

THE WHITE HOUSE
WASHINGTON

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 tomorrow evening to prepare for their Wednesday hearing. The Democratic Governors want to continue to work closely with us and will meet with us 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.

In evaluating the negotiating position the Administration should pursue it is clear that there are two strategies to consider. The first approach would be to maintain your current Medicaid position, which keeps minimum and federally-guaranteed and enforced eligibility, benefits, and financing. Pursuing this strategy would mean that the focus of negotiations would be on the flexibility provisions in administering the program, rather than on the core structure of the program.

The second approach would be to send a signal of additional flexibility on Medicaid and accept more of a block grant-like approach. Pursuing this negotiating strategy would be akin to the welfare discussions and would necessitate an active effort to protect guarantees that are already assured under current law.

Regardless of the approach taken, we would advise that any real or perceived compromise to the Republicans on welfare should be used as leverage to improve your position on Medicaid. We look forward to talking about these issues tomorrow.

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.

blessed. Humble, because there is no way that I can think of myself as some important Government official when I'm on my hands and knees cleaning up where Matthew didn't quite make it to the bathroom.

And blessed, because, there but for the grace of God, go we all.

Now everyone here in this room is among the blessed. We are all successful people. Unlike two-thirds of the American people, I bet that everyone in this room has the wherewithal to know who the Senate Majority Leader is. Hell, I bet everyone here even knows who the Vice President is. Sometimes I think we don't realize how truly blessed we are. For simply an accident of birth might have robbed you of the wonderfully complex minds that you all have.

There are a lot of people like Matthew. You don't realize how many. And there are a lot of people who, even if they are not disabled, can under no stretch of the imagination ever succeed in this world on their own. And that will never change.

Believe me, that's what I think about when I "check on [my child] before [I] go to bed, and as [I] bend over to tuck [him] in." That's what I think about.

Now there are those who say that even without entitlements, no state, and no Governor, would fail to care for the long-term needs of profoundly disabled people like Matthew.

But the truth is, right now, in this allegedly enlightened time of compassionate Governors, states do devote radically different levels of effort to the causes of even the most profoundly disabled. Why, for example, does North Dakota think it takes \$7.67 of every \$1,000 of personal income in the state to care for its mentally retarded and developmentally disabled, while Alabama thinks that it can do the same job with \$1.83 for every \$1,000 of personal income? These are income-adjusted data, now, so it's not just that Alabama is a poor state. This is a fair measure of fiscal effort. And why should Rhode Island think that it needs to spend \$6.21 of every \$1,000 of personal income, while Virginia thinks that \$1.96 is quite enough, thank you?

The truth is that all states do not now treat their needy with the same level of compassion. There was a reason why the Federal Government instituted Nation-wide entitlements in program after program. And the truth is that state after state would take the opportunity of the Governors' Medicaid and welfare proposals to slash their state effort on the needy even further.

But doesn't the Governors' proposal "guarantee" benefits to certain populations? Not hardly. Any "guarantee" that gives states "complete flexibility in defining the amount, duration, and scope of services" is equivalent to giving states authority to restrict benefits so severely that they are meaningless.

This is not responsible. And any budget that would adopt the Governors' Medicaid and welfare proposals would not be a responsible Federal budget.

For responsibility is more than merely balancing the books or ensuring solvency of some imagined trust fund. After all, we would maximize the long-term fiscal solvency of the Medicare Hospital Insurance Trust Fund, for example, by totally extinguishing any

February 14, 1996

For: Jen Klein
From: Amanda
Re: Sullivan v. Zebley

Background:

The Social Security Act authorizes payment of SSI (Supplemental Security Income) under Title XVI to *inter alios* - a child who suffers from any medically determinable physical or mental impairment of "comparable severity" to that which renders an adult disabled. An adult is defined as disabled if he can not engage in "any substantial gainful activity" by reason certain of medically determined physical or mental impairments compared to a list of impairments presumed severe enough to preclude any gainful work. The Secretary of Health and Human Services (SSHS) created a five step process to determine adult disability. In steps one and two the claimant has to prove he is not working and that his impairment is of duration which limits him from working. In step three the claimant has to prove his disability according to the stated definition. If the claimant does not qualify after step three he may qualify at steps four and five by showing he can't do past work or present work in the economy due to age, education, and work experience. However a child claims ends with step 3, if the claimant can not show her impairment matches the list of impairments stated in the adult definition of disability.

Case:

Zebley is a child who was denied SSI and took the case to the District court who granted summary judgment to the SHHS saying that the regulations were not facially invalid of incomplete. Zebley then took the case to the the Court of Appeals third circuit who vacated this judgment saying that the listing does not account for all impairments of "comparable severity" and denies the child claimant "individualized functional assessment" that the statutory requires the secretary provides adults. The court further ordered that the Secretary must give children claimants the opportunity for "individualized assessment of functional limitations".

The Supreme Court affirmed the Third Circuit Court of Appeals decision and in doing so broadened the definition of child disability and the means for which a child is to be determined disabled. The court based its ruling on the decision that the "...SSA's regulations implementing the law for evaluating disability in children did not adequately reflect Congressional intent."

Under the original regulations a child is linked to the definition for adult disability if she suffers from an impairment of " 'comparable severity' to one that would render an adult unable to engage in any substantial gainful activity." This is determined by the list of impairments of disabilities set by the Secretary. This list contains a description of various physical/mental abnormalities and illness mainly categorized by the body system which they affect. Each is defined by several

medical signs. A corollary to this list is "equivalence determination". If the claimant has an unlisted impairment or combination of impairments that is 'equivalent' to a listed impairment he must present medical findings equal in severity to all criteria for the one most similar listed impairment. The claimant can not qualify for benefits under equivalence by showing an overall functional impact is as severe as a listed impairment. However the court ruled that this method of determining child disability does not conform to the statutory standard because it denies coverage to children whose diseases are severe even though they are not listed in the adults listings and can not meaningfully be compared to these listings. Furthermore the Secretary set the medical criteria defining listing impairments at a higher level than is stated in the statutory standard. Thus child disability listings are at the same level of severity as adult listings and are thus more restrictive than the statutory standard.

The court ruled that, one, these listings do not include all illness. Two because of the higher level of severity, the listings exclude claimants who can't perform *substantial gainful activity* but whose condition is not quite severe enough to meet the next level which precludes *any gainful activity*. It also excludes claimants whose impairments exclude him from work given its actual affects on him but does not exclude any and all people with that impairment. Lastly, the equivalence analysis excludes people with unlisted impairments and combinations of impairments. Thus there are many people who do not qualify for disability benefits according to the listings but they have the opportunity to meet the statutory standard in steps four and five of the Secretary's process of determining disability. However, the process to determine child disability stops at step 3, thus children who don not meet the requirement are just denied SSI benefits even if their impairments are of " 'comparable severity' to ones that would actually render an adult disabled." Thus the court held that the child disability regulations are inconsistent with statutory standard of " comparable severity".

The court also changed the means by which a child is determined disabled arguing that children do not have the same opportunities to prove disability as adults do because they are excluded from steps four and five of the Secretary's procedure for determining disability. Although the courts agree with the Secretary in that the vocational analysis of steps four and five is not applicable to children, this does not mean that a functional analysis, such as the impact of the disability on the child's normal daily activities, won't work, particularly if some of the child's own listings are defined in terms of functional criteria. This the court held is no more unmanageable than the adults vocational analysis.

Thus the court broadened the definition of what constitutes a child disability and the method in which such an ability is to be assessed. The new standard for childhood disability claims "... requires the use of an individualized functional assessment of children whose impairments did not meet or equal the severity of listed medical impairments."

Regulations:

The regulations implementing this decision were issued On February 11, 1991. These regulations basically summarized the Supreme Court case and explained in depth the final regulations for deciding disability in childhood cases under SSI. They describe the exact process in determining childhood disability and describe all the steps that are taken. The regulations also define and describe any specific provisions, include notes on the style and language of the regulations, how the decision is made as to whether a child's disability continues or ends, and other regulatory procedures.

* I have a copy of the regulations in full if you want them.

INSERT 1: Title XIX

The NGA resolution repeals Title XIX and replaces it with a new Medicaid title. This raises a host of legal and policy concerns and would create enormous uncertainty for states, beneficiaries and health care providers about their rights and responsibilities under the new statute. This would also lead to a significant increase in litigation. It would also place us in an untenable bargaining position. For every provision in Title XIX that we want to maintain, we would have to give something in return.

INSERT 2: Private Right of Action

The NGA resolution eliminates any federal cause of action under Medicaid by beneficiaries and 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.

The most significant problem with the resolution is that eligibility will vary between states because state courts will interpret the law differently; the same person could be covered in one state but not in another. In addition, fewer remedies are available under state law than under federal law. Finally, the Secretary of Health and Human Services will be unable to litigate adequately on behalf of individuals because there will be significant new administrative burdens placed on the Department and because the only remedy available to the Secretary is the withdrawal of funds to the state.

Administration Position: Retain federal cause of action -- current law.

Possible Back-Up Position:

We have already proposed the repeal of the Boren Amendment and made clear that providers would have no right to sue over payment rates. We could also eliminate the private right of action by providers and health plans completely.

On causes of action brought by beneficiaries, we could follow up on a suggestion made by Governor Chiles and propose separating eligibility claims from some benefit claims. Individuals would retain their current right to bring suits in federal court for eligibility claims but 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.

[Take out second paragraph. Replace with sentence saying this is not high priority for Democrats but Republicans feel very strongly about this.]

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)



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

MEMORANDUM FOR LAURA TYSON

From: The Secretary
Subject: Questions on NGA Medicaid plan

OVERVIEW

The President's stand on Medicaid throughout the budget debate has been very successful because it is grounded in sound principles that are reinforced by his well-known personal commitment to health care coverage. He has received a great deal of credit by insisting on a balanced approach to Medicaid reform that:

- preserves the federal guarantee of a Congressionally-defined benefit package for Medicaid beneficiaries;
- preserves Medicaid protection for currently eligible groups;
- maintains our shared financial partnership with states as they provide health coverage to needy individuals;
- provides unprecedented new flexibility to states in how to operate their programs, pay providers of care, and operate managed care and other arrangements, with continuing programmatic and fiscal accountability, and federal savings that contribute to the balanced budget plan.

Last week, the National Governors Association (NGA) approved the outlines of a plan that they are now refining. The lead Democratic Governors in those negotiations worked long and hard to convince their Republican colleagues to agree to a financing alternative to the block grant that allows the federal funding to appear to be more responsive to enrollment changes. As the President has indicated, those discussions and that movement on the financing structure have been helpful.

QUESTIONS ABOUT THE NGA MEDICAID PLAN

However, as we continue to review the evolving NGA policy, it is clear that it does not meet the principles that have served as the basis for the President's position. The attached documents review the key issues. In brief, the governors' plan repeals title XIX, the current Medicaid program, and replaces it with a new program that falls short of the President's principles.

Eligibility/Benefits/Enforcement

While the NGA policy retains the States' entitlement to federal funding, it repeals the existing federal entitlement or guarantee of Congressionally-defined health benefits for Medicaid beneficiaries. It is important to note that when we use the phrase federal "guarantee" it has a different meaning than when others use it. For us, it means an entitlement, with three key interrelated components -- definitions of eligible groups, benefits, and enforcement. The NGA plan provides for a "guarantee" of coverage that makes marginal improvements in the Republican block grant, but it is only a nominal guarantee.

- **Eligibility.** While the NGA plan includes a number of mandatory groups, it repeals the current law phase-in of Medicaid coverage for children ages 13-18 in families with income below the federal poverty level -- repealing a coverage expansion signed into law in the last Administration. Further, the plan repeals the federal standard for defining disability, replacing it with state definitions -- making uncertain coverage and benefits for populations such as those with HIV; and it is unclear about guaranteed coverage of cash assistance populations and those making the transition from welfare to work;
- **Benefits.** While the NGA plan lists required benefits for the mandatory populations, it provides "complete" flexibility in defining the adequacy of those benefits (amount, duration and scope). It is silent on whether benefits must be comparable among or within groups and areas of the state; makes an unspecified change in the currently required treatment component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and sets no standard for benefits for optional beneficiary groups.
- **Enforcement.** The NGA plan repeals the federal right of action for individuals and limits claims that a state is violating federal law to resolution by state courts. Medicaid would be the sole federal statute conferring no possibility of federal enforcement by its intended beneficiaries.

Financing

The NGA plan's proposed financing may be responsive to enrollment changes -- a change that Democratic governors have insisted on -- but more details are needed. We need to continue to work with the Democratic governors to help them assure that the plan specifics reflect the need for a financing structure that truly adapts to enrollment changes.

Apart from gaining more details about the federal structure, the real financing problem is that the plan could substantially lessen state contributions to health coverage under Medicaid.

- The maximum state matching percentage drops from 50 percent to 40 percent. In the context of a capped program, this could increase the total Medicaid funding cuts

substantially. Analyses of a comparable provision in the Republican plan indicate that an \$83 billion federal cut could yield additional state cuts of over \$200 billion under this approach. Alternatively, in an open-ended financing approach, this provision could substantially increase federal costs, as states could capture more federal matching for the same amount of state funds.

- Moreover, the "real" state share could change because of another provision in the NGA approach. The plan allows states to use questionable provider donation and tax provisions without limits, like those in the late 1980s and early 1990s that significantly drove up federal program costs and reduced actual state spending — ultimately states could take all of their funds out of the program with these mechanisms. Bipartisan legislation in 1992 closed these financial loopholes.

The federal costs and savings of the proposal are important in the context of the President's balanced budget plan, which includes \$59 billion in federal Medicaid savings. At this point, it is unclear whether the NGA plan will achieve federal savings of the type envisioned in the balanced budget plan.

Quality/Beneficiary Financial Protections/Accountability

By repealing title XIX, the NGA plan repeals beneficiary financial protections, and quality and fiscal standards that are essential components of the Medicaid program. For example:

- The NGA plan does not appear to include requirements for quality standards for managed care plans.
- The NGA plan retains the Republican Conference Agreement approach of eliminating federal enforcement of the nursing home standards.
- The NGA plan is silent on beneficiary financial protections: these include spousal impoverishment protections as well as financial protections for the adult children of aged nursing home residents.

NEXT STEPS

The NGA took an important and logical step that reflects the legitimate interests of the governors. The Democratic governors did a good job in moving the Republican governors in the direction of a per enrollee financing structure. However, we should all recognize the inherent constraints on any process driven solely by any one interest, including the governors. The majority of the governors are Republicans who had already signed on to the block grant approach that the President vetoed. In addition, it is difficult, if not impossible, for even our strongest Democratic governors to argue personally with fellow governors for federal standards in many areas that have been central to the President's position, despite the unprecedented flexibility that is already

offered in the President's plan.

The President's approach should continue to serve as the basis for Democratic unity on Medicaid. As the NGA proceeds to flesh out its plan, we need to foster discussions among the Democratic governors and members of Congress about how best to adapt the President's proposal to meet our shared goals.

ATTACHMENTS

- **ENTITLEMENT: ELIGIBILITY/BENEFITS/ENFORCEMENT**
- **FINANCING**
- **ACCOUNTABILITY**

ENTITLEMENT TO A MEANINGFUL BENEFIT PACKAGE

Overview

The most fundamental principle underlying the President's Medicaid reform plan is the concept that beneficiaries are entitled to a meaningful benefit package. So long as they meet the eligibility requirements, certain categories of individuals have an absolute and enforceable guarantee of benefits—a guarantee upon which they can rely. There are three basic components to the Medicaid entitlement:

- Eligibility
- Benefits
- Enforcement

Eligibility

The NGA resolution provisions on eligibility include a number of groups as "guaranteed" eligibles, i.e., coverage is "guaranteed" for the following:

- Pregnant women, and children to 133% of poverty
- Children to age 6 up to 133% of poverty
- Children 6-12 to 100% 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 optional groups
- Other individuals or families as defined by the state but below 275% of poverty

However, the NGA resolution fails to address certain key populations.

- Medicaid would no longer be phased in for children 13 - 18 under 100% of poverty as would be the case under current law. This coverage was enacted with bipartisan support.
- States can apply more limited definitions of disability than exist under federal law. This provision could lead to severely restricted definitions of disability resulting in very limited coverage for a population whose service needs are among the most costly. For example, states could define disability in ways that preclude individuals with certain diagnoses (HIV, or mental illness) from being able to receive needed services under Medicaid. This is particularly significant because the disabled are unable to work and therefore less likely to have other health insurance.

- It is important to note current welfare reform proposals include changes in key areas in the definition of disability to address substantive concerns raised by states and others.
 - 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 related coverage is very unclear, and the NGA resolution provides insufficient information about the links between new welfare definitions and Medicaid coverage.

Benefits

The NGA resolution includes the following list of benefits that are "guaranteed" but only for "guaranteed" coverage groups.

- Inpatient and outpatient hospital
- Physician
- prenatal care
- nursing facility
- home health
- family planning and supplies
- laboratory and x-ray
- pediatric and family nurse practitioner
- nurse midwife
- EPSDT, with limitations on requirements for treatment

The resolution stipulates that all other services would be optional, and there would be a broadened long term care benefit.

Even given the apparent progress made in defining a mandatory benefit package, there are still serious concerns with the provisions of the NGA resolution.

- A responsible health care program must provide benefits that are adequate to achieve their purpose. Under the NGA resolution, states would be given complete flexibility to define the amount, duration and scope of the benefits to be provided. These provisions taken as a whole raise serious concerns about whether the Secretary would have any ability, in the case of over-restrictive state plans, to disapprove a benefit package that would be effectively meaningless.

- Because the NGA resolution is silent about requirements for comparable services for all eligible groups, or provision of services on a statewide basis, there is concern that states might structure benefit packages that are more limited for more costly populations, (e.g., the disabled), or might provide less comprehensive services in certain parts of the state. There are serious questions about the equity that might result under the NGA approach.
- The NGA would limit the treatment option under EPSDT in a manner that is still unclear.
- The Administration has indicated a willingness to discuss additional flexibility--offering optional benefits to optional beneficiaries in the context of the President's plan.

Enforcement

The third essential component of the entitlement is enforcement. The NGA resolution contains provisions requiring states to provide a guaranteed state right of action, but eliminates any federal right of action for individuals and providers. The only access to federal court would be the opportunity to petition the U.S. Supreme Court for review from a decision of state's highest court. The NGA provisions pose a number of serious questions and concerns.

- Implicit in the concept of defined populations and defined benefits is the back-up of a meaningful enforcement mechanism. A federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States.
- Under the NGA proposal, Medicaid would be the single federal statute conferring no possibility of federal enforcement by its intended beneficiaries; seeking enforcement of title XIX would be the one cause of action arising under federal law that would be barred from the federal courts. Such an unprecedented step would be seen by important constituencies as a signal of second-class status and would set off massive reaction from beneficiary groups and their allies. Advocates for the poor would be restricted to the remedies and procedures available under state law, which are often stricter than those under federal law.
- The largest number of suits against states have been filed by providers over payment rates. Under the administration's plan, the Boren Amendment would be repealed, thereby eliminating these causes of action by providers. Going further, the Administration has indicated a willingness to specify that there would be no right of action by providers over payment rates under statutory provisions other than the Boren Amendment. Thus, under the Administration's plan, state concerns about limiting their exposure to suit in federal court would be largely resolved. Given the broader federal policy and the reality that beneficiary suits have not been a problem, further changes to individual right of action would appear to be unnecessary.

- Those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. Efficiency and predictability are best served by using the federal court system, when the same question arises across multiple jurisdictions. Moreover, when Medicaid-based claims interact, as they often do, with other areas of federal law (Medicare, Social Security), the federal courts are more experienced in analyzing these statutory relationships and are better able to understand and decide cases with potentially broad ramifications.
- There is no indication that federal judges--the vast majority of whom were appointed by Republican presidents--ignore or take lightly the legitimate concerns of state administrators.

FINANCING

The National Governors' Association resolution would replace the current financing system with a combination of a fixed federal payment, and a payment adjustment 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.

From the beginning of the current Medicaid debate, the President has maintained that Medicaid must be financed through a federal-state partnership that ensures a reasonable and appropriate amount of funding to provide meaningful benefits to eligibles while also protecting states from increases in enrollment. Although growth in federal expenditures for Medicaid can be slowed, any adjustments must be based on who a state covers, not an arbitrary ceiling (Block Grant) that does not provide states with enough federal funds to provide coverage and benefits in times of economic downturn or increased enrollment.

- Although the NGA resolution reflects progress toward a financing structure based on enrollment, there are still some questions that must be addressed. Many of these questions will not be answered until there is sufficient specificity to enable some assessment of the budget implications of the NGA resolution. We should continue to work with Democratic governors to maintain their progress on this issue.
- Raising the minimum federal match rate from 50 percent to 60 percent will allow states to reduce their spending by over \$200 billion over the next seven years, and will raise the average federal share of total program costs from 57 percent to 63 percent.
- Also, permitting the use of provider tax and donation schemes will allow states to reduce the amount of "real" state dollars which they contribute to the program. During the late 1980s and early 1990s, many States took advantage of these schemes, costing the federal government billions of dollars and helping drive growth rates up to well over 20 percent. The Inspector General continues to express concerns about such financing schemes.

ACCOUNTABILITY

The President's plan proposes unprecedented new flexibility for the states in how to operate their programs, pay providers, and use managed care and other delivery arrangements. At the same time, it retains core standards related to quality and beneficiary financial protections.

The NGA resolution would repeal title XIX and create a new title for the Medicaid program. This has the de facto effect of compromising seriously the existing framework for accountability that provides governance for the Medicaid program today. The NGA resolution is silent in many areas that affect Medicaid reform. And in areas where the resolution is specific, some long-standing protections would be reduced or eliminated.

- The NGA resolution eliminates the federal role in monitoring nursing home quality assurance--yet without federal monitoring and enforcement of state and facility compliance, the uniform quality standards established by OBRA 87 are meaningless.
- Nearly a third of all Medicaid beneficiaries are currently enrolled in some form of managed care. The NGA resolution makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care.
- The NGA resolution does not address beneficiary and family financial protections such as spousal impoverishment and family responsibility that have been central to the Medicaid program for years. These protections are maintained in the President's plan. The NGA resolution also does not address the imposition of copayments and other cost sharing for Medicaid beneficiaries.
- There are ways, similar to the approach taken in the President's plan, to provide states with considerably expanded flexibility in management and operation of their Medicaid programs, without reducing the framework of responsible accountability to meaninglessness. There must be at least a modicum of reporting requirements and monitoring in a program that spends over \$100 billion federal dollars. The NGA resolution expands federal funding and reduces ongoing congressional and executive management of the program.

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



PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: JACK

To: CHRIS
Sen
Nancy Ann

Phone: (202) 690-_____
(202) 690-6870
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Phone: _____
Fax: _____

Number of Pages (Including Cover): _____

Comments:

Inserts to Chris' briefing
document, as requested

Nursing Home Quality Concerns:

- **Federal enforcement authority is eliminated. Uniform quality standards are meaningless without the federal role in validating state survey efforts and enforcing state and facility compliance.**
- **Claims to retain OBRA '87 quality standards, but it is unclear whether many key standards and protections are eliminated as in the Conference Agreement.**

Administration Position: We preserve uniform federal quality standards for nursing home care and a significant federal role in enforcement of standards and innovation to improve care practices mandated in OBRA '87.

Possible Fall-Back Position: None

ICFs/MR Quality Standards Concerns:

- **Repeals Federal quality standards for institutions caring for people with mental retardation and developmental disabilities ("ICFs/MR"); eliminates the guarantee for anything more than custodial care.**
- **Does not require States to issue standards that would ensure even the most basic rights, such as protection from abuse and neglect and treatment designed to assist the MR/DD achieve their greatest level of independence.**

Administration Position: We retain the federal standards that were adopted in the 1970's and strengthened under President Reagan.

Possible Fall-back Position: None

Managed Care Quality Concerns:

- Does not appear to include any requirements for quality standards for managed care plans.
- Does not contain minimum qualification standards for health plans or providers.

Administration Position: We replace out-dated statutory rules with real quality of care protections for managed care enrollees. States would be required to develop overall quality improvement strategies including standards for Medicaid-contracting health plans, State-level monitoring strategies, and State-level data analysis to track managed care outcomes. Medicaid-contracting health plans would be required to meet certain standards, such as demonstrating adequate capacity to deliver contracting services for all populations and maintaining internal quality assurance programs and grievance processes. The Federal government would continue to provide States with technical assistance on quality issues -- such as the current Medicaid HEDIS project -- and monitor State and health plan performance.

Possible Fall-Back Position: none

Financial Protections for Families:

- Not specified.

Administration Position: The Administration plan retains the following current law provisions that protect families against excessive out-of-pocket obligations to pay for the medical expenses of an impaired family member:

- Prohibitions on providers against balance billing, supplemental fees, admission charges, promissory contracts as a condition of receiving the service.
- Copayments are either prohibited or must be nominal.
- Protected income and assets for at-home spouse of persons receiving long-term care.
- Restrictions on liens, estate recoveries to protect surviving spouses and dependent children.

Possible Fall-Back Position:

No fall-back on concept of no excessive obligations on families. However certain modifications could be negotiated on liens and estate recoveries.

OPTIONAL BENEFITS AND FLEXIBILITY TO GOVERNORS

Governors Have Significant Benefit Flexibility Today. Although some Governors think their optional costs are even greater, spending on optional benefits averages just under 50% nationally. So, as you have pointed out recently, Governors already have the ability to lower their costs significantly or reinvest in other benefits simply by eliminating optional benefits.

Eligibility Expansions Without Waivers. Under your Medicaid reform proposal, Governors can expand eligibility without waivers. States can add eligibility groups as long as: (1) the new beneficiaries have incomes up to 150% of the federal poverty level; and (2) spending stays below the per capita limit.

How the Per Capita Cap Works to Provide Flexibility. Under one scenario, for example, the state could spend \$1,000 less than its per capita limit per senior (the limit is based on a 1995 base level of expenditures on both optional and mandatory services, indexed forward). With 1,000 senior enrollees, that would free up \$1 million within the state's aggregate limit (\$1,000 per enrollee times 1,000 senior citizens). The state has three options: (1) save the state share of the funds; (2) spend above its per recipient limit for another group; or (3) use the funds to expand eligibility to new groups with incomes up to 150 percent of the poverty level. Governor Romer believes that this could be the most important of all of our flexibility provisions.

February 8, 1996

MEMORANDUM TO THE PRESIDENT

FROM:

SUBJECT: The Medicaid "Guarantee" and Issues Raised Surrounding the NGA Resolution

The National Governors' Association (NGA) Medicaid resolution passed on Tuesday has received a great deal of attention from the media, the Hill, and provider and advocacy organizations. As a whole, the right has given this proposal widespread praise and 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 briefly analyzes whether the NGA proposal retains the coverage "guarantee." It also provides an update of reactions, to date, from the Governors, the Hill and the interest groups. We are also happy to meet with you to discuss this further.

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. Your latest proposal, incorporated into your balanced budget proposal, provides unprecedented flexibility to the Governors while maintaining the guarantee and saving \$59 billion over seven years.

In response to you and the Republican Leadership, the Governors 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. 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 represents a major step forward. To achieve this victory, however, the outnumbered Democrats were forced to give in on provisions that may

well undermine other aspects of the Federal guarantee.

Four Parts of the Guarantee Under Medicaid

There are four parts that make up the guarantee: financing, eligibility, benefits, and enforcement. Since the debate has so focused on this guarantee, it is likely that any compromise will be evaluated in this context.

- **Financing Guarantee.** First, to protect the States from being excessively burdened by the impact of an economic downturn, the financing needs to follow increases in covered populations and the Federal/State financial partnership must be retained. Although the NGA resolution financing formula has flaws, the so-called "umbrella" seems to successfully achieve the financing guarantee because it assures that Federal dollars will increase as enrollment increases. The primary problems with the NGA financing mechanism are that it allows too many avenues for the States to tap into the Federal treasury that will likely lead to a very high CBO cost scoring. These include:

CHRIS

- **Eligibility Guarantee.** Today, Medicaid guarantees health services to poor children, pregnant women, people with disabilities and older Americans. The NGA proposal repeals the phase in of coverage for about three million poor children between the ages of 13 and 18 with working parents. This phase in, which will be completed by October 2002, was signed into law by President Bush in 1990. 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 will mean that whether a person with a disability is eligible for Medicaid will depend on where he lives.
- **Benefits (Coverage) Guarantee.** The NGA proposal leaves in place the current list of covered benefits for mandatory coverage groups. However, it seems to eliminate any defined benefit package for optional groups. In addition, for both mandatory and optional benefits, the proposal gives states unlimited discretion to determine the amount, duration and scope of services within benefit categories, and to offer different benefits to different groups of beneficiaries or in different areas of the state. For example, 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. It is unclear, however, whether the Governors intended to go this far on both mandatory and optional benefits.

The proposal also redefines the treatment portion of EPSDT (Early and Periodic

THE NGA RESOLUTION**Where We Agree with NGA**

The President's Medicaid reforms includes at least 12 priority 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;**
- (2) **The repeal of the Boren amendment; 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

In any discussion of Medicaid reforms, there are countless issues that will be raised. In general, the issues the White House will likely have to focus on are:

- (1) **The "Guarantee:" Financing, Eligibility, Benefits, Enforcement**
- (2) **Second Tier, But Critical Issues: Nursing Home Standard Enforcement, Financial Protections for Families, and Quality**
- (3) **The Title XIX Debate: Implications of a New Medicaid Title**

THE NGA RESOLUTION AND THE GUARANTEE: ADMINISTRATION POSITIONS

There are 4 elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement. 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:

- States are guaranteed their base formula allotment even if they choose to reduce coverage.
- Many states can reduce their state Medicaid matching requirement.
- States could substitute state tax dollars with revenue raised through provider taxes and donations. *H gives \$1.00. State gives hospital \$1.50. State gets \$.75 from fed. State up \$.25. Hospital up \$.50.*

Administration Position: Our CBO-scored per capita cap approach to Medicaid cost containment has a much more direct "dollars follow people" mechanism and has none of the above-mentioned problems.

Possible Fall-Back Position: We may be able to live with a NGA-like financing approach if it lives up to the Democratic Governors' intent and it eliminates the state matching reduction and the provider tax/donation provision. **The Democratic Governors would support these modifications.**

(2) Eligibility Concerns:

- Repeals current law phase-in of coverage for 1.5 million poor children between the ages of 13 and 18.
- Allows states to define disability, subject to HHS approval, instead of requiring all states to meet a minimum federal definition.

Administration Position: We retain the kids phase-in and we would use the welfare reform's approach to address the Governors' concern about disability eligibility abuse. (This removes certain categories of eligible populations --alcoholics, chemical and substance abusers, etc. -- from mandatory coverage requirements.)

Possible Fall-Back Position: No fall-back for the kids coverage expansion. On disability, we could specifically address additional eligibility abuses raised by the Governors. We could also consider allowing states to define disability, but only if there were strict in statute criteria that the Secretary must use to evaluate designations. **Again, the Democratic Governors would be fine with this position.**

(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.
- Repeals current statewideness and comparability requirements for optional benefits.
- May repeal of the statewideness and comparability requirements for mandatory benefits.
- Redefines the treatment portion of EPSDT (Early and Periodic Screening, Diagnosis and Treatment) so that "states do not have to offer optional services."

Administration Position (Benefits): The Administration 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.

Possible Fall-Back Position: 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. **The Democratic Governors would likely desire to go further on these issues than we may, but it is likely we could work this out.**

(4) **Enforcement Concerns:**

Choose state or fed?

State it for A

State it

Only fed it for

- Eliminates the federal cause of action by Medicaid recipients.

Administration Position: Retains federal cause of action -- current law.

Possible Back-Up Position: We could follow-up on a suggestion made by Governor Chiles and separate 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.

This is not a high priority issue for the Democratic Governors, but they believe that it may be necessary for us to give on this provision in order to get a deal with the Republicans. Movement away from our position most certainly requires a serious policy, legal and political review.

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 beneficiaries in the state).

CHRIS

Where We Agree with NGA

The President's Medicaid reforms includes at least 12 priority 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**, thereby assuring that "dollars follow people" and 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

In any discussion of Medicaid reforms, there are countless issues that will be raised and debated in the legislative process. In general, the issues the White House will likely have to focus on are:

The "Guarantee." Some issues, like those that are directly related to the Medicaid "guarantee" (financing, eligibility, benefits and enforcement), will demand most of our attention and are the focus of the attached document.

Second Tier, But Critical Issues. There are "second tier" issues, such as nursing home standard enforcement, financial protections for families, and quality assurance, that will require Administration attention should negotiations progress successfully.

The Title XIX Debate. And finally, the Republican desire to repeal title XIX and substitute a new Medicaid title raises a host of legal and policy concerns that we cannot even begin to fully contemplate. For example, it would force us (or the states) to go through the ugly process of redefining the legal definition of "medical necessity." (It would also 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 4 elements that make up the Medicaid guarantee: financing, eligibility, benefits, and enforcement. Each of these elements are inextricably linked and changes to 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:

- **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. In fact, estimates from HHS indicate that the \$85 billion in federal savings would translate into \$290 billion in total spending reductions if all states matched at the minimum level.)
- **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. This, and the previously-mentioned provisions that make it easier for states to tap into the federal treasury, may have an impact on how OMB/CBO would score this proposal.

Administration Position: Our CBO-scored per capita cap approach to Medicaid cost containment has a much more direct "dollars follow people" mechanism. We do not have any provisions for reduced state matching rates and do not permit the reinstatement of provider taxes/donations. Moreover, states who reduce their coverage are not permitted to retain federal matching dollars in excess of this coverage.

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 it lives up to the Democratic Governors' intent and it eliminates the state matching reduction and the provider tax/donation provision. **The Democratic Governors would support these modifications.**

(2) Eligibility Concerns:

- The NGA proposal repeals current law that phases-in coverage for 1.5 million poor children between the ages of 13 and 18.
- The NGA proposal allows states to define disability, subject to HHS approval, instead of requiring all states to meet a minimum federal definition. (As currently drafted, this proposal has potential to 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 we would use the welfare reform's approach to address the Governors' concern about disability eligibility abuse. This would provide Governors with the option to not designate as "disabled" those persons who are alcoholics and chemical and substance abusers.

Possible Fall-Back Position: No fall-back for the kids coverage expansion. For the disability eligibility issue, we could add other categories of "optional" eligibility designations that the Governors can illustrate represent 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.) **Again, the Democratic Governors would be fine with this position.**

(3) Benefit Concerns:

- The NGA proposal apparently 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 to provide a hospital benefit.)
- The NGA proposal repeals current statewideness and comparability requirements for optional benefits. (Without these provisions, states could offer different benefits to different groups of recipients, or different benefits to different areas of the state. For example, states could decide to provide a no deductible prescription drug benefit for the elderly and a drug benefit with a \$500 deductible with a \$1,000 cap to people with AIDS.)
- The NGA proposal may repeal the statewideness and comparability requirements for mandatory benefits. (If this is the case, the state could offer 5 months of hospital services for children and 2 weeks for the disabled.)
- The NGA 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."

Administration Position (Benefits): The Administration 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 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 would likely desire to go further on these issues than we may, but it is likely we could work this out.**

(4) **Enforcement Concerns:**

- **The NGA proposal eliminates a federal cause of action by Medicaid recipients.** (Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. 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).

Administration Position: Retains federal right of action -- current law.

Possible Back-Up Position: The Republicans will not accept current law or, for that matter, practically any alternative to their approach. However, to show our interest in attempting to address their concerns, we could follow-up on a suggestion made by Governor Chiles and separate 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.

This is not a high priority issue for the Democratic Governors, but they believe that it may be necessary for us to give on this provision in order to get a deal with the Republicans. There are, however, obvious and major implications of going beyond our back-up position. Movement away from our position most certainly requires a serious policy, legal and political review.

NOTE FOR THE DIRECTOR

FROM: Nancy-Ann Min

NAM

RE: Governors' Medicaid Proposal

DATE: Februaru 14, 1996

I wanted you to be aware that apparently, CBO has reviewed the Governors' Medicaid proposal and concluded that it is "not detailed enough to do a cost estimate" and "could be interpreted to raise costs." (See the attached article from today's Health News Daily).

From our preliminary review, we would agree. But the fact that CBO says this is important, because it slows down the process. As I mentioned this morning, Congressional Democrats are worried that the relevant committees are scheduling hearings next week to highlight the Governors pushing their proposal in a way that will make it more difficult to fix the problems that we have identified.

It appears that CBO may have written a letter on this subject, which we are trying to obtain.

cc: Jack Lew
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Wednesday, February 14, 1996

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MEDICAID REFORM MOMENTUM UNCERTAIN; CBO UNABLE TO SCORE NGA PROPOSAL agreed to unanimously by the nation's governors. The Congressional Budget Office said Feb. 13 that not only is the National Governors' Association Feb. 6 agreement "not detailed enough to do a cost estimate," but it is "so broad and so general" that it "could be interpreted to raise costs." CBO has yet to receive new Medicaid legislative language from Congress since the NGA agreement and is "less hopeful" it will receive language this week than it was last week.

While congressional staffers have estimated that the NGA agreement likely would net seven-year savings between the President's \$59 bil. and Republicans' \$85 bil., CBO noted that several provisions could "open the doors" to increased federal spending. For example, states would more easily draw down federal dollars under the repeal of provider tax/donation laws, and likely would have an incentive to increase enrollment so as to receive supplemental monies under the "umbrella fund."

The "umbrella fund" is a "critical" aspect of the plan, but is only roughly sketched out, CBO notes. The fund remains a trouble spot for any bill. Florida Gov. Lawton Chiles (D), a key player in the negotiations to the governors' deal, insisted that the fund not be capped, but Republican lawmakers are keen to ensure that it not be open-ended. The agreement allows states to cover — and receive federal money for — individuals and families below 275% of poverty and "all other optional groups in the current Medicaid program."

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The DLC Update

Visit the DLC-PPI Web site for more information on welfare, Medicaid, our listservs, and Oregon's historic vote-by-mail election—<http://www.dlcppi.org/>.

The Democratic Leadership Council

Tuesday, February 13, 1996

Governors Forge Ahead With Plan for Welfare and Medicaid

During a recent annual three day winter meeting, the nation's Governors accomplished what Congress failed to do over an entire session: reach a unanimous agreement for reforming both welfare and Medicaid. Although the proposals are only a framework and can be improved, they are an important start that builds on the common ground between the parties and responds to the public demand for reform.

The DLC stands with the nation's governors in trying to break through election-year partisan gridlock to reform welfare and Medicaid. President Clinton and the Congress should follow the governors' lead and make the NGA proposals the basic framework for bipartisan action in these two areas.

On welfare, the Governors' statement that the "continuation of the current welfare system is unacceptable" reflects overwhelming public sentiment and repudiates the advocacy groups fighting to maintain a federal entitlement to cash assistance. The Governors' proposal refocuses the debate on the real issue: how to put people to work by creating a new system of temporary assistance aimed at helping recipients quickly find jobs in the private sector.

The proposal includes the Progressive Policy Institute's idea of giving states a bonus for putting people to work and other key structural changes needed to transform the income maintenance system into an employment system.

The Governors support enough funding to give these reforms a strong chance to succeed, including **\$4 billion more for child**

care than the bill the President vetoed.

On Medicaid, the Governors struck a middle ground between proposals to maintain today's ever-more-costly entitlement and those that abandon minimum coverage entirely through a block grant.

Instead of today's unlimited federal payments to states, the Governors propose a per capita spending limit. In exchange, states get the flexibility to lower costs. Coverage remains guaranteed to Americans lacking health insurance due to poverty or the impact of a recession, whether or not they are welfare recipients.

By taking the lead on these two issues, the Governors have eloquently answered those in Washington who claim they cannot be entrusted with greater responsibility for the health and welfare of their citizens.

Yet the Governors' efforts are already under fire. Many on the Right would rather have a campaign issue than bipartisan action. Many on the Left want to preserve the paternalistic entitlements of the welfare state, in the face of the President's announcement that "the era of big government is over."

The choice is clear: Democrats and Republicans can either answer the Governors' wake up call, or they can spend their time searching for reasons to do nothing and increase the hemorrhaging of confidence in the political system. It may be an election year, but it is clear voters believe it is *time to govern*.

The DLC Update

With this issue, *The DLC Fax* takes on a new name—***The DLC Update***. We've found that with the distribution of this product over electronic mail and the Web, the term "fax" has become a bit inaccurate.

For those of you who find this product an invaluable tool, we'd like to let you know all of the ways it is accessible: (1) **Fax:** *The DLC Update* is broadcast by fax on a weekly basis to DLC elected officials, donors and much of the political establishment; (2) **E-mail:** Anyone with an electronic mail account can receive *The DLC Update* for free. For more info on our public and members-only listservs, visit our Web site or call 800/546-0027; (3) **Web Site:** We'll post the most recent *Update* on our Web home page.

If you have any questions, please feel free to e-mail us at info@dlcppi.org.

Development Luncheon Briefings

Board of Advisors, Roundtable, NDF, and

Sustaining members! We have scheduled two luncheons with Senate AAs from noon to 1:30 pm in the lower level conference room of the DLC offices, 518 C Street, NE. Dates and special guests follow: **Wed, 2/28**, with **Fred Hatfield** (Breaux) and **Bill Andresen** (Lieberman) and **Wed, 3/13**, with **Pete Rouse** (Daschle) and **Bob Hurt** (Nunn). Please call Angela at the DLC, 202/546-0007, to RSVP.

DLC Spring Retreat

Please mark your calendars for the **1996 DLC Spring Retreat, May 2-5**, in **New Orleans** for the second weekend of the **Jazz Festival**. The retreat will be open to current members of the DLC Board of Advisors, PPI Roundtable, and PPI Trustees. The registration fee of \$1500 will include charter air transportation to and from Washington Dulles airport, meals, special events, and tickets for the Jazz Festival.

We look forward to having you with us! Call the Development Department at 202/546-0007 if you have any questions.

ODLC Leader Instrumental in Historic Vote-by-Mail

Congratulations to DLC leader and Oregon Secretary of State **Phil Keisling** for a successful and historic "vote-by-mail" initiative.

Oregonians chose Ron Wyden as their new Senator in a special, vote by mail election in which 65.8% of OR's 1.8 million registered voters cast ballots. This set a new record for highest turnout in a special election in OR in the 20th century. The figure was just under the 68.4% turnout in the 1994 general election, which included dozens of races and 18 ballot measures.

Look for a related article by Keisling in the March/April issue of *The New Democrat*.

For those of you who are interested in bringing vote-by-mail to your state, you can learn more about this innovative initiative by visiting the Oregon Secretary of State's home page, accessible through the ODLC Web site at <http://www.teleport.com/wodk>.

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Health News Daily

Wednesday, February 14, 1996

The bipartisan optimism that immediately followed the NGA agreement may be fading. Referring to a Feb. 12 White House meeting with NGA and Administration officials, an aide to Republican Gov. John Engler (Mich.) reported that "our guys walked away much more skeptical about whether there'll be an agreement." President Clinton was, the aide claimed, "less than enthusiastic" about the plan, acting "much more negative in private" than he has in public statements.

However, bipartisan moderate Senate staffers to the "centrist coalition" led by Sens. John Chafee (R-R.I.) and John Breaux (D-La.) met Feb. 13 to begin an attempt to "start slogging through the issues" and "get an agreement on Medicaid" that would reflect pieces of the governors' proposal, according to one aide.

However, no clear momentum is pushing the process ahead — "so much for this breaking the gridlock," one Medicaid staffer commented. The legislative lead for a Medicaid initiative would likely come from the House. House Speaker Newt Gingrich (R-Ga.) and House Majority Whip Tom DeLay (R-Tex.) have said that drafting a new bill similar to previous GOP block grant legislation could be accomplished in time to attach it to debt ceiling legislation. However, Democratic aides warn that House Republicans would endanger any possible agreement by rushing reworked "Medigrant" legislation through the House.

The House Commerce Committee has not officially announced plans for hearings but may hold sessions the week of Feb. 19. The Senate Finance Committee has tentatively planned a Feb. 22 hearing to study the governors' Medicaid and welfare agreements. Republican Govs. Tommy Thompson (Wis.) and Michael Leavitt (Utah) are expected to testify on Medicaid.

While the plan itself purports to blend "the best aspects of the current program with congressional and Administration alternatives," one moderate Senate aide asked "how good is [the plan] if you don't even know what it is."

The staffer reported that "we've had totally circular conversations with [NGA] about their own policy." For example, it is still unclear whether the agreement calls for repeal of Title XIX or a reformed program that would operate under two titles. The final governors' language states that a reformed "program should be written under a new title of the Social Security Act" and calls for repeal of only specific items — such as the Boren Amendment — that are part of Title XIX. NGA is expected to brief the Senate moderate group in the near future.

The Senate moderates came forward last December in support of a Medicaid per-capita cap plan to save \$62 bil. over seven years. Sen. Breaux then said prior to the governors' meeting that the group would adopt any NGA agreement but has since backed off and called for hearings. Chafee has "serious concerns" that the NGA plan would leave disability determinations to states and would threaten Medicaid's "fiscal integrity" with the provider tax/donation statute repeal, staffers said.

Liberal Democrats, while loath to criticize publicly the bipartisan NGA plan, are not comfortable with the plan's implications for the disadvantaged. For example, the National Citizens' Coalition for Nursing Home Reform states that the plan limits eligibility "only to elderly people who meet SSI income and resource standards," although "few people in nursing homes receiving Medicaid meet SSI levels." The Arc, an organization representing the developmentally disabled criticizes that the "treatment" portion of the Early and Periodic Screening, Diagnosis and Treatment program would be redefined under the NGA plan "so that a state need not cover all Medicaid optional services for children." Furthermore, the group is upset that the governors did not call for continued minimum federal standards for intermediate care facilities for the mentally retarded.

ONLY 10 ACADEMIC MEDICAL CENTERS WILL SURVIVE UNCHANGED IN MANAGED CARE ERA, David Blumenthal, MD, Massachusetts General Hospital predicted at the recently concluded American Association for the Advancement of Science annual meeting in Baltimore. "I think that there are a class of organizations in this country, a very small number, perhaps less than 10, that are well endowed in both capital and reputation in the market," he said.

Currently, there are close to 130 academic health centers in the U.S., of which about one-fifth will be forced to close, according to Blumenthal. Most of the surviving institutions likely will become "academic health systems," which Blumenthal described as "an integrated delivery mechanism that continues to have a major



CENTER ON BUDGET AND POLICY PRIORITIES

Revised February 12, 1996

FEDERAL CAPS AND STATE MATCHING REQUIREMENTS UNDER THE GOVERNORS' MEDICAID PROPOSAL

by Richard Kogan

On February 6, 1996, the National Governors' Association (NGA) endorsed a proposal to redesign the federal/state Medicaid system. This paper addresses only one aspect of that proposal — the combined effect of capping federal payments and reducing state "matching" requirements. It concludes that total Medicaid funding could fall below current-law projections by as much as \$300 billion over seven years, with at least 70 percent of this potential reduction reflecting cuts in *state* Medicaid funding.

Current Matching Requirements

Under current law, Medicaid is funded jointly by the federal and state governments. The federal government pays each state a fixed percentage of its total Medicaid costs and the state government pays the rest. The federal fixed percentage is called the Federal Medical Assistance Percentage, or FMAP. The FMAP for any given state is a function of state per-capita income; the poorer the state, the higher the federal share and the lower the state share. State shares must not exceed 50 percent for the richest states or drop below 17 percent for the poorest. On average, states pay 43 percent of total Medicaid costs.

Consequently, if costs rise in a state for any reason (e.g. more people enroll in Medicaid, providers raise their rates, or the state expands its add-on coverage or benefits package¹), then the federal government pays at least 50 percent of those extra costs. Likewise, if states reduce Medicaid costs, the federal government receives at least 50 percent of the resulting savings.

The NGA Proposal

The NGA proposal would change current law in three fundamental ways.

- The proposal would "cap" federal payments to states; there would be a limit on *federal* costs no matter how high *actual total* costs are. When federal costs are capped, a state can draw down the full federal

¹ Only 45 percent of total Medicaid costs result from federal coverage and benefit guarantees; the rest result from state decisions to supplement coverage and benefits. The federal government makes matching payments at the same rate regardless of the source of the Medicaid costs.

payment to which it is entitled by matching that federal payment (using the state's matching rate). If *total* Medicaid costs in the state were higher than the capped federal payment plus the state's matching contribution, the state would have to pay all additional costs.²

- The NGA proposal would reduce state matching requirements for at least 25 states, and perhaps more. The NGA said, "A state's matching contribution to the program will not exceed 40 percent." Currently, the twelve wealthiest states pay 50 percent and another thirteen states pay more than 40 percent but less than 50 percent. Further, the NGA left open the possibility that state shares could be reduced even more for those 25 states, and could be reduced for others as well.³
- States would be allowed greater use of "funny money" in meeting their matching requirement. That is, states could use financing schemes that allow them to *appear* to meet matching requirements without really spending any state money on Medicaid benefits. (Prohibitions on such schemes were enacted during the Bush Administration.⁴)

Potential Reductions in Federal, State, and Total Medicaid Funding

How deep could total reductions in Medicaid funding be, relative to current law? First consider the effect of capping federal payments. If federal payments are capped, a state might or might not choose to contribute *more* than is needed in order to draw down the full federal payment to which it is entitled. In other words, a state

² The cap on federal payments to a state would equal the sum of A) the "basic grant" to the state (base-year spending increased by a growth formula), and B) "umbrella" payments to a state, intended to cover any unanticipated growth in caseload (that is, any caseload growth that wasn't built into the basic grant). The umbrella payments would be "guaranteed on a per-beneficiary basis." In short, whenever a state is receiving umbrella payments, the federal cap will increase for each new beneficiary. The *amount* of the increase in the federal cap will be determined by some formula (the NGA did not specify) rather than by the new beneficiary's actual medical bills; therefore, *per-beneficiary* federal payments under the umbrella would be capped at the levels specified in that formula, rather than being completely open-ended. Capping federal payments was the basis for both the Republican's budget bill last fall and the Administration's Medicaid proposals, though in different forms. The NGA has melded the two proposals.

³ The Administration's budget plan does not include a reduction in state matching requirements. Neither did the Budget Resolution agreed to by Republicans in Congress, but the Medicaid bill that Republicans drafted, Congress passed, and the President vetoed did include reduced state matching requirements. That bill reduced the maximum state share to 40 percent, as would the NGA proposal. It also changed some factors in calculating FMAPs to reduce some states that had been above 40 percent to below it, and reduce 12 states that had been below 40 percent even further.

⁴ The Administration's budget plan does not change current prohibitions on the use of such financing schemes, but the Republicans' Medicaid bill would have repealed the prohibitions.

might contribute dollars for which it receives no matching federal payment. But there would be no federal requirement for a state to contribute unmatched dollars to the program; a state would do so only if its total Medicaid costs were greater than the sum of the capped federal payment and the state's matching contribution.

But would states be free to reduce total Medicaid costs to a very great extent? The NGA would allow states to define "disability" as narrowly as they wished, to define "benefits" for all beneficiaries as narrowly (and cheaply) as they wished, and to pay providers as little as they can get away with.⁵ Therefore, each state would be allowed to reduce total costs so much that the state would not be making any unmatched contributions. In assessing whether states would do so, it is important to note that the state treasury would get 100 percent of the savings from any such cutbacks; the federal government would get none. This result differs from that under current law, in which a state keeps at most 50 cents of every dollar saved.

This paper estimates the maximum amount states could reduce their funding (by cutting payments to providers, by cutting benefits, and by cutting beneficiaries where allowed) without their losing federal Medicaid payments.

The second factor driving the potential cuts in state Medicaid funding is the reduction in state matching requirements. To illustrate the effect, suppose the federal payment to a state with a 50 percent match rate is currently \$6 billion. In this case, the total Medicaid program in the state would be \$6 billion provided by the federal government and \$6 billion provided by the state government. Suppose the federal payment were capped at \$6 billion, and the state share were reduced from 50 percent to 40 percent (as the NGA proposes). State contributions could then drop to \$4 billion and total Medicaid spending would decrease from \$12 billion to \$10 billion.

Example: Capping the Federal Payment; Cutting the State Share		
	<u>Existing law</u>	<u>NGA proposal</u>
Federal share	\$6 billion (50%)	\$6 billion (60%) [amount capped]
State share	\$6 billion (50%)	\$4 billion (40%)
Total cost	\$12 billion	\$10 billion

Thus, federal caps and matching share reductions combine to allow very deep cuts in state funding.

⁵ The Administration and Republican Medicaid proposals would also allow states to cut provider payments to the extent possible, and the Republican proposal would allow states to define both benefits and beneficiaries in exceedingly narrow (and cheap) terms.

The size of the reduction in state Medicaid funding therefore depends, in any state, on the level of the cap on federal funds *and* on the change in the state matching share. The federal caps are not known at this time, because the NGA did not specify how tight the caps would be or how they would be calculated for each state. However, several governors suggested that total federal cuts should fall between \$59 billion over seven years (the amount in the President's 1997 budget) and \$85 billion over seven years (the amount in the Republican Leadership's January budget offer).

On this basis, it is possible to calculate the range of federal, state, and total cuts in Medicaid funding. Assuming each state contributes just enough to draw down the full federal payment to which it is entitled, then —

- If the seven-year federal cut were \$59 billion and state matching requirements were reduced only as much as the NGA suggests, states would cut their own funding \$182 billion over seven years. The total federal and state seven-year cut would therefore be \$241 billion. The cut would grow with each year, and could reach 19 percent in 2002.
- If the seven-year federal cut were \$85 billion and state matching requirements were reduced as in the Republican Medicaid bill (see note 4), states would cut \$214 billion over seven years. The total seven-year cut would equal \$299 billion,⁶ and could reach 26 percent by 2002.

Potential Reductions in Medicaid Funding
(In billions)

	<u>Minimum</u>		<u>Maximum</u>	
	<u>7-year</u>	<u>In 2002</u>	<u>7-year</u>	<u>In 2002</u>
Federal reductions (net)	\$ 59	11%	\$ 85	18%
State reductions: [*]				
— because of federal cap	\$ 48		\$ 69	
— because of FMAP reduction	\$134		\$145	
Total state reductions	<u>\$182</u>	<u>30%</u>	<u>\$214</u>	<u>37%</u>
Grand total reductions [*]	\$241	19%	\$299	26%

^{*} Assuming states contribute only the amount needed to draw down the maximum federal payment to which they are entitled.

⁶ The level of a new "special" grant for undocumented aliens, also a part of the NGA proposal, makes a small difference in the size of the cuts, because the aliens grant would be exempt from all matching requirements. Therefore, if the *net* federal cut is, for instance, \$59 billion but the new aliens grant is \$3.5 billion, then the *gross* federal cut is \$62.5 billion. It is the gross cut that triggers reductions in state matching payments. An aliens grant of \$3.5 billion was assumed as part of the \$59 billion net federal cut and an aliens grant of \$6.0 billion was assumed as part of the \$85 billion net federal cut. (\$3.5 billion was the size of the aliens grant in the Republican budget bill, and \$6 billion was the size of at least one suggestion made to the governors.)

Note that in each case the states would reduce their funding more than twice as much as the federal government.

Matching with "Funny Money"

In one sense, the above table may be a worst-case scenario, since it assumes that no states contribute unmatched dollars to Medicaid. On the other hand, the cuts in Medicaid resources could be even deeper than shown if states use funny money to meet their matching requirements. And the NGA proposal would drop all existing bars to the use of such funny money.

In the past, some states have used creative financing schemes to make payments that they could call "Medicaid contributions" but that really were not. For example, a state might impose a special "tax" on a provider of health care services to the poor, and then immediately rebate the amount collected to that provider. The provider and the state are in exactly the same financial position as if this back-and-forth transfer had never occurred, and no additional medical services are provided. But the state could call the rebate a "Medicaid contribution" and thus satisfy a matching requirement. Congress largely banned such scam transactions in the early 1990s. (See attached text box for a fuller treatment of the issue.)

Data and Methodology

The current-law baseline level of federal spending in 2002 and over the seven-year period 1996-2002 uses CBO baseline figures. Cuts are measured relative to that baseline. Current law FMAPs come from GAO. The FMAPs under the Republican bill were likewise from GAO. (See attached table of FMAPs.) Baseline spending for the seven-year period and for 2002 was divided among states in proportion to state-by-state baseline spending projections made by the Urban Institute in December, 1995.⁷

It was assumed that gross federal cuts would be made across-the-board, relative to baseline spending,⁸ and that the special payments for undocumented aliens (see note 5) would be distributed as specified in the Republican bill. Finally, the estimated federal cuts in 2002 were taken from the President's budget and the Republicans' January budget offer, respectively.

⁷ See *The Impact of the "Medigrant" Plan on Federal Payments to State*, December 1995, prepared by John Holohan and David Liska of the Urban Institute for the Kaiser Commission on the Future of Medicaid, Table 7.

⁸ An alternative assumption, that the level of grants (other than for undocumented aliens) would be increased across-the-board relative to the Republican Medicaid bill, leads to results that are virtually identical with those shown above in aggregate, though the state-by-state distribution of the cuts would differ.

Examples of How Special Medicaid Financing Methods Allowed States to Draw Down on Federal Dollars Without Spending State Funds

The following example illustrates how these financing methods worked in the past:

Assume a state imposed a provider tax that was paid by hospitals and that raised \$40 million dollars. The state then pays back to the hospitals subject to the tax \$50 million in disproportionate share hospital ("DSH") payments, which under the law are supposed to provide additional funds to hospitals that serve a disproportionately high number of Medicaid and low-income uninsured patients. If the state's federal Medicaid match rate is 50 percent, it can claim \$25 million in federal Medicaid funds based on the \$50 million in DSH payments to the hospitals.

The result: the hospitals gain \$10 million (\$50 million in DSH payments less the \$40 million in provider taxes); the state gains \$15 million (\$25 million in federal matching funds plus \$40 million in provider taxes minus \$50 million in DSH payments); and the federal government pays \$25 million without any net state funds having actually been expended.

Michigan's practices are instructive. (Michigan is not the only or most egregious example of a state that has used such financing methods. It is selected for illustrative purposes because this example was documented by GAO and is straightforward.)

In fiscal year 1993, Michigan raised \$452 million through hospital donations, and then paid the hospitals \$458 million in disproportionate share (DSH) payments. Based on these payments, Michigan claimed \$256 million in federal matching funds. The net effect of these transactions is as follows: the hospitals gained \$6 million (\$458 million in DSH funds less \$452 million in provider donations); the state gained \$250 million (\$256 million in federal matching funds less \$6 million in net payments to the hospitals); and the federal government paid \$256 million in federal matching funds without any net state funds having been expended.

When provider donations were limited by Congress through legislation enacted in 1991 that became effective January 1, 1993, this loophole was closed. Michigan responded by relying on intergovernmental transfers and changing its criteria for deciding which hospitals would qualify for DSH payments, a determination that former law left almost entirely to state discretion. In October, 1993, it paid \$489 million to the one hospital that met its new DSH definition — the state-owned University of Michigan hospital. The state claimed \$276 million in federal matching funds for this payment, but the public hospital returned the full \$489 million payment to the state through an intergovernmental transfer the very same day the payment was made. Through this one transaction, Michigan realized a net gain of \$276 million in federal Medicaid payments, again without expending any state funds. This practice is now also limited by Congress through provisions phased-in beginning in July 1994.

Source: GAO, *States Use Illusory Approaches to Shift Program Costs to Federal Government*, August 1994.

ST-CUT2

Center on Budget

Feb. 8, 1996

Federal Medical Assistance Percentages (FMAPs)

GAO estimates

	Current law, 1996 est.		Republican bill		NGA 40% maximum	
	Federal	State	Federal	State	Federal	State
Alabama	69.9%	30.2%	72.9%	27.1%	69.9%	30.2%
Alaska	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Arizona	65.9%	34.2%	65.9%	34.2%	65.9%	34.2%
Arkansas	73.6%	26.4%	74.1%	25.9%	73.6%	26.4%
California	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Colorado	52.4%	47.6%	60.0%	40.0%	60.0%	40.0%
Connecticut	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Delaware	50.3%	49.7%	60.0%	40.0%	60.0%	40.0%
DC	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Florida	55.8%	44.2%	65.7%	34.3%	60.0%	40.0%
Georgia	61.9%	38.1%	61.9%	38.1%	61.9%	38.1%
Hawaii	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Idaho	68.8%	31.2%	68.8%	31.2%	68.8%	31.2%
Illinois	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Indiana	62.6%	37.4%	62.6%	37.4%	62.6%	37.4%
Iowa	64.2%	35.8%	64.2%	35.8%	64.2%	35.8%
Kansas	59.0%	41.0%	60.0%	40.0%	60.0%	40.0%
Kentucky	70.3%	29.7%	74.7%	25.3%	70.3%	29.7%
Louisiana	71.9%	28.1%	77.1%	22.9%	71.9%	28.1%
Maine	63.3%	36.7%	65.2%	34.8%	63.3%	36.7%
Maryland	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Massachusetts	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
Michigan	58.8%	43.2%	61.2%	38.8%	60.0%	40.0%
Minnesota	53.9%	46.1%	60.0%	40.0%	60.0%	40.0%
Mississippi	78.1%	21.9%	80.7%	19.3%	78.1%	21.9%
Missouri	60.1%	39.9%	60.5%	39.5%	60.1%	39.9%
Montana	69.4%	30.6%	69.4%	30.6%	69.4%	30.6%
Nebraska	59.5%	40.5%	60.0%	40.0%	60.0%	40.0%
Nevada	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Hampshire	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Jersey	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
New Mexico	72.9%	27.1%	73.0%	27.1%	72.9%	27.1%
New York	50.0%	50.0%	60.0%	40.0%	60.0%	40.0%
North Carolina	64.6%	35.4%	64.6%	35.4%	64.6%	35.4%
North Dakota	69.1%	30.9%	69.1%	30.9%	69.1%	30.9%
Ohio	60.2%	39.8%	60.2%	39.8%	60.2%	39.8%
Oklahoma	69.9%	30.1%	69.9%	30.1%	69.9%	30.1%
Oregon	61.0%	39.0%	61.0%	39.0%	61.0%	39.0%
Pennsylvania	52.9%	47.1%	60.0%	40.0%	60.0%	40.0%
Rhode Island	53.8%	46.2%	60.0%	40.0%	60.0%	40.0%
South Carolina	70.8%	29.2%	74.0%	26.0%	70.8%	29.2%
South Dakota	66.7%	33.3%	66.7%	33.3%	66.7%	33.3%
Tennessee	65.6%	34.4%	69.6%	30.4%	65.6%	34.4%
Texas	62.3%	37.7%	62.8%	37.3%	62.3%	37.7%
Utah	73.2%	26.8%	73.2%	26.8%	73.2%	26.8%
Vermont	60.9%	39.1%	60.9%	39.1%	60.9%	39.1%
Virginia	51.4%	48.6%	60.0%	40.0%	60.0%	40.0%
Washington	50.2%	49.8%	60.0%	40.0%	60.0%	40.0%
West Virginia	73.3%	26.7%	75.8%	24.2%	73.3%	26.7%
Wisconsin	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%
Wyoming	59.7%	40.3%	60.0%	40.0%	60.0%	40.0%

SUSPENSION

(Policy Position offered by Governor Thompson and Governor Bob Miller)

RESTRUCTURING MEDICAID

PREAMBLE

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

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

THE NEW PROGRAM

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

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

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

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

Eligibility. Coverage remains guaranteed for:

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

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

Coverage remains optional for:

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

Benefits

- *The following benefits remain guaranteed for the guaranteed populations only.*
 - *Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The*

"T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

- *At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.*
- *States have complete flexibility in defining amount, duration, and scope of services.*

Private Right of Action

- *The following are the only rights of action for individuals or classes for eligibility.*
 - *Before taking action in the state courts, the individual must follow a state administrative appeals process.*
 - *States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.*
 - *Following action in the state courts, an individual or class could appeal directly to the U.S. Supreme Court.*
 - *Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.*
- *There should be no private right of action for providers or health plans.*

Service Delivery

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

Provider Standards and Reimbursements

- *States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.*
- *The Boren amendment and other Boren-like statutory provisions must be repealed.*
- *"One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics.*

- States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.
- For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.

Nursing Home Reforms

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

Plan Administration

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

Provider Taxes and Donations

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

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

1. Base. In determining base expenditures, a state may choose from the following—the average of 1992 through 1994 expenditures, 1994 expenditures, or 1995 expenditures.

Some states may require special provisions to correct for anomalies in their base year expenditures.

2. Growth. This is a formula that accounts for estimated changes in medical costs and estimated changes in a state's caseload. It includes the following:

- ~~a state-specific estimate of caseload growth for each of the eligible groups and the number of people in poverty;~~
- ~~a state-specific estimate of the case mix to reflect the differences in cost of populations in the program;~~
- ~~a national estimate of per-beneficiary costs; and~~
- an estimate of caseload growth;
- the relative cost of care for the populations served; and
- an annual medical inflation factor (specific factor to be determined).

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

3. Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirement to gain access to these federal funds.
4. The Insurance Umbrella. This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.

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

Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

1. States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.
2. Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.
5. Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.
6. Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

DRAFT - 2-8-96

- Memo
- Scoring w/ Dems on Hill / CBO
- OMB Scoring
- Side by side

CONCERNS/OUTSTANDING QUESTIONS
ABOUT THE NGA MEDICAID RESOLUTION

- **Eligibility concerns include:** The repeal of the current law's phase-in for coverage of about 3 million children age 13-17 and the devolution of the "disability" definition to the states.
8 + soft on covering SSI
+ AFDC
- **Benefit concerns include:** The total discretion given to states to alter the amount/duration/scope of services; the repeal of the current law's comparability and statewideness requirement that ensure that recipients in particular groups or locations are not discriminated against; the apparent elimination of any defined benefit package for currently optional populations; and the vague redefinition of the treatment requirements under the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) children's health benefit.
Add to memo -
copayment -
states don't have
to provide
medically necessary
care
- be careful
about EPSDT
- **Enforcement concerns include:** The state-based right of action process advocated by the Governors (and whether it will work to effectively ensure the guarantee).
- **Financing concerns include:** The exclusion of pregnant women and children, as well as the medically needy, from the Federally-financed "umbrella" pool payments; the inclusion in the base formula of the allowance that states can reduce their matching Medicaid rate -- the result producing an additional \$200 billion reduction in state Medicaid spending over seven years, bringing the total Federal/State cut to \$290 billion; the allowance for states to, once again, tax health care providers to help finance their state match; allowing for provider taxes will likely push up the cost of the program that CBO scores because it will be easier for the State to access Federal matching funds.
- **Quality concerns include:** The adequacy of the quality protections for plans under Medicaid, such as HMOs and other managed care plan; the apparent repeal of the Federal-based enforcement of Federal nursing home standards. (The difference between them and us has always come down to definition and enforcement.)
- **Accountability concerns include:**

~~XXXXXXXXXXXXXXXXXXXX~~

February 6, 1996

TO: Distribution

FROM: Chris Jennings
Jennifer Klein

SUBJECT: Medicaid Talking Points and Background Information

Attached are our "cleared" talking points that we are using for questions about the National Governors Association's Resolution. Also attached is a one-pager that outlines our preliminary concerns about some of the specifics in the NGA resolution.

We hope you will find this information useful. Please call us with any questions.

Thanks

TALKING POINTS ON GOVERNORS' MEDICAID POLICY RESOLUTION

- We are pleased that the Governors' have passed a policy resolution that affirms our national commitment to the guarantee under Medicaid. We are also pleased that they have continued the financial partnership between the federal government and the states that allows Medicaid funding to follow increases in enrollment.
- As Congress considers this resolution, we need to make sure that that guarantee is real.
 - There must be a national guarantee to meaningful benefits.
 - There must be national guidelines for eligibility that protect those who are eligible under current law. For example, under current law, coverage for three million children between 13 and 17 is being phased in. That commitment should continue.
 - And we must preserve adequate enforcement to assure this guarantee.

CONCERNS/OUTSTANDING QUESTIONS
ABOUT THE NGA MEDICAID RESOLUTION

- **Eligibility concerns include:** *The repeal of the current law's phase-in for coverage of about 3 million children age 13-17; the devolution of the "disability" definition to the states; the limitation to "frail" elderly population seems to not include all elderly who are currently eligible; and the elimination of the required coverage of premiums for low-income Medicare beneficiaries between 100-120 percent of poverty is repealed.*
- **Benefit concerns include:** *The total discretion given to states to alter the amount/duration/scope of services; the repeal of the current law's comparability and statewideness requirement that ensure that recipients in particular groups or locations are not discriminated against; the apparent elimination of any defined benefit package for currently optional populations; and the vague redefinition of the "T" in the EPSDT children's health benefit.*
- **Enforcement concerns include:** *The state-based right of action process advocated by the Governors (and whether it will work to effectively ensure the guarantee).*
- **Financing concerns include:** *The exclusion of pregnant women and children, as well as the medically needy, from the Federally-financed "umbrella" pool payments; the inclusion in the base formula of the allowance that states can reduce their matching Medicaid rate -- the result producing an additional \$200 billion reduction in state Medicaid spending over seven years, bringing the total Federal/State cut to \$290 billion; the allowance for states to, once again, tax health care providers to help finance their state match; allowing for provider taxes will likely push up the cost of the program that CBO scores.*
- **Quality concerns include:** *The adequacy of the quality protections for plans under Medicaid, such as HMOs and other managed care plan; the apparent repeal of the state-based enforcement of Ronald Reagan's Federal nursing home standards. (The difference between them and us has always come down to definition and enforcement.)*

Benefits

1. Why are mandatory benefits provided for mandatory populations only? Are there any benefit standards for optional populations?
2. EPSDT - plan continues to try to limit the "T" in EPSDT
3. What is the broader definition of long-term care that is alluded to? How are costs controlled in this model?
4. Plan provides for "complete" flexibility in amount/duration/scope of services
 - a. This appears to apply to all services, optional and mandatory - does that make the mandatory service package meaningless?
 - b. Is there no comparability at all among groups and even within groups for any benefits -- optional or mandatory beneficiaries/services?
 - c. Are there no statewideness requirements at all -- can provide different amount duration and scope of benefits in one city/ or even inner city, than in rural area/suburb?

Private right of action

1. Need to maintain private right of action enforceable in federal court.

Service delivery

1. What about quality standards for health plans?

Provider standards and reimbursement

1. Is there not some basic actuarial standard for paying health plans?
2. Need clarification of what besides Boren is repealed?
3. If replace cost-based payment for federally qualified health centers (FQHCs - a repeal that we have supported), need FQHC pool.

Nursing home reforms

1. Need some definition of enforcement of standards by the federal government (this would create major problems for Senator Pryor)

Plan administration

1. Need clarification of what it means when HCFA can only do compliance in case of "substantial" failure to comply?

Taxes/Donations

1. This is likely to increase federal costs substantially because states will be able to generate state share through provider financing. Costs will grow in same manner as we saw federal cost growth in late 80s.
2. This will raise OMB concerns, as well as Inspector General concerns of the type we saw in the 80s.

Financing

1. We are very concerned that this looks more and more like a block grant; formula is very complex if we are moving to a per capita model.
2. They appear to be changing the federal Medical Assistance Percentage in manner similar to conference agreement; doesn't that just magnify the total programmatic cut? (A \$85 billion federal cut could lead to a \$290 billion total federal and state cut)

How do we relate the policies of increasing the federal share with reducing the federal role?

2. Base
 - a. Why would they include DSH in a base calculation of spending per person?
 - b. In a per person financing model, the base would be spending per person. Is this base total spending or spending per person?
 - c. Does the state keep the base, plus inflation, even if it cuts enrollment dramatically? Why would that be allowed in a per person model, especially when federal funds are limited?

3. Growth

- a. Why is it estimated changes and not actual changes in enrollment? Why wait for "umbrella" when we can simply match during the year for actual changes?
- b. What is relevance of the state poverty estimate in the formula? That type of estimate again lends confirmation that this is a block grant, with that one of the factors in the formula, rather than a per enrollee financing model.
- c. Does the use of the "national" estimate of per beneficiary costs means a substantial redistribution of growth from high cost states (NY especially); will low cost states receiving higher adjuster have to actually spend more on Medicaid to get their new amount?

4. Insurance adjuster

- a. Again, this is very complicated if all we are trying to do is per capita methodology; it looks like a formula-driven contingency fund attached to a block grant
- b. Why is this available only for mandatory groups plus persons with disabilities and the elderly? Why not all eligibles?
 - (1) Why exclude pregnant women and children above the mandatory income levels?
 - (2) Why exclude the medically needy?
- c. What does it mean to require that the state has to have "used up" other available funds? How is that implemented by the state or federal government during the course of the year? How does this approach work in a per enrollee model?
- d. Why is the adjuster not implemented for any growth in enrollment -- why must growth exceed 1 percent above that estimated, if we have a per person model?
 - (1) One percent sounds low, but CBO estimate of average annual growth in beneficiaries is 3 percent -- so one percent more is a big difference
 - (2) Again, it makes it sound more "block" like
- d. Is this adjuster a one-time /one year adjuster, or is it built into the state's base for future years? Does the state have to absorb the cost of prior year's growth (in beneficiaries or inflation), or do they get continuing adjustments?

DRAFT**INITIAL REVIEW OF "HIGHLIGHTS" DOCUMENT****Overall**

1. In general, the more we see over the last few days, the more it looks like a block grant with a contingency fund, and not at all like the President's plan. As defined so far, it would be perceived externally as a block grant.
2. Need more detail on exactly how the structure works to make truly substantive comments, but the following identifies current problems and questions.

Eligibility

1. Children - need to continue the current law phase in of children <100 percent of poverty up to age 18, and not stop that phasing schedule at age 12
2. Why is language limited to the "frail" elderly -- wouldn't all elderly meeting income/resource standards be covered?
3. Why doesn't coverage remain guaranteed for all SSI recipients (with continuation of 209(b) option)?
4. We continue to oppose state definition of disability; need federal definition (note: the federal definition is modified in welfare/SSI reform to meet substantive concerns about alcoholics, drug abusers, and some definitions related to children)
5. Why is there a "set aside" for individuals with disabilities -- this makes the plan look more like a block grant? How does a set-aside fit within a per person financing model?
6. Why are Qualified Medicare Beneficiaries (QMBs) included as mandatory, but not the two other currently mandatory groups associated with them. These are Special Low Income Medicare Beneficiaries (SLMBs -- Medicaid pays Medicare premium only for those with income between 100 and 120 percent of poverty level), as well as Qualified Disabled and Working Individuals (QDWIs)?
7. Need clarification about AFDC/ welfare reform coverage:
 - a. Is there coverage during welfare to work transitions?
 - b. What exactly are the AFDC coverage options that are presented -- need more detail on exactly what the state's options are.

FAX TRANSMITTAL

TO:	Marilyn Yager		
ORGANIZATION:	Office of Public Liaison		
Telephone Number: 456-6683	Fax Number: 456-6218 456-6682	# of Pages (including cover sheet) 3	
FROM:	Stan Dorn, Gregg Haifley, and Jim Weill		
	CHILDREN'S DEFENSE FUND HEALTH DIVISION		
Telephone Number: (202) 662-3541 FAX Number: (202) 662-3560	Assistant: Lauren Becker- Robertson (202) 662-3551	Date: 2/2/96 Time:	AM PM
Comments-- Marilyn: Stan, Jim and I have attached a fact sheet giving a preliminary assessment of the impact of the MediGrants II proposal – we have few details about the proposal and have had the sketchy paper for a short time. The proposal is severely flawed in that it inadequately addresses the health needs of children. In fact, it would seriously jeopardize the coverage and benefits of millions of children. Please give Stan (home phone 202-364-4530), Jim Weill (home phone 202-483-5645), or me (home phone 202-797-1569) a call if you have any questions or learn of significant developments over the weekend.			

Please call (202) 662-3551 or 662-3541 if you did not receive all of this fax transmission.

A PRELIMINARY ANALYSIS OF MEDIGRANTS II AND CHILDREN

Only a summary, not statutory language or real specifications describing the MediGrant II proposal, is available. Based on this summary, however, it is already clear that the proposal would harm children.

MediGrants II would eliminate any guarantee of health coverage for children in working poor families over age 12. Under current law, coverage for such children up to age 18 is being phased-in. More than 3 million children would lose guaranteed health coverage in the year 2002 alone.

- Many working poor families with teenaged children could get health coverage for their children only by quitting work and going on welfare.
- This loss of guaranteed coverage is particularly harmful, because work-based coverage of children is rapidly diminishing. If current trends continue, more than half of all American children will lack work-based coverage by the end of the decade, even though more parents than ever will be working.

Above age 12, even children on AFDC would lose guaranteed coverage under this proposal. These are the poorest children in America, generally with incomes below 50% of the federal poverty line.

Even those children who are eligible would lose any guarantee of most of the essential benefits provided under current law. While a few services would be required (e.g., immunizations, physician visits, hospital care), many services children currently receive when necessary would no longer be guaranteed. They include: screenings to identify physical, mental, dental, vision and hearing problems; dental care; eyeglasses and hearing aids, so children can develop normally and see and hear what happens in school; prescription drugs to cure a child's illness or alleviate pain and suffering; rehabilitation and therapy services to help seriously ill children reach their full potential; and a range of other necessary services.

This proposal may repeal the Vaccines for Children program, which has already made substantial improvements in our country's immunization efforts.

This proposal permits states to define which people with disabilities receive Medicaid coverage, including many disabled children, over age 12 or who live in families with incomes slightly above poverty, who now depend on Medicaid for their health coverage.

All parents currently on Medicaid, regardless of how poor they are or whether Medicaid coverage is needed to escape welfare, would lose any guarantee of coverage. This would add more than 8 million people to the ranks of the uninsured, the vast majority of whom are women.

It is unclear whether families could hold states accountable through judicial enforcement. Guarantees that look good on paper may prove meaningless in practice without that right.

States may be allowed to spend much less on Medicaid, substantially cutting funding for the health care system. Under the original Medigrant proposal, state matching percentages are reduced. Moreover, states are given permission to use provider donations and taxes, which, according to CBO, produced "illusory" state matching funds in the past.

The proposal's set-asides do not guarantee coverage for any particular children and families. They are not large enough to guarantee coverage projected under current law. They could be spent to make large payments to providers (or to supplant state spending on health programs), rather than to cover essential benefits for children and families.

The proposal apparently repeals Title XIX of the Social Security Act, ending 30 years of safeguards, often enacted with bipartisan support. For example:

- Current law bars copayments for low-income children and pregnant women. The original Medigrant proposal permits states to charge unlimited copayments when children seek treatment for illness. (The proposal limits only preventive services to nominal copayments.)
- Current law guarantees that children will receive the same Medicaid benefits, regardless of where they live within their state. Under the original Medigrant proposal, children could receive very different levels of benefits, based on their county or city of residence — and its respective "clout" in the state legislature.
- Current law contains minimum safeguards that promote quality and access to care when families are enrolled in managed care plans, without any freedom of choice. The original Medigrant proposal includes no such safeguards.

February 2, 1996

Medicaid Must Retain A Standard Definition of Disability

--"Flexibility" to define "disability" for Medicaid is just **"flexibility" to eliminate the Medicaid safety net for people with disabilities** who are currently eligible. There is no other reason for such flexibility.

--Under current law, in order to qualify for Medicaid a person with a disability must meet two criteria:

The person must be poor, and

The person must meet the SSDI/SSI definition of total disability.

--The SSDI/SSI standard is basically an inability to work (i.e., a person is unable to maintain substantial gainful activity), but it has developed significant precedents and refinements.

The SSI standard has been developed and fine-tuned through regulation and precedent over the years to address **complex disability cases**, such as

--conditions that are sometimes disabling and sometimes not (so-called **"intermittent disabilities"**) that may make a person unemployable but not necessarily permanently disabled (e.g., multiple sclerosis, epilepsy, asthma);

--diseases that are **progressive** (e.g., Parkinson's disease, HIV/AIDS);

--disorders with **non-apparent symptoms** or effects (e.g., severe fatigue associated with lupus or with Lyme disease);

--illnesses **without standard medical profiles** or that do not show up on lab tests (e.g., high-functioning developmental disabilities or other mental and emotional disabilities);* or

--diseases that have **different manifestations** in different groups (e.g., cervical cancer in women with immune deficiencies).

--Without such a well-defined and uniform Federal standard, **people with disabilities will be cut out from the Medicaid program and, in most cases, from health care altogether.**

States will have **incentives to limit or eliminate coverage for those people with disabilities** who require more complex medical care.

*(Note: While some have argued that people may fake disabilities to claim eligibility for Federal cash assistance, it would be irrational for people to fake disabilities solely to have those disabilities treated. Even assuming the fraud takes place in the cash programs, cash poses incentives that medical care does not.)

People with intermittent, progressive, or other complex disabilities will have no reliable precedent on which to rely and will be forced to **re-define and re-litigate** their disability for Medicaid.

States will seek inexpensive healthy people to count toward their funding formulae and neglect to find those with chronic and costly needs.

Without uniform standards, **people with disabilities will be forced to move to find State Medicaid programs that meet their needs.**

If some States provide eligibility and benefits and neighboring States do not, people will have to move to get necessary health care.

For example, in the early days of the AIDS epidemic, many people moved to California to get access to health care denied them elsewhere.

This, in turn, will create a "**race to the bottom**" in which no State will want to provide benefits that might attract more poor, disabled people to their program.

This competition to provide the least will **ultimately limit benefits to people with disabilities nationwide.**

Without uniform standards, **people with disabilities in States providing care will experience "Medicaid-lock,"** similar to the job-lock of employed people with insurance.

If a person with disabilities is eligible for health care in one State and not in another, the person will not be able to move to be with his or her family, to seek appropriate support services, or to retire.

Without uniform standards, people with disabilities and their families will be caught in **confusing bureaucratic delays.**

The Social Security Act will continue to have a definition of disability for purposes of its Social Security Disability Insurance and Supplemental Security Income programs.

In addition, each State will have a different definition of disability for purposes of Medicaid.

People with disabilities and their families will be forced to undergo duplicative State and Federal tests, processes, and paperwork--often **at times when they most need immediate help.**

--Without coverage under Medicaid, **poor people with disabilities will be shut out of the health care system altogether.**

Since Medicaid is currently, by definition, limited to people who are poor and who cannot work, if a State finds a person to be ineligible for the new program, that person will have no employment-related insurance and no personal income or assets to use for health care.

These are the people with no place else to go.

--**The elimination of a Federal definition of "disability" eliminates the guarantee of health care to poor people with disabilities.**



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Ensuring Access to Health Care Services for Our Most Vulnerable Populations

Any effort to preserve important guarantees within the Medicaid bill must also retain a beneficiary's right to go to court to enforce those guarantees. Since the inception of the Medicaid program, a person eligible for Medicaid has had both: 1) a guarantee of access to certain services, and 2) the right to enforce this commitment. A "guarantee," without a right to enforce it, is a hollow promise. Although some recent 'block grant' proposals in Congress threatened to eliminate all guarantees, the consensus is that we should retain at least some guarantees. Without a private right of action, any guarantee of medical services is meaningless, since this is the only effective mechanism for ensuring that a state provides guaranteed services.

Some have argued that alternative mechanisms of enforcement could be created. However, none of these alternatives is effective. For example, if a pregnant woman is eligible for Medicaid and the state denies her services, this woman currently has the right to go to court to obtain those medical services. Some have proposed replacing the private cause of action with an administrative scheme at either the state or federal level. These alternative mechanisms, however, will not work.

1) Federal administrative mechanism:

Under a recent Congressional proposal, the pregnant woman described above could bring her claim to the Secretary of the U.S. Department of Health and Human Services (HHS). However, given that the Secretary of HHS is already responsible for overseeing the implementation of the nation's health care policies, including dozens of programs, it is unlikely that the Secretary or her staff will have the resources to give adequate attention to individual claims. If Congress imposes this new administrative function on the Secretary without providing additional funds, the Secretary would have inadequate resources to effectively monitor and enforce the Medicaid laws across the country. Alternatively, if new resources are appropriated to the Secretary for the purpose of enforcing the Medicaid law, a new and unnecessary federal bureaucracy would be created.

2) State administrative mechanism:

Alternatively, she may present her claim at a hearing before a state administrative body. However, since the administrative entity delegated to hear such claims will probably be the state's own health department (which denied her the services in the first place), it is unlikely that she can get her claim enforced.

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**USE OF PRIVATE CAUSES OF ACTION
IN THE CURRENT MEDICAID ACT**

Introduction

This memorandum explains how private suits are currently brought to enforce the Medicaid Act. This background is put forth in light of the passage of the budget reconciliation bill in the House and Senate, which would eliminate a private party's ability to sue states to protect rights guaranteed by the federal Medicaid law.

This memorandum is organized as follows: Section I briefly summarizes the test applied by the courts to determine whether an implied cause of action exists. This discussion is short because plaintiffs rarely rely on an implied cause of action to enforce the Medicaid Act. Section II discusses in more depth the jurisprudence around 42 U.S.C. § 1983, which is the more common means for bringing a suit against states.

I. Implied Cause of Action

The current Medicaid Act does not explicitly provide a cause of action for private parties to sue state officials to enforce the substantive rights embodied in the statute. As a result, private parties can bring suit against states only in two ways. First, a party can argue that an implied cause of action exists in the Medicaid statute and its regulations. Second, a party can rely on 42 U.S.C. § 1983, which allows citizens to sue state officials who deprive them of federal statutory or constitutional rights under color of state law (see Section II).

An implied cause of action allows plaintiffs to sue for **retrospective relief against state and federal defendants who violate federal law**. In order to rely on an implied cause of action, the plaintiff must prove that Congress intended to provide such an action to enforce the federal statute in question. This high standard substantially limits the availability of this remedy.

The test for finding an implied cause of action was set forth in *Cort v. Ash*.¹ There, the Supreme Court announced four factors to be used to determine whether an implied cause of action exists:

- (1) whether plaintiffs are part of the class for whose benefit the statute was enacted;
- (2) whether there was any indication of Congressional intent to deny or create a private right of action;
- (3) whether implication of a private right of action is consistent with the underlying purpose of the statute; and
- (4) whether the matter is traditionally one relegated to the states.

In applying this test, the Supreme Court has accorded the greatest weight to the second factor -- Congressional intent.² In fact, a number of decisions have suggested that legislative intent is, in most cases, dispositive.³ In demonstrating Congress' intent, the plaintiff must show that a private right of action "can be inferred from the language of the statute, the statutory structure, or some other source [such as the legislative history]"⁴ Because the plaintiff bears the burden of affirmatively proving Congress intended to provide an implied private cause of action, few courts have found an implied cause of action to enforce substantive rights in the Medicaid law. Instead, private parties usually rely on § 1983.⁵

¹ 422 U.S. 66, 78 (1975).

² See, e.g., *Thompson v. Thompson*, 484 U.S. 174, 179 (1983) (noting that "the intent of Congress remains the ultimate issue"); *Touche Ross & Co. v. Redington*, 442 U.S. 560, 575 (1979) (concluding that legislative intent should be the focus of the analysis).

³ See *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 23 (1979) (concluding that "the dispositive question remains whether Congress intended to create any such remedy"); *Merrill Lynch, Pierce, Fenner, and Smith, Inc. v. Kurran*, 456 U.S. 353, 388 (1982) (stating that all four factors need not be considered "when the dispositive question of legislative intent has been resolved"); *In re Corestates Trust Fee Litigation*, 39 F.3d 61, 68 (1994) (stating that "a lack of evidence of legislative intent to create a private right of action, either express or by implication, can by itself provide the answer that a private right of action should not be implied").

⁴ *Northwest Airlines, Inc. v. Transport Workers Union*, 451 U.S. 77, 94 (1981).

⁵ See, e.g., *Illinois Hospital Ass'n v. Edgar*, 765 F. Supp. 1345 (N.D. Fla. 1991) (holding that no implied cause of action exists for a hospital association to sue the State over reimbursement rates); *Michigan Hospital Ass'n v. Dep't of Soc. Servs.*, 738 F. Supp. 1080 (W.D. Mich. 1990) (same); *Fuzie v. Manor Care, Inc.*, 461 F. Supp. 689 (N.D. Ohio 1977) (holding that no implied cause of action exists to enforce regulations for private nursing homes). But see *Oregon Ass'n of Homes for the Aging, Inc. v. Oregon*, 884 F. Supp. 382 (D. Ore. 1994) (finding an implied cause of action to enforce the requirements of the Boren Amendment exists; noting that the structure of the statute (particularly the lack of federal oversight) indicates that the State rather than the Secretary is accountable for inadequate reimbursement rates).

II. Section 1983

This section describes the evolution of 42 U.S.C. § 1983 jurisprudence and explains how this statute has been used to enforce the Medicaid Act in the past. Section 1983 has been used since 1980 by plaintiffs who sue for prospective relief from a state official's violation of federal law. In 1990, the Supreme Court, in *Wilder v. Virginia Hospital Association*,⁶ announced a two-part test to determine the permissibility of a § 1983 suit:

- (1) the statute must create an enforceable right within the meaning of § 1983, and
- (2) the statute must not foreclose the enforcement of the statute through § 1983 suits.

Although the Supreme Court departed from *Wilder* in the 1992 case, *Suter v. Artist M.*,⁷ in ways that threatened to substantially limit the scope of § 1983 actions. Congress responded in 1994 by passing legislation to explicitly limit the reach of *Suter*. As a result, *Wilder* currently appears to provide the relevant framework for analyzing whether a suit can be brought under § 1983. Under *Wilder*, it is likely that § 1983 could be invoked to enforce substantive rights in a new Medicaid Act if that statute does not contain any specific prohibition on private causes of action.

A. General Background of § 1983 and its Relationship to the Medicaid Act

Passed during the 1870's as part of the Reconstruction era legislation, § 1983 provides a private cause of action against anyone who, under color of state law, deprives an individual of "any rights, privileges, or immunities secured by the Constitution and laws . . ."⁸ The Supreme Court has stated that Congress' intent in passing § 1983 was to override "invidious" state legislation against individual rights, to offer a remedy where state laws were inadequate to protect those rights, and to provide a cause of action "where the remedy, although adequate in theory, was not available in practice."⁹

Although § 1983 was originally intended to address the constitutional problems of states denying equal protection to African-Americans, the Supreme Court has refused to restrict § 1983's applicability to violations of constitutional civil rights. In 1980, the Supreme Court officially expanded the scope of § 1983 by ruling that it provides a cause of action against anyone who infringes upon federal **statutory** as well as constitutional rights.¹⁰ As a result of the Court's interpretations, the coverage of § 1983 is to be "broadly construed."¹¹

⁶ 496 U.S. 498, 509 (1990).

⁷ 503 U.S. 347 (1992).

⁸ 42 U.S.C. § 1983 (1988).

⁹ *Monroe v. Pape*, 365 U.S. 167, 173-74 (1961), overruled in part on other grounds by *Monell v. Department of Social Servs.*, 436 U.S. 658, 663 (1978).

¹⁰ *Maine v. Thiboutot*, 448 U.S. 1, 6 (1980).

¹¹ *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 105 (1989).

Unlike the implied right of action, § 1983 provides **only prospective relief from a state official's violation of federal law**. Despite this limitation, private parties have invoked § 1983 frequently to challenge state implementation of a wide variety of federal statutes, including the Medicaid Act. For example, a number of suits were brought under § 1983 to challenge state refusal to provide drugs that had been prescribed by a patient's doctor and qualified as "medically necessary treatment" under the Medicaid regulations.¹² In addition, many health providers relied on § 1983 to ensure that states provided them "adequate and reasonable" reimbursement payments as guaranteed by the Boren Amendment to the Medicaid Act.¹³ Because no explicit cause of action exists in the Medicaid law, § 1983 has become the primary means for bringing suit against states to enforce the Medicaid statute and its corresponding regulations.

In applying § 1983 to the Medicaid Act and other federal statutes, the Supreme Court has recognized two exceptions under which state violations of a federal statute are not actionable. First, § 1983 can not be invoked unless the federal statute creates enforceable rights within the meaning of that statute. Second, § 1983 is not available to enforce a violation of a federal statute "where Congress has foreclosed such enforcement of the statute in the enactment itself."¹⁴ These limitations on the scope of Section 1983 formed the foundation for a general test announced by the Supreme Court in *Wilder v. Virginia Hospital Association*.¹⁵

B. The Wilder Test

In *Wilder*, a nonprofit association of private and public hospitals brought suit against the governor of Virginia under § 1983, alleging that the state's Medicaid reimbursement plan violated the Boren Amendment which required "reasonable and adequate" reimbursement rates to health providers. As the first step in its § 1983 analysis, the Court considered whether the amendment created a substantive federal right that could be enforced by health care providers under § 1983. In making this first-prong determination, the Court asked three questions:¹⁶

¹² See, e.g., *Weaver v. Reagen*, 886 F.2d 194 (8th Cir. 1989) (holding that Missouri violated federal regulations by denying Medicaid coverage of AZT to AIDS patients); *Visser v. Taylor*, 756 F. Supp. 501 (D. Kan. 1990) (granting a preliminary injunction prohibiting denial of her Medicaid coverage for Clozapine for as long as the plaintiff was eligible for Medicaid and the drug was prescribed by her physician).

¹³ See, e.g., *Kansas Health Care Ass'n, Inc. v. Kansas Dep't of Social and Rehabilitation Servs.*, 754 F. Supp. 1502 (D. Kan. 1990) (ruling that reimbursement rates to nursing homes were not "reasonable and adequate" in violation of the Medicaid Act).

¹⁴ *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).

¹⁵ 496 U.S. 498 (1990).

¹⁶ *Id.* at 509.

- (1) Was the provision in question intended to benefit the plaintiff?
- (2) Does the statutory provision in question create binding obligations on the State (or other governmental unit), rather than merely expressing a congressional preference?
- (3) Is the interest the plaintiff asserts specific enough to be enforced judicially, rather than being "vague and amorphous"?

Analyzing these first-prong questions, the Court concluded that the Boren Amendment clearly intended to benefit hospitals seeking reimbursement at reasonable rates.¹⁷ Next, the Court found that the Boren Amendment created a binding obligation because the amendment was "cast in mandatory rather than precatory terms" and federal funding under the Medicaid Act was tied explicitly to the state's compliance with its provisions. In particular, the Medicaid regulations explicitly conditioned federal funding on compliance with the "reasonable and adequate" rates requirement.¹⁸ Finally, the Court held that the reasonable rates requirement was not too "vague and amorphous" to be enforced judicially because the statute provided an objective method for evaluating reasonableness. Although Congress intended to give each state considerable discretion in choosing a rate calculation method, the Court insisted that "there are certainly some rates . . . that no State could ever find to be reasonable and adequate under the Act."¹⁹ Based on these findings, the court ruled that the Boren Amendment created a substantive right enforceable under § 1983.

Turning to the second prong of the § 1983 analysis, the Court considered whether Congress foreclosed a § 1983 action. The Court emphasized that the defendant must point to either an "express provision" or to "other specific evidence from the statute itself" to prove Congress intended to foreclose § 1983 suits.²⁰ With regard to implied foreclosure, the Court stated that a comprehensive remedial scheme demonstrates Congress' intent to preclude § 1983 suits.²¹ As of 1990, the Supreme Court had on only two occasions found a remedial scheme "sufficiently comprehensive . . . to preclude the remedy of suits under § 1983."²² In both of those cases, the statutes provided for some "private judicial or administrative enforcement."²³

¹⁷ *Id.* at 510.

¹⁸ *Id.* at 510-12.

¹⁹ *Id.* at 520.

²⁰ *Id.* at 520-21.

²¹ *Id.* at 521.

²² *Id.* In *Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1, 13 (1981), the Supreme Court held that the comprehensive enforcement scheme found in the Federal Water Pollution Control Act, 33 U.S.C. § 1252 et seq., which granted the EPA enforcement power through the use of noncompliance orders, civil suits, and criminal penalties, and which included two citizens-suit provisions—evidenced a congressional intent to foreclose reliance on § 1983. Similarly, in *Smith v. Robinson*, 468 U.S. 992 (1984), the Court held that the elaborate administrative scheme set forth in the Education of the Handicapped Act, 20 U.S.C. § 1400 et seq., demonstrated Congress' desire to foreclose private reliance on § 1983 as a remedy.

²³ *Id.*

Given this high standard, the Court held that the Medicaid Act, which permits the Secretary of Health and Human Service to withhold approval of the state's plans, or to curtail federal funds to the states not in compliance with the Act, did not constitute a scheme that was sufficiently comprehensive to demonstrate congressional intent to foreclose a § 1983 action. In addition, the Court concluded that limited state administrative procedures which allow health providers to obtain review of individual claims for payment failed to demonstrate an intent to foreclose a private remedy in the federal courts.²⁴ Given this finding, the Court held that the hospitals could sue under § 1983 to challenge alleged violations of the Medicaid Act.

C. *Suter v. Artist M. and the Congressional Response*

The Supreme Court revisited its § 1983 jurisprudence in *Suter v. Artist M.*, ruling that the "reasonable efforts" clause of the Adoption Assistance and Child Welfare Act did not create rights enforceable under § 1983.²⁵ Although the Court did not explicitly overrule *Wilder* in rendering its decision, the Court did depart from the *Wilder* analysis in important ways that threatened to substantially restrict the ability of private parties to bring § 1983 suits. Most importantly, the Court refused to find that an enforceable right exists when a state fails to comply with statutory requirements embodied in a federally-mandated state plan.

In determining whether an enforceable right existed, the Court in *Suter* chose not to explicitly apply the *Wilder* test. Instead, the Court found that the key question was whether Congress had "unambiguously" conferred a right on the beneficiaries to enforce the requirement that the state make "reasonable efforts" to prevent children from being removed from their homes.²⁶ The Court distinguished *Wilder* from this case in two ways. First, the Court ruled that, unlike the Boren Amendment in *Wilder*, which required states to provide "reasonable and adequate reimbursements" to hospitals, the statute imposes no substantive requirements on the states except the obligation to have a state plan approved by the Secretary of HHS. The Court, in a clear departure from *Wilder*, argued that sixteen mandatory federal requirements (one of which was the "reasonable efforts" provision) did not create enforceable rights, despite the statutory requirements being prerequisites for obtaining federal reimbursements.²⁷

Second, the Court concluded that, unlike the Boren Amendment, which set forth detailed factors to be considered in determining methods for calculating rates, the statute in *Suter* failed to provide the requisite guidance as to how to measure and comply with the "reasonable efforts"

²⁴ *Id.* at 523.

²⁵ 503 U.S. 347, 363 (1992).

²⁶ *Id.* at 357.

²⁷ *Id.*

directive.²⁸ The Court thus held that the obligation to use reasonable efforts was so open-ended, and the resulting state discretion so broad, that judicial enforcement was impossible.²⁹

The *Suter* Court also departed from *Wilder* in discussing the second prong of the test, which asks whether Congress has implicitly or explicitly foreclosed 1983 actions. The Court noted that the Adoption Assistance and Child Welfare Act provides the Secretary the authority to reduce or eliminate payments to a State that fails to comply with the statute or its own state plan and requires a judicial determination that such "reasonable efforts" have been made before the State can secure federal reimbursement for foster care payments.³⁰ Despite recognizing "these statutory provisions may not provide a comprehensive enforcement mechanism so as to manifest Congress' intent to foreclose remedies under § 1983," the Court emphasized that "the absence of a remedy to private plaintiffs under § 1983 does not make the reasonable efforts clause a dead letter," presumably because the other enforcement mechanisms existed.³¹

In addition, the *Suter* Court noted that the regulations promulgated by HHS to enforce the statute (which according to the Court only required states obtain approval for their plan by the Secretary) did not clearly state that compliance with the "reasonable efforts" provision is a condition for the receipt of funds from the Federal Government.³² Although the Court refused to rule on the merits of the foreclosure exception because no enforceable right had been found, the Court clearly suggested a new approach to the foreclosure analysis.

Despite the apparent inconsistency between *Wilder* and *Suter*, a number of circuits attempted to harmonize the two decisions.³³ Some courts distinguished the cases, usually emphasizing the lack of congressional guidance on how to measure "reasonable efforts" and suggesting that the state obligations were simply not clear enough to enforce judicially.³⁴ In general, the lower courts attempted to retain the basic analytical framework announced in *Wilder* while paying deference to the Supreme Court's more recent decision.

²⁸ *Id.* at 359-60.

²⁹ At least one court has argued that the *Suter* court simply focused on the third prong of the *Wilder* test and concluded that the interest in that statute was not defined clearly enough by Congress to be enforced by the courts. *Wood v. Tompkins*, 33 F.3d 600, 606 (6th Cir. 1994).

³⁰ 503 U.S. at 361.

³¹ *Id.* at 360-61.

³² *Id.* at 362.

³³ See, e.g., *Miller by Miller v. Wilburn*, 10 F.3d 1315, 1319 (7th Cir. 1993) ("We have previously held that *Suter* . . . is not the death knell of the analytic framework established by *Wilder*."); *Marshall v. Switzer*, 10 F.3d 925, 928 (2d Cir. 1993); *Aibiston v. Maine Commissioner of Human Services*, 7 F.3d 258, 263 (1st Cir. 1993) ("*Suter*'s impact on our § 1983 jurisprudence is neither particularly 'far-reaching' nor 'plainly inconsistent' with prior precedent."); *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519, 525 (8th Cir. 1993) ("Although some commentators have found *Suter* and *Wilder* difficult to reconcile, we choose to synthesize the two cases by proceeding with the two-step . . . analysis used in *Wilder*, bearing in mind the additional considerations mandated by *Suter*.").

³⁴ See *Martin v. Pinnovich*, 840 F. Supp. 1175, 1194-95 (S.D. Ohio 1993).

In 1994, Congress responded to the *Suter* decision by including a statutory provision in the 1994 Social Security Act Amendments that explicitly limited the scope of the decision.³⁵ Added to the Social Security Act as Section 1130A, the provision states the following:

In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter* . . . but not applied in prior Supreme Court decisions respecting such enforceability: *Provided, however*, that this section is not intended to alter the holding in *Suter* . . . that section 671(a)(15) of the Act is not enforceable in a private right of action.³⁶

Through this provision, Congress explicitly rejected the Supreme Court's decision to limit the scope of § 1983, and mandated that the courts continue to use the pre-*Suter* approach except when analyzing § 671(a)(15).

Court interpretations of the new provision support the conclusion that Congress has substantially restricted the reach of *Suter*. In *Jeanine v. Thompson*,³⁷ the court held that "in light of . . . § 1320a-2, only the narrow holding of *Suter* remains intact, and thus, *Suter* stands only for the proposition that . . . § 671(a)(15) is too vague and amorphous to provide a cause of action under § 1983."³⁸ The court determined that the Congressional amendment "overrules the general theory in *Suter* that the only private right of action available under a statute requiring a state plan is an action against the state for not having that plan. Instead, the previous tests of *Wilder* and *Pennhurst* apply to the question whether or not the particulars of a state plan can be enforced by its intended beneficiaries."³⁹

This interpretation of the language in § 1130A has been followed in at least one recent case deciding whether the provisions of the Medicaid Act and its regulations create an enforceable right under § 1983. In *Harris v. James*, a district court concluded that in determining whether an enforceable right exists, the court should "apply the test as it existed prior to the determination of *Suter*"⁴⁰

³⁵ 42 U.S.C. 1320a-2 & 1320a-10.

³⁶ This same language is codified at both 42 U.S.C. § 1320a-10 and 42 U.S.C. § 1320a-2, presumably because the same language was passed in two separate bills during 1994. In practice, the courts often only refer to one of the code sections.

³⁷ 877 F. Supp. 1268 (E.D. Wis. 1995).

³⁸ *Id.* at 1283.

³⁹ *Id.*

⁴⁰ 883 F. Supp. 1511, 1520 (M.D. Ala. 1995).

REFINING THE CURRENT SSI ELIGIBILITY PROVISIONS UNDER WELFARE REFORM

In lieu of state definition of disability some of the substantive concerns related to SSI eligibility are being addressed within welfare reform.

BACKGROUND

- o Within the context of welfare reform issues have been raised around SSI disability related eligibility for drug addicts and alcoholic, and certain disabled children. (There also have been issues raised related to aged aliens eligibility for SSI.)
- o 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.
- o 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

PROPOSAL

- o The Administration has been dealing with both of these issues within 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 the proposal would change the eligibility process by eliminating the Individual Functional Assessment (IFA) process and eliminating maladaptive behavior from inclusion in the SSA regulations.

ESTIMATES

- o Drug Addicts and Alcoholics - Both CBO and SSA 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).
- o Children - 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.

IMPLICATIONS FOR STATES

- o Some have argued that states will welcome these refinements because it reduces the Medicaid rolls. Others have argued for example that some states might want flexibility to be able to keep at least some of the drug addicts and alcoholics on the rolls in order to have Federal matching funds to pay for substance abuse treatment, rather than having to use state only funding.

STATE DEFINITIONS OF DISABILITY WITH SECRETARIAL APPROVAL

ISSUE: What are the problems associated with having states define disability and submitting definitions to the Secretary for approval?

Regardless of Medicaid policy, Federal definition of disability will continue because it is used for the income support programs of SSI and SSDI. Furthermore, individuals qualifying for SSDI become eligible for Medicare. Many individuals because of limited income currently qualify for SSI and SSDI, and Medicaid and Medicare.

There are two potential Medicaid scenarios:

1. Allow States Flexibility in Definition

- o ***Problem of Conflicting Policies*** - Giving states a broader authority to define disability (than is currently available through the more limited 209(b) provision) would create the dilemma that under one set of rules the Federal government recognizes an individual's disability as qualifying for income support (SSI/SSDI) and health benefits (Medicare), but under State definitional standards approved by the Federal government the individual would not qualify for Medicaid. This conflicting policy situation would likely prove to be awkward.

2. Alternative State Flexibility But Within the Context of Strict Federal Regulatory Definitions

- o ***Problem of Burdensome and Confrontational Process*** - In order to avoid the conflicting policies dilemma, a scenario of strict Federal criteria regulating state definitions could be established. This however would create administratively burdensome review process, and potentially set up confrontational situations between states and the federal government. Under such a scenario there are three likely outcomes:
 - Federal government approves all state proposals potentially resulting in the policy conflict identified in #1. above;
 - Federal government gets into administratively burdensome confrontations with states;
or
 - States create definitions that basically mirror Federal definitions, but both states and the Federal government have new administrative burdens of implementation and review.

MEDICAID AND DISABILITY

Background

- o States are generally required to cover recipients of Supplemental Security Income (SSI).
- o However, States may use more restrictive eligibility standards for Medicaid than those for SSI if they were using those standards before implementation of SSI in 1972. States that have chosen to apply more restrictive standards are known as "section 209(b) States."
- o 209(b) States may use different definitions of disability, more restrictive income and resource limits, or methodologies for determining income and resources different from those used under SSI.

Currently 11 States* are 209(b)

Connecticut	Hawaii	Illinois
Indiana	Minnesota	Missouri
New Hampshire	North Dakota	Ohio
Oklahoma	Virginia	

*Note North Carolina dropped its 209(b) status within the past two years.

State 209(b) Alternative Policies

1. States Limiting Disability Eligibility to Age 18 or Older

- Connecticut
- New Hampshire
- Ohio
- Oklahoma

2. States Using More Restrictive Definition

- Indiana (disability must be permanent, rather than SSI last 12 months or end in death)
- New Hampshire (disability must be permanent, rather than SSI last 12 months or end in death)
- Virginia (process does not provide for presumptive disability based on diagnosis alone)

3. More Restrictive Income or Resource Standards

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- o Within the context of welfare reform issues have been raised around SSI disability related eligibility for drug addicts and alcoholic, and certain disabled children. (There also have been issues raised related to aged aliens eligibility for SSI.)
- o 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.
- o 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

PROPOSAL

- o The Administration has been dealing with both of these issues within 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 the proposal would change the eligibility process by eliminating the Individual Functional Assessment (IFA) process and eliminating maladaptive behavior from inclusion in the SSA regulations.

ESTIMATES

- o Drug Addicts and Alcoholics - Both CBO and SSA 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).
- o Children - 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.

IMPLICATIONS FOR STATES

- o Some have argued that states will welcome these refinements because it reduces the Medicaid rolls. Others have argued for example that some states might want flexibility to be able to keep at least some of the drug addicts and alcoholics on the rolls in order to have Federal matching funds to pay for substance abuse treatment, rather than having to use state only funding.

WHY IT IS ESSENTIAL TO PRESERVE AN INDIVIDUAL'S RIGHT TO SUE IN FEDERAL COURT

* Fundamentally, without a right to sue, there cannot be a guarantee in any meaningful sense. A "guarantee" without a remedy for its deprivation amounts to nothing.

* Those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. Efficiency and predictability are best served by using the federal court system, when the same question arises across multiple jurisdictions. Moreover, when Medicaid-based claims interact, as they often do, with other areas of federal law (such as Medicare or Social Security), the federal courts are more experienced in analyzing these statutory schemes, and are better able to understand and decide cases with potentially broad ramifications. Lastly, there is no indication that federal judges -- the majority of whom were appointed by Republican presidents -- ignore or take lightly the legitimate concerns of state administrators.

If state has to enforce a federal cause of action
* Although lawsuits could still be filed under state law, there is an enormous difference in remedies. Very few state laws would allow a beneficiary to obtain an injunction against the continuation of a policy found to be unlawful, and attorneys' fees also are generally not recoverable. This gap in remedies means that state law alone cannot substitute for a federal cause of action.

* Eliminating all right to sue would single out Medicaid as the one federal statute conferring no possibility of enforcement by its intended beneficiaries. Eliminating federal court jurisdiction would leave Medicaid as the only cause of action arising under federal law that would be barred from the federal courts. Such an unprecedented step would be seen by important constituencies as a signal of second-class status and would set off massive reaction from beneficiary groups and their allies.

* Eliminating a right to sue under any federal law (as proposed in the conference report language) would include all civil rights laws. Current law provides protection against discrimination in state programs 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.

WHAT THE ADMINISTRATION IS OFFERING TO INCREASE STATE FLEXIBILITY

* The Administration has already agreed to eliminate causes of action by providers over compensation rates, by repealing the Boren Amendment. The issue of provider compensation rates is the source of the greatest litigation concern to state officials, the most frequent basis for cases filed in federal court, and the area where judicial competence (federal or state) is most questionable.

* On eligibility issues, which are most closely linked to the concept of a guarantee,

individuals would retain their current right to bring suits. However, the law would be changed to make it explicit that a state administrative process must be exhausted prior to filing in court.

* On benefits issues, the right of action in some benefits claims would be limited to state courts. After exhaustion of an HMO internal grievance process (if applicable) and a state administrative process, litigation over factual disputes in individualized benefit claims would be litigated only in state courts, unless a specified threshold amount (tied to the amount required for diversity jurisdiction) were satisfied. A benefits claim could be heard in federal court only if there were an allegation that the state plan (on its face or as interpreted and applied by the state) or a contract between the state and a provider violated a provision of federal law.

Private Right of Action in Federal 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 there must be a federal cause of action heard in *federal* court to enforce Medicaid eligibility for the following reasons:

Consistent Interpretation. Those aspects of the Medicaid program that are common to all states should be subject to consistent interpretation and administration. When the same question arises in different states, efficiency and predictability are best served by using the federal court system. In addition, Medicaid claims interact with, and have ramifications for, other areas of federal law (such as Medicare or Social Security). Federal courts are more experienced in analyzing these statutory schemes and are better able to understand the ramifications for other federal statutes. Finally, there is no indication that federal judges -- the majority of whom were appointed by Republican presidents -- ignore or take lightly the legitimate concerns of state administrators.

Significant Limitation of Remedies. If the Governors intend to eliminate the federal cause of action and require that Medicaid lawsuits be filed under state law, there is an enormous difference in remedies. Very few state laws allow a beneficiaries to obtain injunctions against the continuation of a policy found to be unlawful, and attorneys' fees also are generally not recoverable. This gap in remedies means that state law alone cannot substitute for a federal cause of action. If the Governors intend to require state courts to enforce a federal cause of action, however, the courts must also apply federal remedies.

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, the Secretary can sue only if a state is in "substantial noncompliance" -- a higher standard than exists today -- and it is unclear what remedies are available. If the only remedy that the Secretary can seek is the cut-off of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent.

Departure from Other Federal Statutes. Eliminating the right to sue in federal court would single out Medicaid as the one federal statute conferring no possibility of federal enforcement by its intended beneficiaries. Eliminating federal court jurisdiction would leave Medicaid as the only cause of action arising under federal law that would be barred from the federal courts. Such an unprecedented step would be seen as a signal of second-class status and would set off massive reaction from beneficiary groups and their allies.

Elimination of Remedies under Civil Rights Law. While it is not clear that the Governors intend 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.



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Ensuring Access to Health Care Services for Our Most Vulnerable Populations

Any effort to preserve important guarantees within the Medicaid bill must also retain a beneficiary's right to go to court to enforce those guarantees. Since the inception of the Medicaid program, a person eligible for Medicaid has had: 1) a guarantee of access to certain services, and 2) the right to enforce this commitment. A "guarantee" without a mechanism for accountability and enforcement is a hollow promise.

Some recent 'block grant' proposals in Congress have threatened to eliminate all guarantees in the Medicaid program. Fortunately, many people agree that some guarantees must be maintained. But without a private right of action in the Medicaid program, any guarantee of medical services will be *meaningless*. The private right of action is the most effective mechanism for ensuring that a state will provide guaranteed services.

Some have argued that alternative mechanisms of enforcement -- including a state or federal administrative scheme -- could be created. But none of these alternatives is effective. Consider the case of a pregnant woman whom Congress intended to be eligible for certain core medical services. Assume the state, as a policy matter, denies the woman some services she believes were guaranteed to her by Congress. Alternative mechanisms will not work effectively to protect this woman.

1) Federal administrative mechanism:

Under a recent Congressional proposal, the pregnant woman described above could bring her claim to the Secretary of the U.S. Department of Health and Human Services (HHS). But the Secretary of HHS is already responsible for overseeing the implementation of the nation's health care policies, including dozens of programs. It is unlikely the Secretary or her staff will have the resources to give adequate attention to the woman's claim, even though the state's denial may affect hundreds of other women as well. If Congress imposes this new function on the Secretary without providing additional funds, the Secretary will have inadequate resources to do the job. Alternatively, if new resources are appropriated to the Secretary for the purpose of enforcing the Medicaid law, a new and unnecessary federal bureaucracy would be created.

2) State administrative mechanism:

Some have proposed that in cases like these, the woman should be restricted to presenting her claim to a state administrative body. But the administrative entity that will hear her

claim will probably be the state's own health department which denied the woman services in the first place, based on the state's policy. It is unlikely the woman will get effective relief at this level.

Private Right of Action:

Unlike state and federal administrative mechanisms, the private right of action provides an effective way to obtain guaranteed medical services. With a private right of action, an individual may bring a claim against the state if the state fails to live up to its obligations.

Effectiveness of Private Right of Action

The private right of action is a well-established enforcement mechanism. With a private right of action, states are cognizant of their obligations and are more likely to comply diligently. The private right of action is effective because it gives a strong incentive to states to provide the medical services promised in their own state plans.

Efficiency of Private Right of Action

A private right of action is cost-effective. With a private right of action, no wasteful state or federal administrative mechanism is required to enforce state compliance. Additional funding is unnecessary and individuals receive direct consideration of their particular situation. In addition, a simple case could resolve a policy issue that may affect thousands of Medicaid recipients.

Private Right of Action Supports Congressional Intent

Congress will hopefully renew its commitment to guarantee Medicaid services to some of our most vulnerable populations -- even if significant flexibility is added to the program. But this commitment will not be fulfilled if individuals cannot use the courts to make states abide by federal law. For example, the poor pregnant woman who is denied services by the state will have no recourse against the state in the courts, even though Congress explicitly intended for her to be covered by Medicaid. The private right of action prevents states from circumventing federal law and undermining Congressional intent.

Recommended Action:

The private right of action must be retained in any new Medicaid legislation to ensure that states provide essential medical services to our most vulnerable populations.

Ensuring State Accountability in Providing Guaranteed Medicaid Services

Any guarantee of health care services in forthcoming Medicaid legislation is meaningless unless it coexists with a private right of action. Without the private right of action, the 'guarantees' for which the President has gained a consensus would be meaningless, since the private right of action is the only effective mechanism of holding states accountable for providing 'guaranteed' services.

Since the governors may have agreed to provide a limited number of services in forthcoming legislation, they may be concerned that a private right of action would allow a Medicaid beneficiary to sue for services that were covered under previously-existing Medicaid legislation. This is not the case. An individual could only bring a claim if he or she is denied Medicaid services that are guaranteed in current law.

If the private right of action is not retained in forthcoming Medicaid legislation, the President's efforts to guarantee health care services to our most vulnerable populations would be thwarted. For example:

- If forthcoming Medicaid legislation guarantees medical services to 'pregnant' women and a state improperly denies those services to a woman who has complications arising from a miscarriage, that woman would have no ability to go to court to enforce her federal guarantee of perinatal care.
- If the new Medicaid plan retains the guarantee for immunizing children and a state then excludes from its Medicaid immunization plan vaccinations for measles, mumps and rubella, a child who is refused such vaccines has no ability to obtain these federally guaranteed benefits.
- If the new Medicaid program retains the guarantee of services to people with disabilities, a state may attempt to deny a person treatment services for multiple sclerosis (M.S.) if that state has excluded intermittent disabilities like M.S. under its own definition of 'disability.'
- Even if the new version of the Medicaid program guarantees health care services to elderly persons, a state may deem someone ineligible for Medicaid because the state counts that person's car as an asset when determining eligibility. Like the others above, this person would have no recourse without the private right of action.

February 7, 1996

THE NATIONAL GOVERNORS' ASSOCIATION PLAN ON WELFARE: WHY IT'S BAD FOR CHILDREN

The National Governors Association unanimously adopted a welfare reform resolution on February 6. Closely following the approach of the welfare bills passed by Congress and vetoed by the President, the governors agreed to abandon the federal guarantee for cash assistance, to be replaced with block grants that would not respond when recessions cause increased need. Under the governors' plan, states could also choose block grants for food stamps, school meals programs, and for foster care and adoption assistance for abused and neglected children. Here's why the governors' plan would hurt children:

- **Needy children and families would no longer be able to count on basic income support.** Like the previous welfare bills vetoed by the President, the governors' plan ends the guarantee that needy families receive at least minimal assistance, and requires states to impose a lifetime limit of five years or less, whether jobs are available or not. While the plan would allow 20 percent of the caseload to be exempt from the time limit, more than that (27 percent) would be unlikely to work because the parent either has or is caring for someone with a disability. Families in areas of high unemployment would also have to compete for the scarce exemptions, as would families where parents work continuously, but at very low wages.
- **When unemployment and poverty rise, federal funds would not increase enough to meet the need for basic income support.** The block grant for cash aid and work remains flat-funded for 7 years. The governors' plan does include a \$2 billion contingency fund that states could tap when unemployment or food stamp use rises, but it is not nearly enough to meet actual need during a recession. During the downturn of the early 1990's, federal AFDC funding grew almost \$6 billion, three times the amount in the contingency fund.
- **The plan would allow states to make further cuts in cash aid or work programs.** The governors' resolution allows states to cut up to 25 percent of their spending without losing any federal funds, the same as in the bill vetoed by the President. In addition, states could shift up to 30 percent of funds for income support and work to other programs.
- **Federal standards for child care quality would be eliminated.** While the governors' proposal takes the positive step of adding \$4 billion over seven years for child care, this plan, like the bill vetoed by the President, would gut federal health and safety requirements for child care, and cut funds to improve and expand the supply of child care.
- **The plan would put more children at risk of abuse and neglect.** The proposal would undermine the guarantee of foster care and adoption assistance for abused and neglected children. It would give states the option of capping funds for foster care, adoption, and independent living services, in exchange for the flexibility to use these formerly guaranteed dollars for any of a range of child protection activities. It is likely that eligible children in these states would no longer be guaranteed foster care and adoption assistance when they cannot live safely at home. Even if a state did not opt for a cap, most other federal child protection programs, including those aimed at child abuse prevention and family support, would be repealed and replaced with a child protection block grant.
- **The plan would undermine the nutritional safety net for children.** States would be allowed to end the guarantee of food stamps and convert the program to a block grant. The governors' plan also accepts \$27 billion in food stamp cuts over seven years, reducing food assistance to 14 million children.

For more information on welfare issues, please contact Deborah Weinstein (662-3565) or David Kass (662-3556) in CDF's Family Income Division; on Medicaid issues, please contact Gregg Haifley (662-3541) or Stan Dorn (662-3595) in CDF's Health Division. On these issues or generally on children's issues, please contact Eileen Sweeney (662-3586) in CDF's Office of Government Affairs.

February 7, 1996

THE NATIONAL GOVERNORS' ASSOCIATION PLAN ON MEDICAID: WHY IT'S BAD FOR CHILDREN

- **It would eliminate guaranteed coverage for poor children 13 through 18 years of age with working parents.** This coverage would be phased in, under current law, by October 2002. But during the twelve months beginning this October, the NGA proposal would end guaranteed Medicaid coverage for 400,000 children in working poor families when they turn 13. In the year 2002, the proposal would deny guaranteed coverage to 3 million poor children ages 13 through 18.
- **It would eliminate current law guarantees that children will receive coverage of all medically necessary health care.** Even the children who would receive coverage under the NGA proposal would not be guaranteed meaningful benefits.
 - o The proposal would repeal EPSDT's (Early and Periodic Screening, Diagnosis, and Treatment) guarantee that children must receive all medically necessary services. States could flatly deny coverage of prescription drugs, for example, even if a child's doctor says there is no other way to treat an illness or stop severe pain. States could likewise deny coverage for dental care, hearing aids, eyeglasses, physical therapy for children with disabilities, or other services that are crucial to children's development and learning.
 - o States also would be given unlimited freedom to determine the amount, duration, and scope of services within covered benefits categories. For example, states could limit children to a certain number of hospital days per year--even seriously ill children whose doctors say more care is needed to avoid grave harm.
- **It would eliminate guaranteed health coverage for children who are disabled according to federal SSI definitions.** Instead, states could limit, as they see fit, the number of children with disabilities who receive coverage. This would jeopardize health coverage for more than two million children with disabilities who now receive Medicaid.
- **It would eliminate existing federal guarantees of coverage for children and parents receiving AFDC.** Under the NGA's welfare proposal, states would have no legal responsibility to give AFDC to poor families, who could lose Medicaid along with AFDC. Medicaid coverage would no longer be guaranteed for 1.6 million children who now receive AFDC and are over age 12. Four million parents now receiving AFDC, 88 percent of whom are women, would also lose guaranteed coverage. These are some of America's poorest families, commonly with income below 50 percent of the poverty line.
- **It would deny access to federal courts to overturn illegal state denials of coverage.** Even the limited guarantees that exist on paper could prove meaningless in practice, if states know they will not be enforced.
- **It would allow states to contribute much less to Medicaid, forcing further cutbacks.** States like New York that currently must match federal spending dollar for dollar could instead put up only 67 cents for each federal dollar they receive. To meet even these reduced matching obligations, states could use provider donations and taxes that the Bush Administration and Congress outlawed in the early 1990s. According to the Congressional Budget Office, these practices were used to circumvent state matching requirements in the past. States could withdraw billions of dollars they now spend on Medicaid, dramatically cutting coverage for families.
- **It would let states use federal Medicaid dollars to pay for current state responsibilities.** Medicaid funds could be used, for example, to purchase insurance for state workers and retirees with incomes under 275% of poverty, or to pay the costs of operating state psychiatric hospitals. State funds freed in the process then could be used to fund road construction or other projects, essentially diverting Medicaid funds from their intended purpose of providing health care for low-income families.

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