

1 GROWTH.—At the beginning of each fiscal year, the Sec-
2 retary shall determine for the preceding fiscal year a na-
3 tional medicaid rural health clinic and Federally-qualified
4 health center rate of growth for Federal payments made
5 under this title to all States with a State plan approved
6 under this title (or operating a medicaid program under a
7 waiver of the requirements of this title) based on—

8 “(A) the percentage increase in payments made
9 under this title that occurred during such fiscal year;
10 and

11 “(B) the annual percentage increase that occurred
12 during such year in the populations served by Federally
13 qualified health centers and rural health clinics eligible
14 for a grant under this section.

15 “(d) ENTITLEMENT STATUS OF GRANTS.—

16 “(1) IN GENERAL.—Effective on and after October 1,
17 1996, the requirement established in subsection (a) for the
18 Secretary (relating to making a grant)—

19 “(A) is an entitlement in a public or private non-
20 profit Federally qualified health center and a public or
21 private nonprofit rural health clinic on behalf of indi-
22 viduals served by the center or clinic (but is not an en-
23 titlement in any such individual); and

24 “(B) represents the obligation of the Federal Gov-
25 ernment, subject to paragraph (2), to make a grant
26 under subsection (a) to the center or clinic in the
27 amount determined for the clinic or center under sub-
28 section (b).

29 “(2) CAPPED ENTITLEMENT.—The entitlement estab-
30 lished in paragraph (1) is subject to the extent of the
31 amount appropriated in subsection (c) for the fiscal year.

32 “(3) PRO RATA REDUCTIONS UNDER CAP AMOUNT.—
33 If the Secretary determines that the budget authority pro-
34 vided in subsection (c) for a fiscal year is insufficient to
35 provide the total of all amounts under subsection (b) for
36 the year, the Secretary shall reduce each amount deter-
37 mined under subsection (b) for the year on a pro rata basis

1 to the extent necessary for the grants under this section to
 2 be provided in an aggregate amount equal to the budget
 3 authority available under subsection (c) for the year.

[AFDC eligibility] Add to subtitle C the following

new section:

4 **SEC. 720. FLEXIBILITY IN ELIGIBILITY FOR AFDC-RE-**
 5 **LATED POPULATIONS AND REVISIONS IN**
 6 **TRANSITIONAL WORK PROVISIONS.**

7 (a) **PERMITTING CATEGORICAL ELIGIBILITY TO BE**
 8 **BASED ON CURRENT AFDC PLAN.—**

9 (1) **IN GENERAL.—**Section 1902(a)(10)(A)(i)(I) (42
 10 U.S.C. 1396a(a)(10)(A)(i)(I)) is amended by inserting “,
 11 except that a State plan may elect to apply this subclause
 12 based on its State plan under title IV as in effect on the
 13 date of the enactment of the Medicaid State Flexibility Act
 14 of 1996” before the comma at the end.

15 (2) **CONFORMING AMENDMENT TO TRANSITIONAL**
 16 **WORK PROVISIONS.—**Section 1925(a) (42 U.S.C. 1396r-
 17 6(a)) is amended by adding at the end the following new
 18 paragraph:

19 “(4) **USE OF HISTORICAL ELIGIBILITY STANDARD.—**In
 20 the case of a State that elects, under section
 21 1902(a)(10)(A)(i)(I), to apply such section based on its
 22 State plan under title IV as in effect on the date before the
 23 date of the enactment of the Medicaid State Flexibility Act
 24 of 1996, this section shall be applied as if any reference to
 25 a provision of title IV is a reference to such provision as
 26 in effect on the date before such date of enactment.”.

27 (b) **REPEAL OF SUNSET ON TRANSITIONAL WORK PROVI-**
 28 **SIONS.—**Subsection (f) of section 1925 (42 U.S.C. 1396r-6(f))
 29 is repealed.

30 (c) **PAYMENT OF GROUP HEALTH COINSURANCE AT MED-**
 31 **ICAID RATES UNDER TRANSITIONAL WORK PROVISIONS.—**

32 (1) **IN GENERAL.—**Section 1925(a)(4)(B) (42 U.S.C.
 33 1396r-6(a)(4)(B)) is amended—

34 (A) by striking “and” at the end of clause (i);

1 (B) by striking the period at the end of clause (ii)
2 and inserting “; and”; and

3 (C) by adding at the end the following new clause:

4 “(iii) the State may limit the amount of any
5 deductible or copayment for any health care item or
6 service to the applicable portion of the amount the
7 State would pay if such item or service had been
8 furnished by a provider participating in the pro-
9 gram under the State plan.”.

10 (2) LIMIT ON PAYMENTS FOR ADDITIONAL EXTEN-
11 SION.—Section 1925(b)(4)(D) (42 U.S.C. 1396r-
12 6(b)(4)(D)) is amended by adding at the end the following
13 new sentence: “If the State elects to pay such deductibles
14 and coinsurance, the State may limit the amount of such
15 payments as provided in subsection (a)(4)(C)(iii).”.

16 (d) STATE FLEXIBILITY IN REPORTING REQUIREMENTS
17 UNDER TRANSITIONAL WORK PROVISIONS.—Section 1925(b)
18 (42 U.S.C. 1396r-6(b)) is amended—

19 (1) in paragraph (2)(B), by adding at the end the fol-
20 lowing new clause:

21 “(iv) STATE FLEXIBILITY.—Notwithstanding
22 the previous provisions of this subparagraph, a
23 State may delay or defer the deadlines for any re-
24 porting requirement established under this sub-
25 paragraph.”; and

26 (2) in paragraph (3)(A)(iii)(I), by inserting “or unless
27 the State has waived or modified such reporting require-
28 ment under paragraph (2)(B)” before the semicolon at the
29 end.

[New Optional Eligibles] In subtitle C, insert the
following new section (and conform the table of contents
accordingly):

30 **SEC. 720. STATE FLEXIBILITY IN COVERING ADDI-**
31 **TIONAL POPULATIONS.**

32 (a) EXPANDED ELIGIBILITY.—Section 1902(a)(10) (42
33 U.S.C. 1396a(a)(10)) is amended—

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19

1 (1) by striking "and" at the end of subparagraph (E).

2 (2) by adding "and" at the end of subparagraph (F).

3 and

4 (3) by inserting after subparagraph (F) the following

5 new subparagraph:

6 "(G) at the option of a State, for making medical
7 assistance available to one of the following groups of
8 individuals who would otherwise be ineligible for such
9 assistance:

10 "(i) Individuals (including any reasonable clas-
11 sification of such individuals) whose income does
12 not exceed 100 percent of the poverty line (as de-
13 fined in section 673(2) of the Community Services
14 Block Grant Act (42 U.S.C. 9902(2))).

15 "(ii) Individuals (including any reasonable
16 classification of such individuals) whose income
17 does not exceed a higher percentage of such poverty
18 line, but only if the State establishes (to the satis-
19 faction of the Secretary) that coverage of such indi-
20 viduals under this clause will not result in Federal
21 payments to the State that exceed the payment
22 amounts that would have applied if clause (i) had
23 been applied instead of this clause."

24 (b) CONFORMING AMENDMENT.—Section 1905(a) (42
25 U.S.C. 1396d(a)) is amended, in the matter before paragraph
26 (1)—

27 (1) by striking "or" at the end of clause (x),

28 (2) by inserting "or" at the end of clause (xi), and

29 (3) by inserting after clause (xi) the following new
30 clause:

31 "(xii) individuals described in section
32 1902(a)(10)(G)."

33 (c) DISREGARD OF ADDITIONAL ENROLLEES IN CALCULA-
34 TION OF FEDERAL PAYMENT LIMIT.—Section 1903(d)(7)(B),
35 as added by section 7001(b)(1)(B) of this Act, is amended by
36 adding at the end the following: "The numbers reported by the
37 State under this paragraph shall not include any individuals

Jack/Mary Ann - Have you seen this?

Oh

TO: Bridgett, Karen

FROM: Andy 

RE: Administration's Medicaid Proposal (transmitted May 24, 1996)

DATE: November 13, 1996

OVERVIEW

The May, 1996, version of the Medicaid title of the Administration's FY 1997 balanced budget proposal was scored by CBO (on 2/26/96) at \$55.1 billion over the 7 years FY 1997 - FY 2002:

- \$35 billion from the per capita cap, and
- a net of \$20 billion from DSH (\$39 billion in cuts — a 51 percent reduction — less \$11 billion for transition grants, \$3.5 for illegal aliens, and \$3 for FQHCs and RHCs).

The dramatic decline in the Medicaid growth rate to 3 percent in FY 1996 presents a political opportunity to lower these proposed cuts dramatically. Even Martha Phillips of the Concord Coalition concedes that "Medicaid, for the time being, seems to be under control." (National Journal, 11/9/96 at p. 2395). Whatever the target number for cuts, the Administration will clearly propose some Medicaid legislation in the 105th. Here are some suggestions for revising their 1996 version:

ELEMENTS THAT SHOULD BE DROPPED

- **Per capita cap (sec. 11301) and DSH reductions (sec. 11302).** Based on CBO's spring, 1995, estimates, any "flexibility" changes, like repeal of Boren and expanded managed care, are not likely to score more than \$5 billion or so in savings, if that, over 7 years. If larger cuts must be made, there are only two places to go for scorable savings: DSH and the per capita cap. Depending on CBO's new DSH baseline, I would go there first, recognizing that, even with the ploughbacks, the Administration's proposed 51 percent cut is neither desirable nor, given the skewed distribution of DSH funds, politically sustainable.

My information is that about 20 percent of DSH funds are spent on State mental hospitals, essentially gutting the IMD exclusion and refinancing State mental health spending. What about reducing some of that portion of Federal DSH spending by lowering the OBRA '93 facility specific caps for those institutions to, say, 50 percent of operating costs?

- **Capped optional eligibility (sec. 11311).** This would allow the States to cover anyone up to 150 percent of poverty, but exclude these new eligibles from enrollee counts for purposes of the per capita cap. Any new optional groups -- whether children or any other categories -- should be accompanied by Federal matching funds on the same basis as current eligibles. One place to start might be expanding the welfare-to-work transitional benefit (see below).
- **Closing off existing eligibility options (sec. 11312 - 11313).** The bill would amend section 1115 to prohibit any new waivers from allowing eligibility expansions (waivers as of 10/1/96 would be unaffected), and limiting new 1902(r)(2) expansions to 150 percent of poverty. Unless a per capita cap is absolutely necessary and these changes are needed for the cap to score, there is no reason to close off current law options, particularly in a way that discriminates against States that haven't used them yet.
- **Allowing States to reduce eligibility levels for pregnant women and infants (sec. 11314).** This would repeal the current law provision that once a State opts to raise the income threshold for pregnant women and infants above 133 percent, it must stay at that new, higher level.
- **Allowing MCOs to impose deductibles, copayments, or other cost-sharing (sec. 11334).** This would repeal the current protection for MCO enrollees and allow MCOs to impose "nominal" deductibles or copayments or other cost-sharing on categorically needy enrollees (they can already do so with respect to medically needy, at State option). It is not clear whether this overrides the current law protections against the imposition of cost-sharing on pregnant women and children, but if it does, just imagine the possibilities for underservicing as MCOs use cost-sharing to further reduce payments to subcontracting physicians and hospitals.
- **Repeal of Boren amendment for both hospitals and nursing homes (sec. 11341).** The bill would replace the Boren requirements, including the requirement that States make DSH payments, with a public process requirement for review and comment on hospital and nursing home payment rates. Given the shift toward managed care, this may soon be a moot point for most urban hospitals. But it would be prove very damaging for the enforcement of quality standards in the nursing home context. *disagree*
- **Repeal of FQHC and RHC cost reimbursement (sec. 11341).** The bill repeals the requirement that States pay FQHCs and RHCs 100 percent of their costs, effective October 1, 1998, at which point a new grant program is to be in place. Funded at \$500 million per year in entitlement spending, this program would be administered by the Secretary directly to FQHCs and RHCs. Could \$500 million per year possibly make up for the loss of cost-based reimbursement and underpayment by managed care plans? Even if it was sufficient, doesn't the bill, *disagree*

which is drafted without a linkage between these two policies, in effect ask for the Congress to repeal the current "mandate" without enacting the new "entitlement?"

- **Minimum qualifications for physicians serving children and pregnant women (sec. 11342).** The bill would repeal the provision in current law denying Federal matching funds for payments to physicians treating Medicaid-eligible children or pregnant women unless the physician meets just 1 of 6 different qualifying criteria. Not only should this provision be retained (it was enacted to shut down substandard Medicaid "mills," but it should be clarified to extend to managed care plans as well. *dr*
- **Repeal of obstetrical and pediatric payment rate requirements (sec. 11343).** The bill would repeal the requirement that States annually specify their payment rates for pediatric and obstetrical services to assure that these reimbursement levels are sufficient to attract the participation of enough physicians and nurse midwives and nurse practitioners to give Medicaid beneficiaries adequate access. The bill would also repeal the requirement that States document how their capitation rates to MCOs reflect these payment rates. With the landscape changing to managed care, it is worth rethinking how to assure adequate access to pediatricians and obstetricians in a managed care context. But wholesale repeal seems like overkill. *J. S. S. S.*

ELEMENTS THAT SHOULD BE RETAINED OR MODIFIED

- **Home- and community-based services option (sec. 11331).** This would convert the 1915(c) waivers into a State option and repeal the frail elderly (Rockefeller) and community-supported living arrangements services (Chafee) capped entitlements, both of which expired in FY 1995. The Administration bill should be modified to include minimum protections against neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and provision of services by unqualified personnel, with enforcement by the State Medicaid Fraud Control Units (which already prosecute abuse and neglect of nursing home residents).
- **Managed care (secs. 11321 - 11325).** The bill would repeal the 75/25 rule, the one-month disenrollment protection, and would allow States to restrict beneficiary choice to one of two MCOs, except in rural areas, replacing the 1915(b) waiver with a State option. This is a political inevitability. And, to its credit, the Administration would provide 6-month guaranteed eligibility for MCO enrollees, and would retain some of the important quality and access protections in 1903(m), such as the requirement that capitation rates have an "actuarially sound basis." However, the bill does nothing to address problems with Medicaid managed care repeatedly documented by the media, including marketing abuse,

non-provision of EPSDT and other contracted services, profiteering and excessive administrative costs, auto-enrollment abuses, and nonpayment of emergency room providers. These provisions need much work if beneficiaries and Federal taxpayers are to be adequately protected.

- **Welfare-to-work transitional coverage (sec. 11333).** In the welfare bill, the Republicans extended the sunset on current law 12-month transitional coverage for working welfare families from September 30, 1998, to September 30, 2001. The Administration bill would have made some dubious changes in the current law provision, including (1) allowing States to gut the alternative coverage option by limiting deductible and copayment subsidies to Medicaid fee-for-service rates, (2) repealing the limit on the amount of premiums that States may impose on such families (currently set at 3 percent of average gross monthly earnings), and (3) allowing the States to require reporting of earnings and child care costs more frequently than quarterly. Surely we can do better with this issue, particularly since 15 States, as part of their section 1115 welfare waivers, have increased these transitional benefits. Among the changes to consider, depending on cost, are: repealing the sunset altogether; giving the States the option to cover up to an additional 24 months (for a maximum of 36 months); reducing the frequency of reporting to once every 6 months; and eliminating the requirement that an individual receive cash assistance in 3 of the 6 months before becoming ineligible for cash assistance and therefore eligible for transitional coverage.
- **Repeal of requirement that States buy beneficiaries into group health plans (sec. 11332).** This repeals the OBRA 90 provision (estimated 5-year savings of \$1 billion) requiring States, when "cost-effective," to pay premiums, deductibles, and coinsurance for beneficiaries who are eligible to enroll in their employers' group health plans, and makes purchase of such coverage optional.
- **MMIS (sec. 11351).** This revises the current MMIS requirements to make them more appropriate to a managed care, per capita cap world. This seems useful, and presents an opportunity to add in language to improve the quality and relevance of the information the States collect and report to the Federal government (for example, we don't know the number of QMBs by State or the amount of Federal Medicaid funds spent on managed care by State).
- **Personnel requirements (sec. 11352).** This repeals the requirement that Medicaid agency personnel be selected on a merit (rather than patronage) basis, and the requirement that States employ beneficiaries and other low-income consumers as "community service aides." The amendment retains the current law prohibition against conflicts of interest by State Medicaid agency personnel, which should be expanded to address the issues raised by managed care contracting.
- **Cooperative agreements (sec. 11353).** This repeals the requirement that

State Medicaid agencies coordinate with State Title V MCH Block Grant agencies, especially with regard to immunizations, and that they coordinate with WIC programs.

- **Nurse Aide Training (sec. 11355).** This would allow certain nursing facilities to continue conducting nurse aide training despite having been sanctioned or found to have provided substandard care during a survey. The language, similar to that in H.R. 3633, ought to be clarified to limit the exemption to facilities located in rural areas.
- **Public process for State plan amendments (sec. 11357).** It ought to be modified to prohibit approval of a plan amendment until the review and comment requirements have been satisfied, and it should be extended to any remaining waiver authorities (such as 1115).
- **PACE (sec. 11358).** This would give the On Lok demonstration projects (and similar public and nonprofit organizations providing health and long-term care services to the frail elderly on a risk basis) provider status for purposes of Medicaid and Medicare, and would eliminate the 15-site cap on such entities.

ELEMENTS THAT SHOULD BE ADDED

- **Repeal gutting of civil money penalty authority.** Section 231(d) of the Kennedy-Kassebaum legislation (P.L. 104-191) increases the burden that prosecutors must meet in establishing the liability of providers for civil monetary penalties under Medicaid (and Medicare). It should be repealed, and the previous law standard of "knows or should know" is fraudulent should be reinstated. This intermediate sanction is a critical enforcement tool, and the Kennedy-Kassebaum change makes it much hard to use effectively. ok if
can
- **Repeal criminalization of transfers of assets.** Section 217 of Kennedy-Kassebaum makes it a crime to dispose of assets in order to qualify for Medicaid if the disposal would result in a period of ineligibility for Medicaid. This is overkill. If the Members want to tighten the current law prohibitions on transfers of assets, they can lengthen the "look back" period and increase the period of ineligibility. OK
- **Prohibit States from requiring Medicare beneficiaries (QMBs or Dual Eligibles) to enroll in Medicaid managed care plans.** Evidently some States are taking the position that they can condition receive of premium or cost-sharing assistance, or prescription drugs or other Medicaid benefits, on enrollment in a managed care plan, even if that plan does not meet Medicare standards. This should be prohibited, since it clearly undercuts the Medicare beneficiary's freedom of choice of provider. If States want to do this, they should get an 1115 waiver, like Minnesota did. OK



NATIONAL

ASSOCIATION

OF PUBLIC

HOSPITALS &

HEALTH

SYSTEMS

November 14, 1996

Mr. Bruce Vladeck
 Health Care Financing Administration
 Department of Health and Human Services
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

Dear Mr. Vladeck:

On behalf of the National Association of Public Hospitals and Health Systems (NAPH), I would like to thank you for your leadership and responsiveness in implementing the Medicaid-related provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 in a manner that is sensitive to the needs of America's safety net health system. As you are aware, the loss of Medicaid coverage for a significant number of legal immigrants, as envisioned in this bill, will have spillover effects on the ability of safety net providers to ensure access to necessary health services for all residents of our communities -- citizens as well as immigrants, insured as well as uninsured. Because of the stress that this rollback in coverage places on these providers' resources, it is important that the Medicaid-related provisions of the legislation be interpreted carefully so that no more individuals lose coverage than is required under the law.

In that spirit, I urge you to review HCFA's proposed policy with respect to current legal immigrants who lose their SSI and, derivatively, their Medicaid coverage under the bill. In an October 4 letter to State Medicaid Directors, HCFA indicated that states that currently do not have a non-cash SSI-related eligibility group for Medicaid would be required to amend their state plans to establish such a group if they wish to continue to cover immigrants who have lost SSI. These states would be faced with the dilemma of either disenrolling all current SSI immigrant recipients or effecting a significant expansion in their Medicaid programs well beyond what their resources may permit. Twenty-one states, including Texas, would confront such a predicament.

We believe the law permits a less drastic alternative. It is our reading of the Act that when it delegates to states the authority to "determine the eligibility of" legal aliens for Medicaid, it has authorized states effectively to ignore the alien status of those who otherwise meet SSI eligibility criteria and deem them to be SSI

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Mr. Bruce Vladeck
November 14, 1996
Page 2

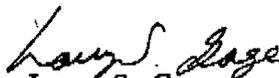
recipients for purposes of determining Medicaid eligibility. In this way, states will not be required to create a new non-cash SSI-related eligibility category, but rather may opt simply to continue the Medicaid eligibility of those who otherwise would have lost it due solely to the loss of SSI. This reading of the statute is also consistent with Congress' otherwise stated intent to continue Medicaid coverage for all current immigrants, while providing states with an option to terminate coverage if they so choose.

In addition, we strongly recommend that HCFA clarify that in determining the Medicaid eligibility of legal immigrants, states only have the option to decide between continuing eligibility or not continuing eligibility for this population. They have not been granted flexibility to provide partial coverage or to distinguish between types of legal immigrants. In providing states with the option to "determine the eligibility" of legal immigrants, and in specifying that for these purposes, "eligibility relates only to the general issue of eligibility or ineligibility on the basis of alienage," Congress has made clear that the decision is an "up or down" one, and that states may not foray into other aspects of the Medicaid program, such as benefits packages, in determining "eligibility."

I am enclosing a copy of a memorandum prepared by the Georgetown Federal Legislation Clinic for Catholic Charities USA which discusses the legal theory supporting our interpretation of the statute in more detail. While this interpretation may not be the *only* possible reading of the law, it is clearly well within the scope of discretion that Congress has granted HCFA as the implementing agency. We urge you to adopt such an approach as you prepare final instructions for states in implementing this complex legislation.

We would be pleased to meet with you, your staff, and/or your lawyers to discuss this interpretation in more detail, if it would be helpful. Please feel free to give me a call at (202) 624-7237. Barbara Eyman (202-624-7359) and Lynne Fagnani (202-414-0101) are also available to answer any questions. In the meantime, I thank you once again for your demonstrated commitment to preserving and protecting our nation's system of safety net providers.

Sincerely,


Larry S. Gage
President

Enclosure
22171634.W51



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STATE DISCRETION TO DETERMINE
MEDICAID ELIGIBILITY FOR QUALIFIED ALIENS

I. INTRODUCTION

Prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Welfare Act"), one of the primary ways in which immigrants qualified for Medicaid was through the receipt of Supplemental Security Income ("SSI") cash payments. Section 402(a) of the Welfare Act now prohibits certain immigrants who are lawfully residing in the United States ("legal immigrants") from receiving SSI payments. Section 402(b) of that Act gives States the discretion to determine whether legal immigrants otherwise eligible for Medicaid under a State plan will remain eligible for Medicaid.

Section 402(b) allows States to ask and answer a single question: "Will we, as a State, continue Medicaid eligibility for legal immigrants who are otherwise eligible for Medicaid under our State plan?" If a State answers this question in the negative, legal immigrants will be denied Medicaid in that State. Conversely, if a State answers affirmatively, legal immigrants will be treated *as if they were citizens* for purposes of Medicaid eligibility in that State. Immigrants who used to be receiving SSI payments will be "deemed" as if they were receiving SSI and will be eligible for Medicaid as part of that "categorically needy" group.

If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for legal immigrants, such immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, legal immigrants who were receiving Medicaid through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in any State that has not notified the Federal government of its desire to eliminate Medicaid coverage for such individuals.

Legal immigrants who previously received SSI cash payments and who live in a State that has elected to cover individuals who meet the income, resource, and disability requirements of SSI, but are not actually receiving SSI cash payments, will automatically fall into this "SSI/optional categorically needy" group and will receive Medicaid. Conversely, legal immigrants who previously received SSI payments in a State that has not elected to create a "SSI/optional categorically needy" group will lose Medicaid coverage if the State fails to notify the Federal government of its intention to cover such individuals.

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II. STATE DISCRETION TO PROVIDE MEDICAID TO IMMIGRANTS

The discretion provided to States by §402(b) of the Welfare Act is both broad and limited. It is *broad* in the sense that States are allowed to decide, notwithstanding any previous restriction in the Medicaid statute, whether or not to provide Medicaid coverage to immigrants lawfully residing in the United States. It is *limited* because States were given the authority to decide only *one* question: whether or not they will treat legal immigrants *as citizens* for purposes of Medicaid eligibility.

The broad discretion granted to States was the end result of a long political process. The House-passed version of the Welfare Act had barred current legal immigrants from Medicaid. In contrast, the Senate-passed version of the legislation gave States discretion to bar legal immigrants from Medicaid. The final conference agreement for the Welfare Act followed the Senate approach, recognizing that a number of States that wished to maintain Medicaid coverage for current legal immigrants would lose considerable Federal funds if the House approach was adopted. Thus, Congress' ultimate political resolution was to provide States the broad discretion and flexibility to grant or deny Medicaid eligibility to legal immigrants.

The limitation on State discretion arises from the convergence of §402(b)(1) and §433 of the Welfare Act. Section 402(b)(1) provides the following:

Notwithstanding any other provision of law . . . a State is authorized to determine the *eligibility* of an alien who is a qualified alien for [Medicaid].

Section 433(a)(1) provides the following definition of "eligibility:"

For purposes of this title, eligibility relates only to the *general issue* of eligibility or ineligibility *on the basis of alienage* (emphasis added).

The combination of §402(b)(1) and §433 makes clear that States are allowed to make one decision: whether they will consider individuals eligible or ineligible *because of* their alienage. If a State decides aliens will be eligible, the State has decided to *disregard alienage* and to treat immigrants legally residing in the United States *as if they were citizens* for the purposes of Medicaid eligibility.

If a State exercises its authority to consider legal immigrants as if they were citizens, these immigrants will be "*deemed*" as if they were receiving SSI payments for purposes of Medicaid eligibility. The concept of "*deeming*" is not a foreign one. Congress has amended Medicaid to create several categories of individuals who are "*deemed*" to be receiving SSI or AFDC for purposes of Medicaid eligibility,¹ and the Health Care Financing Administration

¹ See, e.g., 42 U.S.C. §1396v(a)(3) (Medicaid eligibility maintained for foster children who would have been eligible for AFDC except for removal from the family home by court order

("HCFA") has often issued regulations implementing these statutory changes.² Indeed, Congress took an analogous action in the Welfare Act with regard to families losing AFDC as a result of the repeal of that program. In §114 of the Welfare Act (the "Chafee-Breaux provision"), Congress required States to continue providing Medicaid to individuals who *would have received* AFDC prior to the enactment of the Welfare Act. Section 114 states: "For purposes of this title . . . in determining eligibility for medical assistance, an individual *shall be treated as receiving [AFDC] aid or assistance.*"

In the context of SSI and immigrants, however, rather than amend the Medicaid statute to create a category of individuals deemed as receiving SSI payments, and rather than mandate States to create such a category, Congress chose to delegate the *decision* to create such a category, and the *authority* to do so, to the States. Once a State decides to provide Medicaid coverage to legal immigrants, it has chosen to exercise the option provided it by Congress to deem such individuals as if they were receiving SSI payments. Thus, Congress acted to deny SSI *cash* payments to immigrants legally residing in the United States, but chose to delegate the consequential question of *Medicaid* coverage to the States.

By contrast, the reading of §402 offered by HCFA³ fails to give appropriate weight to Congress' ultimate political resolution with regard to Medicaid and the States, and fails to implement the discretion granted by Congress to the States as part of that resolution. Under HCFA's reading, many States would be required to *expand* their Medicaid program in order to continue covering the *same* people they cover now. At the present time, twenty-nine States have chosen to provide Medicaid to individuals who meet the income and resource requirements, and the disability standard, of SSI but do not actually receive SSI payments.⁴ If these States wish to cover legal immigrants as before, they need do nothing more than recertify such individuals as "SSI/optionally categorically needy." But if any of the remaining twenty-one States wishes to cover the same immigrants they had been covering before, these States must create a *new* "SSI/optional categorically needy" group for *both* citizens and immigrants.

There is no evidence in the legislative history that Congress intended to require States to expand Medicaid coverage in order to serve the same people they were serving before. Indeed, such a result would have been contrary to the spirit of the political resolution reached by Congress to accommodate the States.

or voluntary placement by deeming them as receiving AFDC); *see also* 42 U.S.C. § 1396v(a)(5)(E) (Medicaid eligibility restored for individuals who lost Medicaid because a Social Security cost of living increase made them ineligible for SSI by deeming them as receiving SSI); *see also* CFR cites.

² *See, e.g.*, 42 C.F.R. §435.113, 42 C.F.R. §435.122 .

³ *See* HCFA's October 4, 1996 letter to State Medicaid Directors (Fact Sheet #3).

⁴ In its fact sheet, HCFA calls this group "non-cash SSI-related." We call this group "SSI/optionally categorically needy," based on "Yellow Book" terminology.

Moreover, forcing a State to continue its identical Medicaid coverage for legal immigrants *only* by significantly expanding its existing Medicaid program would be a sufficiently dramatic change that one would expect to see such an intent reflected somewhere in the committee reports or the Congressional Record. As the time-honored principle of statutory interpretation teaches, the "dog didn't bark" in this case.⁵

III. "NOTWITHSTANDING ANY OTHER PROVISION OF LAW"

Section 402(b)(1) provides the following:

Notwithstanding any other provision of law . . . a State is authorized to determine the eligibility of an alien who is a qualified alien for [Medicaid].

For States that wish to continue Medicaid coverage for legal aliens, the phrase "notwithstanding any other provision of law" provides these States with the necessary authority to do so. That is, *notwithstanding* §402(a), which bars SSI cash payments to immigrants lawfully residing in the United States, and *notwithstanding* 42 U.S.C. §1396a(a)(10)(i)(II), which mandates Medicaid coverage solely for individuals "with respect to whom supplemental security income benefits are being paid under title XVI," States are authorized to deem such immigrants *as if* they were receiving SSI cash payments for purposes of Medicaid eligibility.

For States that wish to deny Medicaid coverage for legal immigrants, the phrase "notwithstanding any provision of law" provides States with the authority to take that course of action. That is, *notwithstanding* the legal requirements of the statute authorizing Medicaid,⁶ States may discriminate against immigrants as a group in their Medicaid programs.

Any broader reading of the phrase "notwithstanding any other provision of law" would be inappropriate. There is no evidence in the legislative history that the phrase was intended to encompass a wholesale repeal of all Medicaid rules, such as statewideness, comparability, and amount, duration, and scope, or a wholesale repeal of all statutory civil rights rules.⁷ Such an interpretation would have been a monumental change in healthcare and civil rights principles and would not have been accompanied by silence. (See, e.g., Shine v. Shine, 802 F.2d 583 (1986).)

⁵ See, e.g., Shine v. Shine, 802 F.2d 583 (1986)(explaining principle that a statute "should not be read to effect a reversal of . . . long-standing principles" without legislative history affirmatively evincing such Congressional intent, including "not[ation] in the congressional discussions").

⁶ See, e.g., Medicaid Source Book: Background Data and Analysis ("Yellow Book"), CRS 103-A, Jan. 1993, p. 244.

⁷ For example, Title VI of the Civil Rights Act of 1964 provides that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of or be subject to discrimination under, any program or activity receiving Federal financial assistance. (42 U.S.C. § 2000(d) (1996).)

Instead of such a bizarre and far-reaching interpretation, the phrase "notwithstanding any other provision of law" must be understood in light of the explicit *limited* definition of "eligibility" provided by Congress in §433. Congress intended for States to be given the authority to decide whether alienage would *matter* in the initial decision of whether to provide Medicaid coverage. The phrase "notwithstanding any provision of law" was inserted to provide States with the statutory leeway to exercise this one particular decision. Thus, once States choose to disregard alienage and provide Medicaid, they remain bound by existing Medicaid requirements of statewidness, comparability, and amount, duration and scope.

IV. CONCLUSION

HCFA's guidance to States should read as follows:

The authority granted to States in §402(b)(1) to determine Medicaid eligibility for qualified immigrants requires States to answer a single question: "*Will we, as a State, consider qualified immigrants eligible for Medicaid?*" If a State answers in the negative, all qualified immigrants, subject to certain statutory exceptions, will be barred from receiving Medicaid in that State. If a State answers affirmatively, qualified immigrants will be treated as citizens for the purposes of Medicaid eligibility.

In States that elect to consider qualified immigrants eligible for Medicaid, immigrants who previously qualified because they received SSI cash payments will be deemed as if they were receiving those payments, notwithstanding §402(a), and will be eligible for Medicaid as members of that "categorically needy" group.

A State must inform the Health Care Financing Administration of its choice by stating explicitly in a letter signed by the State Medicaid Director that the State has elected or declined to consider qualified immigrants eligible for Medicaid. A State may also notify HCFA of its decision by amending its State plan.

Once a State makes a decision to provide Medicaid to qualified immigrants, the State must abide by existing Medicaid requirements of statewidness, comparability, and amount, duration, and scope with respect to the class of qualified immigrants.

If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for immigrants, qualified immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, qualified immigrants who were receiving Medicaid

through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in that State.

Qualified immigrants who previously received SSI cash payments in States that have elected to cover individuals who meet the income, resource, and disability requirements of SSI, but are not actually receiving SSI cash payments, will continue to be covered under Medicaid as members of that group. However, if a State has not previously elected to create such a group, and chooses not to do so at the present time, qualified immigrants who had previously received SSI will lose their Medicaid coverage through the State's failure to notify HCFA of its intentions regarding this group of individuals.

Breanz / Chodre

Medicaid Financing Proposal

The Medicaid financing proposal has two components:

- A limit on Federal Medicaid spending on medical assistance (health benefits) and
- A reduction and retargeting of the Medicaid spending on disproportionate share hospitals (DSH).

MEDICAL ASSISTANCE LIMIT:

The total amount of state medical assistance expenditures that the Federal government will match will be limited. States will know in advance the preliminary Federal limit or "allotment". The allotment will be revised when data on enrollment for the year become available. The quarterly grants to states will be consistent with the limits. Each state's allotment will be the greater of:

- (A) the base amount or
- (B) the growth amount plus the umbrella adjustments.

The **base amount** for each state includes the expenditures subject to the limit for 1993, 1994 or 1995 (the year chosen by each state).

The **growth amount** for each state is the product of three numbers:

- (A) Previous year's allotment (the base amount for 1997) plus the umbrella adjustments,
- (B) the inflation adjuster, and
- (C) the estimated weighted average enrollment growth rate.

The ***inflation adjuster*** is a growth-rate limit on the Medicaid spending growth due to health care inflation, utilization and quality changes. It is set in legislation as the sum of the consumer price index (CPI) for previous 12 months and a specified adjustment factor.

The ***estimated weighted average enrollment growth rate*** is used to adjust base year spending and subsequent year allotments for enrollment changes. It is one rate that is composed of the specific enrollment growth for four groups of Medicaid enrollees: aged, disabled, adults and children. It is estimated in advance of each fiscal year by the Secretary. As the actual enrollment information becomes available, it is folded into the formula through the umbrella adjustment.

The **umbrella adjustment** is the mechanism for adjusting the preliminary allotments to account for the actual enrollment trends. Umbrella adjustments occur midway through the fiscal year, and at the end of the fiscal year when the actual enrollment growth is known.

Process for Determining Medical Assistance Limits:

The Secretary of Health and Human Services is primarily responsible for determining the medical assistance limits. The Secretary will produce: (a) a preliminary allotment for each state, prior to the start of the fiscal year, (b) an interim allotment half-way through the fiscal year to account for more recent enrollment trends, and (c) a final allotment at the close of the fiscal year which incorporates actual enrollment growth. The preliminary allotment will be updated through the "umbrella adjustment" which reconciles the estimated enrollment growth with more recent trends (interim allotment) and the actual enrollment growth in the state (final allotment). The Secretary will make the growth estimate based on (a) state estimates of enrollment growth; (b) Medicaid eligibility criteria and standards in each state; (c) legislation enacted or pending in each state; (d) historical trends; and (e) general economic trends.

DISPROPORTIONATE SHARE HOSPITAL (DSH) LIMITS:

The baseline Disproportionate Share Hospital (DSH) funding is divided into three different uses:

- (A) Deficit reduction,
- (B) A targeted DSH program, and
- (C) General medical assistance.

Deficit reduction will account for about one third of current DSH payments.

The targeted DSH program will allocate a share of a fixed Federal funding pool to states based on their share of low-income utilization days in eligible hospitals. The share is determined by the state's percent of the nation's inpatient days and outpatient visits for uninsured and Medicaid patients. States will still contribute to the program through matching payments (using the current matching rates). Funding begins in 1997 and is fully phased in by 2000.

There would also separate streams of funding within the DSH program for (a) states with high numbers of undocumented persons and (b) Federally-qualified health centers and rural health clinics. The 15 states with the highest number of undocumented persons would get a proportionate share of a \$3 billion pool over a five-year period for payments for emergency care for this population. Additionally, a \$3.5 billion pool (\$500 million per year) would be established to supplement payments to Federally-qualified health centers and rural health clinics. Both pools are 100 percent Federally funded.

The amount of DSH for general medical assistance is calculated as a percentage of the 1995 Federal payments to states. It is considered as an add-on to the limits described earlier. It is included in neither the base nor the growth amounts for the purpose of the allotment calculation. States will still contribute matching payments for this amount.

1 (as selected by the State and in this section referred to as
2 the 'base fiscal year' for that State):

3 "(A) Fiscal year 1993.

4 "(B) Fiscal year 1994.

5 "(C) Fiscal year 1995.

6 "(3) GROWTH-ADJUSTED AMOUNT.—

7 "(A) FISCAL YEAR 1997.—The growth-adjusted
8 amount specified in this paragraph for a State for fis-
9 cal year 1997 is equal to the product of—

10 "(i) the base amount specified in paragraph
11 (2) for the State,

12 "(ii) a factor equal to 1 plus the weighted av-
13 erage enrollment growth rate (specified in para-
14 graph (4)) for the State for fiscal year 1996,

15 "(iii) a factor equal to 1 plus the weighted av-
16 erage enrollment growth rate (specified in para-
17 graph (4)) for the State for fiscal year 1997,

18 "(iv) a factor equal to 1 plus the inflation ad-
19 juster (specified in paragraph (5)) for fiscal year
20 1996, and

21 "(v) a factor equal to 1 plus the inflation ad-
22 juster for fiscal year 1997.

23 "(B) SUBSEQUENT FISCAL YEAR.—The growth-
24 adjusted amount specified in this paragraph for a State
25 for a subsequent fiscal year is equal to the product
26 of—

27 "(i) the growth-adjusted amount under this
28 paragraph for the State for the previous fiscal year,

29 "(ii) a factor equal to 1 plus the weighted av-
30 erage enrollment growth rate (specified in para-
31 graph (4)) for the State for the fiscal year, and

32 "(iii) a factor equal to 1 plus the inflation ad-
33 juster (specified in paragraph (5)) for the fiscal
34 year.

35 The growth-adjusted amount under clause (i) is subject
36 to an umbrella adjustment under subsection (d)(5).

1 “(4) WEIGHTED AVERAGE ENROLLMENT GROWTH
2 RATE.—For purposes of this subsection, the ‘weighted aver-
3 age enrollment growth rate’ for a State for a fiscal year is
4 the sum of the following:

5 “(A) The sum of the products, for each of the 4
6 categories of medicaid beneficiary (as defined in sub-
7 section (b)(7)), of (i) the percentage change in the
8 number of full-year equivalent individuals in such cat-
9 egory in the State in the fiscal year (compared to such
10 number in the previous fiscal year, or, for fiscal year
11 1996, in the base fiscal year for the State), and (ii) the
12 proportion, of the State medical assistance expenditures
13 (other than expenditures excluded under subsection (c))
14 for which Federal financial participation was provided
15 to the State in the previous fiscal year, which is attrib-
16 utable to expenditures under paragraphs (1) and (5) of
17 section 1903(a) with respect to medical assistance fur-
18 nished for individuals in such category.

19 “(B) The product of (i) the percentage change in
20 the number of full-year equivalent individuals in any of
21 the separate categories of medicaid beneficiary in the
22 State in the fiscal year (compared to such number in
23 the previous fiscal year, or, for fiscal year 1996, in the
24 base fiscal year for the State), and (ii) 100 percent
25 minus the sum of the proportions specified under
26 clause (ii) of subparagraph (A).

27 “(5) INFLATION ADJUSTER.—In this subsection, the
28 ‘inflation adjuster’ for a fiscal year is—

29 “(A) the percentage by which—

30 “(i) the Secretary’s estimate (before the begin-
31 ning of the fiscal year) of the average value of the
32 consumer price index for all urban consumers (all
33 items, U.S. city average) for months in the particu-
34 lar fiscal year, exceeds

35 “(ii) the average value of such index for
36 months in the previous fiscal year; increased by

37 “(B)(i) 4.0 percentage points for fiscal year 1996;

1 “(ii) 3.0 percentage points for fiscal year 1997;

2 “(iii) 2.0 percentage points for each of fiscal years
3 1998, 1999, and 2000; and

4 “(iv) 1.0 percentage points for each [of fiscal
5 years 2001 and 2002]/[subsequent fiscal year].

6 The Secretary shall not reestimate or recompute the infla-
7 tion adjuster for a fiscal year after the beginning of a fiscal
8 year.

9 “(6) LIMITATION ONLY ON EXPENDITURES FOR
10 WHICH FFP AVAILABLE.—This section does not apply to ex-
11 penditures for which no Federal financial participation is
12 available under this title.

13 “(b) DEFINITIONS RELATING TO CATEGORIES OF INDI-
14 VIDUALS AND MEDICAID BENEFICIARIES.—In this section:

15 “(1) NONDISABLED MEDICAID CHILD.—The term
16 ‘nondisabled medicaid child’ means an individual entitled to
17 medical assistance under the State plan under this title
18 who is not disabled (as such term is used under paragraph
19 (4)), not a QMB-related individual (as defined in para-
20 graph (5)), and is under 21 years of age.

21 “(2) NONDISABLED MEDICAID ADULTS.—The term
22 ‘nondisabled medicaid adult’ means an individual entitled
23 to medical assistance under the State plan under this title
24 who is not disabled (as such term is used under paragraph
25 (4)), not a QMB-related individual (as defined in para-
26 graph (5)), and is at least 21 years of age but under 65
27 years of age.

28 “(3) ELDERLY MEDICAID BENEFICIARY.—The term
29 ‘elderly medicaid beneficiary’ means an individual entitled
30 to medical assistance under the State plan under this title
31 who at least 65 years of age and is not a QMB-related indi-
32 vidual (as defined in paragraph (5)).

33 “(4) DISABLED MEDICAID BENEFICIARIES.—The term
34 ‘disabled medicaid beneficiary’ means an individual entitled
35 to medical assistance under the State plan under this title
36 who is entitled to such assistance on the basis of blindness

1 or disability and is not a QMB-related individual (as de-
2 fined in paragraph (5)).

3 “(5) QMB-RELATED INDIVIDUAL.—The term ‘QMB-
4 related individual’ means an individual who is eligible only
5 for benefits described in section 1902(a)(10)(E) under this
6 title as—

7 “(A) a qualified medicare beneficiary (as defined
8 in section 1905(p)(1)),

9 “(B) a qualified disabled and working individual
10 (as defined in section 1905(s)), or

11 “(C) an individual described in section
12 1902(a)(10)(E)(iii).

13 “(6) MEDICAID BENEFICIARY.—The term ‘medicaid
14 beneficiary’ means an individual enrolled in the State pro-
15 gram under this title, other than an individual described in
16 section 1902(a)(10)(G).

17 “(7) CATEGORY.—Nondisabled medicaid children, non-
18 disabled medicaid adults, elderly medicaid beneficiaries, and
19 disabled medicaid beneficiaries each constitute a separate ‘cat-
20 egory’ of medicaid beneficiaries.

21 “(e) SPECIAL RULES AND EXCEPTIONS.—For purposes of
22 this section, expenditures attributable to any of the following
23 shall not be subject to the limits established under this section
24 and shall not be taken into account in computing base amounts
25 under subsection (a)(2):

26 “(1) DSH.—Payment adjustments under section
27 1923.

28 “(2) MEDICARE COST-SHARING.—Payments for medi-
29 cal assistance described in section 1902(a)(10)(E).

30 “(3) INDIAN HEALTH PROGRAMS.—Amounts for medi-
31 cal assistance for services provided by—

32 “(A) the Indian Health Service;

33 “(B) Indian health programs operated by an In-
34 dian tribe or tribal organization pursuant to a contract,
35 grant, cooperative agreement, or compact with the In-
36 dian Health Service pursuant to the Indian Self-Deter-
37 mination Act (25 U.S.C. 450 et seq.); and

1 “(A) IN GENERAL.—The Secretary shall produce,
2 for each fiscal year (beginning with fiscal year 1997)
3 the following reports that specify the growth-adjusted
4 amount under subsection (a)(3) for each State for the
5 fiscal year (taking into account any umbrella adjust-
6 ment under paragraph (5)):

7 “(i) PRELIMINARY REPORT.—A preliminary
8 report in July before the beginning of the fiscal
9 year.

10 “(ii) INTERIM REPORT.—An interim report at
11 such time during the fiscal year as permits a semi-
12 annual umbrella adjustment under paragraph (5).

13 “(iii) FINAL REPORT.—A final report not later
14 than 6 months after the end of the fiscal year.

15 “(B) CONTENTS OF REPORT.—Each such report
16 for a fiscal year shall include for each State for the fis-
17 cal year an estimate or statement of—

18 “(i) the weighted average enrollment growth
19 rate;

20 “(ii) the number of full-year equivalent indi-
21 viduals in each category of medicaid beneficiary;

22 “(iii) the growth-adjusted amount under sub-
23 section (a)(3); and

24 “(iv) the amount of any umbrella adjustment
25 under paragraph (5).

26 “(3) DETERMINATION OF NUMBER OF FULL-YEAR
27 EQUIVALENT INDIVIDUALS.—

28 “(A) STANDARD FORMULA.—

29 “(i) IN GENERAL.—For purposes of this sec-
30 tion, the number of full-year equivalent individuals
31 in each category described in subsection (b) for a
32 State for a year shall be determined, subject to
33 subparagraph (B), based on actual reports submit-
34 ted by the State to the Secretary.

35 “(ii) PART-YEAR ENROLLEES.—In the case of
36 individuals who were not enrolled under the State
37 program under this title for the entire fiscal year

1 (or are within a group of individuals for only part
2 of a fiscal year), the number shall take into ac-
3 count only the portion of the year in which they
4 were so enrolled or within such group.

5 "(B) ALTERNATIVE FORMULA FOR STATES OPER-
6 ATING UNDER WAIVERS IN BASE YEAR.—

7 "(i) IN GENERAL.—A State that, during fiscal
8 year 1995, had in effect a program under this title
9 under which individuals not otherwise eligible were
10 enrolled pursuant to waivers under section 1115
11 may elect to make the calculations required by this
12 paragraph for fiscal year 1995 in the manner speci-
13 fied in clause (ii).

14 "(ii) ASSUMPTIONS FOR PURPOSES OF ALTER-
15 NATIVE CALCULATION.—For purposes of the cal-
16 culation under this subparagraph it shall be as-
17 sumed—

18 "(I) that only individuals eligible for medi-
19 cal assistance (or who would have been eligible
20 if the State had exercised the option under sec-
21 tion 1902(r)(2)) without regard to such waivers
22 received such assistance; and

23 "(II) that notwithstanding subclause (I),
24 State expenditures for individuals eligible for
25 medical assistance only through such waivers
26 shall be taken into account for purposes of de-
27 termining what percentage of State expendi-
28 tures for each group of individuals defined in
29 subsection (b) bears to total State expenditures
30 for medical assistance in such State.

31 "(iii) DEADLINE FOR ELECTION OF OPTION.—
32 Election by a State of the option under this sub-
33 paragraph must be made not later than September
34 1996.

35 "(C) SECRETARIAL OVERSIGHT.—In order to en-
36 sure the accuracy of the numbers reported by States
37 pursuant to subparagraph (A), the Secretary may—

1 “(i) require documentation, whether on a sam-
2 ple or other basis;

3 “(ii) audit such reports (or require the per-
4 formance of independent audits); and

5 “(iii) revise the numbers so reported.

6 “(4) BASIS FOR ESTIMATIONS.—The Secretary shall
7 estimate the number of full-year equivalents before a fiscal
8 year taking into account—

9 “(A) estimates provided by the State,

10 “(B) the medicaid eligibility criteria and standards
11 under each State plan,

12 “(C) legislation enacted or pending in each State,

13 “(D) historical trends in medicaid enrollment in
14 the State, and

15 “(E) economic conditions in the State.

16 “(5) UMBRELLA ADJUSTMENT.—

17 “(A) IN GENERAL.—Based on reports provided
18 under paragraph (2), the Secretary shall provide for a
19 process for adjustment of estimated limits under this
20 section on a semi-annual basis in order to take into ac-
21 count the most current data available on actual medic-
22 aid beneficiary enrollments in the different categories
23 in each State.

24 “(B) ADJUSTMENTS.—If the actual number of
25 full-year equivalent individuals for a category in a State
26 is—

27 “(i) greater than the number of such equiva-
28 lents previously estimated, then the Secretary shall
29 increase the growth-adjusted amount under this
30 section in order to take into account the actual
31 number of full-year equivalents in that category in
32 that State (as well as the actual number of such
33 equivalents in other categories), or

34 “(ii) less than the number of such equivalents
35 previously estimated, then the Secretary shall de-
36 crease the growth-adjusted amount under this sec-
37 tion in order to take into account the actual num-

1 ber of full-year equivalents in that category in that
2 State (as well as the actual number of such equiva-
3 lents in other categories).

4 Adjustments under this subparagraph shall apply to
5 the fiscal year involved and (under the formulas pro-
6 vided under subsection (a)) for subsequent fiscal years.

7 (2) LIMITATION ON FEDERAL FINANCIAL PARTICIPA-
8 TION.—Section 1903 (42 U.S.C. 1396b) is amended by
9 adding at the end the following new subsection:

10 “(x)(1) Notwithstanding the previous provisions of this
11 section but subject to paragraph (3), the Secretary shall incur
12 no obligation after September 30, 1996, to make payments to
13 a State for State expenditures that exceed the limitation on
14 Federal financial participation specified in section 1931.

15 “(2) No payment shall be made to a State with respect
16 to an obligation incurred before October 1, 1996, unless the
17 State has submitted to the Secretary by not later than June
18 30, 1997, a claim for Federal financial participation for ex-
19 penses paid by the State with respect to such obligation.

20 “(3) Nothing in paragraph (1) shall be construed as af-
21 fecting the obligation of the Federal Government to pay claims
22 described in paragraph (2).

23 “(4) Nothing in this subsection or section 1931 shall be
24 construed as affecting the entitlement of eligible individuals to
25 medical assistance under this title.”

26 (b) ENFORCEMENT-RELATED PROVISIONS.—

27 (1) ASSURING ACTUAL PAYMENTS TO STATES CON-
28 SISTENT WITH LIMITATION.—Section 1903(d) (42 U.S.C.
29 1396b(d)) is amended—

30 (A) in paragraph (2)(A), by striking “The Sec-
31 retary” and inserting “Subject to paragraph (7), the
32 Secretary”, and

33 (B) by adding at the end the following new para-
34 graph:

35 “(7)(A) The Secretary shall take such steps as are nec-
36 essary to assure that payments under this subsection for quar-
37 ters in a fiscal year are consistent with the payment limits es-

1 tabhished under section 1931 for the fiscal year. Such steps
2 may include limiting such payments for one or more quarters
3 in a fiscal year based on—

4 “(i) an appropriate proportion of the payment limits
5 for the fiscal year involved, and

6 “(ii) numbers of individuals within each category, as
7 reported under subparagraph (B) for a recent previous
8 quarter.

9 “(B) Each State shall include, in its report filed under
10 paragraph (1)(A) for a calendar quarter—

11 “(i) the actual number of individuals within each cat-
12 egory described in section 1931(b) for the second previous
13 calendar quarter and (based on the data available) for the
14 previous calendar quarter, and

15 “(ii) an estimate of such numbers for the calendar
16 quarter involved.”

17 (2) RESTRICTION ON AUTHORITY OF STATES TO
18 APPLY LESS RESTRICTIVE INCOME AND RESOURCE METH-
19 ODOLOGIES.—Section 1902(r)(2) (42 U.S.C. 1396a(r)(2))
20 is amended by adding at the end the following new sub-
21 paragraph:

22 “(C) Subparagraph (A) shall not apply to plan amend-
23 ments made on or after October 15, 1995.”

24 (c) CONFORMING AMENDMENT.—Section 1903(i) (42
25 U.S.C. 1396b(i)) is amended—

26 (1) by striking “or” at the end of paragraph (14),

27 (2) by striking the period at the end of paragraph (15)
28 and inserting “; or”, and

29 (3) by inserting after paragraph (15) the following:

30 “(16) in accordance with section 1931, with respect to
31 amounts expended to the extent they exceed applicable lim-
32 its established under section 1931(a).”

33 (d) EFFECTIVE DATE.—The amendments made by this
34 section shall apply to payments for calendar quarters beginning
35 on or after October 1, 1996.

1 **SEC. 7002. ADDITIONAL FUNDING FOR ILLEGAL ALIENS.**

2 Title XIX of the Social Security Act, as previously amend-
3 ed, is amended—

4 (2) by redesignating section 1932 as section 1933; and

5 (3) by inserting after section 1931 the following new

6 section:

7 "FEDERAL FUNDING FOR ILLEGAL ALIENS

8 "SEC. 1932. (a) IN GENERAL.—Subject to the limitation
9 specified under subsection (b), for each of fiscal years 1997
10 through 2001 for each of the 15 States with the largest num-
11 ber of illegal immigrants, the Federal medical assistance per-
12 centage shall be 100 percent for expenditures described in sec-
13 tion 1903(v).

14 "(b) LIMITATION.—The limitation under this subsection
15 for a fiscal year for a State bears the same ratio to
16 \$700,000,000 as the ratio of the number of illegal immigrants
17 in the State bears to the total of such numbers for all 15
18 States described in subsection (a).

19 "(c) DETERMINATION OF NUMBER OF ILLEGAL IMMI-
20 GRANTS.—For purposes of this section, the number of illegal
21 immigrants in a State shall be based on estimated of the Sta-
22 tistics Division of the Immigration and Naturalization Service
23 as of October 1992."

Amend section 7203 to read as follows:

24 **SEC. 7203. REVISIONS TO BOREN AMENDMENT.**

25 (a) IN GENERAL.—Amend subparagraph (A) of section
26 1902(a)(13) (42 U.S.C. 1396a(a)(13)) to read as follows:

27 "(A)(i) for a public process for determination of
28 rates of payment under the plan (including payment
29 adjustments under section 1923) for hospital services,
30 nursing facility services, and services of intermediate
31 care facilities for the mentally retarded under which—

32 "(I) proposed rates and the methodology used
33 to achieve such rates are published, and providers,
34 beneficiaries and their representatives, and other

1 concerned State residents are given a reasonable
2 opportunity for review and comment thereon; and

3 “(II) final rates and the methodology used to
4 achieve such rates are published, together with jus-
5 tifications taking into account review and com-
6 ments thereon; and

7 “(ii) payment of hospital services provided under
8 the plan through the use of rates that take into ac-
9 count the situation of hospitals which serve a dis-
10 proportionate number of low income patients with spe-
11 cial needs and that provide, in the case of hospital pa-
12 tients receiving services at an inappropriate level of
13 care (under conditions similar to those described in sec-
14 tion 1861(v)(1)(G), for lower reimbursement rates re-
15 flecting the level of care actually received (in a manner
16 consistent with section 1861(v)(1)(G));”.

17 (b) **EFFECTIVE DATE.**—The amendment made by sub-
18 section (a) shall apply to quarters beginning on or after Octo-
19 ber 1, 1996. Nothing in such amendment shall be construed as
20 affecting the authority of the Secretary of Health and Human
21 Services (currently in regulations under section 447.272 of title
22 42, Code of Federal Regulations) to limit the payment amounts
23 that the Secretary may recognize for purposes of providing
24 Federal financial participation.

After section 7203, insert the following new section
(and redesignate the succeeding sections and conform the
table of contents accordingly):

25 **SEC. 7204. REVISION OF REQUIREMENTS RELATING TO**
26 **FEDERALLY QUALIFIED HEALTH CENTERS**
27 **AND RURAL HEALTH CLINICS; ESTABLISH-**
28 **MENT OF SEPARATE DIRECT PAYMENT PRO-**
29 **GRAM**

30 (a) **LIMITATION OF CURRENT REQUIREMENTS TO FACILI-**
31 **TIES OF INDIAN TRIBES.**—

32 (1) **PAYMENT RULES.**—Section 1902(a)(13) (42
33 U.S.C. 1396a(a)(13)) is amended by inserting “furnished

1 by an Indian tribe or tribal organization described in the
2 last sentence of section 1905(b)" after "under the plan".

3 (2) COVERAGE REQUIREMENT.—Section 1905(a) (42
4 U.S.C. 1396d(a)) is amended—

5 (A) in paragraph (2)(B), by inserting "if furnished
6 in a facility of an Indian tribe or tribal organization de-
7 scribed in the last sentence of section 1905(b)" after
8 "included in the plan";

9 (B) in paragraph (2)(C), by inserting "if furnished
10 in a facility of such an Indian tribe or tribal organiza-
11 tion" after "included in the plan"; and

12 (C) in paragraph (9)—

13 (i) by inserting "(A)" after "(9)", and

14 (ii) by inserting before the semicolon at the
15 end the following: "(B) consistent with State law
16 permitting such services, rural health clinic services
17 (as defined in subsection (1)(1)) and any other am-
18 bulatory services which are offered by a rural
19 health clinic (as defined in subsection (1)(1)) and
20 which are otherwise included in the plan and which
21 are not described in paragraph (3)(B), and (C)
22 Federally-qualified health center services (as de-
23 fined in subsection (1)(2)) and any other ambula-
24 tory services offered by a Federally-qualified health
25 center and which are otherwise included in the plan
26 and which are not described in paragraph (3)(C)".

27 (3) EFFECTIVE DATE.—The amendments made by
28 this subsection shall apply to services furnished on or after
29 October 1, 1996.

30 (b) GRANT PROGRAM FOR UNFUNDED COSTS OF RURAL
31 HEALTH CLINICS AND FEDERALLY-QUALIFIED HEALTH CEN-
32 TERS.—Title XIX, as previously amended, is further amended
33 by redesignating section 1933 as section 1934 and by inserting
34 after section 1932 the following new section:

1 "GRANTS FOR UNFUNDED COSTS OF RURAL HEALTH CLINICS
2 AND FEDERALLY-QUALIFIED HEALTH CENTERS

3 "SEC. 1933. (a) GRANT PROGRAM FOR UNFUNDED POR-
4 TION OF REASONABLE COSTS INCURRED UNDER STATE
5 PLANS.—The Secretary shall make a grant under this section
6 to each public or private nonprofit rural health clinic and public
7 or private nonprofit Federally-qualified health center for fiscal
8 year 1997 and each subsequent fiscal year. The Secretary shall
9 make payments for such grants in advance, in such install-
10 ments as the Secretary finds appropriate and adjusted to take
11 into account any overpayments or underpayments in grants
12 previously made under this section.

13 "(b) AMOUNT OF GRANT.—Subject to subsection (d), the
14 amount of the grant made under this section to a Federally-
15 qualified health center or rural health clinic for a year is equal
16 to the Secretary's estimate of the difference between—

17 "(1) the total amount of costs projected to be incurred
18 by the center or clinic for the year in providing health care
19 and related services; and

20 "(2) the total amount (exclusive of the grant under
21 this section) projected to be received by the center or clinic
22 for the year as payment for providing health care and relat-
23 ed services.

24 "(c) DIRECT SPENDING.—

25 "(1) IN GENERAL.—For carrying out this section
26 there are hereby appropriated, out of any money in the
27 Treasury not otherwise appropriated, the following amounts
28 (as applicable to the fiscal year involved):

29 "(A) For fiscal year 1997—\$500,000,000.

30 "(B) For fiscal years 1998 and each subsequent
31 fiscal year, the amount determined under this sub-
32 section for the previous fiscal year multiplied by the na-
33 tional medicaid rural health clinic and Federally-quali-
34 fied health center rate of growth, as determined under
35 paragraph (2), for such fiscal year.

36 "(2) NATIONAL MEDICAID RURAL HEALTH CLINIC AND
37 FEDERALLY-QUALIFIED HEALTH CENTER RATE OF