care programs without obtaining waivers from HCFA.
<ul style="list-style-type: none"> <li>• States should be able to establish networks (including PCCMs) through the state plan process rather than through the freedom of choice waiver process. (NGA '93, NGA '95)</li> <li>• Eliminate the 75/25 rule for capitated health plans participating in the Medicaid program (NGA '93, NGA '95.)</li> <li>• Under a freedom of choice waiver, permit states to restrict Medicaid recipients in a rural area to a single HMO if there is only one HMO available. (NGA '93)</li> </ul>	<p>Included.</p> <p>Included.</p> <p>Included.</p>
o Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional services without having to submit a waiver. (NGA '93)	Addressed. Managed care and home and community-based care no longer require waivers.
<u>Quality:</u>	
o OBRA '87 Nursing home reform modifications:	Addressed.
<ul style="list-style-type: none"> <li>• Eliminate restrictions on training sites for nurse aides. (NGA '93)</li> <li>• Eliminate PASARR. (NGA '93, NGA '95)</li> </ul>	<p>Eliminates prohibition on providing nurse-aide training in rural nursing homes.</p> <p>Eliminates duplicative annual resident assessment under PASARR. Retains pre-admission screening.</p>

<p>o OBRA '87 enforcement: the determination of deficiencies require a form of scope and severity index to assure that limited state resources are directed to the enforcement of the most egregious deficiencies. (NGA '93) .</p>	<p>Affirms current law to allow the targeting of state enforcement resources.</p>
<p><u>Administrative:</u></p>	
<p>o Technical disallowances -- prohibit Federal disallowances for "technical" issues that do no harm to beneficiaries. (NGA '93, NGA '95)</p>	<p><b>Under discussion</b> - HCFA's disallowance authority would be modified to enable it to avoid imposing excessive disallowances that are not commensurate to the size of the State's violation.</p>

SUMMARY OF THE CONFERENCE  
AGREEMENT

## 1995 - 1996 CHRONOLOGY OF OFFERS ON MEDICAID

The following is a chronology of offers within the past year which have been submitted by the White House, Congress, and the National Governors' Association for funding Medicaid.

### October of 1995

- Republicans submitted the **Medigrant Initiative** designed to save **\$187 billion** (block grant).

### October of 1995

- **Coalition Bill** designed to save approximately **\$85 Billion** (per capita).

### November of 1995

- **Conference Agreement** which was scored at **\$182 Billion** and repriced at **\$133 Billion** (block grant).

### December of 1995

- **President Clinton 's Balanced Budget** included a Medicaid proposal designed to save **\$54 Billion** (per capita).

### February of 1996

- **Medigrant II** designed to save **\$85 Billion** (block grant).

### February of 1996

- **National Governors' Association** passed a resolution which included a **Hybrid Block Grant/Per Capita** proposal. Savings to be determined.

11/17/95

**Issues Summary**  
**"Medicaid Transformation Act of 1995"**  
**Conference Agreement**  
**November 1995**

**OVERVIEW**

Repeals Title XIX and replaces it with Title XXI, "Medigrant Program for Low-Income Individuals and Families"

**ELIGIBILITY**

[Largely the same as the Senate version, although States may define disability for purposes of mandatory coverage.]

- ◆ Individual entitlement would be eliminated. Current Medicaid enrollees -- including children, the elderly, individuals with disabilities and dually-eligible Medicare beneficiaries -- could, at a State's option, lose eligibility for certain Medicaid-covered services.
  - ▶ States are required to cover pregnant women, children age 12 and under, and the disabled (as defined by the State) with income below the poverty level. However, other provisions in the bill undermine this guarantee. States can vary coverage across geographic areas and can vary duration and scope of services across enrollees. Enrollees have no guarantee of any particular service or any level of covered services.
- ◆ Current spousal impoverishment protections are retained.
- ◆ Individuals would not be able to sue a State in Federal court for the State's failure to comply with Federal Medigrant requirements. Therefore, guaranteed coverage for pregnant women, children and the disabled and spousal impoverishment protections -- as well as any other individual rights within this bill -- are effectively nullified. Only the Federal government could attempt to enforce these statutory provisions through an administrative compliance process.
- ◆ Current restrictions on liens and estate recoveries are eliminated.
- ◆ States could not deny coverage of services based on a pre-existing condition.
- ◆ States cannot require an adult child whose income is below the State median income level to contribute to the cost of nursing home care for a parent.
- ◆ States may cover individuals with incomes below 275 percent of poverty. [Midpoint between

House and Senate.]

### SERVICES

[Largely similar to both the House and Senate.]

- ◆ Required services -- even for hospital or physician services -- would be eliminated.
  - ◆ Immunization services and pre-pregnancy family planning services would remain as the only required services in this bill. However, the VFC program would be repealed, causing immunization costs to increase. [Same as Senate.]
- ◆ Comparability of services between eligibility groups and geographic regions within States would be eliminated. No standard services (e.g., current mandatory services) would be required to be covered in every State.
- ◆ States would be able to vary duration and scope of services from enrollee to enrollee. Therefore, equitable coverage for eligible beneficiaries would not be assured. States would be able to discriminate against certain enrollees (e.g., due to age, sex, or race) by providing different levels of coverage for the same service.
- ◆ The requirement for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) of children would be eliminated.
- ◆ Abortion services would be limited to situations involving rape, incest, and protecting the life of the mother.

### PAYMENT TO STATES - ALLOCATION FORMULA

[Similar methodology to both House and Senate provisions, but with significant differences.]

- ◆ Savings total approximately \$164 billion over seven years.
- ◆ For each fiscal year, the Secretary would calculate both a Federal obligation and an outlay allotment for each State.
  - ◆ The obligation allotments would be slightly higher than the actual amount of Federal funds States can draw down -- the outlay allotment. The rationale for this provision may be that States often incur greater costs than they are able to draw down Federal matching payments in a given fiscal year.
- ◆ No special treatment for disproportionate share hospitals (DSH). DSH payments are included

in the base.

- ◆ All States' outlay allotments would be adjusted (using a scalar factor) so that the total does not exceed the available pool of Federal funds. The pool of Federal funds would be \$96.4 billion in 1996, \$103.2 billion in 1997, \$107.9 billion in 1998, \$112.6 billion in 1999, \$117.4 billion in 2000, \$122.3 billion in 2001 and \$127.4 billion in 2002. The available pool of Federal funds would increase the lower of 4.2 percent or GDP for years after 2002.
- ◆ Outlay allotments for 1996 would be established in statute. [New provision.]
- ◆ A State's outlay allotment for 1997 and subsequent fiscal years would be equivalent to a calculated needs-based amount, subject to a scalar (to make State allotments sum to the total pool) and growth limits:

#### Floors

- ▶ Annual growth in States' outlay allotments would not fall below 3.5 percent in 1997; this increase is reduced to 3 percent in 1998 and 2 percent for subsequent years;
- ▶ All States' computed allotments would be at least 0.24 percent of the Federal pool beginning in 1998.
- ▶ Beginning in 1998, if a State's annual allotment growth exceeds the national growth percentage, annual allotment growth would be limited to 4 percent.

#### Ceilings

- ▶ The growth in States' outlay allotments cannot exceed 9 percent for 1997 and 5.3 percent for subsequent years;
- ▶ Outlay allotments for the ten States with the lowest Federal Medigant spending per resident in poverty would grow at 7 percent;
- ◆ The needs-based amount for each State is generated using measures of State's relative number of residents in poverty, a case-mix index, an input cost index, and national spending per person in poverty.
- ◆ New Hampshire and Louisiana would have outlay allotments of \$360 million and \$2.6 billion through fiscal year 2000. They would be required to contribute State share of \$203 million and \$355 million, respectively, plus 20 percent of the difference between these amounts and the State contribution that would be necessary to draw down their full outlay allotments in 1996. The States' share of this difference would increase by 20 percent increments each year until, in fiscal year 2000, they would be meeting their full obligations. [Same as Senate.]

- ◆ Louisiana and Nebraska would have pre-determined allotment increases of \$37 million and \$106 million, respectively, for 1997; Nevada's allotment would be increased by \$90 million annually for 1996, 1997 and 1998. [New provision.]
- ◆ A supplemental allotment for emergency services to undocumented immigrants would provide additional funding to the fifteen States with the highest number of undocumented immigrants. This allotment would be allocated based on the proportion of undocumented immigrants in each State compared to the total for all States receiving the supplemental allotment. \$3.5 billion from 1996 to 2000.
- ◆ The Federal Medicaid assistance percentage (FMAP) would be either the result of the current formula (based on States' relative per capita incomes), 60 percent, or the lower of the new FMAP (based on total taxable resources and aggregate expenditure need) or the current FMAP plus 10 percent. States would be able to choose between these three options. [Combination of Senate and House provisions.]

### LIMITATIONS

[Mostly similar to House provisions.]

- ◆ States would not receive Federal match for payments made for non-emergency services provided by excluded providers or provided to illegal aliens, payments eligible for third-party coverage, or payments for medically-related costs in excess of five percent of total expenditures. [Similar to House and Senate.]
- ◆ No Federal funding would be available for administrative expenses greater than \$20 million plus 10 percent of total program spending in a given year.
- ◆ No Federal funds would be available for purchase of outpatient drugs from a manufacturer who was not participating in the drug rebate program.

### SET-ASIDES

[Combination of House, Senate and new provisions.]

- ◆ States would be required to devote a minimum proportion of their total program spending on low-income families, low-income elderly, low-income disabled individuals, and services provided by Federally-qualified health centers and rural health centers.
  - ▶ This minimum percentage would be based on 85 percent of the average percentage of State spending on mandatory eligibles within these groups for mandatory services from 1992 to 1994. Spending for all elderly in nursing homes would be included in the

elderly set-aside. The Medicare cost sharing set-aside would be based on 90 percent of the average percentage of State spending on Medicare premiums from 1993 to 1995.

[Same as House and Senate.]

- ▶ The minimum percentage for FQHC and RHC services would be based on 85 percent of the average annual Medicaid expenditures from 1992 through 1994 on services provided by these entities. [New provision.]

- ◆ States would be permitted to spend less than the minimum set-asides if they can determine that the health needs of the population can be "reasonably met" without the required expenditure amount. [Same as House.]
- ◆ States would also be permitted to spend less than the minimum set-asides if an independent actuary certifies that, under the State plan, the State will be spending at least 95 percent of the minimum set-aside for any of these categories. [New provision.]

### **PROVIDER PAYMENTS**

[Largely the same as House and Senate provisions.]

The bill removes all Federal provider payment requirements, including the Boren amendment and payment requirements for Federally-qualified health centers and rural health centers.

- ◆ States would be required to set capitation rates in accordance with actuarial principles.
- ◆ DSH payments are not explicitly retained. However, States must include a description of how these hospitals will be paid in their State plan. [Same as Senate].

### **COST-SHARING**

- ◆ States may impose cost-sharing requirements -- including coinsurance, copayments, deductibles and other charges -- on Medicaid enrollees, except:
  - ▶ States would be prohibited from imposing premiums on families with incomes below the Federal poverty level with a pregnant woman or a child (under age 19).
  - ▶ Copayments for primary and preventive services (as defined by the State) must be nominal for pregnant women and children in families with income below the Federal poverty level.
- ◆ States would have broad flexibility to develop premium and cost-sharing schedules. States could choose to develop premium and cost-sharing requirements that discourage

inappropriate use of emergency services; encourage the use of primary and preventive care, are related to economic factors, employment status, and family size; reflect the availability of other insurance coverage; or are tied to participation in programs that promote personal responsibility (i.e., drug treatment or employment training).

### DELIVERY SYSTEMS

[Same as House and Senate.]

- ◆ Access standards for health plans and other providers would be eliminated.
- ◆ Freedom of choice requirements would be eliminated. Beneficiaries would not be guaranteed a choice of plan or delivery system.
- ◆ States' ability to contract with managed care plans for services, case management, or coordination would be unfettered.

### NURSING HOME QUALITY ASSURANCE

Maintains much of the current statutory structure from the OBRA 87 nursing home reforms, but States will be responsible for setting and enforcing quality standards.

- ◆ States could turn over their standard setting and enforcement responsibilities to private organizations (allows "deemed status"), with no Federal review;
- ◆ Maintains Federal look-behind of State surveys, but changes look-behind to a three-year cycle;
- ◆ Requires States, rather than the Federal government, to establish requirements for nurse aide training, pre-admission screening and annual resident review (PASARR) and administrator qualifications;
- ◆ Eliminates the annual review component of PASARR;
- ◆ Reduces statutory specificity on the level of services and activities that must be provided to nursing home residents;
- ◆ Eliminates current protections that prohibit nursing homes from requiring potential residents to forgo Medicaid coverage at the point of admission or in the future or from requiring additional payments;
- ◆ Modifies residents' rights with regard to transfers; and

- ◆ Eliminates uniform data requirements.

### **MEDICAID DRUG REBATE PROGRAM**

[Largely similar to House and Senate.]

- ◆ Federal payment for outpatient prescription drugs would be available only if the manufacturer has entered into a Medicaid drug rebate agreement with the Secretary.
- ◆ States are not required to participate in the drug rebate program, but they cannot pay for drugs unless they do.
- ◆ Supplemental rebates (beyond those agreed to by the Secretary) are prohibited. [Same as Senate.]

### **MEDICARE COST-SHARING**

[Same as House and Senate.]

Low-income Medicare beneficiaries would not be assured of continuing to receive State-financed assistance with Medicare costs. States could eliminate payments for premiums, coinsurance, and deductibles or reduce the scope of assistance -- e.g., covering only a proportion of the Medicare premium.

### **NATIVE AMERICANS**

[Same as House and Senate.]

- ◆ One hundred percent Federal matching would be extended to services provided by tribal providers as well as Indian Health Service facilities. However, one hundred percent Federal matching for these services would not increase the State's base. This requirement therefore would effectively reduce available Federal funds for other Medicaid populations.
- ◆ State Medigap plans would be required to include a description of how (or whether) Indian Health Service facilities will be included as Medigap providers and how eligible Indians will receive medical assistance.
- ◆ States will be required to consult with Indian tribes and tribal organizations as they develop their Medigap plans.

**DEMONSTRATION PROGRAMS**

[Same as House.]

No provisions for section 1115 demonstration programs. States with 1115 statewide demonstrations would be treated on par with other States.

**ACCOUNTABILITY**

[Similar to House and Senate.]

- ◆ The bill does not require States to be accountable for how they spend Federal funds.
- ◆ Limitations on the use of provider taxes and donations, contained in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, are eliminated. [Same as House.]
- ◆ The State-share limit on inter-governmental transfers is retained. [Same as Senate].
- ◆ The Secretary's authority and ability to enforce compliance would be severely constrained by procedural requirements.
- ◆ Goals, objectives and performance measures in State Medicaid plans are unenforceable. State accountability for State Medicaid plans -- and amendments to these plans -- would be minimal.
- ◆ Current Federal disallowance authority would be compromised. The Federal government would be prohibited from collecting pending disallowances.

**MEDICARE/MEDICAID DEMONSTRATIONS**

[Same as Senate provision.]

Requires the Secretary to conduct up to ten State demonstration projects integrating Medicare and Medicaid delivery systems, financed through a combination of Medicare and Medicaid funds. These projects would focus on coordinated services for chronically ill elderly and disabled individuals who are eligible for both programs. Beneficiaries would not be required to participate in these programs.

SUMMARY OF THE SENATE BIPARTISAN  
BUDGET PROPOSAL

*Fig 1: Newest on  
Upton  
Sue*

## **BIPARTISAN BUDGET PROPOSAL**

This proposal represents a framework that is supported by a bipartisan group of Senators who are united in the goal of balancing the federal budget within 7 years using CBO scorekeeping.

Total savings estimated in this proposal are \$661 billion over the next seven years. Those savings, in conjunction with the economic dividend, will eliminate the federal deficit by the year 2002.

**Discretionary:** The proposal assumes that discretionary spending in each of the next seven years will be slightly less than the amount spent in 1995. Limiting spending in this manner will save \$268 billion over that timeframe.

**Medicare:** The group proposes to slow the rate of growth in the Medicare program by \$154 billion over the next seven years. The plan assumes Medicare Part B premiums will remain at 31.5% of the program's costs for most seniors but allows the premiums to drop to 25% for those with lower incomes. In addition, upper-income seniors would pay a greater share of the cost of their health care. Finally, the group recommends increasing the Medicare eligibility age to conform with increases in the eligibility age for Social Security.

**Medicaid:** The agreement assumes savings in the Medicaid program over the next seven years of \$62 billion by imposing a per capita cap on federal spending.

**Welfare/EITC:** The proposal assumes savings from Welfare programs in line with the Senate-passed reform bill. In addition, the plan calls for changes in the Earned Income Credit program totalling \$5 billion.

**Other Mandatory Savings:** The agreement proposes \$52 billion in savings from farm programs, civil service retirement plans, student loans, veterans benefits, and spectrum sales.

**CPI:** The plan assumes the Consumer Price Index will be lowered to more accurately reflect the cost of living. The proposal would lower the CPI by 0.5 percentage points in 1996, 1997 and 1998. The adjustment would be 0.3 percentage points in the years 1999 through 2002.

**BALANCED BUDGET COMPARISONS**

*Choice Budget*

	Senate Bipartisan	GOP (1/6)	Admin. (1/6)
Discretionary	-268	-348	-295
Medicare	-154	-168	-102
Medicaid	-62	-85	-62
Welfare/EITC	-68	-75	-45
Other Mandatory	-52	-69	-59
Tax Cuts	130	203	87
Tax Loophole Closings	-25	-25	-60
Debt Service	-62	-63	-67
CPI *	-110	-18	-18
<b>Total 7-Year Savings (1)</b>	<b>-681</b>	<b>-650</b>	<b>-601</b>

\* GOP & Admin. plans adopt the "full" BLS CPI correction.

Prepared by BG 1-11-96

SUMMARY OF NGA PROPOSAL

456-7028

**SUSPENSION**

(Policy Position offered by Governor Thompson and Governor Bob Miller)

**RESTRUCTURING MEDICAID****PREAMBLE**

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics.

Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the frail elderly. This year, states and the federal government combined will spend more than \$140 billion in this program providing care to more than 28 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained and those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

**THE NEW PROGRAM**

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the nation's Governors proposal that blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens.

*Program Goals.* The program is guided by four primary goals.

1. The basic health care needs of the nation's most vulnerable populations must be guaranteed.
2. The growth in health care expenditures must be brought under control.

- 3. States must have maximum flexibility in the design and implementation of cost-effective systems of care.
- 4. States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.

**Eligibility.** Coverage remains guaranteed for:

- Pregnant women to 133 percent of poverty.
- Children to age 6 to 133 percent of poverty.
- Children age 6 through 12 to 100 percent of poverty.
- The frail elderly who meet SSI income and resource standards.
- Persons with disabilities as defined by the state in their state plan. States will have a funds set-aside requirement equal to 90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities.
- Medicare cost sharing for Qualified Medicare Beneficiaries.
- Either:
  - Individuals or families who meet current AFDC income and resource standards (states with income standards higher than the national average may lower those standards to the national average); or
  - States can run a single eligibility system for individuals who are eligible for a new welfare program as defined by the state.

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act.

Coverage remains optional for:

- All other optional groups in the current Medicaid program.
- Other individuals or families as defined by the state but below 275 percent of poverty.

**Benefits**

- The following benefits remain guaranteed for the guaranteed populations only.
  - Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The

"T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

- At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.
- States have complete flexibility in defining amount, duration, and scope of services.

#### *Private Right of Action*

- The following are the only rights of action for individuals or classes for eligibility.
  - Before taking action in the state courts, the individual must follow a state administrative appeals process.
  - States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.
  - Following action in the state courts, an individual or class could appeal directly to the U.S. Supreme Court.
  - Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.
- There should be no private right of action for providers or health plans.

#### *Service Delivery*

- States must be able to use all available health care delivery systems for these populations without any special permission from the federal government.
- States must not have federally imposed limits on the number of beneficiaries who may be enrolled in any network.

#### *Provider Standards and Reimbursements*

- States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.
- The Boren amendment and other Boren-like statutory provisions must be repealed.
- "One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics.

- States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.
- For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.

#### *Nursing Home Reforms*

- States will abide by the OBRA '87 standards for nursing homes.
- States will have the flexibility to determine enforcement strategies for nursing home standards and will include them in their state plan.

#### *Plan Administration*

- States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration.
- The plan and plan amendment process must be streamlined to remove HCFA micromanagement of state programs.
- Oversight of state activities by the Secretary must be streamlined to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan.
- HCFA can only impose disallowances that are commensurate with the size of the violation.
- This program should be written under a new title of the Social Security Act.

#### *Provider Taxes and Donations*

- Current provider tax and donation restrictions in federal statutes would be repealed.
- Current and pending state disputes with HHS over provider taxes would be discontinued.

*Financing.* Each state will have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation is available only if the state puts up a matching percentage (methodology to be defined). The allocation is the sum of four factors: base allocation, growth, special grants (special grants have no state matching requirement) and an insurance umbrella, described as follows:

1. Base. In determining base expenditures, a state may choose from the following—the average of 1992 through 1994 expenditures, 1994 expenditures, or 1995 expenditures.

Some states may require special provisions to correct for anomalies in their base year expenditures.

2. Growth. This is a formula that accounts for estimated changes in medical costs and estimated changes in a state's caseload. It includes the following:

- ~~a state specific estimate of caseload growth for each of the eligible groups and the number of people in poverty;~~
- ~~a state specific estimate of the case mix to reflect the differences in cost of populations in the program;~~
- ~~a national estimate of per-beneficiary costs; and~~
- an estimate of caseload growth;
- the relative cost of care for the populations served; and
- an annual medical inflation factor (specific factor to be determined).

This formula is calculated each year for the following year based on the best available data.

3. Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirements to gain access to these federal funds.

4. The Insurance Umbrella. This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.

Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups—persons with disabilities and the elderly.

Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

1. *States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.*
2. *Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.*
5. *Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.*
6. *Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.*

(insert after the first sentence after "Private Right of Action"): All these features will be designed to prevent states from having to defend against an individual on benefits in federal court.

SIDE BY SIDE COMPARISON OF NGA /  
PRESIDENT/MEDIGRANT II/COALITION

## COMPARISON OF MEDICAID PLANS

ISSUES	MEDI GRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like Medi Grant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
<b>STRUCTURE</b>	<p>Block grant</p> <p>New title of Social Security Act</p>	<p>Block grant and insurance umbrella for unexpected excess enrollment</p> <p>New title of Social Security Act</p>		<p>Pet capita cap and DSH reductions.</p> <p>Retain title XIX</p>	<p>Per capita cap and DSH reductions.</p> <p>Retain title XIX</p>
<b>ELIGIBILITY</b>	<p>Coverage "guaranteed" for:</p> <ul style="list-style-type: none"> <li>-Pregnant women, and children under 6 under 133% of poverty</li> <li>-Children 6-12 under 100% of poverty</li> <li>-People with disabilities (as defined by the state) who meet SSI standards</li> <li>-Elderly who meet SSI income and resource standards.</li> </ul> <p>All other eligibility groups would be optional. States may cover individuals up to 275% of poverty</p>	<p>Coverage is "guaranteed" for:</p> <ul style="list-style-type: none"> <li>- Pregnant women, and children under 133% of poverty</li> <li>- Children 6-12 under 100 % of poverty</li> <li>- Persons with disabilities (as defined by the state)</li> <li>- Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs)</li> <li>- Elderly who meet SSI income and resource standards</li> <li>- Families who meet current AFDC income and resource standards, or eligibles for "new welfare".</li> </ul> <p>Coverage is optional for: all other optional groups as defined by the current law, and other individuals or families as defined by the state but below 275% of poverty.</p>		<p>Maintains all current law mandatory and optional groups, including:</p> <ul style="list-style-type: none"> <li>- Pregnant women and children age 1-6 under 133% of poverty</li> <li>- Children age 6 through 12 under 100 % of poverty</li> <li>- Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered</li> <li>- AFDC cash recipients,</li> <li>- SSI Aged, Blind, and Disabled</li> <li>- QMBs</li> </ul> <p>- All current law optional groups, including the Medically Needy</p> <p>Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.</p>	<p>Maintains all current law mandatory and optional groups, including:</p> <ul style="list-style-type: none"> <li>- Pregnant women and children age 1-6 under 133% of poverty</li> <li>- Children age 6 through 12 under 100 % of poverty</li> <li>- Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered</li> <li>- AFDC cash recipients,</li> <li>- SSI Aged, Blind, and Disabled</li> <li>- QMBs</li> </ul> <p>- All current law optional groups, including the Medically Needy</p> <p>Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
<b>BENEFITS</b>	<p>"Guaranteed" for low income families: Inpatient/outpatient hospital, physicians' surgical and medical services, Diagnostic tests, Childhood immunizations, and pre-pregnancy planning services and supplies.</p> <p>Long term care services for the elderly and disabled</p> <p>States are not required to provide any other services.</p>	Does not require FQHC and RHC services.	<p>"Guaranteed" coverage for mandatory populations: inpatient/outpatient, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT*, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>*See EPSDT below under "Like MediGrant II"</p> <p>All currently optional services would remain optional</p>	<p>Retains current law requiring States to cover: inpatient and outpatient hospital, RHC &amp; FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>States may also cover optional services (drugs, physical therapy, dental services, etc.)</p>	<p>Retains current law requiring States to cover: inpatient hospital, outpatient hospital, RHC &amp; FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services.</p> <p>States may also cover optional services (drugs, physical therapy, dental services, etc.)</p>
<b>Amount, Duration, and Scope</b>	Eliminates requirements	"Complete" State flexibility		Retains current state flexibility within comparability and statewideness requirements	Retains current state flexibility within comparability and statewideness requirements
<b>EPSDT</b>	<i>No specific requirement for early, periodic, screening, diagnosis and treatment services (EPDST) for children under age 21.</i>	<i>Unclear: "redefines" treatment - no specifics how it will be redefined.</i>		Retains current law for treatment mandating coverage of services to treat or ameliorate a defect, physical and mental illness, or condition identified by a health screen.	Changes treatment: The Secretary, after consultation with States and provider organizations, would define treatment under EPSDT.
<b>Comparability Statewideness</b>	Eliminates requirements	<i>No provision</i>	<i>No provision</i>	Retains current law requirement that services be comparable and available statewide	Retains current law requirement that services be comparable and available statewide
<b>Vaccines for Children Program</b>	Eliminated	<i>No provision</i>	<i>No provision</i>	Maintained	Maintained
<b>Home and Community-Based Services</b>	Optional service, states no longer needs waiver to provide	<i>Unclear - proposal "broadens" long-term "options." No specifics how options are broadened.</i>	<i>Unclear - proposal "broadens" long-term "options." No specifics how options are broadened</i>	Makes home and community-based services an optional service - States no longer need waivers to cover these services.	Current law

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
<b>RIGHT OF ACTION</b>	<p>No federal right of action for individuals or providers</p> <p><i>Silent on state court right of action</i></p> <p>Individuals can bring issues and/or complaints to the attention of the Secretary</p> <p>Secretary's action re individual complaints is limited to investigation and subsequent notification to the Congress and/or chief executive of the state</p>	<p>No federal right of action for individuals or providers.</p> <p>States must provide state court right of action</p> <p>Must use state administrative mechanisms before going to state court</p> <p>Can petition US Supreme Court for review after all state court action completed</p> <p>Secretary can bring suit in federal court on behalf of individuals or classes.</p>		<p>Maintains current law individual right of action for individuals to bring suit in federal court.</p>	<p>Maintains current law individual right of action for individuals to bring suit in federal court.</p>
<b>FAMILY PROTECTIONS</b>	<p>Allows states to require adult children of nursing home residents with incomes above the state median income to contribute to their parents' nursing home care.</p>	<i>No provision</i>	<i>No provision</i>	<p>Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.</p>	<p>Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.</p>
<b>Spousal Impoverishment</b>	Retains current law	<i>No provision</i>	<i>No provision</i>	Retains current law	Retains current law
<b>Copayments</b>	<p>States have broad flexibility to develop cost sharing schedules that differentiate between income groups, types of services. Greater restrictions on cost sharing for children and pregnant women.</p>	<i>No provision</i>	<i>No provision</i>	<p>Maintains current limitations that copayments be nominal and only for some individuals/benefits. New authority to impose similar nominal copayments on HMO enrollees.</p>	<p>Allows States to impose copayments scaled to income and family size for individuals/benefits currently subject to copayments.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like Medigra II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
<b>FINANCING</b> Federal Spending Limit	Fixed federal payments set by formula: Federal spending will be \$839 billion between 1996-2002 (savings of \$85 billion).	Partially fixed: For base spending, Federal payments are set by a formula. A state gets this amount even if it reduces benefits or enrollment. Federal spending and savings are not known.	Partially responsive: An "Insurance Umbrella" allows for higher Federal payments when enrollment for mandatory and some optional groups is unexpectedly high. Federal spending and savings are not known.	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of \$865 billion between 1996-2002 (savings of \$59 billion).	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of \$839 billion between 1996-2002 (savings of \$85 billion).
<b>State Spending</b>	State matching rates are significantly lowered.  Estimated state spending over seven years: \$493 billion (savings of \$205 billion).  Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.	State matching rates are significantly lowered.  State spending and savings are not known.  Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.		Current matching rates are maintained.  Estimated state spending over seven years: \$653 billion (savings of \$45 billion).  Current restrictions on the use of provider taxes and donations are retained.	Current matching rates are maintained.  Estimated state spending over seven years: \$633 billion (savings of \$65 billion).  Current restrictions on the use of provider taxes and donations are retained.
<b>Funding Formula</b>	1996 allotments are set in legislation. Subsequent years' allotments are based on the product of the number of poor people and the state-adjusted spending per person, subject to maximum or minimum growth rates. Actual enrollment is not included in the formula.	Base funding is set by multiplying the base year -- the states' choice of 1993, 1994, or 1995 spending -- by an inflation factor and estimated enrollment growth. DSH spending is included in the base, but is not grown if DSH is greater than 12% of total spending.	The "Insurance Umbrella" allows states to get Federally-matched capitation payments for mandatory and some optional beneficiaries who are above the estimated enrollment for the year.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary (product of the average 1995 spending by beneficiary group and nominal GDP growth per person (5-year average) plus an adjustment factor). The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary. The spending limit per beneficiary is the product of a rolling average spending by beneficiary group and CPI (3-year average) plus adjustment factors. The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like Medigra II	ADMINISTRATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
<b>PROVIDER PAYMENTS, PROGRAM OPERATION, AND SERVICE DELIVERY</b>	<p>Repeals all provider payment rules – hospitals, nursing homes, hospice, FQHC/RHC and home and community-based services.</p> <p>Repeals requirement that rates be sufficient to guarantee access to services.</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Repeals all provider payment rules.</p> <p><i>Unclear. May repeal requirement that rates be sufficient to guarantee access to services.</i></p>	<p>Repeals Boren Amendment</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Repeals Federal payment rules for hospitals, nursing facilities, FQHCs and RHCs (except for Indian FQHCs/RHCs) and home and community-based services.</p> <p>Retains current requirement that rates be sufficient to guarantee access to services.</p> <p>Repeals payment rules for obstetrical and pediatric care</p>	<p>Retains current federal payment rules.</p> <p>Retains current requirement that rates be sufficient to guarantee access to services.</p> <p>No change to payment rules for obstetrical and pediatric care</p>
<b>Special Provider Qualifications</b>	<p>Repeals physician qualification requirements.</p>	<p>Repeals physician qualification requirements.</p>	<p>Repeals physician qualification requirements.</p>	<p>Repeals physician qualification requirements.</p>	<p>Retains physician qualification requirements.</p>
<b>Managed Care</b>	<p>States' ability to mandate managed care enrollment would be unrestricted.</p> <p>Beneficiaries would have no guarantee of choice of plan or provider.</p> <p>Payments to managed care plans must be based on actuarial methods</p>	<p>States may implement managed care without a waiver</p> <p><i>Unclear. Beneficiaries may have no guarantee of choice of plan or provider.</i></p> <p><i>No provision</i></p>	<p>States may implement managed care without a waiver</p> <p><i>Unclear. Beneficiaries may be guaranteed a choice of plan or provider.</i></p> <p><i>No provision</i></p>	<p>States could mandate enrollment in managed care, except:</p> <ul style="list-style-type: none"> <li>- Beneficiaries must have a choice of plan or delivery system;</li> <li>- States may not require enrollment for Medicare cost-sharing;</li> </ul> <p>States may not restrict choice of provider for family planning services.</p> <p>Retains current law -- payments to managed care plans must be actuarially sound.</p>	<p>States could mandate enrollment in managed care, except:</p> <ul style="list-style-type: none"> <li>-Beneficiaries must have a choice of plan or provider;</li> <li>-States may not require special needs individuals to enroll in managed care plans.</li> </ul> <p>Applies the current "reasonable and adequate" payment standard to managed care systems.</p>
<b>Contracting and Solvency</b>	<p>Repeals all statutory contracting rules.</p> <p>Health plans must meet commercial solvency standards.</p>	<p><i>Unclear. May repeal all contracting rules.</i></p> <p><i>No provision</i></p>	<p><i>Unclear. May retain some current contracting rules.</i></p> <p><i>No provision</i></p>	<p>Repeals problematic contracting rules: 75/25 rule; HHS approval of HMO contracts; payment rules for managed care-contracting FQHCs.</p> <p>Provides new authority for solvency standards.</p>	<p>Repeals current contracting rules.</p> <p>Establishes new solvency standards.</p>

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II      Like Administration		ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
Managed Care Quality	No quality requirements for States or managed care plans.	<i>Unclear</i>	<i>Unclear</i>	Requires States to develop quality improvement programs, which must include access standards and monitoring activities. Establishes new reporting and fraud prevention requirements for health plans.	Establishes new quality requirements for managed care systems, including statutory guarantees of accessibility and timeliness of services, information-sharing requirements, prior authorization and grievance procedures, and encounter data.
Nursing Home Quality	"Retains" current rules, but actually eliminates significant quality standards and protections for nursing home residents.  Significantly diminishes Federal authority to enforce quality standards.	<i>Unclear. May eliminate some current standards, like MediGrant II</i>  States may decide how nursing home standards will be enforced		Retains current nursing home standards and enforcement.	Retains current nursing home standards and enforcement.
Administration	Federal administrative oversight curtailed. Financial penalties would be proportional and permitted only for "substantial" violations.	Disallowances must be proportional to violation. Federal oversight limited and intervention permitted only when State "fails substantially" to comply with law or program.		Repeals and revises various administrative and systems requirements.	No change to current administrative requirements.

CONCERNS WITH NGA PROPOSAL



FEB 15 1996

MEMORANDUM FOR LAURA TYSON

From:

The Secretary

*Don S. Shalala*

Subject:

Questions on NGA Medicaid plan

OVERVIEW

The President's stand on Medicaid throughout the budget debate has been very successful because it is grounded in sound principles that are reinforced by his well-known personal commitment to health care coverage. He has received a great deal of credit by insisting on a balanced approach to Medicaid reform that:

- preserves the federal guarantee of a Congressionally-defined benefit package for Medicaid beneficiaries;
- preserves Medicaid protection for currently eligible groups;
- maintains our shared financial partnership with states as they provide health coverage to needy individuals;
- provides unprecedented new flexibility to states in how to operate their programs, pay providers of care, and operate managed care and other arrangements, with continuing programmatic and fiscal accountability, and federal savings that contribute to the balanced budget plan.

Last week, the National Governors Association (NGA) approved the outlines of a plan that they are now refining. The lead Democratic Governors in those negotiations worked long and hard to convince their Republican colleagues to agree to a financing alternative to the block grant that allows the federal funding to appear to be more responsive to enrollment changes. As the President has indicated, those discussions and that movement on the financing structure have been helpful.

QUESTIONS ABOUT THE NGA MEDICAID PLAN

However, as we continue to review the evolving NGA policy, it is clear that it does not meet the principles that have served as the basis for the President's position. The attached documents review the key issues. In brief, the governors' plan repeals title XIX, the current Medicaid program, and replaces it with a new program that falls short of the President's principles.

## Eligibility/Benefits/Enforcement

While the NGA policy retains the States' entitlement to federal funding, it repeals the existing federal entitlement or guarantee of Congressionally-defined health benefits for Medicaid beneficiaries. It is important to note that when we use the phrase federal "guarantee" it has a different meaning than when others use it. For us, it means an entitlement, with three key interrelated components – definitions of eligible groups, benefits, and enforcement. The NGA plan provides for a "guarantee" of coverage that makes marginal improvements in the Republican block grant, but it is only a nominal guarantee.

- Eligibility. While the NGA plan includes a number of mandatory groups, it repeals the current law phase-in of Medicaid coverage for children ages 13-18 in families with income below the federal poverty level – repealing a coverage expansion signed into law in the last Administration. Further, the plan repeals the federal standard for defining disability, replacing it with state definitions – making uncertain coverage and benefits for populations such as those with HIV; and it is unclear about guaranteed coverage of cash assistance populations and those making the transition from welfare to work;
- Benefits. While the NGA plan lists required benefits for the mandatory populations, it provides "complete" flexibility in defining the adequacy of those benefits (amount, duration and scope). It is silent on whether benefits must be comparable among or within groups and areas of the state; makes an unspecified change in the currently required treatment component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and sets no standard for benefits for optional beneficiary groups.
- Enforcement. The NGA plan repeals the federal right of action for individuals and limits claims that a state is violating federal law to resolution by state courts. Medicaid would be the sole federal statute conferring no possibility of federal enforcement by its intended beneficiaries.

## Financing

The NGA plan's proposed financing may be responsive to enrollment changes -- a change that Democratic governors have insisted on -- but more details are needed. We need to continue to work with the Democratic governors to help them assure that the plan specifics reflect the need for a financing structure that truly adapts to enrollment changes.

Apart from gaining more details about the federal structure, the real financing problem is that the plan could substantially lessen state contributions to health coverage under Medicaid.

- The maximum state matching percentage drops from 50 percent to 40 percent. In the context of a capped program, this could increase the total Medicaid funding cuts

substantially. Analyses of a comparable provision in the Republican plan indicate that an \$85 billion federal cut could yield additional state cuts of over \$200 billion under this approach. Alternatively, in an open-ended financing approach, this provision could substantially increase federal costs, as states could capture more federal matching for the same amount of state funds.

- Moreover, the “real” state share could change because of another provision in the NGA approach. The plan allows states to use questionable provider donation and tax provisions without limits, like those in the late 1980s and early 1990s that significantly drove up federal program costs and reduced actual state spending – ultimately states could take all of their funds out of the program with these mechanisms. Bipartisan legislation in 1992 closed these financial loopholes.

The federal costs and savings of the proposal are important in the context of the President's balanced budget plan, which includes \$59 billion in federal Medicaid savings. At this point, it is unclear whether the NGA plan will achieve federal savings of the type envisioned in the balanced budget plan.

#### **Quality/Beneficiary Financial Protections/Accountability**

By repealing title XIX, the NGA plan repeals beneficiary financial protections, and quality and fiscal standards that are essential components of the Medicaid program. For example:

- The NGA plan does not appear to include requirements for quality standards for managed care plans.
- The NGA plan retains the Republican Conference Agreement approach of eliminating federal enforcement of the nursing home standards.
- The NGA plan is silent on beneficiary financial protections: these include spousal impoverishment protections as well as financial protections for the adult children of aged nursing home residents.

#### **NEXT STEPS**

The NGA took an important and logical step that reflects the legitimate interests of the governors. The Democratic governors did a good job in moving the Republican governors in the direction of a per enrollee financing structure. However, we should all recognize the inherent constraints on any process driven solely by any one interest, including the governors. The majority of the governors are Republicans who had already signed on to the block grant approach that the President vetoed. In addition, it is difficult, if not impossible, for even our strongest Democratic governors to argue personally with fellow governors for federal standards in many areas that have been central to the President's position, despite the unprecedented flexibility that is already

offered in the President's plan.

The President's approach should continue to serve as the basis for Democratic unity on Medicaid. As the NGA proceeds to flesh out its plan, we need to foster discussions among the Democratic governors and members of Congress about how best to adapt the President's proposal to meet our shared goals.

#### ATTACHMENTS

- ENTITLEMENT: ELIGIBILITY/BENEFITS/ENFORCEMENT
- FINANCING
- ACCOUNTABILITY

## ENTITLEMENT TO A MEANINGFUL BENEFIT PACKAGE

### Overview

The most fundamental principle underlying the President's Medicaid reform plan is the concept that beneficiaries are entitled to a meaningful benefit package. So long as they meet the eligibility requirements, certain categories of individuals have an absolute and enforceable guarantee of benefits--a guarantee upon which they can rely. There are three basic components to the Medicaid entitlement:

- Eligibility
- Benefits
- Enforcement

### Eligibility

The NGA resolution provisions on eligibility include a number of groups as "guaranteed" eligibles, i.e., coverage is "guaranteed" for the following:

- Pregnant women, and children to 133% of poverty
- Children to age 6 up to 133% of poverty
- Children 6-12 to 100% of poverty
- The elderly who meet SSI income and resource standards
- Persons with disabilities - "disability" defined by the state
- Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs)
- Families who meet current AFDC income and resource standards; or states may run a single eligibility system for those who are eligible for "new welfare."

Coverage is optional for the following groups:

- All other current law optional groups
- Other individuals or families as defined by the state but below 275% of poverty

However, the NGA resolution fails to address certain key populations.

- Medicaid would no longer be phased in for children 13 - 18 under 100% of poverty as would be the case under current law. This coverage was enacted with bipartisan support.
- States can apply more limited definitions of disability than exist under federal law. This provision could lead to severely restricted definitions of disability resulting in very limited coverage for a population whose service needs are among the most costly. For example, states could define disability in ways that preclude individuals with certain diagnoses (HIV, or mental illness) from being able to receive needed services under Medicaid. This is particularly significant because the disabled are unable to work and therefore less likely to have other health insurance.

- It is important to note current welfare reform proposals include changes in key areas in the definition of disability to address substantive concerns raised by states and others.
  - In the case of drug addicts and alcoholics, the proposal (accepted by the Administration) would change program eligibility to exclude drug addiction and alcoholism as a qualifying disability for purposes of SSI and Medicaid.
  - In the case of disabled children, effective in 1998, the proposal would change the eligibility process by eliminating the Individual Functional Assessment (IFA) process and eliminating maladaptive behavior from inclusion in the Social Security Act.
- Welfare related coverage is very unclear, and the NGA resolution provides insufficient information about the links between new welfare definitions and Medicaid coverage.

### Benefits

The NGA resolution includes the following list of benefits that are "guaranteed" but only for "guaranteed" coverage groups.

- Inpatient and outpatient hospital
- Physician
- prenatal care
- nursing facility
- home health
- family planning and supplies
- laboratory and x-ray
- pediatric and family nurse practitioner
- nurse midwife
- EPSDT, with limitations on requirements for treatment

The resolution stipulates that all other services would be optional, and there would be a broadened long term care benefit.

Even given the apparent progress made in defining a mandatory benefit package, there are still serious concerns with the provisions of the NGA resolution.

- A responsible health care program must provide benefits that are adequate to achieve their purpose. Under the NGA resolution, states would be given complete flexibility to define the amount, duration and scope of the benefits to be provided. These provisions taken as a whole raise serious concerns about whether the Secretary would have any ability, in the case of over-restrictive state plans, to disapprove a benefit package that would be effectively meaningless.

- Because the NGA resolution is silent about requirements for comparable services for all eligible groups, or provision of services on a statewide basis, there is concern that states might structure benefit packages that are more limited for more costly populations, (e.g., the disabled), or might provide less comprehensive services in certain parts of the state. There are serious questions about the equity that might result under the NGA approach.
- The NGA would limit the treatment option under EPSDT in a manner that is still unclear.
- The Administration has indicated a willingness to discuss additional flexibility--offering optional benefits to optional beneficiaries in the context of the President's plan.

### Enforcement

The third essential component of the entitlement is enforcement. The NGA resolution contains provisions requiring states to provide a guaranteed state right of action, but eliminates any federal right of action for individuals and providers. The only access to federal court would be the opportunity to petition the U.S. Supreme Court for review from a decision of state's highest court. The NGA provisions pose a number of serious questions and concerns.

- Implicit in the concept of defined populations and defined benefits is the back-up of a meaningful enforcement mechanism. A federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States.
- Under the NGA proposal, Medicaid would be the single federal statute conferring no possibility of federal enforcement by its intended beneficiaries; seeking enforcement of title XIX would be the one cause of action arising under federal law that would be barred from the federal courts. Such an unprecedented step would be seen by important constituencies as a signal of second-class status and would set off massive reaction from beneficiary groups and their allies. Advocates for the poor would be restricted to the remedies and procedures available under state law, which are often stricter than those under federal law.
- The largest number of suits against states have been filed by providers over payment rates. Under the administration's plan, the Boren Amendment would be repealed, thereby eliminating these causes of action by providers. Going further, the Administration has indicated a willingness to specify that there would be no right of action by providers over payment rates under statutory provisions other than the Boren Amendment. Thus, under the Administration's plan, state concerns about limiting their exposure to suit in federal court would be largely resolved. Given the broader federal policy and the reality that beneficiary suits have not been a problem, further changes to individual right of action would appear to be unnecessary.

- Those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. Efficiency and predictability are best served by using the federal court system, when the same question arises across multiple jurisdictions. Moreover, when Medicaid-based claims interact, as they often do, with other areas of federal law (Medicare, Social Security), the federal courts are more experienced in analyzing these statutory relationships and are better able to understand and decide cases with potentially broad ramifications.
- There is no indication that federal judges--the vast majority of whom were appointed by Republican presidents--ignore or take lightly the legitimate concerns of state administrators.

## FINANCING

The National Governors' Association resolution would replace the current financing system with a combination of a fixed federal payment, and a payment adjustment for unexpected excess enrollment. The minimum federal contribution to the financing of Medicaid would increase from 50 percent to 60 percent, and states' use of provider tax and donation schemes (which are currently prohibited) would be permitted.

From the beginning of the current Medicaid debate, the President has maintained that Medicaid must be financed through a federal-state partnership that ensures a reasonable and appropriate amount of funding to provide meaningful benefits to eligibles while also protecting states from increases in enrollment. Although growth in federal expenditures for Medicaid can be slowed, any adjustments must be based on who a state covers, not an arbitrary ceiling (Block Grant) that does not provide states with enough federal funds to provide coverage and benefits in times of economic downturn or increased enrollment.

- Although the NGA resolution reflects progress toward a financing structure based on enrollment, there are still some questions that must be addressed. Many of these questions will not be answered until there is sufficient specificity to enable some assessment of the budget implications of the NGA resolution. We should continue to work with Democratic governors to maintain their progress on this issue.
- Raising the minimum federal match rate from 50 percent to 60 percent will allow states to reduce their spending by over \$200 billion over the next seven years, and will raise the average federal share of total program costs from 57 percent to 63 percent.
- Also, permitting the use of provider tax and donation schemes will allow states to reduce the amount of "real" state dollars which they contribute to the program. During the late 1980s and early 1990s, many States took advantage of these schemes, costing the federal government billions of dollars and helping drive growth rates up to well over 20 percent. The Inspector General continues to express concerns about such financing schemes.

## ACCOUNTABILITY

The President's plan proposes unprecedented new flexibility for the states in how to operate their programs, pay providers, and use managed care and other delivery arrangements. At the same time, it retains core standards related to quality and beneficiary financial protections.

The NGA resolution would repeal title XIX and create a new title for the Medicaid program. This has the de facto effect of compromising seriously the existing framework for accountability that provides governance for the Medicaid program today. The NGA resolution is silent in many areas that affect Medicaid reform. And in areas where the resolution is specific, some long-standing protections would be reduced or eliminated.

- The NGA resolution eliminates the federal role in monitoring nursing home quality assurance--yet without federal monitoring and enforcement of state and facility compliance, the uniform quality standards established by OBRA 87 are meaningless.
- Nearly a third of all Medicaid beneficiaries are currently enrolled in some form of managed care. The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care.
- The NGA resolution does not address beneficiary and family financial protections such as spousal impoverishment and family responsibility that have been central to the Medicaid program for years. These protections are maintained in the President's plan. The NGA resolution also does not address the imposition of copayments and other cost sharing for Medicaid beneficiaries.
- There are ways, similar to the approach taken in the President's plan, to provide states with considerably expanded flexibility in management and operation of their Medicaid programs, without reducing the framework of responsible accountability to meaninglessness. There must be at least a modicum of reporting requirements and monitoring in a program that spends over \$100 billion federal dollars. The NGA resolution expands federal funding and reduces ongoing congressional and executive management of the program.



# CENTER ON BUDGET AND POLICY PRIORITIES

Revised February 12, 1996

## FEDERAL CAPS AND STATE MATCHING REQUIREMENTS UNDER THE GOVERNORS' MEDICAID PROPOSAL

by Richard Kogan

On February 6, 1996, the National Governors' Association (NGA) endorsed a proposal to redesign the federal/state Medicaid system. This paper addresses only one aspect of that proposal — the combined effect of capping federal payments and reducing state "matching" requirements. It concludes that total Medicaid funding could fall below current-law projections by as much as \$300 billion over seven years, with at least 70 percent of this potential reduction reflecting cuts in *state* Medicaid funding.

### *Current Matching Requirements*

Under current law, Medicaid is funded jointly by the federal and state governments. The federal government pays each state a fixed percentage of its total Medicaid costs and the state government pays the rest. The federal fixed percentage is called the Federal Medical Assistance Percentage, or FMAP. The FMAP for any given state is a function of state per-capita income; the poorer the state, the higher the federal share and the lower the state share. State shares must not exceed 50 percent for the richest states or drop below 17 percent for the poorest. On average, states pay 43 percent of total Medicaid costs.

Consequently, if costs rise in a state for any reason (e.g. more people enroll in Medicaid, providers raise their rates, or the state expands its add-on coverage or benefits package<sup>1</sup>), then the federal government pays at least 50 percent of those extra costs. Likewise, if states reduce Medicaid costs, the federal government receives at least 50 percent of the resulting savings.

### *The NGA Proposal*

The NGA proposal would change current law in three fundamental ways.

- The proposal would "cap" federal payments to states; there would be a limit on *federal* costs no matter how high *actual total* costs are. When federal costs are capped, a state can draw down the full federal

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<sup>1</sup> Only 45 percent of total Medicaid costs result from federal coverage and benefit guarantees; the rest result from state decisions to supplement coverage and benefits. The federal government makes matching payments at the same rate regardless of the source of the Medicaid costs.

payment to which it is entitled by matching that federal payment (using the state's matching rate). If total Medicaid costs in the state were higher than the capped federal payment plus the state's matching contribution, the state would have to pay all additional costs.<sup>2</sup>

- The NGA proposal would reduce state matching requirements for at least 25 states, and perhaps more. The NGA said, "A state's matching contribution to the program will not exceed 40 percent." Currently, the twelve wealthiest states pay 50 percent and another thirteen states pay more than 40 percent but less than 50 percent. Further, the NGA left open the possibility that state shares could be reduced even more for those 25 states, and could be reduced for others as well.<sup>3</sup>
- States would be allowed greater use of "funny money" in meeting their matching requirement. That is, states could use financing schemes that allow them to *appear* to meet matching requirements without really spending any state money on Medicaid benefits. (Prohibitions on such schemes were enacted during the Bush Administration.<sup>4</sup>)

#### *Potential Reductions in Federal, State, and Total Medicaid Funding*

How deep could total reductions in Medicaid funding be, relative to current law? First consider the effect of capping federal payments. If federal payments are capped, a state might or might not choose to contribute *more* than is needed in order to draw down the full federal payment to which it is entitled. In other words, a state

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<sup>2</sup> The cap on federal payments to a state would equal the sum of A) the "basic grant" to the state (base-year spending increased by a growth formula), and B) "umbrella" payments to a state, intended to cover any unanticipated growth in caseload (that is, any caseload growth that wasn't built into the basic grant). The umbrella payments would be "guaranteed on a per-beneficiary basis." In short, whenever a state is receiving umbrella payments, the federal cap will increase for each new beneficiary. The *amount* of the increase in the federal cap will be determined by some formula (the NGA did not specify) rather than by the new beneficiary's actual medical bills; therefore, *per-beneficiary* federal payments under the umbrella would be capped at the levels specified in that formula, rather than being completely open-ended. Capping federal payments was the basis for both the Republican's budget bill last fall and the Administration's Medicaid proposals, though in different forms. The NGA has melded the two proposals.

<sup>3</sup> The Administration's budget plan does not include a reduction in state matching requirements. Neither did the Budget Resolution agreed to by Republicans in Congress, but the Medicaid bill that Republicans drafted, Congress passed, and the President vetoed did include reduced state matching requirements. That bill reduced the maximum state share to 40 percent, as would the NGA proposal. It also changed some factors in calculating FMAPs to reduce some states that had been above 40 percent to below it, and reduce 12 states that had been below 40 percent even further.

<sup>4</sup> The Administration's budget plan does not change current prohibitions on the use of such financing schemes, but the Republicans' Medicaid bill would have repealed the prohibitions.

might contribute dollars for which it receives no matching federal payment. But there would be no federal requirement for a state to contribute unmatched dollars to the program; a state would do so only if its total Medicaid costs were greater than the sum of the capped federal payment and the state's matching contribution.

But would states be free to reduce total Medicaid costs to a very great extent? The NGA would allow states to define "disability" as narrowly as they wished, to define "benefits" for all beneficiaries as narrowly (and cheaply) as they wished, and to pay providers as little as they can get away with.<sup>5</sup> Therefore, each state would be allowed to reduce total costs so much that the state would not be making any unmatched contributions. In assessing whether states would do so, it is important to note that the state treasury would get 100 percent of the savings from any such cutbacks; the federal government would get none. This result differs from that under current law, in which a state keeps at most 50 cents of every dollar saved.

This paper estimates the maximum amount states could reduce their funding (by cutting payments to providers, by cutting benefits, and by cutting beneficiaries where allowed) without their losing federal Medicaid payments.

The second factor driving the potential cuts in state Medicaid funding is the reduction in state matching requirements. To illustrate the effect, suppose the federal payment to a state with a 50 percent match rate is currently \$6 billion. In this case, the total Medicaid program in the state would be \$6 billion provided by the federal government and \$6 billion provided by the state government. Suppose the federal payment were capped at \$6 billion, and the state share were reduced from 50 percent to 40 percent (as the NGA proposes). State contributions could then drop to \$4 billion and total Medicaid spending would decrease from \$12 billion to \$10 billion.

Example: Capping the Federal Payment; Cutting the State Share		
	Existing law	NGA proposal
Federal share	\$6 billion (50%)	\$6 billion (60%) [amount capped]
State share	\$6 billion (50%)	\$4 billion (40%)
Total cost	\$12 billion	\$10 billion

Thus, federal caps and matching share reductions combine to allow very deep cuts in state funding.

<sup>5</sup> The Administration and Republican Medicaid proposals would also allow states to cut provider payments to the extent possible, and the Republican proposal would allow states to define both benefits and beneficiaries in exceedingly narrow (and cheap) terms.

The size of the reduction in state Medicaid funding therefore depends, in any state, on the level of the cap on federal funds and on the change in the state matching share. The federal caps are not known at this time, because the NGA did not specify how tight the caps would be or how they would be calculated for each state. However, several governors suggested that total federal cuts should fall between \$59 billion over seven years (the amount in the President's 1997 budget) and \$85 billion over seven years (the amount in the Republican Leadership's January budget offer).

On this basis, it is possible to calculate the range of federal, state, and total cuts in Medicaid funding. Assuming each state contributes just enough to draw down the full federal payment to which it is entitled, then —

- If the seven-year federal cut were \$59 billion and state matching requirements were reduced only as much as the NGA suggests, states would cut their own funding \$182 billion over seven years. The total federal and state seven-year cut would therefore be \$241 billion. The cut would grow with each year, and could reach 19 percent in 2002.
- If the seven-year federal cut were \$85 billion and state matching requirements were reduced as in the Republican Medicaid bill (see note 4), states would cut \$214 billion over seven years. The total seven-year cut would equal \$299 billion,<sup>6</sup> and could reach 26 percent by 2002.

<b>Potential Reductions in Medicaid Funding</b>				
(In billions)				
	<u>Minimum</u>		<u>Maximum</u>	
	<u>7-year</u>	<u>In 2002</u>	<u>7-year</u>	<u>In 2002</u>
Federal reductions (net)	\$ 59	11%	\$ 85	18%
State reductions: <sup>*</sup>				
— because of federal cap	\$ 48		\$ 69	
— because of FMAP reduction	\$134		\$145	
Total state reductions	<u>\$182</u>	<u>30%</u>	<u>\$214</u>	<u>37%</u>
Grand total reductions <sup>*</sup>	\$241	19%	\$299	26%

<sup>\*</sup> Assuming states contribute only the amount needed to draw down the maximum federal payment to which they are entitled.

<sup>6</sup> The level of a new "special" grant for undocumented aliens, also a part of the NGA proposal, makes a small difference in the size of the cuts, because the aliens grant would be exempt from all matching requirements. Therefore, if the net federal cut is, for instance, \$59 billion but the new aliens grant is \$3.5 billion, then the gross federal cut is \$62.5 billion. It is the gross cut that triggers reductions in state matching payments. An aliens grant of \$3.5 billion was assumed as part of the \$59 billion net federal cut and an aliens grant of \$6.0 billion was assumed as part of the \$85 billion net federal cut. (\$3.5 billion was the size of the aliens grant in the Republican budget bill, and \$6 billion was the size of at least one suggestion made to the governors.)

Note that in each case the states would reduce their funding more than twice as much as the federal government.

### *Matching with "Funny Money"*

In one sense, the above table may be a worst-case scenario, since it assumes that no states contribute unmatched dollars to Medicaid. On the other hand, the cuts in Medicaid resources could be even deeper than shown if states use funny money to meet their matching requirements. And the NGA proposal would drop all existing bars to the use of such funny money.

In the past, some states have used creative financing schemes to make payments that they could call "Medicaid contributions" but that really were not. For example, a state might impose a special "tax" on a provider of health care services to the poor, and then immediately rebate the amount collected to that provider. The provider and the state are in exactly the same financial position as if this back-and-forth transfer had never occurred, and no additional medical services are provided. But the state could call the rebate a "Medicaid contribution" and thus satisfy a matching requirement. Congress largely banned such scam transactions in the early 1990s. (See attached text box for a fuller treatment of the issue.)

### *Data and Methodology*

The current-law baseline level of federal spending in 2002 and over the seven-year period 1996-2002 uses CBO baseline figures. Cuts are measured relative to that baseline. Current law FMAPs come from GAO. The FMAPs under the Republican bill were likewise from GAO. (See attached table of FMAPs.) Baseline spending for the seven-year period and for 2002 was divided among states in proportion to state-by-state baseline spending projections made by the Urban Institute in December, 1995.<sup>7</sup>

It was assumed that gross federal cuts would be made across-the-board, relative to baseline spending,<sup>8</sup> and that the special payments for undocumented aliens (see note 5) would be distributed as specified in the Republican bill. Finally, the estimated federal cuts in 2002 were taken from the President's budget and the Republicans' January budget offer, respectively.

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<sup>7</sup> See *The Impact of the "Medigrant" Plan on Federal Payments to State*, December 1995, prepared by John Holohan and David Liska of the Urban Institute for the Kaiser Commission on the Future of Medicaid. Table 7.

<sup>8</sup> An alternative assumption, that the level of grants (other than for undocumented aliens) would be increased across-the-board relative to the Republican Medicaid bill, leads to results that are virtually identical with those shown above in aggregate, though the state-by-state distribution of the cuts would differ.

### **Examples of How Special Medicaid Financing Methods Allowed States to Draw Down on Federal Dollars Without Spending State Funds**

The following example illustrates how these financing methods worked in the past:

Assume a state imposed a provider tax that was paid by hospitals and that raised \$40 million dollars. The state then pays back to the hospitals subject to the tax \$50 million in disproportionate share hospital ("DSH") payments, which under the law are supposed to provide additional funds to hospitals that serve a disproportionately high number of Medicaid and low-income uninsured patients. If the state's federal Medicaid match rate is 50 percent, it can claim \$25 million in federal Medicaid funds based on the \$50 million in DSH payments to the hospitals.

The result: the hospitals gain \$10 million (\$50 million in DSH payments less the \$40 million in provider taxes); the state gains \$15 million (\$25 million in federal matching funds plus \$40 million in provider taxes minus \$50 million in DSH payments); and the federal government pays \$25 million without any net state funds having actually been expended.

Michigan's practices are instructive. (Michigan is not the only or most egregious example of a state that has used such financing methods. It is selected for illustrative purposes because this example was documented by GAO and is straightforward.)

In fiscal year 1993, Michigan raised \$452 million through hospital donations, and then paid the hospitals \$458 million in disproportionate share (DSH) payments. Based on these payments, Michigan claimed \$256 million in federal matching funds. The net effect of these transactions is as follows: the hospitals gained \$6 million (\$458 million in DSH funds less \$452 million in provider donations); the state gained \$250 million (\$256 million in federal matching funds less \$6 million in net payments to the hospitals); and the federal government paid \$256 million in federal matching funds without any net state funds having been expended.

When provider donations were limited by Congress through legislation enacted in 1991 that became effective January 1, 1993, this loophole was closed. Michigan responded by relying on intergovernmental transfers and changing its criteria for deciding which hospitals would qualify for DSH payments, a determination that former law left almost entirely to state discretion. In October, 1993, it paid \$489 million to the one hospital that met its new DSH definition — the state-owned University of Michigan hospital. The state claimed \$276 million in federal matching funds for this payment, but the public hospital returned the full \$489 million payment to the state through an intergovernmental transfer the very same day the payment was made. Through this one transaction, Michigan realized a net gain of \$276 million in federal Medicaid payments, again without expending any state funds. This practice is now also limited by Congress through provisions phased-in beginning in July 1994.

Source: GAO, *States Use Illusory Approaches to Shift Program Costs to Federal Government*, August 1994.

Federal Medical Assistance Percentages (FMAPs)  
 GAO estimates

	Current law, 1996 est.		Republican bill		NGA 40% maximum	
	Federal	State	Federal	State	Federal	State
Alabama	69.0%	30.2%	72.9%	27.1%	69.9%	30.2%
Alaska	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Arizona	65.9%	34.2%	65.9%	34.2%	65.9%	34.2%
Arkansas	73.6%	26.4%	74.1%	25.9%	73.6%	26.4%
California	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Colorado	52.4%	47.6%	60.0%	40.0%	60.0%	40.0%
Connecticut	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Delaware	50.3%	49.7%	60.0%	40.0%	60.0%	40.0%
DC	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Florida	55.8%	44.2%	65.7%	34.3%	60.0%	40.0%
Georgia	61.9%	38.1%	61.9%	38.1%	61.9%	38.1%
Hawaii	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Idaho	68.8%	31.2%	68.8%	31.2%	68.8%	31.2%
Illinois	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Indiana	62.6%	37.4%	62.6%	37.4%	62.6%	37.4%
Iowa	64.2%	35.8%	64.2%	35.8%	64.2%	35.8%
Kansas	59.0%	41.0%	60.0%	40.0%	60.0%	40.0%
Kentucky	70.3%	29.7%	74.7%	25.3%	70.3%	29.7%
Louisiana	71.9%	28.1%	77.1%	22.9%	71.9%	28.1%
Maine	63.3%	36.7%	65.2%	34.8%	63.3%	36.7%
Maryland	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Massachusetts	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Michigan	56.8%	43.2%	61.2%	38.8%	60.0%	40.0%
Minnesota	53.9%	46.1%	60.0%	40.0%	60.0%	40.0%
Mississippi	78.1%	21.9%	60.7%	39.3%	78.1%	21.9%
Missouri	60.1%	39.9%	60.5%	39.5%	60.1%	39.9%
Montana	69.4%	30.6%	69.4%	30.6%	69.4%	30.6%
Nebraska	59.5%	40.5%	60.0%	40.0%	60.0%	40.0%
Nevada	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Hampshire	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Jersey	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Mexico	72.9%	27.1%	73.0%	27.1%	72.9%	27.1%
New York	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
North Carolina	64.6%	35.4%	64.6%	35.4%	64.6%	35.4%
North Dakota	69.1%	30.9%	69.1%	30.9%	69.1%	30.9%
Ohio	60.2%	39.8%	60.2%	39.8%	60.2%	39.8%
Oklahoma	69.9%	30.1%	69.9%	30.1%	69.9%	30.1%
Oregon	61.0%	39.0%	61.0%	39.0%	61.0%	39.0%
Pennsylvania	52.9%	47.1%	60.0%	40.0%	60.0%	40.0%
Rhode Island	53.8%	46.2%	60.0%	40.0%	60.0%	40.0%
South Carolina	70.8%	29.2%	74.0%	26.0%	70.8%	29.2%
South Dakota	66.7%	33.3%	66.7%	33.3%	66.7%	33.3%
Tennessee	65.6%	34.4%	69.6%	30.4%	65.6%	34.4%
Texas	62.3%	37.7%	62.8%	37.3%	62.3%	37.7%
Utah	73.2%	26.8%	73.2%	26.8%	73.2%	26.8%
Vermont	60.9%	39.1%	60.9%	39.1%	60.9%	39.1%
Virginia	61.4%	38.6%	60.0%	40.0%	60.0%	40.0%
Washington	50.2%	49.8%	60.0%	40.0%	60.0%	40.0%
West Virginia	73.3%	26.7%	76.8%	24.2%	73.3%	26.7%
Wisconsin	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%
Wyoming	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%



# CENTER ON BUDGET AND POLICY PRIORITIES

February 14, 1996

## GOVERNORS' PROPOSAL COULD WEAKEN MEDICAID DRAMATICALLY

by Richard Kogan and Cindy Mann

The Medicaid proposal adopted by the National Governors' Association on February 6 would likely lead to a dramatic erosion in the strength of the Medicaid program. It would weaken Medicaid in three ways.

First, the proposal would not guarantee coverage to certain vulnerable groups, including poor children over age 12 and some poor disabled individuals.

Second, even those who are covered could find their benefit package far weaker than at present. States would essentially have complete discretion to define benefits as they wish; they could establish benefit packages that do not come close to meeting current standards and do not provide adequate medical care.

Third, the proposal could lead to an exceptionally large withdrawal of state funding from Medicaid. States could reduce state funding by between \$180 billion and \$215 billion over seven years without losing any federal Medicaid dollars.

The proposal also creates incentives for states to "game" the funding system by making legal the types of sham financing schemes many states used in the early 1990s until Congress banned them. As a result, the reduction in state Medicaid funding could be much larger than \$215 billion.

In addition, it appears that the federal Medicaid payments to states would not be adjusted upwards if inflation turns out to be higher than currently expected.

The combination of insufficient funding and sweeping flexibility under the Governors' proposal is likely to prove combustible. The combined effect of the reductions in federal funding and the increased incentive for states to withdraw large amounts of state Medicaid funding makes it likely that many states would use their new-found flexibility to scale back benefits and coverage substantially. As a result, the Governors' proposal would likely result in state action to deny coverage to several million poor people who would receive coverage under current law and to weaken the benefits offered under Medicaid for millions who remain insured.

Some of the problems with the Governors' proposal reflect an effort to undertake the enormously complicated task of marrying a block grant and a per capita cap in just a few days. It has serious deficiencies that Governors may not have

intended or fully understood. It would weaken Medicaid far more than a number of Governors who voted for it may have realized.

### Coverage

Certain groups of people would be guaranteed coverage under the program, including pregnant women and children under age six with family incomes below 133 percent of the poverty line; poor children age six through 12, and poor elderly people with income and assets below the limits for the Supplemental Security Income program.

However, other groups of people who are now guaranteed coverage under the Medicaid program would lose that guarantee.

- Under changes enacted in 1990 with bipartisan support, Medicaid coverage for children in poverty is being phased in so that by the year 2002 all poor children under age 19 will be covered. The Governors' proposal would repeal the coverage guarantee being phased in for poor children over age 12. This could affect poor children whose parents work at low-wage jobs that do not offer health insurance for dependents as well as poor children who now receive Medicaid based on their eligibility for AFDC. Three million poor children over age 12 could be denied benefits because of this repeal.
- While poor people defined as disabled would have to be covered under the proposal, there no longer would be any federal standard of disability. Each state would define what "disabled" meant, and states could define this term as narrowly as they liked. A state could, for example, cover only disabled people residing in state institutions or cover only people whose disabilities were life-threatening. Six million people now are enrolled in Medicaid because of their disabilities.

The Governors' proposal does include a "set-aside" requirement that would direct states to spend a certain percentage of their Medicaid funds on the disabled.<sup>1</sup> Since, however, states can reduce overall Medicaid expenditures substantially under the Governors' proposal (see

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<sup>1</sup> The set-aside requirement equals "90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities." For example, if 28 percent of total Medicaid spending in a state in FY 1995 were devoted to the disabled, then in future years at least 25 percent (90 percent of 28 percent) of Medicaid spending would have to be earmarked for the disabled. (This example is used because nationwide 28 percent of Medicaid spending in FY 1995 was devoted to the disabled.)

funding section below), spending on the disabled in 2002 could be 38 percent to 43 percent less than what would be spent under current law.<sup>2</sup>

### *A Guarantee of What?*

Some of the people guaranteed coverage may find the guarantee a hollow one because the proposal would repeal virtually all federal standards for the health care services that must be covered under Medicaid. Federal law would simply contain a list of areas in which states must offer some services, but with no rules, guidelines, or standards to assure that the services are minimally adequate.

Thus, states would have to offer *some* hospital care, physician services, home health care, laboratory services, and other specified benefits. But what hospital care or physician services must be covered would be left entirely up to the states, with no minimum standards set. A state could offer only the most skeletal of benefit packages.

For example, a state seeking to reduce state funding for Medicaid could impose annual or lifetime limits on hospital utilization by limiting coverage for hospital care to five days per month. (A state even could guarantee only a couple of days of hospital care in the case of a heart attack.)

If mid-year fiscal pressures arose, a state could scale back the benefits provided to new applicants compared to those for persons already enrolled in the program. Large differences among states would emerge in the absence of federal minimum standards. This would increase the risks of the "race to the bottom" that many analysts have warned about.

The likelihood that states would take steps to scale back substantially the health care services covered under the program would be greatly enhanced by the parts of the Governors' proposal that provide incentives for states to withdraw state funds from Medicaid. These incentives are discussed in the next section.

### *Would Funding Levels be Adequate to Sustain the Program?*

The Governors' proposal would allow states to reduce their own funding for Medicaid sharply without triggering any further loss of federal funds. Under current law, the cost of Medicaid is shared between the federal and state governments in accordance with "matching rates" established by federal law. If a state's matching rate is set at 50 percent, the state pays half of Medicaid costs in that state, and the

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<sup>2</sup> These percentages are consistent with states reducing overall Medicaid funding by between \$180 billion and \$215 billion over seven years, as discussed in the funding section.

federal government pays the other half. Under current law, states that cut Medicaid benefits or eligibility to reduce state costs automatically lose at least \$1 in federal funds for each dollar they reduce state contributions.

By contrast, under the Governors' proposal, at least half of the states would be allowed to contribute a smaller amount of their own funds to receive the same amount of federal funds. The result would be a reduction in the total resources available for Medicaid services.

For the 12 wealthiest states, the percentage of Medicaid costs the state must bear would be reduced from 50 percent to 40 percent. Thus, a state that otherwise would provide \$6 billion in state funds to receive \$6 billion in federal funds would need provide only \$4 billion in state funds to get the same \$6 billion in federal funding. If a state took advantage of this change, total Medicaid resources in the state would fall from \$12 billion to \$10 billion. (In addition, to the degree the federal Medicaid grant that a state receives is less than it would be under current law, state funding could be reduced further, since states would have a smaller amount of federal funding to match.)

The potential effect of these changes on state Medicaid financing — and consequently on Medicaid benefits and coverage for poor families, children, and elderly and disabled individuals — could be dramatic:

- Under current law, states achieve no more than half of the savings from cutting back on the health services for which beneficiaries are covered. Under the Governors' proposal, states could in many circumstances pocket *all* of the savings from such a cutback by reducing state funding without losing any federal Medicaid money. The financial incentive for a state to scale back the services covered would consequently be greater than in the past.
- The amount that states could reduce state Medicaid funding without losing federal funds would range as high as \$180 billion to \$215 billion over seven years.
- Since states could receive their full federal payment even if they substantially reduced their own contributions, many states are likely to jump at the opportunity.

This \$180 billion to \$215 billion reduction in state funding may be an *underestimate*. The Governors' proposal also would repeal federal rules that prevent states from using financing gimmicks that would allow states to receive federal funds without actually providing the required level of state Medicaid payments. These rules were enacted during the Bush Administration in response to state actions that

used gimmicks to circumvent the matching system. The reductions in state Medicaid funding could be even larger than \$180 billion to \$215 billion if states again begin to use such financing scams.

A final feature of the Governors' proposal would be the creation of "umbrella" payments, under which federal funding would increase to cover unexpected costs above the basic block grant. These payments are intended to give life to the principle that "money goes where the people go." If designed correctly, these payments could protect states against unexpected increases in inflation or in the number of people becoming poor and qualifying for Medicaid.

While details on how these umbrella payments would be structured remain sketchy, it appears the structure may not provide the necessary safeguards for states. In particular, it appears that federal umbrella fund payments — as well as the basic block grant payments — would not respond to increases in inflation that would cause health care costs to be higher than expected.

In addition, if improperly designed, a system to provide extra payments to states for each additional beneficiary can be subject to "gaming" by states and thus may result in substantial, unintended federal cost. Proposals to provide federal Medicaid payments on a per capita basis that the Clinton Administration, House "Coalition" Democrats, and Senate Democrats have advanced all contain safeguards against gaming. The Governors' proposal, however, does not. It allows states to extend Medicaid to categories of individuals who cost little to cover (because states would be permitted to provide people with skeletal benefits) and then to receive federal per-capita payments that exceed the cost of covering these new beneficiaries.

The manner in which the Governors have designed this proposal thus may provide considerable fiscal relief to states but cause the federal government to lose a substantial portion of the Medicaid savings the proposal is supposed to achieve.

#### *Legal Protections Would be Undermined*

The Governors' proposal also ends fundamental legal protections that are now part of Medicaid. The plan would repeal the current law that governs the Medicaid program without specifying which parts of that law would be retained. Thus, the proposal provides no assurance that provisions in current law banning providers from billing Medicaid patients, protecting beneficiaries from unaffordable cost-sharing requirements, or prohibiting discrimination against certain groups of beneficiaries based on their medical condition would be maintained. The proposal does make clear, however, that neither beneficiaries nor providers could turn to the federal courts to enforce any rights provided under the new federal law.

S P E C I A L

# REPORT

A Publication of Families USA, February, 1996

## What Does the National Governors' Association Proposal Mean for Medicaid Beneficiaries?

### OVERVIEW

**O**n February 6, 1996, the National Governors' Association (NGA) unanimously approved a compromise proposal to restructure the Medicaid program. This proposal has been hailed as a breakthrough that could breathe new life into the stalled federal budget negotiations between the President and the Congress. Medicaid reform has been one of the most contentious issues between congressional leaders and the President. Thus, the compromise proposal raised hopes that a federal budget agreement is achievable.

The Governors' proposal reflects the positions of only one of the interest groups in the Medicaid program controversy—the Governors. Not surprisingly, the Governors seek to maximize federal funding while granting themselves the flexibility to cut their own Medicaid budgets. At the same time, the Governors want much more control over the program's operations. In asserting those interests, however, the Governors' proposal significantly weakens the program's historic protections for low- and moderate-income people who depend on Medicaid for their health care. It will also enable state governments to evade their fiscal obligations under the program, resulting in significant cutbacks of service to program beneficiaries.

The NGA's description of the proposal posits that it "guarantees health care to our

■  
**All guarantees of  
meaningful coverage  
will be eliminated**  
■

most needy citizens." But a review of the plan belies that assertion. Significant numbers of very vulnerable groups will lose existing or future coverage—including people with disabilities, seniors, older children, and families receiving public assistance. All guarantees of meaningful coverage will be eliminated. New and unaffordable cost-sharing requirements may be imposed. Federal standards for quality of health care will be nullified. And the ability of program beneficiaries to enforce remaining rights will be weakened.



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Under the Governors' proposal:

- Millions of Americans will be in jeopardy of losing coverage, in particular:
  - children aged 13-18;
  - senior citizens with incomes above the meager federal Supplemental Security Income (SSI) level;
  - those with high medical bills;
  - some parents who receive Aid to Families with Dependent Children (AFDC); and
  - people with disabilities.
- Those who are covered will lose the guarantee they have today to meaningful benefits.
- Low-income and vulnerable Americans can be forced to pay high out-of-pocket charges as a condition of receiving care.
- Existing federal guarantees that high-quality care be provided will be eliminated.
- Federal nursing home quality monitoring will be terminated.
- Beneficiaries will lose their ability to enforce whatever rights they still have in federal court.
- Many states will be allowed to reduce their spending on Medicaid beneficiaries, and all states will be given sufficient flexibility to "game" the matching fund requirement.

The following is an in-depth analysis of specific aspects of this plan. This paper attempts to answer crucial questions in order to understand how the NGA proposal will work for beneficiaries. The sketchiness of the proposal, however, leaves many questions unanswered. More details must be provided by the Governors before the true impact on beneficiaries can be assessed.

**Section I  
MEDICAID BENEFITS COULD BE  
DRAMATICALLY REDUCED**

The Governors' proposal requires states to provide the following benefits to groups that are "guaranteed" Medicaid eligibility (see Section II for list of guaranteed groups):

Inpatient and outpatient hospital services; physician services; prenatal care; nursing facility services; home health care; family planning services and supplies; laboratory and x-ray services; pediatric and family nurse practitioner services; nurse midwife services; and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services (although the treatment mandate is redefined so that states need not cover treatment for all conditions).

This list of benefits approximates those that states must now provide under Medicaid law, with the notable exception of services at federally-qualified health centers and rural health clinics. However, the list of required benefits is virtually meaningless because the Governors' proposal gives states total discretion over the amount, duration, and scope of such services. For program beneficiaries, this raises the following problems:

**No Guarantee of Sufficient Benefits:** Under current Medicaid law, states are required to provide Medicaid services "sufficient in amount, duration, or scope of such services to reasonably achieve their purpose." The Governors' proposal eliminates this requirement. Without it, states can arbitrarily limit the level of services provided. For example, states can

justify the hospital services requirement by providing a very limited number of covered hospital days per year—even as little as one day a year. Without "amount, duration, and scope" protections, beneficiaries have no assurance that the benefits package offered by their state will be even minimally adequate.

#### **No Guarantee of Equal Treatment:**

"Amount, duration, and scope" protections also ensure that a specific service will not arbitrarily be reduced because of a patient's illness, diagnosis, or medical condition. All guaranteed beneficiaries, under current law, must receive "comparable" benefits for comparable medical need. This too appears to be repealed, leaving states free to offer various levels of benefits to individuals with different medical conditions—for instance, offering extensive services for someone with cancer and few services for someone who has sickle cell anemia or AIDS.

#### **No Guarantee of Comparable Services**

**Within States:** The current requirement that a similar benefits package be offered throughout each state appears to be repealed. This could result in rural counties getting fewer services than urban counties, for example. States can provide an expanded benefits package in counties where the local government is able to contribute to the cost of providing the added benefits, so that richer counties can offer more benefits than poorer counties. Or there could be a "race to the bottom" among counties. It would even be possible for Governors and state legislatures to apportion Medicaid funds and services using inappropriate criteria, such as political favoritism based on the party loyalties of county and city officials.

#### **No Guarantee of Benefits All Year Long:**

There is no guarantee that a state will not cut back on benefits if the money runs out in the middle of the year. If a state runs out of money—because inflation grows more quickly than expected or the mix of services becomes more expensive than initially predicted—the state will not be allowed to draw down federal "umbrella funds" (see Section VI for explanation of the umbrella fund). The fear that states might run out of funds is legitimate—witness the recent discovery by the Medicare program that costs had risen higher than expected due to more inpatient hospital days than predicted. If this situation occurs, states will have either to pay for these services with state dollars or to stop providing them.

#### **No Guarantee of Medical Treatment for Sick Children:**

Under current Medicaid law, states are required to provide treatment to children for health conditions identified through periodic screenings, even if the services needed are not covered for adults. The Governors' proposal eliminates this requirement. As a result, a Medicaid provider could screen a child and diagnose a serious illness, then have to tell the family that the state will not pay for the necessary treatment.

**"Optional" Benefits Threatened:** All states are currently able to offer optional services—including prescription drugs, clinic services, prosthetic devices, hearing aids, eyeglasses, and dental care—and receive federal matching funds. Many states are already reducing these benefits. In the face of inevitable federal and state funding cuts (see Section VI), optional services will be exceedingly vulnerable.

In sum, the elimination of federal benefits standards, together with reduced Medicaid funding, will deny any meaningful guarantee of health security to those seniors, children, and persons with disabilities who retain their right to Medicaid services under this proposal. Without a basic benefits standard, states may fear that a richer benefits package will attract older and sicker populations who are more likely to need costlier care. This will give states an incentive to engage in a "race to the bottom."

## **Section II MILLIONS OF MEDICAID BENEFICIARIES COULD LOSE THEIR COVERAGE**

The groups that are guaranteed eligibility under the NGA proposal include:

- Pregnant women with incomes up to 133 percent of poverty (\$16,745 for a family of three);
- Children through age six whose families have incomes up to 133 percent of poverty;
- Children through age 12 whose families have incomes up to 100 percent of poverty (\$12,590 for a family of three);
- People with disabilities (as defined by the state); and
- Elderly persons who meet SSI eligibility standards (\$5640 for a single person or \$8460 for a couple).

While this list includes many of those who are currently assured coverage, there are a number of groups that are no longer guaranteed coverage:

**Poor Children Aged 13-18:** Poor children aged 13 through 18 are currently scheduled to be phased in for mandatory Medicaid coverage from 1996 to 2002. It is estimated that, under the Governors' proposal, over three million children will lose this guarantee.'

**The Elderly Poor:** Under current law, low-income seniors with incomes under 100 percent of poverty can rely on Medicaid to pay their Medicare premiums, deductibles, and copayments. These seniors are called Qualified Medicare Beneficiaries (QMBs). Today, seniors whose incomes are between 100 and 120 percent of poverty can rely on Medicaid to pay their Medicare premiums. These seniors are known as Specified Low-Income Medicare Beneficiaries (SLMBs). The Governors' proposal does require states to continue to pay Medicare cost-sharing for QMBs, but it is silent on the question of premiums for SLMBs, apparently leaving states free to drop this coverage.

The plan allows states to pay lower reimbursement rates to providers serving QMBs than would be paid for other Medicare beneficiaries. This could result in undesirable outcomes. Providers could discourage low-income seniors from using their services. Alternatively, low-income seniors could be required to pay the difference. Current law prohibits this practice, but this protection apparently is eliminated.

**Elderly Nursing Home Residents:** Ninety percent of elderly and disabled persons who receive nursing home care under current law have incomes above the SSI income standard. Under the Governors' proposal, states will have complete flexibility to determine what benefits these people receive and how long they will

ive them. Currently, these nursing home residents are covered at the option of the state; however, if the state chooses to cover this group, it is required to provide comprehensive services all year long. This will no longer be required under the Governors' proposal.

The Governors' proposal is silent on a number of protections in current law for this population. They include:

- an assurance that the spouse of a nursing home resident can keep enough income and assets to live at home (known as "spousal impoverishment" protection);
- an assurance that adult children of nursing home residents will not have to impoverish themselves to pay for their parents' care; and
- an assurance that the state will not take the nursing home resident's house or put a lien on it if certain family members still live there.

**People With Disabilities:** States will be able to establish their own definition of disability. Disabled persons who do not qualify under more restrictive state definitions but currently meet federal guidelines will lose guaranteed coverage. States could decide, for example, that a certain diagnosis, such as AIDS, does not qualify a person as disabled. Or states could decide that only people who are bedridden qualify. A state that wants to reduce expenditures can do so easily by narrowing the definition of disability.

**Parents and Older Children on AFDC:** Under current law, families who are on AFDC are automatically eligible for Medicaid benefits. The Governors' proposal allows states to choose to cover either:

- individuals or families who meet current AFDC income and resource standards (however, states with income standards higher than the national average may lower those standards to the national average); or
- individuals who are eligible for a new welfare program as defined by the state.

Under either of these scenarios, many parents, primarily low-income women, and children who are 13 years or older are likely to lose their coverage, but it is impossible to estimate how many.

The Governors' proposal apparently repeals the current uniform rules for determining what constitutes income (and, presumably, resources, in the case of people with disabilities). Medicaid currently relies on AFDC rules for determining income and assets. Without uniform rules, states will make their own choices, such as what income to count, and how to treat income available from other family members. As a result, the same child could be guaranteed eligibility in one state and not in another.

**People Qualifying Under "Optional" Coverage Categories:** Under current law, as well as in the Governors' proposal, states may opt to extend Medicaid coverage to other specified groups of people beyond the "guaranteed" populations. Under current law, these include persons whose medical expenses are so high that they are left with little money for basic living costs (the "medically needy"); pregnant women and children up to age one in families with incomes up to 185 percent of poverty; and, in some states that do not have a medically needy program, nursing home residents who could not otherwise afford the

cost of care. More than one-sixth of all current Medicaid beneficiaries, and 90 percent of all Medicaid nursing home patients, are in these optional coverage categories.

If federal dollars are cut and states are allowed to reduce their shares significantly, as the proposal recommends, pressure will increase to reduce the number of people covered by Medicaid. In the last few years, several states (Arkansas, Florida, North Carolina, Vermont, and Wyoming) reduced Medicaid eligibility in response to state budgetary pressures.

Over six million optional Medicaid beneficiaries nationally would be at great risk of losing coverage. More than one out of four Medicaid beneficiaries receive optional coverage in fifteen states. These states are: Connecticut (42%); North Dakota (41%); Oregon (40%); Pennsylvania (40%); Massachusetts (39%); Kansas (38%); Arizona (38%); Virginia (35%); Hawaii (34%); Maryland (33%); Illinois (32%); Vermont (30%); Arkansas (28%); Tennessee (27%); and New York (26%).

**People With Incomes Above Poverty May Gain Coverage:** Under the Governors' proposal, states may cover any individual or family (as defined by the state) whose income is up to 275 percent of poverty. This provision could help states cover more people who now lack access to Medicaid or to private insurance, such as non-disabled adults. This would enable states to reduce the number of people who are uninsured, as some states have already done through their approved federal Medicaid waivers. On the other hand, it is possible that federal

Medicaid funds could be diverted to meet existing state responsibilities—by using Medicaid funds to subsidize health coverage for state employees, for example. Such a diversion would likely result in a loss of benefits for the state's current Medicaid beneficiaries since funds would have to be diverted from a finite pot of money (see Section VI).

**Section III  
HIGH COPAYMENTS MAY PREVENT  
POOR FROM SEEKING CARE**

The Governors' proposal appears to repeal current protections ensuring that beneficiaries can afford the cost of medical care. Without these vital protections, states may raise cost-sharing requirements, leaving beneficiaries unable to afford the care they need.

**Unaffordable Cost-Sharing May Be Imposed On Beneficiaries:** Under current law, children, pregnant women, persons in institutions, and those receiving emergency services may not be charged premiums, copayments, or deductibles. All other beneficiaries may only be charged nominal cost-sharing amounts. The Governors' proposal appears to repeal these protections.

**Providers May Turn Away Beneficiaries:** Under current law, providers may not turn away beneficiaries if they do not have the copayment at the time services are requested. This protection also appears to be repealed by the Governors' proposal.

**Providers Could "Balance Bill" Their Patients:** Medicaid currently requires health care providers to accept the Medicaid reimbursement rate (and any required copayment) as "payment in full." This protection also appears to be repealed. In the absence of this protection, providers may charge beneficiaries the difference between what Medicaid pays and what the provider normally charges.

Studies show that low-income persons delay or avoid getting the medical care they need because of cost-sharing requirements.<sup>2</sup> This results in the subsequent need for more costly care and drives up costs in the long run. Cost-sharing protections and prohibitions against balance billing are essential elements of any package which seeks to guarantee health coverage for low-income populations.

#### **Section IV**

### **QUALITY AND AVAILABILITY OF CARE JEOPARDIZED**

Current law includes provisions to protect Medicaid beneficiaries against poor quality health care. The Governors' proposal contains a number of features that threaten the quality of health and long-term care.

**Nursing Home Quality Standards:** While the nursing home quality standards that were passed in 1987 appear to remain intact, federal enforcement of these standards is repealed. Under current law, states enforce these standards under the guidance and oversight of the federal government. The Governors' proposal gives the states the authority to determine all enforcement strategies.

Under current law, states must survey nursing homes annually, using federal procedures. These procedures lay out the steps inspectors must take, such as observing residents, talking with family members, reviewing medical records, and recommending corrective actions. States must also survey nursing homes to investigate complaints by residents, family members, and others. Last year, these state surveys uncovered serious problems in more than 600 nursing homes. Inspectors found deaths due to misuse of physical restraints, drug overdoses, and other problems. These inspections will no longer be required under the Governors' plan.

History shows that, without federal oversight, state enforcement of nursing home standards is episodic and inconsistent. In fact, the 1987 nursing home reform law was enacted after congressional hearings exposed widespread problems due to inadequate state enforcement.

States do not have laws in place that adequately protect nursing home residents through nursing home surveys and enforcement. The National Citizens' Coalition for Nursing Home Reform recently examined ten states' nursing home laws. Nine of those states did not meet minimum federal standards for nursing home surveys. Enforcement provisions in state laws vary dramatically, and states often do not act when they find serious quality-related violations.<sup>3</sup>

**Managed Care Protections:** Under current laws, states must seek waivers from the federal government before requiring Medicaid beneficiaries to enroll in managed care. The Governors' proposal repeals this waiver process

and, apparently, all managed care consumer protections concerning access to quality care. Without such protections, there will be no standards regarding qualifications of doctors or other health providers, no standards to ensure that beneficiaries—especially those in rural areas—have adequate access to providers, and no limits on the number of beneficiaries one managed care plan could serve.

As states move growing numbers of Medicaid beneficiaries into managed care plans, particularly vulnerable disabled and elderly populations, strong consumer protections are vital. Without these protections, a state could turn over most of its Medicaid funding to one private managed care plan. The plan could hire a small number of doctors to serve a large number of patients. Even if the plan provided inadequate care to beneficiaries, it could pocket enormous profits. Audits have documented many abuses in Medicaid managed care plans in the past, including: contractors that received large payments but provided little service to enrollees; fraudulent or deceptive marketing practices; and failure to provide required services, such as childhood immunizations.

**Safety Net Providers Threatened:** The Governors' proposal eliminates all health plan and provider reimbursement protections. Some of these changes could compromise beneficiaries' access to quality care. For example, the proposal eliminates the provisions of current law that assure extra funds for hospitals serving a disproportionate number of low-income people (the Disproportionate Share Hospital, or DSH, program). Safety net hospitals in communities where many Medicaid beneficiaries live could be severely

compromised by the loss of this funding. Beneficiaries who depend on these hospitals may have to suffer from inferior treatment or the loss of the facility from their community.

**Section V  
ENFORCEMENT MECHANISMS  
COMPROMISED**

The Governors' proposal establishes new enforcement procedures for beneficiaries who are inappropriately denied care. The proposal prevents individuals from bringing an action in federal court on any dispute over eligibility or benefits. Instead, a person whose federal or other rights have been violated will first have to exhaust state administrative appeals procedures, then go to state court, and, finally, petition the U.S. Supreme Court.

This process presents numerous obstacles for the individual who is denied coverage or services. First, it requires an individual to go through the entire state hearing appeals process before bringing his or her complaint to state court. Many states have very slow and cumbersome processes which could cause serious delays. Second, federal courts are the usual and best arbiters of disputes over federal law, and the state court system is often ill-equipped to deal with rights arising under federal law. Last, given the crowded docket of the Supreme Court, it is unlikely that the Supreme Court will grant many petitions for review. As a result, there will be little or no federal judicial oversight of violations of federal law.

The Governors' proposal also gives new authority to the Department of Health and Human Services to bring an action in federal

act on behalf of an individual. However, because this is a new function for the department, a new enforcement division will have to be established. It is unlikely that the department could devote sufficient resources to this effort at a time when its funding and staffing are being reduced.

The individual's right to bring a lawsuit in federal court is a crucial feature of the Medicaid program's guarantees. A right without a meaningful remedy is a hollow right. A meaningful guarantee to coverage must therefore include a federal private right of action.

## **Section VI**

### **HOW DEEP WILL FEDERAL AND STATE FUNDING CUTS BE?**

**Uncertainty Over Federal Funds:** The Governors' proposal sets up four different pools of federal money states can draw from. The first two comprise a state's finite dollar allotment. Each state will receive a base amount determined by how much it spent in its chosen base year, plus a second amount that allows the state to cover projected increases in enrollment growth, case mix, and inflation. The exact formula for determining these amounts is yet to be decided. A third pool of money will go to states that have high illegal alien and Native American populations.

The fourth pool of money is a new so-called "insurance umbrella." This represents the heart of the compromise reached by the Governors, and—possibly due to the tentative nature of the compromise—is the least clear. It is supposed to provide states with extra funds when there is unanticipated growth in certain populations qualifying for coverage. The

umbrella fund covers guaranteed populations and optional elderly and disabled beneficiaries. The funds are available to cover both guaranteed and optional services for these beneficiaries. Optionally covered children or families with incomes above the guaranteed eligibility income levels would not qualify for umbrella payments. Excluding children and families above guaranteed eligibility levels is troubling when states have experienced much of their enrollment growth in this category in recent years.

Many questions remain about the umbrella funds:

- Will umbrella money be available for states that experience unanticipated growth in inflation or an unanticipated use of more costly services? If not, the pressure on states to reduce services will increase.

- Will umbrella funds be available if the state covers more high cost seniors, for example, but fewer than anticipated lower-cost people, such as children? If not, the pressure on states to eliminate eligibility for higher-cost beneficiaries will increase.

- Will money be available if the state wants to provide coverage to new optional elderly and disabled coverage groups that it previously did not?

- Will money be available to cover extra people who qualify because they are under a new optional category of people whose incomes are below 275 percent of poverty?

- Will states figure out ways to "game" the system so that more money flows to them without the guarantee that beneficiaries will get more or better services?

The Governors' proposal states that:

"Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need." Until this language is clarified and the unanswered questions are addressed, it is impossible to determine how much and under what circumstances states can tap into federal umbrella funds.

There is no way to determine how much federal savings the Governors' proposal will produce. Dramatically different results are possible depending on how the details of the funding mechanism are decided. A central question is when and how can states claim federal contributions? The plan could become a block grant with a small rainy day contingency fund designed to be used only in unusual circumstances. Alternatively, it could result in a flow of money to the states that enables states to cover significant increases in enrollment.

**State Share Is Reduced:** The Governors' proposal would lower the current ceiling of 50 percent for a state's matching percentage to 40 percent. Today, states contribute between 22 percent and 50 percent of Medicaid funding to draw down their federal share. This change would allow 25 states, including such large states as New York and California, to reduce their state funding by as much as 20 percent. *Preliminary estimates indicate that, if a target of \$86 billion in federal savings is reached, the state match change could result in states withdrawing as much as \$214 billion in state Medicaid funding over a seven-year period.*

**States Determine What Counts As Match:** States will also have unlimited freedom under this proposal to determine what counts as their

matching dollars. Current restrictions on provider donations and taxes will be repealed. Congress enacted these restrictions after some states began to "game" the system to minimize their own contributions. In the late 1980s, several states asked Medicaid providers to make "voluntary" contributions to the state; some states imposed special taxes on providers. Counting this revenue towards their share of Medicaid payments, states drew greater federal matching payments. They then repaid the taxes or donations to Medicaid providers in the form of higher reimbursements. States thus increased their federal Medicaid matching funds without spending any real state-generated revenues. This practice is now limited under federal law.

The flexibility to determine what counts as their match will also allow states to use other federal funds they receive as their match. This will mean that states may spend little of their own funding, but divert federal dollars received through other programs from their intended purpose.

Finally, states could require local governments to contribute some or all of the required match. Several state government officials have already proposed "block granting" their Medicaid and/or welfare programs to local counties. A Medicaid program run on a county-by-county basis creates an even greater likelihood of a "race to the bottom" among counties fearful of attracting persons in the guaranteed categories who need costlier care.

## **CONCLUSION**

The National Governors' Association proposal to restructure Medicaid leaves many unanswered questions. Because the proposal is only an outline of broad areas of agreement, it is

...en to vastly different interpretations. Indeed, it has been characterized by some in Congress as very similar to the MediGrant block grant they passed. Until there are more details, it will be impossible to make a complete assessment of the potential impact.

Nevertheless, a number of important conclusions can be drawn. Some people who are now assured coverage will lose that guarantee. Vital federal consumer protections related to Medicaid managed care and federal enforcement of nursing home standards would be lost under the Governors' proposal. And while proponents claim that the proposal contains a real guarantee of coverage to defined services for specific groups, the reality falls short.

A real guarantee of coverage must include three important elements:

- The benefits package is meaningful and responsive to medical needs;
- Benefits are available all year long, and beneficiaries can afford them; and
- Beneficiaries are able to enforce their rights in federal court if a state illegally denies them care.

The Governors' proposal does not meet this test. The plan does not guarantee meaningful health coverage to anybody; instead, it provides assurances to Governors that they will be able to cut their states' budgets.

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**ENDNOTES**

1. Children's Defense Fund estimate, February 1986.
2. An excellent summary of research findings can be found in "Cost Sharing in Health Insurance—A Reexamination," by M. Edith Rasell, *New England Journal of Medicine* 1985;332:1154-1158.
3. Jae Hee Kim, "State Laws are Inadequate to Protect Residents," in *Congress Brings Back the Horrors: Budget Bill Rolls Back Nursing Home Standards*. The nine states not meeting federal standards were: California, Colorado, Florida, Iowa, Kansas, New York, Oklahoma, Rhode Island, and Texas. (Consumers Union: 1995.)
4. Center on Budget and Policy Priorities, "Reduced State Medicaid Matching Requirements Under the Governors' Proposal," draft, February 8, 1995.

## ELIGIBILITY

DRAFT

### NGA Proposal

Coverage is "guaranteed" for the following groups:

- Pregnant women to 133 percent of poverty.
- Children to age 6 to 133 percent of poverty.
- Children age 6 through 12 to 100 percent of poverty.
- The elderly who meet SSI income and resource standards.
- Persons with disabilities - "disability" defined by the state.
- Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs).
- Families who meet current AFDC income and resource standards; or states may run a single eligibility system for those who are eligible for "new welfare."

Coverage is optional for the following groups:

- All other current law mandatory and optional groups.
- Other individuals or families as defined by the state but below 275 percent of poverty.

### Major Concerns

- Medicaid will not be phased in for children age 13 to 18 under 100 percent of poverty (as is would occur under current law)
- States can apply more limited definitions of disability than exist under current federal law
- Medicaid "guaranteed" coverage does not extend to all disabled and blind recipients of SSI
- States that reduce welfare coverage can thereby sharply reduce Medicaid coverage
- Welfare-related coverage options remain unclear
- There is no requirement for Medicaid coverage for welfare recipients transitioning to work
- The 275% of poverty category would cover one-half of the total population of the United States

## BENEFITS

DRAFT

### NGA Proposal

- Complete state flexibility in amount, duration, and scope
- The following services are "guaranteed" only for "guaranteed" populations:
  - Inpatient/outpatient hospital
  - Physician
  - prenatal care,
  - nursing facility services
  - home health care
  - family planning services and supplies
  - lab and x-ray
  - pediatric and family nurse practitioner
  - nurse midwife services
  - EPSDT, with limitations on requirements for treatment
- All other services optional
- Broadened long term care options

### Major Concerns:

- Complete flexibility in amount, duration, and scope means states could sharply limit the benefits receipts receive. Theoretically, amount, duration, and scope could be zero.
- It is not clear if current law Statewideness requirements will continue to exist. If statewideness does not continue to exist, a State could offer reduced benefits packages in certain parts of the state.
- It is not clear if current law Comparability requirements will continue to exist. If comparability does not exist, then states could reduce benefits for certain populations (such as HIV positive beneficiaries)
- Remains unclear how "Treatment" under EPSDT would be redefined. Could mean that children diagnosed with certain medical conditions may go untreated (under current law, children diagnosed with medical conditions must be treated).
- FQHC/RHC services are removed from the list of current law mandatory services. There are no other specific provisions made such as the transition funding pool included in the Administration plan.
- Status of Vaccine for Children Program remains unclear.
- Nature of long term care option remains unclear

## PRIVATE RIGHT OF ACTION

DRAFT

### NGA Proposal

- Basic design is to prevent individual suits on benefits in federal court.
- Individuals must exhaust state administrative remedies before going to state court.
- Individuals and classes have right of action in state court only.
- After completion of state court action, can appeal to US Supreme Court.
- Secretary can bring action in federal court for individuals not providers or health plans.
- No private right of action for providers or health plans.

### Major Concerns

- No federal right of action means there is no guaranteed enforceable federal entitlement for individuals.
- Absence of federal interpretation could create inconsistency across states.
- State courts have more limited remedies than federal courts.
- Lack of federal enforcement by beneficiaries makes Medicaid unique among federal programs -- the only program with federal requirements and with no ability to enforce them.
- Appears to allow for non-enforcement of civil rights laws.
- Provider appear to lack any remedy if states do not pay for services rendered in good faith.

## PRESERVING TITLE XIX

DRAFT

### NGA Proposal

- Replaces Title XIX and rewrites Medicaid law under a new title of the Social Security Act

### Major Concerns

- Writing Medicaid under a new title of the Social Security Act means that critical elements of current law may be lost.
- Eliminating Title XIX could unintentionally lead to massive changes in long-established ways of doing business -- which could lead to a large number of unintended negative consequences.
- Many issues -- even those long settled -- could be subject to contentious and costly new litigation (even if Congress expressed a general intent to continue certain parts of the current program).
- Current Medicaid statute provides important protections to States, providers, and beneficiaries that the NGA proposal addresses inadequately, or not at all.
- States will have greater difficulty implementing Medicaid reform under a new Title.
  - States could face delays in creating new implementing legislation.
  - Development and issuance of new regulations could reopen debate among competing interests at the state level, leading to further delays.
  - Programs forms, provider agreements, data systems, administrative systems and certification procedures would need more extensive re-examination and revision.

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## FINANCING

### NGA Proposal

- Financing still depends on federal-state matching;
- Minimum federal share of the FMAP increased to 60%, state share no greater than 40%.
- Each state gets a maximum federal allocation based on:
  - Base allocation: 1993, 1994 or 1995, with adjustments to correct for anomalies
  - Growth: supposed to account for **estimated** changes in enrollment, plus an inflation factor
  - Special grants (all federal): to certain states for illegal aliens and IHS and related facilities
  - Insurance umbrella: additional funds for states to account for unanticipated enrollment
    - offers capitation payments for excessive enrollment of "guaranteed" groups and the optional portion of the elderly and disabled groups
    - not available without demonstrable need; states must use other available funds first
- DSH funds included in base, no growth if more than 12% of total program expenditures
- Donations and taxes restrictions eliminated

### Major Concerns

- Maximum federal allocation = Block Grant with contingency fund.
- Federal funding increases in an uncapped program; federal role in program decreases.
- Base Calculations are complex and arbitrary, i.e.:
  - three year option will allow states to pick highest base year spending.
  - adjustments for anomalies (criteria to be determined).
  - inclusion of DSH in base creates inequity among states.
- Growth calculations are not described in detail.
  - based on estimated enrollment growth, not actual enrollment growth.
- Special Grants to states lack adequate detail.
  - service definitions are unclear, e.g., "IHS-related facilities."
  - size of grants not specified (neither total grants nor per state grants).
  - criteria for award also unclear.
- Insurance Umbrella raises question about total funding cap v. open ended funding.
  - unnecessarily complex if purpose is to achieve per capita funding.
  - definition for "use up" available funds still needed.
  - States could potentially game the system by underestimating growth to facilitate access to funds to umbrella funds.
- Scoring this proposal without additional details will be difficult.

## INSURANCE UMBRELLA

DRAFT

### NGA Proposal

- The umbrella fund would make available to states additional funds to account for unanticipated enrollment increases.
  - offers capitation payments for excessive enrollment of "guaranteed" groups and the optional portion of the elderly and disabled groups.
  - funds not available without demonstrable need; states must first use all other available funds.

### Major Concerns

- The structure of the fund remains unclear: is it a capped fund or is it open-ended?
  - If the fund is capped, then the NGA proposal is still a block grant that will leave states at financial risk for enrollment increases due to economic recessions or demographic changes.
  - If the fund is open ended, then there is little control over federal Medicaid spending and the Administration's balanced budget targets will be difficult to achieve.
- The fund is unnecessarily complex if its purpose is to achieve per capita funding limits.
- The technical details of how the fund would operate remain unclear.
- States could potentially game the system by underestimating expected enrollment growth to facilitate access to umbrella funds.

DRAFT

PROVIDER TAXES AND DONATIONS

NGA Proposal

- Current restrictions on provider taxes and donations will be repealed.
- Current and pending state disputes with HHS over provider taxes would be discontinued.

Major Concerns

- Federal expenditures could rise substantially because there are no protections against states using recycling schemes to generate excessive federal matching dollars.
- Real state expenditures could fall significantly due to the use of these recycling schemes.

## STATE FLEXIBILITY

DRAFT

### NGA Proposal

- States can use "all available health care delivery systems" without HCFA waivers.
- States have no limits on the number of beneficiaries enrolled in any one network.
- The state plan and plan amendment process will be streamlined.
- Federal intervention is permitted only when a State fails to "comply substantially" with Federal law or its plan.
- HCFA disallowances are commensurate with the size of the violation.

### Major Concerns

- Beneficiaries enrolled in HMOs may have no choice of managed care plans or doctors.
- The Federal government could have almost no ability to oversee States' use of a significant amount of federal funding.
- There are no details on how the state amendment process will be streamlined.
- There are no clear protections to ensure plans have adequate capacity or quality.

## PROVIDER STANDARDS AND REIMBURSEMENT

DRAFT

### NGA Proposal

- States have complete authority to set provider reimbursement rates (Boren Repealed).
- Cost based reimbursement for FQHCs and RHCs is phased-out over two years.
- States set their own provider qualifications standards.
- States may pay Medicaid rate for QMBs.

### Major Concerns

- There would be no supplemental funding to help FQHCs and RHCs transition away from cost based reimbursement.
- If states pay Medicaid rates for QMBs, then QMBs may be subject to balance billing to make up any difference in payment rates.
- Hospitals and other facilities might be subject to different standards and requirements for Medicare and Medicaid.
- Necessary protections for Indian Health programs would be lost.

## NURSING HOME REFORMS

DRAFT

### NGA Proposal

- States are required to abide by the OBRA 1987 standards for nursing home reform.
- States have the flexibility to decide how nursing home standards will be enforced.

### Major Concerns

- The entire set of 1987 standards may not be actually maintained. (The Conference Agreement was described as maintaining all of these standards, but in reality repealed several important ones).
- The proposal eliminates the Federal role in enforcing the standards. Federal enforcement is the key to assuring consistent quality across states. Without the OBRA 87 enforcement rules, there could be great variations in enforcement and quality.