Describes Senate bill

THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable federal guarantee of coverage for a defined benefit package
- Adequate and appropriately shared federal and state financing
- Beneficiary protections through quality standards and accountability

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, the House Commerce Republican bill would alter existing eligibility criteria thereby eliminating the guarantee of coverage. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal Poverty Level (FPL).**

- **offers each state the option of using either: 1)the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of current policy, which has a federal definition. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.

- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**

- **eliminates the current guarantee of transitional medical assistance for individuals losing cash assistance due to proposed time limits or other provisions in welfare reform.**

- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid. For example, it appears states may even have flexibility to restrict eligibility based on home ownership. Under current law, a home of any value does not affect a person's eligibility. Under the Republican bill, home owners could be found ineligible.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefit packages. There would be no "required" services for optional eligibility groups.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the "amount, duration, and scope" of benefits).** The Secretary does not have clear authority to affect states' decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.

- **Statewideness requirements would be eliminated**. States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain populations that tend to live in specific areas.

- **Comparability requirements would be eliminated**. States could reduce benefits for certain populations (such as HIV positive beneficiaries). Alternatively, states could provide richer benefits to favorable groups.

- **"Treatment" under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services**. Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they would be optional services.

- **The Vaccines for Children Program is repealed,** while making childhood immunization a mandatory service. States are given flexibility to set their own vaccination schedules. Elimination of VFC funding will mean fewer vaccinations.

- **Federal funding for abortion services would be permanently limited to instances of rape, incest, or where the life of the mother is in jeopardy.**

- **Family planning services are limited to "pre-pregnancy" family planning services and supplies.**

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in

federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** Beneficiaries could file a petition for certiorari before the Supreme Court of the United States, but only after all state appeal mechanisms are exhausted. Otherwise, only the Secretary of HHS would be able to sue in federal court on behalf of individuals. No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.

- Medicaid would become a federal program conferring benefits on individuals without a federal enforcement mechanism--a virtually unprecedented situation.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns, and from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The base funding formula in the Republican bill has been seen before: it's the basic Medigrant II formula. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigrant II block grant formula. About 3 percent is attributable to the new umbrella fund.

The funding formula provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.

- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they may be forced either to raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to decrease total Medicaid funding and the state contribution required to generate the capped federal share of dollars spent on Medicaid. States have the incentive to withdraw large amounts of state Medicaid funding, making total cuts much larger than the proposed $72 billion in federal cuts.

- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year. Repealing these limitations would give states the incentive to use these schemes to reduce the state contribution to Medicaid even further.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.

- **The Republican bill does not include critical federal quality standards for institutions caring for people with mental retardation and developmental disabilities.** There are no federal standards to assure basic rights, such as protection from abuse and neglect, treatment designed to assist the person in achieving the greatest level of independence, and the right to adequate health care.

- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.

- **The Republican bill expands states' ability to impose cost sharing on Medicaid beneficiaries.** Unlike current law, which bars states from imposing co-payments on children or on pregnancy related services, the Republican bill would allow cost sharing for children and pregnant women for any service except preventive and primary services, as defined by the state. In addition, co-payments could be imposed for all other services to the elderly and disabled.

- **Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.**

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as "nursing home services." Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.

- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

- **The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries.** Assets, including the home, needed by survivors could be at risk of being claimed by the state.

REVISIONS TO REPUBLICAN MEDICAID PLAN

The House Commerce Committee's approved changes to the Republican Medicaid proposal may appear to improve the plan, but actually are minor or cosmetic in nature and, at the core, do not change the basic facts. This bill is still a block grant. It would do nothing to provide a guarantee to coverage and a meaningful benefit package. The financing structure still puts states at risk for increases in costs associated with enrollment changes.

Eligibility

Methodology

State discretion to determine eligibility is restricted compared to the original bill. For example, certain methodologies and standards that are used in certain parts of the eligibility determination process are required under certain circumstances (e.g., income and assets for determining eligibility for disability are specified, if states elect the SSI definition of disability).

- **However, the states still have enough choices to eliminate coverage for many.**

Medicaid Coverage for Welfare Transition

Retains and modifies transitional Medicaid coverage for employed former welfare beneficiaries for twelve months. Eliminates the current 1998 sunset provision for this coverage, thus creating a permanent mandatory Medicaid eligibility category.

- **This superficial improvement does not provide real guarantees of coverage -- such as a Federal right of action or any requirement for adequate benefits -- for former welfare beneficiaries.**

Eligibility Phase-In

Reinstates the eligibility phase-in of children aged 13 to 18 with incomes below poverty as mandatory eligibles.

- **Children aged 13 to 18 appear to be "guaranteed" coverage. However, these children have no real guarantee of coverage as long as amount, duration and scope requirements and Federal right of action are repealed.**

Services

FQHC and RHC Services

Retains FQHC and RHC services as mandatory Medicaid services and requires States to

guarantee that FQHCs and RHCs receive 85 percent of FY 1995 spending on FQHC/RHC services through FY 2000. States could request lower set-aside amounts for later years. Allows States to establish separate solvency standards for FQHC/RHC-controlled health plans.

- **These changes establish a temporary funding guarantee for one type of safety-net provider, but, because the set-aside is based on 1995 spending, the real value of this guarantee would erode with time.**

- **In addition, FQHC/RHC services are "guaranteed" only to the extent that other services are "guaranteed" -- and without amount, duration and scope requirements and a Federal right of action, no services are truly "guaranteed".**

Physician Assistants

Adds physician assistant services as a guaranteed Medicaid service.

- **This amendment enhances the list of "guaranteed" services but does not provide any assurance that enrollees will be able to access this or any other service, as long as amount, duration and scope requirements and Federal right of action are repealed.**

Financing

Block Grant Formula

Lowers (by comparison to the original bill) the growth of state base allotments for 1997, and adds an additional layer of complexity to the already complex (40 pages of legislative language), block grant formula. The bill now conforms with GAO's state-by-state estimates.

- **No changes have been made to the basic structure of the program--it's still about 97 percent block grant and 3 percent limited umbrella fund that is available for only one year.**

Donations and Taxes

Retains current restrictions on States' use of voluntary donations and provider taxes to generate State share. Permits HHS to waive these restrictions, at State request, after the first two years. Requires GAO to study States' use of tax and donation schemes under the revised Medicaid program.

- **The extension of current law restrictions would ensure that, for at least the first two years before the waiver authority begins, States must use "real" dollars to match block-grant funding. Exactly what GAO would study while these practices continue to be prohibited under the revised financing structure is unclear.**

- **The current restrictions on taxes and donations could be undermined after the first two years because HHS would have no basis for denying waiver requests. There would be no evidence or analysis of abusive practices in the first two years of the program and therefore no new information for developing criteria to use when evaluating waiver requests.**

Cost Sharing

The changes to the cost sharing provisions are extensive. They do in fact, limit the liability of Medicaid patients for cost sharing in many instances.

- **However, as with other changes, they are cosmetic, not real. For every protection that would be provided, there are conflicting provisions that would counteract the effect of the proposed change.**

Although the revised proposal would prohibit premiums for the guaranteed population, it would, at the same time, allow States to impose premiums, up to 2 percent of individual gross income, on all other Medicaid beneficiaries.

- **Imposition of a 2 percent premium may not sound like much, but to a low income person, it is potentially a huge barrier to care.**

- **The bill also permits cost sharing (nominal cost sharing for guaranteed populations, and comparable to HMO cost sharing for other groups) for Medicaid beneficiaries. It is possible that a pregnant woman with a hospital episode of $5000, for example, could still be at risk for a cost sharing payment of $300.**

The bill prohibits balance billing by providers.

- **It would nonetheless permit providers to charge cost sharing, and would remove the prohibition on denial of service to a beneficiary unable to pay the cost sharing.**

Indian Health

As amended, the bill requires States to include payment provisions for health services provided to Indians in their State plans and requires States to consult with Indian tribes while developing the State plan.

- **This change provides some minor procedural assurances but does not address the inadequacy of the supplemental pool that appears to be the sole source of Medicaid financing for Indian health care.**

New language clarifies that States that receive an allotment for Indians may use it for tribes and

urban Indian organizations as well as for IHS.

- **This change heightens the inadequacy of the special grants funding, since the funds will be stretched across multiple types of providers.**

The bill still limits special grant funds to states with at least one IHS facility.

- **The bill still limits special grant funds to States with at least one IHS facility, thus excluding California which has significant Indian populations and no IHS facilities.**

Nurse-Aide Training

Allows nurse-aide training programs to continue in certain rural nursing homes, including those that are subject to an extended survey for quality deficiencies. A similar provision was included in the Medicaid portion of the President's balanced budget proposal.

- **This amendment largely conforms with the President's proposal and provides States with additional administrative flexibility. (Note: the amendment does not appear to apply to Medicare and thus poses problems for dually-certified facilities.)**

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE

June 20, 1996

THEY ARE STILL INSISTING ON A BLOCK GRANT FORMULA THAT THE GOVERNORS HAVE ALREADY REJECTED. *The Federal-State partnership is severed. The Republican proposal does not meet the Governors' principle that funding must automatically adjust for all changes in enrollment.* Under the Republican proposal, fully 97% of Federal Medicaid spending is a block grant. The remaining 3% is dedicated to an umbrella fund posing as protection for States with high enrollment growth. However, this umbrella is full of holes because it is difficult to access and provides only a one-time payment for population increases, not sustained support for States with higher than expected enrollment.

MEDICAID CUTS COULD STILL TOTAL $250 BILLION. While the Republicans cut Federal Medicaid spending by $72 billion, the total Medicaid cuts could still reach $250 billion over 6 years if States spend only the minimum required to receive their full grant allocation. This is because the Republican proposal reduces State matching requirements.

MEDICAID GUARANTEE TO MEANINGFUL BENEFITS NO LONGER SECURE FOR MILLIONS OF CHILDREN, PEOPLE WITH DISABILITIES, AND OLDER AMERICANS. The Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts possibly reaching up to $250 billion, States could be forced to deny health benefits to millions of children, people with disabilities, and older Americans, putting millions of middle class families at risk of paying for health care for their parents, children or family members with disabilities.

- **Children.** Deep total cuts in Medicaid would put severe financial pressure on States to reduce health benefits for many of the 18 million children who currently receive Medicaid.

- **People with Disabilities.** The Republican plan still jeopardizes the Medicaid guarantee for the over 6 million people with disabilities who currently receive Medicaid by allowing States the option to define who meets the disability criteria. The Republican's excessive Medicaid cuts may force States to restrict the scope of eligible disabling conditions, or cut back on benefits.

- **Older Americans.** Many of the Medicaid benefits critical to older Americans and people with disabilities are optional -- including prescription drugs, home and community-based care, and assistive devices such as wheelchairs and communication devices -- and cuts reaching up to $250 billion could force States to cut back on these optional benefits.

THE GUARANTEE OF FINANCIAL PROTECTION FOR THE MIDDLE CLASS IS ENDED. Under the Republican bill, current law protections for Medicaid beneficiaries who own homes appears to be eliminated. As such, States will have the option to treat homes as assets, which would result in ineligibility for nursing home coverage. The only way to then obtain coverage could be to sell the home or family farm and apply this and other assets to the cost of care until the beneficiary is poor enough to meet the State-defined resource threshold. In addition, States and providers will face overwhelming financial incentives to shift long-term care costs to patients and their families. Since current Federal protections against excessive cost-sharing requirements would be eliminated, many patients and their families would pay more for less.

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.

June 20, 1996

THE REPUBLICANS' FINANCING PROPOSAL -- CENTRAL TO MEDICAID REFORM -- IGNORES THE GOVERNORS' RECOMMENDATIONS. Unanimously, the Nation's Governors agreed to a financing formula that increases Federal funding when caseload and inflation increase. *The Republican bill's financing formula does not meet this principle.*

- **It is still a block grant.** The Federal-State partnership in financing Medicaid is severed. Under the Republican bill, fully 97 percent of Federal Medicaid spending is block granted. The Federal spending formula is permanently set in legislation so that if States experience a recession or a period of inflation, they are virtually unprotected.

- **Funding does not follow the people.** There is no component of the block grant that adjusts for caseload increases. Without incorporating caseload increases, funding will not keep pace with the caseload, possibly forcing States to deny health benefits to millions of children, people with disabilities, and older Americans.

- **The "umbrella" is full of holes.** Although 97 percent of Federal Medicaid spending is fixed in the block grant, there is a small "umbrella" fund that is supposed to protect states with high enrollment growth. However, this "umbrella" fund is full of holes because it is difficult to access and provides only additional payments for year-to-year population increases, not sustained support for States with higher than expected enrollment.

THE REPUBLICAN BILL GOES BACK TO A MEANINGLESS BENEFITS PACKAGE. The NGA proposal moved towards standards for the amount, scope, duration, of benefits.

- **The Republican bill moves away from the NGA acknowledgement of the need for benefits standards.** Without standards, there is no such thing as meaningful benefits or a guarantee of coverage. In addition, the limits of federal funds may force States to offer meaningless benefits. For example, "coverage" of inpatient hospital care could consist of one day a year.

THE REPUBLICAN BILL ENDS A GUARANTEE OF FINANCIAL PROTECTION FOR MIDDLE CLASS FAMILIES. The NGA proposal did not remove protections against excessive cost sharing requirements for Medicaid beneficiaries.

- **The Republicans will likely force families to pay more for less.** The Republican bill removes current protections against excessive cost sharing requirements -- although the NGA proposal did not endorse this. Since total Medicaid spending will be cut by $250 billion over six years under the Republican proposal, providers will face overwhelming financial incentives to shift long-term care costs to patients and their families.

VACCINES FOR CHILDREN PROGRAM (VFC) IS ELIMINATED. The NGA proposal did not recommend that the Vaccines for Children program be repealed.

- **Children would suffer without adequate vaccinations.** The Republican bill ends the Vaccine for Children program and lets States establish their own vaccinations programs. Repeal of VFC funding will reduce the number of children immunized.

Democratic Policy Committee

Richard A. Gephardt, Chairman
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Facsimile Cover Sheet

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From: Andy Schneider

Date : 6-17-96 **Pages:** 8 (not including cover)

TO: Rob

FROM: Andy

RE: Commerce Committee 6/13/96 Markup of Republican Medicaid Repeal

DATE: 6/17

The Commerce Committee Thursday evening voted to repeal the Medicaid program and replace it with a block grant. The vote was 26-14, with one Democrat (Mr. Hall of Texas) joining all the Republicans present in voting to order the "Medicaid Restructuring Act of 1996," as amended, reported to the Budget Committee, as directed by reconciliation instructions in the FY 1997 Budget Resolution (H. Con. Res. 178). Here is a summary of the amendments.

The "Medicaid Restructuring Act" was introduced on May 22 in H.R. 3507, the Republican "welfare reform" bill. The Commerce Committee did not actually take up H.R. 3507, however; it took up a Committee Print labelled "Title II -- Committee on Commerce," which may be part of a new reconciliation bill when it emerges from the Budget Committee. In any event, this Committee Print is basically the same text as Division B ("Restructuring Medicaid") of H.R. 3507 with some amendments, which are described below. The Committee Print also includes a part restricting "Federal public benefits," including those under the Republican Medicaid block grant, to both legal and illegal aliens; these provisions are also described below.

Committee Print: Amendments to H.R. 3507

1.) *Income and Resource Methodologies.* Under H.R. 3507, States have complete discretion to establish the methodologies for determining whether individuals or families meet the income and resource standards for eligibility under their block grant programs. The Committee Print specifies that in the case of pregnant women and children, the States must use the same methodologies for determining income as they used on May 1, 1996; in the case of disabled and elderly individuals, States must use the income and resource methodologies used under the SSI program; and in the case of low-income families, States must use the income and resource methodologies used under the State's AFDC program as of May 1, 1996.

2.) *Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services.* H.R. 3507 lists FQHC and RHC services as a category in the "guaranteed" benefit package that States must offer, but limits this coverage to the first two years that the block grant is in effect. The Committee Print deletes the two-year limitation; however, it does not alter in any way the complete flexibility that the States have under the bill to limit the amount, duration, and scope of FQHC or RHC services, or to vary coverage for those services from area to area within the State.

3.) *Premiums and Cost-sharing.* H.R. 3507 allows States to impose premiums and cost-sharing (including deductibles, co-insurance, and copayments) in any amounts on any covered service, with one exception: States may not require pregnant women and children with incomes under 100 percent of poverty to pay premiums, and they may only impose "nominal" cost-sharing on these populations with respect to primary and preventive care services. The Committee Print revises this policy. It prohibits States from imposing premiums on any of the "guaranteed" populations; for other groups the State elects to cover, premiums may not exceed 2 percent of gross income. It limits the cost-sharing States may impose on the "guaranteed" populations with respect to any covered service to amounts that are "nominal," defined as not greater than 6 percent of the cost of the service or, if greater, 50 cents; for other groups the State elects to cover, cost-sharing may not exceed the average, nominal cost-sharing imposed in the State for helath plans offered by HMOs. Finally, the Committee Print prohibits providers participating in the program from billing eligible individuals for more than the permissible cost-sharing amounts.

4.) *Family Responsibility.* H.R. 3507 prohibits States from requiring the adult children of individuals to contribute toward the cost of nursing home care or other long-term care services (to the extent that these services are covered under the plan). The Committee Print expands this prohibition by including "hospital and other institutional services" among the types of care the cost of which States may not require adult children to pay (to the extent that these services are covered under the plan).

5.) *Block Grant allotments for Illegal Aliens.* H.R. 3507 provides fixed allotments of Federal block grant funds for each of the fiscal years 1997 through 2001 to specified States to help defray the cost of emergency care services to illegal aliens. The Committee Print delays this 5-year allotment period by one year, so that the allotments would be paid out from fiscal year 1998 through fiscal year 2002. The fixed dollar allotments would remain unchanged for each of the (delayed) fiscal years.

6.) *Block Grant Allotments for Native Americans.* H.R. 3507 provides fixed allotments of Federal block grant funds for each of the fiscal years 1997 through 2002 to States for the cost of services provided to eligible Native Americans through the Indian Health Service and tribally-run facilities. The Committee Print eliminates the allotment of $72 million for FY 1997 and redistributes the $72 million over the susequent 6 fiscal years, so that the total amount of Federal block grant funds available to States for this purpose remains constant at $500 million.

Committee Print: Restricting "Federal Public Benefits" for Aliens

1.) *Illegal Aliens.* H.R. 3507 limits Federal block grant matching payments for services to illegal aliens (i.e., aliens not permanently residing in the U.S. under color of law) who are otherwise eligible for Medicaid to services necessary for the treatment of an emergency medical condition (including, at State option, prenatal care). The bill also provides fixed allotments to specified States for the costs of these services (see above

for discussion of the Committee Print amendment to this provision). The Committee Print allows illegal aliens to qualify for "Federal public benefits," which include services paid for with the new Federal Medicaid block grant funds, for 3 types of services: (1) emergency medical services; (2) public health assistance for immunizations; and (3) public health assistance for testing and treatment of a serious communicable disease if necessary to prevent the spread of the disease. The relationship between these broader "Federal public benefits" exceptions and the narrower block grant emergency care exception is uncertain; it is possible that the Committee Print "Federal public benefits" language nullifies H.R. 3507's prenatal care coverage option).

2.) *Legal Aliens.* H.R. 3507 is silent on the treatment of legal aliens (i.e., aliens permanently residing in the U.S. under color of law). Although H.R. 3507 gives States broad discretion in determining eligibility criteria, States would in all likelihood be required to cover otherwise eligible legal aliens because the U.S. Constitution prohibits States from discriminating among classes of aliens who are permanently residing in the U.S. under color of law. The Committee Print prohibits legal aliens who have entered the country on or after the date of enactment from qualifying for "Federal public benefits" (including services under the new Medicaid block grant) for a period of 5 years after entry into the U.S., with the following exceptions. The 5-year bar does not apply to refugees, aliens granted asylum, or veterans. It also does not apply to the following types of services: (1) emergency medical services; (2) public health assistance for immunizations; and (3) public health assistance for testing and treatment of a serious communicable disease if necessary to prevent the spread of the disease. Thus, it appears that under H.R. 3507, as modified by the "Federal public benefits" Committee Print, States may not use Federal Medicaid block grant funds to provide coverage to otherwise eligible legal aliens entering the country on or after enactment except in the case of emergency care, immunizations, and testing and treatment of serious communicable disease.

Amendments Adopted by the Committee

1.) *Transitional Coverage for Working Welfare Families* (Deal, as amended by Waxman). Under current law, States are required to provide 1 year Medicaid coverage to families that leave welfare due to earnings and who continue to report earnings during the transitional year; this current law requirement sunsets on September 30, 1998. The Republican bill would repeal the current law requirement and make welfare-to-work transitional Medicaid coverage a State option under the new block grant. The amendment will require States to provide 1 year of Medicaid coverage to families who become ineligible for Medicaid due to increased earnings from employment or the collection of child support. This requirement would not sunset. (An amendment offered by Mr. Waxman to the Deal amendment striking a September 30, 1998 sunset provision included in the amendment as offered was adopted by a vote of 20-19).

2.) *Coverage of Children 13 - 18* (Whitfield). Under current law, Medicaid coverage is

being phased in on an annual basis for children aged 13 through 18 whose family incomes do not exceed 100 percent of the poverty level (technically, children born after September 30, 1983). Under the Republican bill, coverage of children over 5 but under 13 whose family income does not exceed 100 percent of poverty is described as "guaranteed," while coverage of children age 13 through 18 in families at or below poverty is described as "optional." The amendment would include children born after September 30, 1983, up through the age of 18, in the class of poor children whose eligibility is described as "guaranteed."

3.) *Set-Aside for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services* (Upton). Under current law, States must cover medically necessary FQHC and RHC services and must pay 100 percent of the reasonable cost of those services. The Republican bill repeals these current law provisions and, as amended by the Committee Print (see above), includes FQHC and RHC services among the list of 11 service categories described as "guaranteed." States may limit the amount, duration, or scope of all "guaranteed" services, including FQHC and RHC services, as they choose. The amendment establishes a set-aside of block grant funds for FQHC and RHC services by requiring States, up through FY 2000, to spend on these services no less than 85 percent of the amount they spent in FY 1995. After FY 2000, States will be allowed to lower their set-aside obligations. (An amendment to the Upton amendment offered by Mr. Stupak and Mr. Richardson, which would have raised the 85 percent threshold to 100 percent and clarified that it applied separately to each category, was defeated by a vote of 19-21).

4.) *Nurse Aide Training* (Burr). Under the Republican bill, in order to receive Medicaid block grant funds, a nursing home may only use nurse aides that are trained and competent. Nursing homes may conduct the training programs to qualify nurse aides unless the home has been cited or penalized for quality problems within the previous two years. The amendment authorizes the State to waive this prohibition when no other training or competency evaluation program is offered within a reasonable distance of the facility and the State assures oversight of the facility.

5.) *Provider "Donations" and "Taxes"* (Ganske). Under current law, States are effectively prohibited from using provider "donations" as State Medicaid matching funds, and they are limited in the use of revenues from provider "taxes" to draw down Federal matching funds (among other things, permissible taxes must be uniform, broad based, and the providers cannot be held harmless). Under the Republican bill, these current law provisions are repealed, and States have the authority to use revenues in any amount from provider "donations" or "taxes" to satisfy their State matching obligation. The amendment reinstates the current law provisions relating to provider "donations" and "taxes," but, effective two years after enactment, authorizes the Secretary to waive these provisions on a State-by-State basis if it would not financially undermine the program or otherwise be abusive. (An amendment offered by Mr. Dingell to the Ganske amendment to delete the Secretary's waiver authority was defeated 17-25).

6.) *Physician Assistant Services* (Towns). The Republican bill lists 11 categories of services that the bill describes as "guaranteed" even though the States may limit the amount, duration, or scope of any of these categories however they choose. The amendment adds the category of physician assistance services to this listing, subject to the same limitations as to amount, duration, and scope.

7.) *Technical Amendments* (Bilirakis).

Amendments Rejected by the Committee

1.) *Fraud and Abuse* (Dingell). Under current law, States are effectively prohibited from using provider "donations" as State Medicaid matching funds, and they are limited in the use of revenues from provider taxes to draw down Federal matching funds (among other things, permissible taxes must be uniform, broad based, and the providers cannot be held harmless). In addition, State officers or employees who are responsible for the expenditure of substantial amounts of Federal Medicaid funds are subject to Federal laws prohibiting conflicts of interest. The Republican bill repeals the current law prohibitions on provider "donations" and "taxes" as well as the current law prohibitions on conflicts of interest by State officials. The amendment would have restored the current law provisions relating to provider "donations" and "taxes" and conflicts of interest. (The Committee defeated this amendment on a 23-20 vote by adopting a substitute amendment offered by Mr. Bliley that directs the GAO to study the use of provider "donations" and "taxes" by the States and report to the Congress within 2 years with recommendations. Subsequent to consideration of this amendment, the Committee adopted the Ganske amendment (see above) which reinstates the current law prohibitions provider "taxes" and "donations" for two years, then allows the Secretary of HHS to waive the current law provisions on a State-by-State basis. The Ganske amendment does not reinstate the current law prohibitions on conflicts of interest by State officials handling Federal Medicaid funds).

2.) *Real Guarantee of Coverage for Children* (Eshoo). The Republican bill repeals the current law Federal guarantee of coverage for medically necessary physician, hospital, and related basic health services for children, including the guarantee of coverage for treatment services necessary to correct a condition identified during a medical screening (under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit). The amendment would have fully restored the current law entitlement for eligible children, including the full EPSDT benefit, by (1) requiring States to cover the services for this population in at least the same amount, duration, and scope as the services they were covering under their Medicaid programs as of June 1, 1996, and (2) by allowing children to seek enforcement of this guarantee in Federal court. (Defeated 19-23).

3.) *Real Guarantee of Coverage for Elderly Needing Nursing Home Care* (Markey/Pallone). The Republican bill repeals the current Federal guarantee of coverage for medically necessary nursing home services for eligible elderly individuals.

The amendment would have fully restored the current law entitlement for coverage of nursing home services (in an amount, duration, and scope as provided under each State's plan as of June 1, 1996) for elderly individuals who (1) require nursing home services and (2) meet the Medicaid eligibility standards in effect in the State as of June 1, 1996. The amendment would also have allowed these elderly individuals to seek enforcement of this guarantee in Federal court (Defeated 19-24).

4.) *Real Guarantee of Coverage for Elderly Alzheimer's Victims* (Deutsch).The Republican bill repeals the current Federal guarantee of coverage for medically necessary nursing home services for eligible elderly individuals. The amendment would have fully restored the current law entitlement for coverage of nursing home services (in an amount, duration, and scope as provided under each State's plan as of June 1, 1996) for elderly individuals who (1) have Alzheimer's disease, (2) require nursing home services, and (3) meet the Medicaid eligibility standards in effect in the State as of June 1, 1996. The amendment would also have allowed these elderly individuals to seek enforcement of this guarantee in Federal court. (Defeated 16-20).

5.) *Real Guarantee of Coverage for Elderly Veterans Needing Nursing Home Care* (Gordon). The Republican bill repeals the current Federal guarantee of coverage for medically necessary nursing home services for eligible elderly individuals. The amendment would have fully restored the current law entitlement for coverage of nursing home services (in an amount, duration, and scope no less than that provided under each State's plan as of June 1, 1996) for each elderly veteran who (1) now or in the future needs nursing home care and (2) is eligible for Medicaid under the eligibility rules in effect in the State as of June 1, 1996. The amendment would also have allowed these elderly individuals to seek enforcement of this guarantee in Federal court. (Defeated 17-22)

6.) *Continue Current Coverage for Elderly Beneficiaries Now in Nursing Homes* (Klink). The Republican bill repeals the current Federal guarantee of coverage for medically necessary nursing home services for eligible elderly individuals. The amendment would have fully restored the current law entitlement for coverage of nursing home services (in an amount, duration, and scope no less than that provided under each State's plan as of June 1, 1996) for elderly individuals who, as of June 1, 1996, were (1) living in nursing homes and (2) eligible for Medicaid in their State. The amendment would also have allowed these elderly individuals to seek enforcement of this guarantee in Federal court. (Defeated 16-23).

7.) *Restore Current Law Guarantee of Treatment for Children* (Ganske). Under current law, eligible children are entitled to early and periodic screening, diagnostic, and treatment (EPSDT) services, including all needed treatment for conditions identified during an EPSDT medical screening. The Republican bill repeals the current law requirement that States provide needed treatment services for conditions identified during a medical screening, and it allows States to limit the amount, duration, and scope of the screening and diagnostic services as well. The amendment would have

fully restored the current law EPSDT benefit for eligible children by requiring that the States cover the EPSDT services in the same amount, duration, and scope as was in effect under each State's Medicaid plan as of June 1, 1996. (Defeated 18-22).

8.) *Real Guarantee of Coverage for Indians* (Richardson). The Republican bill repeals the current Federal guarantee of coverage for basic health care services for Native American children, women, disabled, and elderly individuals who meet Medicaid's eligibility standards. The amendment would have fully restored the current law entitlement by (1) requiring States to cover the services they were covering under their Medicaid plans as of June 1, 1996, for Indians eligible (currently or in the future) under the standards in effect in each State at that time; (2) exempting these Native Americans from the bill's repeal of the Federal entitlement; and (3) exempting these Native Americans from the bill's prohibition against use of the Federal courts to enforce their rights. (Defeated 18-22).

9.) *Restore Current Law Right of Elderly to Choose Their Own Nursing Home* (Engel and Brown). The Republican bill repeals the current law right of beneficiaries to choose the physician, hospital, or other provider from which they wish to receive covered services (providers are not required to participate in the program); instead, it allows the State to determine the provider from which a beneficiary receives care. The amendment would have restored the current right of elderly beneficiaries to choose the nursing home from which they receive Medicaid services (nursing homes would not be required to participate). (Defeated 15-24).

10.) *Real Guarantee of Coverage for Pregnant Women and Infants* (Furse). The Republican bill repeals the current guarantee of coverage for medically necessary health care services for pregnant women and infants with incomes at or below 133 percent of the poverty level and bars them from enforcing that guarantee in Federal court. The amendment would have fully restored the current law entitlement for pregnant women and infants by (1) requiring States to cover the services they were covering under their Medicaid plans as of June 1, 1996, for pregnant women and infants eligible (currently or in the future) under the standards in effect in each State at that time; (2) exempting these individuals from the bill's repeal of the Federal entitlement; and (3) exempting these individuals from the bill's prohibition against use of the Federal courts to enforce their rights (Defeated 14-25).

11.) *Continue Current Law Coverage for Breast and Cervical Cancer Services* (Brown). The Republican bill repeals the current law requirement that States cover medically necessary physician and hospital services in an amount, duration, and scope reasonably sufficient to achieve their purpose. States would have the flexibility to limit coverage based on diagnosis or condition (i.e., physician services for lung cancer but not cervical cancer). The amendment would have required States to cover screening, diagnosis, and treatment services for breast and cervical cancer at least to the extent these services were covered under each State's Medicaid plan as of June 1, 1996. (Defeated 17-23).

12.) *Continue Current Law Benefits Parity for Residents of Rural Areas.* (Stupak). The Republican bill repeals the current law requirement that covered services be comparable in amount, duration, and scope throughout the State and allows States to vary benefits from area to area. The amendment would have prohibited States from providing benefits to individuals living in rural areas that were less in amount, duration, or scope than those provided to individuals in urban areas, and vice versa. (Defeated 14-24).

13.) *Allow Current "Section 1115" Waiver States to Continue to Operate Their Demonstrations* (Furse). Under the authority of section 1115 of the Social Security Act, the Administration has granted 12 States waivers of current law requirements in order to demonstrate (over a five-year period) innovative approaches to delivering Medicaid services on a statewide basis, usually through managed care. 8 of these waivers are currently operational: Arizona, Delaware, Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, Vermont. The amendment would have allowed -- but not required -- these States to continue operating their demonstrations through the duration of their waivers. (Defeated 14-25)

14.) *Restore Minimum Payment Standards for Hospitals and Nursing Homes and Managed Care Plans* (Pallone). The Republican bill repeals the current law requirement ("Boren amendment") that payments to hospitals and nursing homes be "reasonable and adequate," as well as the current law requirement that capitation payments to managed care plans be "actuarially sound." It also prohibits providers from seeking to enforce their rights under the program against the State in Federal Court. The Pallone amendment would have: (1) reinstated and strengthened the "Boren" payment floors for hospitals and nursing homes; (2) required that rates paid to capitated health care organizations be "reasonable and adequate;" and (3) authorized providers to seek enforcement of these payment floors in Federal court. (Defeated 16-24).

MEMORANDUM

May 24, 1996

TO: Carol Rasco and Laura Tyson
FR: Chris Jennings
RE: Health Care Developments/Background Materials
cc: Jen K., Elizabeth Drye, Tom O'Donnell

Although debate around welfare reform and the minimum wage has understandably gained the bulk of attention this week, there have been some noteworthy developments on the Kassebaum-Kennedy and Medicaid fronts that are worth reporting. In addition, I should take this opportunity to remind you that the Medicare Health Insurance Trust Fund report is scheduled to be released June 5th. The Republicans will be all over it and it may be advisable to discuss early next week our strategy/message on its release.

First, although the conferees have still not been selected for the conference on the Kassebaum-Kennedy bill, the Republicans and their staffs have held a number of meetings in an attempt to expedite movement/agreement among at least the Republicans on the Hill. My best sources inform me that the Senators want to get something done prior to, or soon after, Leader Dole's departure from the Senate. However, the House Republicans are already feeling their oats and apparently are comfortable with a leisurely pace; they feel delay enhances their leverage with the more moderate (and soon to be "Dole-less") Senate and the President. They also feel their interests are least served by a signed bill and want to extract as much from the Conference as possible before they relent; this means, at least for now, they are signaling no interest in any compromise on Medical Savings Accounts (MSAs).

We have been asked for weeks now for an MSA alternative proposal by Hill Members. Since our position is that we support the Senate-passed bill (with no MSA), we have consistently declined these repeated invitations. The Republicans also felt constrained to not put a more watered down version of their proposal on the table. It appeared we had a classic stalemate until I received a call from the Finance Committee Republican Staff Director asking for a more detailed listing of our specific concerns about MSAs. She theorized that such a list might help Republicans be a bit more responsive to our concerns and could help break the impasse. John Hilley thought we should send something over. Building on some of our past MSA critiques (and working with Treasury and HHS) we prepared the enclosed document and forwarded it to the Hill yesterday. (FYI, the House Republicans were furious that the Senate made the request because they thought it could help to undermine their positioning on this almost theological issue to them.).

There are three other extremely controversial issues that will complicate any conference: medical malpractice, the deregulation of Multiple Employer Welfare Arrangements (MEWAs), and the mental health parity issue. Medical malpractice seems to be the least of our problems as some Republicans in the Senate have problems with dealing with this controversial issue on THIS bill. Until very recently, we also thought that the MEWA issue could be easily disposed of since the Senate has little appetite for them. However, there is one Senator who is an exception -- likely new Leader Trent Lott. It may well be that we face a serious complication on this issue with him. Having said this, clearly right after the MSA problem, the greatest other challenge to getting an acceptable bill to the President is the controversy and complications surrounding the mental health parity provision. The business community is absolutely beside themselves in opposition. However, remarkably, rumors persist that something more significant than a commission may still emerge. (Because our position is supporting the passed amendment, we are going to hold back as long as possible before becoming at all engaged on this issue.)

There are a host of important, but second tier issues that Nancy Ann, Jen and I have reviewed. They range from the treatment of private long-term insurance standards, to Medicare fraud and abuse provisions, to administrative simplification, to Medicare Medigap duplication issues, etc. We have completed a 30-plus page side-by-side that we are using for our discussions with the Hill. (If you are interested in seeing it, please call and we would be happy to get it over to you.)

Second, on Wednesday, the Republicans released what they purported to be the bipartisan NGA Welfare and Medicaid agreement. The Medicaid agreement seems to be a classic Howard Cohen (Republican Commerce Committee staffer) special. It is extremely complicated and creative, but in the end extremely flawed.

Attached are two "one-pagers" on the Republicans Medicaid bill that was just unveiled. The first focuses on the Republican plan from the perspective of the Administration. The second illustrates why the Republican plan does not reflect the bipartisan NGA agreement (as the Republicans have claimed) and helps explain why the Democratic Governors are so opposed to it. (The Dem. Governors may send a Welfare/Medicaid letter to the Congress as early as today to raise their serious objections, particularly focusing on Medicaid; the other option they may be considering waiting for a formal reply right after their meeting next week with the President.)

Also attached is a just completed, more detailed, HHS analysis of the major shortcomings of the Republican bill. Without restating the enclosed, we feel very comfortable describing their newest offering as a poorly disguised block grant that undermines the guarantee of meaningful coverage for Medicaid's 36 million recipients

Third and finally, we have just updated our health care issue brief for the President. Since the perception sometimes is that nothing other than our failed attempt in health care has occurred under the President's watch, the information contained is helpful in countering that impression. We thought you might like to have on hand to use in speeches or to give to people who may be interested in having on hand. We hope you find this to be helpful.

REPUBLICANS STILL INSIST ON ENDING THE MEDICAID GUARANTEE

May 24, 1996

THEY ARE STILL INSISTING ON A BLOCK GRANT FORMULA THAT THE GOVERNORS HAVE ALREADY REJECTED. *The Federal-State partnership is severed. The Republican proposal does not meet the Governors' principle that funding must automatically adjust for all changes in enrollment.* Under the Republican proposal, fully 97% of Federal Medicaid spending is a block grant. The remaining 3% is dedicated to an umbrella fund posing as protection for States with high enrollment growth. However, this umbrella is full of holes because it is difficult to access and provides only a one-time payment for population increases, not sustained support for States with higher than expected enrollment.

MEDICAID CUTS COULD STILL TOTAL $265 BILLION. While the Republicans cut Federal Medicaid spending by $72 billion, the total Medicaid cuts could still reach $265 billion over 6 years if States spend only the minimum required to receive their full grant allocation. This is because the Republican proposal reduces State matching requirements.

MEDICAID GUARANTEE TO MEANINGFUL BENEFITS NO LONGER SECURE FOR MILLIONS OF CHILDREN, PEOPLE WITH DISABILITIES, AND OLDER AMERICANS. The Republican Medicaid plan still undermines the guarantee to meaningful health benefits. With total cuts reaching up to $265 billion, States could be forced to deny health benefits to millions of children, people with disabilities, and older Americans, putting millions of middle class families at risk of paying for health care for their parents, children or family members with disabilities.

- **Children.** Deep total cuts in Medicaid would put severe financial pressure on States to reduce health benefits for many of the 18 million children who currently receive Medicaid. In addition, the Republican proposal would deny the guarantee of coverage for 2.5 million children aged 13-18.

- **People with Disabilities.** The Republican plan still jeopardizes the Medicaid guarantee for the over 6 million people with disabilities who currently receive Medicaid by allowing States the option to define who meets the disability criteria. Their excessive Medicaid cuts may force States to restrict the scope of eligible disabilities, or cut back on benefits.

- **Older Americans.** Many of the Medicaid benefits critical to older Americans and people with disabilities are optional -- including prescription drugs, home and community-based care, and assistive devices such as wheelchairs and communication devices -- and cuts reaching up to $265 billion could force States to cut back on these optional benefits.

THE GUARANTEE OF FINANCIAL PROTECTION FOR THE MIDDLE CLASS IS ENDED. Under the Republican bill, current law protections for Medicaid beneficiaries who own homes appears to be eliminated. As such, States may have the option to treat homes as assets, which would result in ineligibility for nursing home coverage. The only way to then obtain coverage could be to sell the home or family farm as an asset and spend down until the beneficiary met the State-defined resource threshold. In addition, States and providers will face overwhelming financial incentives to shift long-term care costs to patients and their families. Since Federal protections against excessive cost-sharing requirements are eliminated, many patients and their families will pay more for less.

THE REPUBLICAN MEDICAID BILL MIRRORS VETOED BLOCK GRANT -- NOT BIPARTISAN NGA AGREEMENT.

May 24, 1996

THE REPUBLICANS' FINANCING PROPOSAL -- CENTRAL TO MEDICAID REFORM -- IGNORES THE GOVERNORS' RECOMMENDATIONS. Unanimously, the Nation's Governors agreed to a financing formula that increases Federal funding when caseload and inflation increase. *The Republican bill's financing formula does not meet this principle.*

- **It is still a block grant.** The Federal-State partnership in financing Medicaid is severed. Under the Republican bill, fully 97 percent of Federal Medicaid spending is block granted. The Federal spending formula is permanently set in legislation so that if States experience a recession or a period of inflation, they are virtually unprotected.

- **Funding does not follow the people.** There is no component of the block grant that adjusts for caseload increases. Without incorporating caseload increases, funding will not keep pace with the caseload, possibly forcing States to deny health benefits to millions of children, people with disabilities, and older Americans.

- **The "umbrella" is full of holes.** Although 97 percent of Federal Medicaid spending is fixed in the block grant, there is a small "umbrella" fund that is supposed to protect states with high enrollment growth. However, this "umbrella" fund is full of holes because it is difficult to access and provides only a one-time payment for population increases, not sustained support for States with higher than expected enrollment.

THE REPUBLICAN BILL GOES BACK TO A MEANINGLESS BENEFITS PACKAGE. The NGA proposal moved towards standards for the amount, scope, duration, and benefits.

- **The Republican bill moves away from the NGA acknowledgement of the need for benefits standards.** Without standards, there is no such thing as meaningful benefits or a guarantee of coverage. For example, "coverage" of inpatient hospital care could consist of one day a year.

THE REPUBLICAN BILL ENDS A GUARANTEE OF FINANCIAL PROTECTION FOR MIDDLE CLASS FAMILIES. The NGA proposal did not remove protections against excessive cost sharing requirements for Medicaid beneficiaries.

- **The Republicans will force families to pay more for less.** The Republican bill removes current protections against excessive cost sharing requirements -- although the NGA proposal did not endorse this. Since total Medicaid spending will be cut by $265 billion over six years under this proposal, providers will face overwhelming financial incentives to shift long-term care costs to patients and their families.

VACCINES FOR CHILDREN PROGRAM (VFC) IS ELIMINATED. The NGA proposal did not recommend that the Vaccines for Children program be repealed.

- **Children would suffer without adequate vaccinations.** The Republican bill ends the Vaccine for Children program and lets States establish their own vaccinations programs. Repeal of VFC funding will reduce the number of children immunized.

DRAFT

THE REPUBLICAN BILL STILL FAILS TO MEET THE PRESIDENT'S BASIC PRINCIPLES FOR MEDICAID REFORM

The Republican bill still fails to meet many of the President's basic principles for Medicaid reform.

These principles include:

- A real, enforceable guarantee of coverage for a defined benefit package
- Appropriate federal and state financing
- Beneficiary protections through quality standards and accountability

THE REAL GUARANTEE OF COVERAGE

Any "guarantee" of Medicaid coverage has three critical components: 1) eligibility, 2) benefits, and 3) enforcement. Without any one of these necessary elements, there is no true guarantee of coverage. The Republican bill has significant problems in all three areas of the coverage guarantee.

Eligibility

While the Administration proposal maintains all current law mandatory and optional eligibility groups, the House Commerce Republican bill would alter eligibility criteria thereby eliminating the guarantee of coverage for some groups. The bill:

- **repeals the phase-in of Medicaid coverage for children ages 13-18 in families with income below the Federal poverty level.**
- **offers each state the option of using either: 1)the federal definition of disability, or 2) its own definition of disability.** This could result in fifty separate state definitions, instead of the one in current policy. State definitions of disability could eliminate coverage for disabled people who have more specific and complicated needs for Medicaid; or states could redefine disability to shift costs to the federal government.
- **permits additional eligibility limitations based on age, residence, and employment or immigration status.**
- **eliminates the guarantee of medical assistance for individuals losing cash assistance due to time limits or other provisions in welfare reform.**
- **lets states define what constitutes income and resources.** If income and resource tests are more restrictive than current law, then a large number of current beneficiaries could lose their eligibility for Medicaid.

Benefits

While the Administration proposal would maintain all current law mandatory and optional services, the Republican bill could lead to drastically scaled-back and inadequate benefits packages.

- **The bill gives states complete flexibility to define the adequacy of required benefits (the "amount, duration, and scope" of benefits).** The Secretary does not have clear authority to affect states' decisions regarding amount, duration, and scope. As a result, states could restrict benefits drastically, thereby further undermining the guarantee to coverage.

- **Statewideness requirements would be eliminated.** States could arbitrarily offer different coverage and benefits packages in different parts of the state. This could also result in loss of coverage for certain special populations that tend to live in specific areas.

- **Comparability requirements would be eliminated.** States could reduce benefits for certain populations (such as HIV positive beneficiaries).

- **"Treatment" under EPSDT is severely curtailed and requires treatment only for dental, hearing and vision services.** Treatment is not required for other services, illnesses or conditions discovered by health screens and exams. This means that children diagnosed with certain medical conditions may go untreated. Under current law, children diagnosed (in an EPSDT screening) with medical conditions must be treated.

- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are mandatory services only for the first eight quarters after the program is enacted in a state.** After that time, they are optional services. (Note that in the Spring overview document, they are listed as guaranteed services.)

- **The Vaccines for Children Program is repealed,** and states are given flexibility to set their own vaccination schedules.

- **Federal funding for abortion services is limited to instances of rape, incest, or where the life of the mother is in jeopardy.**

- **Family planning services are limited to "pre-pregnancy" family planning services only.** States would be able to determine which family planning methods would be available.

Enforcement

A real guarantee of health coverage must include an adequate enforcement mechanism. The Administration proposal maintains the right of beneficiaries to enforce their federal program benefits in federal courts, assuring that Medicaid recipients have the same due process rights everywhere in the United States. However, the Republican bill has serious weaknesses when it comes to enforcing the rights of Medicaid beneficiaries.

- **The Republican bill removes the right of beneficiaries to sue in federal courts.** No federal right of action means there are no guaranteed enforceable federal benefits for individuals.

- Without federal court rulings, Medicaid law may not have consistent interpretations across the nation.

- Medicaid would become the sole federal statute conferring benefits on individuals with no possibility of federal enforcement for its intended beneficiaries.

FINANCING

The Administration proposal protects States from enrollment increases due to economic downturns, and from demographic changes by maintaining the shared federal-state financial responsibility through a per capita cap. The Republican bill does not guarantee funding for all new enrollees.

The funding formula in the Republican bill has been seen before: it's the basic Medigrant II. It's a funding stream and allocation across states with essentially the same component parts defined by the same formulas and legislative language in earlier Republican bills. Now the block grant is embellished by a limited umbrella fund. About 97% of funds flow through the Medigrant II block grant. About 3 percent is attributable to the new umbrella fund.

The funding provides very limited risk protection for enrollment growth.

- **Funding growth is not linked to comparisons between actual and projected enrollment, and the umbrella provides one time only adjustments that do not carry forward to subsequent years.** This is not the kind of protection to be expected from a true federal-state partnership. Instead, like earlier Republican plans, it limits federal responsibility and shifts the fiscal burden to the states. The calculations associated with access to the umbrella mechanism limit access to the fund and treat states unevenly.

- **The Republican funding scheme clearly restructures the dynamics of the Medicaid program.** States will always be faced with poor and sick populations. Without a guarantee of federal funding to support meeting the needs of those populations, it will be left to the states to balance revenue against societal needs--they will be forced to either raise taxes or reduce services. These dynamics clearly undermine the concept of "guaranteed" coverage of defined populations with a meaningful benefit package.

- **The Republican bill would repeal the limitations placed on provider taxes and donations schemes.** When states had unlimited use of such financing mechanisms in the late 1980's and early 1990's, Medicaid spending growth reached almost 30 percent annually. Once bipartisan legislation limited these schemes, Medicaid spending growth fell substantially -- to about 10 percent a year.

- **The Republican bill would change the minimum Federal Matching Assistance Percentage (FMAP) from 50 percent to 60 percent.** This change would allow many states to significantly decrease the state contribution and increase federal dollars spent on Medicaid. Given the block grant structure of the financing proposal, this change would shift funding from poorer states with higher current FMAPs to the 23 wealthier states that currently have 50 percent FMAPs.

PROTECTIONS FOR BENEFICIARIES AND TAXPAYERS

The Administration proposal maintains a variety of current law quality protections including managed care plans, and also contains financial protections for the family members of nursing home residents.

The Republican bill would either eliminate or reduce at least the following long-standing provisions that ensure quality and protect the family members of beneficiaries.

- **The bill repeals title XIX and replaces it with a new title.** This change seriously compromises the existing framework of quality standards, beneficiary and family financial protections, and program accountability by eliminating numerous provisions that protect beneficiaries, providers, and states.

- **There is no mention of quality standards for managed care plans.** Given that almost one-third of Medicaid beneficiaries are now in managed care, managed care quality provisions are essential to protect the health of millions of people.

- **The Republican bill contains no standards for cost sharing other than some limits related to primary and preventive care for children and pregnant women.** Beneficiaries and their families who are protected by current law against excessive cost sharing could face new obligations to pay for their care or that of a family member. Without cost sharing standards, benefit packages could be essentially meaningless for other services for children and pregnant women, and for all services for the elderly and disabled.

- **Under the Republican bill, adult children could be required to pay for hospital care, physicians services, or any other service (except long term care) for their parents on Medicaid.**

- **The prohibition in current law against balance billing by providers for amounts above the Medicaid rate would be repealed for most services.** Although the Republican bill retains a nominal prohibition on balance billing by nursing homes, this could be easily circumvented by redefining what is covered as "nursing home services." Because states have complete flexibility to define benefit levels (amount, duration, and scope), elements of care now in the basic benefit, the cost of which is in the basic rate and not subject to balance billing, could become the responsibility of the patient.

- **The Republican bill would allow states to review asset transfers as far back as they would like in determining eligibility for Medicaid.** Currently, the look back period is 36 months. In addition, states could broaden the scope of the penalty (now limited to denial of certain long term care benefits) to any or all benefits. Implementation of such an approach could seriously limit eligibility for Medicaid, even in those instances where assets were transferred years in advance of application for Medicaid, or were not transferred for the purpose of gaining eligibility.

- **The bill replaces current law with complete flexibility regarding recoveries from estates of deceased beneficiaries.** Assets, including the home, needed by survivors could be at risk of being claimed by the state.

- **Under the Republican bill, states would have both a financial incentive and the opportunity to receive federal matching payments for the costs of services that are currently supported with state funds only (e.g., state psychiatric hospitals).** This cost shift is possible because states would have flexibility in defining eligibility (e.g., for the disabled), and benefit levels (amount, duration, and scope), and the elimination of the IMD exclusion.

HOUSE COMMITTEE ON COMMERCE

Restructuring the Medicaid Program

A Legislative Proposal Founded on the Bipartisan Medicaid Reform Principles of the National Governors Association

Chairman Thomas J. Bliley, Jr.
House Committee on Commerce

Spring 1996

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1

The Rationale for Reform

The Medicaid program is a costly, bureaucratic, and counter-productive attempt to provide low-income Americans the health coverage they need. Without reform, the Medicaid program will continue to fail the families and individuals it is intended to serve. With reform, States will be empowered to provide more effective, responsive, and efficient care to many more needy Americans.

This booklet summarizes the major provisions of "Restructuring the Medicaid Program," a legislative proposal developed by the House Committee on Commerce and the Senate Committee on Finance that is founded on the Medicaid reform principles unanimously adopted by the National Governors Association on February 6, 1996.

Like the Governors' bipartisan agreement, the Committees' legislative language is focused upon the need to address long-standing flaws in the Medicaid program:

- impersonal service delivery,
- excessively complex bureaucracy,
- unresponsive federal micromanagement,
- strictly limited State flexibility, and
- rampant waste and inefficiency.

The failure of the Medicaid program is also evident by the tremendous budgetary pressure it places on States. As a result of its uncontrollable costs and numerous federal mandates, the Medicaid program has doubled as a share of State budgets since 1987. In response, States have been forced to restrict investment in many other essential human services. In fact, State Governors and other officials testified before the House Commerce and Senate Finance Committees that funds needed for such critical human services as child welfare, education, mental health, public safety, and public transportation must instead be spent on Medicaid.

Much of the blame for this pressure is due to the current Medicaid program's unsustainable costs. During fiscal years 1990 through 1994, federal Medicaid spending grew at an estimated average annual rate of 19.1 percent. Although the Congressional Budget Office projects average growth rates of about 10 percent over the next 7 years -- absent reform -- even these estimates are alarming given Medicaid's status as the single largest item in many State budgets.

For all of its spending growth, however, the Medicaid program does not appear to adequately serve eligible recipients. Due in large part to federal micromanagement, complex bureaucratic requirements, and outdated service delivery, the program does not provide the quality health care, patient responsiveness, and more efficient administration common in the private sector. States complain that federal legislation and regulations put in place over the past 10 years have diminished their ability to manage and control their Medicaid programs. In particular, States protest costly federal mandates as well as obstacles to the development of more responsive and efficient service delivery innovations. Another issue often raised by the States concerns the Boren Amendment which has enabled some providers to sue States in federal court in order to obtain arbitrarily-determined higher payment rates.

As a result, States have long sought enhanced operational flexibility so that they can better meet the health care needs of their low-income residents. However, the extensive application requirements and bureaucratic micromanagement of the Health Care Financing Administration's waiver process have enabled few States to fully free themselves from existing obstacles to better Medicaid service delivery.

Finally, the Medicaid program, as currently structured, is a frequent target of waste, fraud, and abuse. The General Accounting Office estimates that as many as 10 cents of every Medicaid dollar may be lost to waste, fraud, and abuse. According to many observers, this loss is largely due to the Medicaid program's unwieldy centralized bureaucracy and inefficient administration.

These are among the problems addressed by the Governors' unanimously-adopted bipartisan Medicaid reform plan. In the interest of ensuring that the Governors' vision for a better Medicaid program receives continued attention, the House Commerce and Senate Finance Committees have developed legislative language "Restructuring the Medicaid Program," the major provisions of which are detailed in the following pages.

2

Restructuring the Medicaid Program . . .

Ensures Guaranteed Coverage

Coverage Guarantees are Established to Protect Vulnerable Americans:

- Pregnant women with family income below 133 percent of the poverty line;
- Children under age 6 with family income below 133 percent of the poverty line and children age 6 through 12 with family income below 100 percent of the poverty line;
- Children receiving foster care and adoption assistance;
- Disabled individuals who meet specified income and resource standards;
- Elderly individuals who meet SSI income and resource standards, certain optional elderly recipients, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and certain other Medicare beneficiaries; and
- Other poor adults who receive public assistance and who are not included in any of the above groups.

3

Restructuring the Medicaid Program . . .

Ensures Guaranteed Benefits

All Guaranteed Recipients are Guaranteed a Generous Package of Benefits, Including:

- Inpatient and Outpatient Hospital Services;
- Physicians' Surgical and Medical Services;
- Laboratory and X-ray Services;
- Nursing Facility Services and Home Health Care;
- Services Provided by Federally-Qualified Health Centers and Rural Health Centers;
- Prenatal Care, Pediatric Services, and Immunizations for Children;
- Prepregnancy Family Planning Services and Supplies;
- Family Nurse Practitioner and Nurse Midwife Services; and
- Early Periodic Screening and Diagnostic Services for Children.

4

Restructuring the Medicaid Program . . .

Ensures Guaranteed Funding

Three Funding Sources are Established for the Distribution to all States and Territories of Funding at Levels Greater Than Ever Distributed Under Title XIX:

- A "base allotment" with an annually-calculated funding formula employing differential rates of growth to ensure that all States and territories receive annually-increasing federal grants and substantially reduce existing disparities in State funding;
- An "umbrella fund" providing additional resources on a per capita basis to any State experiencing growth in the guaranteed population groups that exceeds the States' financing capacity provided by the base allotments and special grants; and
- Special grants provided to:
  - States to serve their populations of Native Americans.
  - Specified States with large populations of illegal aliens.

5

Restructuring the Medicaid Program . . .

Ensures Recipient Safeguards

Nursing Home Standards, Medicaid Recipient Protections, and State Enforcement Capabilities are Strengthened

- Current law protections against the impoverishment of spouses of institutionalized recipients are retained to protect community spouses from having to become impoverished before their institutionalized spouses can be deemed eligible for medical assistance. The plan also places limitations on the liens that may be placed on residents' property;

- States are prohibited from requiring the adult children of institutionalized parents to contribute to the cost of nursing facility services; and

- Current law nursing home standards are retained, and States are empowered with enforcement responsibility for non-State nursing facilities. The Secretary retains primary responsibility for the enforcement of State nursing facilities and is responsible for ensuring State enforcement of all other facilities. If a State fails to meet the requirements of this plan, the Secretary may initiate such actions as the withholding of State Medicaid funds.

6

Restructuring the Medicaid Program . . .

Ensures Private Appeal Rights

Access to a Broad Range of Appeal Rights and Procedures is Guaranteed to all Recipients:

- States are required to provide for an administrative procedure enabling an individual alleging a denial of benefits to receive a hearing.
- States are required to provide for judicial review in the State court system to an individual or class of individuals alleging a denial of benefits.
- An individual or class of individuals alleging a denial of benefits may file a petition for certiorari before the United States Supreme Court.
- The Secretary may bring an action alleging denial of benefits in federal court against a State on behalf of an individual or class of individuals.

7

Restructuring the Medicaid Program . . .

Ensures Operational Flexibility

Unprecedented Flexibility Is Provided for the Operation and Administration of State Medicaid Programs:

- A system of State-designed performance goals is established;
- State plan submission and amendment procedures are streamlined;
- States are permitted to develop service delivery innovations without a federal waiver;
- The Boren Amendment is repealed, and disallowance protections are established; and
- Greater coordination in the development and implementation of State Medicaid plans is fostered through a process of public input by providers and the populations served.

8

Restructuring the Medicaid Program . . .

Combats Waste, Fraud, and Abuse

Existing Measures to Prevent Waste, Fraud, and Abuse are Significantly Strengthened:

- States are required to establish and maintain an effective program for the detection and prevention of fraud and abuse;
- States are given the discretion to limit from participation suspect providers and are required to exclude from participation any provider found guilty of defrauding the Medicare program;
- Stringent provider and contractor reporting requirements are established;
- States are required to detail in their State plans measures to be implemented to deter fraud and abuse and enhance quality;
- States are required to contract with independent entities for periodic independent evaluations; and
- States are required to undertake annual audits to ensure fiscal integrity of their programs.

[redacted]

Appendix

"Restructuring Medicaid" -- The Unanimous Bipartisan Policy Agreement of the National Governors Association

Attached the NGA Resolution →

URGENT

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

6/7/96

LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 4666

FILE NO: 2362

Total Page(s): 26

TO: Legislative Liaison Officer - See Distribution below:

FROM: Janet FORSGREN Janet Forsgren (for) Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI 395-4871 Legislative Assistant's Line: 395-7362
C=US, A=TELEMAIL, P=GOV+EOP, O=OMB, OU1=LRD, S=PELLICCI, G=ROBERT, I=J
pellicci_r@a1.eop.gov

SUBJECT: HHS Proposed Testimony on the Republican's most recent Medicaid proposal

DEADLINE: 10:00 a.m. Monday, June 10,1996

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Hearing is before the House Committee on Commerce on Tuesday, June 11th. HHS Secretary Shalala is the witness.

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RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: **4666**

FILE NO: **2362**

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.
If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.
You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Testimony on the Republican's most recent Medicaid proposal

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

Thursday June 6, 5:00

SECRETARY'S MEDICAID TESTIMONY

HOUSE COMMERCE COMMITTEE

Mr. Chairman, and members of the Committee: I want to thank you for inviting me to testify today about the Republican's most recent Medicaid proposal.

As this Committee continues its consideration of options to reform the Medicaid program and pursue a blenaced budget, we appreciate the opportunity to state clearly the President' visions for reform in this area.

The Clinton Administration believes that we must balance the budget by the year 2002 and give more responsibility to the states and local communities. But we must do it in a way that is consistent with our country's traditional values.

As the President has said time and time again: We can balance the budget and find common ground -- without turning our backs on our values, our families, and our future.

In Medicaid, we believe we can give the states the flexibility they need, while maintaining a strong Federal-state partnership built on a foundation of shared

resources, accountability to the taxpayers, and national protections for the most vulnerable Americans.

That is why the President has proposed a common sense plan that balances the budget, gives unprecedented flexibility to the states, and reforms Medicaid without breaking our promises to our citizens -- from the seniors living in nursing homes to the families struggling to work their way out of poverty. And that is why he has refused to sign legislation which breaks these promises.

Medicaid provides vitally important health and long-term care coverage for approximately 36 million Americans and their families:

- It provides primary and preventive care for 18 million low-income children;

- It covers 6 million individuals with disabilities -- providing the health, rehabilitation, and long-term care services that would otherwise be unaffordable for these individuals and their families;

- It covers 4 million senior citizens -- including long-term care benefits that provide financial protection for beneficiaries, spouses, and the adult children of those requiring nursing home care.

- Finally, it pays the Medicare premium and cost sharing for low income seniors, thus making Medicare benefits affordable for these individuals.

The Clinton Administration is dedicated to preserving and improving Medicaid, so that it can continue to fulfill our nation's promises to these millions of children, elderly, and disabled Americans and their families. To achieve this goal, this Administration has vigorously assisted state efforts to test innovative new approaches to delivering and financing care for Medicaid patients. During our first 3 years in office, this Administration approved 91 major Freedom of Choice waivers, and 163 new and renewed Home and Community-Based Services waivers. In addition, since January 1993 this Administration has approved 12 statewide Medicaid demonstrations, 8 of which are currently operational. This compares to a total of one such demonstration approved under all previous administrations. In addition, we are currently reviewing proposals submitted by 10 other states. Some statewide demonstrations expand access to the uninsured, others test new methods for delivering mental health services, and still others have simplified eligibility requirements.

The flexibility provided by these waivers has allowed states to experiment with methods to improve the efficiency with which they provide care. States have used th resulting savings to cover additional populations with unmet health care

needs. When all of the currently approved demonstrations are implemented, nearly 2.2 million individuals who did not receive Medicaid coverage will be eligible for services.

As part of his balanced budget plan, the President has proposed a carefully designed and balanced approach to Medicaid reform which builds on this experience. His plan preserves Medicaid (title XIX of the Social Security Act) and makes important changes that will give states unprecedented flexibility to design their programs to meet the needs of the people they serve. The President's plan:

- preserves Medicaid protection for all currently eligible groups;

- maintains our shared financial partnership with the states as they provide health coverage to needy individuals;

- preserves the Federal guarantee of a congressionally-defined benefit package for Medicaid beneficiaries;

- (as shown on my chart) provides states far greater flexibility to better manage their programs, pay providers of care, and operate managed care and other arrangements with reasonable Federal requirements to

The President's Medicaid Proposal: Flexibility for States

Promote Managed Care	✓ Permits enrollment in managed care without waivers ✓ Eliminates certain Federal contracting rules – Eliminates 75/25 rule – Eliminates Federal review of contracts over $100,000
Increase Flexibility in Eligibility/Benefits	✓ Permits home and community-based care programs without waivers ✓ Allows eligibility simplification
Eliminate Federal Provider Payment Rules	✓ Repeals Boren Amendment ✓ Replaces cost-based payment with federal grants to health centers (FQHCs/RHCs) ✓ Eliminates qualification requirements for certain physicians (Ob/Peds)
Streamline Administration	✓ Eliminates annual state reporting requirements for certain providers ✓ Simplifies computer system requirements ✓ Eliminates personnel requirements ✓ Eliminates cooperative agreement requirements ✓ Eliminates duplicative nursing home reviews

maintain programmatic and fiscal accountability; and

- o contributes Federal savings to the balanced budget plan through reductions in disproportionate share hospital payments and the use of a per capita cap on Federal matching that adjusts automatically to changes in state Medicaid enrollment and changes in the economy.

As you know, the President strongly opposed -- and ultimately vetoed -- the congressional approach to Medicaid reform because it did not adhere to these principles. The Congress voted to repeal the Medicaid program and replace it with a new "Medigrant" program that did not include meaningful guarantees of eligibility or benefits. The Congress also proposed a "block-grant" funding mechanism that breached the 30 year Federal partnership with the states to share in changes in state Medicaid spending and left states with the full financial responsibility for providing health care to these individuals.

In order to advance the debate, the National Governors' Association approved the outlines of a bipartisan Medicaid reform plan. As I testified before this Committee in March, the Administration thought the governors' plan -- produced through a bipartisan process-- held some promise and we were hopeful that, once more details were known, there would be a real basis for Medicaid reform. The governors clearly worked very hard to move the debate forward. At

the same time, however, I discussed the Administration's concerns about some of the elements of the governors' plan.

Last month, the Republican majority introduced a revised version of their Medicaid bill, which I will discuss today. This bill moves us further away from the bipartisan agreements reached by the governors, and much closer to the original Republican bill which the President vetoed last year. Our view is shared by the Democratic governors who were instrumental in crafting the original NGA proposal. In a letter sent to Senator Roth last week, four Democratic governors stated that:

> "[The Republicans'] Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year and rejected by the Governors at our winter meeting...

Let me be clear: the new Republican bill, like its predecessor, fails to meet the President's basic principles for Medicaid reform. If this bill is sent to the President, he will veto it, just like he did its predecessor.

I discussed the President's basic principles for Medicaid reform when I testified before this committee last fall and this spring. As shown on this chart, they are: (1) the need for a real, enforceable Federal guarantee of coverage to a congressionally-defined benefit package; (2) appropriate Federal and state

Principles of Medicaid Reform

- Enforceable Federal Guarantee of Coverage and Benefits:
  - Guaranteed eligibility
  - Meaningful benefits
  - Federal enforcement
- Shared Financial Partnership with States
  - Federal dollars follow the people
  - Federal savings to help balance the budget
- Protections for Beneficiaries, Families, and Taxpayers
  - Limit out-of-pocket costs
  - Assure quality of care
  - Maintain fiscal accountability

financing; and (3) quality standards, beneficiary protections, and accountability. I will now discuss why the new Republican Medicaid plan fails to meet each of these three principles.

The Federal Guarantee of Coverage and Benefits

The Federal "guarantee" of coverage and benefits is at the core of the Federal Medicaid program. Unfortunately, the term "guarantee" has been assigned very different meanings in the context of the current Medicaid debate. When we use the term guarantee in the context of a Federal statute like Medicaid, we mean a real guarantee, composed of three interrelated components: definitions of 1) eligibility; 2) benefits, and 3) enforcement.

Eligibility

Let's begin with eligibility. The new Republican bill would deny millions of Americans the guarantee of Medicaid eligibility which they have under current law. The bill repeals the current law phase-in of Medicaid coverage for children ages 13 to 18 in families with income below the Federal poverty level -- a bipartisan coverage expansion signed into law by President Bush.

In addition, the new Republican bill repeals the Federal standard for defining

disability and replaces it with the possibility of 50 separate state definitions. This has the effect of making Medicaid coverage and benefits for those with disabilities uncertain and variable across the nation. For example, some states could use restricted definitions of disability resulting in very limited coverage for populations whose service needs are pronounced and among the most costly. In fact, States may be forced to narrow their definitions of disability in order to cope with lower Federal funding levels. In such situations, narrow state definitions of disability could preclude individuals with HIV, certain physical disabilities, or mental illness from receiving critically needed services under Medicaid. We should not turn back the clock on those with disabilities by permitting 50 different state definitions for purposes of Medicaid coverage.

The new Republican bill also eliminates the requirement that Medicaid be provided to persons who leave AFDC in order to join the workforce. Under current law, welfare recipients are guaranteed Medicaid coverage for one year after they start a job. By eliminating this guarantee, the Republican proposal will serve to discourage individuals from leaving welfare -- clearly a counterproductive outcome.

Finally, the new Republican bill gives states the authority to impose additional eligibility limits based on age, residence, employment or immigration status, or more restrictive definitions of assets and income. This provision will enable states, if financially necessary, to restrict eligibility even among those

people who supposedly are "guaranteed" coverage.

Benefits

Eligibility is only one component of the guarantee. The next question is "eligibility for what?", which brings us to benefits. The new Republican bill "guarantees" some benefits for those populations who are "guaranteed" eligibility. But this guarantee is hollow. It contains so many loopholes that it is essentially meaningless.

One giant loophole relates to the adequacy of the benefits. Current Medicaid law and regulations already give states substantial flexibility in defining the amount, duration, and scope of benefits, and states have used this flexibility to respond tailor their Medicaid packages to their unique circumstances. This latitude is tempered by a very reasonable constraint -- benefits must be "sufficient to reasonably achieve their purpose." The Republican bill removes this constraint, giving states complete flexibility on amount, duration, and scope. Thus, states could "guarantee" coverage for hospital and physician services, but -- if forced to do so -- could limit this coverage to unreasonably low levels such as 3 days of hospital care and one physician visit per year. This type of guarantee is meaningless for persons who truly need medical care.

Another loophole in this "guarantee" is that the new Republican bill

eliminates the current law standards of comparability and "statewideness" of services. Without those standards, some states could offer different coverage and benefit packages in different parts of the state, or to different groups based on their age or diagnosis. Eliminating these comparability and statewideness requirements leaves states free to discriminate against persons who live in certain areas, who have specific diseases (such as AIDS), or who lack political clout (such as children).

The new Republican bill also severely curtails the treatment services which must be provided under the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. Under the Republican bill, children must be screened for a range of health problems, but treatment is only required for dental, hearing, and vision problems. If a child is diagnosed with any other medical problem, they are not guaranteed treatment for it -- a situation which is not permitted under current law. Therefore, an asthmatic child would not be guaranteed coverage for treatment, such as asthma-controlling drugs or inhalers. Diagnosis without treatment is bad medical care and a wasteful use of taxpayers' dollars.

Enforcement

The third essential component of the Federal guarantee is enforcement. Implicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism. A Federal cause of action for beneficiaries

assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States. The new Republican bill requires states to provide a state right of action, but eliminates any Federal right of action for individuals and providers who assert that a state is violating Federal Medicaid laws. The only access to Federal court for such claims would be the opportunity to petition the U.S. Supreme Court for review of a decision of a state's highest court.

By denying beneficiaries access to the Federal courts, the Republican bill eliminates individuals' guarantee to enforceable Federal benefits. Thus, Medicaid would confer a Federal right to benefits but completely lack a Federal enforcement mechanism - a virtually unprecedented situation. In addition, eliminating the Federal right of action promotes inconsistent interpretations of the Medicaid statute across the country. Common sense tells us that those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. When the same question arises across multiple jurisdictions, decision-making in the Federal court system maximizes equity and predictability. This is particularly true when Medicaid interacts, as is often the case, with other Federal statutes, such as Medicare, Social Security, Supplemental Security Income, and Aid to Families with Dependent Children. Federal courts are more experienced in analyzing these Federal programs and are better able to understand and decide cases involving relationships among them. We should not

construct a system that will encourage different outcomes in different states.

Suits against states filed by providers over payment rates have caused the greatest problem to the states. Under the Administration's plan, the Boren Amendment and related provider payment provisions would be repealed, thereby eliminating these causes of action by providers. Thus, the Administration's plan resolves states' major concern about limiting their exposure to providers' suits in Federal court, and does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits.

On balance, when we assess the three components required to make any guarantee real -- the definitions of eligibility, benefits, and enforcement -- we find that the so-called "guarantee" of Medicaid coverage and benefits contained in the new Republican bill is neither real nor enforceable for beneficairies. Let me also be clear that this is not about whether the governors can be trusted. They can be trusted, which is why our proposal offers states unprecedented flexibility in program management and why we have worked with so many states on their innovative demonstrations. The issue is whether an individual, regardless of where he or she lives, is <u>guaranteed</u> meaningful coverage.

Financing

The President's second principle for Medicaid reform is an appropriate financing structure -- namely, one which maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Under this partnership, Federal dollars follow the people, meaning that the Federal government shares responsibility with the states for increased costs associated with increases in enrollment. As with the Federal guarantee of coverage and benefits, the new Republican bill falls far short of meeting this principle.

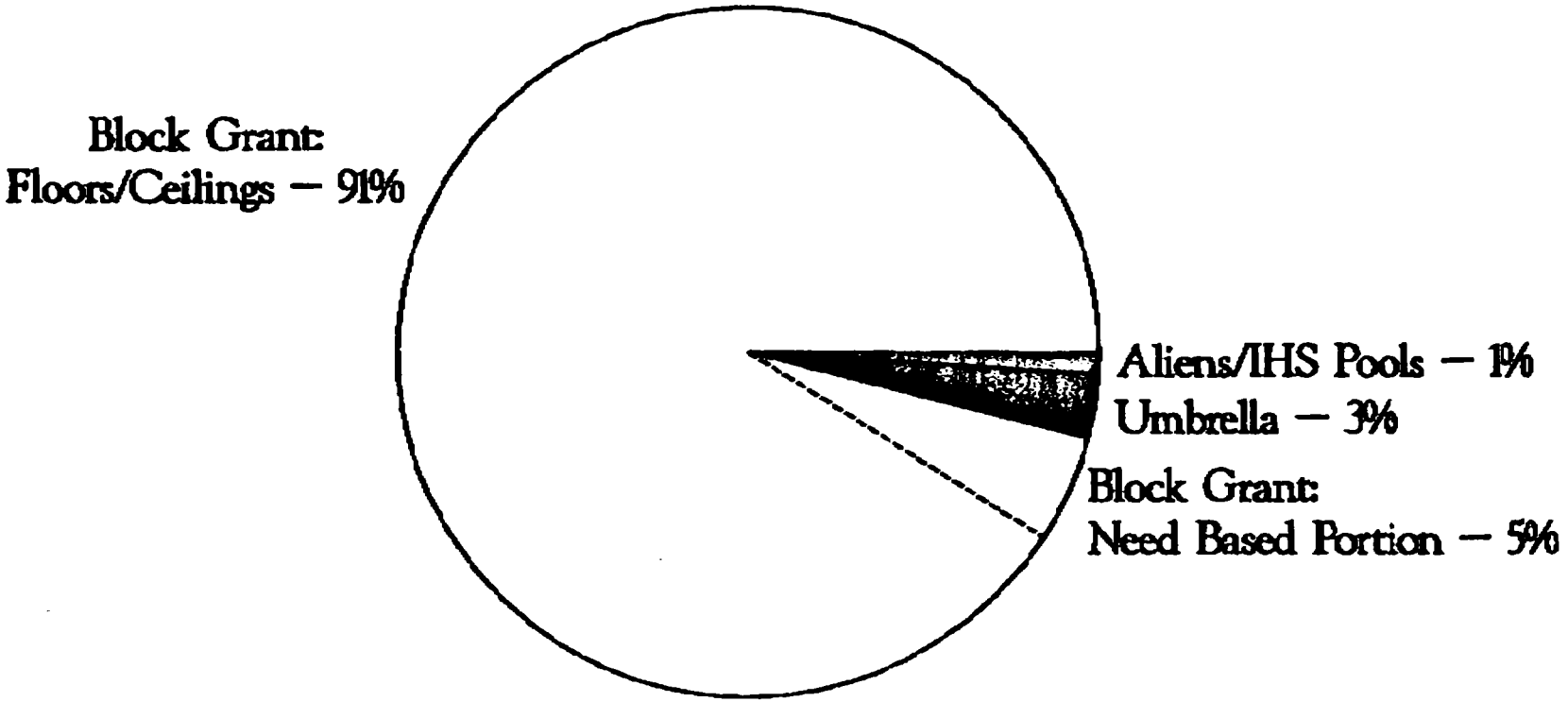
I have seen the components of the new Republican financing arrangement before -- and it was not in the governors' agreement. Rather, I saw it in the basic MediGrant II. This newest financing structure is simply a dressed-up block grant formula, with a tiny embellishment to pay lip service to the governors' principles that funding must automatically adjust for enrollment.

To demonstrate this point, I will walk through each of the components of the financing structure of the new Republican bill, and I will use this chart to illustrate my points.

Base Allotment

The first component of the Republican funding system is called the base allotment. These allotments, which account for an average of 98 percent of total

Republican Medicaid Bill: Funding Not Based on Need



Source: DHHS analysis based on legislative provisions of the 5/21 Republican Medicaid Bill.

Federal spending over the 6 year period (as shown on the chart) are distributed to states based on a formula which includes factors such as "needs-based amounts" and "program need". Given this structure, at first it might appear that each state's base allotment is determined based on its actual need, including enrollment growth and caseload changes.

However, the base allotment is not what it seems. After careful analysis, my staff have concluded that only 5 percent out of this 96 percent of funding is actually distributed based on need. The remaining 91 percent is distributed to states based on what is essentially a block grant system. Under this system, states' allotments are determined through the use of "floors" and "ceilings", rather than by the results of the needs-based formula. Each year, between 44 and 49 states' allotments are determined through a floor or ceiling. For these states, the new Republican bill is a block grant, just with a new name.

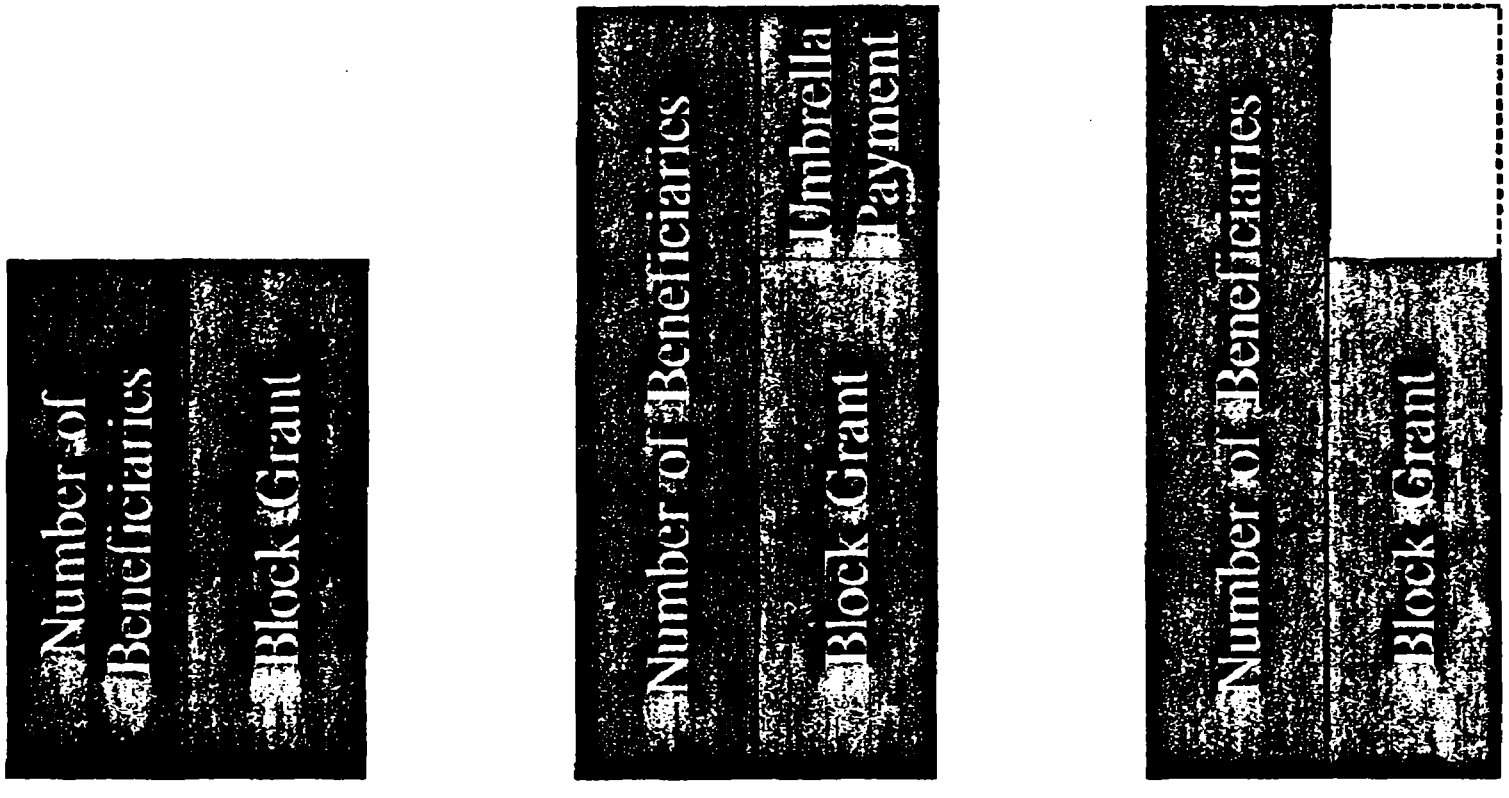
Furthermore, even the 5 percent "needs-based" funding does not truly reflect states' financial need for their Medicaid programs. This is because it is determined by the number of poor people in a state rather than Medicaid enrollment growth. As a result, if the number of Medicaid recipients in a state increases but the number of poor people does not, the state's base allotment would not increase.

Umbrella Fund

The second component of the financing structure is called the "umbrella fund", and it consists of supplemental Federal money that is to be distributed to states with high enrollment growth. But if the Republican umbrella is the states' only protection against the costs of high enrollment growth, the states are going to get drenched. The entire umbrella fund accounts for only 3 percent of all Federal Medicaid spending; thus, it could provide only a fraction of what States would need in times of recession or natural disaster. In addition, it covers increases in enrollment only for the year of the increase -- not for any later years during which the new enrollees continue to receive Medicaid. Thus, if a state suffered a three-year recession which caused its Medicaid enrollment to rise, it could get umbrella funds for new enrollees for their first year, but could be forced to bear the entire cost of these enrollees for any later years which they remained on Medicaid.

This is shown on my next chart. Assume that the recession begins in year 2. As you can see, this recession causes a dramatic increase in the state's enrollment, which triggers an umbrella payment to assist the state in covering the costs of these new enrollees. In year three, however, the state's enrollment remains at the same level as in year two, but this time there is no umbrella payment, because these payments are based only on changes in enrollment, not total enrollment. Thus, the state is forced to bear the cost of the much higher

Republican Medicaid Bill: Dollars Do Not Follow People!



enrollment with the same amount of Federal assistance as it received in year one.

Pools for Undocumented Aliens and Indians

The final component of the financing structure is $4.3 billion for assisting states in providing care for undocumented aliens and Indians. The first pool is allocated across the 15 states with the highest numbers of undocumented aliens. The second pool is to allocated among all states which have Indian-funded health facilities or programs.

Changes in FMAP and Taxes and Donations Laws

In addition to replacing the current financing partnership with a block grant to states, the new Republican bill also includes two changes in the way in which states finance their share of Medicaid costs. It increases the rate of Federal contribution to Medicaid (known as the FMAP) for many states, thereby reducing the amount of their own funds which states would need to spent in order to collect Federal matching funds. It also repeals the restrictions on states' use of provider tax and donation financing mechanisms.

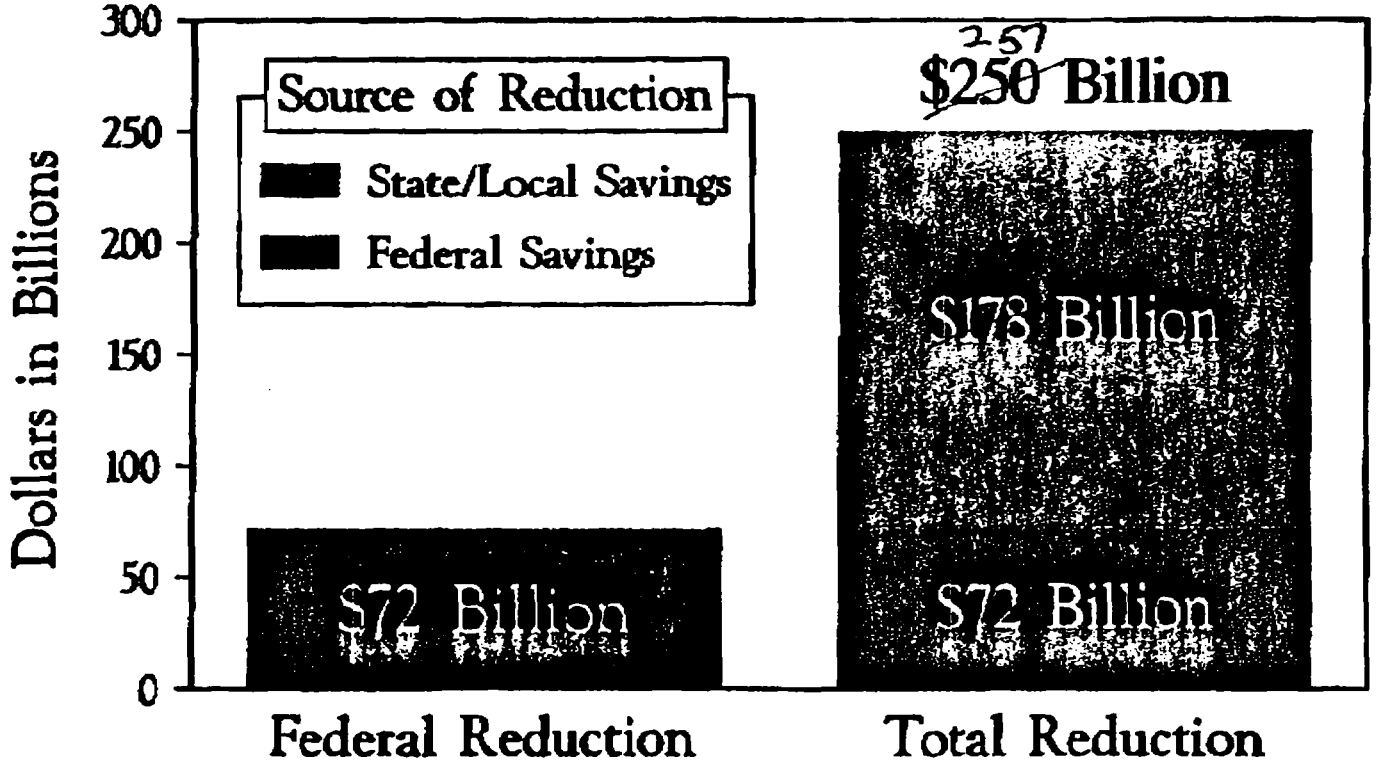
While these proposals are appealing to many states, they raise significant concerns. Specifically, the proposed changes to the FMAP will raise the Federal

share of national Medicaid spending from 57 percent to 63 percent. In addition, the FMAP changes could encourage states to reduce their contributions to the program, resulting in even deeper reductions in total Medicaid spending than this bill suggests. As shown in the left bar of this chart, the new Republican bill will reduce total Federal spending on Medicaid by $72 billion over 6 years. But total reductions in Medicaid spending could be far greater. The Center for Budget and Policy Priorities estimates that the proposed FMAP changes and the Federal cuts would enable states to reduce their own spending on Medicaid by about $185 billion over 6 years without decreasing the amount of Federal funds for which they are eligible. Thus, as shown in the right-hand bar on the chart, the new Republican bill could lead to a total reduction of approximately $257 billion in Medicaid spending over the next 6 years.

Defining and revising the appropriate Federal and state contributions and spending levels will always be one of the most difficult issues to settle in any Medicaid reform plan. There is no question that these matters merit careful attention in the long-term. However, given the enormous fiscal implications, the President's plan proposes to gain advice from an intergovernmental advisory commission on the appropriate Federal and state funding before the Congress proceeds to change the current distribution.

The new Republican bill also would permit unconstrained use of provider tax

Republican Medicaid Bill: Funding Reductions*



** Assumes minimum State expenditure for maximum Federal matching payment*

Source: ~~HHS analysis based on the May 2lst Republican Medicaid Plan~~

Based on analysis by The Center for Budget and Policy Priorities

and donation financing approaches for the "state" share of Medicaid. These are the exact mechanisms that the Congress, in a bipartisan fashion, recently limited -- in the case of taxes -- or outlawed completely -- in the case of donations. During the late 1980s and early 1990s, many states took advantage of these funding mechanisms, costing the Federal government billions of dollars and helping drive annual Medicaid spending growth rates up to well over 20 percent. Now the Republican bill seeks to remove these restrictions that were passed with overwhelming bipartisan support just a few years ago. Without these restrictions, States would be free to finance significant portions of the State share without contributing any real State dollars, leading to substantially lower overall support for the Medicaid program.

In summary, the new Republican bill fails to meet the President's second principle for Medicaid reform -- a financing structure which maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Neither does it meet the principles agreed to on a bipartisan basis by the governors. The governors' proposal reflected a willingness to assume a greater responsibility for the management of the Medicaid program, but only if they had a strong financial partner to help meet the costs. The NGA proposal was carefully designed to provide this Federal-state partnership, and was based on a funding mechanism that clearly protected states from the full costs associated with actual

changes in enrollment. The money was supposed to follow the people, in order to protect states from unexpected, uncontrollable enrollment increases. When the latest Republican proposal was released, it did not take the Governors long to realize that the centerpiece of their deal was no longer part of the mix. Under the new Republican bill, it would be difficult for states to accept the shift of responsibility for the Medicaid program without adequate financing.

Protecting beneficiaries, families, and taxpayers

This brings me to the President's third principle for Medicaid reform: protection of beneficiaries, families, and taxpayers. Once again, the new Republican bill fails to meet to President' principle.

The new Republican bill would repeal title XIX and create a new title for the Medicaid program. This has the effect of seriously compromising the framework for quality standards, beneficiary and family financial protections that limit families' out-of-pocket costs, and program accountability.

Out-of-Pocket Costs

This bill reduces or eliminates many long-standing family and beneficiary

protections. For example, it would permit states to require adult children of Medicaid beneficiaries to contribute to the cost of their care, except for long-term care. In addition, the bill grants states broad discretion to impose cost-sharing requirements upon Medicaid beneficiaries. It imposes minimal cost-sharing limits only for certain services to children and pregnant women below poverty, leaving other women, children, and most disabled and elderly fully exposed to potentially serious financial consequences. This lack of limits on cost-sharing is another factor which effectively undermines these persons' "guarantee" of eligibility and benefits.

In addition, while the bill retains current law provisions aimed to protect spouses and other relatives of nursing home patients from excessive liability for the cost of care, loss of the more general cost sharing protections significantly minimizes these protections. For example, nursing home residents who have spent down their income to become eligible for Medicaid could be charged any level of cost-sharing. In addition, services included in the nursing home benefit could be reduced, leaving the spouses or children of nursing home residents to bear the full cost of these services. Furthermore, states could charge elderly or disabled persons any level of premium, which could be set so high as to effectively exclude them from the program.

Quality Assurance Requirements for Managed Care

In addition, the new Republican bill makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care. This is a particularly important area since Medicaid managed care enrollment is increasing so dramatically. About one-third of beneficiaries are now in managed care, a 140 percent increase in enrollment over the past three years. The President's plan recognizes the need for updating managed care quality standards. It replaces some outdated approaches with a quality improvement program that must include appropriate standards for Medicaid-contracting health plans and data analysis that tracks utilization and outcomes.

Fiscal Accountability

Finally, the President recognizes that the Federal government finances well over half of Medicaid spending nationwide, at a cost to Federal taxpayers of more than $100 billion a year. As a result, the Federal government has a responsibility to assure that these funds are spent efficiently and appropriately.

Fulfilling this responsibility requires imposing a minimal amount of reporting and monitoring requirements on States.

There are ways, similar to the approach taken in the President's plan, that would to provide states with considerably expanded flexibility in management and operation of their Medicaid programs, without reducing the framework of

responsible accountability to meaninglessness. The new Republican bill, unfortunately, fails to include an meaningful framework for ensuring fiscal accountability. For example, as I discussed earlier, the bill includes no quality assurance requirements or monitoring responsibilities for Medicaid managed care, and it contains no mechanism to ensure that changes in benefits and cost-sharing do not jeopardize the sufficiency of coverage. Thus, under the Republican bill the Federal government will finance a greater percentage of the Medicaid program, but will have fewer assurances that its money is being well spent.

In summary, like its predecessor last fall, the new Republican bill fails to meet the President's third principle -- protecting beneficiaries, families, and taxpayers.

CONCLUSION

Let me conclude by focusing on one fundamental structural issue -- whether we approach the task of Medicaid reform by making changes in the current title XIX of the Social Security Act, or by repealing that program and replacing it with a new title. We support reform, not repeal, of title XIX. The potential unintended consequences of repealing and replacing this program are staggering -- for states, beneficiaries, providers, and the Federal government, especially when you consider

that it would reopen thirty years of settled litigation. The Congress can address many of the most pressing concerns about any Medicaid reform plan by amending the current law.

From the beginning of the current Medicaid debate, the President has maintained that Medicaid must be financed through a Federal-state partnership that ensures Federal funding and provides a real, enforceable guarantee of coverage for a defined package of health and long-term care benefits. The President's plan proposes unprecedented flexibility for the states to operate their programs, pay providers, and use managed care and other delivery arrangements, while retaining and revising key standards related to quality and beneficiary financial protections. The President's proposal would achieve those objectives in a way that would also help balance the budget by 2002.

The last time I testified before this committee, I was encouraged that the governors' bipartisan efforts appeared to be moving us toward a solution which met all of the President's principles. I am disappointed to be here today commenting on a bill that is extremely similar to the one that the President vetoed last fall and that departs dramatically from the bipartisan agreements reached by the governors. While the President can not approve this bill, I can assure you that he stands ready to work with the members of this committee and the entire Congress to design a reformed Medicaid program that will keep its promises to

beneficiaries, states, and taxpayers.

Again, I would like to thank this Committee for the opportunity to testify today and I look forward to answering your questions.