

MEDICAID: WHAT IS AT STAKE IN THE BUDGET NEGOTIATIONS

January 23, 1996

MEDICAID GUARANTEE. Republicans are insisting on ending the Medicaid guarantee to meaningful health benefits for millions of people with disabilities, pregnant women, poor children, and older Americans in need of nursing home care -- even though it is not necessary to balance the budget.

Republicans want to replace the Medicaid guarantee with a deeply underfunded block grant that could *deny health benefits to 3-6 million Americans in 2002, including more than 1 million children.* And the *only* required benefits would be immunizations and limited family planning -- hardly what one would call "coverage." The depth of the Medicaid cuts could force States to significantly reduce coverage, increasing the number of uninsured people, uncompensated care, and cost-shifting to people with private insurance.

President Clinton is refusing to go backwards on coverage, insisting on retaining the guarantee of meaningful Medicaid health benefits for people with disabilities, pregnant women, poor children, and older Americans in need of nursing home care.

DEPTH OF THE CUTS. Republicans want to cut Federal Medicaid funding to States by \$85 billion in order to pay for an excessive tax cut for the well-off.

Republicans are insisting on \$85 billion in Medicaid cuts -- 45% more than the President -- largely to fund an excessive tax cut. They would cut spending growth per person to rates one-third below inflation. And the total Medicaid cuts would more than triple if States only spent the minimum required.

President Clinton's balanced budget achieves \$59 billion in savings by capping spending growth per beneficiary, giving States incentives to reduce costs without denying anyone health care coverage while providing States with unprecedented flexibility to operate their programs and pay providers.

LEAVES STATES VULNERABLE. Republicans are insisting on block granting Medicaid, which will leave States vulnerable to economic downturns, inflation, demographic changes, and natural disasters -- even though it is not necessary to balance the budget.

Under a block grant, States would be responsible for 100% of the additional costs from circumstances beyond their control. According to analysis by the Center on Budget and Policy Priorities, if inflation were just 1 percentage point higher than projected over 7 years, States would have to spend about \$65 billion more, or cut eligibility, benefits, or establish waiting lists.

President Clinton is standing firm on maintaining the 30-year Federal partnership with States, protecting States from circumstances beyond their control and increasing State flexibility.

NURSING HOME QUALITY STANDARDS. Republicans want to repeal Federal enforcement of the nursing home quality standards that have dramatically improved the quality of nursing home care -- even though it is not necessary to balance the budget.

Excessive Medicaid cuts combined with the elimination of Federal enforcement of nursing home quality standards may lead to inadequate and inconsistent enforcement of quality.

President Clinton's balanced budget retains Federal quality standards and enforcement. Since these Federal standards were signed into law by President Reagan, there has been a 50% reduction in dehydration among nursing home residents, a 31% reduction in hospitalization rates, and a 25% reduction in the use of physical restraints.

FINANCIAL PROTECTIONS. Republicans want to repeal financial protections for families, their homes and farms -- even though this is not necessary to balance the budget.

Republicans would repeal the laws that prevent States from forcing adult children to have to pay for their parents' nursing home care, if their income is above the State median income -- even though it is not necessary to balance the budget. They would repeal laws that protect families from having to sell their home or family farm in order to qualify for Medicaid, and would repeal the laws that restrict the placing of liens on homes and family farms of Medicaid recipients.

President Clinton's balanced budget maintains current financial protections.

POOR ELDERLY AND PEOPLE WITH DISABILITIES' ACCESS TO MEDICARE. Republicans are insisting on repealing the guarantee that Medicaid pay poor older Americans and people with disabilities' Medicare premiums, deductibles, and copayments.

The Medicaid guarantee of assistance with Medicare premiums, deductibles, and copayments ensures that more than 5 million poor older Americans and people with disabilities can afford Medicare physician services. Yet Republicans do not set aside *any* Medicaid block grant funding for Medicare deductibles and copayments, and set aside less than half of the funds needed to cover premiums. Hundreds of thousands of poor and near poor older Americans and people with disabilities could lose funding for their Medicare premiums -- at the same time that Republicans would increase Medicare premiums.

President Clinton's balanced budget maintains the guarantee of this critical assistance.

SPOUSAL IMPOVERISHMENT PROTECTIONS. Republicans would undermine protections for spouses of nursing home residents from impoverishment -- even though it is not necessary to balance the budget.

Republicans undermine these spousal impoverishment protections by repealing the guarantee of nursing home coverage, making it more difficult for the Federal government to ensure that States enforce spousal impoverishment protections, and repealing the right of spouses to seek redress in Federal court if they are wrongly denied protection.

President Clinton's balanced budget maintains the current spousal impoverishment protections which have protected about 450,000 spouses of nursing home residents since they went into effect. Most of these spouses are women.

THE WHITE HOUSE
WASHINGTON

February 3, 1996

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco and Laura Tyson

RE: Status of Medicaid discussions

PURPOSE:

To provide an update on the status of the Medicaid discussions with the Governors and the Hill, as well as to provide background information on your Medicaid reform initiatives.

BACKGROUND:

Status of Governors Meetings

For weeks, in response to requests made by the Hill and us, the Democratic and Republican Governors have been meeting to see if they could produce a bipartisan agreement on Medicaid. The lead Governors for the Democrats have been Romer, Chiles, and Miller; for the Republicans, it has been Thompson, Engler, and Leavitt. To date, although there is widespread agreement on the need for significant expansions in flexibility, no agreement has yet been forged on how to structure and finance a reformed Medicaid program.

On Thursday evening, and yesterday afternoon and evening, the Governors met for countless hours to review the latest of the Republican Medicaid restructuring proposals. During their meetings, the Republicans outlined their new financing formula that, for the first time, outlines how they would allocate the downsized \$85 billion (from \$117 billion) reduction in Federal dollars amongst the states.

In their new plan, the Republicans apparently have attempted to blend their block grant with a new contingency fund that is distributed through a per capita formula. Their plan would lock in states' Federal base allotments and grow them at differential rates. The use of differential rates is meant to address the

widespread spending and growth rate variations between state Medicaid programs. States would be guaranteed these allotments even if they significantly decreased the number of Medicaid recipients their programs served as long as they spent savings on health care.

To address the major policy shortcoming of a block grant (no recession/inflation protection), the Republican Governors have established a new contingency pool of \$8 billion that states could apparently tap if they experienced unexpected enrollment increases. Unlike past contingency funds that have been capped, the Republican Governors are claiming that the pool would increase as much as necessary to meet new and unexpected population growth. If true, this approach could be characterized as a back-up per capita cap protection. (It is important to note that we have not been given any statutory language or accompanying CBO scoring of this concept.)

Upon closer examination, however, there appears to be a number of notable and potentially quite serious shortcomings with the contingency fund. First, the dollars are only available to help pick up the costs of higher than projected enrollment of mandatory benefits and populations. Since over 50 percent of program expenditures are for optional services/populations, this does not provide anywhere near the level of "insurance" protection your per capita cap does. Moreover, since their new pool does not include the disabled in their calculation (since they allow the states to define disability), the recession protection provided is probably closer to 30-40 percent of the program costs for most states. This lack of protection is totally unacceptable to the Democratic Governors, particularly Chiles, and would be inconsistent with your current policy.

In response to criticisms of this shortcoming by Democratic Governors, the Republican Governors are now saying that they would be willing to consider the establishment of a separate contingency fund for optional services. Apparently Ray Scheppach is trying to develop such an option. As of this writing, we have yet to see or hear anything specific about this proposal. If Ray develops something that is workable and is financed without hurting other aspects of their allocation formula, some Democratic Governors may well be quite interested.

State-by-State Formula

By releasing their new state-by-state Medicaid funding distribution yesterday, the Republicans have forced us into releasing ours. We had purposely resisted until we saw theirs first and could modify ours to ensure it was better for almost every state. (Not every state does better because the Republicans are closing in on our savings number and because we could not develop a defensible policy rationale to do "rifle-shot" policy fixes.)

The revised "draft" formula, which we finished this morning, will be handed out to the Democratic Governors today. It is attached for your review and includes one additional category aimed to show the advantage of a per capita cap during a projected recession. As you know, because of the intense politics and economics associated with Medicaid, this formula will change countless times before any final policy is enacted.

State Flexibility and Preservation of Federal Guarantee

At least as important as the formula is the need to get a sense of where the Governors stand on the basic structure of the program. Although the Governors have yet to take up these issues this week, there is no indication that the Republicans have, for example, retracted their insistence that there no longer be a Federal court right of action for enforcement of eligibility and benefit guarantees. The Democratic Governors tell us that the Republicans view this issue as their "holy grail" and that they do not believe Republicans will settle for anything less than state court enforcement of eligibility and benefits.

It is also clear that the Republicans will insist on significantly altering the Federally-defined benefit package, including dropping the treatment requirement from the EPSDT benefit. Moreover, while we have confidentially discussed with the Democratic Governors the possibility of removing the comparability and statewideness requirements for some optional benefits, the Republicans want to drop these protections for all benefits, including prescription drugs.

In response to the Democratic Governors and after reviewing the flexibility recommendations by the NGA, we have incorporated an unprecedented number of provisions explicitly aimed at freeing the Governors' hands in administering Medicaid. As you will note from the attached summary of your proposal, it is an impressive list by any measure. In fact, you should know that your proposal provides for far more flexibility than does the "Blue Dog" Coalition proposal. (They have not repealed Boren, they have not dropped the cost-based reimbursement requirements for community health centers, etc.)

The Democratic Governors acknowledge that we have come a long way in their direction on flexibility. They would like to negotiate some more provisions, particularly relating to benefits flexibility. We believe there is some room to move, but probably not as much as they would desire. Having said this, no Medicaid reform package that preserves the Federally-enforced eligibility guarantee to a nationally-defined set of benefits can match a block grant in terms of flexibility.

The Congress

The Congress is all over the place when it comes to Medicaid. In general, though, the vast majority of the Democrats, including such Members as Stenholm and Exon, stand squarely behind your Medicaid approach and are unified in opposition to anything that appears to be a block grant. There are exceptions to this generalization on the Democratic side and, in the case of Members like Chafee, there are exceptions to the generally unified support by Republicans for a block grant and very little Federal oversight.

Officially, the only plan that does not have a per capita cap approach that preserves a Federally-defined benefit package is the Republican package. The Breaux/Chafee, the Coalition, the Daschle and your plan all include some version of your per capita cap proposal.

Having said this, a number of conservative Democrats, like Breaux, Condit and Peterson, are much more interested in a budget "deal" than in complicated policy implications. That is why they constantly tell the Governors how easily they can deliver Congressional Democrats on a Medicaid deal if the Governors can deliver on a bipartisan compromise. In an effort to push this along, these Members have all indicated their interest in the Republican plan in the last 48 hours. Governor Engler is using these statements to inaccurately suggest that there is widespread "Blue-Dog" Democratic support for their revised plan.

Congressmen Stenholm and most of his followers, as well as Senator Chafee, appear to have no interest in signing onto a "cloaked" block-grant approach. They, as well as Dingell and his followers (Dingell voted for the coalition bill) have strong policy concerns about the direction they think the Republicans are headed. The Democratic base, anchored by Henry Waxman, are extremely nervous about the Republicans and our position. There is little doubt that we are being closely scrutinized by the more liberal Democrats (and, by the way, the press) on this issue.

The Advocacy and Provider Organizations

The groups are quite impressed by, and appreciative of, your defense of the Medicaid program. They definitely have problems with our flexibility package. (For example, the advocates all hate our provision to eliminate the waiver process for managed care; the providers hate our provision to repeal the Boren Amendment.) However, with the exception of perhaps a few hard core Medicaid protectionists, they probably will live with our position if we do not stray too far from our current position. If we move too far in the direction of the Republicans, though, we may well be the target of some hard-hitting criticisms.

We have already received within the last 24 hours a critique of the Republican Governors' proposal by the Children's Defense Fund. They accurately point out that the elimination of the current law phase-in of low income kids from 13 through 17 would result in "more than 3 million children" losing "guaranteed health coverage" in 2002 alone. A coalition of provider groups, including the American Hospital Association and the academic health centers, also sent a letter to the Hill yesterday strongly opposing a block grant approach and the elimination of the Federal guarantee for Medicaid eligibility.

Conclusion

Leon is meeting with the Democratic Governors this afternoon to attempt to ensure they don't go in any direction you are not comfortable with. We will continue to update you on major developments with the Governors and the Members.

Should there be a sudden and unexpected, bipartisan Governors' agreement, we would recommend that you delay in providing a direct response for a short period of time. A slight delay would give you (and us) some time to get a sense of what would be the policy/political implications of supporting such a measure.



NEWS RELEASE

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NEW PROVIDER COALITION CALLS ON CONGRESS TO PRESERVE MEDICAID AS A FEDERAL ENTITLEMENT

WASHINGTON (February 2, 1996) – The American Hospital Association today joined a coalition of health care provider organizations opposing any Medicaid proposal that does not preserve the program as a federal entitlement, particularly a block grant approach that lacks a federal guarantee to meaningful benefits for our most vulnerable populations.

In a letter to each member of Congress, the coalition said, "As providers of health care to these people, we stand united in our support for a reformed Medicaid that allows states more flexibility in the design and administration of their programs. We are also unified, however, in our strong opposition to excessive reductions in funding, and radical restructuring of the program that could jeopardize peoples' access to health care and our ability to provide it."

The American Association of Homes and Services for the Aging, the American Health Care Association, the Association of American Medical Colleges, and the National Association of Home Care joined AHA in signing the letter. The organizations said they would oppose any Medicaid restructuring proposal that does not meet the following principles:

- **Preservation of the Medicaid entitlement** -- "Fifty states defining and enforcing eligibility to a widely varying benefits package would break this nation's 30-year national health care safety-net commitment."

(more)

- **Continued federal financial responsibility for Medicaid --** “A block grant approach would eliminate the responsibility of the federal government and, in economic downturns, would force states to reduce coverage, slash reimbursement and/or raise taxes.”
- **Continued state financial responsibility for Medicaid --** “State matching rate changes that reduce the minimum Medicaid contribution by states would take additional billions out of the health care system.”
- **A financial environment in which providers can continue to serve Medicaid and private patients –** Continuing, by law, to ensure that provider payments are adequate, and that states’ ability to shift the financing burden to providers is limited, will “enable providers to continue our commitment to serving all who come through our doors.”

A copy of the letter is attached.

The AHA is a not-for-profit organization of health care provider organizations that are committed to health improvement in their communities. The AHA is the national advocate for its members, which include 5,000 hospitals, health care systems, networks, and other providers of care. Founded in 1898, AHA provides education for health care leaders and is a source of information on health care issues and trends.

February 1, 1996

Dear Representative:

As you struggle to balance the Federal budget, it is important to never lose sight of the critical role the Medicaid program plays in caring for more than 35 million of our most vulnerable populations, including the elderly, people with disabilities, pregnant women, and children.

As providers of health care to these people, the undersigned organizations stand united in our support for a reformed Medicaid program that allows states more flexibility in the design and administration of their programs. We are also unified, however, in our strong opposition to excessive reductions in funding, and radical restructuring of the program that could jeopardize people's access to needed care and our ability to provide it. Block grants that have no Federal guarantee of access to health coverage and meaningful benefits for our most vulnerable populations, no Federal requirement that states spend grant dollars on the provision of health services, no Federal requirement that states maintain their financial commitment to funding the program, and no Federal requirement to assure access to quality services through provider payment safeguards, are examples of radical restructuring that the provider community finds unacceptable.

While savings necessary to help balance the budget are achievable, they need not and should not come at the expense of eliminating our longstanding national commitment to a Federal health care entitlement for all categories of vulnerable Americans covered under the Medicaid program. We oppose any Medicaid restructuring proposal that does not meet the following principles:

- **Preservation of the Medicaid Entitlement.** The Federal eligibility entitlement to a set of nationally-defined benefits must be maintained. Fifty states defining and enforcing eligibility to a widely-varying benefits package would break this nation's 30-year national health care safety-net commitment.
- **Continued Federal Financial Responsibility for Medicaid.** The Federal government should continue to be a responsive financing partner with the states when they suffer unexpected periods of recession and inflation. A block grant approach would eliminate the responsibility of the Federal government and, in economic downturns, force states to reduce coverage, slash reimbursement and/or raise taxes.

Page 2
February 1, 1996

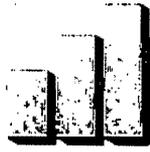
- **Continued State Financial Responsibility for Medicaid.** The states' longstanding financial partnership in funding the Medicaid program should also be maintained. State matching rate changes that reduce the minimum Medicaid contribution by states would take additional billions out of the health care system. Obviously, a cut of this magnitude could force states to deny coverage for millions of Americans. This would result in a significant increase in uncompensated care to a health care system already overburdened by over 40 million uninsured Americans.

- **A Financial Environment in which Providers Can Continue to Serve Medicaid and Private Patients.** Although we understand the desire for additional flexibility for states, we believe that there are a number of provisions being considered by Congress and the Administration that may severely harm providers. They include repealing current law that contains provider payment safeguards that assure access to quality services through adequate payment, and safeguards for providers that limit a state's ability to shift the financing burden for the program to providers through such mechanisms as provider taxes. Protecting these laws will enable providers to continue our commitment to serving all who come through our doors.

Block grant approaches that would totally repeal the current Medicaid statute and do not include the Federal guarantees we have outlined do not meet our principles. Proposals that limit Federal spending on a per beneficiary basis and preserves the Federally entitlement do meet our principles. What is more, they achieve our principles without undermining the national commitment to a health care safety net and without going backward in providing desperately needed coverage to millions of Americans.

As we stand at the brink of the new millennium, it is our collective responsibility to restore our nation's fiscal strength while maintaining our compassion. A viable Medicaid program will help us meet that challenge.

American Association of Homes and Services for the Aging
American Health Care Association
American Hospital Association
Association of American Medical Colleges
National Association for Home Care



CENTER ON BUDGET AND POLICY PRIORITIES

February 4, 1996

A "PER-CAPITA SUPPLEMENT" OFFERS VERY LIMITED PROTECTION FOR STATES

The Medigrant II proposal developed by the Republican Congressional leadership would replace the Medicaid program with a block grant. It would allow states a supplemental federal payment if enrollment of certain groups of people grew more rapidly than the rate at which the state's block grant grew. Thus, if enrollment of young children increased in any given year by 3 percent, and the state's block grant allocation increased by only 1 percent above inflation, the state would get a supplemental payment to account for these "excess" enrollees. While discussions have moved beyond the specifics of the Medigrant II proposal, the framework of that proposal appears to be the basis for these discussions. Some of the key issues that arise are noted below.

- **The supplemental payment would reflect enrollment changes relating to only a small group of beneficiaries.** Under the Medigrant II proposal, states would receive enrollment-related supplements for "mandatory" enrollees, which are defined in the proposal to include only a small portion of Medicaid beneficiaries. States would be responsible for enrollment-related increases in costs for all people who are not identified as "mandatory" enrollees, including elderly and disabled persons with incomes or resources above the SSI limits, children over age 12, and low-income parents.
- **The plan would put states at risk if they chose to cover vulnerable populations.** If a state decided to cover any group of people that was not a "mandatory" group, such as children over age 12, or elderly people whose incomes or resources were above the SSI limits, and enrollment exceeded projections due to any number of factors — including population growth or a downturn in the economy — the state either would have to bear the full cost of the additional enrollment-related costs or be forced to make very difficult decisions to scale back services or cut back on eligibility.
- **The proposal would undercut efforts to move families from welfare to work.** Under current law, states receive federal payments for providing Medicaid coverage to families who leave welfare for employment. However, under the proposal, since neither children over age 12 nor low-income parents would be considered "mandatory" enrollees, all costs of covering these two groups of people above the federal block

grant payments would be borne fully by the states. Thus, at the same time that states may be subject to strict new work participation requirements under a welfare block grant, they would be subject to tight federal caps that would make it increasingly difficult for them to pay the cost of providing medical assistance to families with low-wage earners.

- **The proposal offers no relief to states under pressure to cover the nursing home costs of elderly people with incomes above the SSI limits.** Currently, Medicaid pays for more than half of all nursing home care in the country, but under the proposal only a small portion of the nursing home care now covered by states would be considered when a state's supplemental payment was determined. Given the strong political pressure that will be operating in many states to cover nursing home care for elderly and disabled people with incomes well above the SSI limits, states might well find themselves forced to cut services to other groups of beneficiaries to cover the cost of serving nursing home residents.
- **If the benefit guarantees for mandatory enrollees are weak, states may be forced to restrict benefits for even the most vulnerable groups of people in order to offset costs associated with nonmandatory enrollees.** It appears that while some benefits would be required for mandatory enrollees, current federal rules concerning the amount and scope of these benefits would be eliminated, and other critical benefits, such as prescription medications, eyeglasses and hearing aids for children, would not be required at all. While states might want to offer a broader package of benefits than would be required, states may find themselves forced to severely restrict benefits — even for mandatory groups such as very young children — in order to pay for coverage of nonmandatory groups of people.

DRAFT - 2-8-96

Medicaid of the Governors

CONCERNS/OUTSTANDING QUESTIONS
ABOUT THE NGA MEDICAID RESOLUTION

- **Eligibility concerns include:** The repeal of the current law's phase-in for coverage of about 3 million children age 13-17 and the devolution of the "disability" definition to the states.
- **Benefit concerns include:** The total discretion given to states to alter the amount/duration/scope of services; the repeal of the current law's comparability and statewideness requirement that ensure that recipients in particular groups or locations are not discriminated against; the apparent elimination of any defined benefit package for currently optional populations; and the vague redefinition of the treatment requirements under the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) children's health benefit.
- **Enforcement concerns include:** The state-based right of action process advocated by the Governors (and whether it will work to effectively ensure the guarantee).
- **Financing concerns include:** The exclusion of pregnant women and children, as well as the medically needy, from the Federally-financed "umbrella" pool payments; the inclusion in the base formula of the allowance that states can reduce their matching Medicaid rate -- the result producing an additional \$200 billion reduction in state Medicaid spending over seven years, bringing the total Federal/State cut to \$290 billion; the allowance for states to, once again, tax health care providers to help finance their state match; allowing for provider taxes will likely push up the cost of the program that CBO scores because it will be easier for the State to access Federal matching funds.
- **Quality concerns include:** The adequacy of the quality protections for plans under Medicaid, such as HMOs and other managed care plan; the apparent repeal of the Federal-based enforcement of Federal nursing home standards. (The difference between them and us has always come down to definition and enforcement.)
- **Accountability concerns include:**

THE WHITE HOUSE
WASHINGTON

February 19, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco, Laura Tyson and Alice Rivlin

SUBJECT: National Governors' Association Medicaid Resolution

This memo highlights our major concerns with the National Governors' Association (NGA) Medicaid resolution. It summarizes these concerns, outlines our current position with regard to each issue, suggests some possible fall-back positions, and provides you with a reading of the Democratic Governors' positions on each of these issues. It also includes a summary of the Hill and Interest Group reaction to the resolution. We thought you might find this to be useful background information for our Medicaid meeting with you tomorrow morning.

Background

Governors Chiles, Miller, Romer, Engler, Leavitt, and Thompson are coming back in town tomorrow. They are scheduled to testify at Medicaid hearings on Wednesday and Thursday before the House Commerce and Senate Finance Committees. The Governors' testimony will focus on the recently adopted National Governors' Association resolution, and they will attempt to begin to fill in some of the details behind this resolution. Next week, Secretary Shalala has been invited to appear before the Senate Finance Committee to outline the Administration's response to the NGA resolution.

The six Governors will also meet for three hours tomorrow evening to prepare for their Wednesday hearing. The Democratic Governors want to continue to work closely with us and will meet with us before meeting with the Republican Governors. They rightly believe they achieved a significant victory by getting the Republicans to agree to a new financing mechanism that ensures that "dollars follow people." They also believe that there are a number of provisions that were vaguely drafted, which have been interpreted by many as extremely problematic (such as the NGA benefits section), that can be "clarified" through the normal NGA policy development process. Having said this, the Democratic Governors also acknowledge that they are a number of significant flaws in the NGA agreement that should be addressed.

Where We Agree with NGA

Before outlining our differences and concerns with the NGA resolution, it is important to summarize briefly where we have significant agreement. Your Medicaid reforms include at least 12 NGA-endorsed flexibility recommendations, including arguably the three most important structural changes:

- (1) **The establishment of a new financing mechanism that links and constrains federal financing to enrollment** through the use of an open-ended "umbrella" that assures that "dollars follow people" and that states are protected from economic downturns;
- (2) **The repeal of the Boren amendment and other federal provider reimbursement requirements;** and
- (3) **The liberation of states from the waiver process for:**
 - Managed care
 - Home and community-based care
 - Coverage expansions up to 150 percent of poverty

Outstanding Issues Related to NGA Resolution

There are three sets of issues that will be debated in the legislative process: (1) the "guarantee"; (2) second tier issues; and (3) the Title XIX debate.

The "Guarantee." Those issues that are directly related to the Medicaid "guarantee" (financing, eligibility, benefits and enforcement) will demand most of your attention and are the focus of this memo.

Second Tier, But Critical Issues. There are "second tier" issues, such as nursing home standard enforcement, financial protections for families (like spousal impoverishment), and managed care quality assurance, that will require Administration attention should negotiations progress. These issues helped us personalize the Republican Medicaid cuts and they are viewed as critical by most Democrats. (For example, Senator Pryor feels strongly about the nursing home enforcement issue.)

The Title XIX Debate. Finally, the Republican desire to repeal title XIX and substitute a new Medicaid title raises a host of concerns. Drafting a brand new title for Medicaid in the limited time we have left in this Congress would inevitably lead to unforeseen legal, policy and political consequences. This would include having to determine how to deal with case law -- such as what is the definition of "medical necessity" -- that has developed over the past 30 years. Perhaps most importantly, taking this route would place us in an untenable bargaining position; we would have to give "chits" just to "reinstate" provisions that are current law.

THE NGA RESOLUTION AND THE GUARANTEE: ADMINISTRATION POSITIONS

There are four elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement. Each of these elements is inextricably linked to the others and changes to any one of them must be carefully constructed to avoid undermining the foundation of the guarantee and the program. The following outlines the primary concerns we have with the proposal and summarizes current and possible fall-back Administration positions on these issues.

(1) Financing Concerns:

The NGA proposal uses a financing mechanism that is different from ours but that also assures that dollars follow increases in enrollment. However, it has the following problems:

- **States are guaranteed their base formula allotment even if they choose to reduce coverage.** This provision -- drafted for states like Michigan -- is a significant departure from the historical Medicaid federal/state partnership, where federal financing support rises and falls with changes in coverage.
- **Many states can reduce their state Medicaid matching requirement.** This provision -- hastily inserted for Governor Pataki -- would significantly decrease overall Medicaid spending OR significantly increase Federal spending. It would reduce the maximum state match from 50 percent to 40 percent. If federal spending is capped and all states matched at their minimum levels, the matching rate change would reduce total Medicaid spending by an additional \$140 billion over seven years (on top of the already assumed \$85 billion in federal savings and \$65 billion in state savings). *This could lead to large estimates of coverage loss unless the major eligibility and benefit protections mentioned later in this memo are assured.* If federal spending were not capped, the cost-shift resulting from the lower state match would totally offset the \$85 billion in federal savings.
- **States could substitute state tax dollars with revenue raised through provider taxes and donations.** Since this is "borrowed" money, it would effectively reduce states' real spending on Medicaid. Because this would make it easier to raise state matching dollars, CBO (and OMB) would likely conclude that this provision would also significantly reduce Federal savings.

Administration Position: Our CBO-scored per capita cap approach to Medicaid cost containment has a "dollars follow people" mechanism that is more direct than the NGA umbrella and does not include any of the problems mentioned above. We would keep the current matching formula, but propose that a national commission be established to make recommendations on how to address perceived inequities.

Possible Fall-Back Position: The Republican Governors are likely to refuse an Administration-like per capita cap financing mechanism. We may be able to live with a NGA-like financing approach if, as the Democratic Governors' intended, it truly allows dollars to follow people and if the state matching reduction and the provider tax/donation provisions are fixed. Governors Chiles, Romer, and Miller all have indicated they share our concerns with these provisions and support our position. (In fact, the six "Medicaid" Governors never discussed the provider tax and state matching reduction issues; they were added as last second amendments to the resolution.)

(2) **Eligibility Concerns:**

- Repeals current law that phases-in coverage for 1.5 million poor children between the ages of 13 and 18. OMB estimates a maximum of \$6 billion in federal savings if all states do not phase-in coverage. (This would overturn a law enacted by President Bush in 1990.)
- Allows states to define disability, subject to HHS approval, instead of requiring all states to meet a minimum federal definition. This proposal could result in widespread variation in eligibility determinations among states and could threaten the eligibility guarantee for people with disabilities.

Administration Position: We retain the kids phase-in and use the welfare reform's approach to address the Governors' concern about disability eligibility abuse. This gives Governors the option not to designate as "disabled" those persons who are alcoholics and chemical and substance abusers, as well as tightens the eligibility definition for children under SSI.

Possible Fall-Back Position: No fall-back for the kids coverage expansion. On disability, we could limit eligibility for other groups if the Governors can demonstrate that there have been eligibility abuses. If this compromise is still not acceptable, we could consider allowing states to define disability, but with much stricter criteria that the Secretary must use to evaluate designations. (This latter approach needs to be politically vetted.) The Democratic Governors would probably be fine with either of these positions, although Governor Romer thinks the states should not be defining disability eligibility.

(3) **Benefit Concerns:**

- Eliminates the current "adequacy" requirement for benefits and gives states unlimited discretion to determine the amount, duration and scope of services within benefit categories. Under these provisions, the HHS Secretary would have no legal basis for concluding that a one-day hospital benefit was insufficient to meet the federal requirement for a hospital benefit.

- **Repeals current statewideness and comparability requirements for optional benefits.** Without these provisions, states could offer different benefits to different groups of recipients or provide different benefits in different areas of the state. For example, states could decide to provide a no-deductible/no cap prescription drug benefit for a disabled person who had a stroke and a drug benefit with a \$500 deductible and a \$1,000 cap for a person with AIDS.
- **May repeal the statewideness and comparability requirements for mandatory benefits.** If this is the case, states could offer 5 months of hospital services for children and 2 weeks for the disabled.
- **Redefines the treatment portion of EPSDT (Early and Periodic Screening, Diagnosis and Treatment) so that states need not cover all Medicaid optional services for children.**

Administration Position: The Administration maintains that these concerns must be addressed or the national guarantee to benefits is legitimately called into question. Your proposal retains the current benefit package and protections. On EPSDT, it clarifies that benefits provided to children under the treatment requirement need not be given to any other population (under the comparability requirements.)

Possible Fall-Back Position: Maintain the benefits adequacy standard. Maintain current protections for mandatory benefits, but negotiate significant changes in the requirements on the optional benefits, including eliminating or significantly liberalizing current comparability and statewideness requirements. Negotiate further modifications to the "treatment" requirement within EPSDT, including that the requirement need not extend beyond a certain age group OR the possibility that the benefits provided need not exceed the states' optional package. (These are "hot-button" options that would no doubt have to be carefully rolled out if pursued.) **The Democratic Governors support retention of the "adequacy standard," but -- like the NGA -- have not yet finalized their position on the other benefit issues.**

(4) **Enforcement Concerns:**

- **Eliminates any federal cause of action under Medicaid by beneficiaries, health care providers and health plans.** Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

There are four major concerns with this proposal. First, the eligibility would vary between states because state courts would interpret the law differently; the same person could be covered in one state but not in another. Second, fewer remedies would be available under state law than under federal law. Third, Medicaid would be the only federal statute that confers individual rights that could not be enforced in federal courts by its intended beneficiaries.

Finally, the HHS Secretary would be unable to litigate adequately on behalf of individuals because there would be significant new administrative burdens placed on the Department and because the only remedy available to the Secretary would be the withdrawal of funds to the state.

Administration Position: We repeal the Boren amendment and make it clear that providers have no right to sue over payment rates. We retain current law for eligibility and benefit claims brought by individuals.

Possible Back-Up Position: In addition to the outright repeal of the Boren Amendment, we could also eliminate the private right of action by providers and health plans completely (so that they could no longer sue over provider qualifications or other issues not related to reimbursement).

On causes of action brought by recipients, we could follow up on a suggestion made by Governor Chiles and propose separating eligibility claims from some benefit claims. Under this approach:

- There would be no suits by providers health plans over reimbursement rates or any other issue.
- Everyone filing a claim would be required to exhaust administrative remedies. A recent survey of state Medicaid agencies found that in the 40 states that responded, less than 5% of fair hearing decisions were appealed to a court. In California, for example, 4,600 fair hearings were held and less than 1% were appealed. In Wisconsin, 376 fair hearings were held, and 8 (2%) were appealed. (Texas Legal Services Center, 1994.)
- Most disputes over benefits would be heard in state court. Benefits claims would only be heard in federal court if there were an allegation that the state plan or a contract between the state and a provider violated federal law.
- Claims brought by individuals over eligibility would be heard in federal court. Across the country, there were 6 reported cases over eligibility in 1994, 8 in 1993, 6 in 1992 and 8 in 1991. (National Health Law Program, Inc., 1995.)

This is not a high priority issue for the Democratic Governors, and we believe that they would support our approach. However, they have reported that the Republican Governors have a philosophical aversion to any Federal right of action. What is clear from our conversations with the NGA staff, though, is that the Governors have not focused on this issue in any great detail.

Conclusion

We hope this information is helpful to you in deciding how the Administration should position itself on the Medicaid front. Attached is a background document on the congressional and interest group response to the NGA proposal.

In evaluating the negotiating position the Administration should pursue it is clear that there are two strategies to consider. The first approach would be to maintain your current Medicaid position, which keeps minimum and federally-guaranteed and enforced eligibility, benefits, and financing. Pursuing this strategy would mean that the focus of negotiations would be on the flexibility provisions in administering the program, rather than on the core structure of the program.

The second approach would be to send a signal of additional flexibility on Medicaid and accept more of a block grant-like approach. Pursuing this negotiating strategy would be akin to the welfare discussions and would necessitate an active effort to protect guarantees that are already assured under current law.

Regardless of the approach taken, we would advise that any real or perceived compromise to the Republicans on welfare should be used as leverage to improve your position on Medicaid. We look forward to talking about these issues tomorrow.

CONGRESSIONAL AND INTEREST GROUP RESPONSE TO NGA

- **Hill Response to the NGA Resolution:** Most Republicans, through the RNC and comments by the Speaker, are strongly embracing the NGA proposal. They claim that it is a virtual mirror-image of their Medicaid proposal. The RNC is literally passing out paper declaring "victory." The only exception to a complete endorsement from the Republicans is related to their perception of the financing mechanism. They are sending signals that they oppose the open-ended nature of it and are suggesting that they may push for some type of cap. (The Democratic Governors have already indicated that they would "walk" from the deal if this occurred.)

Republicans appear to want to push a "bipartisanly-supported NGA" bill out and dare us to criticize it. It is for this reason that they have so quickly scheduled hearings for this Wednesday and Thursday, and have invited Secretary Shalala to testify next week before the Finance Committee. Having said this, they are reportedly being responsive to NGA calls to not prematurely unveil a Republican "NGA Medicaid" bill and risk a meltdown of the bipartisan agreement. There is no question, however, that they are (behind the scenes) drafting legislation and attempting to get CBO to score it and it is not inconceivable that they may introduce something prior to Secretary Shalala's testimony.

The Republican reaction has fueled the suspicions of the Democrats and, with extremely few exceptions, there has been a generally negative reaction to the NGA proposal. The "base" Democrats, like Henry Waxman, have been extremely critical of the proposal and have charged that it offers no guarantee and may even be a block grant in sheep's clothing.

Congressman Stenholm and Congressman Dingell were apparently quite disappointed in the lack of state accountability, the reduction in state match, and raised concerns about the adequacy of the legal enforcement provisions. They argue that it is not unreasonable to expect a federally-enforced, national eligibility and standards floor in return for a large federal investment. To back up their point, their staffs have been circulating a chart that shows how the coalition proposal would provide \$840 billion to state Medicaid programs, at the same time the states are trying to significantly decrease their Medicaid expenditures.

On the Senate side, Senator Breaux distanced himself a bit and called for hearings so he could fully understand the implications of the proposal. His staff reports that Senator Breaux thought the Democratic Governors were going to be able to "cut a better deal than they did." On the moderate Republican side of the aisle, Senator Chafee privately raised concerns about the proposal and suggested it appeared to be something akin to a federal maintenance of effort with too little accountability.

Clearly, however, both Senators' Breaux and Chafee want to keep the Medicaid discussions alive for the sake of a budget deal and will continue to avoid being overly critical in public. According to Senator Breaux's staff, the primary authors of any alternative Medicaid bill will likely be Senator Chafee and Senator Graham. Lastly, there are also reports that Senator Roth's staff is working with the House Commerce Committee to draft up their own version of the "NGA resolution." Since they have fairly "green" Medicaid staff who have previously worked at the House Commerce Committee, it is likely that their bill will largely mirror the House Republican bill.

- **Interest Group Response to the NGA Resolution:** We have received only negative reactions from the groups, including the unions, the American Hospital Association, the American Academy of Pediatrics, the Children's Defense Fund, the Alzheimers' Association and the Consortium for Citizens with Disabilities. The groups, particularly those who represent children and the disabled, feel that enactment of a proposal like the Governors' resolution would significantly increase the number of uninsured and renege on what they believe is a jointly-held commitment with the Administration to expand, or at least not reduce, the number of insured. The AIDS groups are particularly concerned because they greatly fear the benefit changes and the state-by-state definition of disability provision.

The other interest groups are largely staying quiet and waiting to see how we respond to the likely "clarifying" changes expected to emerge from the NGA over the next week or so. Some of them are taking this position because they do not want to undermine our position. Others are holding off because they want to be perceived as "players" in the upcoming negotiation.

The Office of Public Liaison believes that your strong stand on Medicaid has built bridges that extend far beyond the traditional Medicaid constituencies. Public Liaison believes that significant changes from these groups' perception of our past Medicaid position may damage this strong alliance and may be difficult to repair.

February 19, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco and Laura Tyson

SUBJECT: Medicaid and the National Governors Association Resolution

THE NGA RESOLUTION

Where We Agree with NGA

The President's Medicaid reforms includes at least 12 priority NGA-endorsed flexibility recommendations, including arguably the three most important structural changes:

- (1) **The establishment of a new financing mechanism that links and constrains federal financing to enrollment, thereby assuring that "dollars follow people" and states are protected from economic downturns;**
- (2) **The repeal of the Boren amendment and other federal provider reimbursement requirements; and**
- (3) **The liberation of states from the waiver process for:**
 - **Managed care**
 - **Home and community-based care**
 - **Coverage expansions up to 150 percent of poverty**

Outstanding Issues Related to NGA Resolution

In any discussion of Medicaid reforms, there are countless issues that will be raised and debated in the legislative process. In general, the issues the White House will likely have to focus on are:

The "Guarantee." Some issues, like those that are directly related to the Medicaid "guarantee" (financing, eligibility, benefits and enforcement), will demand most of our attention and are the focus of the attached document.

Second Tier, But Critical Issues. There are "second tier" issues, such as nursing home standard enforcement, financial protections for families, and quality assurance, that will require Administration attention should negotiations progress successfully.

The Title XIX Debate. And finally, the Republican desire to repeal title XIX and substitute a new Medicaid title raises a host of legal and policy concerns that we cannot even begin to fully contemplate. For example, it would force us (or the states) to go through the ugly process of redefining the legal definition of "medical necessity." (It would also place us in an untenable bargaining position; we would have to give "chits" just to "reinstate" provisions that are current law.)

THE NGA RESOLUTION AND THE GUARANTEE: ADMINISTRATION POSITIONS

There are 4 elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement. Each of these elements are inextricably linked and changes to them must be carefully constructed to avoid undermining the foundation of the guarantee and the program. The following outlines the primary concerns we have with the proposal and summarizes current and possible fall-back Administration positions on these issues.

(1) Financing Concerns:

- **States are guaranteed their base formula allotment even if they choose to reduce coverage.** (This provision -- drafted for states like Michigan -- is a significant departure from the historical Medicaid federal/state partnership, where federal financing support rises and falls with changes in coverage.)
- **Many states can reduce their state Medicaid matching requirement.** (This provision--hastily inserted for Governor Pataki would significantly decrease overall Medicaid spending. In fact, estimates from HHS indicate that the \$85 billion in federal savings would translate into \$290 billion in total spending reductions if all states matched at the minimum level.)
- **States could substitute state tax dollars with revenue raised through**

provider taxes and donations. Since this is "borrowed" money, it would effectively reduce states' real spending on Medicaid. This, and the previously-mentioned provisions that make it easier for states to tap into the federal treasury, may have an impact on how OMB/CBO would score this proposal.

Administration Position: Our CBO-scored per capita cap approach to Medicaid cost containment has a much more direct "dollars follow people" mechanism. We do not have any provisions for reduced state matching rates and do not permit the reinstatement of provider taxes/donations. Moreover, states who reduce their coverage are not permitted to retain federal matching dollars in excess of this coverage.

Possible Fall-Back Position: The Republican Governors are likely to refuse an Administration-like per capita cap financing mechanism. We may be able to live with a NGA-like financing approach if it lives up to the Democratic Governors' intent and it eliminates the state matching reduction and the provider tax/donation provision. **The Democratic Governors would support these modifications.**

(2) **Eligibility Concerns:**

- **The NGA proposal repeals current law that phases-in coverage for 1.5 million poor children between the ages of 13 and 18.**
- **The NGA proposal allows states to define disability, subject to HHS approval, instead of requiring all states to meet a minimum federal definition. (As currently drafted, this proposal has potential to result in widespread variation in eligibility determinations among states and could threaten the eligibility guarantee for people with disabilities.)**

Administration Position: We retain the kids phase-in and we would use the welfare reform's approach to address the Governors' concern about disability eligibility abuse. This would provide Governors with the option to not designate as "disabled" those persons who are alcoholics and chemical and substance abusers.

Possible Fall-Back Position: No fall-back for the kids coverage expansion. For the disability eligibility issue, we could add other categories of "optional" eligibility designations that the Governors can illustrate represent eligibility abuses. If this compromise is still not acceptable, we could consider allowing states to define disability, but with much stricter criteria that the Secretary must use to evaluate designations. (This latter approach needs to be politically vetted.) **Again, the Democratic Governors would be fine with this position.**

(3) **Benefit Concerns:**

- **The elimination of the current "adequacy" requirement for benefits and gives states unlimited discretion to determine the amount, duration and scope of services within benefit categories. (Under these provisions, the HHS Secretary would have no legal basis for concluding that a one-day hospital benefit was insufficient to meet the federal requirement to provide a hospital benefit.)**
- **The repeal of current statewideness and comparability requirements for optional benefits. (Without these provisions, states could offer different benefits to different groups of recipients, or different benefits to different areas of the state. For example, states could decide to provide a no deductible prescription drug benefit for the elderly and a drug benefit with a \$500 deductible with a \$1,000 cap to people with AIDS.)**
- **The possible repeal of the statewideness and comparability requirements for mandatory benefits. (If this is the case, the state could offer 5 months of hospital services for children and 2 weeks for the disabled.)**
- **The redefinition of the treatment portion of EPSDT (Early and Periodic Screening, Diagnosis and Treatment) so that "states need not cover all Medicaid optional services for children."**

Administration Position (Benefits): The Administration retains the current benefit package and protections. On EPSDT, it clarifies that benefits provided to children under the treatment requirement need not be given to any other population (under the comparability requirements.)

Possible Fall-Back Position: Maintain current protections for mandatory benefits, but negotiate significant changes in the requirements on the optional benefits, including eliminating or significantly liberalizing current comparability and statewideness requirements. Negotiate further modifications to the "treatment" requirement within EPSDT, including that the requirement need not extend beyond a certain age group OR the possibility that the benefits provided need not exceed the states' optional package. (These are "hot-button" options that would no doubt have to be carefully rolled out if pursued.) **The Democratic Governors would likely desire to go further on these issues than we may, but it is likely we could work this out.**

(4) **Enforcement Concerns:**

- **The NGA proposal eliminates a federal cause of action by Medicaid recipients.** (Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. The most significant problem is that, under this proposal, eligibility will vary between states because state courts will interpret the law differently. In addition, fewer remedies are available under state law than under federal law).

Administration Position: Retains federal right of action -- current law.

Possible Back-Up Position: The Republicans will not accept current law or, for that matter, practically any alternative to their approach. However, to show our interest in attempting to address their concerns, we could follow-up on a suggestion made by Governor Chiles and separate eligibility claims from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

This is not a high priority issue for the Democratic Governors, but they believe that it may be necessary for us to give on this provision in order to get a deal with the Republicans. There are, however, obvious and major implications of going beyond our back-up position. Movement away from our position most certainly requires a serious policy, legal and political review.

THE WHITE HOUSE

WASHINGTON

February 20, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: TODD STERN *TDS*

SUBJECT: NGA Governors' Proposal

This summarizes the Rasco/Tyson/Rivlin memo submitted for your 10 am meeting this morning. The NGA plan raises concerns about each of the four elements that comprise the Medicaid guarantee -- financing, eligibility, benefits and enforcement.

Financing. NGA establishes an umbrella to guarantee that "dollars follow people", but (i) States get guaranteed allotments even if they reduce coverage, contrary to current system where federal financing rises or falls with changes in coverage; (ii) States can reduce match from 50% to 40%, meaning either federal spending goes way up or, if federal spending is capped, overall cuts in Medicaid go way up; (iii) States could substitute state tax dollars with provider taxes/donations, effectively reducing States' real Medicaid spending. **Our position** -- per-capita cap; **fall-back** -- an umbrella only if state matching and provider tax/donation problems are fixed.

Eligibility. NGA repeals phase-in covering 1.5 million kids 13-18; and allows States to define disability, leading to widespread variation in coverage. **Our position** -- retain kids phase-in and lets States limit disability definition for alcoholics and other substance abusers and tighten definition for kids under SSI; **fall back** -- let States limit eligibility more if they can show abuses.

Benefits. NGA eliminates "adequacy" requirement so States can determine amount, duration and scope of services; repeal statewideness and comparability for optional benefits and maybe for mandatory; redefines EPSDT so States need not cover all optional services for kids. **Our position** -- retain current benefits and protections; **fall back** -- change requirements on optional benefits and modify EPSDT "treatment" requirement.

Enforcement. NGA eliminates federal private right of action for beneficiaries, providers and health plans raising four concerns -- varying state court interpretations; fewer remedies; Medicaid would become only federal statute conferring private rights that couldn't be enforced in federal court; HHS Secretary couldn't litigate effectively on behalf of individuals. **Our position** -- repeal Boren amendment to make clear providers can't sue over payment rates, but retains current law for individuals' eligibility and benefit claims; **fall back** -- eliminate private right of action for providers and health plans, and put most benefit disputes (other than those claiming violation of law) in state courts.

The memo also notes that there are second-tier issues apart from the guarantee (e.g., nursing home standard enforcement, financial protections for families); and questions whether Title XIX should be replaced with a new title or retained and modified.

THE WHITE HOUSE

WASHINGTON

March 7, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: John Hilley

SUBJECT: Current Status of Breaux/Chafee Medicaid Alternative

cc: Carol Rasco, Alice Rivlin and Laura Tyson

During the last two days, the Members of the Breaux/Chafee balanced budget group have been meeting on the Medicaid provisions of their balanced budget proposal. If the tentative decisions they have made hold, the cuts and structural reforms in their package will virtually mirror your current proposal or, at minimum, be consistent with some of the compromises you have indicated would be acceptable. This memo, which Chris Jennings helped me draft, provides a quick summary of their current proposal and a sense of the politics and timing surrounding it.

Background on Current Breaux/Chafee Medicaid Policy

We have always evaluated any Medicaid proposal on the degree to which it provides for needed, new flexibility to the Governors and how well it ensures the financing, eligibility, benefits, and enforcement provisions that we believe are essential elements of the Medicaid "guarantee." The current Breaux/Chafee Medicaid proposal has either adequately addressed our previously stated concerns about the NGA resolution or, as is the case with the enforcement issue, has yet to make a final call on a problematic provision. Specifically:

Flexibility: They incorporate all of your major new state flexibility provisions, including the repeal of Boren, the repeal of the cost-based reimbursement requirement for community health centers, and the elimination of the waiver process for states implementing managed care or attempting to expand coverage. They also change the status of community health center services to an optional, rather than a mandatory service.

Financing: They build off the NGA financing formula, but eliminate the reduced state matching and the new provider tax provisions that the Governors advocated. Like your per capita cap, the structure seems to assure that federal dollars increase with enrollment. Also as in your financing proposal, they assume DSH cuts, with a portion of the savings being dedicated to set-asides for undocumented aliens (as was the case in the Republican bill as well) and community and rural health centers.

Eligibility: They reinstate the children 13-18 phase-in provision and they keep a federal definition of disability, but amend it as in the welfare agreement. (As you may recall, this makes coverage optional for alcoholics, chemical and substance abusers, and some functionally-impaired SSI children.)

Benefits: They appear to keep current law and standards for both mandatory and optional benefits, with the exception of giving the HHS Secretary the authority to narrow the definition of treatment services under EPSDT. (Their benefits recommendations are, therefore, more "liberal" than the fall-back position that we have discussed with you.)

Enforcement: Although they reportedly are sympathetic to maintaining a federal right of action of individuals, they have not made a final decision on this issue. It is clear, however, that they are looking at options that you have supported previously, including the requirement that recipients go through the entire administrative appeals process prior to being able to file a case against the state.

Miscellaneous: They are retaining current federal nursing home standards and enforcement provisions. They are very sympathetic to keeping Medicaid in Title XIX, but they have not made a final decision on this issue.

Process

While developments surrounding the Breaux/Chafee Medicaid package are extremely encouraging, they cannot be viewed as "real" until and unless they are publicly released. The most important, and as yet unanswered, question is how Senator Dole will react to the package. Since the Republican Governors will not find this compromise to their liking, Senator Dole may come to a similar conclusion and pressure the moderate Republicans to backtrack. Even if they don't backtrack, it would be conceivable to see Republicans take the position that they support this package ONLY in the context of a balanced budget. They might say that they took a more moderate Medicaid approach only because they were "winning" on some of the other Republican entitlement priorities. For example, they might (internally) cite their 31 percent Medicare Part B premium provision that is assumed in the Breaux/Chafee package. If they take this "only in the context of a balanced budget" position, we may find any Republican-supported Medicaid/Welfare amendment on a debt limit to be a much more harsh and unacceptable Medicaid proposal than the one outlined above.

Timing

It is uncertain when the Breaux/Chafee group will go public with their new Medicaid and balanced budget proposal. They want to get it scored by CBO before they do, but they also understand that each passing day makes it more unlikely any package will have sufficient momentum to pass the Congress. It seems likely, however, that it will take at least another week before they will be able to release their package.

We will continue to keep a close watch on the Breaux/Chafee group. However, our best strategy seems to stay a step away from their work. If we are associated with it, the Republicans (and even some Democrats) may feel obliged to move to a more conservative position. We will keep you posted on developments.

Congressional Moderates' Position on Medicaid Reform

	House Coalition	Senate Moderates
FLEXIBILITY		
<u>President's flexibility package</u> -- Managed care and home and community services without Federal waivers. Flexibility on quality standards.	+	+
FINANCING		
<u>Dollars follow people/economic downturn formula.</u>	+	+
<u>No reduction in state matching rate.</u>	+	+
<u>Provider tax protections.</u>	+	+
ELIGIBILITY		
<u>Coverage for kids 13-18</u> -- retains current law that phases in kids.	?	+
<u>Federal definition of disability</u> -- with welfare exclusion of alcoholics, chemical & substance abusers from mandatory coverage.	+	+
BENEFITS		
<u>Retain 'adequacy' standards</u>	+	+
<u>Retain statewideness/comparability standards.</u>	+	+
<u>EPSDT</u> --have Secretary designate benefits that are being abused.	+	+
ENFORCEMENT		
<u>Repeal Boren amendment.</u>	-	+
<u>Federal right of action</u> -- preserve Federal right of action for eligibility and benefits disputes.	?	+
STRUCTURE/SECOND TIER ISSUES		
<u>Preserve current law protections by drafting off of Title XIX.</u>	+	+
<u>Quality assurance: managed care/nursing home standards, enforcement.</u>	0	+
<u>Family financial protections.</u>	+	+
OVERALL SAVINGS		
Administration \$59 billion; House Coalition \$85 billion; Senate \$62 billion.		

(+) indicates a position that is consistent with the Administration; (-) indicates position inconsistent with the Administration; (0) indicates partial support; (?) indicates unclear position.

MEDICAID BACKGROUND

Attached are two recent memos outlining our concerns about the National Governors' Association (NGA) Medicaid agreement and possible acceptable alternatives. The February 20th memo outlines our fall-back position and the March 19th memo outlines where the Breaux/Chafee coalition now stands on Medicaid. (The good news about Breaux/Chafee is that their current -- as yet unreleased -- provisions have addressed ALL of our major concerns about the NGA proposal).

In short, the concerns we have about the Governors' proposal can be classified into four broad categories: (1) Eligibility; (2) Benefits; (3) Enforcement; and (4) Financing. These categories also can be used to help describe the make up of the Medicaid "guarantee" (it is best not to use the word entitlement) that the President seeks to protect.

- (1) **Eligibility: Who gets the guarantee?** Under the Governor's proposal, 2.5 million kids ages 13-18 and an untold number of people with disabilities (because states will now be allowed to define disability) will no longer be guaranteed coverage. (The Breaux/Chafee plan retains current law with regard to these populations.)
- (2) **Benefits: What benefits are guaranteed?** While the Governors maintain the current required benefit package, it does not retain the standards to make certain these benefits are real. For example, it does not require that these benefits are provided statewide and could allow states to define benefits in a discriminatory way for different populations.
- (3) **Enforcement: How is the guarantee legally enforced?** The NGA proposal eliminates the right of action within the Federal court system for those recipients who feel they have not been provided the services with which they are guaranteed. Instead, it proposes to have 50 different state courts enforce this guarantee, thus virtually ensuring that there will be multiple definitions of the national Medicaid guarantee of eligibility and benefits. As far as we know, this would be the first Federal statute that eliminates this right for eligibility disputes.
- (4) **Financing: How is the financing guaranteed?** The NGA proposal improved on the Republican block grant in that it ensured that states will automatically get increased federal support should enrollment unexpectedly increase (such as in an economic downturn.) However, their provision to allow states to lower their state matching dollars and still collect the same amount of Federal dollars, combined with their expansion in the use of provider taxes to access Federal funds, will either significantly increase Federal costs or, if the Federal match is capped, will effectively be a block grant. Neither outcome is acceptable.

Current Administration Position Vis a Vis Medicaid

We are now talking to the Democratic Governors about finding a way for them to exit from the NGA discussions. It is becoming more and more clear that the Republicans on the Hill are simply using the Governors for cover to cut and block grant Medicaid. The latest rumors indicate that the Republicans are even rejecting the most positive element of the NGA agreement, i.e., their provision to ensure that Federal dollars will follow enrollment increases. (They may release their new "vision" of the NGA agreement as early as next week.)

If the Republicans go back to capping (block-granting) the Medicaid program, the Democratic Governors will use this as an excuse to break free from the NGA process. They will say that the only way to get an acceptable agreement that can be enacted is to conduct Medicaid reform discussions on the Hill in a bipartisan manner. They will likely cite the Breaux/Chafee coalition as a good example of this. We will also be asking the Democratic Governors to publicly state that welfare reform should not be held hostage to ongoing (and yet to be concluded) discussions on Medicaid.