MEMORANDUM

March 12, 1996

TO: Carol Rasco, Laura Tyson, and Alice Rivlin

FR: Chris Jennings and Jennifer Klein

RE: Overview of NGA Draft Legislative Language

cc: Gene Sperling, Nancy-Ann Min, Elizabeth Drye

Attached is a document prepared by the Department of Health and Human Services which provides an overview of the NGA draft legislative language. I have placed asterisks by the issues that will probably cause the most difficulties.

It is interesting to note that a large portion of the draft bill comes from the Conference Agreement. Of the 66 total pages in the draft bill (excluding the sections on Spousal Impoverishment, Nursing Home Quality, and the Drug Rebate Program which are largely copied from current law), only 14 are actually new and not from the Conference Agreement.

I hope you find this information useful. Please feel free to call me at 6-5660 with any questions or concerns.

OVERVIEW OF NGA DRAFT LEGISLATIVE LANGUAGE
10:00 Tuesday 3/12/96

Structure

- New title of Social Security Act: Consistent with NGA outline and Conference Agreement.

- The NGA bill appears to be based on the Conference Agreement, with modifications in those areas where the Governors had explicit policies which differed from the Conference Agreement. Wherever the governors did not have a specific position on an issue, the draft bill language generally defaults to the Conference Agreement.

  - For example, the draft bill frequently refers to Title XXI, which exists under the Conference Agreement but not under the NGA plan.

  - Of the 144 pages in the draft legislation, only about 23.2 are new--the rest of the pages are taken from the Conference Agreement.

    -- If the sections on Spousal Impoverishment, Nursing Home Quality, and the Drug Rebate Program are not included--because they are largely copied from current law--there are only 66 total pages in the draft bill, of which only about 14.1 are actually new and not from the Conference Agreement.

Federal Right of Action

- Consistent with NGA outline.

Eligibility

- Mandatory populations - Generally consistent with NGA outline; consistent with the Conference Agreement.

- Optional populations -- Unclear.

  - The bill is silent in discussing the "optional" eligible. (The section on definitions makes reference to optional populations, but they are not listed in the eligibility section of the draft bill. This section is consistent with the Conference Agreement.)

- Limitations on Eligibility -- Expands on NGA documents, consistent with Conference Agreement.

- The bill requires States to report whether they impose any restrictions on eligibility based on age, residence, spend-down status, immigration status, or employment status. This clause implies that States are permitted to restrict eligibility based on these factors. While such limitations were never mentioned in previous NGA documents, they were included in the Conference Agreement.

- Disabled Eligibility -- Consistent with Conference Agreement and NGA outline, with the following two exceptions:

  - While the 2/27 revisions gave States three options for how to define disability, the bill does not contain these options. Rather, it simply states that States will define disability.

  - The bill limits the 209(b) exception to States who currently use it. This provision was not included in previous NGA documents.

- Disabled Set-Aside -- Consistent with NGA outline. Higher than Conference Agreement. (90% versus 85%)

- Medicare populations -- Consistent with NGA documents, including the 2/27 revisions.

  - The bill provides SLMBs and QDWIs the same guarantees as QMBs. It also allows States to pay Medicaid rates for services provided to these individuals.

- AFDC populations -- Consistent with NGA revisions. Conference Agreement is silent on this point.

- Welfare-to-Work -- Inconsistent with NGA revisions. Conference Agreement is silent on this point.

  - While the 2/27 revisions guaranteed Medicaid eligibility for one year for people transitioning from welfare to work, the bill does not mention this issue.

- Measurement of income – Expands on NGA documents; consistent with Conference Agreement

  - The bill eliminates the current requirement that States must use AFDC methodology for measuring income and assets when determining eligibility. It allows States to decide how income and assets should be measured.

Benefits

- "Guaranteed" benefits -- Mostly consistent with NGA outline (and broader than the Conference Agreement). However, the bill expands on previous NGA documents with the following two provisions:

  - *Family planning services*: The bill limits these to "pre-pregnancy family planning services". This term is not defined. The Conference Agreement did define "family planning" as pre-pregnancy only.

  - *FQHCs and RHCs*: Services provided through these entities are included on the list of "guaranteed" benefits for the first two years only of the new program.

- Optional benefits: Expands on NGA documents in the following areas:

  - *Institutions for Mental Disease*: The bill allows State Medicaid programs to pay for services provided at IMDs for individuals between the ages of 21 and 64.

  - *Over-the-Counter Drugs*: The bill includes over-the-counter drugs as an optional service.

  - *Abortion*: The bill states that abortion is permitted only in the case of rape or incest or to save the life of the mother. This would be the first time that the use of federal funds for abortion services would be statutorily defined.

- Amount, Duration, and Scope -- Consistent with original NGA outline and Conference Agreement; does not include the standards for ADS which were included in the 2/27 revisions.

- Comparability and Statewideness -- No provision; consistent with NGA outline and the Conference Agreement.

- EPSDT -- Treatment component is consistent with NGA; rules about qualified providers are an expansion of previous NGA documents. (The Conference Agreement does not address EPSDT; it would be left to the states to define.)

  - *Qualified providers*: The bill eliminates the current requirement that States must allow any qualified provider to provide EPSDT services.

- Vaccines for Children: Expands on previous NGA documents; consistent with the Conference Agreement.

  - While previous NGA documents did not address this issue, the bill would repeal VFC effective the day of enactment.

- Drug Rebate Program: Consistent with NGA's 2/27 revisions; identical to Conference Agreement.

Quality of Service

Nursing Home:

- Quality Standards: They appear to be consistent with NGA documents.

- Federal Role in Enforcement: This role is still unclear; further review is required.

Managed Care:

- There are no provisions on managed care quality; this is consistent with NGA documents.

ICF/MR:

- There are no provisions on ICF-MR quality; this is consistent with NGA documents.

Service Delivery

- Allows states to use any delivery system. This is consistent with the NGA documents and the Conference Agreement. Expands on NGA to include solvency standards and capitation rate setting that is consistent with the Conference Agreement.

Payment Flexibility

- Boren Amendment: Consistent with NGA documents and the Conference Agreement.

- FQHCs and RHCs: Consistent with NGA documents; inconsistent with the Conference Agreement.

Indian Health Service

- The States' Relationships with IHS facilities: Expands on NGA documents; consistent with Conference Agreement.

    - While the NGA documents did not address this issue, the bill makes it optional for States to deal with IHS providers.

- Funding for IHS Facilities: Language on funding has not yet been provided.

Utilization Controls

- Cost-sharing: Expands on NGA documents; consistent with Conference Agreement.
  - While previous NGA documents did not address this issue, the bill provides language similar to the Conference Agreement.
- Utilization Incentives: Expands on NGA documents; consistent with Conference Agreement.
  - The bill allows States to establish incentives for people to not use services.

Family Protections

- Spousal Impoverishment: Largely consistent with the 2/27 NGA revisions and the Conference Agreement. Also expands on both of these items.
  - Consistent with NGA revisions, the bill maintains the current law protections.
  - The bill expands on previous NGA documents in two ways:
    - by increasing the personal needs allowance for nursing home residents (added in the Conference Agreement), and
    - by allowing States to deem the income of outside spouses to help pay for spouses inside nursing homes.
- Adult Children of Nursing Home Residents: Expands on NGA documents; inconsistent with the Conference Agreement.
  - While the NGA documents did not address this issue, the bill states that adult children can not be held responsible for their parents' nursing home bills. (The Conference Agreement would hold some children responsible.)
- Liens: Expands on NGA documents. Inconsistent with the Conference Agreement.
  - The bill maintains current law rules about imposing liens. (Previous NGA documents did not address this issue.)
- Asset Transfer: Inconsistent with NGA revisions. Consistent with the Conference Agreement.
  - While the 2/27 NGA revisions addressed the issue of asset transfers, the bill is silent on this issue.

- Estate Recoveries: Inconsistent with NGA revisions. Consistent with the Conference Agreement.

  - While the 2/27 revisions addressed the issue of estate recoveries, the bill is silent on this issue.

1115 Waivers

- Consistent with NGA outline and revisions. Consistent with the Conference Agreement.

  - The bill makes no mention of 1115 waivers.

COMMENTS ON REPUBLICAN GOVERNORS' PRESS CONFERENCE

Question: The Republican Governors announced today that they have reached agreement with their Democratic counterparts on Medicaid and welfare, and that they are working with a bipartisan group on the hill to complete a bill. The President has said he wants welfare and Medicaid reform. Will he sign it?

Answer: The President's position has not changed. He wants to balance the budget and reform the welfare system. However, as we have said before, we have concerns about parts of the Governors' proposals. In addition, Republican and Democratic Governors have not worked out all of their disagreements. We will continue to work with them and look at the details of their proposals as they reach agreement.

DRAFT TALKING POINTS
WELFARE/MEDICAID HEARING

The Administration's views on the NGA's Medicaid and welfare proposals have not changed. The NGA proposals were a useful step forward. By generally endorsing the importance of guaranteed health care, and highlighting the importance of resources for child care and job training, the NGA has provided an important service.

Their action was a bipartisan statement that the President was right to veto the flawed legislation passed by Congress - legislation that did too little to encourage work, and too much that could harm children and the national guarantee of health coverage for the elderly and disabled. The NGA's actions have increased the possibility that Republicans and Democrats in Congress will produce bipartisan solutions on these issues.

We are not defending the status quo - we believe both the welfare system and the Medicaid system should be reformed. We believe the budget should be balanced. The President has put forward good, solid reform proposals in all these areas. The welfare reforms we have endorsed are designed to reward work, demand responsibility, and protect children. In Medicaid, we have sought to control costs and increase state flexibility, while preserving the guarantee of health coverage for the poor, the old, the disabled, and the very young. In balancing the budget, we have proposed reasonable policies which reduce spending, but protect our investment in Medicare, education, and the environment.

Because the NGA proposal is a work in progress, the Administration does have many questions about its details -- questions that must be answered before we endorse or oppose their proposals. Overall, our goal as we reform Medicaid and AFDC is to protect Americans who can't work -- children, the elderly, and the disabled -- while creating new incentives for those who can work to become independent of the welfare system. That's why it is important to preserve the guarantee of Medicaid coverage; enact sensible SSI reforms; strengthen the child welfare system; and maintain the nutritional safety net.

Now that the NGA has made its proposals, our goal should be to ensure accountability for the taxpayers. While we applaud the NGA's contributions, we do have questions about reaching our common national objectives, and maintaining the federal-state partnership necessary to reach them. As we've said all along, the guarantee of Medicaid coverage must be real and enforceable. And on welfare, any legislation passed by Congress must require states to maintain their own effort; provide sufficient child care; and protect the nutritional safety net that Food Stamps and the school lunch program provide.

would pose a threat to public health or the environment;

- Siting, construction, operation, and decommissioning of microbiological and biomedical facilities;
- Transfer, lease, disposition, or acquisition of uncontaminated land for habitat preservation or wildlife management;
- Siting, construction, operation, or decommissioning of small water treatment facilities — those with a capacity of less than 250,000 gallons per day;
- Relocation and subsequent use of machinery and equipment such as laboratory apparatus, electronic hardware, and health and safety equipment;
- Restoration, creation, or enhancement of small wetlands;
- Traffic flow adjustments on existing roads; and
- Small-scale temporary measures to reduce migration of contaminated ground water.

The department said it plans to issue the rule in final form in June.

DOE added that it determined that the changes would not constitute a major federal action under NEPA. Therefore, the department said it did not prepare an environmental assessment or EIS for the proposed rule.

Comments on the proposal are due by April 5. They should be sent to Carol M. Borgstrom, director, Office of NEPA Policy and Assistance, EH-42, U.S. Department of Energy, 1000 Independence Ave. S.W., Washington, D.C. 20585-0119. Alternatively, comments may be sent to neparule@spok.eh.doe.gov via e-mail.

The proposed rule may be reviewed at http://www.eh.doe.gov/nepa on the Internet.

For more information on the proposal, contact Borgstrom at the above address, (202) 586-4600.□

Medicaid

FINANCE COMMITTEE PRODS GOVERNORS; HATCH RAISES CONSTITUTIONALITY ISSUE

The Senate Finance Committee prodded governors with questions about the National Governors' Association Medicaid agreement Feb. 22 as disability coverage, benefits, and provider taxes emerged as some of the biggest problem areas.

In addition, Sen. Orrin Hatch (R-Utah) raised the possibility that the NGA plan to repeal the private cause of action in federal courts over Medicaid eligibility and benefits might be unconstitutional, noting that the provision "may require further study and refinement."

The governors who crafted the agreement faced many of the same questions they were asked at a House Commerce Committee hearing Feb. 21, as several Finance Committee members worried that the NGA proposal would give states too much discretion to define who is disabled and determine the amount, scope, and duration of Medicaid benefits.

Both issues were being revisited by the governors, who faced increasing pressure over the provisions and the likelihood that Congress would reject the package if those provisions were not changed.

Wisconsin Gov. Tommy Thompson (R) and Colorado Gov. Roy Romer (D) said they were discussing setting some form of benchmark for the amount, scope, and duration of benefits, possibly using the minimum health maintenance organization or commercial health policy in a given state. Nevada Gov. Bob Miller (D) said they were considering a similar threshold of coverage for disability benefits.

"We think we can come up with something that will comply, but don't lock us into the federal definition" of individuals with disabilities, Thompson said.

The governors also are trying to clarify what conditions would allow the Department of Health and Human Services to step in and file lawsuits in federal court on behalf of individuals or classes, Miller said. This was a crucial counterweight the governors put in to allow federal courts to address Medicaid grievances in some way, since individuals no longer would be able to file federal lawsuits themselves.

Thompson said any changes worked out by the governors would be passed on to the congressional staffs who would write the legislative language for the NGA proposal.

Is State Enforcement Unconstitutional?

The repeal of the private right of action in federal courts may be turning into a legal and constitutional issue, since individuals would have to go through a state administrative appeals process and then state courts—not federal courts—to resolve any grievances over eligibility or benefits.

They could petition the U.S. Supreme Court if they are not satisfied with state judges' decisions, but legal experts have questioned whether the Supreme Court would agree to hear such cases when so many other lawsuits are competing for docket space.

At the hearing, Hatch, who chairs the Senate Judiciary Committee, said there could be constitutional problems if the federal courts have no opportunity to review a federal statute. He said the Judiciary Committee staff may have to help the governors flesh out the provision and write the legislative language "to make sure this provision is, at a minimum, constitutional."

Mark Regan, a staff attorney with the National Health Law Program, said Hatch's comments appeared to suggest a legal conflict over the possibility that a federal right to Medicaid coverage would not be enforced by the federal courts.

"That's a weird situation. . . . It would be unusual, if not unconstitutional," Regan said.

Michigan Gov. John Engler (R) agreed to work with the Judiciary Committee on the provision. "It would be very bad for this [proposal] to be struck down and have to go back to the same old system," he said.

'Wish List' Will Not Pass

The governors had to answer uncomfortable questions about their proposals to repeal all federal restrictions on provider taxes—which were imposed to keep states from padding their expenditures to draw down additional federal funds—and to increase the minimum federal match from 50 percent to 60 percent of state expenditures, allowing states to spend less to earn their federal funds.

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"It cannot just be a wish list from governors. That is not going to pass," said Sen. Kent Conrad (D-ND).

In both cases, there was some finger-pointing at governors who were not in the room. Romer said governors who were not part of the six-member Medicaid task force insisted on adding the state match provision, while Florida Gov. Lawton Chiles (D-Fla) said the provider-tax provision also was added by other governors before NGA signed off on the task force's recommendations.

Romer said the reduced state match was one of the concerns raised by President Clinton in discussions with the governors. In addition, Miller said, the president was concerned about the definition of disabilities and the governors' proposal to scale back the treatments offered in the Early and Periodic Screening, Diagnosis, and Treatment program for children.

At times, Romer did a better job of pointing out the NGA plan's weaknesses than the Finance Committee members who were asking the questions. He warned that the lower state match could cost $200 billion in reduced state spending, and even confessed that he had "gamed" the system through provider-tax schemes in the past before Congress imposed the restrictions that the governors' plan would repeal.

And when Sen. John Chafee (R-RI) asked whether states could take advantage of a provision allowing states to cover new populations up to 275 percent of the federal poverty line, using the provision to force Medicaid to pay for health coverage for state workers in that income range, Romer acknowledged that "it's absolutely possible."

No More Gaming

Other governors disagreed on whether the provider-tax provision would lead to a repeat of the scams practiced by states in the late 1930s.

"The short answer is, there are no protections keeping states from doing the same thing," Chiles said. Thompson and Engler, however, said states no longer would have an incentive to use provider taxes to draw down extra federal money, since most states that used such provider-tax schemes in the late 1980s did so to increase their federal disproportionate-share hospital (DSH) payments—which no longer would exist as separate payments under the NGA proposal.

And Engler denied that states would use their newfound flexibility to start a "race to the bottom" to provide the skimpiest possible Medicaid programs, noting that 62 percent of all Medicaid spending now is on optional coverage, not mandatory coverage.

"If we wanted a race to the bottom, we have a lot of money today with which we could begin that race. We have not done it," Engler said.

Thompson assured committee members that "we are not here to game the system," and offered to work with them to resolve any complaints because "we are so eager to get something passed that we are willing to work with you on anything."

After the hearing, Thompson said it would be "catastrophic" for some states if no Medicaid legislation is passed within the next month because several states, notably New York, already have factored Medicaid savings into their 1997 budgets. "I see a train wreck coming in the next couple of months" if nothing is done, he said.□

— By David Nather

Hazardous Substances

OECD GROUP AGREES TO CONTROL LEAD, CREATE CHEMICAL RELEASE INVENTORIES

The Organization for Economic Cooperation and Development's Council on Feb. 20 approved Council Acts to control lead exposure and create pollution release and transfer registries among member countries, a U.S. official told BNA Feb. 22.

The OECD Council, which is composed of ambassadors from the 26 member countries, met immediately following the OECD environment ministers meeting on Feb. 20, according to Diane Beal, special assistant for international activities in the Environmental Protection Agency's Office of Pollution Prevention and Toxics.

The OECD Council, Beal said, adopted four Council Acts—the highest level of agreement among member countries:

- A resolution supporting a Ministerial Declaration on lead risk reduction approved by the environment ministers;
- A recommendation implementing the pollutant release and transfer registries—publicly available databases similar to the U.S.'s Toxic Release Inventory;
- A resolution on improving the environmental performance of the OECD; and
- A recommendation on improving the environmental performance of governments.

The Council is the highest standing group of decision-makers within the OECD. A Council Act can contain three types of agreements—decisions, recommendations, and resolutions. A decision is the strongest because it is considered binding, even though OECD does not have any enforcement mechanism. Council Acts containing recommendations and resolutions are less forceful and are non-binding.

Council Acts, Ministerial Declaration

The most contested issue was a measure to address lead — OECD's first attempt to collectively impose controls on a commercial chemical.

At the Feb. 20 meeting, OECD's environment ministers adopted a four-page declaration that lists 10 high-priority activities to reduce risk of exposure to lead. The Ministerial Declaration also provides for voluntary initiatives by lead industries to share in the responsibility for action on lead risk reduction.

Following the meeting of environment ministers, the Council met and adopted a short Council Act that calls for periodic oversight activities by the OECD Environment Policy Committee to monitor risk reduction progress on lead among member countries and for creation of a framework for cooperative action with industry among other activities.

"What this is all about is taking a very positive step to control lead exposure and its worldwide impact on

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Testimony

of

Donna E. Shalala

U.S. Secretary of Health and Human Services

at

Committee on Finance

United States Senate

February 28, 1996

Mr. Chairman, Senator Moynihan, and members of the Committee: I want to thank you for giving me the opportunity to testify today about the National Governors' Association (NGA) resolutions on Medicaid and welfare and the President's vision for reform in these areas.

Throughout the years, this committee has built a great tradition of bipartisan leadership on these issues. We look forward to working closely with you to reach bipartisan consensus on Medicaid and welfare reform legislation.

This hearing comes at a critical juncture in our nation's history.

Right now, from kitchen tables to the halls of Congress, we are engaged in a historic debate about the size, scope, and role of the federal government.

This debate is about much more than deficits and devolution. At its heart, it's about who we are as Americans -- and what kind of legacy we want to leave for our children.

The Clinton Administration believes that we must balance the budget in seven years and shift more responsibility to the states and local communities. But, we must do it in a way that is consistent with our values.

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

We believe we can give the states the flexibility they need -- while still maintaining a strong federal-state partnership built on a foundation of shared resources, accountability to the taxpayers, and national protections for the most vulnerable Americans.

That's why the President has proposed a common sense plan that balances the budget, gives new flexibility to the states, and reforms welfare and Medicaid, without breaking our promises to our citizens -- from the seniors living in nursing homes to the families struggling to break free from the chains of poverty.

That is the challenge we must meet as we work to reform Medicaid and welfare. That is the standard by which we must judge any reform, including the resolutions recently adopted by the National Governors' Association.

We greatly appreciate the efforts of the NGA in fashioning a bipartisan consensus on the foundations of a plan and their ongoing work to add further detail to their resolutions. We believe that they have made a positive contribution to the debate and have increased the likelihood that Republicans and Democrats will produce bipartisan solutions to reforming our welfare and Medicaid programs. While we applaud their tenacity and their contributions, we do have serious questions about some of the proposals they have put forward: questions about maintaining national objectives and the federal-state partnership necessary to achieve them.

It is now up to this Administration and this Congress to build on the spirit of the Governors' efforts. It is time for all of us to work together to reach our mutual goals: flexibility for the states; incentives for AFDC recipients to move from welfare to work; the preservation of health insurance coverage for those who need it most; and protections for our most precious resource, our children.

MEDICAID

Let me turn first to the Medicaid program. Medicaid provides vitally important health and long-term care coverage for 36 million Americans and their families, including the following:

- It provides primary and preventive care for 18 million low-income children;
- It covers 6 million individuals with disabilities -- providing the health, rehabilitation, and long-term care services that would otherwise be unaffordable for these individuals and their families;
- It covers 4 million senior citizens -- including long-term care benefits that provide financial protection for beneficiaries, spouses, and the adult children of those requiring nursing home care.
- Finally, it pays the Medicare premium and cost sharing for low income seniors, which is the only way to make the use of Medicare benefits affordable for these individuals.

As part of his balanced budget plan, the President has proposed a carefully designed and balanced approach to Medicaid reform. His plan preserves Medicaid (title XIX of the Social Security Act) but makes important changes that will give states unprecedented

flexibility to enhance the program's ability to meet the needs of the people it serves. The President's plan:

- o preserves the federal guarantee of a congressionally-defined benefit package for Medicaid beneficiaries;
- o preserves Medicaid protection for all currently eligible groups;
- o maintains our shared financial partnership with the states as they provide health coverage to needy individuals;
- o provides unprecedented new flexibility so that states can better manage their programs and pay providers of care and operate managed care and other arrangements without unnecessary federal requirements, while maintaining programmatic and fiscal accountability; and
- o contributes federal savings to the balanced budget plan through the use of a per capita cap on federal matching that adjusts automatically to changes in state Medicaid enrollment, changes in the economy and reductions in disproportionate share hospital payments.

As you know, the President strongly opposed -- and ultimately vetoed -- the congressional approach to Medicaid reform because it did not meet these standards. The Congress voted to repeal the Medicaid program and replace it with a new "Medigrant" program that did not include meaningful guarantees of eligibility or benefits. The Congress also proposed a "block-grant" funding mechanism that breached the 30 year federal partnership with the states to share in changes in state Medicaid spending.

As I mentioned earlier, NGA recently approved the outlines of its own Medicaid reform plan, which has been helpful to the debate. In particular, we have been pleased that the Governors appear to agree with one of the key elements of our plan -- namely that federal financing must be responsive to actual, and often unanticipated, changes in Medicaid enrollment in the states and changes in the economy.

However, while the details of the NGA plan are still not completely fleshed out, we are concerned that the elements of the NGA resolution do not reflect the priorities set out in the President's Medicaid plan in certain areas. These are: (1) the need for a real, enforceable federal guarantee of coverage to a congressionally-defined benefit package; (2) appropriate federal and state financing; and (3) quality standards, beneficiary protections, and accountability.

The federal guarantee of coverage and benefits

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

Eligibility

Let's begin with eligibility. The NGA plan sets out a number of current law groups that states must cover in their plan. However, problems remain in the NGA definition. First, it repeals the current law phase-in of Medicaid coverage for children ages 13-18 in families with income below the federal poverty level -- a bipartisan coverage expansion signed into law by President Bush.

In addition, the NGA resolution repeals the federal standard for defining disability and replaces it with 50 separate state definitions. This has the effect of making Medicaid coverage and benefits for those with disabilities uncertain and variable around the nation. For example, it would be possible for states to use restricted definitions of disability resulting in very limited coverage for populations whose service needs are pronounced and among the most costly. In such situations, we are concerned that narrow state definitions of disability could preclude individuals with HIV, certain physical disabilities, or mental illness, from receiving critically needed services under Medicaid. We should not turn back the clock on those with disabilities by permitting 50 different state definitions for purposes of Medicaid coverage.

It appears that the Governors have retained the linkage between cash assistance and eligibility for Medicaid. However, there are still some outstanding questions that require clarification, including how currently covered populations, like the welfare-to-work eligibles, will be covered after the enactment of welfare reform.

Benefits

Eligibility is only one component of the guarantee -- because the question is eligibility for what -- bringing us to benefits. The NGA resolution lists benefits that are characterized as "guaranteed for the guaranteed populations only." The resolution also says that all other benefits defined as optional under the current program would remain optional, and that there would be an additional set of long-term care options.

This new framework raises several unresolved questions. The first relates to the adequacy of the benefits. Current Medicaid law and regulations already give states substantial flexibility in defining the amount, duration, and scope of benefits, and states have used this flexibility to respond to their unique circumstances. This latitude is tempered by a very reasonable constraint -- benefits must be "sufficient to reasonably achieve their purpose". We have concerns that by specifying "complete" flexibility on amount, duration, and scope, the NGA proposal provides no standard against which to assess the reasonableness of a state's benefit plan. Without a standard, any federal "guarantee" is illusory. We believe the Governors understood this as they acknowledged in their testimony last week that the provision in their resolution on this issue has shortcomings that need to be addressed.

The NGA resolution also is silent on the current law standards of comparability and "statewideness" of services -- among and within eligible groups -- for mandatory as well as optional services. In the absence of further information about such provisions, there is no standard against which the "guaranteed" benefits and potential discrimination against certain groups or diseases can be assessed, and therefore we are concerned about the potential for discrimination against certain groups or diseases.

The NGA proposal also would limit the treatment portion of the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program, so that states need not cover all Medicaid optional services for children. The NGA does not yet specify exactly how this

would be done, so it is difficult to assess the impact of the provision -- other than the certainty that some children would not receive treatments despite the clinical recommendations for those services arising from the EPSDT screening and diagnosis process.

Enforcement

The third essential component of the federal guarantee is enforcement. Implicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism. A federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States. The NGA resolution requires states to provide a state right of action, but eliminates any federal right of action for individuals and providers who assert that a state is violating federal Medicaid laws. The only access to federal court for such claims would be the opportunity to petition the U.S. Supreme Court for review of a decision of a state's highest court.

The NGA provisions pose a number of serious questions and concerns. Under the proposal, we believe Medicaid would be the sole federal statute conferring benefits on individuals with no possibility of federal enforcement by its intended beneficiaries.

Review by federal courts also promotes efficiency. As a practical matter, common sense tells us that those aspects of the Medicaid program that are common to all states should

be subject to consistent interpretation and administration. When the same question arises across multiple jurisdictions, decision-making in the federal court system maximizes efficiency and predictability. This is particularly true when Medicaid interacts, as is often the case, with other federal statutes (such as Medicare, Social Security, SSI and AFDC). Federal courts are more experienced in analyzing these federal programs and are better able to understand and decide cases involving relationships among them. When courts are being asked to interpret statutory provisions that apply to all participating jurisdictions, we should not construct a system that will encourage different outcomes in different states.

Suits against states filed by providers over payment rates have caused the greatest problem to the states. Under the Administration's plan, the Boren Amendment and related provider payment provisions would be repealed, thereby eliminating these causes of action by providers. Thus, under the Administration's plan, state concerns about limiting their exposure to suit in federal court would be resolved largely.

On balance, when we assess the three components required to make any guarantee real -- the definitions of eligibility, benefits, and enforcement in the NGA resolution -- we continue to have concerns because the federal guarantee of Medicaid coverage and benefits does not appear to be real and enforceable for recipients.

Financing

The second key issue is the financing contained in the NGA resolution. The NGA

resolution would replace the current financing system with a combination of a fixed federal payment and a payment adjustment for unexpected increased enrollment. The Governors' financing mechanism has the potential to be creative and a workable formula that constrains growth without providing incentives to drop coverage. Their funding approach, which ensures Medicaid dollars increase with enrollment, represents a constructive addition to the debate. As the Governors have noted, however, these provisions must be fleshed out in much greater detail before anyone can assess whether the financing actually flows based on changes in enrollment and the economy.

The NGA proposal also includes two changes in the state share of financing Medicaid. The minimum federal contribution to the financing of Medicaid would increase from 50 percent to 60 percent, and states' use of provider tax and donation financing mechanisms would once again be unconstrained.

While these proposals are appealing to many states, they raise significant concerns. Depending on the overall structure of the program and on state decisions about program spending, raising the minimum federal match rate from 50 percent to 60 percent either could result in significant increases in federal spending, or reductions in state contributions to Medicaid -- and in total Medicaid funding for health care. For example, an analysis of this provision by the Center on Budget and Policy Priorities indicated that if the seven-year federal funding reduction were $85 billion and state matching requirements were reduced in the same manner as the congressional reconciliation bill, states could reduce state Medicaid

funding by as much as $182 billion to $214 billion over seven years. Under this scenario, the total federal and state seven year cut could total from $241 billion to $299 billion, and the funding cut could be between 19 percent and 26 percent in 2002.

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

The NGA plan would also permit unconstrained use of provider tax and donation financing approaches for the "state" share of Medicaid. These are the exact mechanisms that the Congress recently limited -- in the case of taxes -- or outlawed completely -- in the case of donations. During the late 1980s and early 1990s, many states took advantage of these funding approaches, costing the federal government billions of dollars and helping drive annual Medicaid spending growth rates up to well over 20 percent. The Congress wisely enacted limits on these mechanisms that remain appropriate today.

In addition, the NGA proposal treats American Indians and Alaska Natives (AI/ANs) in its category of "special grants" that includes "grants to certain states to cover illegal aliens

and to assist Indian Health Service and related facilities in the provision of health care to Native Americans". Native Americans have a unique status in that they have a government to government relationship with the United States that distinguishes them from other special populations. Based upon this legal status, they are entitled to benefits promised under federal treaties and trust responsibilities and to any benefits for which they are otherwise eligible as U.S. citizens. The NGA resolution regarding Indian Health services does not acknowledge this legal relationship, nor does it recognize the fact that American Indians possess dual citizenship. They are citizens of both the state and their tribe. The NGA resolution does not recognize the state government's responsibilities to American Indian citizens. We are concerned by policies which make the federal government the sole provider of health care to American Indians and Alaska Natives and abrogate the right of these citizens to participate in state funded services on the same basis as any other state citizen.

Finally, we all have to examine the NGA proposal and financing structure in the context of the effort by the President and the Congress to achieve a balanced budget in seven years. We do not yet know whether this plan will achieve the scoreable savings that are required under the President's balanced budget plan -- or under the congressional proposals. If it does not, it would have to be modified to produce savings. Otherwise, other portions of the budget would have to be revised to bring the budget into balance.

Protections for beneficiaries and taxpayers

The NGA resolution would repeal title XIX and create a new title for the Medicaid

program. This has the effect of seriously compromising the framework for quality standards, beneficiary and family financial protections, and program accountability.

The NGA resolution is silent in many areas. In other areas where the resolution is specific, some long-standing protections would be reduced or eliminated. For example, the NGA resolution eliminates the federal role in monitoring nursing home quality assurance. Yet without federal monitoring and enforcement of state and facility compliance, the bipartisan uniform quality standards established by the Omnibus Budget Reconciliation Act of 1987 could be undermined significantly.

The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care. This is a particularly important area since Medicaid managed care enrollment is increasing so dramatically -- about one-third of beneficiaries are now in managed care, a 140 percent increase in enrollment over the past three years. The President's plan recognizes the need for updating managed care quality standards. It repeals some outdated approaches and requires states to establish a quality improvement program that must include developing appropriate standards for Medicaid-contracting health plans and using data analysis to track utilization and managed care outcomes.

Finally, the NGA resolution does not clearly address beneficiary and family financial protections such as spousal impoverishment and family responsibility protections that have

been central to the Medicaid program for some time. The NGA resolution also does not address the imposition of co-payments and other cost sharing for Medicaid beneficiaries. Further clarification in all of these areas is needed, because these are central elements of the financial security that Medicaid provides today for beneficiaries and their families.

Conclusion

Let me conclude by focusing on one fundamental structural issue -- whether we approach the task of Medicaid reform by making changes in the current title XIX of the Social Security Act, or by repealing that program and replacing it with a new title. We support reform, not repeal, of Title XIX. The potential unintended consequences of repealing and replacing this program are staggering -- for states, beneficiaries, providers, and the federal government, especially when you consider that it would reopen thirty years of settled litigation. The Congress can address many of the most pressing concerns about any Medicaid reform plan by amending the current law.

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

a way that would also help contribute to a balanced budget by 2002. We believe that the NGA resolution has made a significant contribution to our mutual efforts to reform the Medicaid program. We look forward to working with the Governors, Members of Congress, consumer groups, health care providers, and other interested parties in the near future on this important issue.

WELFARE REFORM

Now I would like to turn to welfare reform. Let me start by reiterating some points the President made in his State of the Union address. Welfare caseloads have declined by 1.4 million since March of 1994 -- a decline of 10 percent. A larger percentage of those still on the rolls are engaged in work and related activities. Fewer children live in poverty. Food stamp rolls have gone down. Teen pregnancy rates have gone down. At the same time, child support collections have gone up, as the Administration has improved state collection efforts, the IRS's seizure of income tax refunds, and the ability of the federal government to make federal employees accountable for the support they owe their children.

Over the last three years, we have worked with governors and elected officials to give 37 states the flexibility to design welfare reform strategies that meet their specific needs. This Administration has encouraged states to find innovative ways to move people from welfare to work and to promote parental responsibility, and these efforts already are making a difference for more than 10 million recipients throughout the country. States, led by Governors of both parties, now are demanding work; time-limiting assistance; requiring teens

to stay in school and live at home; and strengthening child support enforcement.

President Clinton also has worked with the Congress to expand dramatically the Earned Income Tax Credit to make work pay over welfare. This program, which President Reagan said was the most pro-family, pro-work initiative undertaken by the United States in the last generation, meant that, in 1994, families with children with incomes under $28,000 paid about $1,300 less in income tax than they would have if the laws hadn't been changed in 1993.

Yet, as the President said in January, we should take advantage of bipartisan consensus on time limits, work requirements, and child support enforcement to enact national welfare reform legislation. The President has consistently called for bipartisan welfare reform and the Administration applauds the way Republicans and Democrats came together to put forth the NGA recommendations. As you may recall, the President started us down this road when he brought together a bipartisan group of congressional leaders, Governors, and federal and local officials to discuss welfare reform at the Blair House last year.

We all want welfare reform that promotes work, requires responsibility, and protects children. Real welfare reform is first and foremost about work: requiring recipients to make the transition into the work force as quickly as possible and giving them the tools they need to enter and succeed in the labor market. This will require a change in the culture of welfare offices so that every action provides support and encouragement for the transition to work.

The President, as part of his balanced budget plan, has proposed a balanced approach to welfare reform that achieves these goals. It replaces welfare with a new, time-limited, conditional entitlement in return for work and gives states new flexibility to design their own approaches to welfare reform. Within two years, parents must go to work or lose their benefits, and after five years, benefits end. The plan provides vouchers for children whose parents reach the time limit, and protects States in the event of economic downturns or population growth. It also has tough child support enforcement measures and preserves the national commitment to nutrition assistance, foster care, and adoption assistance, preserving states' ability to respond to growing caseloads.

The Administration will continue to judge legislation adopted by the Congress on the basis of whether it promotes work, responsibility, and family, and protects children. And, following the example of the NGA and the Senate last fall, we strongly hope for legislation that will be endorsed by a majority of Democrats and Republicans in both chambers of Congress.

The NGA proposal makes numerous modifications to the conference welfare bill -- many of which, if adopted by the Congress, would be improvements. Some of NGA's recommendations fall short and should be improved.

On the positive side, the NGA proposal reflects an understanding of the child care resources states will need in implementing welfare reform. By adding $4 billion for child

care above the level in the conference report for H.R. 4, the NGA proposal acknowledges that single parents can only find and keep jobs if their children are cared for safely. The additional investment is essential to ensure that child care resources are available for those required to move from welfare to work and -- equally important -- to ensure that child care is available for low income working families at-risk of welfare dependency. We are troubled, however, that the NGA proposal fails to include Senate provisions for ensuring safe and healthy child care, and that the increased federal spending does not require a state match.

By adding $1 billion to the H.R. 4 contingency fund and allowing states to draw funds if poverty rises, the NGA proposal properly recognizes that states may experience unexpected changes in population or downturns in their economy. In the event of a national economic downturn, however, even a $2 billion contingency fund might be exhausted quite rapidly. During the last recession, for example, total AFDC benefit payments rose from $17.2 billion in 1989 to $21.9 billion in 1992, a $4.7 billion increase over the base year in one year alone. A provision should be added to the bill allowing states to draw down matching dollars during a national recession even if the $2 billion in the contingency fund has been expended. We also believe the trigger mechanism should be improved to ensure greater responsiveness to the states' need for additional resources.

The NGA proposal also would eliminate the requirement in the Senate bill that states meet their full 1994 level of effort in order to be eligible for the contingency fund. The removal of this requirement would allow a state to draw down additional federal dollars

while actually reducing its own contribution to the family assistance program. It is difficult to understand why a state in need of contingency fund dollars to meet the demand for assistance would simultaneously be allowed to cut its own spending on poor families below the 1994 level. We support restoring the contingency fund maintenance of effort provision contained in H.R. 4.

The NGA proposal also properly recognizes the importance of child support enforcement to welfare reform. Last year, the President insisted that welfare reform include the toughest child support enforcement reforms in this country's history. Since then, Republicans and Democrats have worked together in a bipartisan spirit and included all of the major proposals for child support enforcement reform that the President requested: streamlined paternity establishment, new hire reporting, uniform interstate child support laws, computerized statewide collections, and drivers license revocation. We applaud the efforts of the NGA and the members of this Committee for their hard work on the child support enforcement provisions. It has been bipartisanship at its best.

On Food Stamps, the NGA proposal makes two important improvements to the H.R. 4 conference bill. First, it does not impose a funding cap on the Food Stamp program as the conference bill did. A cap on Food Stamp spending would jeopardize the ability of the Food Stamp program to get food to people who need it. Second, the NGA proposal protects families with relatively high shelter costs -- mostly families with children -- by adopting the

Senate's approach to the program's deductions from income.

The NGA proposal also makes substantial improvements to the performance bonus provisions in the conference agreement by establishing a separate funding stream to pay for bonuses -- rather than allowing states to reduce their maintenance of effort. It makes modifications to the work requirements to make them more feasible and less costly for states to meet. In particular, the Administration is very supportive of provisions that allow part-time work for mothers with pre-school age children and that reduce the maximum number of hours per week from 35 to 25.

The Governors' proposal also is noteworthy because it limits proposed cuts to the Earned Income Tax Credit. We cannot be serious about welfare reform if we cripple the primary work incentive for low-income parents. Along with child care and health coverage, the EITC is vital to helping people move from welfare to work.

Finally, the Administration is supportive of several provisions that the NGA adopted from the Senate-passed bill -- a 20 percent caseload exemption from the time limit for battered women, women with disabilities and others who may need a hardship exemption; a state option to implement a family cap; and requirements that teen mothers live at home and stay in school.

The Federal-State Partnership

While the NGA proposal improves on the conference bill in a number of ways, the Administration has serious concerns about several provisions. While it is critical that states have the flexibility to design programs to meet their specific needs, it is equally essential that the federal government ensure accountability in the use of tax dollars and make certain the safety net for poor children is maintained. The federal-state match system under current law always has been the "glue" that holds this partnership together and was part of the welfare reform plan the Administration proposed as part of its balanced budget plan.

A serious concern about the NGA proposal generally is that the federal-state partnership is severely weakened. As I have already mentioned, the Administration prefers the provision in the Senate bill that requires 80 percent maintenance of effort of the 1994 level, and a requirement for a 100 percent maintenance of effort for access to the contingency fund. We also oppose the NGA provision allowing a state to transfer up to 30 percent of its cash assistance block to other programs such as Title XX, the Social Services Block Grant. Since most states spend considerable state dollars on social services, this transfer effectively permits substitution of federal dollars for state dollars.

The problem is exacerbated in the Governors' proposal by the fact that the additional $4 billion in child care funds requires neither a state match nor even maintenance of the FY 1994 level of state effort on child care.

In total, these provisions imply that states could, by law, reduce their spending substantially under the MOE and transfer provisions while federal spending on AFDC and child care programs would continue. One analysis presented before the House Ways and Means Committee by the Center on Budget and Policy Priorities last week argued that states could hypothetically reduce spending by more that $50 billion over the next seven years if they reduced spending to 75 percent of their current effort and transferred 30 percent of cash block grant funds to other activities. Most states would not reduce spending this dramatically, but there is no reason why states should be allowed to reduce spending while Federal support continues at roughly current levels.

Finally, the NGA proposal needs to provide greater accountability for taxpayer dollars and stronger protections against worker displacement. Provisions should be added that provide for accountability in state plan implementation and require a program specific audit within federal guidelines.

Protections for Children

The NGA proposal also contains several provisions that threaten the safety net for poor children. Federal and state child protection programs provide an essential safety net for the nation's abused, neglected and adopted children, and children in foster care. As we embark upon bold new welfare reform initiatives, it is critical to maintain a strong child protection system for these extremely vulnerable children. Unlike the Senate's bipartisan approach to child protection, the NGA proposal jeopardizes this essential safety net by

allowing states to replace with block grants current entitlements for adoption, foster care, independent living and family preservation. With disturbingly uneven state performance in this area, it also is troubling that the NGA's proposed redesign of the nation's child protection system fails to include a mechanism to enforce protections vital for the lives and well-being of abused and neglected children. The NGA proposal also would block grant important programs focused on prevention of child abuse and neglect. If the system includes no targeted prevention funding, crisis-driven decision-making may deplete resources for prevention.

Food Stamps and Child Nutrition. On behalf of the Secretary of Agriculture, I'd like to discuss a few issues relating to the nutrition programs. While the NGA agreement does include some improvements to the conference report's provisions on Food Stamps, the NGA proposal did not go as far as it should, and serious concerns remain.

- The NGA proposal continues to provide a state option for a Food Stamp block grant. The nutrition and health of millions of children, working families, and elderly could be jeopardized if many states took advantage of this option, as they might under the terms contained in the proposal. Although the Administration is committed to simplification and increased flexibility in the Food Stamp program, we are strongly opposed to a Food Stamp block grant.

- In addition, the NGA proposal continues the proposed Simplified Program to

households which receive both Food Stamps and AFDC. While the Administration supports a Simplified Program and has developed its own proposal, the NGA proposal undermines national standards that work and creates a hidden cost for states.

- The NGA proposal severely time limits Food Stamp receipt for many unemployed adults. Anyone who is not willing to work should be removed from the program. But those who are willing to work should have the opportunity and the support necessary to put them to work. Many who are willing to work could lose their Food Stamps because states are unwilling or unable to provide sufficient work and training opportunities. Without resources to provide work opportunities, states could face the burden of caring for thousands of people who have lost nutrition assistance.

- The NGA proposal retains the conference bill's provision for school nutrition block grant demonstrations. The block grant demonstrations would undermine the program's ability to respond automatically to economic changes and to maintain national nutrition standards.

Guarantees of fair and equitable treatment. The NGA proposal does contain a requirement that states set forth and commit themselves to objective criteria for the delivery of benefits and fair and equitable treatment. This is an improvement over the conference bill, which contained no guarantees that states would commit to objective eligibility and other criteria and promptly and equitably serve those who met them. To ensure that applicants and

recipients are not subject to arbitrary treatment -- for example, being placed on waiting lists -- state plans should be explicit, contain certain elements, and bind the states to their commitments. Among those commitments should be applications, eligibility and sanctions criteria, and procedures and time frames for decisions. Moreover, statewideness and equity across families in each state must be the goal. Applicants and beneficiaries should be told the reasons for decisions on their cases. Mistakes in the administration of the program should be correctable. Once these objectives are met, applicants, recipients and other taxpayers in each state will understand the benefits and concomitant responsibilities under their state plans.

Restrictions On Benefits To Immigrants

The recent NGA proposal does not address the immigrant provisions included in the H.R. 4 welfare reform conference bill. That bill would have banned most legal immigrants, including the disabled, the elderly, and children, from receiving means-tested benefits. It That bill also would have excluded illegal aliens from all child nutrition benefits, creating an unprecedented local administrative burden and ultimately denying benefits to millions of eligible children. This provision alone would require all 45 million students enrolled in participating schools to document their citizenship to participate in the federally-supported school lunch program, placing an enormous administrative burden on local school systems.

The Administration opposes deep and unfair cuts in benefits to legal immigrants.

Instead, the Administration strongly supports strengthening and enforcing sponsor responsibility for immigrants, by extending deeming provisions until citizenship. It is particularly important to note that the NGA, in its letter to the welfare conferees dated October 10, 1995, specifically *supported* the deeming approach of the Administration and *opposed* the banning provisions in H.R. 4. We are deeply concerned that the legal immigrant provisions of H.R. 4 will represent an enormous cost shift to certain states, as well as to federal taxpayers, leaving state and local governments solely responsible for assistance to legal immigrants.

In short, the NGA welfare proposal represents an important bipartisan step forward in enhancing the ability of the states to reform welfare by promoting work, encouraging parental responsibility and protecting children. It needs to be improved in important ways. We look forward to working in a bipartisan way to build on the improvements that have been made and to achieve welfare reform of which we can all be proud.

In conclusion, Mr. Chairman, let me restate the Administration's commitment to enact both a balanced budget and Medicaid and welfare reform legislation. As the President has said, budget cutting shouldn't be wrapped in a cloak of reform. Let's pass needed Medicaid and welfare reforms. Let's cut the deficit. But let's not mix up the two and pretend that one is the other.

I know the President shares my hope that with the leadership of this committee, the same level of bipartisan cooperation will exist again on the critical issues of Medicaid and welfare reform.

Because when we are all long gone and the history books of this period have been written, what will they say about our role in this great debate?

Did we give the American people a government that honors their values and spends their money wisely?

Did we balance the budget and shift responsibility away from Washington without breaking our historic promises of health care to seniors, children, and people with disabilities?

Did we enact real welfare reform -- not by punishing innocent children, but by encouraging work and responsibility?

Did we give our citizens the tools they need to be both good parents and good workers?

Did we move forward on common ground with a common vision?

Quite simply, did we do the right thing?

That is the challenge facing this Administration, this Committee, and this Congress. And, that is the challenge we must meet together.

Again, I want to thank this Committee for giving me the opportunity to testify today and I look forward to answering your questions.

February 20, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: TODD STERN

SUBJECT: NGA Governors' Proposal

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

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

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

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

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

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

Talking points
2/27/96

BACKGROUND: The New York Times reports today on Secretary Shalala's views of the NGA Medicaid and welfare proposals, quoting a leaked version of her testimony obtained from "Administration officials." While the New York Times reports that she will raise "major objections" to welfare and Medicaid changes on Wednesday, in fact, her testimony will track the previously stated views of the President, Leon Panetta, and other White House officials.

The Administration's views on the NGA's Medicaid and welfare proposals have not changed. The NGA proposals were a useful step forward. By endorsing the importance of guaranteed health care, and highlighting the importance of resources for child care and job training, the NGA has provided an important service.

Their action was a bipartisan statement that the President was right to veto the flawed legislation passed by Congress - legislation that did too little to encourage work, and too much that could harm children and the national guarantee of health coverage for the elderly and disabled. The NGA's actions have increased the possibility that Republicans and Democrats in Congress will produce bipartisan solutions on these issues.

We are not defending the status quo - we believe both the welfare system and the Medicaid system should be reformed. We believe the budget should be balanced. The President has put forward good, solid reform proposals in all these areas. The welfare reforms we have endorsed are designed to reward work, demand responsibility, and protect children. In Medicaid, we have sought to control costs and increase state flexibility, while preserving the guarantee of health coverage for the poor, the old, the disabled, and the very young. In balancing the budget, we have proposed reasonable policies which reduce spending, but protect our investment in Medicare, education, and the environment.

Because the NGA proposal is a work in progress, the Administration does have many questions about its details -- questions that must be answered before we endorse or oppose their proposals. Overall, our goal as we reform Medicaid and AFDC is to protect Americans who can't work -- children, the elderly, and the disabled -- while creating new incentives for those who can work to become independent of the welfare system. That's why it is important to preserve the guarantee of Medicaid coverage; enact sensible SSI reforms; strengthen the child welfare system; and maintain the nutritional safety net.

Now that the NGA has made its proposals, our goal should be to ensure accountability for the taxpayers. While we applaud the NGA's contributions, we do have questions about reaching our common national objectives, and maintaining the federal-state partnership necessary to reach them. As we've said all along, the guarantee of Medicaid coverage must be real and enforceable. And on welfare, any legislation passed by Congress must require states to maintain their own effort; provide sufficient child care; and protect the nutritional safety net that Food Stamps and the school lunch program provide.

AS ADOPTED 2/6/96

RESTRUCTURING MEDICAID

PREAMBLE

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics.

Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the elderly. This year, states and the federal government combined will spend more than $140 billion in this program providing care to more than 28 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained and those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

THE NEW PROGRAM

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the nation's Governors proposal that blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens.

Program Goals. *The program is guided by four primary goals.*

1. *The basic health care needs of the nation's most vulnerable populations must be guaranteed.*
2. *The growth in health care expenditures must be brought under control.*

3. *States must have maximum flexibility in the design and implementation of cost-effective systems of care.*
4. *States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.*

Eligibility. *Coverage remains guaranteed for:*

- *Pregnant women to 133 percent of poverty.*
- *Children to age 6 to 133 percent of poverty.*
- *Children age 6 through 12 to 100 percent of poverty.*
- *The elderly who meet SSI income and resource standards.*
- *Persons with disabilities as defined by the state in their state plan. 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.*
- *Medicare cost sharing for 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 eligible for a new welfare program as defined by the state.*

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act.

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 percent of poverty.*

Benefits

- *The following benefits remain guaranteed for the guaranteed populations only.*
  - *Inpatient and outpatient hospital services, physician services, prenatal care, 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, and 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 only rights of action for individuals or classes for eligibility. All of these features will be designed to prevent states from having to defend against an individual's suit on benefits in federal court.*
  - *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 petition 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.*
- *There should be no private right of action for providers or health plans.*

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.*
- *For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.*

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.*
- *This program should be written under a new title of the Social Security Act.*

Provider Taxes and Donations

- *Current provider tax and donation restrictions in federal 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. In determining base expenditures, a state may choose from the following—1993 expenditures, 1994 expenditures, or 1995 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.*
2. *Growth. This is a formula that accounts for estimated changes in the state's caseload (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the best available data.*
3. *Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. 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. These funds are an entitlement to states and not subject to annual appropriations.*

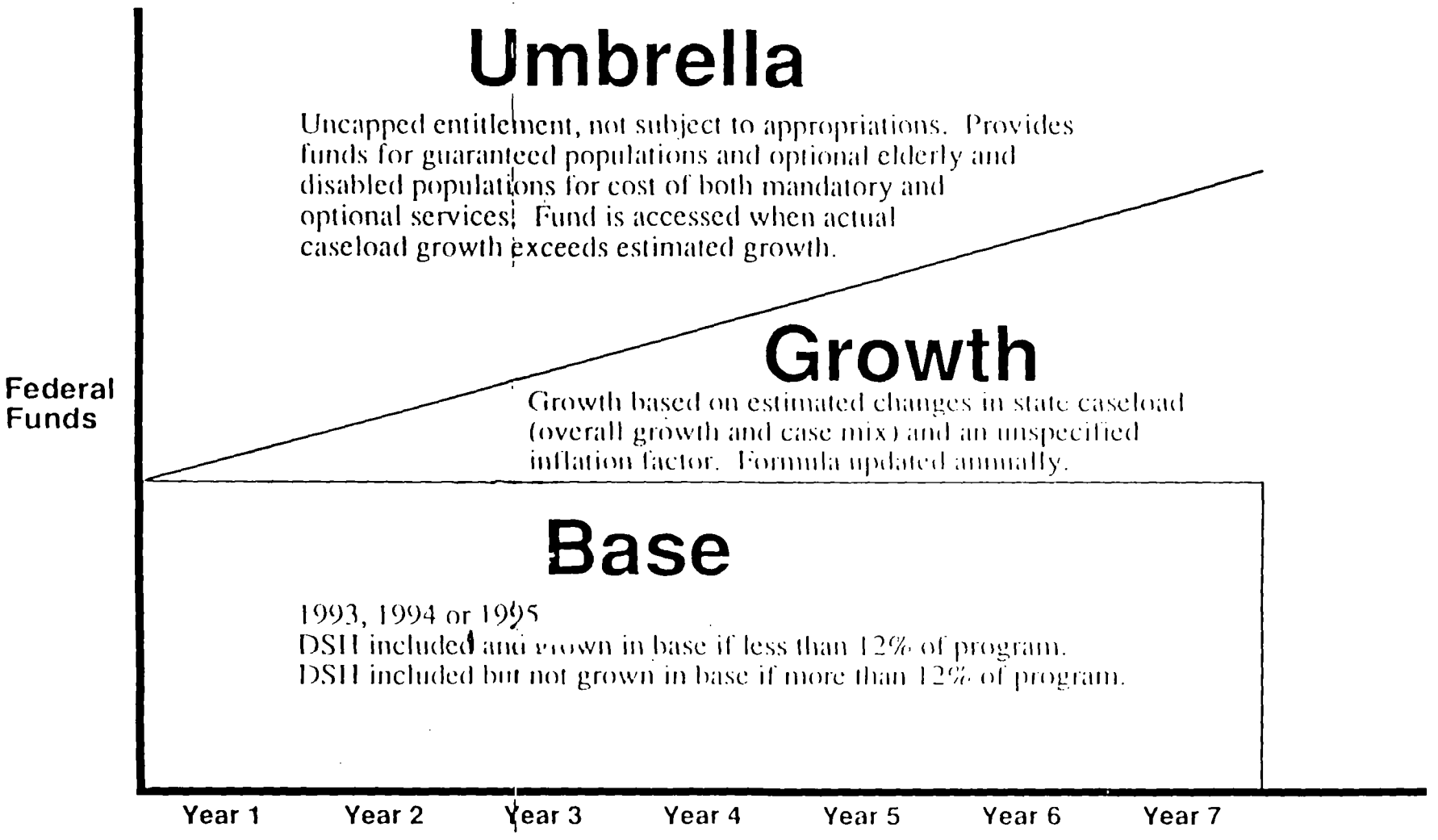
   Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups—persons with disabilities and the elderly.

   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. *Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.*
5. *Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.*
6. *Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for*

low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

Provision for Territories. *The National Governors' Association strongly encourages Congress to work with the Governors of Puerto Rico, Guam, and other territories towards allocating equitable federal funding for their medical assistance programs.*


Umbrella
Uncapped entitlement, not subject to appropriations. Provides funds for guaranteed populations and optional elderly and disabled populations for cost of both mandatory and optional services. Fund is accessed when actual caseload growth exceeds estimated growth.
Growth
Growth based on estimated changes in state caseload (overall growth and case mix) and an unspecified inflation factor. Formula updated annually.
Base
1993, 1994 or 1995
DSH included and grown in base if less than 12% of program.
DSH included but not grown in base if more than 12% of program.
Federal Funds
Year 1
Year 2
Year 3
Year 4
Year 5
Year 6
Year 7

THE NATIONAL GOVERNORS' ASSOCIATION (NGA) MEDICAID 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 and legislation to reform Medicaid, we need to make sure that guarantee is real.

  -- There must be national guidelines for eligibility that protect those who are eligible under current law. This means that current law, which provides that 1.5 million children between the ages of 13 and 18 are being phased-in for coverage, should be retained. It also means that people who meet the national definition of disability should be guaranteed coverage.

  -- There must be a national guarantee to meaningful benefits.

  -- And we must preserve adequate legal enforcement of this guarantee.

- We are working with the Governors to clarify the intent behind the individual provisions of the NGA resolution. Their recent testimony before the Congress shed some additional light on their proposal, but they have yet to finalize their policy.

- In the weeks to come, we will continue to work the Governors, the Congress, consumer advocates, health care providers, and other interested parties to assure that any Medicaid reform legislation provides for enhanced flexibility to the states while preserving the program's fundamental guarantee.

2/23/96

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COMMITTEES
COMMERCE
GOVERNMENT REFORM AND OVERSIGHT

PHILIP M. SCHLIRO
ADMINISTRATIVE ASSISTANT

Congress of the United States
House of Representatives
Washington, DC 20515-0529

HENRY A. WAXMAN
29TH DISTRICT, CALIFORNIA

HAW
f

TELEFAX COVER SHEET

TO: MELANNE VERVEER

FROM: KAREN NELSON

Number of pages including cover sheet: _____

Henry saw Mrs. Clinton at the event last night, and she asked him to send you a copy of the House Republican Conference document crowing about how the Governors' agreement is really Medicare II and ends the Medicaid entitlement. I also thought you might be amused by the Blisley puff piece, particularly his claims on Medicaid.

If you have any problems reading this material, please call (202) 225-3976.

Karen

House Republican Conference

TALKING POINTS

JOHN BOEHNER
Chairman
8th District, Ohio

February 6, 1996

VICTORY!

Governors embrace Republican effort to move power back to the states;
Reform of Welfare, Medicaid mirror GOP crafted, Clinton vetoed proposals

GOV'S UNANIMOUSLY EMBRACE GOP VISION OF MOVING POWER BACK TO STATES...
- National Governors Association meeting produces proposals for Welfare reform, Medicaid;
- Proposals mirror GOP passed reforms – reforms Clinton repeatedly vetoed;

...NO WONDER BILL CLINTON GIVES IT THE COLD SHOULDER
- While the proposals do not contain 100% of the GOP reforms, it does represent the identical philosophy, and most of the reforms, contained in Republican balanced budget offers;
- A White House reporter said Clinton "*...sure gave short shrift to the governors' proposals...*"
- The president called the unanimous endorsement by the nation's governors of these largely Republican initiatives merely a "*...step in the right direction;*"
- Savings from each proposal are expected to come very close to GOP budget goals;

WELFARE
- Ends the federal entitlement and replaces it with a block grant to the states;
- Contains real work requirements and lifetime limits of five years;
- States are given flexibility to adopt even stricter time limits if they choose;
- States are given flexibility to eliminate incentives for illegitimacy – basic services for children are protected but states are not required to give monthly cash benefits to teenage mothers;
- States allowed to limit extra payments to mothers who have additional children on welfare;

MEDIGRANT II
- Ends federal entitlement of Medicaid, replaced with MediGrants;
- Gives states the flexibility to deliver health care more fairly, efficiently and at a lower cost;
- Guarantees protection for most vulnerable populations – pregnant women, children, elderly poor, the disabled, and other low-income individuals.

COMMERCE COMMITTEE
NEWS RELEASE

FOR IMMEDIATE RELEASE
WEDNESDAY, FEBRUARY 8, 1996

CONTACT : MIKE COLLINS
TEL. : (202) 225-5735

BLILEY: HISTORIC TELECOMMUNICATIONS BILL "JUST A START"
Commerce Chairman Lists Accomplishments and Objectives on Heels of Telecom Passage

WASHINGTON (February 8) - On the heels of overwhelming House and Senate approval of the historic Bliley-Pressler Telecommunications Reform Act, the Chairman of the House Commerce Committee today set forth an even more ambitious agenda for the remaining months of the 104th Congress.

U.S. Rep. Thomas J. Bliley, Jr. (R-VA) reflected today on a dizzying array of legislative accomplishments, from breaking up the monopoly in local telephone service to landmark reform of the nation's securities class action litigation system and passage of important revisions to the Clean Air Act Amendments. He has also spearheaded efforts to restructure the nation's product liability system, rein in the power of federal bureaucrats, and restructure the nation's Medicare and Medicaid systems.

In a Congress marked by partisan bickering and ideological gridlock, Bliley has earned widespread praise for his ability to form broad, bipartisan coalitions in support of his Committee's initiatives. A *National Journal* profile described the courtly, bow-tied southerner as "Mr. Smooth," and noted that Bliley "knows a thing or two about getting his way." The magazine noted that Bliley plays "a quieter brand of hardball" than his predecessors on the powerful Commerce Committee.

His formidable skills as a negotiator and coalition-builder were perhaps best displayed during his year-long fight to secure passage of the Telecommunications Act, a sweeping overhaul of the nation's telephone, cable, broadcasting and on-line computing industries that breaks up the Bell monopoly in local telephone service and will lower rates and improve service by allowing long-distance and local telephone companies and cable television providers to compete in one another's business. Bliley eventually steered through the House on February 1, 1996, by a vote of 414-16. The massive legislation represents the first comprehensive reform of the nation's communications laws since 1934, and had been stalled in Congressional haggling with telephone, broadcast and cable company lobbyists since it was originally introduced 14 years ago.

The Washington Post praised Bliley and his counterpart, Sen. Larry Pressler (R-SD), with "gingerly defusing" opposition by Senate Majority Leader Bob Dole and "steering clear of other, more partisan landmines" in handing the 104th Congress its "most substantive legislative accomplishment" to date.

Considering the breadth of Bliley's effort to reduce federal red-tape and pare down federal intervention in the U.S. economy, however, his work has just begun.

Bliley has set forth an exhausting legislative agenda for the Second Session which includes

restructuring the Superfund program, reauthorizing the Securities [illegible] refining the Clean Air Act Amendments and reforming the the Food and Drug Administration's procedures for approval of food, drugs and medical devices.

Bliley's legislative program has represented a 180-degree shift for the Committee: where before Commerce was the source of many (if not most) federal rules and regulations, today the emphasis is on *lessening* federal interference with job creation, streamlining or eliminating existing bureaucracies, and removing impediments to the development and approval of new products and technologies.

Already, Bliley's efforts have borne considerable fruit. During the momentous first 100 Days of the 104th Congress, Commerce played a pivotal role in the drafting of key elements of the Republican "Contract with America," including landmark reforms of the nation's product liability and securities class action litigation rules, and sweeping new guidelines to impose common-sense restrictions on federal regulators.

Besides telecommunications reform, the Committee's accomplishments and objectives in the coming months include:

- **Preserving Medicare.** With jurisdiction over the Medicare Part "B" program, the Commerce Committee -- working together with the Ways and Means Committee -- was principally responsible for drafting legislation to preserve the Medicare system, whose bankruptcy was already projected by 2002 and today appears even closer. Although vetoed by President Clinton, Bliley's Committee spearheaded legislation to give seniors the same enhanced health care choices as younger workers while retaining the existing Medicare "fee-for-service" structure for those who desire it, with no increases in co-payments or deductibles and holding Part "B" premiums at the current 31 percent of program costs.

- **Fixing Medicaid.** With primary jurisdiction over Medicaid, Bliley has made it a priority to control the program's growth and give States wider flexibility in administration of the program, which is currently the fastest-growing entitlement in government, now costing taxpayers upwards of $160 billion a year and expanding at a rate of 10 percent annually. Although the plan called for generous but controlled increases in Medicaid funding (about 39 percent over 7 years), President Clinton vetoed the Bliley "MediGrant" proposal; Bliley has continued quiet negotiations with Democrat Representatives and a bipartisan group of Governors to give the States greater flexibility so that Medicaid will be better and more fairly managed, with improved quality. Those negotiations bore fruit on February 6, when the National Governors Association -- consisting of all Governors, Democrat and Republican alike -- unanimously approved a measure very similar to the Bliley MediGrant effort; the Chairman has already directed staff to begin working to reduce the plan to legislative language prior to early hearings when Congress reconvenes.

- **Restructuring the Securities and Exchange Commission.** Working closely with SEC Chairman Arthur Levitt, Appropriations subcommittee chairman Harold Rogers (R-KY) and Ways and Means Committee Chairman Bill Archer (R-TX), Chairman Bliley has negotiated a restructuring of the financing mechanisms for the SEC that will end the financing crises which have distracted the Commission on a nearly annual basis; under the proposal, the SEC will become subject to the normal appropriations process, and SEC filing fees will be reduced by 50 percent over 5 years. At the same time, Finance subcommittee Chairman Jack Fields (R-TX) has introduced a landmark proposal for reform of the nation's securities laws, and Rep. Dan Frisa (R-NY) has launched an effort to restructure the internal mechanisms of the Commission.

- **Securities Litigation Reform.** A 1994 venture one study, the companies surveyed that went public in 1986 had been named in a Securities Class Action law suit by 1993 -- and while 40 percent of these cases are eventually thrown out by the courts, the cost of defending these actions is massive, averaging $692,000 in legal fees and 1,055 hours of management time. The Commerce Committee crafted a measure that sharply discourages the filing of speculative "harassment"-style suits, yet protects the rights of investors victimized by fraud. After passing both Houses by lopsided, bipartisan majorities, this measure, too, received a Presidential veto, but less than 12 hours later, on December 20, 1995, Bliley handed President Clinton the first successful veto override of his Presidency, by a lopsided vote of 319-100. After the Senate joined the House in overriding the veto, the measure became law.

- **Clean Air Act Amendments Reform.** Overcoming initial White House opposition to the measures, Bliley has already secured enactment of reforms affecting two of the most potentially expensive provisions of the 1990 Clean Air Act Amendments involving mobile pollution sources. The President has signed into law reforms that eliminate the so-called "centralized auto emission testing" and "employee commute option" provisions of the Amendments. The centralized auto emission provision would have closed thousands of State-licensed, independently-owned emissions testing facilities, replacing them with a handful of federally-run centralized facilities; Bliley charged that the measure would have caused major inconvenience for the motoring public, without any appreciable increase in the accuracy of emission tests. The "employee commute option" would have created a massive federal bureaucracy to enforce "car-pooling" requirements for millions of American commuters in selected communities across the nation. A series of Oversight and Investigations subcommittee hearings have exposed additional flaws in the EPA's enforcement of the 1990 Clean Air Act Amendments and led to the EPA's April 5 withdrawal of the proposed "Enhanced Monitoring" rules for industrial pollutants; in a letter to the EPA following commencement of the hearings, a bipartisan majority of the full Commerce Committee charged that EPA had "transformed two words in the Clean Air Act Amendments - 'enhanced monitoring' - into hundreds of pages of onerous, costly regulations that ... effectively rewrite the Clean Air Act monitoring requirements."

- **Regulatory Reform.** In what could be the most significant government reform measure in decades, the Commerce Committee drafted legislation which requires federal regulators to calculate the compliance costs of new federal regulations, and balance them against the demonstrable risks those regulations are intended to avoid. The sweeping reform proposal dramatically alters the nation's regulatory process to ensure, for the first time, that the benefits of regulatory activity outweigh the compliance costs and that no other, more cost-effective or less onerous alternatives, are practical.

- **Product Liability Reform.** Between 1973 and 1988, the number of product liability lawsuits in the Federal courts increased by 1,000 percent, at an estimated cost to the U.S. economy of nearly $80 billion a year -- a sum equal to the combined profits of America's 200 largest corporations. Despite widespread popular support for reform, the powerful trial lawyers' lobby has managed to stifle all attempts to improve the system. The Commerce Committee was at the forefront of bold new reforms to the product liability system that reduce abusive lawsuits that increase prices paid by consumers and jeopardize American productivity by placing in reasonable proportion the amount of damages awarded in the lawsuits without reducing consumers' ability to sue. The measure, now in a House-Senate Conference, includes caps on punitive damages, a statute of repose to end liability claims in perpetuity, ending punitive damage claims for FDA-approved drugs and devices altogether, a bar on recovery by persons under the influence of drugs and alcohol, and a uniform nationwide statute of limitations to discourage litigants from "forum-shopping."

- **Superfund Reform.** In a widely-praised speech last month before the U.S. Conference of Mayors, Chairman Bliley has called reform of Superfund "an urban issue," citing studies which show most of the sites located in inner-city areas. His speech identified Superfund reform as a "moral imperative," and asserted that, after 10 years and the expenditure of more than $15 billion, Superfund has resulted in the cleanup of fewer than 75 toxic waste sites.

- **Oversight of the Food and Drug Administration.** The subcommittee on Oversight and Investigations has commenced a series of hearings on the FDA's approval process for medicines, medical devices and biotechnologies. The hearings have been widely credited with prompting the Administration's FDA reform proposals, and have also led FDA to grant expedited review of a revolutionary new device which will enable upwards of 20 million diabetics to test their blood sugar levels without having to directly test their blood or urine; the instrument, called a "non-invasive glucose monitor," enables users to test their blood sugar by use of infra-red light. In addition, FDA reform legislation is anticipated early this Session in Chairman Michael Bilirakis' (R-FL) Health and Environment subcommittee.

- **Food Safety Reform and Revision of the "Delaney Clause."** Chairman Bliley has expressed his desire to proceed with comprehensive hearings on food safety issues, including reform of the so-called "Delaney clause."

- **Deregulating Electric Utilities.** Chairman Bliley plans to commence hearings later this year, with the objective of sweeping deregulation of the electric utility industry, including comprehensive reforms of the Public Utility Holding Company Act and the Public Utility Regulatory Policy Act.

- **Monitoring Global Climate Change Negotiations.** The subcommittee on Energy and Power has launched two separate oversight hearings on the 1992 Rio de Janeiro Climate Treaty. On May 16, the subcommittee held the first Congressional hearing in either House on the April, 1995 "Berlin Mandate" for 20 percent reductions of greenhouse gases by developed nations by the year 2005 (without any corresponding effort by the developing nations), and the long-range impact of the Berlin negotiations on the economy and U.S. competitiveness.

- **Pipeline Safety.** The Committee has sent to the floor legislation to add risk assessment, risk management and risk prioritization requirements as part of the reauthorization of the Natural Gas Pipeline and Hazardous Liquid Pipeline Safety Acts.

- 30 -

NATIONAL CONFERENCE OF STATE LEGISLATURES

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FYI-
John Hart

MEMORANDUM

TO	Members of the NCSL Task Force on Federal Budget Negotiations
FROM	Joy Johnson Wilson Director, Health Committee
DATE	February 20, 1996
SUBJECT	Medicaid Reform

Enclosed for your information is a comparison of selected provisions of the major Medicaid reform proposals under consideration here in Washington, D.C. The last column on the chart reflects current NCSL policy.

Please note that there are a number of similarities among the proposals. Below are a few:

- Establishes limit on federal financial participation;
- Maintains entitlement status to some individuals;
- Maintains current benefit structure (Medigrant is an exception);
- Repeals the Boren Amendment (Coalition Alternative is the exception);
- Would make managed care an option, no longer requiring a federal waiver;
- Maintains current nursing home reform regulations;
- Provides for special funding for states with large numbers of undocumented aliens (Coalition Alternative is the exception);
- Establishes new limits on the Disproportionate Share Hospital (DSH) program; and
- Requires states to spend state funds to draw down federal dollars;

NCSL Policy

Briefly, this is how current NCSL policy compares to some of the major provisions.

NCSL opposes:

- Under current NCSL policy, NCSL would oppose federally established eligibility and benefits if the federal financial participation is capped.

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NCSL supports:

- Establishment of a contingency fund;
- Managed Care as an optional benefit with considerable flexibility in program operation;
- Establishment of a fund to assist states with large numbers of undocumented aliens;
- Additional flexibility for states to impose cost-sharing requirements;
- Repeal of federal requirements on provider reimbursement (Boren Amendment & cost-based reimbursement for Rural Health Centers and Federally Qualified Health Centers);
- Repeal or major revision of the Medicaid provider tax and donations law; and
- A role for state legislators on any federal Medicaid advisory board or commission.

NCSL has no position on:

- Maintenance of effort requirements;
- Benefit package specifics;
- Changing state match;
- Future of Disproportionate Share Hospital (DSH) payments;
- Changes in rights of beneficiaries to sue states regarding denial of benefits or state plan compliance (Private Right of Action);
- Distribution formula;

MEDICAID AND THE NGA RESOLUTION

- **The Medicaid "Guarantee" Has 4 Key Components:**

  1. **Financing:** Do dollars follow people? (Is the NGA financing approach acceptable policy, even within context of guarantee?)

  2. **Eligibility:** Who is covered? Are there any significant changes from current law?

  3. **Coverage:** What is covered? Is the coverage real?

  4. **Enforcement:** How is the guarantee enforced? Is it adequate to enforce the guarantee?

- **Other Outstanding Medicaid Issues Include:**

  1. **Title XIX:** NGA calls for a new title. What are implications?

  2. **Nursing Home Standards/Enforcement**

  3. **Family Financial Protections**

  4. **Quality Standards**

To Jon - FYI
Fr: Chris J

QUESTIONS ABOUT NGA MEDICAID RESTRUCTURING PROPOSAL

Eligibility: General

- Optional eligibility groups: Would States have total flexibility to define these groups (subject to a Federal ceiling on income, described in the next bullet)?

- Limits on caseload increases: Are there any limits upon Medicaid eligibility criteria or enrollment growth for the State option to expand eligibility up to 275 percent of poverty?

- Methodological issues: Would methods of determining Medicaid eligibility for non-cash groups continue to be the methods of the AFDC or SSI programs, or would States be completely free to use methods of their own devising? ("Methods" means what income and resources get counted and how.)

- Impact: How many individuals would be likely to receive Medicaid coverage under the guarantee in the NGA plan? How does this number compare with the number of individuals who are covered under current law? Would there be coverage loss and if so for which populations? How large would any such loss be?

- Coverage: How would the NGA proposal assure that insurance coverage does not decline?

Eligibility: Elderly and Disabled

Medicaid/SSI Nexus and the Elderly: NGA would limit guaranteed eligibility for SSI recipients to elderly persons who meet SSI income and resource standards.

- Would guaranteed Medicaid coverage be limited to all elderly who actually receive SSI cash payment, or, would it also include elderly persons whose income and resources are low enough but who are not receiving a payment for some other reason (e.g., no application, failure to provide necessary information)?

- Would States be allowed to continue to contract with SSA for making concurrent SSI/Medicaid eligibility determinations?

- Does the NGA proposal envision requesting changes to Federal SSI eligibility requirements?

- Would Medicaid eligibility for recipients of State cash supplementation payments continue as under current law?

- Would the 209(b) States be permitted to retain their more restrictive criteria, as under current law? (Currently there are eleven 209(b) States. While any State could convert to this status, conversions are typically from 209(b) to SSI status.)

Eligibility: Qualified Medicare Beneficiaries (QMBS) and Medicare Cost-Sharing NGA would guarantee payment of Medicare cost sharing for QMBs.

- Would the proposal follow the current law definition of "QMB" or permit State flexibility to establish eligibility criteria and methods?

- Does the term include related groups, such as Selected Low-Income Medicare Beneficiaries (SLMBs) and Qualified Disabled Working Individuals (QDWIs)?

- Would changes be made to the cost-sharing benefit that is now mandated? Or to the Federal/State matching rates for spending on cost-sharing?

Eligibility: Persons with Disabilities: NGA would allow each State to define which persons with disabilities would be guaranteed coverage in its State plan, subject review of the State definition by the Secretary and the State's willingness to spend at least 90% of the funds it had historically devoted to this population.

- Would State definitions be subject to any Federal restrictions or guidelines? For example, would they be required to use any elements of the current Federal SSI definition of disability?

- Under what criteria would the State definition of disability be reviewed by the Federal government?

- Would the Secretary be expected or permitted to develop standards to address potential inequities or inadequacies in various State definitions?

- Would low-income disabled Medicare beneficiaries (who by definition meet the Federal definition) also have to meet the State's definition in order to qualify as QMB/SLMB/QDWI?

- Would States be permitted to define disability and exclude persons with particular diagnoses (e.g., HIV, mental health, substance abuse) or other characteristics (e.g., homeless)? Similarly, would they be prohibited from using broad flexibility to define amount, duration and scope of services to limit or deny services to certain types of populations (e.g., those in urban or rural areas or Indian reservations)?

- Could states broaden the definition to cover additional persons -- including those who are now more traditionally a State responsibility?

Eligibility: 90 Percent Set-aside for Persons with Disabilities

- Would there be restrictions on how States could use the set-aside funds? Are they only for mandatory benefits?

- What kinds of spending are included in the FY 1995 base year computation? Just spending for mandatory services to mandatory eligibles who have disabilities? Or also spending for optional services and/or optional eligibles who have disabilities? (Note that a large part of long-term care spending in the base year is in optional categories.) Spending on disabled QMB/SLMB/QDWIs? Spending on persons eligible based on their disabilities or, more broadly, persons with disabilities whose eligibility is in another category, e.g. poverty-related children?

- Is the set aside dollar amount a percentage of total spending? If it is a percentage of total spending, it is applied to the total spending, DSH, etc.?

- Does the set-aside amount increase over time? By a CPI-like index? By a disabled or poverty-related person basis?

- What monitoring mechanisms would be used to ensure that the set-aside is spent as required?

- Would States be free from the current law IMD exclusion?

- Alternatively, would States be permitted to spread their set-aside funds much more broadly by covering a variety of costs for persons with disabilities who are members of families with higher incomes? Would States be permitted to use Medicaid money to pay for people to care for family members who are disabled and Medicaid-eligible?

Eligibility and Out-of-Pocket Payments: Implications for Beneficiaries' Families

- Would States be required, as they are under current law, to protect income and resources for spouses of those who are institutionalized?

- Would States be constrained in whether and how they require adult children to provide financial support to cover some or all the costs of their parents' medical, and especially long-term care, expenses?

- Would States be restricted by Federal law in any way with respect to imposing liens on beneficiaries' property, on recovering from the estates of deceased beneficiaries, or on denying benefits to people who artificially impoverish themselves by giving away assets?

- Would federal or State limits be imposed on amounts that beneficiaries may be required to contribute to the cost of their care, e.g., copayments, balance billing by providers, nursing home admission fees or contracts to pay at the higher private patient rate?

Eligibility: Families with Children

- Poverty-related pregnant women and children:

  - Would the proposal retain the current law requirement to phase in coverage of about 3 million children, aged 13-18 with incomes below 100 percent of poverty? (Under the NGA proposal, mandatory coverage of other mandatory poverty-related groups continues.)

- AFDC Families: NGA would require States to provide Medicaid to AFDC-like families in either of these two ways: (1) States could elect to cover family members meeting the State's current AFDC income and resource standards. (States with standards higher than the national average could choose to use the national average instead.) Or (2) States could cover persons eligible for AFDC under new post-welfare reform rules.

  - Would the additional administrative cost of maintaining a dual system under the first option be Federally matched?

  - Would the AFDC national average income (variation under the first option) be fixed or adjusted continually as States reduced higher current income standards to the average?

  - would current eligibles retain coverage?

  - Would new eligibility standards for State cash assistance programs under welfare reform be likely to lead to changes in Medicaid eligibility? What would those standards look like? Which groups would be most likely to lose Medicaid coverage and how many individuals would be in those groups? What would be the impacts on Medicaid spending? What would be the impact of the set-aside requirement for this population?

  - Is any Medicaid transition for families leaving cash assistance to go to work still required (or optional)? Who would it cover and how would it operate?

Benefits

- Who defines benefits? What criteria are used?
- Are there any benefit standards for optional populations?
- What happens to the Vaccines for Children Program?
- What happens to the Drug Rebate Program?
- How will the "T" in EPSDT be "redefined" -- and who will define it (Congress, Secretary, States?) Will there be comparability across states -- i.e., a uniform benefit package for all children?
- Will a minimum be established for treatment services under EPSDT -- e.g., treatment services must include all mandatory and optional services under the State plan?.
- If a Medicaid beneficiary ages out of the EPSDT program, but still needs a service related to earlier EPSDT treatment (such as immunosuppressive drugs following an organ transplant), will the beneficiary still receive the service? Will the service still be provided if the it is an optional service under the State plan?
- How will long term care options be "broadened?"
- Will there be any minimum standard for amount, duration and scope such as the current law requirement of "sufficient to achieve its purpose"?
- Will there be any service comparability or Statewideness requirements?
- Will States be allowed to vary their programs for beneficiaries within an eligibility group in different geographical locations?
- Will States still be required to provide emergency services to undocumented immigrants?

Private Right of Action

- Would all individual lawsuits be subject to new limitations on rights of action, regardless of whether they concern eligibility or a claim to benefits? If not, what distinction does this new limitation draw?

- Would the proposal restrict lawsuits under federal civil rights statutes which apply to the States, such as the Americans with Disabilities Act or Title VI?

- Could an individual provider (i.e., a physician) file a lawsuit against the State alleging violation of a civil rights statute such as the ADA?

- Would the proposed "State administrative appeals process" differ from the current State fair hearings system? If so, how?

- Do current laws exist that satisfy the requirement for States offering individuals or classes a private right of action in the State courts? If so, what are they? What are the criteria for which existing laws, if any, would satisfy this requirement?

- Would the proposal result in Congress mandating States to enact new laws to provide the right of action? If so, what would be criteria for such new laws? Is this constitutional under the Tenth Amendment?

- Currently, a federal law cause of action (for example, under Section 1983) asserting that a State plan violates Title XIX can be filed in either State court or federal court. Would Section 1983 cases continue to be litigatable, but limited only to State courts? Or does this proposal envision barring Section 1983 suits by individuals or classes, whether in federal or State courts?

- Which federal law causes of action would remain in force, if any, that could form the basis for lawsuits by beneficiaries in State court? Does this proposal intend to transfer existing federal law claims to State courts, or to extinguish certain federal law causes of action? Or does this proposal only shift the forum for adjudication of the cause of action?

- Does the proposal intend to amend Title 28 (the Judicial Code) as to jurisdiction of the federal district courts?

- Does the proposal intend to amend Title 28 as to the scope of Supreme Court review of State court decisions, to ensure ultimate federal court review?

- What remedies would be available to beneficiaries who filed actions in State courts?

- In what circumstances could the Secretary bring actions in the federal courts on behalf of individuals or classes? Based upon which causes of action? What remedies would be available in such lawsuits?

  -- By what process, and based on what standards, would the Secretary determine whether to bring such actions?

- How will individuals with disabilities be protected from these changes to right of action?

Service Delivery

- Will beneficiaries be guaranteed a choice of health plan? Will they be guaranteed a choice of provider or physician within the plan?

- Could individuals who are dually-eligible for Medicaid and Medicare coverage or QMBs be required to enroll in managed care to receive Medicaid coverage for premiums and cost-sharing for Medicare services? Could dual eligibles and QMBs be enrolled in managed care without a choice of plan?

- Will health plans be required to demonstrate adequate provider capacity to serve Medicaid enrollees? Will health plans be required to demonstrate capacity to provide specialty services needed by disabled enrollees?

- Will health plans be required to demonstrate adequate network arrangements -- i.e., primary care, specialty care, hospital services -- to deliver the full range of Medicaid-contracted services?

- Would there be any assurances that IHS, Tribal, and urban Indian programs would be able to participate as managed care providers and be the default assignment designation for Indian Medicaid eligibles?

- Are there special provisions for public-sector providers, such as community health centers and public health clinics?

- Will there be any federal access standards for Medicaid-contracting health plans (i.e., time/distance, 24-hour/7 day referrals)?

- What systems will be in place to monitor these delivery systems for underutilization, fraud and abuse or other problems? Will the Federal government have a role?

- How will the Federal government be able to ensure that Federal matching funds are being used to provide health services within these delivery systems?

- Will States be required to make payments to health plans who captitation rates are actuarially sound?
- Will the Federal government do any prospective review -- such as the current State plan amendment process -- when States choose to use alternative delivery systems?
- How will beneficiaries be protected against health plan insolvencies?
- Will plans be able to discriminate on the basis of health status?
- Will States monitor health plan marketing activities?

Managed Care Quality

- How will States ensure that beneficiaries are receiving high quality health services? Will they have any quality requirements for Medicaid-contracting health plans?
- Will States be required to develop State-level quality assurance programs for managed care systems? Will States monitor for under-utilization within capitated systems?
- Will States require plans to provide encounter data? Will States use this data to monitor utilization and outcomes?
- How will States ensure that health plans maintain grievance procedures? How will States guarantee that these procedures operate in a timely manner when beneficiaries appeal a denial of service?
- Will there be any quality requirements for primary care case management providers?
- Could the Federal government develop standards for quality assurance programs?

Provider Standards and Reimbursement

- How will FQHCs and RHCs be supported during a transition to managed care? Would there be any mechanism to appropriately recognize the unique role and needs of Tribal and urban Indian FQHCs/RHCs to continue cost-based funding beyond any transition or general elimination of such rates?

- Would current law requirements that payment rate levels ensure access and quality be repealed?

- How will the Medicare trust funds be adequately reimbursed if States can pay less than others for Medicare services? Would low-income Medicare beneficiaries be protected from balance billing?

- Will States be allowed to exempt providers (e.g., hospitals, nursing homes, home health agencies, ESRD facilities) from meeting Medicare conditions of participation?

- Will States be required to seek public comment on payment rates?

- How will quality be assured -- for ICF/MRs, for example?

- What would be the status of current hospital accreditation requirements in the Medicare statute? If states adopt something else, will hospitals be faced with two sets of processes for review/accreditation? Should Medicare's requirements be State specific?

Nursing Home Reform

- Does the NGA proposal retain the OBRA '87 standards in their entirety?

- The NGA plan gives States the flexibility to determine enforcement strategies for nursing home standards. Is the federal role in enforcement, e.g., validation surveys and the authority to sanction facilities, eliminated? If not, what is the federal role?

- How will states be paid for their enforcement activities? What modifications to the 1864 agreements/Medicaid State plan will be required?

Administration

- How much time would the Secretary have to review the State plans? What would happen if the review is not completed in a timely fashion?

- Would the current "compliance" process be used if there were Federal concerns with the State plan or some new procedure?

- Would the Secretary be responsible for ensuring uniformity of coverage among the States?

- Would there be any mechanisms to assure appropriate consultation by States with IHS, Tribes, tribal organizations, and urban Indian organizations in development of the State plan and operation of the State program?

- What would constitute substantial failure to comply with Federal statute or a State plan?

- How would HCFA's role be "streamlined" in the State plan approval process?

- What elements of the State plan would the Secretary be able to evaluate? If the plan is not adequate, would the Secretary be required to reject the entire plan?

- Would the IG and DOJ's authority to impose remedies on States that violate the statute be limited?

- What kind of authority would HCFA have to pursue reductions in waste, fraud and abuse?

- Which elements of Title XIX would be retained?

- Will the cross references to other sections of the Social Security Act be retained to ensure that general protections against fraud, abuse and waste; administration and judicial review; and the ability to carry out program research and demonstration programs are retained?

Financing: General

- The plan states that there is a maximum Federal allocation, based on the sum of four components, including the umbrella. Are the total payments nationally for states capped in legislation?

- If the national "growth rate" exceeds the cap, would all States then get lower growth than the State-specific growth rate?

Financing: State Matching Rate

- What is the new FMAP? Is it current FMAP with a higher floor, or the new FMAP in the Conference Agreement?

- If the insurance umbrella is uncapped, will this change in FMAP lead to increases in federal costs?

Financing: Base

- Will the base be recalculated each year or is there a fixed base year?
- Will umbrella payments be included in the base? Will growth due to umbrella payments be part of the calculation of estimated growth for the following year?
- Is the base calculated on total spending or per person spending?
- Are administrative costs included in the base?
- Does this plan allow the State to keep the base, plus inflation, even if it reduces enrollment? Is this different if it replaces them with 275% of poverty category? How can this be reconciled with a per person funding model?
- The NGA proposal states that "some states may require special provisions to correct anomalies in base year expenditures?" What are these provisions?
- Are DSH payments in 1993 and 1994 allowed, even if they were subject to subsequent disallowances?
- How are adjustments and disallowances treated in the base year? In future years?
- What is the rationale and impact of allowing States to choose from one of three base years? How does this affect savings? Which States are likely to pick which base year?

Financing: Inflation Growth

- Is there a cap on the growth component?
- Is growth based on *estimated* changes in caseload and not on actual changes? Are there retrospective payments?
- Is the "anticipated enrollment" the growth rate for the base year minus CPI?
- Will there be a single national growth rate each year, or different rates for different States?
- Who will calculate the growth rate: CBO, OMB, HHS, or States? When will the estimate be calculated?
- What factors are likely to be included in the growth rate formula?

- How will the formula adjust for casemix? Will there be a single, national adjustment? (i.e. will it be assumed that each State has the same mix of enrollees?) If not, how will State-specific adjustments be accounted for?

- Is the inflation factor a projection of inflation or some historical average? If it is a projection, what data will be used? What is the base of the inflation factor -- CPI, GDP, or some other measure? Will the inflation factor be adjusted? Will it be upward or downward?

- Is the anticipated growth rate applied to a base year enrollment (e.g., 1995) or the previous year's enrollment?

- Are there any special provisions for continuation of growth rates established in 1115 demonstration states?

Financing: Enrollment Growth

- What does "enrollment" mean in this context -- that beneficiaries have a Medicaid card or that they use services? Does enrollment include mandatory, current optional, and new optional (275%) people?

- For AFDC, is the actual growth based off of 1995 current mandatory people? What happens if a State switches to a new eligibility system that gives more people lower AFDC benefits -- are all of those new people counted toward the actual enrollment growth?

- When would estimates of case load be done? Are they adjusted through the year?

Financing: Insurance Umbrella

- Is Federal spending capped or is it open ended? If capped, how much Federal funding would there be?

- Is the insurance umbrella capped? If so, how much will be in the umbrella pool? Is the pool solely federally funded? What will happen if the pool amount is not sufficient to meet State needs?

- Why is the umbrella fund only available for mandatory groups and persons with disabilities and the elderly?

- What groups are eligible for umbrella payments? Why is the umbrella fund only available for mandatory groups and persons with disabilities and the elderly?

- Are umbrella funds only available for the fiscal year when "excess" growth occurs?

- Since States may use their own definitions of "disability," could they choose to define disability broadly and thereby expand access to the insurance umbrella funds? (Note: This problem could be intensified because States also determine amount, duration and scope of services.)

- How does the financing of the umbrella actually work? When do payments and reconciliation occur?

- How does the NGA plan address the incentive for States to underestimate caseload growth so they can tap into the umbrella pool?

- Will some States (i.e., high expenditure States) be able to access the umbrella fund easier than others?

- Is the adjuster a one-time/one year adjuster, or is it built into the state's base for future years? Does the State have to absorb the cost of prior year's growth (in beneficiaries or inflation), or does it get continuing adjustments?

- Insurance umbrella funds are "guaranteed on a per-beneficiary basis for populations not included in the estimates of the base and the growth." How would this determination be made?

- How does the proposal prevent a State from slowing enrollment and payments until the next fiscal year thereby increasing its access to the umbrella fund in the following year?

- The plan requires that a State must "have used up other available base and growth funds" in order to have access to the umbrella funds. How would this be implemented by the State or federal government during the course of the year?

- Does the expression "must have used up other available base and growth funds" mean only that the State must have spent up to its cap? Must all Federal funds in previous years have been used up also?

- What does "demonstrable need" mean in this context?

- Does the capitated amount vary depending on what State you are in? If there is a national estimate, won't this lead to a substantial redistribution of growth from high cost states (NY especially)? Will low cost states receiving higher adjuster have to actually spend more on Medicaid to get their new amount?

Financing: Special Grants

- How will the allocation of special grant funds be determined?
- What mechanism is there for State accountability for special grant expenditures?
- Would special grant amounts count toward a State's overall Federal funding limit?
- How large would these funds be? Would the amount change over time to allow for inflation, growth in enrollment, or other factors? How do these amounts relate to the total amount of funding currently spent on these services? Would the funds exist temporarily or permanently? How would these funds be allocated across States?
- What services would States be allowed to provide using the funds from the special fund for undocumented immigrants? Would States still be limited (as they are under current Federal law) to using Federal funds only to pay for emergency health care services, including emergency labor and delivery of a child?
- How would States determine the immigration status and Medicaid eligibility of undocumented persons? Would States still be required to use the two-part SAVE process for verifying immigration status with INS?
- How would IHS facilities would be treated? Would the money now spent on Medicaid services by IHS owned or leased facilities (for which States currently receive 100 percent Federal reimbursement) be moved to the special fund account, or would those funds still count in a State's base, with the special grant as "new money"? If the current spending is included in the State's base, what assurances would there be that it would continue to be used to meet the needs of under-served American Indians and Alaska Natives (AI/AN)?
- Would the special grant funds be limited to IHS owned or leased facilities, or could they also be used to cover services provided by Tribal and urban Indian facilities? Could they also be used to cover services provided to Indian people by non-Indian health providers?
- Would the amount of special grant funding be adequate to pay for all services to Medicaid eligibles by whichever providers are covered? Would it be increased in future years to allow for corrections to the current under-enrollment of Indian people who are eligible for Medicaid?

- What protections are there for equal protection for services to Indian people, on the grounds that they are eligible for IHS services, even though they are legal residents of a State and otherwise eligible for Medicaid on the same basis as other legal residents of the State?

Provider Taxes and Donations

- Are any protections against excessive gaming of the federal payments to the State using provider donations and taxes, disproportionate share payments, etc. included in this plan?

- Repealing all tax/donation limitations is likely to increase the federal share of costs substantially because states will be able to generate State share through provider financing. Has the increase in federal costs been estimated?

Disproportionate Share Hospital Program

- Are DSH payments subject to growth rates?

- The plan says that States must use DSH funds to pay for care for low-income persons. How will this provision be enforced?

- It appears that the restriction on DSH limitation to 100% of costs is removed. Is any other similar provision put in its place?