CENTER ON BUDGET AND POLICY PRIORITIES

February 6, 1996

THE GOVERNORS' MEDICAID PROPOSAL

The policy position on Medicaid adopted by the Governors at the National Governors' Association suggests some improvements to the Republican Congress' Medicaid block grant proposal but contains many very troubling elements and leaves many key questions unanswered. The proposal would eliminate the guarantee of coverage to many of the vulnerable people now protected under the program, allow states to make virtually all of the critical decisions on the benefits to be provided, and compound the damage caused by federal budget cuts by allowing very large reductions in state funding for the program.

Coverage guarantees

Certain groups of people would be guaranteed coverage, including:

- pregnant women and children under age six with income below 133 percent of the federal poverty level; and
- children age six through 12 with income below 100 percent of the federal poverty level.

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

- Under changes enacted in 1990 with bipartisan support, Medicaid coverage for children with income below the federal poverty line is being phased-n so that by the year 2002 all poor children under age 18 will be covered. The Governors' proposal would repeal the phase-in and eliminate the obligation to cover poor children over age 12. This could affect poor children who now receive Medicaid based on their eligibility for AFDC as well as poor children whose parents work at low-wage jobs without health insurance coverage for dependents.
- The problem caused by the elimination of the phased-in guarantee for poor children over age 12 is compounded by the changes proposed for families who now receive Medicaid based on their receipt of AFDC benefits. Under the proposal, a state would have the option of (1) covering poor children and parents whose income and assets were below the state's current AFDC standards; (2) restricting Medicaid

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eligibility by reducing its income and asset standards to the national average for the AFDC program (which are well below the federal poverty level); or (3) guaranteeing Medicaid to only those parents and children who qualify for welfare under whatever program a state creates under a welfare block grant. If states choose the most restrictive option, millions of very low-income parents and children could lose their health care coverage.

- Disabled people would have to be covered under the proposal, but there no longer would be any federal definition of disability. A state could, for example, cover only disabled people residing in state institutions, or cover only people whose disabilities were life-threatening.

- Under current law, all people age sixty-five years of age or older who receive SSI must be covered by Medicaid. Under the governors' proposal, only "frail" elderly people with income and assets below SSI standards would have to be covered. (No definition of "frail" is offered by the governors.) Those elders who are not "frail" would lose the guarantee of health care coverage and might only be able to access health care once they become incapacitated.

A Guarantee of What?

While the proposal goes somewhat beyond the Republican Congress' block grant proposal in terms of the categories of people who states would have to cover under their Medicaid programs, it repeals virtually all federal standards relating to the benefits that must be offered. Under the proposal, a state would have to offer *some* hospital care, physician services, home health care, laboratory services, and other specified benefits, but all of the current rules on the amount and scope of benefits that must be provided would be repealed.

Thus, under the proposal, a state seeking to control its costs could impose very low annual or lifetime limits on hospital utilization. It could limit prescription drug coverage to a dollar amount per month, or it could offer different levels of benefits to people with AIDS than it allowed for people with cancer. In addition, the proposal ends the current federal requirements concerning the treatment services that must be made available to poor children by restricting the Early Periodic Screening Diagnostic and Treatment ("EPSDT") program.

Funding

The funding issues are critical, but their resolution is quite ambiguous. The general plan is a federal block grant, supplemented by an "umbrella" payment to

cover some costs not covered by the block grant. The umbrella payments would be determined by formula, and would not be capped.

This approach is tilted toward state fiscal interests because all states would be guaranteed block grant payments regardless of the number of people served or the costs of those services, while states that had higher-than expected costs could qualify for additional federal payments. Thus, the federal government would share most risks of higher-than-expected costs, but would not share the fiscal benefits of lower-than-expected costs.

Inflation and caseload. For Medicaid funding to be adequate, federal payments to states must respond to higher-than-expected caseload *and* higher-than-expected inflation. It is not clear whether either the basic block grant or the "umbrella" fund would increase if inflation turns out to be higher than currently expected.[1]

For the umbrella payments to provide adequate protection against higher-than-expected caseload, those payments to states must last as long as the higher-than-expected caseload lasts. Providing *temporary* federal payment increases to cover *permanent* increases in caseload will be inadequate.[2] But it is not at all clear whether the umbrella payments are designed to provide the necessary multiyear protection. (The same issue applies to inflation protection. If umbrella payments cover higher-than-expected prices, as they should, those payments must continue for as long as prices remain above expectations.)

Additionally, under existing law, states incur similar financial risks whether they enroll persons with *guaranteed* eligibility or with *optional* eligibility; in each case, the state is liable for a fixed share of the medical costs. Under the new proposal, states will likely receive extra federal payments for each person newly enrolled *if* he or she is covered by umbrella payments (e.g., for everyone *except* children and parents who do not have guaranteed coverage). But states will not receive extra

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[1] Early descriptions of the umbrella fund, circulated on February 2 and 3, showed that it *did*, in fact, respond to increases in inflation even though it was not advertised as doing so. It is possible that this vital design feature has been lost.

[2] Suppose a state's caseload rises faster than expected because of in-migration in a particular year. In that year, the state will receive extra umbrella payments. In the next year the caseload *growth rate* may return to normal, but all the new enrollees could remain permanently, and if so must be covered. Therefore, access to the umbrella payments must recognize *cumulative* increases from 1995, relative to expected increases covered by the block grant. Early descriptions of the umbrella payments, circulated on February 2 and 3, were fatally flawed by not recognizing the potential multiyear, cumulative effect of extra caseload growth. It is completely unclear whether this flaw has been remedied.

federal payments for "optional" children and parents. States may respond to the new unequal risks by dropping coverage of those children and parents.

State contributions to Medicaid. Under the proposal, states would be allowed substantial reductions in their proportionate share of Medicaid payments, and would be allowed to make their contributions out of "funny money."[3] This can have serious consequences.

- If states are willing to cut benefits, they can pocket all the savings. Under current law, states would achieve at most one-half of the savings. Thus, the financial incentive for a state to provide inadequate benefits is significantly greater than under current law. This is a particular danger in light of the proposal's suggestion that virtually all federal rules on benefits should be repealed.

- The amount of reductions in *state* spending could reach or exceed $200 billion over seven years because of the reductions in state sharing and the use of funny money; these reductions could be achieved at the expense of providers, of people not guaranteed coverage, or of benefits. The Center estimates that as many as 6.4 million Medicaid recipients could lose coverage by 2002 if states took full advantage of lower matching requirements.[4]

- The umbrella payments to states will be made on a per-recipient basis, akin to"per-capita cap" proposals for Medicaid made over the past two years. Such proposals run the risk of increased federal costs as states actively seek out and enroll new beneficiaries but provide them with virtually no benefits. Those risks are constrained as long as state matching requirements (with real money) are meaningful, and as long as the cost of providing benefits to new enrollees is similar to the cost of existing enrollees (e.g. because of meaningful benefit requirements). The new proposal has neither of those safeguards, and so may simply provide fiscal relief to states while expanding the federal deficit.

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[3] For example, states would be allowed to count rebates of provider taxes (back to the providers) as though such rebates provided medical benefits; thus those state rebates would count toward meeting state matching requirements. This type of financing arrangement had been used by some states to draw down large amounts of federal "Disproportionate Share Hospital" (DSH) payments in past years, but had been banned by Congress. That ban would be repealed. See *An Illusory State Match Requirement? The Republican Medicaid Proposals Bring Back State Financing Gimmicks* by Cindy Mann, December 9, 1995.

[4] See *Federal Budget Plans Could Lead to Sharp State Funding Reductions in Medicaid and AFDC* by Richard Kogan, February 2, 1996. The analysis was based on previous calculations made by the Urban Institute.

Protections for Beneficiaries

The proposal would repeal the existing Medicaid statute (Title XIX of the Social Security Act) and start over. As a result, protections in existing law, such as the requirement that states not impose large copayments on recipients or that providers not bill recipients for extra charges, could disappear. The proposal is silent on these and other important issues.

Likewise, the ability to sue in federal court to enforce any rights "guaranteed" under the federal new law is repealed. This repeal may extend to other federal statutes designed to assure equitable treatment to all persons, such as the Americans with Disabilities Act and the Civil Rights Act.

CENTER ON BUDGET AND POLICY PRIORITIES

FOR IMMEDIATE RELEASE:
February 6, 1996

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MEDICAID COVERAGE COULD ERODE DRAMATICALLY UNDER GOVERNORS' PROPOSAL

The Medicaid proposal endorsed today by the National Governors' Association could lead to a dramatic erosion in the strength of the Medicaid program, according to an analysis by the Center on Budget and Policy Priorities. The proposal would weaken Medicaid in three ways, the Center said.

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

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

Third, the Governors' proposal could lead to an exceptionally large withdrawal of *state* funding from Medicaid. The proposal would enable states to reduce state funding by as much as $200 billion over seven years without losing federal Medicaid funding.

The proposal also creates incentives for states to "game" the funding system by making legal the types of sham financing schemes many states used in the early 1990s until Congress banned them. As a result, the actual reduction in state Medicaid funding could be even larger than $200 billion.

In addition, the rainy day "umbrella" that would be established does not appear to provide sufficient additional federal funding to meet the increased needs for Medicaid because, for example, of a recession.

Because the proposal would likely lead to inadequate resources for Medicaid, it would likely result in state action to deny coverage to millions of poor people who receive coverage under current law and to weaken the benefits offered under Medicaid for millions who remain insured.

— more —

"The Governors' proposal reflects an effort to undertake the enormously complicated task of marrying a block grant and a per capita cap in just a few days," Center director Robert Greenstein said. "It has serious deficiencies that Governors may not have intended or fully understood. It would weaken Medicaid far more than a number of Governors who voted for it may have realized."

Coverage

Certain groups of people would be guaranteed coverage under the program, including pregnant women and children under age six with family incomes below 133 percent of the poverty level and poor children age six through 12.

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

- Under changes enacted in 1990 with bipartisan support, Medicaid coverage for children with income below the federal poverty line is being phased-in so that by the year 2002 all poor children under age 18 will be covered. The Governors' proposal would repeal the phase-in and eliminate any obligation to cover poor children over age 12. This could affect poor children who now receive Medicaid based on their eligibility for AFDC as well as poor children whose parents work at low-wage jobs that do not offer health insurance coverage for dependents.

- Under current law, all people age sixty-five years of age or older who receive SSI must be covered by Medicaid. Under the Governors' proposal, only "frail" elderly people with very low incomes would have to be covered. (No definition of "frail" is offered.) Those elders who are not "frail" would lose the guarantee of health care coverage and might only be able to access health care once they have become ill or incapacitated.

- Disabled people would have to be covered under the proposal, but there would no longer be any minimum federal standard of disability. A state could, for example, only cover disabled people residing in state institutions, or only cover people whose disabilities were life-threatening.

A Guarantee of What?

The Governors' proposal would repeal virtually all federal standards relating to the benefits that must be offered, said the Center. Under the proposal a state would have to offer *some* hospital care, physician services, home health care, laboratory services, and other specified benefits, but all of the current rules on the amount and scope of benefits that must be provided would be repealed.

A state seeking to control its costs could impose annual or lifetime limits on hospital utilization, for example, or it could limit prescription drug coverage to a dollar amount per month, or allow different levels of benefits for people with AIDS than it allowed for people with cancer. (In the extreme, a state could guarantee one day of hospital care in the case of a heart attack.) Likewise, no individual state would be required to provide uniformity of benefits; it could provide extensive pre-natal care for some pregnant women and limited care for others.

Would Funding Levels be Adequate to Sustain the Program?

Several of the financing features of the Governors' proposal would result in a sharp reduction in Medicaid funding, said the Center. Most notable is that the proposal would allow states to dramatically reduce their own funding for Medicaid without triggering any further loss in federal funds. Under current law, the cost of Medicaid is shared between the federal and state governments in accordance with "matching rates" established by federal laws. If a state's matching rate is set at 50 percent, the state pays half of Medicaid costs in that state. Thus, under current law, states that cut Medicaid benefits or eligibility to reduce state costs automatically lose at least $1 in federal funds for each dollar they reduce state contributions.

The Governors' proposal would fundamentally alter this matching requirement. As a result:

- Under many circumstances, states could pocket all the savings from a coverage or benefit reduction. Under current law, states would achieve at most one-half of the savings. Thus, the financial incentive for a state to provide inadequate benefits would be significantly greater than heretofore.

- Based on estimates of similar provisions in the Congressional Republican Medicaid proposal, the amount of reductions in state spending could reach or exceed $200 billion over seven years because of the reductions in state sharing. These reductions could be achieved at

the expense of providers, of people not guaranteed coverage, or of benefits. The Center estimates that as many as 6.4 million Medicaid recipients could lose coverage by 2002 if states took full advantage of lower matching rates.

The Governors' proposal also establishes an "umbrella" fund under which federal funding would be increased to cover unexpected costs over and above the basic block grant. Although details on this umbrella fund remain somewhat sketchy, it appears that the fund would not provide the necessary safeguard against unexpected increases in inflation or caseload growth. The fund may also create perverse incentives for states to game the system.

- For Medicaid funding to be adequate, federal payments to states must respond to higher-than-expected inflation and higher-than-expected caseloads. It is not clear whether either the basic block grant or the "umbrella" fund would increase if inflation turns out to be higher than currently expected.

- For the umbrella payments to provide adequate protection against higher-than-expected caseload, those payments to states must last as long as the higher-than-expected caseload lasts. Providing *temporary* federal payment increases to cover *permanent* increases in caseload will be inadequate. It is not at all clear whether the umbrella payments are designed to provide the necessary multiyear protection; it appears they only provide for temporary payments.

- The umbrella payments to states would be made on a per-recipient basis. Such proposals run the risk of greatly increasing federal costs as states actively seek out and enroll new beneficiaries but provide them with virtually no benefits. Those risks are constrained as long as state matching requirements are meaningful, and as long as the cost of providing benefits to new enrollees is similar to the cost of existing enrollees. The new proposal has neither of those safeguards, and so may simply be a method to provide fiscal relief to states while expanding the federal deficit.

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TALKING POINTS ON GOVERNORS' MEDICAID POLICY RESOLUTION

- We are pleased that the Governors' have passed a policy resolution that affirms our national commitment to the guarantee under Medicaid. We are also pleased that they have continued the financial partnership between the federal government and the states that allows Medicaid funding to follow increases in enrollment.

- As Congress considers this resolution, we need to make sure that that guarantee is real.

    - There must be a national guarantee to meaningful benefits.

    - There must be national guidelines for eligibility that protect those who are eligible under current law. For example, under current law, coverage for three million children between 13 and 17 is being phased in. That commitment should continue.

    - And we must preserve adequate enforcement to assure this guarantee.

CONCERNS/OUTSTANDING QUESTIONS ABOUT THE NGA MEDICAID RESOLUTION

- **Eligibility concerns include:** The repeal of the current law's phase-in for coverage of about 3 million children age 13-17; the devolution of the "disability" definition to the states; the limitation to "frail" elderly population seems to not include all elderly who are currently eligible; and *the elimination of the required coverage of premiums for low-income Medicare beneficiaries between 100-120 percent of poverty is repealed.*

- **Benefit concerns include:** *The total discretion given to states to alter the amount/duration/scope of services; the repeal of the current law's comparability and statewideness requirement that ensure that recipients in particular groups or locations are not discriminated against; the apparent elimination of any defined benefit package for currently optional populations;* and the vague redefinition of the "T" in the EPSDT children's health benefit.

- **Enforcement concerns include:** The state-based right of action process advocated by the Governors (and whether it will work to effectively ensure the guarantee).

- **Financing concerns include:** The exclusion of pregnant women and children, *as well as the medically needy*, from the Federally-financed "umbrella" pool payments; *the inclusion in the base formula of the allowance that states can reduce their matching Medicaid rate -- the result producing an additional $200 billion reduction in state Medicaid spending over seven years, bringing the total Federal/State cut to $290 billion; the allowance for states to, once again, tax health care providers to help finance their state match; allowing for provider taxes will likely push up the cost of the program that CBO scores.*

- **Quality concerns include:** *The adequacy of the quality protections for plans under Medicaid, such as HMOs and other managed care plan; the apparent repeal of the state-based enforcement of Ronald Reagan's Federal nursing home standards.* (The difference between them and us has always come down to definition and enforcement.)

DEMOCRATIC GOVERNORS' ASSOCIATION

FOR IMMEDIATE RELEASE
February 6, 1996

Contact: Doug Richardson
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DEMOCRATIC GOVERNORS HAIL NGA MEDICAID AGREEMENT

WASHINGTON -- A bipartisan Medicaid policy endorsed today by the National Governors' Association meets the key guidelines established by Democratic Governors and President Clinton, the Chairman of the Democratic Governors' Association said.

"I am pleased this bipartisan agreement strongly supports the President's position guaranteeing health care for our most vulnerable," said West Virginia Governor Gaston Caperton, the Chairman of the DGA.

The NGA today unanimously adopted a Medicaid policy that guarantees coverage for people currently covered, provides for funding that follows recipients and keeps in place the shared federal-state responsibility for funding the program, and gives states increased flexibility to manage their Medicaid programs in more cost-effective ways.

"The agreement reflects the point the president has always made and drove home today" in a speech to the Governors, Governor Caperton said. "We need flexibility to manage our Medicaid programs in the most cost-effective way. This agreement -- along with our welfare work -- really helps us protect our children, especially in uncertain times."

Nevada Governor Bob Miller, the NGA Vice Chair, said the NGA Medicaid agreement "is not only good policy but it also may jump start the stalled budget talks in Washington."

Governor Miller was one of three Democratic Governors who worked for weeks to try to forge a compromise on Medicaid. Colorado Governor Roy Romer and Florida Governor Lawton Chiles were also members of the Democratic team.

Throughout their talks, the Democratic Governors insisted that coverage for the nation's most vulnerable citizens must be guaranteed. President Clinton set the same goal for a Medicaid proposal.

"This bipartisan proposal meets the President's demand that the federal government not retreat on its guarantee to the elderly, poor children and the disabled," said Governor Miller. "The President challenged us to seek common ground, and we've done just that."

In a speech to the Governors today, President Clinton called the NGA agreement "a huge step in the right direction." He said he would watch closely as the Governors translate their agreement into legislative language and obtain an estimate of the cost savings the agreement would achieve.

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MEDICAID INSERT

- There is virtually unanimous consensus that the status quo is unacceptable for welfare. But let's be clear: the status quo is also unacceptable for the Medicaid program. I know no people agree with that more than your representatives on this issue: Govenors' Miller, Romer, Chiles, Thompson, Leavitt, and Engler. I appreciate all their hard work and I know you do too.

- We can and we should reduce the growth in what we spend on the Medicaid program. We can and we should provide for long overdue and added flexibility to administer the program.

- If we don't, we won't be serving our taxpayers or our Medicaid recipients. And if we don't, we certainly won't be able to do what you all do every year -- balance the budget.

- No one has been more committed than I to breaking through the Federal regulatory micromanagement of Medicaid. And I can guarantee you this, no one will work harder with you to break through the unnecessary statutory micromanagement of the program as well. I am confident that our mutually beneficial partnership will yield very positive dividends in the upcoming weeks and months.

- But as we work together on a reformed Medicaid program, we must preserve what is good about the program. As we provide for the type of flexibility you need to administer your programs in a more cost-effective and individualized manner, we must also uphold what is fundamentally right about the program.

- To achieve this goal, there are three basic principles that must be met by any Medicaid reform proposal.

- First, there must be a Federal guarantee to a set of meaningful benefits to qualifying Americans.

- Second, we must uphold the shared Federal/State responsibility for financing this program. Just as we count on you to effectively and fairly administer the Medicaid program, you need to be able to count on us when economic downturns increase your enrollment.

- And third, we must reduce and, where possible, eliminate the unnecessary regulatory and statutory strings that make it impossible for you to design and administer the best Medicaid program for your citizens.

Now, what do I mean by a Federal guarantee? It is this simple: Whoever you are, wherever you live, as long as you meet nationally–defined eligibility requirements, you are eligible for services. And if a program says you don't qualify and you think you do, you can appeal through the Federal court system.

This Federal guarantee not only answers the question 'who qualifies,' but it also sets a floor for the services recipients are qualified to receive -- regardless of where they live. This part of the Federal guarantee is also critical.

As I understand it, some of you have had a number of discussions about how to best define the minimum benefit package. Most of us know that the current mandatory benefit only accounts for about 50 percent of the cost of the program. The rest is optional. It is my belief that we probably should not significantly re–open this mandatory benefit package debate at this time. Based on what I have learned about your discussions so far, you seem to be following this course.

One issue that I want you to consider going slow on is EPSDT. I understand there are problems on the treatment side of this largely preventive benefit, but let's not "throw out baby out with the bath water." If we need to reform it, let's reform it. But let's think of constructive solutions that fall far short of totally eliminating the treatment portion of these important services.

But, just as the Federal Government relies on you to provide for the national guarantee, you have to be able to rely on us as a reliable and certain financing partner. When a recession hits home -- as it did for me in Arkansas in the early 1980's -- you should be able to count on us to come up with the additional financial support to help you pay for all the costs of the inevitable enrollment increases. The per person payment in my bill does just that and I cannot sign any legislation that does not continue this financial partnership.

I am, therefore, quite pleased that the 6 Governors working on Medicaid are working on a new formula that attempts to ensure that the dollars follow people when there are unexpected enrollment increases. As I understand the provision, the proposal would provide financial assistance (for both the mandatory and optional benefits) for states facing unexpected enrollment increases.

It goes to show, once again, that Governors can and will work together to produce bipartisan and constructive options. It sounds like you are moving close together on the commitment to guaranteed funding for states facing economic downturns. I view this as constructive and I look forward to having time to review the details.

And lastly, no Medicaid reform package will be acceptable to me if it does not provide for the type of flexibility you need -- the type of flexibility that I desperately wanted when I was Governor -- to administer this program.

And when I say flexibility, I mean unprecedented flexibility. I sat around here year

after year passing resolutions calling on the Congress to free us of the burdens they were placing on us in administering our Medicaid programs.

Each year, little or nothing happened. This year can and should be different. My balanced budget -- and in the budget I am releasing today -- includes with it at least 12 NGA-sponsored Medicaid flexibility recommendations. They include:

-- a long-overdue repeal of the Boren amendment that has tied your hands (and tied my hand) for years;

-- the repeal of the cost-based reimbursement requirement for health clinics and a number of other burdensome reimbursement restrictions;

-- the elimination of the burdensome waiver process for managed care and its accompanying *75/25* enrollment rule; and

-- the elimination of the waiver process for home and community-based waivers;

-- the elimination of the requirement that states who choose to expand coverage of pregnant women and children over the mandatory levels cannot return to the minimum level if financial or policy situations necessitate this change; and

-- the ability to expand covered populations up to 150 percent of poverty without a waiver.

These are real and meaningful changes, and I want to show you why I think so.

I hold in my hand a list of 173 Boren cases filed over the last several years. Guest what, no more cases will ever be filed under Boren if we can work together in passing Medicaid reform.

Here are copies of the 1915 (b) and (c) managed care and home and community based waiver forms that you collectively filled out 679 times over the years. Well, under my plan, you will not have to do this one more time.

And here is a copy of a submission my old Medicaid Director had to fill out just to report that he was changing payment rates for obstetric and pediatric care. Never again.

These are important reforms and I am certain we can do more. But let's not waste an opportunity of a lifetime to reform Medicaid the right way. With you as an active and supportive partner, I am confident we can get the job done the right way for you, the Medicaid program and the people it serves.

DEMOCRATIC NATIONAL COMMITTEE
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TO: GINNY **PAGES (W/COVER)** 2

FROM: SELDIN

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COMMENTS: FOR YOUR APPROVAL

Draft

**GOP GOVERNORS DEFY CONGRESSIONAL EXTREMISTS;
EMBRACE PRESIDENT CLINTON'S
BIPARTISAN APPROACH TO MEDICAID REFORM**

WASHINGTON, DC – Democratic and Republican Governors handed President Clinton a major victory in the ongoing budget debate yesterday, embracing his bipartisan approach of giving states more flexibility to pursue innovations in the Medicaid program while retaining the promise of guaranteed health care to the millions of seniors, children, and working families covered by that program. Republicans in Congress had insisted on a more extremist approach that would have removed the guarantee of Medicaid for those who rely on it.

"This is a big step forward, for the Governors, for the President, and most importantly for America's families," said DNC National Chairman Don Fowler. "Republican Congressional leaders should abide by this decision and give up on their dangerous, extreme, unnecessary scheme to deny the guarantee of Medicaid to the nursing home patients, working parents, and others to whom it has been promised."

"With the budget savings that the leadership and the President have already agreed on, and with this new Medicaid agreement, we could balance the budget, give middle class families some modest tax relief, and make much-needed investments in improving educational quality, expanding college opportunity, and creating jobs while we clean up the urban environment. We could do these things today. It's up to the Republican leadership in Congress – all they have to do is give up on the extremist policies they have been insisting on."

Throughout the debate over how to balance the budget, President Clinton has fought for the kind of Medicaid reform that the Governors are expected to endorse unanimously today – giving states the flexibility to improve services and save taxpayers' money, but without ending the federal guarantee of care to those who need it.

Speaking to the National Governors Association this morning, President Clinton called the agreement "a huge step in the right direction." He said he would watch closely as the Governors translate their agreement into legislative language and obtain an estimate of the cost savings the agreement would achieve.

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- We have serious reservations

- Rule their saying, okay fine, sign it.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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RATES (SEC. 2114 OF MEDIGRANT; SEC. 2114 OF MEDICAID)

House bill

If a State contracted with HMOs or similar entities on a risk basis for a package of services including at least inpatient hospital and physician care, the MediGrant plan would have to describe: (1) the use of actuarial science in projecting expenditures and utilization for enrollees and setting capitation payment rates; (2) required qualifications for participating organizations; and (3) a process for dissemination to contractors of information on capitation rates and historical fee-for-service cost and utilization data. The State would also have to provide for public notice and an opportunity to comment on this information before each contract year; the notice would have to include the amounts of capitation payments made under the MediGrant plan in the preceding year and expected to be made in the coming year (unless exempt from disclosure under State law).

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House provision.

PREVENTING SPOUSAL IMPOVERISHMENT (SEC. 2115 OF MEDIGRANT; SEC. 2116 OF MEDICAID)

House bill

The income eligibility rules would not permit income of community spouses to be used in determining the nursing home spouse's eligibility unless the income were actually made available to the institutionalized spouse. As in current law, after eligibility has been determined, States would be required to set a minimum monthly maintenance needs allowance for living expenses of the community spouse according to statutory limits. (Currently, this minimum is $1,254 per month and the maximum is $1,871 per month. These amounts may be increased depending on the amount of the community spouse's actual shelter costs and other factors.)

From a couple's combined resources, an amount would be protected for the community spouse. This amount would be the greater of one-half of the couple's resources at the time the institutionalized spouse entered the nursing home, up to a maximum, or a standard established by the State. (Currently, the State resource standard may be no lower than $14,964 and no greater than $74,820.)

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House provision with a Senate amendment to exclude from determinations of income reparations payments from the Federal Republic of Germany.

CONSTRUCTION (SEC. 2116 OF MEDIGRANT; SEC. 2115 OF MEDICAID)

House bill

The bill specifies that no provision shall be construed as creating an individual or group entitlement to medical assistance under Federal law. In addition, the bill grants states flexibility in determining: (a) coverage of any particular service or type of provider or any level of payment; (b) geographical coverage areas; and (c) selection of providers. The MediGrant plan also removes existing limitations on States' ability to contract with managed care plans or individual providers on a capitated or other basis, to contract for case management or coordination services, or to set capitation rates on the basis of competition or negotiation.

Senate amendment

Except for provisions related to immunizations for children and pre-pregnancy family planning services, no provision of this title would be construed as requiring a State to (a) cover any particular items or services; (b) provide for any particular type of provider or any level of payment; (c) provide for the same medical assistance in all geographical areas or political subdivisions of the State; (d) provide for comparability of services to eligible individuals; or (e) provide for freedom of choice of providers; or as limiting the State's ability to contract with managed care plans or individual providers on a capitated or other basis, to contract for case management or coordination services, or to set capitation rates on the basis of competition or negotiation.

Conference agreement

The conference agreement follows the House provision with an amendment. The amendment moves to Section 7002 the construction that no federal entitlement under federal law has been created in any individual, including any provider.

LIMITATIONS ON CAUSES OF ACTION (SEC. 2117 OF MEDIGRANT)

House bill

The bill would remove the existing right for an applicant, beneficiary, provider or health plan to sue a State official under 42 U.S.C. § 1983 to require prospective enforcement of the Medicaid statute. However, the plan would have no effect on any action brought under State law.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House provision with an amendment. The amendment moves to Section 2154 the limitation on causes of action under federal law.

"(C) DEFINITIONS.—For purposes of this paragraph—

"(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity,

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence, and

"(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, if the listed product is generally available to the public through retail pharmacies in that State.

"(7) REBATE PERIOD.—The term 'rebate period' means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.".

SEC. 7002. TERMINATION OF CURRENT PROGRAM AND TRANSITION.

(a) TERMINATION OF CURRENT PROGRAM; LIMITATION ON MEDICAID PAYMENTS IN FISCAL YEAR 1996.—

(1) REPEAL OF TITLE.—Title XIX of the Social Security Act is repealed effective October 1, 1996, except that the repeal of section 1928 of such Act is effective on the date of the enactment of this Act and the succeeding two sections of such title shall be effective during fiscal year 1996 in the same manner and to the same extent as such sections were effective during fiscal year 1995.

(2) LIMITATION ON OBLIGATION AUTHORITY.—Notwithstanding any other provision of such title—

(A) POST-ENACTMENT, PRE-MEDIGRANT.—Subject to subparagraph (B), the Secretary of Health and Human Services (in this section referred to as the "Secretary") may enter into obligations under such title with any State (as defined for purposes of such title) for expenses incurred after the date of the enactment of this Act and during fiscal year 1996, but not in excess of the obligation allotment for that State for fiscal year 1996 under section 2121(a)(4) of the Social Security Act (as added by section 7001).

(B) NONE AFTER MEDIGRANT.—The Secretary is not authorized to enter into any obligation with any State under title XIX of such Act for expenses incurred on or after the earlier of—

(i) October 1, 1996, or

(ii) the first day of the first quarter on which the State MediGrant plan under title XXI of such Act (as added by section 7001) is first effective.

(C) AGREEMENT.—A State's submission of claims for payment under section 1903 of such Act after the date of the enactment of this Act with respect to which the limitation described in subparagraph (A) applies is deemed to constitute the State's acceptance of the obligation limitation

under such subparagraph (including the formula for computing the amount of such obligation limitation).

(D) EFFECT ON MEDICAL ASSISTANCE.—Effective on the date of the enactment of this section—

(i) except as provided in this paragraph, the Federal Government has no obligation to provide payment with respect to items and services provided under title XIX of the Social Security Act, and

(ii) such title and title XXI of such Act shall not be construed as providing for an entitlement, under Federal law in relation to the Federal Government, in an individual or person (including any provider) at the time of provision or receipt of services.

(3) REQUIREMENT FOR TIMELY SUBMITTAL OF CLAIMS.—No payment shall be made to a State under title XIX of such Act with respect to an obligation incurred before the date of the enactment of this Act, unless the State has submitted to the Secretary, by not later than June 30, 1996, a claim for Federal financial participation for expenses paid by the State with respect to such obligations. Nothing in paragraph (2) shall be construed as affecting the obligation of the Federal Government to pay claims described in the previous sentence.

(b) MEDICAID-TO-MEDIGRANT TRANSITION PROVISIONS.—

(1) Notwithstanding any provision of law, in the case where payment has been made under section 1903(a) of the Social Security Act to a State before October 1, 1995, and for which a disallowance has not been taken as of such date (or, if so taken, has not been completed, including judicial review, by such date), the Secretary of Health and Human Services shall discontinue the disallowance proceeding and, if such disallowance has been taken as of the date of the enactment of this Act, any payment reductions effected shall be rescinded and the payments returned to the State.

(2) The repeal under subsection (a)(1) of section 1928 of the Social Security Act shall not affect the distribution of vaccines purchased and delivered to the States before the date of the enactment of this Act. No vaccine may be purchased after such date by the Federal Government or any State under any contract under section 1928(d) of the Social Security Act.

(3) No judicial or administrative decision rendered regarding requirements imposed under title XIX of the Social Security Act with respect to a State shall have any application to the MediGrant plan of the State title under XXI of such Act. A State may, pursuant to the previous sentence, seek the abrogation or modification of any such decision after the date of termination of the State plan under title XIX of such Act.

(4) No cause of action under title XIX of the Social Security Act which seeks to require a State to establish or maintain minimum payment rates under such title or claim which seeks reimbursement for any period before the date of the enactment of this Act based on the alleged failure of the State to comply with such title and which has not become final as of such date shall be brought or continued.

THE PRESIDENT'S MEDICAID POLICY

The President's plan achieves $59 billion (vs. $85 billion for the Republicans) in Federal Medicaid savings from a per capita cap mechanism, combined with savings from Disproportionate Share payments. He retains the individual guarantee, enforced through the Federal courts, to a set of meaningful (and nationally defined) benefits, and he provides for unprecedented flexibility for Governors in administering/delivering these health care services.

"Bottom-Line" Essentials for Any Deal on Medicaid

(1) Dollars need to follow people. As we are committed to reduce Medicaid per person costs and constrain the overall growth of the program, the Federal Government must maintain its shared financing partnership with the states. When a state faces an economic downturn, it must have an immediate and reliable Federal financing partner to help pay for unanticipated enrollment increases. Such an approach will assure that Federal dollars follow the increasing number of covered people.

(2) There must be a workable enforcement mechanism that guarantees eligibility to Medicaid coverage. We believe that preservation of the Federal court right of action for recipients (not providers, since the President is repealing all vestiges of the Boren amendment) assures this guarantee. Any alternative to this approach must satisfy the President that the enforcement of the Federal guarantee is not undermined.

(3) There must be a meaningful and Federally-defined benefits package for all eligible populations -- regardless of what state they live in. This means that states must still ensure that their mandatory benefit packages must not only be consistent with a meaningful and nationally-defined mandatory benefit, but that they also meet current comparability (non-discriminatory protections across populations) and statewideness requirements.

(4) There must be real, workable and significant flexibility for states to administer their programs. Our repeal of Boren, elimination of waiver requirements for managed care, and elimination of the cost-based reimbursement requirement for health clinics are just a few of the many new and unprecedented flexibility provisions that we are committed to enacting.

MAJOR CONCERNS OF YESTERDAY'S NGA DOCUMENT

- **Package of flexibility provisions went well beyond discussion with the President.** (Items not mentioned in yesterday's POTUS meeting with the Governors are *italicized*). The summary of flexibility provisions mirrors the many provisions of the Republican Medigrant II bill that our base Democrats and groups would find totally unacceptable. Taken together with the write-up of the financing provisions, the new proposal might well be labeled by the outside world as a block grant with a contingency fund.

- **Eligibility concerns include:** The repeal of the current law's phase-in for coverage of about 3 million children age 13-17; the devolution of the "disability" definition to the states; and *the elimination of the required coverage of premiums for low-income Medicare beneficiaries between 100-120 percent of poverty is repealed.*

- **Benefit concerns include:** *The total discretion given to states to alter the amount/duration/scope of services; the repeal of the current law's comparability and statewideness requirement that ensure that recipients in particular groups or locations are not discriminated against; the apparent elimination of any defined benefit package for currently optional populations;* and the vague redefinition of the "T" in the EPSDT children's health benefit.

- **Enforcement concerns include:** The state-based right of action process advocated by the Governors (and whether or how it will work to effectively ensure the guarantee).

- **Financing concerns include:** The exclusion of pregnant women and children, *as well as the medically needy*, from the Federally-financed "umbrella" pool payments; *the inclusion in the base formula of the allowance that states can reduce their matching Medicaid rate -- the result producing an additional $200 billion reduction in state Medicaid spending over seven years, bringing the total Federal/State cut to $290 billion; the allowance for states to, once again, tax health care providers to help finance their state match; allowing for provider taxes will likely push up the cost of the program that CBO scores, since CBO remembers what happened in the late 80's and early 90's when states used this creative financing scheme to access more Federal dollars and to reduce their state burden.*

- **Quality concerns include:** *The adequacy of the quality protections for plans under Medicaid, such as HMOs and other managed care plan; the state-based enforcement of Ronald Reagan's Federal nursing home standards.* (The difference between them and us has always come down to definition and enforcement.)

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DRAFT

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DRAFT

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- **Package of flexibility provisions went well beyond discussion with the President.** The summary of flexibility provisions mirrors many provisions of the Republican Medigrant II bill. Taken together with the write-up of the financing provisions, the new proposal raises significant concerns.

- **Eligibility concerns include:** The repeal of the current law's phase-in for coverage of about 3 million children age 13-17; the devolution of the "disability" definition to the states; the limitation to "frail" elderly population seems to not include all elderly who are currently eligible; and *the elimination of the required coverage of premiums for low-income Medicare beneficiaries between 100-120 percent of poverty is repealed.*

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Draft 2/6/96

PRESIDENT WILLIAM J. CLINTON

REMARKS TO

THE NATIONAL GOVERNORS' ASSOCIATION

WASHINGTON, D.C.

FEBRUARY 6, 1996

[Acknowledgements: Governor Thompson for introduction; Governor Miller; governors and friends...]

Thank you for the invitation to address this most important meeting. During the past few days, together, we have tackled the toughest challenges facing our nation. And we have done it by reaching across lines of party, geography and ideology, seeking common ground.

I think we should begin by reminding ourselves that even though we face some historic choices about the direction of our country, this is a time of great potential.

Because of our strong partnership and the hard work of our citizens, America is strong and growing stronger. We have the lowest combined rates of unemployment and inflation in 27 years, a record number of new businesses. And across the country, old industries are being revived and new ones are being born -- an auto industry that once again leads the world . . . 700,000 new jobs in construction . . . the world's number one manufacturer of telecommunications satellites.

And perhaps most important, we are seeing Americans coming together again around our fundamental values.

The crime rate, the welfare and food stamp rolls, the poverty rate and the teen pregnancy rate are all down.

We all know that this new era of microchips and global trade presents our people with vast new opportunities. But it also introduces new pressures and new challenges. While more of our citizens are living better, too many of them are working harder just to keep up, and they justifiably wonder if they will be winners in this new era.

The central challenge we face as political leaders is to give the American people the tools to make the most of their lives while keeping the American Dream alive for themselves and their children.

We know what our challenges are. A few weeks ago, I outlined them in the State of the Union: honoring the obligation we owe our children and building strong families; renewing educational opportunity so we can compete and win in the 21st century; providing economic security for families who are willing to work for it; taking back our streets from drugs, crime and gangs . . . . . .

. . . protecting our environment for today and for future generations; maintaining America's leadership in the fight for freedom and peace throughout the world; and reinventing government to make our democracy work better for the American people.

The question before us today is not whether we will meet these challenges...but how. How can we harness all the energy, all the dynamism driving this new economy, so that our people can reap the rewards of change? How do we use enduring values to help guide us into the new age?

We need to meet these new challenges in an old-fashioned way -- together. American families don't hold purist views about how to meet our challenges. They don't think that Washington has all the answers, and they don't think that state capitols have all the answers, either. They want what works. And what works is us, working together -- across party lines, the national government and state governments, working toward common ground.

It is clear from the experience of the past 30 years that centralized, one-size-fits-all government does not work and will not meet the challenges of our time. But it is also clear from the last 12 months that getting rid of government is not the answer, either.

We cannot go back to a time of fend for yourself. If we believe that our nation owes a duty to our parents and our children; that we should provide opportunity to everyone who is willing to take responsibility; that as Americans, we owe a duty to one another, then we cannot walk away.

Our nation must meet our challenges in new ways. The national government should not try to do everything. But it must articulate a clear national vision, set goals and challenge people from every walk of life to meet those goals, and give them the help they need to be successful. That mobilizes communities, businesses, churches, schools to face our problems.

Our Crime Bill set a national goal of 100,000 more police on the street, but challenged mayors, police, and civic groups to make community policing a reality. And I am proud to say that in communities across the nation, this approach is working. Our Goals 2000 education reform set tough national standards, but challenged states and local communities to meet these standards. And we are challenging every state to allow parents to chose their child's public school, and to let parents and teachers set up charter schools that have to meet tough standards.

With the Unfunded Mandates law, passed with an overwhelming bipartisan margin; with dozens of Medicaid and welfare waivers, more than all other administrations combined; with new flexibility for states ranging from the Clean Air Act to highway funding, we have worked as a partner with states and cities, and with men and women of goodwill from both parties.

This approach -- all of us working together -- is how we will solve our most pressing problems: the budget; health care; and welfare.

The budget deficit was a bipartisan creation and it will only bend to a bipartisan solution. For too long, Congress and the President were putting into place fiscal policies that would never be seriously advanced by any governor who had to balance a budget. In the 12 years before I took office the deficit sky-rocketed and the national debt quadrupled. I am proud that we cut the deficit nearly in half, but we all know that is not enough. We have to finish the job and balance the budget.

And we will only do it if we work together, regardless of party, in a way that upholds America's fundamental values.

Yesterday, I submitted a budget that reaches balance in seven years based on CBO numbers. This is a budget that is good for America.

As you know, during the past few months, we've had more than 50 hours of negotiations on how to balance the budget. This has been a difficult process, but behind all the impassioned public debate, Speaker Gingrich, Majority Leader Dole, and the Democratic congressional leaders and I have achieved solid, quiet progress at the negotiating table.

Together, we have found about $700 billion in real savings -- all certified by the Congressional Budget Office to be real, attainable and accurate. We both agree on steps to slow the inflation of health care costs under the Medicare. We both agree on how to provide Medicaid services more efficiently. We both agree on savings in welfare spending by requiring recipients to work, and by setting time limits for their stay on welfare. We both agree to hundreds of billions of cuts in government spending to create a leaner, and more efficient national government.

So, I say to the leaders of Congress: These cuts we have already identified are enough to balance the budget in seven years --- **just pass it**. These cuts are enough to afford a modest tax cut for working Americans. These cuts are enough to end a legacy of deficits, and to protect Medicare, Medicaid, education and the environment. We can continue to negotiate; we can continue to talk. But take these cuts, balance the budget, and **just pass it**. **Just pass it**.

A second area where we can found common ground, bipartisanship and a new way of solving problems is how we provide health care for our people.

I want to commend the National Governors Association for the progress that you have made toward hammering out our differences on Medicaid.

Three decades ago we made a national commitment that if you are pregnant, if your child becomes disabled, if you are an elderly American who can't afford nursing home care, you will not be denied quality health care. It was the right thing to do then, and it is the right thing to do today.

I am glad we now agree that we must preserve our national guarantee of medical care for poor children, pregnant women, people with disabilities and older Americans. And I am glad that we agree that states should have more flexibility in how to administer the program.

This is a step in the right direction.

But to make it a real guarantee, we cannot halt our progress in extending health care to young people.

To make it a real guarantee, we cannot allow an America in which a disabled person's health coverage depends on what state they live in.

To make it a real guarantee, we cannot allow an America in which people lose their Medicare coverage because they can't afford the premium.

To make it a real guarantee, there must be basic, enforceable national standards for what constitutes meaningful health coverage.

Let me repeat: I am pleased that we now agree that America should keep its national guarantee of medical care, with real flexibility for states in how to meet that guarantee. But the guarantee must be real. And it must provide meaningful medical care for children, seniors, pregnant women, and the disabled, regardless of what state they live in.

Whatever else we do on health care, we should change the rules of the game so that working people never lose access to health care. Our nation is the only leading economy in the world where insurance companies are allowed to deny citizens coverage or raise their rates just because they're sick.

People with pre-existing conditions like diabetes, high blood pressure or heart disease, can simply be turned down. Tens of millions more people simply lost their health coverage as they move from one job to another. For working families that's like walking on a tightrope without a net.

But there is bipartisan legislation that would protect these working families and require insurers to cover men and women who have lost insurance because they change or lose jobs. The Kassebaum-Kennedy bill is not government-run health care. It imposes no mandates on employers.

But it gives working people the tools to protect themselves and their families and to take advantage of the opportunities offered by the new economy. It has 43 bipartisan cosponsors and passed through its committee unanimously. It has the support of business, doctors, and consumer groups. So, I call on the Congressional leadership today to stand up to the insurance industry and schedule a vote.

And finally, that same spirit of team work and bipartisanship should animate our efforts to achieve real welfare reform.

I believe we are close to agreement on sweeping reform that is consistent with the principles the American people demand: requiring work, strengthening families, inspiring responsibility, and protecting children. I look forward to your final recommendations. I am glad that governors in both parties agree that the bill Congress sent me wasn't strong enough, and that we must do more -- and can do more -- to protect children and move people from welfare to work.

I believe that if we continue to make progress, we can put partisan differences aside and end welfare as we know it.

My test for judging what you agree to is real welfare reform will be: Do we move people from welfare to work? A parent who works reconnects themselves and their family to the American community and American values. Whatever we do, let us make sure that we replace the current welfare system with the fundamental American value of work.

A balanced budget. Welfare reform. Health care for working Americans. We can do all these things -- if we do them together. America was built on challenges, not promises. And when we pull together to meet those challenges, we never, never fail.

I believe we are standing on the threshold of a bold new era. Now is the time to act on our ideals. Abraham Lincoln said: "We can succeed only by concert. It is not, 'Can any of us imagine better?' but, 'Can we all do better?'" Today, here, together, we must answer: Yes.

Thank you.

To: Chris Jennings

Fr. Nicole Lamboley

Dt: 2/5/96

~~Confidential~~

C-6220

DRAFT — being discussed as we fax.

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: JMA DATE: 2-13-14

-hge

2/5/96
3:15 pm

HIGHLIGHTS

Eligibility

Coverage remains guaranteed for

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

Coverage remains optional for

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

Benefits

- The following benefits remain guaranteed for the guaranteed populations only.
  - Inpatient and outpatient hospital services, physician services, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, Early and Periodic Screening, Diagnosis and Treatment Services., (The "T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)
- At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.
- States have complete flexibility in defining amount, duration, and scope of services.

Private Right of Action

- The following are the rights of action for individuals (or classes) for eligibility.
  - Before taking action in the state courts, the individual must follow a state administrative appeals process.
  - States must offer individuals (or classes) a private right of action in the state courts as a condition of participation in the program.
  - Following action in the state courts, an individual (or class) could appeal directly to the U.S. Supreme Court.
  - Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals (or classes) but not for providers or health plans.

→ 40% Match rate

→ Right of Action

2/5/96
3:15 pm

Service Delivery

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

Provider Standards and Reimbursements

- States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.
- The Boren amendment and other boren-like statutory provisions must be repealed.
- "One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics.
- States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.

Nursing Home Reforms

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

Plan Administration

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

Provider Taxes and Donations

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

Financing

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

1. Base. Total Medicaid expenditures, (DSH dollars remain unresolved) for the state in FY 1995. (Some states may require special provisions to correct for anomalies in their program in base year 1995)

* Big problem for providers. Don't assume to significantly reduce Vote contributions to Medicaid match.

2/5/96
3:15 pm

2. Growth. This is a formula that accounts for estimated changes in medical costs and estimated changes in a state's caseload. It includes the following
   - a state specific estimate of poverty,
   - a state specific estimate of the case mix to reflect the differences in cost of populations in the program,
   - a national estimate of per-beneficiary costs, and
   - an annual medical inflation factor (specific factor to be determined).

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

3. Special Grants. A special grant fund will be made available for certain states to cover illegal aliens. States will have no matching requirement to gain access to these federal funds.

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

   Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups – persons with disabilities and the elderly. → no kids & pregnant women.

   Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.
   1. States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.
   2. A state must exceed one percent variation in population above the base and growth to gain access to the insurance umbrella.

→ Question of whether a true dollar follows people approach, more increase in enrollment under ICs would not be compensated by the Federal Govt.

Talking Points
NGA Resolution on Welfare Reform
February 6, 1996

As the President said in his speech to the NGA this morning, real welfare reform must require work, promote family and responsibility, and protect children. The governors' resolution reinforces what the President has said all along -- that the conference report he vetoed fell short of real welfare reform, and must be improved.

The Administration is pleased with the NGA's recommendations in several areas of promoting work and protecting children -- substantial increase in child care funds, a better contingency fund, a substantial performance bonus, equal treatment for recipients, reductions in the overall level of savings, provisions on SSI children's disability programs, increasing the hardship exemption, improving the work requirements, and making the family cap a state option. The Administration continues to have serious concerns about other important issues -- including child welfare, Food Stamps, school lunch, maintenance-of-effort, and benefits for legal immigrants.

The NGA resolution suggests valuable improvements over the conference report and the Senate bill in several key areas that are priorities for the President:

Child Care -- The NGA resolution calls for adding $4 billion for child care to the conference report, which is $5 billion more than the Senate bill. Senator Dole acknowledged the need for more child care money in his speech to the NGA this morning. The Administration believes, however, that states should match this additional child care funding, and maintain current quality standards.

Contingency Fund -- The NGA called for doubling the contingency fund to $2 billion, and providing an additional trigger based on Food Stamps population. The Administration has made additional suggestions to strengthen the countercyclical mechanism of this provision.

Performance Bonus -- The NGA endorsed additional funding for a 5% performance bonus to reward states that meet the work requirements -- a key provision that the President has long championed and that was a centerpiece of the Daschle-Breaux-Mikulski bill. This is a significant improvement over both the conference report and the Senate bill.

Equal Treatment -- The NGA resolution includes an important requirement that was not in either the conference report or the Senate bill, to ensure that states set forth objective criteria for the delivery of benefits and fair and equitable treatment.

SSI Disabled Children -- The NGA resolution adopts the SSI children provisions of the Senate bill, but moves back the effective date a year, to 1998.

The NGA resolution recommends other important changes that are similar to the Senate bill:

Work Requirements -- The NGA resolution adopts work requirements and state flexibility similar to the Senate bill, which will somewhat reduce state costs of running work programs.

Hardship Exemption -- The NGA resolution endorses the 20% hardship exemption in the Senate bill for recipients who reach the five-year limit. The conference report had reduced this provision to 15%.

Family Cap -- The NGA resolution endorses the Administration policy that states should decide for themselves whether to limit benefits for additional children born to parents on welfare. Like the Senate bill, the NGA would make the family cap a state option -- rather than a mandatory provision with an opt-out, as the conference report included.

Overall Savings -- The NGA resolution cuts more deeply into Food Stamps than the Administration's balanced budget plan -- at levels deeper than the Senate bill. Because the NGA resolution calls for additional spending on child care, the contingency fund, and the performance bonus, its overall net savings are slightly below the Senate bill but still considerably higher than the Administration's balanced budget plan.

The Administration continues to have serious reservations about some other provisions in the NGA resolution:

Child Welfare -- The Administration has strongly opposed block granting child welfare. The Senate bill maintained current law in this area. The NGA resolution would allow states the option to block grant certain programs.

Food Stamps -- The NGA resolution fails to criticize certain Food Stamp provisions of the conference report which the Administration has strongly opposed, including the state option to block grant Food Stamps and the arbitrary cutoff of able-bodied childless adults.

School Lunch -- The Administration has strongly opposed block granting the school lunch program. The NGA resolution would maintain the entitlement for children, but block grant administrative costs.

Maintenance-of-Effort -- The NGA resolution is silent on the issue of maintenance-of-effort. The Administration strongly favors the Senate provision of 80% maintenance-of-effort, rather than the 75% requirement in the conference report. In addition, the Administration opposes the Conference provisions that enable states to transfer funds out of the block grant for other purposes.

Immigrants -- The NGA resolution is silent on the question of benefits for legal immigrants. The Administration's balanced budget plan requires deeming until citizenship. The Administration strongly opposes the level of immigrant cuts in the conference report and

the Senate bill.

Medicaid -- While details have not yet been provided, the NGA resolution on Mediaid suggests that welfare recipients should continue to be guaranteed health coverage. The Senate bill maintains this link between welfare and medicaid, but the Conference report broke it.

COMPARISON OF WELFARE REFORM MAJOR PROVISIONS

	HOUSE BILL	SENATE BILL	CONFERENCE BILL (H.R. 4)	NGA PROPOSAL
Block Granting AFDC	Block grants AFDC, EA, and JOBS into a single capped entitlement to states.	Block grants AFDC, EA, JOBS, and child care into a single capped entitlement to states. The block grant provides a separate allocation specifically for child care.	Block grants AFDC, EA, and JOBS into a single capped entitlement to states.	Block grants AFDC, EA, and JOBS into a single capped entitlement to states. The block grant provides a separate allocation specifically for child care.
Time Limits	Families who have been on the rolls for 5 cumulative years (or less at state option) would be ineligible for cash aid. States would be permitted to exempt up to 10% of the caseload from the time limit. States would be permitted to provide noncash benefits to families that have reached their time limits.	Families who have been on the rolls for 5 cumulative years (or less at state option) would be ineligible for cash aid. States would be permitted to exempt up to 20% of the caseload from the time limit.	Families who have been on the rolls for 5 cumulative years (or less at state option) would be ineligible for cash aid. States would be permitted to exempt up to 15% of the caseload from the time limit. States are permitted to provide noncash benefits vouchers to families that are time limited.	Families who have been on the rolls for 5 cumulative years (or less at state option) would be ineligible for cash aid. States would be permitted to exempt up to 20% of the caseload from the time limit. States are permitted to provide noncash benefits vouchers to families that are time limited.
Work Requirements	A state's required work participation rate would be set at 10% in 1996, rising to 50% by 2003. For 2-parent families, the participation rate would be 50% in FY 1996, rising to 90% in FY 1998. Individuals must work an average of 20 hours per week in FY 1996, increasing to 35 hours in FY 2002.	A state's required work participation rate would be set at 25% in 1996, rising to 50% by 2000. The bill allows mothers with children under 6 to work part-time (20 hours per week) through 2002. The bill also allows states to exempt families with children under 1 from work requirements.	A state's required work participation rate would be set at 15% in 1996, rising to 50% by 2002. States have the option to exempt single parents with children under age 1 from work requirement. No part-time work option for mothers with young children.	A state's required work participation rate would be set at 15% in 1996, rising to 50% in 2002. The resolution allows mothers with children under 6 to work part-time (20 hours per week) through 2002. Recipients must work an average of at least 25 hours per week. The resolution also allows states to exempt families with children under 1 from work requirements; changes the participation rate calculation to take into account those who leave cash assistance for work; and allows job search and job readiness to count as a work activity for up to 12 weeks.
Child Care	A child care block grant would be authorized at $2.1 billion annually as discretionary spending for FYs 1996 through 2000. Overall, child care would be cut by $1.95 billion over 7 years (new CBO baseline).	From FY 1996 through 2000, $8 billion would be available as a capped entitlement to states for child care assistance. An additional $1 billion per year is available in discretionary spending under CCDBG. Overall, a $755 million increase in mandatory funding over 7 years (new CBO baseline). Recipients cannot be sanctioned for not working if child care is unavailable.	The bill contains a total of $7 billion in discretionary funding and $10 billion in mandatory funding. Overall, increases mandatory child care funding over current law by $1.9 billion over 7 years (new CBO baseline).	The resolution contains a total of $7 billion in discretionary funding and $14 billion in mandatory funding: an increase of $4 billion over the conference report and $5 billion over the Senate bill. Overall, increases mandatory child care funding over current law by $5.9 billion over 7 years (new CBO baseline).

	HOUSE BILL	SENATE BILL	CONFERENCE BILL (H.R. 4)	NGA PROPOSAL
Economic Contingency Grant Fund	States with high unemployment could borrow from a $1 billion national Rainy Day loan fund. Funds would have to be repaid.	$1 billion would be appropriated for FYs 1996-2002 for matching grants to states with high unemployment rates. An emergency loan fund of $1.7 billion, and a $880 million grant fund for low-benefit, high population-growth states would also be available.	The bill includes $1 billion for grants to states with high unemployment (state must match); $800 million grant fund for states with high population growth, benefits lower than 35% of the national average, or above average growth and below average AFDC benefits (no state match); and $1.7 billion loan fund.	Adds $1 billion to the proposed funding for the contingency fund for a total of $2 billion. States can meet one of two triggers to access the contingency fund: the unemployment trigger in the conference agreement and a new trigger based on food stamps. Under the second trigger, states would be eligible for the contingency fund if their food stamp caseload increases by 10% over FY 1995 caseload levels.
Performance Bonus to Reward Work	No performance bonus	Establishes a performance bonus set-aside within the block grant for states, but does not add additional resources.	No cash performance bonus	Provides cash bonuses of 5% annually to states that exceed specified employment-related performance target percentages. (Approximately $2 billion plus.) These bonuses would be in addition to block grant base.
Family Cap	States could not use federal funds to provide cash benefits to children born while parent is receiving assistance.	No federal mandate to deny assistance; option for state action as in Administration bill.	States would be required to deny cash benefits to children born to welfare recipients unless the state legislature explicitly votes to provide benefits.	No federal mandate to deny assistance; option for state action as in Administration bill.
Child Support	Includes major comprehensive child support enforcement measures proposed by the Clinton Administration, including paternity establishment, state central registries of child support orders, and uniform procedures for interstate cases, and penalties such as license revocation. Eliminates the $50 pass-through of child support to cash assistance recipients.	Same as the House bill; includes all Clinton Administration proposals.	Same as the House bill; includes all Clinton Administration proposals.	Same as the House and Senate bills; includes all Clinton Administration proposals.
SSI For Children	Children who are now eligible for SSI under the medical listings would continue to receive cash benefits and Medicaid. For applicants after enactment, cash benefits would only be available for children who meet the medical listing and are institutionalized or would be institutionalized if they do not receive personal assistance services required because of their disability. All children who meet the medical listings would be eligible for services under a state block grant funded at 75% of the amount otherwise payable in cash benefits. There would be no guarantee of services under the block grant.	SSI and Medicaid eligibility would be restricted to those children who meet the medical listing; Individual Functional Assessment (IFA) and references to maladaptive behavior would be repealed.	SSI and Medicaid eligibility would be restricted to children who meet the medical listing. IFA and references to maladaptive behavior would be repealed. Effective January 1, 1997, for current recipients and new applicants, a 2-tiered benefit system would be established. Children who need personal assistance in order to remain at home would receive 100% of the benefit. Children who meet the listings but not the personal assistance criteria would receive 75% of the benefit.	Same as the Senate bill. Effective date is deferred until January 1, 1998.

	HOUSE BILL	SENATE BILL	CONFERENCE BILL (H.R. 4)	NGA PROPOSAL
Maintenance of Effort	No requirements	States would be required to maintain 80% of FY 1994 spending on AFDC and related programs for FYs 1996-99.	States would be required to maintain 75% of FY 1994 spending on AFDC and related programs for FYs 1996-2000.	No provision
Personal Responsibility Contract	No personal responsibility contract	Includes personal responsibility contracts for welfare recipients, under which benefits would be reduced for failure to comply.	No personal responsibility contract	No provision
Child Nutrition	Replaces child nutrition programs operated outside of schools, WIC, and commodity distribution programs with a block grant to states. Creates a separate block grant to states for school-based child nutrition programs. These provisions would result in cuts of $10 billion over 7 years.	No block grants proposed. Contains program cuts amounting to $4 billion over 7 years.	No mandatory child nutrition block grants, but permits up to 7 school nutrition block grant demonstrations. WIC remains a separate program. Child nutrition spending would be reduced by about $6.3 billion over 7 years.	Provides for school lunch block grant demonstration, under which the current entitlement for children is maintained; states would continue to receive the proportion of administrative costs based on current law but in a block grant.
Child Protection and Adoption	Block grants direct benefits and administration programs used to recruit adoptive parents and investigate child abuse. Cuts funding to states by $6.3 billion.	Maintains current entitlement for foster care and adoption payments and for administrative programs. No funding reductions.	Maintains the entitlement for direct payments to families and block grants administration programs. Overall, reduces mandatory funding by $400 million over 7 years.	Maintains the entitlement for direct payments to families and provides a state option to take foster care, adoption assistance, and independent living program as a capped entitlement. States that take the option must continue to maintain effort at 100%. States must maintain protections and standards under current law. States can reverse their decision on a yearly basis.
Teen Parent Provisions	States would be prohibited from providing cash benefits to minor mothers.	In order to receive assistance, unmarried minor parents would be required to live with an adult or in an adult-supervised setting and participate in educational or training activities.	Same as the Senate bill	Same as the Senate bill
Food Stamps	The House bill would reduce federal funding for food stamps by $40 billion over 7 years, and would cap federal program expenditures regardless of growth (old CBO scoring). The bill would limit maximum benefit increases to 2% per year, regardless of the increase in food costs. It would terminate benefits for non-disabled childless individuals between 18 and 50 years old unless they are working at least half-time or in a work program. Optional food stamp block grant would be available to states that operate a statewide EBT system.	The Senate bill would reduce federal funding for food stamps by $24 billion over 7 years (new CBO scoring). Able-bodied childless adults between 18 and 50 would be ineligible for food stamps after 6 months unless they work half-time or participate in a work or training activity. States would have the option to receive food assistance as a capped block grant. States that choose to implement a block grant would be required to use 80% of the funds for nutrition assistance; the remaining funds could be used for administrative costs or transferred to work-related programs.	The conference bill would reduce federal funding for food stamps by $27.5 billion over 7 years (new CBO scoring). Able-bodied childless adults between 18 and 50 would be required to participate in workfare or employment and training program as a condition of eligibility. An optional food stamp block grant would be available to states that have a fully implemented EBT system or meet certain accuracy standards. States choosing block grants would be required to meet specified requirements, and would have to restrict benefits to illegal immigrants.	Maintains the Senate language which reauthorizes the food stamp program in its current uncapped entitlement form. Also adopts Senate language on income deductions. (Resolution will lower food stamps savings.) Able-bodied childless adults between 18 and 50 would be required to participate in workfare or employment and training program as a condition of eligibility. An optional food stamp block grant would be available to states that have a fully implemented EBT system or meet certain accuracy standards. States choosing block grants would be required to meet specified requirements.

THE PRESIDENT'S MEDICAID PLAN: WHAT IT MEANS FOR STATES

MEDICAID GUARANTEE PRESERVED. The President's plan retains the guarantee of meaningful Medicaid health benefits for children, pregnant women, people with disabilities and older Americans.

Republicans end the Medicaid guarantee and replace it with a deeply underfunded block grant that could deny health benefits to 3 to 6 million Americans in 2002, including more than 1 million children. The only required benefits would be immunizations and limited family planning. The reduction in coverage would increase the number of uninsured people, uncompensated care, and cost shifting to people with private insurance.

PROVIDES UNPRECEDENTED STATE FLEXIBILITY. The President's Medicaid plan gives states unprecedented flexibility in the administration of their Medicaid programs. To take a few examples:

- **Gives States flexibility to establish provider payment rates**. The plan repeals the Boren Amendment and the requirement that states pay federally qualified health centers and rural health centers on a cost basis.

- **Gives States new flexibility to use managed care.** States can implement managed care without seeking federal waivers. The plan also repeals burdensome managed care rules, including federal contract approvals, annual quality reviews and the requirement that 25% of all enrollees in a plan be private patients. In addition, states can require HMO enrollees to pay nominal copayments.

- **Repeals or simplifies Federal administrative requirements.** A number of requirements are repealed, including: special minimum qualifications for pediatricians and obstetricians; federally-mandated administrative requirements for state personnel standards and cooperative agreements with other state programs; and annual resident review in nursing homes.

The Republican plan would eliminate virtually all national standards and leave states to contend with deep cuts and a structure that freezes federal spending regardless of changing economic conditions.

CUTS ARE SIGNIFICANTLY LESS. The President's plan saves $59 billion over seven years from Medicaid. The Republicans cut $85 billion from Medicaid -- 45% more than the President. Under the Republican plan, spending growth per person would be 33% below inflation.

Even more importantly, under the President's plan, federal spending increases if states are faced with a recession, inflation, demographic changes or some other unforeseen event that causes enrollment to increase. States are left unprotected under the Republican plan.

CONTROLS MEDICAID SPENDING WITHOUT PUTTING STATES AT FINANCIAL RISK. The President proposes a "per capita cap." Federal payments under this policy automatically adjust to a state's enrollment: if a state has an unexpected increase in enrollment, federal payments increase. In this way, the cap limits federal Medicaid spending while maintaining the federal commitment to share the risk of economic downturns, inflation demographic changes and other circumstances beyond the control of states.

Under the block grant proposed by the Republicans, states would be responsible for 100% of the additional costs from circumstances beyond their control. According to analysis by the Center of Budget and Policy Priorities, if inflation were just 1 percentage point higher than projected over seven years, Medicaid costs would rise by about $65 billion -- all of which would be absorbed by states under a block grant.

REDUCES DISPROPORTIONATE SHARE PAYMENTS BUT INCREASES STATE CONTROL. Under the President's plan, the current disproportionate share (DSH) program is gradually replaced by a new, more targeted program. States are able to focus their funding on hospitals that serve a high number of uninsured and Medicaid patients, and have flexibility to cover additional hospitals that they deem needy. Three payment pools ease the transition to the new DSH program and the per capita cap. The first assists states with high numbers of undocumented persons. The second concentrates funds on federally qualified health centers and rural health centers as Medicaid cost-based reimbursement ends. The third is a transition pool to help selected states convert from the current system to the new one.

The Republicans end the DSH program, increasing already severe funding problems of inner city, public and rural hospitals that care for uninsured and Medicaid patients, and disproportionately hurting states with many hospitals that have large uncompensated care burdens.

RESOLUTION NUMBER: HR-8
RESOLUTION TITLE: PUBLIC HEALTH SERVICES

Jennifer Klein
456-2599

Summary of Resolution:

The resolution outlines core public health services and the responsibilities of federal, state, and local governments for implementing those services. It recommends that state and local governments should have primary responsibility for the delivery of public health services, and that the federal government should finance public health delivery, collect information on a national level and take the lead on certain public health functions that are national in scope. It also recommends that delivery of public health services be coordinated with managed care, block grant programs related to public health, maternal and child health services, health promotion and prevention and disease prevention and control.

Summary of Administration Position:

The resolution outlines a definition of states' roles that is generally consistent with Administration policies. However, our position on the federal role differs in two ways:

First, the resolution fails to describe important characteristics of any federal grant program. For example, resolution 8.4.2 calls for authority to transfer funds among block grant programs, which is not consistent with the need for accountability in the allocation and use of federally appropriated funds. While the Administration strongly endorses performance measures for health block grant programs, our position is that those measures must be mutually agreed upon between federal and state agencies and must also assure accountability.

Second, the resolution focuses mainly on health services for the underserved and leaves out other appropriate federal activities. This Administration has proposed and implemented policies, such as our proposed Performance Partnership Grant legislation, that define public health and the federal role more broadly. For example:

- The resolution does not adequately recognize that public health services are necessary to protect and improve the health of the entire population, as well as to assure access to health care for vulnerable and underserved populations.
- It fails to include essential federal responsibilities for defining -- in collaboration with states -- consistent public health policies and standards to ensure nationwide health protections, such as in areas safeguarded through Food and Drug Administration regulations.
- It does not address mental health and substance abuse prevention and treatment programs as necessary parts of public health.
- It does not include prevention of injury as a component of federal-state partnerships in health promotion and prevention.
- It does not recognize the key role of public health as guarantor of quality, especially in publicly funded managed health care for vulnerable populations.

RESOLUTION NUMBER: HR-31

RESOLUTION TITLE: INDIAN HEALTH SERVICES

STAFF CONTACT: Mike Schmidt
456-5567
Jennifer Klein
456-2599

SUMMARY OF RESOLUTION

The NGA recommends that: (1) the federal government take full responsibility for funding the Indian Health Service and Tribally-run health services; (2) if states continue to be involved in providing health services to recipients of Indian/Tribally-run health services, the federal government provide adequate levels of funding; and (3) the disbursement of federal funds for these health care services not count against any cap that may be imposed.

SUMMARY OF ADMINISTRATION POSITION

This issue is a part of the ongoing reconciliation debate over Medicaid. Under the Republican proposal to block grant Medicaid, funding for IHS and Tribally-run health services would no longer be entitled, and the funding would become part of the state's capped Medicaid allotment. That means that increases in federal IHS spending would decrease federal funds available for non-IHS Medicaid beneficiaries.

Under the President's Medicaid proposal, Indian Health Service facilities receive 100% reimbursement, and Tribally-run services are reimbursed under the matching rules in current law. The President's proposal maintains the entitlement for Indian Health Service funding and excludes federal Medicaid funds for IHS programs from the per capita cap.

The President's proposal excludes funding for IHS from the per capita cap (as recommended by the NGA), but it continues to require states to share responsibility for these costs (which is inconsistent with the NGA position). The Administration has not taken a formal position on this issue during the course of the Medicaid debate.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Public Health and Science
Office of Disease Prevention and Health Promotion
200 Independence Ave., S.W., Room 740G
Washington, D.C. 20201

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TOTAL PAGES (including this cover page): 2

DATE: 1/25/95 / 6 pm

TO: Jennifer Klein

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FROM: Jim Harrell

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MESSAGE:

Revised edition!

Public Health Services

Resolution Summary

The resolution outlines the services of public health and sets forth responsibilities of federal, state, and local levels in implementing those services. It outlines principles that should form the base for federal assistance to state and local governments, retaining major responsibility for public health at the state government level. It also defines the respective federal and state roles for coordination of public health services with managed care, block grant programs related to public health, maternal and child health services, health promotion and prevention, and disease prevention and control.

Summary of Administration Position

The Governors should be commended for addressing public health in their policy resolutions. The draft resolution outlines a definition of states' roles that is generally consistent with Administration policies, although, in practice somewhat limited, as it tends to focus mainly on health services for the under-served (see below). However, it does not sufficiently address appropriate federal roles as defined by our proposed Performance Partnership Grant legislation and other current public health policies and activities. For example:

- It does not adequately recognize that public health services (at state and federal levels) are necessary for protection and improvement of the health of the entire population, as well as assuring access to health care for vulnerable and under-served populations.
- It fails to include essential federal responsibilities for defining, collaboratively with states, consistent public health policies and standards to ensure nationwide health protection, such as in areas safeguarded through Food and Drug Administration regulations.
- It does not address mental health and substance abuse prevention and treatment programs as necessary parts of public health.
- It does not include prevention of injury as a component of federal-state partnerships in health promotion and prevention.
- It does not recognize the key role of public health as guarantor of quality, especially in publicly funded managed health care for vulnerable populations.

In addition, the resolution fails to describe important characteristics of any federal health grant program. For example, the resolution in 8.4.2 calls for authority to transfer funds among block grant programs, which is not consistent with the necessity for accountability in the allocation and use of federally appropriated funds. While the Administration strongly endorses performance measures for health block grant programs, our position is that those measures must be mutually agreed upon between federal and state agencies, also to assure accountability..

In summary, while the resolution is an appropriate, if somewhat limited, statement of the state role in public health, it is not an adequate description of federal responsibilities in public health services, as defined by Administration policies and legislative proposals.

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TOTAL PAGES (including this cover page): 2

DATE: 1/25/96

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phealth

Public Health Services

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- It does not adequately recognize that public health services are necessary for protection and improvement of the health of the entire population, as well as assuring access to health care for vulnerable and under-served populations.
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In addition, the resolution fails to describe important characteristics of any federal health grant program. For example, the resolution in 8.4.2 calls for authority to transfer funds among block grant programs, which is not consistent with the necessity for accountability in the allocation and use of federally appropriated funds. While the Administration strongly endorses performance measures for health block grant programs, our position is that those measures must be mutually agreed upon between federal and state agencies, also to assure accountability..

In summary, while the resolution is an appropriate statement of the state role in public health, it is not an adequate description of federal responsibilities in public health services, as defined by Administration policies and legislative proposals.

HR-8. PUBLIC HEALTH SERVICES

8.1 PREAMBLE

EFFECTIVE PUBLIC HEALTH SERVICES ENSURE ACCESS TO COMMUNITY-BASED PREVENTIVE AND PRIMARY HEALTH CARE FOR VULNERABLE AND MEDICALLY UNDERSERVED POPULATIONS. SUCH SERVICES IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS. AT A TIME WHEN GOVERNMENT HEALTH CARE EXPENDITURES ARE CONSUMING A GREATER PROPORTION OF FEDERAL AND STATE BUDGETS, THE GOVERNORS BELIEVE THAT A RENEWED EMPHASIS ON PREVENTIVE COMMUNITY-BASED PUBLIC HEALTH SERVICES WILL BE A COST-EFFECTIVE WAY TO IMPROVE HEALTH STATUS.

8.2 CORE PUBLIC HEALTH SERVICES

THE GOVERNORS ENCOURAGE SUPPORT FOR THE CORE PUBLIC HEALTH FUNCTIONS. CORE FUNCTIONS ARE THOSE ACTIVITIES ROUTINELY CARRIED OUT BY PUBLIC HEALTH AGENCIES THAT PROMOTE COMMUNITY-BASED HEALTH SERVICES. CORE PUBLIC HEALTH ACTIVITIES INCLUDE:

- PREVENTING EPIDEMICS;
- PROTECTING THE ENVIRONMENT, WORKPLACES, HOUSING, FOOD, AND WATER;
- PROMOTING HEALTHY BEHAVIOR;
- MONITORING THE HEALTH CONDITIONS OF THE POPULATION;
- MOBILIZING COMMUNITIES FOR ACTION WHERE THERE ARE THREATS TO HEALTH;
- RESPONDING TO DISASTERS;
- ENSURING THAT MEDICAL SERVICES ARE OF HIGH QUALITY AND ARE NECESSARY;
- TRAINING SPECIALISTS IN INVESTIGATING AND PREVENTING DISEASES; AND
- DEVELOPING POLICIES TO PROMOTE HEALTH.

EFFECTIVE PUBLIC HEALTH SYSTEMS THAT INCLUDE THESE CORE FUNCTIONS IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS,

RESULTING IN LOWER MEDICAL SERVICES EXPENSES. CONVERSELY, AN INADEQUATE PUBLIC HEALTH INFRASTRUCTURE CAN RESULT IN INCREASED HEALTH CARE COSTS, SUBSTANTIAL ECONOMIC LOSS, UNNECESSARY SUFFERING, AND PREMATURE DEATH.

8.3 FEDERAL, STATE, AND LOCAL RESPONSIBILITIES

SINCE THE ENACTMENT OF THE FIRST QUARANTINE LAW, THE DELIVERY OF PUBLIC HEALTH SERVICES HAS BEEN A RESPONSIBILITY OF STATE AND LOCAL GOVERNMENTS. THE DELIVERY OF PUBLIC HEALTH SERVICES IS BEST CARRIED OUT BY STATES, WHICH CAN ALLOCATE RESOURCES AND DEVELOP POLICIES THAT RESPOND TO THEIR UNIQUE NEEDS AND HEALTH PROBLEMS. THE GOVERNORS, HOWEVER, BELIEVE THAT THE FEDERAL GOVERNMENT HAS A RESPONSIBILITY TO PROVIDE FINANCIAL AND TECHNICAL ASSISTANCE TO THE STATES AND, IN TURN, TO LOCAL GOVERNMENTS FOR THE DELIVERY OF PUBLIC HEALTH SERVICES. THE FEDERAL GOVERNMENT'S ROLE IS FINANCING PUBLIC HEALTH DELIVERY, COLLECTING INFORMATION ON A NATIONAL LEVEL, AND TAKING THE LEAD ON CERTAIN PUBLIC HEALTH FUNCTIONS THAT ARE NATIONAL IN SCOPE.

FEDERAL ASSISTANCE TO STATE AND LOCAL GOVERNMENTS SHOULD BE BASED ON THE FOLLOWING PRINCIPLES.

- THE RESPONSIBILITY FOR THE DELIVERY OF PUBLIC HEALTH SERVICES MUST REMAIN WITH STATE AND LOCAL GOVERNMENTS.
- FEDERAL FINANCIAL ASSISTANCE SHOULD BE BROAD-BASED ENOUGH TO PERMIT STATES TO TARGET AVAILABLE RESOURCES ON THE HIGHEST PRIORITY HEALTH PROBLEMS AFFECTING THE CITIZENS OF EACH STATE.
- STATE GOVERNMENT, THROUGH A STATE HEALTH PLAN, SHOULD BE RESPONSIBLE FOR THE DESIGN OF PUBLIC HEALTH PROGRAMS.
- ALL PUBLIC HEALTH ACTIVITIES FINANCIALLY ASSISTED BY THE FEDERAL GOVERNMENT WITHIN A STATE SHOULD BE UNDER THE SPONSORSHIP OF AGENCIES SPECIFIED BY THE STATE.
- THE FEDERAL GOVERNMENT SHOULD ESTABLISH POLICIES FOR THE SURVEILLANCE OF ENVIRONMENTAL THREATS TO THE PUBLIC HEALTH AND FOR MONITORING HEALTH TRENDS AND IDENTIFYING

THE LONG-TERM CHRONIC HEALTH EFFECTS OF EXPOSURE TO TOXIC SUBSTANCES AND OTHER ENVIRONMENTAL CONTAMINANTS.

- THE FEDERAL GOVERNMENT, IN CONCERT WITH STATE AND LOCAL GOVERNMENTS, SHOULD PROVIDE THE LEADERSHIP NECESSARY TO ESTABLISH NATIONWIDE HEALTH PROMOTION EFFORTS SUCH AS THOSE FOCUSED ON CHILDHOOD IMMUNIZATION, HIV/AIDS PREVENTION, AND THE HAZARDS TO MINORS OF SMOKING.
- THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PROVIDE LEADERSHIP ON HEALTH AND MEDICAL CARE RESEARCH THROUGH THE NATIONAL INSTITUTES OF HEALTH.

8.4 COORDINATION OF SERVICES

THE GOVERNORS BELIEVE THAT COOPERATIVE FEDERAL, STATE, LOCAL, AND PRIVATE INITIATIVES BASED ON THESE PRINCIPLES WILL ASSIST THE DEVELOPMENT OF A COORDINATED DELIVERY SYSTEM FOR PUBLIC HEALTH SERVICES. THE DEVELOPMENT OF A COORDINATED SYSTEM OF PUBLIC HEALTH SERVICES CAN HELP ENSURE THAT OUR CITIZENS HAVE THE OPTIMAL OPPORTUNITY TO LEAD HEALTHY LIVES IN AN ENVIRONMENT THAT MINIMIZES EXPOSURE TO HAZARDOUS PRACTICES, ENVIRONMENTS, AND PRODUCTS.

8.4.1 MANAGED CARE. MANY STATES ARE USING MANAGED CARE AS A PRIMARY STRATEGY FOR CONTAINING HEALTH CARE COSTS AND SHIFTING RESPONSIBILITY FOR SERVICE DELIVERY TO PRIVATE SECTOR PROVIDERS. THESE CHANGES ARE RESHAPING THE RESPONSIBILITIES OF PUBLIC HEALTH AGENCIES AND WILL REQUIRE THAT PUBLIC HEALTH PROFESSIONALS DEVELOP NEW SKILLS NECESSARY TO SUPPORT PRIVATE SECTOR EFFORTS AND TO ADDRESS THE PUBLIC HEALTH NEEDS OF THE ENTIRE POPULATION.

THE GOVERNORS ENCOURAGE PUBLIC HEALTH AGENCIES AND PRIVATE SECTOR PROVIDERS TO CLEARLY DEFINE THEIR RESPECTIVE RESPONSIBILITIES AND DEVELOP COMPLEMENTARY STRATEGIES FOR THE EFFECTIVE USE OF THE STRENGTHS AND RESOURCES OF EACH SYSTEM TO MAINTAIN AND IMPROVE HEALTH.

8.4.2 HEALTH SERVICES BLOCK GRANTS. BLOCK GRANTS CONTINUE TO BE AN IMPORTANT SOURCE OF FUNDING FOR MANY CRITICAL PUBLIC HEALTH PROGRAMS. THE GOVERNORS BELIEVE THAT THESE FEDERAL GRANTS MUST

CONTINUE IN ORDER TO MEET PUBLIC HEALTH NEEDS. HOWEVER, THEY ALSO BELIEVE THAT THESE GRANTS SHOULD BE BASED ON PERFORMANCE. STATES SHOULD BE GIVEN THE AUTONOMY TO SET THEIR OWN OBJECTIVES, TO TARGET RESOURCES, AND TO TAILOR PROGRAMS BASED ON THEIR INDIVIDUAL PERFORMANCE OBJECTIVES. PROVIDING FOR MORE STATE FLEXIBILITY IN EXISTING HEALTH SERVICE BLOCK GRANTS, SPECIFICALLY BY REMOVING COMPLEX ALLOCATION AND SET-ASIDE REQUIREMENTS AND BY ALLOWING FOR INTERBLOCK TRANSFER, IS ESSENTIAL.

8.4.3 **MATERNAL AND CHILD HEALTH SERVICES.** THE GOVERNORS BELIEVE THAT IMPROVING THE HEALTH STATUS OF AMERICA'S CHILDREN SHOULD BE A TOP PRIORITY OF ALL LEVELS OF GOVERNMENT. TO HELP MEET THIS PRIORITY, FEDERAL SUPPORT FOR MATERNAL AND CHILD HEALTH SERVICES AND NUTRITION PROGRAMS SUCH AS THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) SHOULD BE MAINTAINED. SINCE ITS CREATION IN 1972, WIC HAS PROVIDED SUPPLEMENTAL FOOD, NUTRITION EDUCATION, AND HEALTH CARE REFERRAL SERVICES TO MILLIONS OF LOW-INCOME PREGNANT WOMEN, INFANTS, AND CHILDREN. WIC IS AN EFFECTIVE ENTREPRENEURIAL PROGRAM WITH A PROVEN TRACK RECORD. THE PROGRAM SHOULD BE FURTHER IMPROVED BY REDUCING PRESCRIPTIVE AND BURDENSOME REGULATIONS ON STATE AND LOCAL AGENCIES AND BY GIVING STATES GREATER FLEXIBILITY TO ADMINISTER THE PROGRAM.

8.4.4 **HEALTH PROMOTION AND PREVENTION.** THE GOVERNORS CONTINUE TO LOOK TO THE FEDERAL GOVERNMENT FOR LEADERSHIP IN PROVIDING FOR HEALTH EDUCATION AND PROMOTION PROGRAMS THAT ENCOURAGE PREVENTION AND LEAD TO HEALTHIER LIFESTYLES. FOR EXAMPLE, FEDERAL EFFORTS, WITH STATE SUPPORT, HAVE MADE THE PUBLIC AWARE OF THE IMPORTANCE OF BREAST CANCER SCREENING PROGRAMS THAT COULD LEAD TO EARLY DETECTION AND TREATMENT OF BREAST CANCER. IN MANY INSTANCES, HEALTH EDUCATION AND PROMOTION PROGRAMS CAN PLAY AN IMPORTANT ROLE IN MODIFYING UNHEALTHY PRACTICES AND CAN REDUCE THE INCIDENCE OF CANCER, HEART DISEASE, STROKE, AND COMMUNICABLE DISEASES.

FEDERAL FINANCIAL ASSISTANCE SHOULD BE MADE AVAILABLE TO STATES FOR PUBLIC HEALTH SERVICES THAT CAN BE DEMONSTRATED TO REDUCE NET FEDERAL EXPENDITURES BY PREVENTING ILLNESS AND EXPENSIVE HOSPITALIZATION AND THAT ARE DEMONSTRATED TO BE OF

SPECIAL NEED IN THE AFFECTED STATES. ALLOCATIONS OF SUCH FUNDING SHOULD RECOGNIZE THE IMPORTANCE OF ATTAINABLE PERFORMANCE OBJECTIVES AS WELL AS A STATE'S NEED.

IN ADDITION, THE FEDERAL GOVERNMENT SHOULD ENSURE THE CAPACITY OF FEDERAL AGENCIES THAT WORK IN CONCERT WITH STATES TO MAINTAIN HIGH LEVELS OF CHILDHOOD IMMUNIZATION, REDUCE CHRONIC AND COMMUNICABLE DISEASES, AND RESPOND TO PUBLIC HEALTH EMERGENCIES.

8.4.5 **DISEASE PREVENTION AND CONTROL.** PROVIDING FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASES IS AN IMPORTANT PUBLIC HEALTH ACTIVITY. CURRENT FEDERAL EFFORTS TO SUPPORT AND COORDINATE STATE PROGRAMS FOR STRONG SURVEILLANCE, INVESTIGATION, REPORTING, AND OTHER DISEASE PREVENTION AND CONTROL ACTIVITIES SHOULD BE MAINTAINED.

~~8.1 Preamble~~

~~Effective community-based public health services improve the health of our citizens and prevent illness that results in the use of expensive medical services. The National Governors' Association is concerned that the current cost and institutional bias of the major publicly financed medical care programs has diminished our capacity to provide community-based public health services. Public health services are particularly critical for low-income individuals and families who are not eligible for Medicaid or other health care financing coverage. The Governors therefore believe that renewed emphasis on the provision of community-based public health services should be an integral element of cooperative federal/state initiatives to improve the health of our nation's citizens and the efficiency of our delivery systems.~~

~~8.2 Federal, State, and Local Responsibilities~~

~~Since the enactment of the first quarantine law, the delivery of public health services has been a responsibility of state and local governments. States continue to be in a better position to allocate resources and develop policies that respond to differing local needs and health care characteristics. The Governors, however, believe that the federal government has a responsibility to provide financial assistance to state and, in turn, local governments for the delivery of public health services. They also call on the federal government, in cooperation with state and local governments, to assume more responsibility for certain public health functions that are primarily national in nature. Federal assistance to state and local governments should be based on the following principles.~~

- ~~The responsibility for the delivery of public health services must remain with state and local governments.~~
- ~~Federal financial assistance must be flexible enough, preferably in the form of broad-based grants, to permit states to target available resources on the highest priority health problems affecting the citizens of each state.~~
- ~~State government, through a state health plan, should be responsible for the design of public health programs that reflect national priorities, while focusing on local needs.~~

- All public health activities financially assisted by the federal government within a state should be under the sponsorship of agencies specified by the state.
- The federal government should establish policies for the surveillance of environmental threats to the public health and the establishment of health registries to monitor health trends and identify the long-term chronic health effects of exposure to toxic substances and other environmental contaminants.
- The federal government, in concert with state and local governments, should provide the leadership necessary to establish nationwide health promotion efforts such as those focused on childhood immunization and the hazards of smoking.

8.3 **Coordination of Services**

The Governors believe that cooperative federal, state, and local initiatives based on these principles will assist the development of a coordinated intergovernmental delivery system for public health services. The development of a coordinated system of public health services can help to ensure that our citizens have the optimal opportunity to lead healthy lives in an environment that minimizes exposure to hazardous practices, environments, and products. Toward this end, the Governors call on the President and Congress to review and expand on the following elements of federal public health services assistance.

8.3.1 **Health Services Block Grants.** Although the Governors continue to strongly support the block grant concept, states have been forced to adjust to severe reductions at the time of initial program consolidation. The Governors oppose additional federal fund reductions, even if associated with further consolidation of federal public health programs. The establishment of the three health services block grants in the Omnibus Reconciliation Act of 1981 has enhanced the states' ability to target limited federal resources. However, NGA believes that the effectiveness of the block grants could be greatly improved by:

- removing the remaining categorical elements, such as the complex allocation and set-aside requirements in the alcohol, drug abuse, and mental health services block grant;
- establishing uniform reporting requirements; and
- establishing uniform provisions for transferring funds between block grants.

The association also believes that any increased state responsibility for federal programs should be accompanied by adequate federal financial assistance.

8.3.2 **Maternal and Child Health Services.** The health status of American children has improved dramatically over the last two decades. Federal programs such as Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps have contributed significantly to this improvement, and the Governors recognize the important link between health care and income security. As a result, the Governors are concerned that millions of children living below the federal poverty level are not covered by Medicaid or lack access to a regular source of health care or adequate income assistance.

The Governors believe that meeting the health care needs of underserved or unserved children should be a priority as well as a responsibility of all levels of government. Federal support for maternal and child health services and nutrition programs such as the Supplemental Food Program for Women, Infants, and Children (WIC), should be increased. A Harvard University study concluded that every dollar spent in WIC services resulted in three dollars of Medicaid savings. Despite these savings, the current level of federal support will enable far less than half of the potentially eligible women and infants to participate in the WIC program.

8.3.3 **Health Promotion and Prevention.** The Governors call on the federal government to expand its health promotion activities and encourage critical state preventive health initiatives and programs. Most health care professionals believe that personal behavior and habits such as smoking, exercise, diet, and alcohol and drug abuse are major determinants of morbidity and mortality. In many instances, health education and promotion programs can play an important role in modifying unhealthful practices. Federal financial assistance should be made available to states on a flexible basis for public health services that can be demonstrated to

~~reduce net federal expenditures by preventing illness and expensive hospitalization and are demonstrated to be of special need in the affected state.~~

~~In addition, the federal government should enhance the capacity of federal agencies, such as the Centers for Disease Control, that work in concert with state public health officials to maintain high levels of childhood immunization, reduce chronic diseases, and respond to public health emergencies.~~

Time limited (effective WINTER MEETING 1996-WINTER MEETING 1998 ~~Winter Meeting 1994 Winter Meeting 1996~~).

Adopted Annual Meeting 1980; revised Annual Meeting 1981, Winter Meeting 1982, Annual Meeting 1984, Winter Meeting 1986, Annual Meeting 1986, Winter Meeting 1988, Winter Meeting 1989, Annual Meeting 1989, Winter Meeting 1990, and Winter Meeting 1994 (formerly Policy C-5).

Public Health Services

Resolution Summary

The resolution outlines the services of public health and sets forth responsibilities of federal, state, and local levels in implementing those services. It outlines principles that should form the base for federal assistance to state and local governments, retaining major responsibility for public health at the state government level. It also defines the respective federal and state roles for coordination of public health services with managed care, block grant programs related to public health, maternal and child health services, health promotion and prevention and disease prevention and control.

Summary of Administration Position

The Governors should be commended for addressing public health in their policy resolutions. The draft resolution outlines a definition of states' roles that is generally consistent with Administration policies: however, it does not sufficiently address appropriate federal roles as defined by our proposed Performance Partnership Grant legislation and other current public health policies and activities. For example:

- It does not adequately recognize that public health services are necessary for protection and improvement of the health of the entire population, as well as assuring access to health care for vulnerable and under-served populations.

- It fails to include essential federal responsibilities for defining, collaboratively with states, consistent public health policies and standards to ensure nationwide health protections, such as in areas safeguarded through Food and Drug Administration regulations.

- It does not address mental health and substance abuse prevention and treatment programs as necessary parts of public health.

- It does not include prevention of injury as a component of federal-state partnerships in health promotion and prevention.

- It does not recognize the key role of public health as guarantor of quality, especially in publicly funded managed health care for vulnerable populations.

In addition, the resolution fails to describe important characteristics of any federal grant program. For example, the resolution in 8.4.2 calls for authority to transfer funds among block grant programs, which is not consistent with the necessity for accountability in the allocation and use of federally appropriated funds. While the administration strongly endorses performance measures for health block grant programs, our position is that those measures must be mutually agreed upon between federal and state agencies, also assure accountability.

In summary, while the resolution is an appropriate statement of the state role in public health, it is not an adequate description of federal responsibilities in public health services, as defined by Administration policies and legislative proposals.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

25-Jan-1996 10:51am

TO: (See Below)

FROM: Dorothy L. Karayannis
Domestic Policy Council

SUBJECT: REMINDER

Please share with me your one pagers by NOON tomorrow.

You can hand them off to me, or if applicable, you can insert them into i:\dpc\data\nga.res

Thanks.

Distribution:

TO: Jeremy D. Benami
TO: Christopher C. Jennings
TO: Jennifer L. Klein
TO: Stephen C. Warnath
TO: Dennis Burke
TO: Brian E. Burke
TO: Michael T. Schmidt
TO: Gaynor R. McCown
TO: Paul J. Weinstein, Jr
TO: Carol H. Rasco

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Jan-1996 11:12am

TO: (See Below)

FROM: Jeremy D. Benami
Domestic Policy Council

SUBJECT: NGA resolutions

As mentioned in the staff meeting this morning, I am sending around to each of you NGA resolutions in your policy area. I would appreciate it if each of you could review the language and prepare a one page summary by FRIDAY following this format:

RESOLUTION NUMBER:
RESOLUTION TITLE:

YOUR NAME
YOUR PHONE NUMBER

Summary of Resolution: one or two sentences (more if necessary) summarizing what the NGA is trying to do with the resolution.

Summrary of Administration position: short analysis of the administration's view of the proposed policy - i.e., any previous administration statement/legislative proposal/etc. on the topic, whether we would support, oppose, take no position.

Please get these one pagers to Dorothy by noon Friday. She will be putting the appropriate resolutions in your box this morning.

Thanks. Call me with questions.

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TO: Dennis Burke
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TO: Michael T. Schmidt
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TO: Paul J. Weinstein, Jr

THE WHITE HOUSE
WASHINGTON

Hi Jen:

these are the

NGA policy reviews /

resolutions Jeremy

spoke of this morning.

jen k.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Jan-1996 11:23am

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LIST OF PROPOSED CHANGES IN POLICY

COMMITTEE ON ECONOMIC DEVELOPMENT AND COMMERCE

NEC

EDC-3	Proposed Amendments	"Military Base Closure, Disposal, and Reuse"
EDC-12	Proposed Amendments	"Air Transportation"
EDC-16	Proposed Amendments	"Surface Transportation"
EDC-19	Proposed Policy Position	"Hazardous Materials Transportation"

COMMITTEE ON HUMAN RESOURCES (7)

NEC? HR-6	Proposed Amendments	"Fair Labor Standards Act"
JEN/CHRIS HR-8	Proposed Amendment (in the form of a substitute)	"Public Health Services"
DENNIS HR-11	Proposed Amendment (in the form of a substitute)	"Community Policing and Federal Support of Prisons"
MIKE HR-31	Proposed Policy Position	"Indian Health Services"
STEVE HR-32	Proposed Policy Position	"Civil Rights Enforcement and Consent Decrees"
HR-33	Proposed Policy Position	"Low-Income Home Energy Assistance Program"
GAYNOR HR-5	Proposed Reaffirmation	"Elementary and Secondary Education"
GAYNOR HR-9	Proposed Reaffirmation	"Head Start"

COMMITTEE ON NATURAL RESOURCES 1

BRIAN NR-6	Proposed Amendment	"Environmental Priorities and Unfunded Mandates"
NR-17	Proposed Policy Position	"Management of Federal Lands"

EXECUTIVE COMMITTEE 2

PAUL Permanent Policy	Proposed Amendments	"Principles for State-Federal Relations"
NEC EC-18	Proposed Policy Position	"Consumer Price Index"
STEVE EC-4	Proposed Reaffirmation	"Health Care for Undocumented Immigrants"

New language is typed double-spaced and in ALL CAPS, with deleted material lined-throughout (—).

NATIONAL GOVERNORS' ASSOCIATION

Tommy G. Thompson
Governor of Wisconsin
Chairman

Bob Miller
Governor of Nevada
Vice Chairman

Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1512
Telephone (202) 624-5300

1996 Winter Meeting

COMMITTEE ON HUMAN RESOURCES

Governor Arne H. Carlson, Chair
Governor Tom Carper, Vice Chair

Nolan E. Jones, Group Director

Proposed Changes in Policy

Reaffirm Existing Policy

New language is typed double-spaced and in ALL CAPS, with deleted material lined-throughout (—).

The Committee on Human Resources recommends the consideration of three new policy positions, amendments to three existing policy positions (two in the form of substitutes), and the reaffirmation of two existing policy positions. Policy proposals are time limited to two years, unless otherwise noted. Background information and fiscal impact data follow.

1. Fair Labor Standards Act (Amendments to HR-6, incorporating HR-10)

   The proposal, which consolidates HR-6 and HR-10 (FLSA Application to State Prison Inmates), points out the problems caused by federal courts' interpretation of the Fair Labor Standards Act (FLSA). It seeks regulatory relief from the U.S. Department of Labor and legislative relief to limit the scope of FLSA, including prison inmates.

   There should be no additional costs to the federal government, and the proposal may prevent some incalculable liabilities on states.

2. Public Health Services (Amendment in the form of a substitute to HR-8)

   The proposal is an amendment in the form of a substitute to a policy that was scheduled to sunset at the 1996 winter meeting. The proposed public health services policy recognizes that public health services go beyond the provision of primary and preventive health care and that core public health functions are an essential component of our nation's public health infrastructure. The policy outlines a set of principles for defining federal, state, and local responsibilities in the financing and provision of public health services. In addition, the policy identifies areas for coordination of services among federal, state, and local governments and the private sector. Those areas of coordination include managed care, health services block grants, maternal and child health services, WIC, health promotion and prevention, and disease prevention and control.

3. Community Policing and Federal Support of Prisons (Amendment in the form of a substitute to HR-11)

   The proposed policy supports the continuation of the Edward Byrne Memorial Block Grant program. The proposal also supports the federally funded prison grants program but does not support any federally imposed set of criminal procedures and sentencing requirements.

   These programs require a state match to federal dollars.

4. Indian Health Services (New Policy Position, HR-31)

   The proposed new policy recognizes the trust responsibility of the federal government in the provision of health care services to Indian peoples. It reaffirms the Governors' belief that the federal government, not the states, has a responsibility for the provision and financing of health care to Native Americans.

5. Civil Rights Enforcement and Consent Decrees (New Policy Position, HR-32)

   The proposed new policy expresses the Governors' support of civil rights for all persons, including individuals who are institutionalized. The proposal urges Congress to enact into law certain principles to guide the U.S. Department of Justice in its enforcement of the Civil Rights of Institutionalized Persons Act. Limited fiscal impact on the states or the federal government is anticipated.

HR-8. PUBLIC HEALTH SERVICES

8.1 PREAMBLE

EFFECTIVE PUBLIC HEALTH SERVICES ENSURE ACCESS TO COMMUNITY-BASED PREVENTIVE AND PRIMARY HEALTH CARE FOR VULNERABLE AND MEDICALLY UNDERSERVED POPULATIONS. SUCH SERVICES IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS. AT A TIME WHEN GOVERNMENT HEALTH CARE EXPENDITURES ARE CONSUMING A GREATER PROPORTION OF FEDERAL AND STATE BUDGETS, THE GOVERNORS BELIEVE THAT A RENEWED EMPHASIS ON PREVENTIVE COMMUNITY-BASED PUBLIC HEALTH SERVICES WILL BE A COST-EFFECTIVE WAY TO IMPROVE HEALTH STATUS.

8.2 CORE PUBLIC HEALTH SERVICES

THE GOVERNORS ENCOURAGE SUPPORT FOR THE CORE PUBLIC HEALTH FUNCTIONS. CORE FUNCTIONS ARE THOSE ACTIVITIES ROUTINELY CARRIED OUT BY PUBLIC HEALTH AGENCIES THAT PROMOTE COMMUNITY-BASED HEALTH SERVICES. CORE PUBLIC HEALTH ACTIVITIES INCLUDE:

- PREVENTING EPIDEMICS;
- PROTECTING THE ENVIRONMENT, WORKPLACES, HOUSING, FOOD, AND WATER;
- PROMOTING HEALTHY BEHAVIOR;
- MONITORING THE HEALTH CONDITIONS OF THE POPULATION;
- MOBILIZING COMMUNITIES FOR ACTION WHERE THERE ARE THREATS TO HEALTH;
- RESPONDING TO DISASTERS;
- ENSURING THAT MEDICAL SERVICES ARE OF HIGH QUALITY AND ARE NECESSARY;
- TRAINING SPECIALISTS IN INVESTIGATING AND PREVENTING DISEASES; AND
- DEVELOPING POLICIES TO PROMOTE HEALTH.

EFFECTIVE PUBLIC HEALTH SYSTEMS THAT INCLUDE THESE CORE FUNCTIONS IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS,

RESULTING IN LOWER MEDICAL SERVICES EXPENSES. CONVERSELY, AN INADEQUATE PUBLIC HEALTH INFRASTRUCTURE CAN RESULT IN INCREASED HEALTH CARE COSTS, SUBSTANTIAL ECONOMIC LOSS, UNNECESSARY SUFFERING, AND PREMATURE DEATH.

8.3 FEDERAL, STATE, AND LOCAL RESPONSIBILITIES

SINCE THE ENACTMENT OF THE FIRST QUARANTINE LAW, THE DELIVERY OF PUBLIC HEALTH SERVICES HAS BEEN A RESPONSIBILITY OF STATE AND LOCAL GOVERNMENTS. THE DELIVERY OF PUBLIC HEALTH SERVICES IS BEST CARRIED OUT BY STATES, WHICH CAN ALLOCATE RESOURCES AND DEVELOP POLICIES THAT RESPOND TO THEIR UNIQUE NEEDS AND HEALTH PROBLEMS. THE GOVERNORS, HOWEVER, BELIEVE THAT THE FEDERAL GOVERNMENT HAS A RESPONSIBILITY TO PROVIDE FINANCIAL AND TECHNICAL ASSISTANCE TO THE STATES AND, IN TURN, TO LOCAL GOVERNMENTS FOR THE DELIVERY OF PUBLIC HEALTH SERVICES. THE FEDERAL GOVERNMENT'S ROLE IS FINANCING PUBLIC HEALTH DELIVERY, COLLECTING INFORMATION ON A NATIONAL LEVEL, AND TAKING THE LEAD ON CERTAIN PUBLIC HEALTH FUNCTIONS THAT ARE NATIONAL IN SCOPE.

FEDERAL ASSISTANCE TO STATE AND LOCAL GOVERNMENTS SHOULD BE BASED ON THE FOLLOWING PRINCIPLES.

- THE RESPONSIBILITY FOR THE DELIVERY OF PUBLIC HEALTH SERVICES MUST REMAIN WITH STATE AND LOCAL GOVERNMENTS.
- FEDERAL FINANCIAL ASSISTANCE SHOULD BE BROAD-BASED ENOUGH TO PERMIT STATES TO TARGET AVAILABLE RESOURCES ON THE HIGHEST PRIORITY HEALTH PROBLEMS AFFECTING THE CITIZENS OF EACH STATE.
- STATE GOVERNMENT, THROUGH A STATE HEALTH PLAN, SHOULD BE RESPONSIBLE FOR THE DESIGN OF PUBLIC HEALTH PROGRAMS.
- ALL PUBLIC HEALTH ACTIVITIES FINANCIALLY ASSISTED BY THE FEDERAL GOVERNMENT WITHIN A STATE SHOULD BE UNDER THE SPONSORSHIP OF AGENCIES SPECIFIED BY THE STATE.
- THE FEDERAL GOVERNMENT SHOULD ESTABLISH POLICIES FOR THE SURVEILLANCE OF ENVIRONMENTAL THREATS TO THE PUBLIC HEALTH AND FOR MONITORING HEALTH TRENDS AND IDENTIFYING

THE LONG-TERM CHRONIC HEALTH EFFECTS OF EXPOSURE TO TOXIC SUBSTANCES AND OTHER ENVIRONMENTAL CONTAMINANTS.

- THE FEDERAL GOVERNMENT, IN CONCERT WITH STATE AND LOCAL GOVERNMENTS, SHOULD PROVIDE THE LEADERSHIP NECESSARY TO ESTABLISH NATIONWIDE HEALTH PROMOTION EFFORTS SUCH AS THOSE FOCUSED ON CHILDHOOD IMMUNIZATION, HIV/AIDS PREVENTION, AND THE HAZARDS TO MINORS OF SMOKING.
- THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PROVIDE LEADERSHIP ON HEALTH AND MEDICAL CARE RESEARCH THROUGH THE NATIONAL INSTITUTES OF HEALTH.

8.4 COORDINATION OF SERVICES

THE GOVERNORS BELIEVE THAT COOPERATIVE FEDERAL, STATE, LOCAL, AND PRIVATE INITIATIVES BASED ON THESE PRINCIPLES WILL ASSIST THE DEVELOPMENT OF A COORDINATED DELIVERY SYSTEM FOR PUBLIC HEALTH SERVICES. THE DEVELOPMENT OF A COORDINATED SYSTEM OF PUBLIC HEALTH SERVICES CAN HELP ENSURE THAT OUR CITIZENS HAVE THE OPTIMAL OPPORTUNITY TO LEAD HEALTHY LIVES IN AN ENVIRONMENT THAT MINIMIZES EXPOSURE TO HAZARDOUS PRACTICES, ENVIRONMENTS, AND PRODUCTS.

8.4.1 **MANAGED CARE.** MANY STATES ARE USING MANAGED CARE AS A PRIMARY STRATEGY FOR CONTAINING HEALTH CARE COSTS AND SHIFTING RESPONSIBILITY FOR SERVICE DELIVERY TO PRIVATE SECTOR PROVIDERS. THESE CHANGES ARE RESHAPING THE RESPONSIBILITIES OF PUBLIC HEALTH AGENCIES AND WILL REQUIRE THAT PUBLIC HEALTH PROFESSIONALS DEVELOP NEW SKILLS NECESSARY TO SUPPORT PRIVATE SECTOR EFFORTS AND TO ADDRESS THE PUBLIC HEALTH NEEDS OF THE ENTIRE POPULATION.

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~~Effective community-based public health services improve the health of our citizens and prevent illness that results in the use of expensive medical services. The National Governors' Association is concerned that the current cost and institutional bias of the major publicly financed medical care programs has diminished our capacity to provide community-based public health services. Public health services are particularly critical for low-income individuals and families who are not eligible for Medicaid or other health care financing coverage. The Governors therefore believe that renewed emphasis on the provision of community-based public health services should be an integral element of cooperative federal/state initiatives to improve the health of our nation's citizens and the efficiency of our delivery systems.~~

~~8.2 Federal, State, and Local Responsibilities~~

~~Since the enactment of the first quarantine law, the delivery of public health services has been a responsibility of state and local governments. States continue to be in a better position to allocate resources and develop policies that respond to differing local needs and health care characteristics. The Governors, however, believe that the federal government has a responsibility to provide financial assistance to state and, in turn, local governments for the delivery of public health services. They also call on the federal government, in cooperation with state and local governments, to assume more responsibility for certain public health functions that are primarily national in nature. Federal assistance to state and local governments should be based on the following principles.~~

- ~~The responsibility for the delivery of public health services must remain with state and local governments.~~
- ~~Federal financial assistance must be flexible enough, preferably in the form of broad-based grants, to permit states to target available resources on the highest priority health problems affecting the citizens of each state.~~
- ~~State government, through a state health plan, should be responsible for the design of public health programs that reflect national priorities, while focusing on local needs.~~

- All public health activities financially assisted by the federal government within a state should be under the sponsorship of agencies specified by the state.
- The federal government should establish policies for the surveillance of environmental threats to the public health and the establishment of health registries to monitor health trends and identify the long-term chronic health effects of exposure to toxic substances and other environmental contaminants.
- The federal government, in concert with state and local governments, should provide the leadership necessary to establish nationwide health promotion efforts such as those focused on childhood immunization and the hazards of smoking.

8.3 **Coordination of Services**

The Governors believe that cooperative federal, state, and local initiatives based on these principles will assist the development of a coordinated intergovernmental delivery system for public health services. The development of a coordinated system of public health services can help to ensure that our citizens have the optimal opportunity to lead healthy lives in an environment that minimizes exposure to hazardous practices, environments, and products. Toward this end, the Governors call on the President and Congress to review and expand on the following elements of federal public health services assistance.

8.3.1 **Health Services Block Grants.** Although the Governors continue to strongly support the block grant concept, states have been forced to adjust to severe reductions at the time of initial program consolidation. The Governors oppose additional federal fund reductions, even if associated with further consolidation of federal public health programs. The establishment of the three health services block grants in the Omnibus Reconciliation Act of 1981 has enhanced the states' ability to target limited federal resources. However, NGA believes that the effectiveness of the block grants could be greatly improved by:

- removing the remaining categorical elements, such as the complex allocation and set-aside requirements in the alcohol, drug abuse, and mental health services block grant;
- establishing uniform reporting requirements; and
- establishing uniform provisions for transferring funds between block grants.

The association also believes that any increased state responsibility for federal programs should be accompanied by adequate federal financial assistance.

8.3.2 **Maternal and Child Health Services.** The health status of American children has improved dramatically over the last two decades. Federal programs such as Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps have contributed significantly to this improvement, and the Governors recognize the important link between health care and income security. As a result, the Governors are concerned that millions of children living below the federal poverty level are not covered by Medicaid or lack access to a regular source of health care or adequate income assistance.

The Governors believe that meeting the health care needs of underserved or unserved children should be a priority as well as a responsibility of all levels of government. Federal support for maternal and child health services and nutrition programs such as the Supplemental Food Program for Women, Infants, and Children (WIC), should be increased. A Harvard University study concluded that every dollar spent in WIC services resulted in three dollars of Medicaid savings. Despite these savings, the current level of federal support will enable far less than half of the potentially eligible women and infants to participate in the WIC program.

8.3.3 **Health Promotion and Prevention.** The Governors call on the federal government to expand its health promotion activities and encourage critical state preventive health initiatives and programs. Most health care professionals believe that personal behavior and habits such as smoking, exercise, diet, and alcohol and drug abuse are major determinants of morbidity and mortality. In many instances, health education and promotion programs can play an important role in modifying unhealthful practices. Federal financial assistance should be made available to states on a flexible basis for public health services that can be demonstrated to

~~reduce net federal expenditures by preventing illness and expensive hospitalization and are demonstrated to be of special need in the affected state.~~

~~In addition, the federal government should enhance the capacity of federal agencies, such as the Centers for Disease Control, that work in concert with state public health officials to maintain high levels of childhood immunization, reduce chronic diseases, and respond to public health emergencies.~~

Time limited (effective WINTER MEETING 1996-WINTER MEETING 1998 ~~Winter Meeting 1994-Winter Meeting 1996~~).

Adopted Annual Meeting 1980; revised Annual Meeting 1981, Winter Meeting 1982, Annual Meeting 1984, Winter Meeting 1986, Annual Meeting 1986, Winter Meeting 1988, Winter Meeting 1989, Annual Meeting 1989, Winter Meeting 1990, and Winter Meeting 1994 (formerly Policy C-5).