JAN - FYI

MEMORANDUM

TO: Carol R. February 12, 1996

FR: Chris J.

RE: Disability Current Law Language/Regulations and an Alternative

Following up on your request, I am enclosing background information on current law and regulatory oversight of Medicaid disability determinations/eligibility/etc. Attached you will find:

- The Green Book two-page summary of SSI disability benefits.
- The statutory language that provides for current definition/eligibility of different disability categories. (There are more than 50 pages of language dedicated to the SSI statute; I provided you with the pages I thought you might find most relevant.)
- The regulations that back-up the statutory language, with an attached sample of how one category is actually implemented.
- An English language version of how the welfare reform folks took care of disability designation problem -- redifining the eligibility section, but still retaining the Federal statutory foundation.
- A possible statutory insert that we could use for Medicaid as well to deal with the concerns about "alcoholics", "drug addicts", and Zebley kids. This section obviously needs work, but probably would not be too difficult to do.

Hope this information is useful. Please call me with questions.

Green Book

Section 6. SSI Program Description

The Supplemental Security Income (SSI) program is a means-tested, federally administered income assistance program authorized by title XVI of the Social Security Act. Established by the 1972 amendments to the Social Security Act (Public Law 92–603) and begun in 1974, SSI provides monthly cash payments in accordance with uniform, nationwide eligibility requirements to needy aged, blind and disabled persons. The SSI program replaced the former Federal grants to the States for old-age assistance, aid to the blind and aid to the permanently disabled. These grants continue in Guam, Puerto Rico and the Virgin Islands. SSI, however, operates in the Commonwealth of the Northern Mariana Islands.

Table 6–1 summarizes the trends in the SSI program since its inception in 1974:

(1) The number of recipients on SSI has risen from nearly 4 million in 1974 to nearly 6 million in December 1993. The number of SSI recipients declined early in the program as the number of aged individuals on SSI declined, but that trend reversed in the mid-1980s as rapid growth in disabled recipients outstripped the minimal change in the elderly and blind SSI populations. From 1984 through 1993, the disabled population on SSI grew at an annual average rate of about 9.2 percent.

(2) Total annual benefits paid under the SSI program rose at an average rate of 7.9 percent from about $5.3 billion in 1974 to $23.6 billion in 1993. After adjusting for inflation, however, total annual benefits rose by an annual average rate of 2.2 percent.

(3) The monthly Federal benefit rates for individuals and couples rose from $140 and $210 in 1074 to $446 and $669 in 1994, respectively. Nearly all of these changes resulted from the statutory indexation of the Federal benefit rates to the Consumer Price Index (CPI).

(4) The proportion of SSI recipients receiving Social Security benefits declined from nearly 53 percent in 1974 to about 40 percent in 1993. The fraction of SSI recipients receiving some other type of unearned income rose from about 11 percent in 1974 to 13 percent in 1993, and the fraction with earnings jumped from about 3 percent in 1974 to more than 4 percent in December 1993.

(5) The Federal benefit rate as a percent of the appropriate poverty level for individuals has ranged from 72 to 77 percent and is currently 75 percent; for couples it has ranged from 86 to 91 percent and is currently at 89.5 percent. Most States supplement the Federal benefit for at least some participants.

(6) The SSI program pays benefits to children who are blind or have other disabilities. Some of the increases in participation since 1991 reflect the revised definition of disability for

children as a result of the Supreme Court's decision in the *Sullivan* v. *Zebley* case.

BASIC ELIGIBILITY

To qualify for SSI payments, a person must satisfy the program criteria for age, blindness or disability. The aged are defined as persons 65 years and older. The blind are individuals with 20/200 vision or less with the use of a correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less. Disabled individuals are those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months.

Also, a child under age 18 who has an impairment of comparable severity with that of an adult may be considered disabled. On February 20, 1990, the Supreme Court affirmed the Court of Appeals (Third Circuit) decision in *Sullivan* v. *Zebley*. As a result, SSA is completing a reevaluation of childhood disability claims for SSI benefits which were denied because the child's functional limitations were not considered in making the decision on the severity of the impairment. Federal regulations that revise the disability evaluation and determination process for SSI claims of disabled children (i.e., implementing the *Zebley* decision) were issued in February 1991.

A person also must be needy, i.e., have limited income and resources (discussed later) to be eligible for SSI. However, disabled SSI recipients whose incomes exceed the limits because of earnings but who continue to be medically disabled, may continue to be eligible for Medicaid. In addition, to qualify for SSI, a person must (1) be a U.S. citizen or an immigrant lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law and, (2) be a resident of the United States or the Northern Mariana Islands, or a child of military personnel stationed outside the United States.

for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.

Funds Set Aside for Burial Expenses

(d)(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Secretary finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a), he shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Secretary may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

MEANING OF TERMS

Aged, Blind, or Disabled Individual

SEC. 1614. [42 U.S.C. 1382c] (a)(1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i)[40] is a resident of the United States, and is either (I)[41] a citizen or (II)[42] an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or section 212(d)(5) of the Immigration and Nationality Act[43]), or[44]

(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title.[45]

(2) An individual shall be considered to be blind for purposes of this title if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this title if he is blind as defined under a State plan approved under title X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in

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[40] P.L. 101-239, §8009(b)(1)(B), inserted "(i)".
[41] P.L. 101-239, §8009(b)(1)(A), redesignated clause (i) as subclause (I).
[42] P.L. 101-239, §8009(b)(1)(A), redesignated clause (ii) as subclause (II).
[43] P.L. 82-414.
[44] P.L. 101-239, §8009(b)(1)(C), struck out the period and substituted ", or".
[45] P.L. 101-239, §8009(b)(2), added clause (ii), applicable with respect to benefits for months after March 1990.

the region where such individual lives or in several regions of the country.

(C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(D) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria shall be found not to be disabled.

(E) Notwithstanding the provisions of subparagraphs (A) through (D), an individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

(F) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(G) In making determinations with respect to disability under this title, the provisions of sections 221(h), 221(k), and 223(d)(5) shall apply in the same manner as they apply to determinations of disability under title II.

(H) In making any determination under this title with respect to the disability of a child who has not attained the age of 18 years and to whom section 221(h) does not apply, the Secretary shall make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the disability of the child (as determined by the Secretary) evaluates the case of such child.**

**P.L. 101-508, §5036(a), added subparagraph (H), applicable to determinations made 6 or more months after November 5, 1990.

(4) A recipient of benefits based on disability under this title may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) substantial evidence which demonstrates that—

(i) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity; or

(B) substantial evidence (except in the case of an individual eligible to receive benefits under section 1619) which—

(i) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(I) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity, or

(ii) demonstrates that—

(I) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity; or

(C) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(D) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this paragraph shall be construed to require a determination that an individual receiving benefits based on disability under this title is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of his or her entitlement or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity. Any determination under this paragraph shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Secretary. Any determination made

under this paragraph shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled.

Eligible Spouse

(b) For purposes of this title, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits or requests restoration of eligibility under this title during the month, at the time the application or request is filed.[a] If two aged, blind, or disabled individuals are husband and wife as described in the preceding sentence, only one of them may be an "eligible individual" within the meaning of section 1611(a).

Definition of Child

(c) For purposes of this title, the term "child" means an individual who is neither married nor (as determined by the Secretary) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-two and (as determined by the Secretary) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

Determination of Marital Relationships

(d) In determining whether two individuals are husband and wife for purposes of this title, appropriate State law shall be applied; except that—

(1) if a man and woman have been determined to be husband and wife under section 216(h)(1) for purposes of title II they shall be considered (from and after the date of such determination or the date of their application for benefits under this title, whichever is later) to be husband and wife for purposes of this title, or

(2) if a man and woman are found to be holding themselves out to the community in which they reside as husband and wife, they shall be so considered for purposes of this title notwithstanding any other provision of this section.

United States

(e) For purposes of this title, the term "United States", when used in a geographical sense, means the 50 States and the District of Columbia.

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[a] P.L. 101-239, §8012(a), struck out "For purposes of this title, the term 'eligible spouse' means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months." and substituted this sentence, effective October 1, 1990.

Overall

quired unless a statistically valid quality control sample has shown that a State's determination of age procedures do not yield an acceptable low rate of error.

§416.803 Type of evidence to be submitted.

Where an individual is required to submit evidence of date of birth as indicated in §416.801, he shall submit a public record of birth or a religious record of birth or baptism established or recorded before his fifth birthday, if available. Where no such document recorded or established before age 5 is available the individual shall submit as evidence of age another document or documents which may serve as the basis for a determination of the individual's date of birth provided such evidence is corroborated by other evidence or by information in the records of the Administration.

§416.804 Evaluation of evidence.

Generally, the highest probative value will be accorded to a public record of birth or a religious record of birth or baptism established or recorded before age 5. Where such record is not available, and other documents are submitted as evidence of age, in determining their probative value, consideration will be given to when such other documents were established or recorded, and the circumstances attending their establishment or recordation. Among the documents which may be submitted for such purpose are: school record, census record, Bible or other family record, church record of baptism or confirmation in youth or early adult life, insurance policy, marriage record, employment record, labor union record, fraternal organization record, military record, voting record, vaccination record, delayed birth certificate, birth certificate of child of applicant, physician's or midwife's record of birth, immigration record, naturalization record, or passport.

§416.804 Certified copy in lieu of original.

In lieu of the original of any record, except a Bible or other family record, there may be submitted as evidence of age a copy of such record or a statement as to the date of birth shown by such record, which has been duly certified (see §404.701(g) of this chapter).

§416.805 When additional evidence may be required.

If the evidence submitted is not convincing, additional evidence may be required.

§416.806 Expedited adjudication based on documentary evidence of age.

Where documentary evidence of age recorded at least 3 years before the application is filed, which reasonably supports an aged applicant's allegation as to his age, is submitted, payment of benefits may be initiated even though additional evidence of age may be required by §§416.801 through 416.805. The applicant will be advised that additional evidence is required and that, if it is subsequently established that the prior finding of age is incorrect, the applicant will be liable for refund of any overpayment he has received. If any of the evidence initially submitted tends to show that the age of the applicant or such other person does not correspond with the alleged age, no benefits will be paid until the evidence required by §§416.801 through 416.805 is submitted.

Subpart I—Determining Disability and Blindness

AUTHORITY: Secs. 1102, 1611, 1614(a), 1619, 1631 (a), (c), and (d)(1), and 1633 of the Social Security Act; 42 U.S.C. 1302, 1382, 1382c(a), 1382h, 1383 (a), (c), and (d)(1), and 1383b; secs. 2, 5, 6, and 16 of Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808.

SOURCE: 45 FR 55621, Aug. 20, 1980, unless otherwise noted.

GENERAL

§416.901 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness you must be disabled or blind as defined in title XVI of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability or blindness determinations and state that dis-

ability and blindness determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§416.905 through 416.910.

(c) Sections 416.912 through 416.918 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability for adults filing new applications are stated in §§416.920 through 416.922. We describe the steps that we go through and the order in which they are considered.

(e) Our general rules on evaluating disability for children filing new applications are stated in §§416.924 through 416.924e.

(f) Our rules on medical considerations are found in §§416.925 through 416.930. We explain in these rules—

(1) The purpose and use of the Listing of Impairments found in appendix 1 of subpart P of part 404 of this chapter;

(2) What we mean by the term *medical equivalence* and how we determine medical equivalence;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work, and how we apply the rule.

(g) In §§416.931 through 416.934 we explain that we may make payments on the basis of presumptive disability or presumptive blindness.

(h) In §§416.935 through 416.939 we explain the rules which apply in cases of drug addiction and alcoholism.

(i) In §§416.945 through 416.946 we explain what we mean by the term *residual functional capacity*, state when an assessment of residual functional capacity is required, and who may make it.

(j) Our rules on vocational considerations are found in §§416.960 through 416.969a. We explain when vocational factors must be considered along with the medical evidence, discuss the role of residual functional capacity in evaluating your ability to work, discuss the vocational factors of age, education, and work experience, describe what we mean by work which exists in the national economy, discuss the amount of exertion and the type of skill required for work, describe how the Guidelines in appendix 2 of subpart P of part 404 of this chapter apply to claims under part 416, and explain when, for purposes of applying the Guidelines in appendix 2, we consider the limitations or restrictions imposed by your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both.

(k) Our rules on substantial gainful activity are found in §§416.971 through 416.974. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(l) In §§416.981 through 416.985 we discuss blindness.

(m) Our rules on when disability or blindness continues and stops are contained in §§416.986 and 416.988 through 416.998. We explain what your responsibilities are in telling us of any events that may cause a change in your disability or blindness status, when you may have a trial work period, and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in determining whether you are still disabled.

[45 FR 55621, Aug. 20, 1980, as amended at 50 FR 50136, Dec. 6, 1985; 56 FR 3553, Feb. 11, 1991; 56 FR 57944, Nov. 14, 1991]

§416.902 General definitions and terms for this subpart.

As used in this subpart—

Adult means a person who is age 18 or older.

Child means a person who has not attained age 18.

Medical sources refers to treating sources, sources of record, and consultative examiners for us. See §416.913.

Secretary means the Secretary of Health and Human Services.

Source of record means a hospital, clinic or other source that has provided you with medical treatment or evaluation, as well as a physician or psychologist who has treated or evaluated you but does not have or did not have an ongoing treatment relationship with you.

State agency means that agency of a State which has been designated by the State to carry out the disability or blindness determination function.

Treating source means your own physician or psychologist who has provided you with medical treatment or evaluation and who has or has had an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with a physician or psychologist when the medical evidence establishes that you see or have seen the physician or psychologist with a frequency consistent with accepted medical practice for the type of treatment and evaluation required for your medical condition(s). We may consider a physician or psychologist who has treated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment is typical for your condition(s). We will not consider a physician or psychologist to be your treating physician if your relationship with the physician or psychologist is not based on your need for treatment, but solely on your need to obtain a report in support of your claim for benefits. In such a case, we will consider the physician or psychologist to be a consulting physician or psychologist.

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You refers to the person who has applied for or is receiving benefits based on disability or blindness.

[56 FR 30662, Aug. 1, 1991, as amended at 58 FR 47677, Sept. 9, 1993]

Determinations

§416.903 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Secretary for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Secretary may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart J of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for the Secretary for—

(1) Any person living in a State which is not making for the Secretary any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and

(2) Any person living outside the United States.

(c) *What determinations are authorized.* The Secretary has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;

(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Initial determinations for mental impairments.* An initial determination by a State agency or the Social Security Administration that you are not disabled (or a Social Security Administra-

tion review of a State agency's initial determination), in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See § 416.1016 for the qualifications we consider necessary for a psychologist to be a psychological consultant and § 416.1017 for what we consider *reasonable effort*.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Secretary may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant other than a qualified psychologist unless the mental impairment alone would justify a finding of disability.

(f) *Determinations for childhood impairments.* In making a determination under title XVI with respect to the disability of a child to whom paragraph (e) of this section does not apply, we will make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the child's impairment(s) evaluates the case of the child.

[46 FR 29011, May 29, 1981, as amended at 52 FR 33927, Sept. 9, 1987; 58 FR 47577, Sept. 9, 1993]

§ 416.903a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who until a final determination is made has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§ 416.919 and 416.919g(b).

[56 FR 36960, Aug. 1, 1991]

§ 416.904 Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

Definition of Disability

§ 416.905 Basic definition of disability for adults.

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience (see § 416.920).

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 416.981 through 416.985.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5542, Feb. 11, 1991]

§416.906 Basic definition of disability for children.

If you are under age 18, we will consider you disabled if you are suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over age 18) disabled. We discuss our rules for determining disability in children in §§416.924, and 416.924a through 416.924e.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 5533, Feb. 11, 1991]

§416.907 Disability under a State plan.

You will also be considered disabled for payment of supplemental security income benefits if—

(a) You were found to be permanently and totally disabled as defined under a State plan approved under title XIV or XVI of the Social Security Act, as in effect for October 1972;

(b) You received aid under the State plan because of your disability for the month of December 1973 and for at least one month before July 1973; and

(c) You continue to be disabled as defined under the State plan.

§416.908 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see §416.927). (See §416.928 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 36963, Aug. 1, 1991]

§416.909 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§416.910 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See §416.972 for further details about what we mean by substantial gainful activity.)

§416.911 Definition of disabling impairment.

A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter or which, when considered with your age, education and work experience, would result in a finding that you are disabled under §416.994. In determining whether you have a disabling impairment, earnings are not considered.

[50 FR 50137, Dec. 6, 1985]

Evidence

§416.912 Evidence of your impairment.

(a) *General.* In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

(b) *What we mean by "evidence."* Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. This includes, but is not limited to:

(1) Objective medical evidence, that is, medical signs and laboratory findings as defined in §416.928 (b) and (c);

(2) Other evidence from medical sources, such as medical history, opinions, and statements about treatment you have received;

(3) Statements you or others make about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements you make to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings;

(4) Information from other sources, as described in § 416.913(e);

(5) Decisions by any governmental or nongovernmental agency about whether you are disabled or blind; and

(6) At the administrative law judge and Appeals Council levels, certain findings, other than the ultimate determination about whether you are disabled, made by State agency medical or psychological consultants and other program physicians or psychologists, and opinions expressed by medical advisors based on their review of the evidence in your case record. See § 416.927(f) (2) and (3).

(c) *Your responsibility.* You must provide medical evidence showing that you have an impairment(s) and how severe it is during the time you say that you are disabled. If we ask you, you must also provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other factors showing how your impairment(s) affects your ability to work. In §§ 416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors.

(d) *Our responsibility.* Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

(1) "Every reasonable effort" means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(2) By "complete medical history," we mean the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe that your disability began earlier.

(e) *Recontacting medical sources.* When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.

(1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating

...g your medical source. In every instance where medical evidence is obtained over the telephone, the telephone report will be sent to the source for review, signature and return.

(2) We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings.

(f) *Need for consultative examination.* If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See §§ 416.917 through 416.919t for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

[56 FR 36935, Aug. 1, 1991]

§ 416.913 Medical evidence of your impairment.

(a) *Acceptable sources.* We need reports about your impairments from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Licensed or certified psychologists;

(4) Licensed optometrists for the measurement of visual acuity and visual fields (see paragraph (f) of this section for the evidence needed for statutory blindness); and

(5) Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanitorium, medical institution, or health care facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Social Security Administration, Veterans' Administration, or State agency. However, we will not return an uncertified copy or summary for certification unless there is some question about the document.

(6) A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is also considered acceptable medical evidence.

(b) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See § 416.927.

(c) *Statements about what you can still do.* Statements about what you can still do (based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed below. See §§ 416.927 and 416.945(c).

(1) The medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Secretary may waive compliance with the entitlement and payment requirements for disabled beneficiaries to carry our experiments and demonstration projects in the title II disability program. The projects involve altering certain limitations and conditions that currently apply to applicants and beneficiaries to test their effect on the program.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experiment or demonstration project, we may temporarily set aside one or more of the current benefit entitlement or payment requirements, limitations or conditions and apply alternative provisions to you. We may also modify current methods of administering the Act as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not disadvantage you in contrast to current provisions, procedures or policies. If you are not selected to participate in the experiments or demonstration projects, (or if you are placed in a control group which is not subject to alternative requirements and methods) we will continue to apply to you the current benefit entitlement and payment requirements, limitations and conditions and methods of administration in the title II disability program.

(2) *Alternative provisions or methods of administration.* The alternative provisions or methods of administration that apply to you in an experiment or demonstration project may include (but are not limited to) one or more of the following:

(i) Reducing your benefits (instead of not paying) on the basis of the amount of your earnings in excess of the SGA amount;

(ii) Extending your benefit eligibility period that follows 9 months of trial work, perhaps coupled with benefit reductions related to your earnings;

(iii) Extending your Medicare benefits if you are severely impaired and return to work even though you may not be entitled to monthly cash benefits;

(iv) Altering the 24-month waiting period for Medicare entitlement; and

(v) Stimulating new forms of rehabilitation.

(d) *Selection of participants.* We will select a probability sample of participants for the work incentive experiments and demonstration projects from newly awarded beneficiaries who meet certain pre-selection criteria (for example, individuals who are likely to be able to do substantial work despite continuing severe impairments). These criteria are designed to provide large subsamples of beneficiaries who are not likely either to recover medically or die. Participants may also be selected from persons who have been receiving DI benefits for 6 months or more at the time of selection.

(e) *Duration of experiments and demonstration projects.* A notice describing each experiment or demonstration project will be published in the FEDERAL REGISTER before each experiment or project is placed in operation. The work incentive experiments and rehabilitation demonstrations will be activated in 1982. A final report on the results of the experiments and projects is to be completed and transmitted to Congress by June 9, 1993. However, the authority for the experiments and demonstration projects will not terminate at that time. Some of the alternative provisions or methods of administration may continue to apply to participants in an experiment or demonstration project beyond that date in order to assure the validity of the research. Each experiment and demonstration project will have a termination date (up to 10 years from the start of the experiment or demonstration project).

[48 FR 7575, Feb. 23, 1983, as amended at 52 FR 37635, Oct. 8, 1987; 55 FR 51687, Dec. 17, 1990]

APPENDIX 1 TO SUBPART P—LISTING OF IMPAIRMENTS

The body system listings in parts A and B of the Listing of Impairments will no longer be effective on the following dates unless extended by the Secretary or revised and promulgated again.

1. Growth Impairment (100.00): December 8, 1996.

2. Musculoskeletal System (1.00 and 101.00): June 6, 1996.

2. Special Senses and Speech (2.00 and 102.00): December 6, 1996.

3. Respiratory System (3.00 and 103.00): October 7, 2000.

4. The cardiovascular system listings (4.00 and 104.00) within 4 years. Consequently, the listings in this body system will no longer be effective on February 10, 1998.

5. Digestive System (5.00 and 105.00): December 5, 1997.

7. Genito-Urinary System (6.00 and 106.00): December 5, 1997.

8. Hemic and Lymphatic System (7.00 and 107.00): December 6, 1995.

9. Skin (8.00): June 6, 1997.

10. Endocrine System and Obesity (9.00) and Endocrine System (109.00): June 6, 1997.

11. Multiple Body Systems (110.00): July 2, 1998.

12. Neurological (11.00 and 111.00): June 5, 1998

13. Mental Disorders (12.00): August 28, 1995.

14. Mental Disorders (112.00): December 13, 1995.

15. Neoplastic Diseases, Malignant (13.00 and 113.00): December 6, 1995.

16. Immune System (14.00 and 114.00): July 2, 1998.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.
1.00 Musculoskeletal System.
2.00 Special Senses and Speech.
3.00 Respiratory System.
4.00 Cardiovascular System.
5.00 Digestive System.
6.00 Genito-Urinary System.
7.00 Hemic and Lymphatic System.
8.00 Skin.
9.00 Endocrine System and Obesity.
10.00 [Reserved]
11.00 Neurological.
12.00 Mental Disorders.
13.00 Neoplastic Diseases, Malignant.
14.00 Immune System.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine*, associated with vertebrogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms. The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00–11.18.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of strophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising

test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion* are based on the techniques described in the "Joint Motion Method of Measuring and Recording," published by the American Academy of Orthopedic Surgeons in 1965, or the "Guides to the Evaluation of Permanent Impairment—The Extremities and Back" (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either:

1. Positive serologic test for rheumatoid factor; or

2. Antinuclear antibodies, or

3. Elevated sedimentation rate; or

4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip, knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint. If return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 *Arthritis of one major joint in each of the upper extremities (due to any cause):*

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, excluding scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 *Disorders of the spine:*

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral position, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus pulposus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

SSI Drug Addict and Alcoholic (DA&A) Provisions

BACKGROUND AND CURRENT LAW

- SSI disability rolls associated with drug addiction and alcoholism have grown substantially. At the end of 1989, approximately 17,000 qualified under this category; by 1993 this had grown to approximately 70,000 individuals receiving SSI benefits based on a DA & A disability determination, and as of May 1995 the figure was about 110,000.

- Program was revised in 1994 to place time limitiations (36 months) on SSI benefits to drug addicts and alcoholics.

- Medicaid eligibility continues as long as terminated beneficiary continues to be disabled.

NEW CONGRESSIONAL PROPOSALS

- Included in Reconciliation Bill (Sec. 12201), eliminates all SSI benefits for DA&A, Medicaid is block granted in Reconciliation Bill.

- Provision moved from freestanding Welfare Reform Bill to the Senior Citizens Right to Work Act of 1995 (H.R.2684), passed the House, put on the calendar in the Senate (S.1466). Eliminates all SSI benefits for DA&A, and does not preserve Medicaid eligibility. Same changes made to benefits under OASDI and Medicare.

- Both the Reconciliation Bill and H.R. 2684 proposed some funding ($50 - $100 million) in FY 1997 and FY 1998 within the Public Health Service (PHS) for substance abuse treatment.

ESTIMATES

- See attached highlighted 11/21/95 table from CBO on dollars for Senior Citizens Right to Work Act of 1995. CBO shows cost and people numbers for both SSI and Medicaid, as well as OASDI and Medicare.

- For baseline purposes, CBO estimates that DA&A caseload in SSI would grow to about 160,000 in 1996 and to about 200,000 in 2002. Both CBO and SSA (see attached tables) estimate that only about 50,000 people would ultimately be thrown off the rolls since a significant portion (CBO on average assumes about 75 percent) would requalify based on other disabilities (e.g., mental illness).

Prepared by: SStephens: OASPE, 1/18/95

SSI CHILDREN'S DISABILITY PROVISIONS

BACKGROUND

- Since 1989, SSI children's disability rolls have grown substantially, from almost 300,000 to 935,000 by the end of 1995, accounting for a larger portion of the SSI rolls -- up from 6.5 percent to 14.2 percent during that same 5 year period

- Most of the growth is thought to be due to a number of factors including:
  --Outreach program targeted to poor blind and disabled children;
  --Revised medical standards for assessing mental impairments in children which added to the listings such impairments as attention deficit hyperactivity disorder, personality and mood disorders;
  --New individualized functional assessment (IFA) resulting from the Supreme Court Zebley decision which substantially expanded eligibility for children who did not meet SSA's medical listing criteria.

NEW CONGRESSIONAL PROPOSALS

- The Reconciliation Bill and the Welfare Reform conference agreement (H.R. 4) proposed a number of changes in the children's SSI program including:
  --eliminating the IFA process
  --eliminating from the Social Security Regulations references to maladaptive behavior
  --creating a two tiered system of cash benefits, in which a 100 percent of present law benefit rate would continue for children who would require specialized care outside the home unless the child were receiving person assistance (criteria specified in statute); disabled children not meeting the criteria would receive a 75 percent cash benefit.

- The Senate passed version of the Welfare Reform Bill eliminated the IFA process and maladaptive behavior but it did not create a two tier system of cash benefits. This approach to SSI has been endored by the President and Senator Dashle.

ESTIMATES

- SSA estimates that these changes would ultimately remove by 1997 approximately 190,000 children (or 20 percent) from the rolls; (some children currently qualified under the IFA process would upon appeal and further case development qualify under the listings); for purposes of estimating 2002 impacts SSA uses a range of 315,000 - 320,000 at the reduction in the average number of children receiving Federal SSI benefits, or about 25 percent reduction.

- CBO estimated Medicaid savings (see attached 12/21/95 table) associated with this change of $20 million in 1997 rising to $55 million by 2002, for a seven year total savings of $230 million.

Prepared by: SStephens: OASPE, 1/22/95

SSI/Disabil Alcohol/Drugs

(2) Disregard of trust funds. Section 1613(a) (42 U.S.C. 1382b(a)) is amended

(A) by striking ''and'' at the end of paragraph (10),

(B) by striking the period at the end of paragraph (11) and inserting ''; and'', and

(C) by inserting after paragraph (11) the following:

''(12) all amounts deposited in, or interest credited to, a dedicated savings account described in section 1631(a)(2)(B)(xiv).''.

(3) Effective date. The amendments made by this subsection shall apply to payments made after the date of the enactment of this Act.

SEC. 5604. DENIAL OF SUPPLEMENTAL SECURITY INCOME BENEFITS BY REASON OF DISABILITY TO DRUG ADDICTS AND ALCOHOLICS.

(a) In General. Section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)) is amended by adding at the end the following:

''(I) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.''.

(b) REPRESENTATIVE PAYEE REQUIREMENTS.

(1) Section 1631(a)(2)(A)(ii)(II) of the Social Security Act (42 U.S.C. 1383(a)(2)(A)(ii)(II)) is amended to read as follows:

> ''(II) In the case of an individual eligible for benefits under this title by reason of disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition that prevents the individual from managing such benefits."

(2) Section 1631(a)(2)(B)(vii) of that Act (42 U.S.C. 1383(a)(2)(B)(vii)) is amended by striking ''eligible for benefits'' and all that follows through ''is disabled'' and inserting ''described in subparagraph (A)(ii)(II)''.

SSI Disability Children

Subtitle F_SSI Reform

Title V, Subtitle F

SEC. 5601. DEFINITION AND ELIGIBILITY RULES.

(a) Definition of Childhood Disability._Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)) is amended_

(1) in subparagraph (A), by striking ''An individual'' and inserting ''Except as provided in subparagraph (C), an individual'';

(2) in subparagraph (A), by striking ''(or, in the case of an individual under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)'';

(3) by redesignating subparagraphs (C) through (H) as subparagraphs (D) through (I), respectively;

(4) by inserting after subparagraph (B) the following new subparagraph:

''(C) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.''; and

(5) in subparagraph (F), as so redesignated by paragraph (3) of this subsection, by striking ''(D)'' and inserting ''(E)''.

(b) Changes to Childhood SSI Regulations._

(1) Modification to medical criteria for evaluation of mental and emotional disorders._The Commissioner of Social Security shall modify sections 112.00C.2. and 112.02B.2.c.(2) of appendix 1 to subpart P of part 404 of title 20, Code of Federal Regulations, to eliminate references to maladaptive behavior in the domain of personal/behavioral function.

(2) Discontinuance of individualized functional assessment._The Commissioner of Social Security shall discontinue the individualized

functional assessment for children set forth in sections 416.924d and 416.924e of title 20, Code of Federal Regulations.

(c) Effective Date; Regulations; Application to Current Recipients.—

(1) In general.—The amendments made by subsections (a) and (b) shall apply to applicants for benefits for months beginning on or after January 1, 1997.

(2) Regulations.—The Commissioner of Social Security shall issue such regulations as the Commissioner determines to be necessary to implement the amendments made by subsections (a) and (b), not later than January 1, 1997.

(3) Application to current recipients.—

(A) Eligibility determinations.—Beginning on January 1, 1997, and ending not later than January 1, 1998, the Commissioner of Social Security shall redetermine the eligibility of any individual under age 18 who is receiving supplemental security income benefits based on a disability under title XVI of the Social Security Act as of the date of the enactment of this Act and whose eligibility for such benefits may terminate by reason of the amendments made by subsection (a) or (b). With respect to any redetermination under this subparagraph—

(i) section 1614(a)(4) of the Social Security Act (42 U.S.C. 1382c(a)(4)) shall not apply;

(ii) the Commissioner of Social Security shall apply the eligibility criteria for new applicants for benefits under title XVI of such Act;

(iii) the Commissioner shall give such redetermination priority over all continuing eligibility reviews and other reviews under such title; and

(iv) such redetermination shall be counted as a review or redetermination otherwise required to be made under section 208 of the Social Security Independence and Program Improvements Act of 1994 or any other provision of title XVI of the Social Security Act.

(B) Notice.—Not later than 90 days after the date of the enactment of this Act, the Commissioner of Social Security shall notify an individual described in subparagraph (A) of the provisions of this paragraph.

SEC. 5602. ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.

DRAFT

2-16-96

COMPARISON OF MEDICAID PLANS

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
STRUCTURE	Block grant New title of Social Security Act	Block grant and insurance umbrella for unexpected excess enrollment New title of Social Security Act		Per capita cap and DSH reductions. Retain title XIX	Per capita cap and DSH reductions. Retain title XIX
ELIGIBILITY	Coverage "guaranteed" for: -Pregnant women, and children under 6 under 133% of poverty -Children 6-12 under 100% of poverty -People with disabilities (as defined by the state) who meet SSI standards -Elderly who meet SSI income and resource standards. All other eligibility groups would be optional. States may cover individuals up to 275% of poverty	Coverage is "guaranteed" for: - Pregnant women, and children under 133% of poverty - Children 6-12 under 100 % of poverty - Persons with disabilities (as defined by the state) - Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs) - Elderly who meet SSI income and resource standards - Families who meet current AFDC income and resource standards, or eligibles for "new welfare". Coverage is optional for: all other optional groups as defined by the current law, and other individuals or families as defined by the state but below 275% of poverty.		Maintains all current law mandatory and optional groups, including: - Pregnant women and children age 1-6 under 133% of poverty - Children age 6 through 12 under 100 % of poverty - Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered - AFDC cash recipients, - SSI Aged, Blind, and Disabled - QMBs - All current law optional groups, including the Medically Needy Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.	Maintains all current law mandatory and optional groups, including: - Pregnant women and children age 1-6 under 133% of poverty - Children age 6 through 12 under 100 % of poverty - Children age 12-18 under 100% of poverty to be phased in so that by year 2002, all children up to age 18 will be covered - AFDC cash recipients, - SSI Aged, Blind, and Disabled - QMBs - All current law optional groups, including the Medically Needy Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	NATIONAL GOVERNORS ASSOCIATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
BENEFITS	"Guaranteed" for low income families: Inpatient/outpatient hospital, physicians' surgical and medical services, Diagnostic tests, Childhood immunizations, and pre-pregnancy planning services and supplies. Long term care services for the elderly and disabled States are not required to provide any other services.	Does not require FQHC and RHC services.	"Guaranteed" coverage for mandatory populations: inpatient/outpatient, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT*, family planning services and supplies, physicians' services, nurse-midwife services. *See EPSDT below under "Like MediGrant II" All currently optional services would remain optional	Retains current law requiring States to cover: inpatient and outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. States may also cover optional services (drugs, physical therapy, dental services, etc.)	Retains current law requiring States to cover: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurse practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. States may also cover optional services (drugs, physical therapy, dental services, etc.)
Amount, Duration, and Scope	Eliminates requirements	"Complete" State flexibility		Retains current state flexibility within comparability and statewideness requirements	Retains current state flexibility within comparability and statewideness requirements
EPSDT	*No specific requirement for early, periodic, screening, diagnosis and treatment services (EPDST) for children under age 21.*	*Unclear : "redefines" treatment - no specifics how it will be redefined.*		Retains current law for treatment mandating coverage of services to treat or ameliorate a defect, physical and mental illness, or condition identified by a health screen.	Changes treatment: The Secretary, after consultation with States and provider organizations, would define treatment under EPSDT.
Comparability Statewideness	Eliminates requirements	*No provision*	*No provision*	Retains current law requirement that services be comparable and available statewide	Retains current law requirement that services be comparable and available statewide
Vaccines for Children Program	Eliminated	*No provision*	*No provision*	Maintained	Maintained
Home and Community Based Services	Optional service, states no longer needs waiver to provide	*Unclear - proposal "broadens" long-term "options." No specifics how options are broadened.*	*Unclear - proposal "broadens" long-term "options." No specifics how options are broadened*	Makes home and community-based services an optional service - States no longer need waivers to cover these services.	Current law

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
RIGHT OF ACTION	No federal right of action for individuals or providers *Silent on state court right of action* Individuals can bring issues and/or complaints to the attention of the Secretary Secretary's action re individual complaints is limited to investigation and subsequent notification to the Congress and/or chief executive of the state	No federal right of action for individuals or providers. States must provide state court right of action Must use state administrative mechanisms before going to state court Can petition US Supreme Court for review after all state court action completed Secretary can bring suit in federal court on behalf of individuals or classes.		Maintains current law individual right of action for individuals to bring suit in federal court.	Maintains current law individual right of action for individuals to bring suit in federal court.
FAMILY PROTECTIONS	Allows states to require adult children of nursing home residents with incomes above the state median income to contribute to their parents' nursing home care.	*No provision*	*No provision*	Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.	Retains current law prohibiting states from presuming that relatives other than spouses will provide financial support.
Spousal Impoverishment	Retains current law	*No provision*	*No provision*	Retains current law	Retains current law
Copayments	States have broad flexibility to develop cost sharing schedules that differentiate between income groups, types of services. Greater restrictions on cost sharing for children and pregnant women.	*No provision*	*No provision*	Maintains current limitations that copayments be nominal and only for some individuals/benefits. New authority to impose similar nominal copayments on HMO enrollees.	Allows States to impose copayments scaled to income and family size for individuals/benefits currently subject to copayments.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	NATIONAL GOVERNORS ASSOCIATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
FINANCING **Federal Spending Limit**	Fixed federal payments set by formula: Federal spending will be $839 billion between 1996-2002 (savings of $85 billion).	Partially fixed: For base spending, Federal payments are set by a formula. A state gets this amount even if it reduces benefits or enrollment. Federal spending and savings are not known.	Partially responsive: An "Insurance Umbrella" allows for higher Federal payments when enrollment for mandatory and some optional groups is unexpectedly high. Federal spending and savings are not known.	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of $865 billion between 1996-2002 (savings of $59 billion).	Responsive: Federal benefit spending limits are based on enrollment growth. The limits increase and decrease with changes in enrollment growth. DSH payments are fixed. Estimated Federal spending of $839 billion between 1996-2002 (savings of $85 billion).
State Spending	State matching rates are significantly lowered. Estimated state spending over seven years: $493 billion (savings of $205 billion). Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.	State matching rates are significantly lowered. State spending and savings are not known. Provider taxes and donations restrictions are repealed, allowing states to "borrow" money from providers to replace state tax dollars.		Current matching rates are maintained. Estimated state spending over seven years: $653 billion (savings of $45 billion). Current restrictions on the use of provider taxes and donations are retained.	Current matching rates are maintained. Estimated state spending over seven years: $633 billion (savings of $65 billion). Current restrictions on the use of provider taxes and donations are retained.
Funding Formula	1996 allotments are set in legislation. Subsequent years' allotments are based on the product of the number of poor people and the state-adjusted spending per person, subject to maximum or minimum growth rates. Actual enrollment is not included in the formula.	Base funding is set by multiplying the base year – the states' choice of 1993, 1994, or 1995 spending -- by an inflation factor and estimated enrollment growth. DSH spending is included in the base, but is not grown if DSH is greater than 12% of total spending.	The "Insurance Umbrella" allows states to get Federally-matched capitation payments for mandatory and some optional beneficiaries who are above the estimated enrollment for the year.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary (product of the average 1995 spending by beneficiary group and nominal GDP growth per person (5-year average) plus an adjustment factor). The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.	Federal benefit spending limits are calculated by multiplying the states' enrollment by a spending limit per beneficiary. The spending limit per beneficiary is the product of a rolling average spending by beneficiary group and CPI (3-year average) plus adjustment factors. The group-specific limits are summed so that each state has one, enrollment-based limit that is matchable by the Federal government. The DSH limits, which are gradually phased in, are based on states' share of the number of low-income patient days.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	NATIONAL GOVERNORS ASSOCIATION Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
PROVIDER PAYMENTS, PROGRAM OPERATION, AND SERVICE DELIVERY	Repeals all provider payment rules -- hospitals, nursing homes, hospice, FQHC/RHC and home and community-based services.	Repeals all provider payment rules.	Repeals Boren Amendment	Repeals Federal payment rules for hospitals, nursing facilities, FQHCs and RHCs (except for Indian FQHCs/RHCs) and home and community-based services.	Retains current federal payment rules.
	Repeals requirement that rates be sufficient to guarantee access to services.	*Unclear. May repeal requirement that rates be sufficient to guarantee access to services.*		Retains current requirement that rates be sufficient to guarantee access to services.	Retains current requirement that rates be sufficient to guarantee access to services.
	Repeals payment rules for obstetrical and pediatric care		Repeals payment rules for obstetrical and pediatric care	Repeals payment rules for obstetrical and pediatric care	No change to payment rules for obstetrical and pediatric care
Special Provider Qualifications	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Repeals physician qualification requirements.	Retains physician qualification requirements.
Managed Care	States' ability to mandate managed care enrollment would be unrestricted.	States may implement managed care without a waiver	States may implement managed care without a waiver	States could mandate enrollment in managed care, except:	States could mandate enrollment in managed care, except:
	Beneficiaries would have no guarantee of choice of plan or provider.	*Unclear. Beneficiaries may have no guarantee of choice of plan or provider.*	*Unclear. Beneficiaries may be guaranteed a choice of plan or provider.*	- Beneficiaries must have a choice of plan or delivery system; - States may not require enrollment for Medicare cost-sharing; States may not restrict choice of provider for family planning services.	-Beneficiaries must have a choice of plan or provider; -States may not require special needs individuals to enroll in managed care plans.
	Payments to managed care plans must be based on actuarial methods	*No provision*	*No provision*	Retains current law -- payments to managed care plans must be actuarially sound.	Applies the current "reasonable and adequate" payment standard to managed care systems.
Contracting and Solvency	Repeals all statutory contracting rules.	*Unclear. May repeal all contracting rules.*	*Unclear. May retain some current contracting rules.*	Repeals problematic contracting rules: 75/25 rule; HHS approval of HMO contracts; payment rules for managed care-contracting FQHCs.	Repeals current contracting rules.
	Health plans must meet commercial solvency standards.	*No provision*	*No provision*	Provides new authority for solvency standards.	Establishes new solvency standards.

ISSUES	MEDIGRANT II BLOCK GRANT	NATIONAL GOVERNORS ASSOCIATION Like MediGrant II	Like Administration	ADMINISTRATION PER CAPITA CAP	COALITION PER CAPITA CAP
Managed Care Quality	No quality requirements for States or managed care plans.	*Unclear*	*Unclear*	Requires States to develop quality improvement programs, which must include access standards and monitoring activities. Establishes new reporting and fraud prevention requirements for health plans.	Establishes new quality requirements for managed care systems, including statutory guarantees of accessibility and timeliness of services, information-sharing requirements, prior authorization and grievance procedures, and encounter data.
Nursing Home Quality	"Retains" current rules, but actually eliminates significant quality standards and protections for nursing home residents. Significantly diminishes Federal authority to enforce quality standards.	*Unclear. May eliminate some current standards, like MediGrant II.* States may decide how nursing home standards will be enforced		Retains current nursing home standards and enforcement.	Retains current nursing home standards and enforcement.
Administration	Federal administrative oversight curtailed. Financial penalties would be proportional and permitted only for "substantial" violations.	Disallowances must be proportional to violation. Federal oversight limited and intervention permitted only when State "fails substantially" to comply with law or program.		Repeals and revises various administrative and systems requirements.	No change to current administrative requirements.

TO: Hillary Rodham Clinton
Melanne Verveer
FROM: Jennifer Klein JK.
RE: National Governors' Association Medicaid Resolution
DATE: 2/9/96

The National Governors' Association (NGA) Medicaid resolution that passed on Tuesday has received a great deal of attention from the media, the Hill, and the health care provider and advocacy community. As a whole, the "right" has given this proposal widespread praise and has raised concern only about the resolution's financing provisions. The "left" has been extremely critical of the proposal, charging that the provisions on benefits, eligibility and enforcement strip the Medicaid program of its "guarantee."

This memo addresses the parts of the NGA proposal that relate to the guarantee. (While there are numerous outstanding issues, including how the resolution addresses quality standards, nursing home standard enforcement, and spousal impoverishment, we thought it was most important to focus on the fundamental structural issues first.) The memo also describes reactions from the Governors, the Hill and the interest groups.

NGA staff will brief White House and HHS staff on Monday evening to clarify their policy and to outline the process they have put in place to resolve remaining policy differences between Republican and Democratic Governors. We also understand that Leon plans to hold an internal meeting to discuss the resolution and that a meeting with the President may follow.

BACKGROUND

From the beginning of the Medicaid debate, the Administration has consistently taken the position that it is possible to constrain program growth while still maintaining Medicaid's guarantee of coverage to the elderly, the disabled, children and pregnant women. The Medicaid portion of the President's balanced budget proposal provides unprecedented flexibility for states while maintaining the guarantee and saving $59 billion over seven years.

Over the past several months, the Governors have attempted to hammer out a compromise Medicaid position to further the budget negotiations. The Democratic Governors worked tirelessly to move the Republicans from their insistence on a block grant, and the Republicans hesitantly agreed to a new funding formula that assures that federal dollars increase with enrollment increases during economic downturns. The Democratic Governors rightly believe that their success in getting the Republicans to agree to a guaranteed funding stream is a significant step forward. To achieve this victory, however, the outnumbered Democrats were apparently forced to give in on provisions that may well undermine the federal guarantee.

FOUR PARTS OF THE GUARANTEE UNDER MEDICAID

There are four elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement.

- **Financing Guarantee.** The NGA proposal seems to ensure that there will be adequate funding to maintain the guarantee by including an "umbrella" financing mechanism. This mechanism automatically provides additional federal support as economic downturns produce enrollment increases. Interestingly, the umbrella only increases, while under current law, federal financing rises and falls with changes in coverage and state contributions.

  However, the NGA proposal lowers the required state match to from 50% to 40% (inserted at the last second for Governor Pataki). This could significantly decrease overall Medicaid spending. HHS estimates that the $85 billion in federal savings would translate into $290 billion in total spending reductions if all states matched at the minimum level. In addition, the state may be able to substitute state dollars with revenue raised through provider taxes and donations. Since this is "borrowed" money, it would effectively reduce states' real spending on Medicaid. We do not yet know how CBO will score these financing changes.

- **Eligibility Guarantee.** The NGA proposal seems to retain coverage for most groups who are currently eligible but has some notable exceptions. It repeals the phase-in of coverage by 2002 for poor children between the ages of 13 and 18 that was signed into law by President Bush in 1990. (According to the Children's Defense Fund, about three million children would lose coverage.) In addition, the proposal allows states to define disability, subject to federal approval, instead of requiring all states to meet a minimum federal definition, as is now the law. This could result in widespread variation in eligibility determinations among states and, in the minds of some, could threaten the guarantee of eligibility for people with disabilities.

- **Benefits Guarantee.** The NGA proposal leaves in place the current, nationally defined list of covered benefits for mandatory coverage groups. However, the proposal seems to eliminate the requirement that all medically necessary services within the benefit categories be provided. It also gives states unlimited discretion to determine the amount, duration and scope of services within benefit categories and permits states to offer different benefits to different groups of beneficiaries or in different areas of the state. For example, under these provisions, states could limit the number of hospital days per year provided to children, even if a doctor decides that the care is medically necessary. States could also decide to cover five days of hospital services for disabled children but only two days for people with AIDS. Finally, they could chose to cover a particular benefit in some areas of the state, but not for example, on an Indian reservation. Although the resolution's language seems fairly clear, it is hard to believe that the Governors, particularly the Democrats, really

intended to go this far on both mandatory and optional benefits.

The proposal also redefines the treatment portion of EPSDT (Early and Periodic Screening, Diagnosis and Treatment) so that "states need not cover all Medicaid optional services for children." They have not yet resolved what treatment would be covered.

- **Enforcement of the Guarantee.** The NGA proposal eliminates a federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

  Attached is a more detailed description of the issues raised by the NGA proposal to eliminate the federal cause of action. The most significant problem is that, under this proposal, eligibility will vary between states because state courts will interpret the law differently. In addition, fewer remedies are available under state law than under federal law. The Secretary of Health and Human Services will be unable to litigate adequately on behalf of individuals because the significant new administrative burden that will be placed on the Department will likely cause delays and because the only remedy available to the Secretary is the withdrawal of funds (which will make matters worse for the recipients in the state).

REACTION TO THE NGA PROPOSAL

- **Governors' Position:** The six Governors on the Medicaid Policy Group (Romer, Chiles, Miller, Thompson, Engler and Leavitt) are working with NGA staff to clarify the Medicaid resolution and to resolve remaining disagreements.

  As with any hastily drafted document, there are a number of provisions that Democratic Governors either did not know about or are uncomfortable with. It is not clear that the Democratic Governors intended to repeal Title XIX (Medicaid) completely. In addition, Governor Chiles was apparently unaware that the resolution repeals restrictions on the use of provider taxes and donations. Governor Romer has told us he is uncomfortable with the disability language and the reduction in state matching. And it seems that all the Democrats are uneasy with dropping the phase-in of 13 to 18 year old kids.

- **Hill Position:** Most Republicans, through the RNC and comments by the Speaker, are strongly embracing the NGA proposal. They claim that it is a virtual mirror-image of their Medigrant proposal. Republicans are apparently planning to draft a bill quickly and dare us to criticize it. There are rumors that they may attach their interpretation of the NGA resolution to the debt ceiling bill.

The Republican reaction has fueled the suspicions of the Democrats and, with few exceptions, there has been a generally negative reaction to the NGA proposal. In the House, the "base" Democrats have charged that the proposal offers no guarantee and may even be a block grant in sheep's clothing. Congressman Stenholm and Congressman Dingell are concerned about the lack of state accountability, the reduction in state match, and the adequacy of the legal enforcement provisions. They argue that it is not unreasonable to expect federal eligibility requirements, standards and enforcement in return for a large federal investment.

On the Senate side, Senator Breaux has called for hearings so he can fully understand the implications of the proposal. Senator Chafee has raised significant concerns and has suggested that it appears to require federal maintenance of effort and little to no accountability. Clearly, however, both Senators Breaux and Chafee want to keep the Medicaid discussions alive for the sake of a budget deal and will continue to avoid being overly critical in public.

- **Interest Groups:** There has been a strong negative reaction from the groups, including the American Hospital Association, the American Academy of Pediatrics, the Catholic Health Association, the Children's Defense Fund, the Alzheimers' Association, and AIDS and other disability groups. These groups feel that enactment of a proposal like the Governors' resolution would end the guarantee and significantly increase the number of uninsured. The Office of Public Liaison is concerned because the President has won the trust of many groups by taking a strong stand on Medicaid; a reversal may be difficult to repair.

CONCLUSION

As you can see, we have real concerns. Things may change, however, as discussions with the NGA continue. We will keep you informed.

PRIVATE RIGHT OF ACTION

A Federal Private Right of Action is Important to Maintaining the Guarantee. The NGA proposal (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

Both Republican and Democratic Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the NGA proposal, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.

- **Significant Limitation of Remedies.** Most state laws establish higher hurdles for plaintiffs and provide less relief than federal law. Under most state statutes that allow courts to review administrative actions, there is no *de novo* review (the record before the court is limited to information considered by the agency) and relief is granted only when a claimant can show that the agency action was arbitrary and capricious, not merely wrong. In addition, most state laws do not allow beneficiaries to recover attorneys' fees, making it more difficult for them to afford legal counsel.

  The NGA proposal (and the conference report) maintains a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance"

-- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

- **Elimination of Remedies under Civil Rights Law.** While it is not clear that the NGA intends to go this far, the conference agreement precludes the right to enforce civil rights laws. Protection against discrimination in state programs has been established under the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990. If this is what the Governors intended, the civil rights community is likely to be very concerned.

The President's Proposal Increases Flexibility While Maintaining the Guarantee. The President's plan eliminates causes of action by providers over payment rates by repealing the Boren Amendment. This removes state officials' greatest source of concern over litigation and the most frequent basis for cases filed in federal court.

The proposal maintains current law on private enforcement of beneficiary rights under Medicaid. To address the Governors' concerns, eligibility claims could be separated from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

February 20, 1996

TO: Peter Edelman
Jo Ivey Boufford
John Callahan
Nan Hunter
Jerry Klepner
John Monahan
Melissa Skolfield
Bruce Vladeck
Bob Williams

FROM: John Spiegel

SUBJECT: Background Paper on Key Medicaid Issues, the NGA Resolution, and Potential Fall-back Positions

The attached paper describes the Administration, Conference/MediGrant II, Coalition, and NGA positions on several key Medicaid issues, and lays out potential fall-back positions. If you have any comments please get them to me (690-6870) by noon. Jack would like to get this to the Secretary today. Thanks.

cc: Wendell Primus
Robyn Stone

DRAFT

Medicaid Review
Key Issues, NGA Proposals/ Potential Fall-backs

- Eligibility
  - Simplification
  - Definition of disability
  - Welfare Link
- Benefits
  - Mandatory
  - Adequacy - Amount, Duration, and Scope
  - Comparability -- Optional Services
  - EPSDT Treatment
  - LTC Options
  - Cost Sharing
- Federal Entitlement/Right of Action
  - Eligibles
  - Individual Benefits
  - Provider Payments
- Federal Financing
  - Federal formula
  - FMAP
  - Provider Donations and Taxes
- Quality
  - Nursing Homes
  - Managed Care

Eligibility

- **Administration Proposal** - Maintains the current law mandatory and optional groups. Also adds a new eligibility option for individuals below 150% of poverty, subject to a budget neutrality requirement

- **Conference Agreement/MediGrant II** - Under the Conference Agreement, states would be required to cover poverty level pregnant women, children under 13, and the disabled (as defined by the state). No other populations would be guaranteed coverage. States would determine eligibility requirements, define income, set asset limits, and could choose to cover only limited subsets of current eligibility groups.

  Under MediGrant II, coverage is "guaranteed" for the following groups: pregnant women to and children to age 6 below 133 percent of poverty, children age 6 through 12 below 100 percent of poverty, the elderly who meet SSI income and resource standards, and persons with disabilities ("disability" would be defined by the state).

- **Coalition Proposal** - Same as Administration Proposal. Certain expansion populations (1902(r)(2)) would not be allowed after October 15, 1995.

- **NGA Proposal** - Coverage is "guaranteed" for the following groups: pregnant women and children to age 6 below 133 percent of poverty, children age 6 through 12 below 100 percent of poverty, the elderly who meet SSI income and resource standards, persons with disabilities ("disability" defined by the state), Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs), families who meet current AFDC income and resource standards; or states may run a single eligibility system for those who are eligible for "new welfare"

  Coverage is optional for the following groups: all other current law mandatory and optional groups, other individuals or families as defined by the state but below 275 percent of poverty.

  Concerns with NGA proposal

  -- Repeals the current law phase-in of coverage for children ages 13-18 in families with income below the federal poverty level;

  -- Repeals the federal definition of disability for purposes of Medicaid coverage; provides for state definitions instead;

  -- Unclear in its coverage of cash assistance recipients, especially under welfare reform.

Fall Back to Administration's plan

Eligibility simplification: States could be allowed to simplify Medicaid eligibility by making

eligibility optional for a number of "grandfathered" groups that are currently mandatory (these groups, typically shrinking in size over time, qualified under old rules but, under new eligibility standards, would have lost Medicaid eligibility).

Disability/alcoholism/drug abuse: Would retain the federal definition of disability, but revised as under welfare reform to address substantive areas of concern that have been identified. Disability as it relates to alcoholism and drug abuse and SSI benefits would be redefined in the context of welfare reform.

> In the case of drug addicts and alcoholics, the proposal accepted by the Administration would change program eligibility to exclude drug addiction and alcoholism as a qualifying disability for purposes of SSI and Medicaid.
>
> In the case of disabled children, effective in 1998, the proposal would change the eligibility process by eliminating the Individual Functional Assessment (IFA) process and eliminating maladaptive behavior from inclusion in the Social Security Act.

Welfare transitions: Whatever the specific outcomes of welfare reform, changes in welfare-related Medicaid eligibility must be considered.

Congressional consultation required.

Benefits

- **Administration Proposal** - Retains current law, which requires states to cover mandatory services: inpatient hospital, outpatient hospital, RHC & FQHC services, laboratory and x-ray services, nurses practitioners' services, nursing facility and home health services, EPSDT, family planning services and supplies, physicians' services, nurse-midwife services. States may also cover optional services: prescription drugs, podiatrist, optometrist, dental, physical therapy, ICF/MR, rehabilitative services, etc.

  A state's coverage of mandatory and optional benefits must be comparable across all categorically needy groups (e.g., services must be the same for AFDC and SSI eligibles). For medically needy groups, benefits must be the same within each group, but can vary from group to group. Also, states' benefit policies must be the same statewide.

  States will now be allowed to impose nominal cost-sharing on HMO enrollees, consistent with cost sharing guidelines for fee-for-service enrollees, However, States may not impose premiums, enrollment fees, or similar charges upon categorically needy Medicaid beneficiaries (e.g., AFDC, SSI). A State may not impose coinsurance copayments, or deductibles on any services for children, family planning, pregnancy related services, emergency services, hospice, in-patient services for spend-down eligibles. A State may impose nominal charges upon other services within Federal regulatory limits.

- **Conference Agreement/MediGrant II** - Under the Conference Agreement, States are not required to provide a minimum benefit package to beneficiaries (exception immunizations to children and pre-pregnancy family planning services and supplies). States would define covered benefits and benefit levels.

  Under MediGrant II states must provide the following guaranteed benefits to low income individuals: inpatient and outpatient hospital Services, physicians surgical and medical services, diagnostic tests, childhood immunizations, prepregnancy planning services and supplies. States must provide the following guaranteed benefits to elderly and disabled individuals: long-term care services.

  Each State would be granted extremely broad discretion to impose cost sharing requirements upon Medicaid beneficiaries. Although no premium could be charged on a family including a pregnant woman or child with income below 100% of the Federal poverty level, these groups could face nominal coinsurance, copayments, and deductibles. Even this protected group could be subject to cost sharing for any services.

- **Coalition Proposal** - Retains current law mandatory and optional services. However, the Secretary would define treatment under EPSDT.

  Maintains most current law cost sharing protections, but eliminates the current law

requirement that coinsurance, copayments, and deductibles be nominal and replaces it with a requirement that such charges reflect income, resources, and family size of the beneficiary.

- **NGA Proposal** - The following services are "guaranteed" only for "guaranteed" populations: Inpatient/outpatient hospital, physician, prenatal care, nursing facility services, home health care, family planning services and supplies, lab and x-ray, pediatric and family nurse practitioner, nurse midwife services, EPSDT (but the "Treatment" in EPSDT would be "redefined" in an unspecified manner). All other services are optional and long term care options would be "broadened."

  Concerns with NGA proposal:

  -- The "treatment" component of EPSDT is redefined in an unspecified manner

  -- FQHC/RHC services are not maintained as mandatory services.

  -- States would have complete state flexibility in defining adequacy of covered benefits -- the amount, duration, and scope of services -- with no federal standard against which to assess state benefit plans.

  -- The plan is silent as regards comparability of benefits within and among groups, and about statewideness of covered benefits.

  -- The NGA proposal is silent on cost sharing.

Fall Back to Administration's Plan

Mandatory benefits: The core benefits should continue to include the currently mandatory Medicaid services as listed by the NGA. The administration has proposed pooled funding for FQHC and RHC services in lieu of cost-based payments, which could address some of the governors' concerns about including these benefits.

Adequacy - amount, duration, and scope: The statute must retain some standard for assessing the adequacy of covered benefits beyond the list provided in the plan, such as the current requirement that benefits be adequate to achieve their purpose.

Comparability: Some degree of flexibility on comparability of benefits could be considered to allow states to target optional services. Administration staff have asked the governors' staff to help develop a proposal under which comparability would not be required for the following:

a. for optional beneficiaries, all optional services

b. for mandatory beneficiaries, optional services would be divided into two categories with input from governors' staff:

- some, such as personal care services, would not be subject to comparability requirements;

- others, such as prescription drugs, would continue to be subject to such requirements (note: split of optional services into two categories to be developed)

EPSDT: We can clarify the "Treatment" provision of current law to specify that comparability and statewideness do not apply: states only have to provide those services which are not covered under state plan amendments to children who receive EPSDT services. All other Medicaid recipients would only be entitled to the services covered in the state plan amendments.

LTC: Payment for Care of Relations: HHS will pursue discussions with state staff to explore this option.

Cost Sharing: President's plan provides flexibility to extend cost sharing to HMO enrollees.

Congressional consultation required.

Federal Entitlement/Right of Action

- **Administration Proposal** - Preserves the individual federal entitlement to health care coverage for low-income individuals. This means that individuals who qualify for Medicaid under today's federal rules would be guaranteed coverage for a defined and meaningful package of health and long-term care benefits. Individuals would retain the right to sue in Federal as well as state court to enforce their entitlement.

- **Conference Agreement/MediGrant II** - Explicitly repeals an individual's federal entitlement to health care coverage. Individuals would not be able to sue in federal court if denied eligibility by a state.

- **Coalition Proposal** - Same as Administration proposal.

- **NGA Proposal** - The basic design of the proposal is to prevent individual suits on benefits in federal court. Individuals must exhaust state administrative remedies before going to state court. Individuals and classes have right of action in state court only. After completion of state court action, individuals can appeal to US Supreme Court. The Secretary can bring action in federal court for individuals, but not providers or health plans. There is no private right of action for providers or health plans.

  Concerns with NGA proposal

  -- Repeals federal right of action for individuals;
  -- Makes Medicaid sole federal statute conferring benefits on beneficiaries in which enforcement would be barred from the federal courts.
  -- Federal components of Medicaid that are common among the states should be subject to consistent interpretation and administration, with efficiency and predictability best served by the federal court system.

Fall Back to Administration's Plan

The following clarification of the right to sue is possible:

Eligibility: Maintain the current law requirements under which individuals have a right of action in federal court. However, it could be made explicit that a state administrative process must be exhausted prior to filing in federal court on eligibility-related claims.

Benefits: A working group of staff and counsel in HHS and the White House are developing a proposal for benefits under which the right of action for some benefit issues would remain in federal court, others would be limited to state courts. The following is one approach:

For individualized, fact-based benefit claims, exhaustion of a health plan or HMO process and a state administrative process could be required, with appeal only to state courts of appropriate jurisdiction, unless the claim exceeds a specified threshold amount.

An "individualized benefit claim" would be defined as a claim by a recipient under this Title solely that an error of fact has been made, under a contract, policy or practice that is not in dispute, in deciding:

(a) whether to provide or cover a service for the individual, including a determination of medical necessity or a decision as to amount, duration, and scope of services; or
(b) whether or in what amount to charge a co-payment or deductible to the individual.

Counsel are meeting to better develop these options.

Providers

The statute could be amended specifically so that there is no provider right of action on payment rates.

Congressional consultations required.

Federal Financing

- **Administration Proposal** - The Administration's proposal retains the current law federal matching rate formula (Federal Medical Assistance Percentage, or FMAP). Under current law, the matching rate in a state is based on per capita income in that state relative to the nation. By law, the minimum FMAP rate is 50 percent and the maximum FMAP rate is 83 percent.

  Under the Administration's per capita cap proposal, the federal limit for each state is based on the state's historical Medicaid spending level. All states receive the same growth rate. Thus, there is little redistribution of federal funds across states.

- **Conference Agreement/MediGrant II** - Under the Conference Agreement, each state can choose its FMAP from among several options. The agreement also raises the minimum FMAP rate from 50 percent to 60 percent. The effect of the Conference Agreement is to reduce the amount of dollars a state must spend to draw down a given level of federal funds. This approach could lower total (state and federal) funds spent on Medicaid.

  Each state's block grant depends partly on historical costs and partly on arbitrary adjustments to a state's historical costs. However, not state has its grant determined by the formula in every year. Instead, grants are determined by the ceiling and floor growth rates. The overall effect of the Conference Agreement's block grant allocations is to favor lower-income, high population growth states at the expense of higher-income, low population growth states.

- **Coalition Proposal** - The Coalition Proposal also retains the current law FMAP formula. The financing structure is conceptually similar to the Administration Proposal. However, the specific methodology differs significantly. As with the Administration Proposal, there is little redistribution of federal funds across states

- **NGA Proposal** - Would replace the current financing system with a combination of a fixed federal payment, and an "insurance umbrella" for unexpected excess enrollment. 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 schemes (which are currently prohibited) would be permitted.

  <u>Concerns with NGA plan</u>

  -- Need clarification of federal financing to assure that it meets objective of federal financing that adapts automatically to enrollment changes.

  -- Need clarification of budget scoring in the context of a balanced budget plan.

  -- FMAP change could be very expensive for federal government; and/or could lead to significant state defunding of program.

-- Repeals provider donation and tax provisions that were enacted in recent years to prevent states from using these approaches to refinance the real state share.

Fall Back to Administration's Plan

Overall: We need to clarify with the governors how the federal financing actually works to assure that it parallels our per capita financing methodology -- a methodology that served as the model for governors negotiating on the plan.

State share: The FMAP formula should not be opened up in the current negotiations; it is potential scoring problem under a per capita cap, and it could lead to substantial lowering of total funds devoted to health care for the poor. However, establishment of some sort of inter-governmental advisory commission to examine the issue could be considered. A commission could also consider the allocation of funds across states.

Provider donations and taxes: The recently enacted restrictions should be retained.

Congressional consultation required.

Quality: Nursing Homes and Managed Care

- **Administration Proposal** - For nursing homes, the administration retains current law. Current law contains uniform federal standards and requirements for 1) quality of care 2) survey and certification and 3) enforcement of standards. The duplicative annual assessment review requirements PASAAR will be repealed.

  Revises and updates managed care quality protections.

- **Conference Agreement/MediGrant II** - For nursing homes, retains broad federal guidelines for quality assurance, but severely reduces the federal role in validating state survey efforts and enforcing state and facility compliance.

  No Quality requirements for states or managed care plans.

- **Coalition Proposal** - For nursing homes, retains current law. For managed care, establishes new quality requirements, including statutory guarantees of accessibility and timeliness of services, information-sharing requirements, prior authorization and grievance procedures, and encounter data.

- **NGA Proposal** - Appears to maintains current nursing home quality standards, but eliminates the federal role in monitoring nursing home quality assurance. The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care.

  Concerns with NGA proposal

  -- eliminates federal role in monitoring nursing home standards;

  -- is silent on standards for intermediate care facilities for the mentally retarded (ICF/MR);

  -- is silent on quality requirements for Medicaid managed care.

Fall Back to Administration's Plan

The administration's plan already repeals the duplicative annual review of nursing home patients that was previously identifed by NGA as a problem, and it repeals outdated Medicaid managed care requirements that the NGA identified as problemmatic, such as the "75-25" rule, and replaces them with state quality assurance programs. There does not appear to be a strong programmatic or political rationale for any further substantial revisions in quality standards.

Congressional consultations required.

CENTER ON BUDGET AND POLICY PRIORITIES

Embargoed until 9:30 a.m. February 20, 1996

GOVERNORS PROPOSALS COULD LEAD TO SHARP *STATE* FUNDING REDUCTIONS IN MEDICAID AND AFDC

Combined *State* Funding Reduction Could Be as Much as $270 Billion

When assessing the budgetary effect of proposals to reform Medicaid and AFDC, reductions in *federal* funding are only part of the story. Federal reforms can trigger even larger reductions in *state* funding for these programs.

The recent Medicaid and AFDC reform proposals endorsed by the National Governors Association (NGA) are a case in point. Under the Governors proposals, states could reduce their contributions for Medicaid by between $182 billion and $214 billion over the next seven years, compared with what states are projected to contribute under current law, without losing a dollar in federal Medicaid funds. States also could reduce the amount they spend on AFDC and welfare-to-work programs by $28 billion and divert another $30 billion intended for use on these programs without affecting the level of federal welfare block grant funds they receive.

Both Medicaid and AFDC are financed jointly by the federal and state governments. Under current law, the costs of these programs are shared between the federal and state governments in accordance with state "matching rates" established by federal law. If a state's matching rate is set at 50 percent, the state pays half of Medicaid and AFDC costs in that state, with the federal government paying the other half. Thus, under current law, states that cut Medicaid and AFDC benefits to reduce state costs automatically lose at least $1 in federal funds — and as much as $4 in federal funds — for each dollar they reduce state contributions.

The Governors' plan would change the Medicaid and AFDC financing structures in ways that enable states to reduce their funding for these programs by varying degrees without triggering *any* further losses in federal funds. This fundamental change in the incentives underlying the funding structures of these programs makes substantial state funding reductions much more likely in the future.

The effects of the NGA proposals over the next seven years would include the following.

- The Governors' Medicaid proposal is intended to cut *federal* funding for Medicaid by between $59 billion and $85 billion over seven years. As much as $182 billion to $214 billion in *state* Medicaid cuts could occur on top of these federal cuts because states would be permitted to reduce substantially their share of total Medicaid costs and still receive their maximum allowable federal funding.

- Combined federal and state Medicaid reductions under the NGA plan consequently could be as much as $241 billion to $299 billion.

- The Governors' plan also would provide states with broad flexibility to deny Medicaid coverage to certain groups and to scale back the health services Medicaid covers. States could scale back coverage substantially to reduce Medicaid costs, enabling them to withdraw large amounts of state funds. The result would be considerably weaker benefits offered under Medicaid for millions who remain covered and/or the loss of Medicaid coverage altogether for several million people. While cost-containment measures also could restrict costs, such measures cannot reasonably be expected to yield more than a small fraction of the $241 billion to $299 billion in potential Medicaid funding reductions.

- The NGA plan also could lead to reductions of up to $28 billion in *state* funding for AFDC, welfare-to-work, and related public assistance programs, because current state matching requirements for welfare programs would be replaced by a lower state funding requirement. In addition, states would be permitted to divert $30 billion of their federal welfare block grant dollars to other programs, using these funds to replace state funds currently used in other areas.

- When only *federal* funding is considered, the NGA plan would lead to funding reductions in Medicaid and welfare combined of between $50 billion and $80 billion. But when reductions in both federal *and state* funding are considered, the potential reduction grows dramatically. The NGA plan could lead to overall cuts in Medicaid and AFDC funding that total as much as $290 billion to $350 billion over the next seven years.

Medicaid and welfare funding reductions of similar magnitude could occur under the latest Congressional Republican budget offer. Under the Administration's latest budget, by contrast, the amount that states could reduce state Medicaid and AFDC funding without losing additional federal funds would be about one-sixth of the state funding reduction that could occur under the NGA and Republican proposals. As a result, the Administration's plan could lead to combined *federal and state* Medicaid and AFDC reductions only one-third the size of the overall reduction that could occur under the Governors' and Republican proposals.

Medicaid Funding Reductions

The Governors' proposal does not specify the precise amount by which it would reduce federal Medicaid funding. Several Governors have indicated, however, their intent is to reduce federal funding over the next seven years by between $59 billion

(the Administration's proposed savings level) and $85 billion (the latest savings level that Republican Congressional leaders have proposed).

A reduction in the amount of federal funding provided to a state automatically reduces the amount of state funding that a state must provide to meet its Medicaid matching requirement. Currently, states must contribute between 25 cents and one dollar for each dollar of federal Medicaid funding, depending on the state. Reductions of $59 billion to $85 billion in federal Medicaid funding would enable states to contribute between $48 billion and $69 billion less.

The Governors plan enables states to cut much more than $48 billion to $69 billion in state Medicaid funding, however, because it contains a key additional feature: the percentage of total Medicaid costs that states must bear to receive their full federal payments would be reduced for at least 25 states. For example, for the 12 wealthiest states, the percentage of Medicaid costs the state must bear would be lowered from 50 percent to 40 percent.

As a result, states would be able to withdraw even more state funds without such action having any effect on the level of federal Medicaid funding they would receive. This feature of the NGA proposal would enable states to reduce state Medicaid funding by as much as $134 billion to $145 billion more without losing any federal Medicaid block grant funds.

In combination, states could reduce state Medicaid funding by $182 billion to $214 billion over seven years and still receive their full federal grant. The *combined* federal and state Medicaid reduction could total from $241 billion to $299 billion over seven years, with program funding being reduced 19 percent to 26 percent in 2002, compared with what CBO projects would be expended under current law.

The figures in the table show the maximum amounts states could withdraw without such actions affecting the amount of federal Medicaid dollars they receive. Under the Governors plan, states working to secure maximum federal Medicaid funding would have to provide Medicaid matching payments up to a specified dollar

Potential Seven-Year Medicaid Reductions Under NGA Plan
(in billions of dollars)

	Lower Estimate	Upper Estimate
Federal reductions	-59	-85
State reductions under existing matching rates	-48	-69
State reductions due to changes in matching rates	-134	-145
Total Potential Reductions	-241	-299

amount for each state. States could provide more than this amount but would receive no additional federal Medicaid funding as a result of doing so.

Would states really institute state funding reductions on top of the federal funding reductions? To answer this question, consider what it would mean if a state rejected such a course and expended fully as much on Medicaid as the state is projected to spend under current Medicaid law. A state following such a course would contribute large amounts of state Medicaid funding that secured no federal funds in return. Furthermore, the federal government would reap all of the Medicaid savings realized in the state; the state itself would secure no savings.

In short, the Governors' proposal would provide states with a much greater financial incentive to reduce funding than has been the case in the past. Under current law, states lose between $1 and $4 of federal Medicaid funding for each $1 reduction in state Medicaid funding. Under the Governors' proposal, states could reduce their Medicaid contribution substantially without losing any federal money.

While some states might provide some additional, unmatched funds if the NGA proposal were to become law, many other states probably would not. And few states would be likely to provide as much state Medicaid money as they would provide if current law remained in effect. The fact that various governors and other state officials already are beginning to talk of cutting state Medicaid budgets if a proposal like NGA's is enacted is an early indication that state Medicaid funding reductions would occur.

In many states, the most likely scenario is that the state would contribute as much as needed to draw down its full federal block grant allocation, but no more than that. The calculations in this paper show the amount by which state Medicaid resources would shrink if states spend no more than the amount needed to secure their full federal allocations. These figures represent the maximum potential reductions in state Medicaid funding that could ensue. (A separate Center analysis, *Federal Caps and State Matching Requirements under the Governors' Medicaid Proposal*, explores these issues in greater detail.)

Reduced Benefits and Coverage Would Occur

The Medicaid reductions under the Governors' plan could increase the number of persons without health insurance by several million people and could weaken the benefits package for millions more who remain insured. Under the Governors' plan, states would have the latitude to deny coverage to many groups and to weaken benefit packages as they wish.

- The Governors' proposal does not guarantee coverage to certain vulnerable groups, including three million poor children over age 12 and many poor disabled individuals.

  In addition, many of those covered under the NGA plan could find their benefit package far weaker than at present. States would essentially have complete discretion to define benefits as they wish; they could establish skeletal benefit packages for some groups of beneficiaries that do not come close to meeting current standards.

- The cost-containment measures most often cited as being able to help reduce Medicaid costs — managed care and reductions in payments to medical care providers — might result in significant savings. But even broad implementation of managed care and deep cuts in provider payments are not likely to achieve more than $27 billion to $46 billion in savings over seven years.[1] This constitutes between one-tenth and one-fifth of the potential reductions in Medicaid funding under the Governors' plan.

- In short, the depth of the potential Medicaid funding reductions under the NGA plan far exceeds the savings that can reasonably be expected from efficiencies in methods of delivery, such as greater use of managed care, and reductions in payments to medical care providers. (The Congressional Budget Office reached a similar conclusion in an analysis of an earlier proposal that would have led to cuts of this size).

  As a result, the combined effect of the reductions in federal funding and the increased incentive for states to withdraw large amounts of state Medicaid funding make it likely that many states would use their new-found flexibility to scale back benefits and coverage to a substantial degree.

Use of Financing Gimmicks Would Result in Additional State Funding Reductions

The Governors' proposal also would repeal federal rules that prevent states from using financing gimmicks to secure federal funds without actually providing the required level of state Medicaid contributions. These rules were enacted during the Bush Administration in response to growing state use of gimmicks and sham financial schemes to circumvent the Medicaid matching system. The reductions in state

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[1] For information on how these figures are derived, see Cindy Mann and Richard Kogan, *The Conference Budget Resolution would prompt cuts in Medicaid Eligibility and Benefits*, Center on Budget and Policy Priorities, June 29, 1995.

Medicaid funding could be even larger than $182 billion to $214 billion if states again begin to use such financing scams. (This issue, as well, is explained in the Center's accompanying analysis of the Governors' Medicaid proposal.)

Reductions in State Public Assistance Funding

The Governors' *welfare* plan also would enable states to withdraw funds without losing federal dollars. The plan would repeal existing state matching requirements for AFDC, emergency assistance, welfare-to-work, and child care programs. The current matching requirements would be replaced by a requirement that each state contribute at least 75 percent of what it contributed for these programs in 1994.

As a result, states would be able to reduce their funding 25 percent below 1994 levels without losing any federal welfare block-grant funds.[2] If all states did so, state funding for welfare programs would be reduced $28 billion between 1997 and 2002,[3] compared with what states are projected to spend under current law.

As with Medicaid, some states could — and likely would — choose to contribute more than the minimum amount of funding needed to draw down their full federal block grant allocation. Other states likely would reduce their funding by the full amount allowed. The figure of $28 billion represents the maximum potential cut.

The Governors' proposal also would permit states to transfer up to 30 percent of their federal welfare block grant funds to one of several other programs. For example, a state could transfer these federal funds to the Social Services Block Grant. States currently pay for an array of social services largely with state dollars; the cost of these services substantially exceeds the modest federal funding the Social Services Block Grant provides. A state could save substantial state money by diverting funds from the welfare block grant to the Social Services Block Grant and using these resources, in lieu of state dollars, to fund social service programs.

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[2] The Congressional Budget Office projects that, under current law, federal and state welfare costs will exceed the 1994 level during the seven-year period from 1996 through 2002, growing modestly to reflect such factors as population growth. Thus, the amount that states would be required to contribute from state funds — 75 percent of state welfare funding in 1994 — would represent a reduction of more than 25 percent when compared with what states are projected to expend under current law.

[3] The welfare conference agreement on which the Governors' plan is based would permit states to remain in the current law AFDC program during fiscal year 1996. CBO assumes that nearly all states would take this option. Therefore, estimates of state funding reductions are calculated between fiscal 1997 and fiscal 2002, rather than over the seven-year period from 1996 to 2002.

Between 1997 and 2002, this transfer provision would place in jeopardy $30 billion of federal block grant funds by allowing that amount to be diverted from income support and work programs for poor families to other programs. Nor would the amounts diverted to, say, social services programs necessarily increase total social services resources since a state could reduce its own social service funding accordingly. In effect, the $30 billion could become a form of general revenue sharing. States could transfer the welfare money to certain other programs, reduce state funding on those programs by an equivalent amount, and then use the withdrawn state funds for any purpose, including education, roads, football stadiums, or tax cuts.

If all states provided the funds necessary to receive their full federal block grant allocations but no more than that — that is, if state funding equaled 75 percent of each state's 1994 state expenditure level — and if states also transferred 30 percent of their federal block grant funds for other purposes, the total amount withdrawn from cash assistance and welfare-to-work efforts for poor families with children would total $58 billion over seven years. While not all states would follow this course and the total funds withdrawn thus would be less than $58 billion over seven years, the amount lost to these programs can be expected to be very substantial.

As compared to the Congressional welfare bill, the Governors' proposal does call for adding $4 billion in federal child care funding over seven years, $1 billion additional in federal "contingency" funding for states experiencing increases in poverty, and funds for federal job performance bonuses to states. States would be eligible for these additional child care resources even if they had withdrawn substantial state resources from income support, work, and child care programs. The added child care funding may in part supplant state resources that otherwise would be provided for child care. More important, the Governors' proposal would eliminate a provision of the welfare conference report that would require states to maintain state funding at 100 percent of their 1994 level to receive federal contingency funds. This provision is the only "carrot" in the Congressional welfare bill for states to maintain rather than reduce funding for these programs. Under the Governors' proposal, states could secure additional federal contingency funds when poverty rose while reducing state funding at the same time.

Combined Medicaid and Welfare Effects

The Governors' plan would cut total *federal* expenditures for Medicaid and welfare by between $50 billion and $80 billion over seven years.[4] These figures pale in comparison with the reduction in *state* funding reductions that could ensue.

[4] This range reflects the reduction in federal Medicaid expenditures of between $59 billion and $85 billion and increases in federal welfare expenditures of between $5 billion and $10 billion.

Governors Plan Could Also Lead to Other Cuts in State Aid for the Elderly and Disabled and the Working Poor

Federal changes under consideration in several other areas, such as the Supplemental Security Income program for the elderly and disabled poor and the Earned Income Tax Credit (EITC) for workers with low incomes, also could lead to reductions in state funding. The NGA and Republican plans, but not the Administration plan, would allow states to eliminate state SSI supplemental benefits. Under current law, about half the states are required to provide modest state SSI benefits as a supplement to federal SSI benefits. (Federal SSI benefits, by themselves, lift poor elderly individuals only to about three-fourths of the poverty line.) Under current law, these state SSI benefits are estimated to cost more than $20 billion over the next seven years.

If the proposal to repeal the requirement for state SSI benefit supplements becomes law, most states are unlikely to eliminate their state SSI benefits entirely, at least not in the short run. But repealing the existing mandate could lead to substantial reductions in state SSI benefits in some states.

In addition, all three plans envision some reductions in the EITC. The reductions total $15 billion under the Republican plan, no more than $10 billion under the Governors plan, and $5 billion under the Administration plan. These reductions would trigger modest additional EITC reductions, totaling perhaps several hundred million dollars over seven years, in the seven states that have a state EITC based on the federal credit. The state EITC reductions would likely be about three times larger under the Republican plan than under the Administration plan.

The Governors' plan could produce as much as $240 billion to $270 billion in *state* funding reductions in these two programs. This includes $58 billion in potential state funding reductions for welfare and related programs and $182 billion to $214 billion in potential state Medicaid funding reductions.[1] (This total does *not* include the potential for states to reduce state Medicaid funding further by "gaming" the Medicaid state matching requirements.)

When the reductions in federal Medicaid and welfare funding are taken into account, total combined reduction in federal and state funding could climb as much as $290 billion to $350 billion over seven years.

Comparison with Latest Congressional and Administration Plans

The Administration's latest budget offer would yield a potential combined reduction in federal and state funding for Medicaid and welfare of about $105 billion, one-third the reduction that would occur under the Governors' and Congressional

Republican proposals.[5] The three proposals differ moderately in the amount they would reduce federal funding. The largest difference occurs in the potential reductions in state funding under these proposals.

The Administration proposal would permit states to reduce their Medicaid funding about $45 billion without losing federal funds,[6] compared with $182 billion to $214 billion under the Governors' plan. In the welfare area, states would not be able to reduce state funding under the Administration plan without forgoing some federal funds.

The Administration approach does not preclude states from taking actions to produce savings in welfare and Medicaid. It means, however, that if larger savings are achieved, the federal government would share the savings with the states rather than having the states secure all of the additional savings and the federal government secure none of them.

[5] The potential combined reduction in Medicaid and welfare spending over seven years under the latest Congressional Republican budget offer would be similar to the upper range of $350 billion estimated for the Governors' proposal.

[6] The figure of $45 billion is consistent with the Administration's plan to reduce federal Medicaid spending by $59 billion. The figure might be a few billion dollars higher if the Administration includes special purpose grants to states that do not require state matching. At this point, it is unclear if the Administration will include such grants.

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.

"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 1980s.

"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 new-found 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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E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Feb-1996 11:16am

TO: Carol H. Rasco

FROM: Christopher C. Jennings
Domestic Policy Council

CC: Jennifer L. Klein

SUBJECT: Medicaid Benefits Update

There was a strange Governors staff plus one Governor (Leavitt) meeting last night about the benefits issue. I don't have all the details, but it sounds like they asked NGA (through Carl) to produce an option on the "adequacy" standard that is not only bad policy, but undermines their credibility.

As you know,the current legal/regulatory enforcement of benefit "adequacy" allows for very limited benefits and, as far as I know, has not caused any problems with the states. Despite this, Carl has been asked to draft up an alternative that would have states using their insurance commissioner's definition of benefits to determine whether they were "adequate."

There are two major problems with this: First, there would no doubt be different definitions of adequacy, even for the mandatory benefits. (So, for example, one state could say 10 days of hospital care was fine and another state could concude it was not -- such an approach, in my mind, fundamentally undermines the President's and anyone elses reading of a national, guaranteed, floor benefit.) Second, state insurance commissioners do not have the same benefit packages that the Medicaid program does; specifically their benefits usually don't cover anything like the nursing home and other chronic care benefit pacakges that Medicaid does.

I am very concerned about this development for two reasons: First, the only thing that we have really pushed the Governors to do relative to the "guarantee" (other than to make sure their financing formula works) is to fill in more acceptable details on the benefits side. (There is ambiguity in the original NGA resolution and they have some room to operate). If they can't even move to us on this issue, it will be hard for us to continue to make the argument that we think the worst fears of the advocacy community are wrong. Second, if our job is to build on their foundation and strengthen their and our position (as I think it is), their work has to be viewed as credible. Approaches such as this do not serve this purpose.

As you may know, there are a lot of people who would suggest in the Democratic "base" to let them make this package as bad as possible. (It is easier to throw rocks at it.) So, it is my impression if we do not tell them about these things, few people will. I have not talked with the Governors' staffs directly about this, but will attempt to raise this issue if ok with you? If you happen to talk with Ray or other relevant players, would you be wiling to raise this as well?

Thanks...

cj

AIDS Action foundation

FAX TRANSMISSION COVER SHEET

TO: Jennifer Klein
Office of the First Lady

FAX #: (202) 456-9412

FROM: JOSÉ ZUNIGA, Deputy Director for Public Affairs, ext. 3042

DATE: 2/22/96

RE: Medicaid & NGA op-ed by Mark Barnes

NUMBER OF PAGES (including cover): 5

* *

Mark Barnes asked me to fax to you his Medicaid op-ed focusing on the NGA restructuring plan. This op-ed is being shopped around to Op-Ed pages nationwide.

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

If you experience difficulty in receiving this fax, please call 202/986-1300.

MEDICAID BLOCK GRANT FEVER
A Fever That Could Cost Countless Lives

by Mark Barnes

Block-grant fever is upon us: Eulogized in Lamar Alexander's campaign speeches. Touted by the National Governors' Association (NGA) in its "new" approach to Medicaid reform. Preached by the Republican leadership in Congress. Despite this apparent stampede, the block-granting of Medicaid remains one of the most contentious issues separating President Clinton and GOP congressional leadership in ongoing budget negotiations.

On the one side, President Clinton has pledged full support for Medicaid's entitlement status and for federal cost-sharing for medical care for the poor. On the other, congressional Republicans seem equally committed to ending Medicaid's tap into the federal treasury by block-granting the program to states and removing all meaningful federal standards on eligibility, benefits, quality of care and consumer protections.

The NGA's bipartisan compromise on this issue, designed to "break the gridlock in budget negotiations," on balance is much closer to the Republican leadership's approach than to President Clinton's:

- The governors would allow increased federal contributions to states with increases in people in poverty, but would block-grant the program to the states, removing all federal oversight of eligibility for disabled people and of HMO-type managed care programs for the poor.

- The governors would allow states to define the scope, amount and duration of medical benefits that states must give to the poor, so that Mississippi, for example, could decide that one hospital day per year, one nursing home day per year, and one doctor's office visit per year for a poor

elderly person or AIDS patient would be the full extent of medical coverage.

■ The governors would end, once and for all, the right of Medicaid recipients to challenge denials of medical services in federal courts; in New York and other states, that could mean a years-long wait in the clogged state courts for any redress for coverage denials. AIDS and cancer patients obviously do not have that time to wait.

So what is the problem here? Why should we not trust these governors in their wisdom to do what's right for their states? That is an easy question to answer: We need to remember that governors are a special interest group themselves, seeking in this proposal about $100 billion a year in federal taxpayer money without accountability to the federal government. What elected officials wouldn't like to be handed billions of dollars, never themselves have to vote to raise the money in taxes in the first place, and then be subject to no oversight as to how the money is spent? This is a patronage and power bonanza for the governors and is reason enough to be suspicious of the NGA approach to Medicaid.

A willingness to trust entirely in the wisdom of the states -- in Medicaid as in many other health and welfare programs now being eyed for potential block granting -- puts at risk the many vulnerable people who rely on Medicaid for their basic medical care and prescription drugs. Among these are people living with AIDS, of whom about half receive their basic medical care from Medicaid. Examples around the country show the problems of Medicaid block-granting-without-strings. When states have acted alone, as in defining optional benefits under Medicaid for persons with AIDS, the results on occasion have been catastrophic.

Take, for example, Missouri, whose Medicaid program in the late 1980s refused to pay for AZT for people with AIDS, and was forced to do so only by a lawsuit brought by AIDS advocates. Even today,

under the "flexibility" of federal standards that leave many Medicaid coverage choices entirely up to the states, the Texas and South Carolina state Medicaid programs will pay for a patient to be on only three prescriptions per month, this although the advanced AIDS or terminally-ill elderly patient often needs ten or more prescription drugs to sustain failing body systems.

Another 14 states do not even provide prescription drugs under their Medicaid programs to the medically indigent. States have been left to make their own choices, and have done so, often to the detriment of terminally ill people who then must choose between paying rent and getting the drugs and medical care they need.

In AIDS, there is more danger now than ever before in leaving coverage decisions up to the states. Recent treatment advances in drugs called protease inhibitors promise to extend the lives of people with AIDS for years, making them feel better and able to continue to work. Yet these drugs are expensive, costing about $14,000 per patient per year. Will Alabama, or any state with governors and state legislatures hostile to AIDS causes, decide to cover these drugs? I doubt it.

For evidence, look at Tennessee, where the state senator heading the committee that oversees Tennessee's Medicaid program (TennCare) recently questioned whether the state ought to cover care of AIDS patients at all: "Has anyone made a decision for taxpayers to pay for a bizarre lifestyle?," he said in early February, in response to reports of the promise of these new AIDS drugs. Or as a remarkably literate and well-informed woman in Topeka, Kansas, put it, in her written response to a C-SPAN broadcast of a speech in which I criticized the NGA's Medicaid block-grant proposal: "Our governor will prioritize our block grant money -- the children, poor, elderly, disabled will be cared for. You'll have to find someone in your group to pay for your irresponsible sex life." Leaving aside her presumptions about my sex life, would she think the same, I wonder, of elderly people crippled by heart disease or cancer from years of

choosing to gorge on red meat and cigarettes?

Our federal government's purpose is to assure the common, national good. In an epidemic that knows no state boundaries, that affects all of our families and communities, the way to approach Medicaid and other vital prevention and care programs is not just to punt the issue to the states and hope for the best. Judging from history and motives, there is more reason to have confidence in the federal government than in the beneficent governors, a prominent Tennessee senator, and a lady from Topeka, with all she represents. In AIDS, the cost of block-granting without accountability would be measured in lives needlessly shortened and lost. Regardless of what the governors think, we as a nation should not be willing to pay that price.

# # #

Mark Barnes is executive of AIDS Action Council, the only national organization devoted solely to advocating on federal AIDS policy, legislation, and funding. Founded in 1984, AIDS Action represents more than 1,000 community-based AIDS service organizations nationwide.

MEDICAID AND THE NGA RESOLUTION: DISCUSSION POINTS

- **Status Update On: Meetings with the Governors/Congressional Hearings**

- **Administration Proposal and Commonground with the NGA Resolution:**

  (1) The establishment of a new financing mechanism that links and constrains federal financing to enrollment;

  (2) The repeal of the Boren amendment; and

  (3) The liberation of states from the waiver process.

- **Outstanding Issues Related to NGA Resolution:**

  (1) The "Guarantee;"

  (2) Second Tier, But Critical Issues; and

  (3) The Title XIX Debate.

- **The NGA Resolution and the Guarantee:**

  (1) Financing;

  (2) Eligibility;

  (3) Benefits; and

  (4) Enforcement

- **Congressional and Interest Group Response to the NGA Resolution**

- **Discussion of Medicaid Negotiating Positioning/Strategy**

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PRIVATE RIGHT OF ACTION

A Federal Private Right of Action is Important to Maintaining the Guarantee. The Governors (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

The Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

You have taken the position that you support maintaining the guarantee under Medicaid. Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. A "guarantee" without a right to enforce it and a remedy for its deprivation is a hollow promise. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the Governors' plan, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.

- **Significant Limitation of Remedies.** The remedies available under state law are generally more limited than under federal law. Very few state laws allow beneficiaries to obtain injunctions against the continuation of policies found to be unlawful or to recover attorneys fees.

  The Governors (and the conference report) claim to maintain a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that confers individual rights that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

Your Proposal Increases Flexibility While Maintaining the Guarantee. Under your plan, you eliminate causes of action by providers over payment rates by repealing the Boren Amendment. This removes state officials' greatest source of concern over litigation. You could also eliminate health care providers and plans right to sue in federal court for any reason.

Your proposal maintains current law on private enforcement of beneficiary rights under Medicaid. You could take steps to address the Governors' concerns by separating eligibility claims from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

Under this approach:

- There would be no suits by health care providers or health plans over reimbursement rates or any other issue.

- Everyone filing a claim would be required to exhaust administrative remedies. A recent survey of state Medicaid agencies found that in the 40 states that responded, less than 5% of fair hearing decisions were appealed to a court. In California, for example, 4,600 fair hearings were held and less than 1% were appealed. In Wisconsin, 376 fair hearings were held, and 8 (2%) were appealed. (Texas Legal Services Center, 1994)

- Most disputes over benefits would be heard in state court.

- Claims brought by individuals over eligibility would be heard in federal court. **Across the country, there were 6 reported cases over eligibility in 1994, 8 in 1993, 6 in 1992 and 8 in 1991.** (National Health Law Program, Inc., 1995)

Todd

February 19, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco, Laura Tyson and Alice Rivlin

SUBJECT: National Governors' Association Medicaid Resolution

This memo highlights our major concerns with the National Governors' Association (NGA) Medicaid resolution. It summarizes these concerns, outlines our current position with regard to each issue, suggests some possible fall-back positions, and provides you with a reading of the Democratic Governors' positions on each of these issues. It also includes a summary of the Hill and Interest Group reaction to the resolution. We thought you might find this to be useful background information for our Medicaid meeting with you tomorrow morning.

Background

Governors Chiles, Miller, Romer, Engler, Leavitt, and Thompson are coming back in town tomorrow. They are scheduled to testify at Medicaid hearings on Wednesday and Thursday before the House Commerce and Senate Finance Committees. The Governors' testimony will focus on the recently adopted National Governors' Association resolution, and they will attempt to begin to fill in some of the details behind this resolution. Next week, Secretary Shalala has been invited to appear before the Senate Finance Committee to outline the Administration's response to the NGA resolution.

The six Governors will also meet for three hours on Wednesday evening. The Democratic Governors want to continue to work closely with us and will meet with us tomorrow before meeting with the Republican Governors. They rightly believe they achieved a significant victory by getting the Republicans to agree to a new financing mechanism that ensures that "dollars follow people." They also believe that there are a number of provisions that were vaguely drafted, which have been interpreted by many as extremely problematic (such as the NGA benefits section), that can be "clarified" through the normal NGA policy development process. Having said this, the Democratic Governors also acknowledge that they are a number of significant flaws in the NGA agreement that should be addressed.

Where We Agree with NGA

Before outlining our differences and concerns with the NGA resolution, it is important to summarize briefly where we have significant agreement. Your Medicaid reforms include at least 12 NGA-endorsed flexibility recommendations, including arguably the three most important structural changes:

(1) **The establishment of a new financing mechanism that links and constrains federal financing to enrollment** through the use of an open-ended "umbrella" that assures that "dollars follow people" and that states are protected from economic downturns;

(2) **The repeal of the Boren amendment** and other federal provider reimbursement requirements; and

(3) **The liberation of states from the waiver process for:**

- Managed care
- Home and community-based care
- Coverage expansions up to 150 percent of poverty

Outstanding Issues Related to NGA Resolution

There are three sets of issues that will be debated in the legislative process: (1) the "guarantee"; (2) second tier issues; and (3) the Title XIX debate.

The "Guarantee." Those issues that are directly related to the Medicaid "guarantee" (financing, eligibility, benefits and enforcement) will demand most of your attention and are the focus of this memo.

Second Tier, But Critical Issues. There are "second tier" issues, such as nursing home standard enforcement, financial protections for families (like spousal impoverishment), and managed care quality assurance, that will require Administration attention should negotiations progress. These issues helped us personalize the Republican Medicaid cuts and they are viewed as critical by most Democrats. (For example, Senator Pryor feels strongly about the nursing home enforcement issue.)

The Title XIX Debate. Finally, the Republican desire to repeal title XIX and substitute a new Medicaid title raises a host of concerns. Drafting a brand new title for Medicaid in the limited time we have left in this Congress would inevitably lead to unforeseen legal, policy and political consequences. This would include having to determine how to deal with case law -- such as what is the definition of "medical necessity" -- that has developed over the past 30 years. Perhaps most importantly, taking this route would place us in an untenable bargaining position; we would have to give "chits" just to "reinstate" provisions that are current law.

THE NGA RESOLUTION AND THE GUARANTEE: ADMINISTRATION POSITIONS

There are four elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement. Each of these elements is inextricably linked to the others and changes to any one of them must be carefully constructed to avoid undermining the foundation of the guarantee and the program. The following outlines the primary concerns we have with the proposal and summarizes current and possible fall-back Administration positions on these issues.

(1) Financing Concerns:

The NGA proposal uses a financing mechanism that is different from ours but that also assures that dollars follow increases in enrollment. However, it has the following problems:

- **States are guaranteed their base formula allotment even if they choose to reduce coverage.** This provision -- drafted for states like Michigan -- is a significant departure from the historical Medicaid federal/state partnership, where federal financing support rises and falls with changes in coverage.

- **Many states can reduce their state Medicaid matching requirement.** This provision -- hastily inserted for Governor Pataki -- would significantly decrease overall Medicaid spending OR significantly increase Federal spending. It would reduce the maximum state match from 50 percent to 40 percent. If federal spending is capped and all states matched at their minimum levels, the matching rate change would reduce total Medicaid spending by an additional $140 billion over seven years (on top of the already assumed $85 billion in federal savings and $65 billion in state savings). *This could lead to large estimates of coverage loss unless the major eligibility and benefit protections mentioned later in this memo are assured.* If federal spending were not capped, the cost-shift resulting from the lower state match would totally offset the $85 billion in federal savings.

- **States could substitute state tax dollars with revenue raised through provider taxes and donations.** Since this is "borrowed" money, it would effectively reduce states' real spending on Medicaid. Because this would make it easier to raise state matching dollars, CBO (and OMB) would likely conclude that this provision would also significantly reduce Federal savings.

Administration Position: Our CBO-scored per capita cap approach to Medicaid cost containment has a "dollars follow people" mechanism that is more direct than the NGA umbrella and does not include any of the problems mentioned above. We would keep the current matching formula, but propose that a national commission be established to make recommendations on how to address perceived inequities.

Possible Fall-Back Position: The Republican Governors are likely to refuse an Administration-like per capita cap financing mechanism. We may be able to live with a NGA-like financing approach if, as the Democratic Governors' intended, it truly allows dollars to follow people and if the state matching reduction and the provider tax/donation provisions are fixed. **Governors Chiles, Romer, and Miller all have indicated they share our concerns with these provisions and support our position. (In fact, the six "Medicaid" Governors never discussed the provider tax and state matching reduction issues; they were added as last second amendments to the resolution.)**

(2) **Eligibility Concerns:**

- **Repeals current law that phases-in coverage for 1.5 million poor children between the ages of 13 and 18.** OMB estimates a maximum of $6 billion in federal savings if all states do not phase-in coverage. (This would overturn a law enacted by President Bush in 1990.)

- **Allows states to define disability, subject to HHS approval, instead of requiring all states to meet a minimum federal definition.** This proposal could result in widespread variation in eligibility determinations among states and could threaten the eligibility guarantee for people with disabilities.

Administration Position: We retain the kids phase-in and use the welfare reform's approach to address the Governors' concern about disability eligibility abuse. This gives Governors the option not to designate as "disabled" those persons who are alcoholics and chemical and substance abusers, as well as tightens the eligibility definition for children under SSI.

Possible Fall-Back Position: No fall-back for the kids coverage expansion. On disability, we could limit eligibility for other groups if the Governors can demonstrate that there have been eligibility abuses. If this compromise is still not acceptable, we could consider allowing states to define disability, but with much stricter criteria that the Secretary must use to evaluate designations. (This latter approach needs to be politically vetted.) **The Democratic Governors would probably be fine with either of these positions, although Governor Romer thinks the states should not be defining disability eligibility.**

(3) **Benefit Concerns:**

- **Eliminates the current "adequacy" requirement for benefits and gives states unlimited discretion to determine the amount, duration and scope of services within benefit categories.** Under these provisions, the HHS Secretary would have no legal basis for concluding that a one-day hospital benefit was insufficient to meet the federal requirement for a hospital benefit.

- **Repeals current statewideness and comparability requirements for optional benefits.** Without these provisions, states could offer different benefits to different groups of recipients or provide different benefits in different areas of the state. For example, states could decide to provide a no-deductible/no cap prescription drug benefit for a disabled person who had a stroke and a drug benefit with a $500 deductible and a $1,000 cap for a person with AIDS.

- **May repeal the statewideness and comparability requirements for mandatory benefits.** If this is the case, states could offer 5 months of hospital services for children and 2 weeks for the disabled.

- **Redefines the treatment portion of EPSDT (Early and Periodic Screening, Diagnosis and Treatment) so that states need not cover all Medicaid optional services for children.**

Administration Position: The Administration maintains that these concerns must be addressed or the national guarantee to benefits is legitimately called into question. Your proposal retains the current benefit package and protections. On EPSDT, it clarifies that benefits provided to children under the treatment requirement need not be given to any other population (under the comparability requirements.)

Possible Fall-Back Position: Maintain the benefits adequacy standard. Maintain current protections for mandatory benefits, but negotiate significant changes in the requirements on the optional benefits, including eliminating or significantly liberalizing current comparability and statewideness requirements. Negotiate further modifications to the "treatment" requirement within EPSDT, including that the requirement need not extend beyond a certain age group OR the possibility that the benefits provided need not exceed the states' optional package. (These are "hot-button" options that would no doubt have to be carefully rolled out if pursued.) **The Democratic Governors support retention of the "adequacy standard," but -- like the NGA -- have not yet finalized their position on the other benefit issues.**

(4) Enforcement Concerns:

- **Eliminates any federal cause of action under Medicaid by beneficiaries, health care providers and health plans.** Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

  There are four major concerns with this proposal. First, the eligibility would vary between states because state courts would interpret the law differently; the same person could be covered in one state but not in another. Second, fewer remedies would be available under state law than under federal law. Third, Medicaid would be the only federal statute that confers individual rights that could not be enforced in federal courts by its intended beneficiaries.

Finally, the HHS Secretary would be unable to litigate adequately on behalf of individuals because there would be significant new administrative burdens placed on the Department and because the only remedy available to the Secretary would be the withdrawal of funds to the state.

Administration Position: We repeal the Boren amendment and make it clear that providers have no right to sue over payment rates. We retain current law for eligibility and benefit claims brought by individuals.

Possible Back-Up Position: In addition to the outright repeal of the Boren Amendment, we could also eliminate the private right of action by providers and health plans completely (so that they could no longer sue over provider qualifications or other issues not related to reimbursement).

On causes of action brought by recipients, we could follow up on a suggestion made by Governor Chiles and propose separating eligibility claims from some benefit claims. Under this approach:

- There would be no suits by providers health plans over reimbursement rates or any other issue.

- Everyone filing a claim would be required to exhaust administrative remedies. A recent survey of state Medicaid agencies found that in the 40 states that responded, less than 5% of fair hearing decisions were appealed to a court. In California, for example, 4,600 fair hearings were held and less than 1% were appealed. In Wisconsin, 376 fair hearings were held, and 8 (2%) were appealed. (Texas Legal Services Center, 1994.)

- Most disputes over benefits would be heard in state court. Benefits claims would only be heard in federal court if there were an allegation that the state plan or a contract between the state and a provider violated federal law.

- Claims brought by individuals over eligibility would be heard in federal court. **Across the country, there were 6 reported cases over eligibility in 1994, 8 in 1993, 6 in 1992 and 8 in 1991.** (National Health Law Program, Inc., 1995.)

This is not a high priority issue for the Democratic Governors, and we believe that they would support our approach. However, they have reported that the Republican Governors have a philosophical aversion to any Federal right of action. What is clear from our conversations with the NGA staff, though, is that the Governors have not focused on this issue in any great detail.

Conclusion

We hope this information is helpful to you in deciding how the Administration should position itself on the Medicaid front. Attached is a background document on the congressional and interest group response to the NGA proposal.

CONGRESSIONAL AND INTEREST GROUP RESPONSE TO NGA

- **Hill Response to the NGA Resolution:** Most Republicans, through the RNC and comments by the Speaker, are strongly embracing the NGA proposal. They claim that it is a virtual mirror-image of their Medigrant proposal. The RNC is literally passing out paper declaring "victory." The only exception to a complete endorsement from the Republicans is related to their perception of the financing mechanism. They are sending signals that they oppose the open-ended nature of it and are suggesting that they may push for some type of cap. (The Democratic Governors have already indicated that they would "walk" from the deal if this occurred.)

Republicans appear to want to push a "bipartisanly-supported NGA" bill out and dare us to criticize it. It is for this reason that they have so quickly scheduled hearings for this Wednesday and Thursday, and have invited Secretary Shalala to testify next week before the Finance Committee. Having said this, they are reportedly being responsive to NGA calls to not prematurely unveil a Republican "NGA Medicaid" bill and risk a meltdown of the bipartisan agreement. There is no question, however, that they are (behind the scenes) drafting legislation and attempting to get CBO to score it and it is not inconceivable that they may introduce something prior to Secretary Shalala's testimony.

The Republican reaction has fueled the suspicions of the Democrats and, with extremely few exceptions, there has been a generally negative reaction to the NGA proposal. The "base" Democrats, like Henry Waxman, have been extremely critical of the proposal and have charged that it offers no guarantee and may even be a block grant in sheep's clothing.

Congressman Stenholm and Congressman Dingell were apparently quite disappointed in the lack of state accountability, the reduction in state match, and raised concerns about the adequacy of the legal enforcement provisions. They argue that it is not unreasonable to expect a federally-enforced, national eligibility and standards floor in return for a large federal investment. To back up their point, their staffs have been circulating a chart that shows how the coalition proposal would provide $840 billion to state Medicaid programs, at the same time the states are trying to significantly decrease their Medicaid expenditures.

On the Senate side, Senator Breaux distanced himself a bit and called for hearings so he could fully understand the implications of the proposal. His staff reports that Senator Breaux thought the Democratic Governors were going to be able to "cut a better deal than they did." On the moderate Republican side of the aisle, Senator Chafee privately raised concerns about the proposal and suggested it appeared to be something akin to a federal maintenance of effort with too little accountability.

Clearly, however, both Senators' Breaux and Chafee want to keep the Medicaid discussions alive for the sake of a budget deal and will continue to avoid being overly critical in public. According to Senator Breaux's staff, the primary authors of any alternative Medicaid bill will likely be Senator Chafee and Senator Graham. Lastly, there are also reports that Senator Roth's staff is working with the House Commerce Committee to draft up their own version of the "NGA resolution." Since they have fairly "green" Medicaid staff who have previously worked at the House Commerce Committee, it is likely that their bill will largely mirror the House Republican bill.

- **Interest Group Response to the NGA Resolution:** We have received only negative reactions from the groups, including the unions, the American Hospital Association, the American Academy of Pediatrics, the Children's Defense Fund, the Alzheimers' Association and the Consortium for Citizens with Disabilities. The groups, particularly those who represent children and the disabled, feel that enactment of a proposal like the Governors' resolution would significantly increase the number of uninsured and renege on what they believe is a jointly-held commitment with the Administration to expand, or at least not reduce, the number of insured. The AIDS groups are particularly concerned because they greatly fear the benefit changes and the state-by-state definition of disability provision.

The other interest groups are largely staying quiet and waiting to see how we respond to the likely "clarifying" changes expected to emerge from the NGA over the next week or so. Some of them are taking this position because they do not want to undermine our position. Others are holding off because they want to be perceived as "players" in the upcoming negotiation.

The Office of Public Liaison believes that your strong stand on Medicaid has built bridges that extend far beyond the traditional Medicaid constituencies. Public Liaison believes that significant changes from these groups' perception of our past Medicaid position may damage this strong alliance and may be difficult to repair.