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*** ~~CONFIDENTIAL~~ ***

November 25, 1996 revised

POTENTIAL MEDICAID FY 1998 PROPOSALS

*Note: When available, a crude estimate of the FY 98-02 savings or cost of each proposal, reflected as low impact (L), medium impact (M), or high impact (H), is included in the left margin.

Italicized proposal are new proposals; non-italicized proposals are proposals from the 1996 per capita cap proposal.

Medicaid Proposals included in the Initiative for Children

- Baseline cost? • *Improve eligibility process to ensure eligibles are enrolled (Administrative)*
- Baseline cost? • *Expand outreach (Administrative)*
- cost L • *Market Medicaid enrollment to public (Administrative)*
- cost L • *Optional eligibility group for older children --accelerate enrollment of children's poverty-related eligibility groups*

Targeting Financial Assistance

- \$10 B • Reduce disproportionate share hospital (DSH) payments to states and establish Federal standards to target certain essential providers:
 - For example allocate 70-75% to public hospitals, 10-15% to FQHCs, and 10-20% other providers
 - Insure that DSH payments go directly to providers -- Modified
 - DSH proposal would be linked to change in proposal related to cost-based reimbursement for FQHCs

Working Families Proposals

- cost H • *Allow eligibility simplification at percent of poverty*
- cost H • *Modify Medically Needy income threshold*
- neutral • *Create process to permit permanent extension of 1115 Demonstrations that meet Federal criteria*
- save L • *Support State expansions to expansion populations by allowing optional premiums for expansions populations w/ incomes > 100% of poverty*

State Flexibility

- o **Payment Rates**
- save L • Repeal the Boren amendment for hospitals

- minimal • Modify Boren amendment for nursing homes
- save L • Move to eliminate cost-based reimbursement for health clinics with transition linked to DSH proposal
- neutral • Eliminate OB/Peds physician qualification requirements
- neutral • Eliminate annual state reporting requirements for certain providers (Ob/Peds)

o Administrative

- save L • Simplify computer systems requirements
- save L • Eliminate personnel requirements
- cost L • *Require all states to participate in person-based data system (MSIS)*
- cost L • *Deem new SSI eligibles in first month*

o Managed Care

- cost ? • *Modify upper payment limit for capitation rates, enhance actuarial standards*
- ??? • Convert 1915(b) waivers to State Plan Amendments
- ??? • Eliminate 75/25 rule
- ??? • *Modify Federal review of managed care contracts with higher threshold - Modified.*
- neutral • *Develop quality review and monitoring procedures (Administrative)*
- neutral • *Create process to permit permanent extension of 1115 Demonstrations that meet Federal criteria*

Other

o Long Term care (LTC) Access

- cost L • *Allow States to simplify income and asset rules for institutionalized individuals*
- ?? • *Repeal authority for criminal penalties for persons who transfer assets to qualify for Medicaid*
- neutral • *PACE Demonstrations -- Grant full permanent provider status for entities*

o Nursing Home Reform

- neutral • *Nurse Aide Training Waivers*
- neutral • *Give States incentive to use alternative remedies to correct nursing home quality of care deficiencies*
- neutral • *Eliminate the duplicative inspection of care requirements in mental hospitals and ICFs/MR -- rely on survey and certification review process*
- neutral • *Alternative Sanctions in ICFs/MR*
- cost L • *Survey and Certification. match from 75% to 85%*

o Home and Community Based Services (HCBS)

- cost H • *Convert HCBS 1915(c) waivers into State Plan Option*
- cost L • *Legislate demonstration authority to allow direct payment to individuals*

- for HCBS*
- cost ? • *Eliminate the institutional level of care requirement for home and community-based services*
 - cost L • *Provide enhanced 75% Administrative Matching Rate for HCBS administration*

o American Indians/Alaska Natives

- neutral • *Allow tribal/urban Indian providers to bill directly for Medicaid*
- cost L • *Extend 100% Federal matching to urban Indian organizations*
- minima • *Provide Federal survey and certification of tribal/village providers*
- neutral • *Guarantee qualified IHS, tribal, and urban Indian organization providers (ITUs) the right to participate in State managed care networks*
- neutral • *Allow ITUs to participate in managed care systems as primary care case managers (PCCMs)*
- neutral • *Require hospitals to accept Medicare-like rates for non-Medicare Indian patients paid for by ITUs (as they must now for patients paid for by CHAMPUS & VA) -- Medicare*
- cost L • *Allow ITU free-standing clinics to bill Medicare Part B-- Medicare*

o Working Disabled to be Included in SSA Package

- cost M • *Provide premium-free Hospital Insurance (Part A) to all working disabled beneficiaries under Medicare -- included in Medicare and SSA legislative proposal lists*
- cost L • *Allow SSI beneficiaries who earn more than the 1619(b) thresholds to buy into Medicaid -- included in SSA list*

Medicaid Proposals Related to Welfare and Immigration Reform

o Welfare

cost H • *State option to extend transitional Medicaid for an additional 12 months*

o Immigration

cost M • *Optional eligibility for "qualified aliens" who would be eligible for SSI cash except for the welfare reform ban*

cost L • *Restore parity for Cuban/Haitian entrants*

?? • *Add limits to amount of Medicaid sponsor deeming*

?? • *Exclude certain resources from Medicaid sponsor deeming*

cost M • *Allow prenatal care option for newly arriving legal immigrants*

cost H • *State option to provide Medicaid to newly arriving legal immigrant children and pregnant women*

Proposals Included in Per Capita Cap Proposal, Not on FY98 List

- Per capita cap proposal
- Repeal requirement for States to pay private insurance premiums when cost-effective.
- Permit all States to roll back higher, optional income levels for pregnant women and children to the Federally mandated level.
- Repeal cooperative agreements requirements.
- Establish commission on equity in Medicaid financing (FMAP).
- Two provisions related to per capita cap financing structure:
 - Modify and strengthen Medicaid Eligibility Quality Control system.
 - New reporting requirements to ensure program integrity.

FAX TRANSMISSION

COUNCIL OF JEWISH FEDERATIONS

1640 RHODE ISLAND AVENUE, SUITE 500

WASHINGTON, D.C. 20036

(202) 736-5881

FAX: (202) 785-4937

To: Chris Jennings
cc: Diana Fortuna

Date: 12/9/96

Pages: 9 pages, including this
cover sheet.

From: Lee Goldberg
Legislative Associate

Subject: Medicaid and Welfare Reform Implementation

Comments:

Enclosed is a brief explanation of the issues and our most recent communications with HCFA, which I am sending as per our conversation on Thursday after the meeting with Families USA. I appreciate your attention to this matter. Let me know if there is any additional information you may need.



Council of Jewish Federations

WASHINGTON ACTION OFFICE • 1640 Rhode Island Ave., NW, Suite 500 • Washington, DC 20036 • (202) 785-5900 • FAX (202) 785-4937

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DIANA AVIV
Director,
Washington Action Office

December 6, 1996

Dr. Bruce C. Vladeck
Administrator
Health Care Financing & Administration
Department of Health and Human Services
200 Independence Ave., SW, Room 314G
Washington, DC 20201

Dear Dr. Vladeck:

On behalf of the Council of Jewish Federations, I am writing to express our concerns about implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). As you know, President Clinton has said that the recent changes in the federal welfare law are too harsh in its treatment of legal legal immigrants and refugees. On November 26, 1996, the Health Care Financing Administration (HCFA) issued its draft Medicaid manual providing the states with guidance in implementing PRWORA. Although HCFA has done a commendable job in clarifying many important policy issues, we are concerned that the manual fails to cover a number of key issues that are likely to decrease the harsh impact of the recent changes in the welfare law.

As you know, the Council of Jewish Federations (CJF) is a national organization representing 189 local Jewish Federations. CJF serves as the central planning organization and assists Federations in the fundraising efforts for domestic and overseas needs. Local Federations help to coordinate Jewish health and social services for approximately 800 municipalities throughout the U.S. and Canada. This Jewish social service network embraces more than 6.1 million Jews and provides needed assistance to those in the Jewish community and many in the general community as well. There are at least four issues that we feel strongly about and that require your immediate attention.

Assuring the State Option to Continue Coverage

In enacting PRWORA, Congress gave states the option of continuing to provide Medicaid benefits under the categories of coverage that is left as a state option. Our concern is that many states do not have appropriate

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optional categories and many others that do will be reluctant continue coverage if exercising this option entails additional administrative costs.

One way to ensure that states maximize Medicaid eligibility is to permit them to "deem" as Medicaid eligible those legal immigrants and refugees who meet the SSI income and resource standards but who have lost their SSI eligibility as result of PRWORA. In the past, the HCFA has employed this type of "deeming" for individuals who lose their Medicaid coverage due to changes in SSI law that make them ineligible for that program. Under PRWORA, the authority to determine has been granted to the states and HCFA should issue guidance to the states reiterating the authority of states to continue coverage for legal immigrants and refugees without having to amend their state Medicaid plan.

So far, HCFA has been silent on this issue. Its November 26th draft Medicaid manual does not address the power of the states to deem legal immigrants and refugees eligible for Medicaid and we urge the Administration to clarify this issue in any revision to that document.

Assuring Due Process:

We appreciate the efforts that HCFA and other agencies in the Administration are making to communicate with states regarding the need to adhere to due process protections that have long been recognized in the Medicaid program. Unfortunately, there is evidence that some states are planning on terminating Medicaid beneficiaries who lose their SSI benefits without conducting a full redetermination of their eligibility. We urge the Administration to continue to take all steps necessary to insure that beneficiaries who face the loss of benefits are accorded due process protections required by law. Specifically, HCFA must add to its November 26th Medicaid manual language that requires states to conduct a full redetermination process and to offer legal immigrants and refugees an opportunity for a hearing, pursuant to federal regulations. Legal immigrants and refugees who are found ineligible should be permitted to continue to receive benefits while they appeal an adverse action.

Limiting Federal Matching Funds

We are concerned by language in HCFA's November 26th Medicaid manual that may limit federal financial participation (FFP) in Medicaid for individuals whose eligibility must be redetermined. According to the HCFA document, federal matching payments will be limited to a period that may be as short as 20-days and as long as 52-days after the start of the redetermination process. In areas where there is a significant immigrant population, the state Medicaid agency may be overwhelmed by the need to process within the time limits the tens of thousands of individuals who require a determination of eligibility - - especially if states are not permitted the option of "deeming" legal immigrants and refugees eligible for Medicaid under an optional state program. We are concerned that such time limits provide a strong incentive for states to act fast and terminate benefits. Limiting the time period for federal matching thus becomes an obstacle to continued coverage for legal immigrants and refugees. We urge HCFA

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to delete references to FFP in the draft Medicaid manual and make clear that FFP will be available beyond those time frames.

Retaining the Availability of Retroactive Medicaid

Under current federal law, states participating in the Medicaid program must provide benefits to all eligible Medicaid beneficiaries to cover the cost of care and services provided to the beneficiary during the three month period preceding the date of application. To be eligible for retroactive Medicaid, the beneficiary must have been eligible for medical assistance at the time and services were furnished. This provision is intended to fulfill an important public policy objective -- assuring access to care for individuals who have a sudden illness and have not had an opportunity to formally apply for benefits.

We are concerned that HCFA's draft Medicaid manual substantially reduces the availability of retroactive Medicaid by limiting it to states that have elected to cover an optional group that meets SSI income and resource requirements, or the individuals that meet the requirements of another optional group covered under a state plan. We urge HCFA to redraft that portion of the Medicaid manual to make clear that once an individual establishes his or her Medicaid eligibility, that individual is entitled to three months of retroactive medical assistance, provided the individual met the SSI income and resource criteria during period when services were furnished.

We appreciate President Clinton's commitment to ameliorating the severity of provisions in this law that single out legal immigrants and refugees for unduly harsh treatment. We believe that these corrective actions would help to fulfill the President's pledge.

Sincerely,

Diana Aviv
Director, Washington Action Office

Minimizing the Reductions in Medicaid Coverage

The Need for Advocacy at the Federal Level

The welfare law grants states the authority to make decisions on Medicaid eligibility based on alienage. Many of the key issues in the implementation of welfare reform will be decided by state agencies. However, states actions will be shaped by guidance from the Health Care Financing Administration (HCFA), the agency within the Department of Health & Human Services that administers the Medicaid program. How HCFA interprets the federal welfare statute can significantly minimize the loss in Medicaid coverage. This paper will explain the four major issues on which HCFA can influence the scope of Medicaid coverage

HCFA and federal officials in other agencies are soliciting input from state officials and from service providers on its draft Medicaid Manual and for upcoming policy decisions on Medicaid. We strongly recommend that Federations encourage your local agencies to contact state and federal officials on the issues discussed below. Attached is a model letter and two lists of officials to contact. One is a list of federal officials and the other is a list of the State Medicaid officials that have a formal role in advising HCFA on welfare reform implementation.

Statutory Changes

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) bars legal immigrants and refugees in the country for more than five years from receiving SSI. Individuals receiving SSI are automatically eligible for Medicaid consequently for many individuals, the bar on SSI will also affect Medicaid. There new law will make two very important changes to Medicaid eligibility. First, "qualified aliens"¹ who entered the United States on or after August 22, 1996, will be ineligible for Medicaid for a period of five years. Second, the statute grants states the option of making qualified aliens permanently ineligible for Medicaid. There are exemptions for refugees and legal immigrants based on their work history and other factors.²

¹ Qualified aliens include: legal permanent residents, refugees, asylees, parolees, individuals permanently residing under color of law, aliens granted withholding of deportation by the Immigration & Naturalization Service (INS), aliens granted conditional entry into the United States and certain battered alien spouses and their children. All other noncitizens are considered "non-qualified aliens" and are permitted even fewer benefits.

² The following qualified aliens are exempt from restrictions on SSI and Medicaid: refugees and asylees who have been in the country five years or less, qualified aliens who have worked 40-quarters without receiving benefits, honorably discharged veterans and their immediate family and individuals whose deportation has been withheld by the INS for five years.

Key Concerns**(1) HCFA Should Permit States To "Deem" Legal Immigrants and Refugees Who Lose Their SSI As Categorically Eligible For Medicaid.**

In enacting PRWORA, Congress gave states the option to continue Medicaid benefits.

Approximately 28 states provide coverage for individuals who meet the SSI requirements even if they do not receive cash payments.³ Individuals in these states will continue to receive the core set of services they received prior to the change in law, including skilled nursing care and home health services.

Individuals in the remaining 22 states may not be so fortunate. In some states, legal immigrants and refugees may qualify for Medicaid under one of the state's other optional categories, or under a program for the medically needy⁴, although those that qualify as medically needy may not be able to access the full range of Medicaid services that are currently available to them. Unless certain steps are taken by the Administration in implementing the welfare law, states that do not have medically needy or other optional programs will not be able to continue to provide coverage for legal immigrants and refugees without having to amend their state plan -- something that is politically difficult to achieve.

Even for states that have a medically needy program or that have Medicaid coverage for optional groups, the process of redetermining the eligibility of legal immigrants and refugees is administratively burdensome and expensive. In California, for example, the state Medicaid office will be forced to undertake well over 200,000 eligibility redeterminations. New York's already

³ These states are: Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

⁴ The medically needy are persons who become entitled to Medicaid when their income meets state criteria, after deducting income spent on medical services. The medically needy category covers those persons who may not be poor, but nevertheless cannot cover the costs of their health care. Several states with large immigrant populations, including Florida and Illinois, have medically needy programs but also have state income criteria that are well below the SSI benefit levels. This means that legal immigrants and refugees in those states who are cut off of SSI may have a difficult time regaining Medicaid coverage through this optional program. In general, a state that provides the medically needy with fewer services. For example, some states do not offer hospice services, emergency hospital services or personal care services for the medically needy.

beleaguered Medicaid program will have to review approximately 105,000 cases. Unlike the provision of law creating the Temporary Aid to Needy Families block grant, there is no additional administrative money for the states for undertaking these Medicaid redeterminations.

The administrative expense and the lack of coverage can be avoided by permitting states the option of declaring eligible or "deeming" as Medicaid eligible those legal immigrants and refugees who lose their SSI eligibility. This action would not automatically extend Medicaid coverage to all legal immigrants and refugees -- only to those who meet the SSI income and resource requirements, have now been declared ineligible because of their alienage status. The result is that states wishing to continue coverage of legal immigrants and refugees would be able to do so without changing their Medicaid program or taking on significant new administrative expenses.

This type of "deeming" procedure is not new. HCFA has done something similar in the past to restore the Medicaid eligibility of beneficiaries who lose their SSI.⁵

Recommended Action: *HCFA should include in its Medicaid Manual guidance that states may deem as eligible for Medicaid those aliens that will lose their SSI benefits. Guidance from HCFA explaining its interpretation of federal law will be influential because of HCFA's expertise on Medicaid and its legal responsibility for the Medicaid program. HCFA's approval of categorical deeming is especially important in the six states where there is no medically needy program and apparently no categorically needy program for legal legal immigrants and refugees.⁶ HCFA's November 26th Medicaid Manual Issuance implementing the PRWORA fails to mention the power of the states to "deem" legal immigrants and refugees as eligible.*

(2) States Must Honor The Constitutionally Protected Due Process Rights Of Beneficiaries.

The loss of cash assistance under the AFDC or SSI programs should not result in automatic termination from the Medicaid program. States are required to perform redeterminations for those individuals that lose SSI. State agencies that do not find a basis for continued Medicaid eligibility

⁵ For example, the federal government restored the Medicaid eligibility of individuals whose Social Security payments increased and provided them with an income that was above the SSI income criteria, cutting off their SSI payments and their Medicaid eligibility. In another case, families with stepchildren who lost Medicaid because welfare deeming rules made them ineligible for Aid to Families with Dependent Children. In both cases, Medicaid was restored by having HCFA deem the litigants eligible for Medicaid.

⁶ Those states are: Alabama, Delaware, New Mexico, South Dakota, Texas and Wyoming.

must provide individual beneficiaries with a notice and an opportunity for a hearing prior to the termination of benefits. Medicaid benefits must continue during the redetermination process and during any appeals of the state agency's final determination. These procedural protections are constitutionally mandated and have not been altered by any of the provisions of the welfare reform law.⁷

Recommended Action: *Although HCFA communicated to state Medicaid directors the need for redeterminations and a full appeals process, the agency's November 26th draft Medicaid Manual implementing the PRWORA fails to mention these important due process rights. HCFA should monitor state implementation and sanction states that seek to terminate Medicaid beneficiaries in violation of their due process rights. Specifically, HCFA should amend its manual to require that states carry out a full redetermination and that they provide beneficiaries with continued benefits during the review process.*

(3) Continuation of Federal Payments During the Redetermination Period.

We are concerned by language in HCFA's November 26th draft Medicaid Manual that refers to federal regulations that limit federal matching funds for individuals whose eligibility must be redetermined. According to the document released by HCFA, federal financial participation in Medicaid (called the FFP) will be limited to a period that may be as short as 20-days and as long as 52-days after the start of the redetermination process. In areas where there is a significant immigrant population, the state Medicaid agency may be unable to process within the time limits the tens of thousands of individuals who require a determination of eligibility.

According to the Social Security Administration, there are over 500,000 legal immigrants and refugees who are currently receiving SSI. Although some of the immigrants and refugees may be able to establish their SSI eligibility, many will have their benefits cut off and will require a redetermination of their Medicaid eligibility. The likelihood that states will be able to process large numbers of redeterminations within a short time frame is slim - - especially if states are not permitted the option of "deeming" legal immigrants and refugees eligible for Medicaid under an optional state program. The time limit on federal payments provides a strong incentive for states to act fast and terminate benefits. Limiting the time period for federal matching funds during redetermination is not required by statute and is an obstacle to continued coverage for legal immigrants and refugees.

⁷ The right to notice and a fair hearing and the right to receive benefits until a final determination of ineligibility were first established by the Supreme Court in Goldberg v. Kelley, 397 U.S. 254 (1970) and has codified for Medicaid at 42 CFR §431.

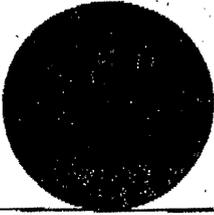
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Recommended Action: *Delete references in the draft Medicaid Manual to the time limits on FFP and make it clear that HCFA intends to continue to make FFP available beyond those time frames, by amending or waiving current regulatory requirements.*

(4) Retaining the Availability of Retroactive Medicaid

Under federal law, states participating in the Medicaid program must provide benefits to all eligible Medicaid beneficiaries to cover the cost of care and services provided to the beneficiary during the three month period preceding the date of application. To be eligible for retroactive Medicaid, the beneficiary must have been eligible for medical assistance at the time and services were furnished. This provision is intended to fulfill an important public policy objective -- assuring access to care for individuals who have a sudden illness and have not had an opportunity to formally apply for benefits. As drafted, HCFA's draft Medicaid manual substantially reduces the availability of retroactive Medicaid by limiting it to states that have elected to cover an optional group that meets SSI income and resource requirements, or if the individuals meet the requirements of another optional group covered under a state plan.

Recommended Action: *We urge HCFA to redraft that portion of the Medicaid manual to make clear that once an individual establishes his or her Medicaid eligibility, that individual is entitled to three months of retroactive medical assistance, provided the individual met the SSI income and resource criteria during that three month time period when services were furnished.*



P.E.A.C.H., INC.

Private Essential Access Community Hospitals

**POSITION PAPER:
THE IMPACT OF MEDICAID COVERAGE IN
WELFARE REFORM LEGISLATION
Federal Conference Committee Resolution of S.1795 & H.R.3507**

- Private Essential Access Community Hospitals, Inc. (PEACH, Inc.) represents private Disproportionate Share Hospitals, which provide critically necessary health care services to California's low-income citizens. As members of the health care safety net, PEACH's member hospitals are very concerned about provisions in the House and Senate versions of the current welfare reform bills which would affect legal residents' access to Medicaid coverage.
- We are particularly concerned about provisions in H.R.3507 & S.1795 which bar legal residents from eligibility for Medicaid for five years, and require that after five years, the income and resources of the legal immigrant's sponsor and sponsor's spouse be "deemed" to be the income of the legal immigrant.
- Barring legal residents from Medicaid eligibility puts the health of all urban residents at risk. Study after study has shown that denying basic preventive care leads to long-term health problems, rapid spread of disease, and greater risk of death in highly congested urban centers. The moral and financial consequences of denying basic health care could be devastating.
- Moreover, the United States Commission on Immigration Reform opposes any broad, categorical denial of public benefits to legal immigrants, stating clearly that **"the safety net provided by needs-tested programs should be available to those whom we have affirmatively accepted as legal immigrants in our communities."** As critical participants in the health care safety net, private DSH hospitals have a responsibility to provide health services to everyone, including those on their way to becoming full members of our society.
- Denying Medicaid payment to facilities will not stop legal immigrants from needing care. Rather, it will shift costs from the federal government to state and local entities, and facilities in those entities. The cost shift, in California estimated at \$10 billion over the next six years, will disproportionately fall on safety net providers. California private community hospitals simply cannot afford to foot the bill for this very large population. Studies conducted by the UCLA Center for Policy Research estimate that 830,000 California legal immigrants will lose Medi-Cal benefits and become uninsured.
- The 830,000 non-citizen Californians who would lose Medi-Cal coverage would experience a near total reduction of their access to primary care, prenatal care, and other health services, resulting in a heavier burden of illness, increased use of private emergency rooms, higher costs due to delayed care, and more uncompensated care provided by hospitals and clinics.
- We urge the Conference Committee not to limit access to the health care safety net or impair the ability of health care providers to provide essential health care services for their communities by **exempting Medicaid from the five year eligibility bar and deeming requirements.**



P.E.A.C.H., INC.

Private Essential Access Community Hospitals

Sister Margaret Keaveney, D.C., Chairperson
St. Francis Medical Center

Jack Fries, Vice President
St. Luke's Hospital

Fred Harder, Secretary/Treasurer
Paradise Valley Hospital

- Bay Harbor Hospital, 134 beds
- California Hospital Medical Center, 310 beds
- City of Hope National Medical Center, 212 beds
- College Hospital Medical Center, 122 beds
- Community Hospitals of Huntington Park, 226 beds
- Garfield Medical Center, 211 beds
- George L. Mee Memorial Hospital, 42 beds
- Greater El Monte Community Hospital, 113 beds
- Huntington East Valley Hospital, 128 beds
- John F. Kennedy Memorial Hospital, 130 beds
- Loma Linda University Medical Center, 797 beds
- Pacific Alliance Medical Center, 155 beds
- Pacifica Hospital of the Valley, 254 beds
- Paradise Valley Hospital, 228 beds
- Pomona Valley Hospital Medical Center, 449 beds
- Queen of Angels/Hollywood Presbyterian Hospital, 410 beds
- Robert F. Kennedy Medical Center, 274 beds
- Santa Ana Hospital, 97 beds
- Santa Marta Hospital, 110 beds
- St. Francis Medical Center, 478 beds
- St. Luke's Hospital, 260 beds
- St. Mary Medical Center, 556 beds
- St. Rose Hospital, 175 beds
- Suburban Medical Center, 184 beds
- White Memorial Medical Center, 452 beds

P.E.A.C.H., Inc. Private Essential Access Community Hospitals

1121 L Street • Suite 302 • Sacramento • CA • 95814 • (916) 446-6000



Someone to Stand by You

November 15, 1996

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200 Independence Avenue SW, Room 615F
Washington, D.C. 20201

Honorable Janet Reno, Esq.
Attorney General of the United States
Department of Justice
950 Pennsylvania Avenue NW, Room 4400
Washington, D.C. 20530-0001

Dear Honorables Shalala and Reno:

I write to you in my capacity as Chair of the Government Benefits Subcommittee of The Alzheimer's Association, New York City Chapter, and on behalf of all seniors around the country who seek guidance as to how your offices intend to interpret subsection (6) of 42 U.S.C. § 1320 a-7b(a).

Effective January 1, 1997, subsection (6) (copy annexed) creates a new criminal offense when a person ". . . knowingly and willfully disposes of assets . . . in order . . . to become eligible for medical assistance under a State plan under title XIX . . . if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c) . . ." While subsection (6) seeks to make certain asset transfers prior to applying for Medicaid a criminal offense, the statute is ambiguous and vague.

First, the statute does not appear to impose criminal sanctions on conduct described in subsection (6). Criminal sanctions are imposed only for the acts enumerated in subsections 1-5 (statements, representations, concealments, failures or conversions). In light of this omission, do the acts specified in subsection (6) constitute a crime, and if so what is the penalty?

Second, it is unclear whether the statute applies in a situation commonly faced by elderly individuals where a Medicaid application is made after a period of ineligibility has expired. Under current federal and state Medicaid law, a period of ineligibility is imposed

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSN. INC.
NEW YORK CITY CHAPTER

420 Lexington Avenue • Suite 610 • New York, NY 10170 • Phone (212) 983-0700 • Fax (212) 697-6158

A nonprofit, charitable, tax exempt organization dedicated to family service, education and research

when assets are transferred for less than fair market value by an individual within a statutory "look-back" period of three years (five years for assets transferred into trusts) prior to the application for Medicaid. The period of ineligibility is calculated by dividing the uncompensated value of the assets transferred by the state's average monthly cost of nursing home care. The result is the number of months for which the individual is denied benefits commencing from the date of the transfer. Asset transfers made more than three or five years prior to applying for assistance do not result in the imposition of a period of ineligibility, and thus would not result in the application of this new provision.

The question is, however, whether the new criminal law applies if an application for nursing home Medicaid is filed within the "look-back" period but after the expiration of the ineligibility period. In such a case, the individual is clearly eligible for benefits. For example: if a New York City resident transfers \$25,000, she would be precluded from receiving nursing home benefits for a period of four months (\$25,000 divided by \$6,521, the New York City average monthly nursing home cost). If she files for Medicaid one year later, she would be entitled to benefits because the ineligibility period mandated by current law would have expired. Would you confirm that the newly enacted penal statute does not apply in a situation such as this where an application is filed after the period of ineligibility has expired, but within the "look-back" period?

The ambiguity and vagueness of this statute will have a chilling effect on seniors and others with disabilities seeking necessary assistance in meeting their health care needs. In light of these concerns, the National Academy of Elder Law Attorneys and the Elder Law Section of the New York State Bar Association have urged the repeal of this law.

Finally, without clarity on the issues I have raised, seniors and others with disabilities will be deprived of access to health care assistance to which they are entitled under law.

Honorables Shalala and Reno
Page 3
November 14, 1996

Thank you for your prompt attention to this request.

Respectfully,



Ellice Fatoullah, Chair
Government Benefits
Subcommittee

cc:

Bruce Vladeck, Administrator
Health Care Financing Administration
200 Independence Avenue S.W., Room 314G
Washington, D.C. 20201

Jamie S. Gorelick, Esq.
Deputy Attorney General
Department of Justice
950 Pennsylvania Avenue NW
Washington, D.C. 20530-0001

Chris Jennings
Old Executive Office Building
Washington, D.C. 20506

John Jager, Executive Director
The Alzheimer's Association - New York City Chapter
420 Lexington Avenue, Suite 610
New York, N.Y. 10170

Ira S. Wiesner, President
National Academy of Elder Law Attorneys
1604 N. Country Club Road
Tuscan, AZ 85716

Vincent J. Russo, Chair
Elder Law Section
New York State Bar Association
One Elk Street
Albany, N.Y. 12207



DEC 4 1996

6325 Security Boulevard
Baltimore, MD 21207

Ellice Fatoullah, Chair
Government Benefits Subcommittee
Alzheimer's Association
420 Lexington Avenue
Suite 610
New York, New York 10170

Dear Ms. Fatoullah:

I am responding to your letter to Donna Shalala, Secretary, Department of Health and Human Services, and Janet Reno, Attorney General of the United States, concerning a provision (section 217) of the Health Insurance Portability and Accountability Act. Your letter was referred to this office for reply.

Section 217 establishes criminal penalties for transferring assets for less than fair market value under the Medicaid program. Under the statute, such penalties may apply if a State Medicaid program imposes a penalty for transferring assets for less than fair market value under section 1917(c) of the Social Security Act. Your letter asks a number of questions about section 217 and how it will be interpreted.

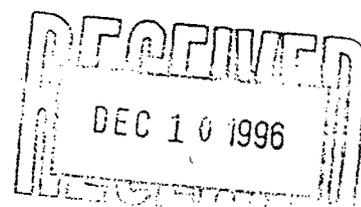
Primary responsibility for implementing section 217 rests with the Department of Justice. We note that your letter was addressed both to Secretary Shalala and Attorney General Reno. The Department of Justice should respond directly to you based on your letter to Attorney General Reno. However, we will forward a copy of your letter, and this reply, to the Department of Justice to ensure that they are aware of your concerns.

Sincerely,



Joseph D. Dunne
T. Randolph Graydon
Co-Directors
Office of Beneficiary Services
Medicaid Bureau

cc: Office of the Attorney General
Department of Justice
950 Pennsylvania Avenue NW, Room 4400
Washington, D.C. 20530-0001





Someone to Stand by You

December 24, 1996

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President Bill Clinton
The White House
Washington, D.C. 20201

Dear President Clinton:

I write to you in my capacity as Chair of the Government Benefits Subcommittee of The Alzheimer's Association, New York City Chapter, and on behalf of all seniors and people with disabilities around the country who seek guidance as to how your administration intends to interpret subsection (6) of 42 U.S.C. § 1320 a-7b(a).

As the annexed correspondence indicates, I wrote to both Secretary Donna Shalala and Attorney General Janet Reno seeking clarification of subsection (6). Unfortunately, the response I received from Secretary Shalala was to refer the matter to the Attorney General; and the response I received from the Attorney General was that she could not respond to our questions because she is permitted to render legal advice only to the President and executive agencies of the federal government. Accordingly, we are asking you to seek an interpretation of subsection (6) from the Attorney General on behalf senior citizens and people with disabilities throughout the country.

Effective January 1, 1997, subsection (6) (copy annexed) creates a new criminal offense when a person ". . . knowingly and willfully disposes of assets . . . in order . . . to become eligible for medical assistance under a State plan under title XIX . . . if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c) . . ." While subsection (6) seeks to make certain asset transfers prior to applying for Medicaid a criminal offense, the statute is ambiguous and vague.

First, the statute does not appear to impose criminal sanctions on conduct described in subsection (6). Criminal sanctions are imposed only for the acts enumerated in subsections 1-5 (statements, representations, concealments, failures or conversions). In light of this omission, do the acts specified in subsection (6) constitute a crime, and if so what is the penalty?

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSN. INC.
NEW YORK CITY CHAPTER

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Second, it is unclear whether the statute applies in a situation commonly faced by elderly individuals where a Medicaid application is made after a period of ineligibility has expired. Under current federal and state Medicaid law, a period of ineligibility is imposed when assets are transferred for less than fair market value by an individual within a statutory "look-back" period of three years (five years for assets transferred into trusts) prior to the application for Medicaid. The period of ineligibility is calculated by dividing the uncompensated value of the assets transferred by the state's average monthly cost of nursing home care. The result is the number of months for which the individual is denied benefits commencing from the date of the transfer. Asset transfers made more than three or five years prior to applying for assistance do not result in the imposition of a period of ineligibility, and thus would not result in the application of this new provision.

The question is, however, whether the new criminal law applies if an application for nursing home Medicaid is filed within the "look-back" period but after the expiration of the ineligibility period. In such a case, the individual is clearly eligible for benefits. For example: if a New York City resident transfers \$25,000, she would be precluded from receiving nursing home benefits for a period of four months (\$25,000 divided by \$6,521, the New York City average monthly nursing home cost). If she files for Medicaid one year later, she would be entitled to benefits because the ineligibility period mandated by current law would have expired. Would you have the Attorney General confirm that the newly enacted penal statute does not apply in a situation such as this where an application is filed after the period of ineligibility has expired, but within the "look-back" period?

The ambiguity and vagueness of this statute will have a chilling effect on seniors and others with disabilities seeking necessary assistance in meeting their health care needs. In light of these concerns, the National Academy of Elder Law Attorneys and the Elder Law Section of the New York State Bar Association have urged the repeal of this law.

President Bill Clinton
December 24, 1996
Page 3
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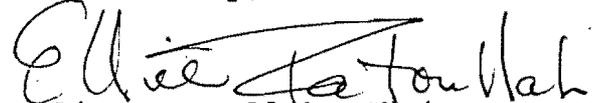
Finally, without clarity on the issues I have raised, seniors and others with disabilities will be deprived of access to health care assistance to which they are entitled under law.

While the newly enacted law provides for a procedure whereby the Secretary of Health and Human Services in consultation with the Attorney General may issue written advisory opinions which would address the issues we are raising, the statute does not apply to requests made for opinions until six months after the enactment of the statute. This means that from January 1, 1997 to July 1, 1997 senior citizens and people with disabilities who transfer assets do so at risk of violating the criminal provisions of subsection (6).

Accordingly, I am asking you to intervene on behalf of these populations and seek immediate clarification from the Attorney General that no crime is committed if the transfer is made within the "look-back" period but after the expiration of the penalty period.

I thank you for your prompt attention to this request.

Respectfully,


Ellice Fatoullah, Chair
Government Benefits
Subcommittee

cc:

Bruce Vladeck, Administrator
Health Care Financing Administration
200 Independence Avenue S.W., Room 314G
Washington, D.C. 20201

Jamie S. Gorelick, Esq.
Deputy Attorney General
Department of Justice
950 Pennsylvania Avenue NW
Washington, D.C. 20530-0001

President Bill Clinton
December 24, 1996
Page 4
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Chris Jennings ✓
Old Executive Office Building
Washington, D.C. 20506

John Jager, Executive Director
The Alzheimer's Association - New York City Chapter
420 Lexington Avenue, Suite 610
New York, N.Y. 10170

Ira S. Wiesner, President
National Academy of Elder Law Attorneys
1604 N. Country Club Road
Tuscan, AZ 85716

Vincent J. Russo, Chair
Elder Law Section
New York State Bar Association
One Elk Street
Albany, N.Y. 12207



U. S. Department of Justice

Criminal Division

Washington, D.C. 20530

DEC - 9 1996

Ms. Ellice Fatoullah, Chair
Government Benefits Subcommittee
Alzheimer's Disease and Related
Disorders Assn., Inc.,
New York City Chapter
420 Lexington Avenue, Suite 610
New York, New York 10170

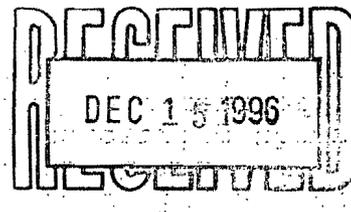
Dear Ms. Fatoullah:

This is in response to your letter of November 15, 1996 to Donna Shalala, Secretary, Department of Health and Human Services, and to Janet Reno, Attorney General, concerning the new subsection (6) of 42 U.S.C. § 1320a-7b(a). The Department of Justice is permitted to render legal advice only to the President and executive agencies of the federal government. Accordingly, this office cannot advise you concerning interpretation of that new statute.

We note that you have brought this matter to the attention of the National Academy of Elder Law Attorneys and the New York State Bar Association, and we wish you well in resolving it.

Sincerely,

Karen A. Morrissette
Deputy Chief, Fraud Section



42 USC Sec. 1320a-7b

TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 7 - SOCIAL SECURITY
SUBCHAPTER XI - GENERAL PROVISIONS AND PEER REVIEW

Part A - General Provisions

Sec. 1320a-7b. Criminal penalties for acts involving Medicare or State health care programs

-STATUTE-

(a) MAKING OR CAUSING TO BE MADE FALSE STATEMENTS OR REPRESENTATIONS

Whoever - (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under subchapter XVIII of this chapter or a State health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under subchapter XIX of this chapter is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of that subchapter or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

December 20, 1996

MEMORANDUM TO HILLARY RODHAM CLINTON

FROM: Chris Jennings

RE: Medicaid and Health Care Investments

At your request, I have enclosed a copy of the Medicaid/Health Care Investments presentation given to the President this morning. A final decision has not yet been made, but it appears that the President believes Medicaid savings should be lower than the number Frank Raines has been carrying in the budget tables (\$30 billion in five years, \$17 billion in FY 02).

During the meeting, the President indicated his willingness to retain the per capita cap as long as it does not achieve savings off the baseline until FY 01 or FY 02. This will likely result in \$3 to \$10 billion in per capita cap savings over five years. Additionally, the President expressed his concern about making severe cuts in Disproportionate Share Hospital (DSH) payments and, as a result, may be more comfortable with our more moderate DSH savings proposal (about \$10 billion over five years). This would leave our total Medicaid savings numbers to about \$10 billion in FY 02 and \$20 billion over five years.

Personally, I believe the Medicaid number should be no more than \$8 billion in FY 02 and \$15 billion over five years to avoid implementing either a politically unpopular and excessively tight per capita cap or severe DSH savings. In short, this approach would provide us flexibility to work out an agreement with the governors on the best way to achieve needed savings. This would help us invest the governors in our efforts to expand health care coverage to children.

As for the children's initiatives, the President seemed very interested in all the options offered and, in particular, package B on page 9 of the enclosed document. (As you will note, package B drops the last year financing of the workers in between jobs option). To pay for this package and cover an additional 5 million children, it would likely require \$3.5 billion in FY 02 and \$12 billion over 5 years. As always, competing demands with other priorities pose the challenge to finding these dollars.

Lastly, the Vice President continues to raise the possibility of moving the SPECTRUM sale from FY 03 to FY 02 to generate additional resources to reduce the impact of cuts and allow for increased domestic investments. This may be the best option to ensure an adequate kids package and to achieve a more moderate Medicaid savings number (and achieve a balanced budget in 2002).

If you have any questions, please call me.

9V-15-96 FRI 10:35

P.02

Table 1
Insurance Coverage of Pregnant Women and Children, 1993

All Pregnant Women and Children Through Age 18

Poverty Level	Total ¹	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	18.0	5.7%	77.1%	3.3%	13.9%
100-133%	4.8	26.6%	41.9%	7.6%	23.9%
134-185%	7.4	49.6%	18.7%	7.6%	24.1%
186-299%	15.4	72.5%	5.5%	7.6%	14.4%
300% +	26.5	85.0%	1.6%	6.0%	7.5%
All	72.1	55.0%	25.7%	6.0%	13.4%

Pregnant Women and Infants

Poverty Level	Total ¹	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	2.2	5.6%	82.7%	2.2%	9.5%
100-133%	0.5	24.0%	54.5%	8.6%	12.8%
134-185%	0.7	31.3%	30.1%	3.9%	12.6%
186-299%	1.3	72.4%	11.3%	8.2%	8.1%
300% +	2.4	87.1%	1.5%	4.6%	6.7%
All	7.0	50.9%	35.3%	4.9%	8.9%

Children Age 1 to 5 Years

Poverty Level	Total ¹	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	5.7	9.5%	87.3%	1.9%	7.3%
100-133%	1.3	21.2%	58.0%	4.3%	16.6%
134-185%	1.9	45.7%	28.4%	4.1%	21.8%
186-299%	3.7	75.6%	6.7%	5.0%	12.7%
300% +	6.2	86.8%	2.1%	4.4%	6.7%
All	18.7	50.7%	35.3%	3.7%	10.3%

Children Age 6 to 12 Years

Poverty Level	Total ¹	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	5.9	7.1%	77.1%	2.8%	13.1%
100-133%	1.7	30.6%	36.3%	6.0%	27.1%
134-185%	2.7	57.7%	12.6%	6.1%	23.7%
186-299%	5.9	75.4%	4.2%	5.7%	14.6%
300% +	9.2	85.8%	1.5%	5.0%	7.7%
All	25.4	58.4%	23.2%	4.8%	13.6%

Children Age 13 to 18 Years

Poverty Level	Total ¹	Employer Sponsored	Medicaid	Private and Other	Uninsured
0-99%	4.2	6.9%	60.3%	6.6%	26.2%
100-133%	1.4	27.5%	29.5%	12.3%	30.7%
134-185%	2.1	42.0%	14.3%	13.3%	30.3%
186-299%	4.5	66.0%	4.6%	12.0%	17.3%
300% +	8.8	82.2%	1.2%	8.6%	8.0%
All	21.0	56.2%	16.8%	9.6%	17.3%

Source: Urban Institute tabulations from the March Current Population Survey, 1994.

Note: Percentages may not sum to 100 because of rounding. Medicaid enrollment reflects corrections by the Urban Institute's TRIM2 model, as well as corrections for individuals reporting both employer-sponsored insurance and Medicaid. The population excludes the elderly, the institutionalized and families with an active military member. "Other" coverage groups includes the non-elderly covered through Medicare, VA, CHAMPUS, and military health

¹ Millions of persons

MEDICAID PRESENTATION

12/5/96

Agenda

1. Our FY97 Budget Proposal
2. Baseline Changes
3. Per Capita Cap
 - a. Where we were
 - b. What has changed
 - c. Discussion
4. Disproportionate Share Hospitals (DSH)
 - a. Where we were
 - b. What has changed
 - c. Discussion

5. Other initiatives with implications for Medicaid

Our FY97 Budget

- OMB: \$59 billion over 6 years
CBO: \$54 billion over 6 years
- Per capita cap on growth rates
- Disproportionate Share Hospitals (DSH)
 - Cuts and retargets DSH funding
 - Large and small "pools" that offset DSH cuts
- Expands State flexibility

Baseline Changes

- Lost 1 year - now 5 years
- Baseline down significantly, but don't know how much
 - See Figure 1
 - Reasons for decline
- Providers squeezed in private sector at the same time that the welfare law's legal immigrant ban may increase level of uncompensated care
- Now only 4 ways to achieve savings: a block grant, lowering the federal match, a per capita cap, and DSH

Per Capita Cap

- Where we were
 - See Figure 2
- What has changed
 - Baseline (see Figures 3 & 4)
 - No block grant
- Discussion
 - Original reasons for per capita cap
 - Strength: protects enrollment
 - Weakness: varied impact on states (see Figure 5), growth already constrained by match (see Figure 6)
 - Congressional, governors, and interest group views
 - Reasons for and against

Disproportionate Share Hospitals

- History of program (see Figure 7)
 - 1991 and 1993 agreements
 - High DSH states dependent (see Figure 8)
 - Policy justification remains for DSH savings
- Where we were: DSH savings and retargeting, pools
- What has changed
 - Baseline similar
 - No alternative to compare to state by state
- Discussion
 - Original reasons for DSH savings
 - Strength: protects enrollment
 - Weakness: varied impact on states
 - Congressional, governors and interest group views
 - Reasons for and against

Other Initiatives with Implications for Medicaid

- Financing of proposed changes in the welfare law
- Financing of children's initiative