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MEDICAID REFORM WITHIN THE EXISTING STATUTORY FRAMEWORK

The current Medicaid program (title XIX of the Social Security Act) and its implementation through federal and state policies has evolved through many years of federal and state debate and problem solving in order to balance the needs and interests of all those involved in the program--state and federal government and taxpayers, providers and beneficiaries.

Significant changes, such as the new state flexibility in the President's plan, require that problems with the current statute be identified and revised in order to achieve an orderly and cost conscious transition. Such careful change is essential when dealing with a program serving 36 million individuals and spending nearly $200 billion federal and state dollars. The alternative -- creation of a new statute and program -- would foster unpredictable change and unintended consequences.

Beyond the specific policy concerns that have been raised about the draft plan, additional issues arise in any plan that creates a new title.

- **State and federal implementation issues.** Following enactment of Medicaid reform legislation, state and federal governments could begin revising their existing programs more easily if the familiar ground of the existing Medicaid statute were revised rather than replaced. Start up costs and delays in implementation would lead to very limited short term savings, and long term savings could be seriously compromised.

  -- Delays in developing new legislation could be a problem--particularly in states where the legislature meets only biennially.

  -- Development and issuance of new federal and state regulations and procedures would be time consuming, and mechanisms to provide federal funding might not be in place until a number of issues are resolved.

  -- All federal and state program forms, provider agreements, data systems, administrative systems, and survey and certification procedures would need re-examination.

- **Legal Issues.** A vast number of issues--even those that have been long-settled--could be the subject of contentious and time consuming new litigation. This would be true even if Congress expressed its intent to continue certain parts of the program with little or no change.

- **Protections for federal and state governments, beneficiaries, and providers.** In addition to the many legal, administrative, and procedural issues that must be dealt with, there are important provisions in the current statute that provide protections to federal and state governments and taxpayers, beneficiaries, and providers.

Some examples of types of title XIX protections that could be lost are as follows.

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- **Beneficiaries are subject to rules within which they receive services under Medicaid.** Some of these will be changed consciously, others would likely change through lack of awareness, and would have potentially significantly serious unintended consequences. Some examples:

  --1916 Cost sharing protections in current law (substantially different from those in the proposed new title.) The existing cost sharing provisions identify the specific beneficiary populations that are subject to cost sharing. They also delineate the conditions under which cost sharing can be imposed. Providers and beneficiaries alike are aware of the requirements.

  --1920 Allows presumptive eligibility for pregnant women in certain situations, which allows immediate service by providers to pregnant women while the formal eligibility process is being completed.

  --1902(b) Prohibits special eligibility limits such as duration or specific location of residency requirements, citizenship requirements other than that the individual be a citizen of the U.S. This prevents one state from establishing a longer state residency requirement than its neighboring states.

  --1902(a)(17) Provides for standards for how income and resources are to be determined, and for taking into account only income and resources that are actually available to the individual. These assure that neighboring states use some comparable definitions for purposes of determining income under provisions such as required coverage of individuals under the federal poverty level.

  --1907 Generally may not compel a beneficiary to accept services contrary to individual religious beliefs; this is a protection of individual religious liberties within Medicaid, important to groups such as Christian Scientists.

  --1902(a)(7) Protection from disclosure of information. This creates the framework for privacy and release of information in the course of routine state Mediciad administration.

- **States and the federal government have procedural and due process guarantees, as well as links with other programs**. For example:

  --1902(a)(16) Individuals are the responsibility of their state of residence. Thus, states are not required to pay for services to residents of other states. If a resident of one state receives service in another state, the state of residence is not required to cover items not included in its state plan, nor is it required to pay for the services at rates higher than in its state plan.

  --1914 Linking Medicaid withholding with Medicare withholding of overpayments to certain providers, with due notice requirements to the States. This assures coordination between Medicare and Medicaid in the case of overpayments.

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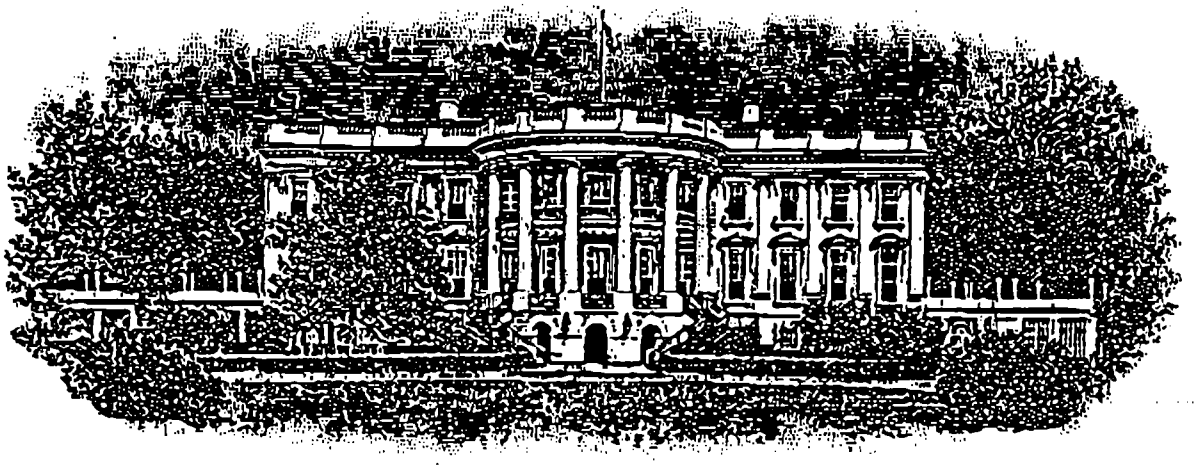
- **Providers are assured that the Medicaid program will operate within certain expectations.** For example,

  --1902 (a)(37) Payment of claims within 30 days. This is a standard business practice and protects providers from cash flow and other payment problems that could affect their willingness to participate in the Medicaid program.

  --1902(a)(48) Method of demonstrating eligibility to provider when beneficiary has no fixed address. This gives providers some degree of confidence that individuals seeking Medicaid eligibility have a likelihood that they will not be determined ineligible because they have no fixed address.

The White House



DOMESTIC POLICY

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CENTER ON BUDGET AND POLICY PRIORITIES

March 21, 1996

When Is a Guarantee Not a Guarantee, Part I
(Analysis of the March 7th draft Medicaid bill, without the financing provisions)

The March 7th draft of the Medicaid bill does not give life to the Governors' agreement that certain groups of people would be guaranteed at least some health care coverage. While the draft includes provisions directing states to provide coverage to younger children, pregnant women, and some disabled and elderly people as called for in the NGA resolution, other provisions in the draft negate any semblance of a real guarantee of coverage. *If the March 7th bill were to become law, there would be no federally-defined group of people who would be assured affordable coverage.*

By repealing Title XIX and using Medigrant as the basis for this draft, the bill eliminates many provisions in federal law that were not specifically addressed by the governors' agreement. Some of these provisions are major and others are less significant, but in combination the loss of these federal rules make the so-called guarantees in the bill largely cosmetic. The result is something far different from the balance between federal guarantees and state flexibility that the Democratic governors hoped to achieve.

To the extent that the governors, or some of them, intended the February 6th NGA agreement to mean that there would be a federal health care safety net for at least some groups of vulnerable people, the March 7th draft bill most certainly does not reflect the governors' agreement. Here are just some of the ways in which the draft bill undermines the governors' agreement to assure coverage to poor children under age 12, pregnant women, and elderly and disabled people.

1. **The Governors agreed that federal law should assure that children and pregnant women with incomes below specified levels would be covered. However, because the March 7th draft eliminates all federal rules relating to how income and assets would be counted, the federally-prescribed income levels that appear in the draft bill become virtually meaningless.**

   - **All federal rules governing what income would be counted are eliminated.** States could consider gross rather than net income in determining eligibility for Medicaid. They could choose to disallow any of the current deductions (such as those for work related expenses, including child care) that are intended to assure that only income that is available to pay for medical care is considered when

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056
Robert Greenstein, Executive Director

Medicaid eligibility is determined. In addition, states could count non-cash benefits when calculating financial eligibility. Receipt of housing assistance or child care subsidies might disqualify children or pregnant women from Medicaid even if their cash income were well below the poverty level.

- **All federal rules governing what assets would be counted are eliminated.** Asset rules would be left entirely to the states. A child whose parent loses her job and her source of income could be denied Medicaid if the family owns its own home. A car needed for work could make a pregnant woman ineligible for coverage, regardless of the level of her income or the value of her car.

- **All federal rules governing *whose* income and assets are to be counted are eliminated.** In determining eligibility for Medicaid, a state could decide to count the income of anyone — or everyone —residing together, regardless of whether those persons actually support or have any legal obligation to support the Medicaid applicant. An infant whose family income is below the poverty level could be denied Medicaid if his or her grandmother moved in to help the family with child care. Children could be denied coverage based on the income of unrelated boarders. Moreover, states could count income of nonsupporting family members who do not reside with the Medicaid applicant, for example, by deeming income of absent parents.

2. **The income protections agreed to by the Governors also are undermined by provisions in the bill that would leave people with incomes below the poverty level with unaffordable health care costs.**

- **Virtually all federal rules preventing states from imposing unaffordable cost-sharing requirements are eliminated.** Only very limited protections for pregnant women and children would remain. Poor children and pregnant women, for example, could be required to pay a 20 percent copayment for hospital care or for sick visits to the doctor. Elderly or disabled people could be faced with large deductibles for diagnostic laboratory tests or medications before Medicaid coverage would begin.

  The bill also would eliminate the provision in current law that prohibits providers from denying services if the required cost-sharing cannot be paid at the time the service is rendered. In addition, the bill would permit states to condition cost-sharing on participation in state mandated programs that "promote personal responsibility". Thus, a pregnant woman with little or no income could be required to pay a copayment for prenatal care if she refused to attend abstinence counseling, and she could be denied that prenatal care if she did not have the means to pay.

- **The federal rule banning providers from billing Medicaid patients is eliminated.** The March 7th draft explicitly states that Medicaid payments can cover only part of the cost of services, and the current ban on balance billing is dropped (except with respect to long term care). Providers could bill patients even those who are mandatory beneficiaries — for the difference between customary charges and the Medicaid payment. For example, if the normal hospital charge for an outpatient surgical procedure is $1,000 but the Medicaid payment to the hospital is $800, the hospital could bill the patient for $200. The gap between Medicaid rates and customary charges already is large in many states, and the elimination of federal provider rate standards and the reductions in federal and state Medicaid funding will likely result in even lower provider rates. Without the protection against balance billing, low-income beneficiaries will be liable for a growing share of the cost of services.

- **Federal rules regarding private insurance buy-ins would be eliminated.** Under current law, persons with access to private insurance must enroll in the plan if the state determines enrollment to be cost-effective. Medicaid, however, must pay premiums, deductibles, coinsurance and other cost sharing requirements imposed by the private plan. Thus, under current law, if a low-income child's parent enrolls in her employer's health plan and the plan called for a $250 deductible, Medicaid would pay the deductible and the private plan would cover other costs. The March 7th draft drops these cost-sharing protections and permits states to deny benefits to individuals where benefits are available under another public or private plan without regard to the cost to the individual. Thus, in this example, the child could be denied Medicaid because her parent's employer offered a health insurance plan, even if the child could not access coverage under the plan because the family could not afford to pay the deductible.

3. **There would be no legally enforceable assurance that the protected populations would be guaranteed coverage.**

- **Even mandatory groups of people could lose coverage if costs exceeded the federal caps.** The draft bill provides that the "guarantees" for the mandatory groups of beneficiaries are subject to the caps on federal funding. If, in any given year, federal funds are insufficient to cover all children, pregnant women, and elderly and disabled people who fall within the mandatory groups, a state could drop coverage even for these groups of beneficiaries. (A full analysis of the implications of this provision depends on the details of the financing provisions.)

- **Even mandatory beneficiaries would not have an effective opportunity to enforce any right to coverage.** Access to federal court would be denied in all instances (except for discretionary appeals to the U.S. Supreme Court). Moreover, access to state court would be limited to the issue of benefits (although there does not appear to be a right to any level of benefits that would be enforceable in state court). *There would be no private right of action in state or federal court to enforce the right to coverage.* Thus, for example, disabled people who believe that they fall within the state's definition of "disabled", would have no ability to go to court to enforce their right to coverage.

4. **Coverage guarantees agreed to by the Governors are further eroded by many provisions in the draft bill that would allow states to deny, terminate or limit benefits. States would be under no requirement to have fair or objective standards for determining benefit packages.**

- **Mandatory enrollees could be denied coverage based on durational residency requirements.** The bill allows states to impose residency requirements without limitation. States could, for example, establish rules that denied coverage to severely disabled or chronically ill people who had not lived in the state for at least two years.

- **States could meet their obligation to provide Medicaid coverage to disabled people by reimbursing themselves for the cost of state psychiatric facilities.** Another change from current law would allow states to use federal Medicaid payments to fund state mental health facilities (states cannot now use Medicaid payments for facilities that treat persons ages 21 - 64). If a state funded its state psychiatric facilities through Medicaid, the cost could consume much if not most of the state's set-aside requirement for the disabled. (This is particularly true if a state withdrew state funding from the Medicaid program, as allowed under the NGA agreement, and thereby lowered the dollar value of the set-aside.)

- **States could stop paying for benefits for people who develop a costly medical condition.** Federal rules assuring comparability of services, statewideness, as well as rules that prohibit states from discriminating among beneficiaries based on diagnosis, illness or condition would be substantially modified or eliminated. These changes would allow a state, for example, to deny payment for chemotherapy for certain cancer patients, or to refuse to cover high cost medications for patients with HIV.

- **States could allow counties or cities to determine benefits and to deny payment for needed services that are not available locally.** Under the draft, states could turn their Medicaid program into local block grants, as at least one Republican governor has already proposed to do. Benefits could be set by counties or other local jurisdictions since rules requiring a statewide benefit package are eliminated. Thus, a county with a teaching hospital might offer one set of benefits, while a county with no specialty services available might offer another benefit package. Moreover it appears that the bill would permit a county to deny coverage to persons who recently moved into the county and to deny county residents payment for services obtained outside the county. Again, it appears that these restrictions could apply to mandatory as well as optional groups of beneficiaries.

Conclusion

These are just some of the problems identified from a preliminary review of the March 7th draft. The implications of repealing Title XIX and eliminating federal legal protections for all groups of beneficiaries no doubt go far beyond the issues noted above. Moreover, to the extent that the financing provisions in the bill do not adequately assure that funding "follows enrollees" and allow for large state funding reductions and illusory financing schemes, the dangers that would result from the provisions discussed above would be far worse than noted.

The March 7th draft would end the federal health care safety net for even the most vulnerable groups of people now served by the Medicaid program.

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MEDICAID REFORM WITHIN THE EXISTING STATUTORY FRAMEWORK

The current Medicaid program (title XIX of the Social Security Act) and its implementation through federal and state policies has evolved through many years of federal and state debate and problem solving in order to balance the needs and interests of all those involved in the program--state and federal government and taxpayers, providers and beneficiaries.

Significant changes, such as the new state flexibility in the President's plan, require that problems with the current statute be identified and revised in order to achieve an orderly and cost conscious transition. Such careful change is essential when dealing with a program serving 36 million individuals and spending nearly $200 billion federal and state dollars. The alternative -- creation of a new statute and program -- would foster unpredictable change and unintended consequences.

- **Legal Issues.** A vast number of issues--even those that have been long-settled--could be the subject of contentious and time consuming new litigation. This would be true even if Congress expressed its intent to continue certain parts of the program with little or no change.

- **Federal and state Implementation Issues.** Following enactment of Medicaid reform legislation, the federal government and the states could begin revising their existing programs more easily if the familiar ground of the existing Medicaid statute were revised rather than replaced. Start up costs and delays in implementation would lead to very limited short term savings, and long term savings could be seriously compromised.

  -- Delays in developing new legislation could be a problem--particularly in states where the legislature meets only biennially.

  -- Development and issuance of new federal and state regulations and procedures would be time consuming and could reopen debates on key issues.

  -- All federal and state program forms, provider agreements, data systems, administrative systems, and survey and certification procedures would need re-examination.

- **Protections for federal and state governments, beneficiaries, and providers.** In addition to the many legal, administrative, and procedural issues that must be dealt with, there are important provisions in the current statute that provide protections to federal and state governments and taxpayers, beneficiaries, and providers. These areas are not dealt with at all in either MediGrant II or the NGA proposal.

Some examples of title XIX protections that could be lost are provided in the materials that follow.

- **States and the federal government have procedural and due process guarantees, as well as links with other programs.** Some examples:

  Due process guarantees for states in the case of disallowances

  -- 1903(d)(2)(D) No State liability for uncollected overpayment

  [other examples?]

  Authority to collect secondary payments and medical support obligations

  --1912 Assignment of rights of payment (e.g., settlement of law suits due to auto accidents, collection of medical support payments)

  [other examples?]

  Coordination with other federal programs/provider exclusions/overpayments

  -- 1914 - linking Medicaid withholding with Medicare withholding of overpayments to certain providers

  -- 1903(i)(2) withholding federal matching for payments for providers excluded from participation in Medicare, title V, title XX.

  -- 1925(d) States not responsible for otherwise required extension of eligibility in cases of fraud

  [other examples?]

  Other administrative provisions

  – 1902(a)(5) Single state agency requirement

  [others?]

  -- 1154 Peer Review Organization Provisions cross reference
  -- 1902(a)(30) UR requirements can be met by a PRO

- **Beneficiaries are subject to rules within which they receive services under Medicaid.** Some of these will be changed consciously, others would likely change through lack of awareness, and would have potentially significantly serious unintended consequences. Some examples:

  Cost sharing

-- 1916 cost sharing protections in current law (substantially different from those in the proposed new title.)

[other?]

Targeted eligibility protections

-- 1902 (a)(34) payment for care three months before date of application if individual would have been eligible if they had applied then

-- 1920, allowing for presumptive eligibility for pregnant women in certain situations

-- 1902(a)(10)(A)(ii)(VI) - special provisions for disabled children (Katie Beckett rules)

-- 1902(a)(8) - requiring that beneficiaries must be provided the opportunity to make application with reasonable promptness

-- 1902(a)(55) - providing for outstationed eligibility processes for taking applications

-- 1902(b) - prohibits special eligibility limits such as duration of residency requirements, citizenship requirements other than that the individual be a citizen of the U.S.;

-- 1902(a)(17) - provides for standards for how income and resources are to be determined, and for taking into account only income and resources that are actually available to the individual.

[are there others?]

Special beneficiary protections

-- 1907 No action affecting individual religious beliefs

-- 1902(a)(7) protection from disclosure of information

- **Providers are assured that states will be good and** reliable business partners, and that the Medicaid program will operate within certain expectations.

[is this a good category for governors?]

-- 1138 Provisions dealing with relationships and requirements for OPOs
-- 1923 (d) Qualification as a DSH hospital

-- 1902 (a)(37) Payment of claims within 30 days
-- 1921 Privacy and confidentiality of information requirements and relationship to Health Care Quality Improvement Act of 1984

WHY TITLE XIX'S FRAMEWORK IS IMPORTANT

Overview: At the core of the Medicaid Act are principles which must be preserved to ensure basic accountability and fairness. The danger of scrapping the Medicaid Act and losing these basic protections is clear from the fact that most protections did not appear in the Reconciliation bill and **none** appears in the National Governors' Association six-page proposal. The need for every one of these protections remains even if a state shifts over to comprehensive, mandatory managed care. These core principles found in the Medicaid Act include:

1. Accountability to the Federal Government:

* a single state agency must be responsible for supervising the program [§ 1902(a)(5)];

* because states must cover "all" eligible persons, they cannot undercut Federal guarantees of eligibility [1902(a)(8)].

2. Protections for states:

* an assurance that impoverished visitors from other states will be covered by their home state's Medicaid program [1902(a)(16)];

* assistance in applying state law to the operations of ERISA plans so that third-party health insurance covers what otherwise would be Medicaid costs [1902(a)(25) and § 609 of ERISA];

* procedural fairness in compliance disputes with the Federal Government [1904 and implementing regulations].

3. Accountability to the beneficiaries:

* states cannot ration benefits by refusing to take new applications [1902(a)(8)];

* notices of adverse action must be provided and beneficiaries must have the opportunity to take disputes to a fair hearing [1902(a)(4)];

* decisions must be made and services provided with reasonable promptness [1902(a)(3) and (8)];

* beneficiaries' confidentiality is protected [1902(a)(7)].

4. Fairness among recipients:

* the program must be in effect in all political subdivisions of a state [1902(a)(1)];

* the program must use reasonable and consistent standards for evaluating income and resources in determining eligibility [1902(a)(17)].

What are the essential elements of Medicaid?

a. States must be accountable to the Federal Government and to recipients.

Federal Government limits state money if state does not comply with plan, 1904

There have to be some federal sanctions -- states have become all too accomplished at using Medicaid money for purposes unrelated to poor people's health care.

State plan requirements enforceable, 1123, 1130A

There is a 30-year history of basic beneficiary protections not being fully implemented by states and not fully being enforced by the Federal Government. It makes sense to allow beneficiaries to assert their interests directly.

States to supervise program with a single state agency, 1902(a)(5)

There needs to be one state official or agency in charge of administering the Medicaid program; if control is fractured, it is easy to avoid accountability.

States to make reports to the Federal Government, 1902(a)(6)

The Federal Government and beneficiaries both need information on how well a state program is working.

States to allow Federal monitoring of 1915 waivers, 1915(f)

There is a particular danger in managed care situations that a state will wash its hands of access problems and assume that the private sector will take care of everything. Coercive regulation may not be wise, but information about what is happening is essential.

Data to be provided on success of children's screening program, 1902(a)(43)(D)

The vendor-payment emphasis of traditional Medicaid makes it hard for Medicaid agencies to start operating comprehensive, innovative preventive care programs. States need to have EPSDT goals and to provide a way of measuring how well they are doing in reaching those goals.

States to supply matching funds, 1902(a)(2); FMAPs, with greater federal match for certain activities, 1903(a) and (j), 1905(b)

A matching-fund system ensures that states are not 100% on the hook financially for innovations they want to make or for responses they need to make if numbers of beneficiaries increase. At the same time, from the federal side, a matching-fund system gives states incentives to use federal money wisely, because state money, not just federal money, will be at stake. It also makes sense, in terms of unfunded mandates, for some federally required activities to draw down an enhanced federal match. A statute on these issues inevitably will be detailed in order to protect interstate equities, but the details do not have to be identical to those in current law.

Provider tax schemes, etc., prohibited, 1903(w)

Churning dollars within a state to draw down federal matching funds has cost billions of federal dollars. Unfortunately, because improper practices overlap with proper ones, a very detailed statute is necessary.

States to provide some sort of assurance re basic quality of providers, 1902(a)(9), 1902(a)(22)

Federal dollars will be wasted if they are used to provide substandard care; the present statutes are not particularly intrusive.

States not to make payments to sanctioned providers, 1902(a)(39)/1902(p), states to give notice to Federal Government and state medical board of sanctions, 1902(a)(41), states to publicize problems, 1902(a)(49)/1921

A state's left hand, making payments, should know what the right hand, policing health care providers, is doing. So should the Federal Government and consumers of health care.

Physician self-referral prohibition to be consistent with Medicare, 1903(s)

Whatever the Medicare policy is, Medicaid should duplicate it. The dangers of self-referral are the same.

b. State programs must use procedures which are fair to recipients.

Opportunity to apply, 1902(a)(8)

Fundamental fairness requires the door of the Medicaid office to be open.

Notice & hearing, 1902(a)(3)

Medicaid coverage can be a life-or-death matter. Basic due process should be provided. National standards remove the need to litigate due process issues state by state.

Furnish aid with reasonable promptness, 1902(a)(8)

A coverage card is meaningless if someone cannot get services.

Confidentiality, 1902(a)(7)

Applying for assistance requires one to disclose intimate personal details which should not be public information.

Reasonable and reasonably uniform assessment of income and resources, with income and resources not to be counted unless available, 1902(a)(17)

No means-tested program should be arbitrary in its assessment of income and resources, or conjure up sources of support that do not exist or are not available. Because people's eligibility can be assessed under different categories, e.g., disabled mother taking care of deprived children, evaluation of income and resources should use reasonably uniform standards, so that a small change in a family's circumstances does not drastically alter its coverage. Some details in the statute, related to cash assistance,

are not essential if Medicaid's links to cash assistance are weakened. However, this makes relative uniformity in income and resource evaluation even more important.

If state chooses to cover medically needy people, that is, people whose medical bills reduce their available income so much that they are functionally as poor as people who otherwise would be covered, state must not assess these people's income and resources differently from the way it assesses others', so there is not a "cliff" at the edge of ordinary eligibility, 1902(a)(10)(C), 1902(a)(17)

A few dollars' fluctuation in income should not make hundreds of dollars' difference in the availability of medical care.

Income exclusion for German reparations, 1902(r)(1), and so on

As a matter of social policy, Congress sometimes decides that a socially beneficial payment should be held by the recipient, not used to offset the recipient's need for medical care or other public benefits. (Other examples: Japanese/Aleut reparations, tribal payments.) If the socially beneficial payment is federal, the appropriate place for that decision to be made is in the statute authorizing the payment; but if the socially beneficial payment comes from somewhere else, e.g., Germany, then the exclusion needs to be in the Medicaid statute.

States to use outstations, not just welfare offices, for taking applications, 1902(a)(55)

Despite enhanced federal matching funds for program administration, many states do not adequately ensure that applications are available at the point of service -- the hospital or the clinic. In the long run, outstationing helps clinics and hospitals by ensuring that more 'one-encounter' patients will be covered.

Advance directives to be made available, 1902(a)(57) and (58)/1902(w)

Same general idea as standards for nursing homes (see below).

Can't require families to apply for cash assistance in order to get medical coverage, 1902(c)(2)

Why should Medicaid have unnecessary welfare stigma, and why should applicants have unnecessarily to deal with complex welfare-type applications?

Procedure for making disability determinations before Social Security determinations final, 1902(v)

Existing statute offers states options in how to protect applicants who have to deal with the slow Social Security disability determinations system.

c. States must make a core group of deserving poor people eligible.

Children with family incomes below certain poverty levels, 1902(a)(10)(A)(i)(IV), (VI), (VII)/1902(l)

The premise of the current system is that children's coverage should not depend on how many parents are in the household and that coverage for younger children is most

important because with many conditions early medical intervention is more effective than later medical intervention.

? Caretakers of children if the caretakers are actually themselves receiving cash aid ?, 1902(a)(10)(A)(i)(I)

Medicaid is just as ambivalent as the welfare system about the proper role of people caring for poor children. The eligibility categories for caretakers are all welfare-linked.

Newborns if mother was eligible, 1902(e)(4)

The last thing families should have to deal with is a dispute over a newborn's Medicaid eligibility. Continuity of care is essential.

Children who are inpatients when age limit threatens to make them ineligible, 1902(e)(7)

So long as the eligibility system tests both age and family income, it will be possible for eligibility problems to interrupt an essential course of treatment.

Pregnant women, once found eligible, for pregnancy & postpartum, 1902(e)(5) and (6)

Prenatal care is so important that a pregnant woman, once found eligible, should not have to worry about maintaining eligibility.

Poor elderly and disabled people, 1902(a)(10)(A)(i)(II)

Elderly and disabled people poor enough to need SSI are almost certain to have medical needs they cannot meet out of their SSI checks. The real question is whether there is any more need to have a "209(b)" grandfather clause for states which did not want to have to cover all SSI recipients more than 20 years ago.

Poor elderly and disabled people who need assistance with Medicare cost-sharing, 1902(a)(10)(E)/1905(p), 1905(s), unless this is federalized

The Medicare hospital deductible is about one month's income for an elderly or disabled person at the poverty line. The Part B premium is substantial -- and must be paid if elderly and disabled people are to get basic preventive care. Poor people cannot afford Medigap policies, so the Government must meet their needs some other way. It would make sense for the system to be federalized, but so long as it is not, people needing help with Medicare cost sharing should continue to get it from Medicaid.

People who have worked their way out of bare-bones poverty but need medical coverage to keep from sliding back into poverty, 1619(b)/1905(q)

Part of the "work incentive" for disabled SSI recipients should be an assurance that necessary medical coverage will continue.

People who have worked their way above ordinary income eligibility levels, or gotten increased child support, and need transitional medical coverage, 1902(a)(52)/1925, 406(h)

Fear of losing Medicaid has been an important reason why poor families have been reluctant to send a breadwinner to work or insist that child support be paid. Low-wage jobs do not typically come with health insurance. Transitional coverage is essential.

People who through the operations of some other government benefit program are forced over income thresholds even though the medical coverage is more important than the extra cash, Pickle, 1973 grandfatherees, disabled adult children, Kennelly widow(er)s

Each of these immensely complicated eligibility categories has been a response to a simple problem -- the Government, in the course of providing greater cash assistance, has threatened to deprive people getting that assistance of Medicaid, or has threatened to make Medicaid much harder to get.

If state chooses to cover medically needy people, that is, people whose medical bills reduce their available income so much that they are functionally as poor as people who otherwise would be covered, states must fully recognize medical costs as they are incurred, 1902(a)(17)

The whole premise of a medically needy program is that as a functional matter medical bills make one poor. States need honestly to evaluate medical costs.

No durational residency requirements, 1902(b)(2)

Among other things, durational residency requirements are unconstitutional.

No fixed-address requirements for bona fide residents, 1902(b)(2)

States and localities are often tempted to discriminate against homeless people, who may in fact have the greatest need for reliable medical care.

No automatic denial to teen mothers because teen mothers denied cash assistance, 1902(e)(10)

Why should children who have children be denied services simply because a state feels that they will not properly manage cash? Medicaid is a vendor payment program.

Emergency assistance for aliens, 1903(v)

The difficult Medicaid compromise here is that most routine care should be denied, but emergency care should be provided. That compromise is preserved in pending welfare reform and immigration legislation, and should be preserved in Medicaid itself.

Are full descriptions of optional eligibility categories an essential part of Medicaid? The reason many of these categories are spelled out in great detail in the statute is that the statute, or HCFA interpreting the statute, imposes a general policy that federal money cannot help provide coverage for someone unless the statute specifically authorizes this. For example, 6 year olds with family incomes at 99% of poverty are eligible, but 6 year olds with family incomes at 101% of poverty are not. Under this approach, a detailed description of the optional eligibility category is necessary, at least in theory, to prevent states from making too many people eligible. Then, of course, the description needs to become even more detailed to ensure that states choosing the option actually do make eligible the people intended to be benefitted. Random examples of the detail this involves: the Katie Beckett option [1902(e)(3)]; poverty-linked coverage for aged and disabled [1902(m)]; the TB option

[1902(z)]; presumptive eligibility for pregnant women [1920]. Options to restrict eligibility below the typical federal minimum, as in "section 209(b)" [1902(f)], work the same way.

While we understand how this system developed, we do not view it as essential to Medicaid. It is possible to imagine much more open choices for states among eligibility options, guided by the general principles listed above.

d. States must offer a core set of basic services.

Physicians' services, 1905(a)(5)

Self-evident; some details in the current statute might be modified.

Hospital services, both inpatient and outpatient, 1905(a)(1) and (2)(A)

Also self-evident.

Safety net providers' services (federally qualified health centers, rural health clinics), 1905(a)(2)(B) and (C), 1905(l); rural health clinic certification overlap with Medicare, 1910(a)

Also self-evident, reflecting the fact that the purely private sector often does not adequately serve the areas where poor people live.

Services from IHS facilities, 1911, 1905(l)(2)(B), Medicare cross references

Similarly, this reflects the fact that purely private sector services do not adequately reach Indians. Special cost arrangements reflect the Federal Government's trust responsibility towards Indians.

Nursing facility services, 1905(a)(4)(A)

Self-evident, so long as the country lacks a better-thought-out system for paying for long-term care.

ICF/MR services, 1905(a)(15), 1902(a)(31)

Self-evident.

Home health services for persons who otherwise would need nursing facility services, 1902(a)(10)(D)

Applies when it would be cost-effective, as it usually is.

Children's screening, diagnostic, and treatment services, 1905(a)(4)(B)/1905(r), 1902(a)(43)

Reflects a national commitment to children's health.

Quality services for children & pregnant women, 1903(i)(12)

Standards under which payment will be made are very basic and not unduly burdensome.

Family planning services, 1905(a)(4)(C)

Necessary services that would not be available any other way.

Assistance with Medicare cost-sharing, 1902(a)(10)(E)/1905(p), 1905(s), unless this is federalized

Cost-effective in those situations in which states would otherwise have to pay the full bill under Medicaid; in the long run, system should be Federally funded.

Drug rebate system, 1902(a)(54)/1927

See below.

Pediatric vaccines, 1902(a)(62)/1928

National system makes as much sense as drug rebate system does.

Definitions of services, e.g., 1905(c)-(i), (l), (o), (r)

As states (properly) must provide services in a sufficient amount, duration, and scope to meet their purposes, it makes sense to have the scope of services defined in Federal statute rather than via lawsuit.

Are full descriptions of optional services an essential part of Medicaid? Consider, e.g., the ventilator-care option [1902(e)(9)]; group health plan continuation option [1902(e)(11)]; home & community care exception to Federal payment limits [1902(h)]; many details of proper HCBS waivers [1915(c)] and other waivers, such as the frail elderly waiver [1929]; and the community supported living arrangements option [1930]. Again, the cumbersomeness of the options is a response to the rigid Federal definition of what "medical assistance" is. We do not view this rigid definition as a necessary part of Medicaid. Federal budget control might better be exercised through a system of per capita caps on each state's total allocation of federal money.

One instance of a situation in which detailed national standards are necessary, even though a service is formally an "option," is prescription drugs. The drug industry operates nationally and a nationwide buying program, involving rebates, is a natural and necessary response.

e. States must offer services in non-discriminatory ways.

Statewide, 1902(a)(1)

Vital protection for both rural and inner-city areas.

Comparable, as among recipients of equal medical need, 1902(a)(10)(B), see "comparability exceptions" following 1902(a)(10)(F)

Helps to avert strong tendency for any large program to discriminate among recipients. Any exceptions to equality should be explicit, not hidden.

Limits on cost-sharing, protecting the most vulnerable populations & not discouraging access to care in emergencies, 1902(a)(14)/1916

RAND study indicates that regardless of effect of cost-sharing on the health of the population as a whole, substantial cost-sharing is not appropriate for people who are poor and sick. Meanwhile, cost-sharing requirements should not discourage emergency, preventive, and pediatric care. Finally, allowing substantial cost-sharing to be imposed on nursing home residents would deprive them of their small allowances for personal needs.

No balance billing, see 1916, 1128B(d)(1), 42 C.F.R. § 447.15

If poor people are to contribute to the cost of their care, they should do it through an organized system of copayments, not through hidden decisions by providers.

Services to people temporarily out of state, 1902(a)(16)

Poor people do travel and do need care in emergencies. The statute and regulations are not intrusive.

If freedom of choice to be limited, restraints must preserve adequate access to care, 1902(a)(23)(A), 1903(m), 1915(c)

There has to be some check on the service-denial incentives within mandatory managed care.

If freedom of choice to be limited, person must still have access to family planning services, 1902(a)(23)(B)

Recongnizes that many managed care organizations are not well set up to deliver family planning services, which typically are available through a separate system.

Rates sufficient to ensure equal access, 1902(a)(30)(A)

In free-enterprise system, coverage card is meaningless if provders will not participate.

Special emphasis on OB/pediatric rates, 1926

Medicaid's role in providing prenatal care, delivery services, and pediatric services is so important that special attention to attracting able providers is necessary.

Retroactive coverage if person would have been eligible at the time, 1902(a)(34)

If there were national health insurance, a retroactive coverage system would not be necessary. But many people's first major encounter with the medical system is when they suffer a disabling injury. Retroactive coverage allows that bill to be paid.

Information about preventive care to be provided, 1902(a)(43); WIC, 1902(a)(53)

Screening systems offer an invaluable opportunity to put people in touch with other important services.

Way for homeless people to demonstrate eligibility to provider, 1902(a)(48)

A person without a fixed address has special problems showing that he is Medicaid-eligible. The statute does not require states to address these problems in any particular way, but does require that they be addressed.

Service cannot be excluded simply because school district might pay for it as educationally "related service," 1903(c)

It is wrong to allow a Medicaid program and a school district to play 'hot potato' with children's services.

States must have standards re organ transplants, 1903(i)(1)

Transplants can be extremely expensive and are usually a life-or-death matter for the recipient. Publicly available standards are essential if proper planning is to take place.

States must not coerce people in violation of religious beliefs, 1907

Self-evident (I hope).

Protections for people threatened with denial of care because they allegedly have overused services, 1915(a)(2)

Due process ensures that people are still able to get services while being prevented from abusing them.

Restrictions on transfer-of-assets penalties states may impose, 1917(c)

The imperfect statutory compromise deals with tension between two facts: lengthy long-term care is beyond most middle-class people's means; but such people should not get care without making some contribution.

Allow formation of trusts for disabled people, 1917(d)

For the long-term disabled, it is unfair to require all resources to be spent on medical care when they can be put in carefully regulated trusts to meet long-term needs.

f. States must ensure that people in institutions receive quality care.

Plan of care, etc., for people in nursing homes, 1902(a)(28)/1919

Extremely detailed statute reponds to horrible history of abuse and inadequate state regulation of nursing homes.

Plan of care, etc., for people in mental hospitals, 1902(a)(20), 1902(a)(26)

See above.

Plan of care, etc., for people in ICF/MRs, 1902(a)(31); ICF/MR decertification procedures, 1902(a)(33), 1902(i), 1910(b); regulation, 1922

See above.

Plan of care, etc., for children in psychiatric institutions, 1905(h)

See above.

Certification of need for care, 1902(a)(44)

People should not be warehoused in institutions without some medical judgment that institutional care is appropriate.

Minimum personal needs allowance, 1902(a)(50)/1902(q)
30 dollars per month to meet a month's worth of personal needs is not over-generous.

Disregard for SSI received by people temporarily in institutions, 1902(o)
Makes transition back into community much easier.

Allowance in cost of care contribution system for money spent on medical care, 1902(r)(1)
Recognizes that person in institution may have medical needs that neither institution nor Medicaid can meet.

Psychiatric hospital sanctions, 1902(y)
Responds to great potential for abuse (and overcharging) in psychiatric hospitals.

g. States must limit the degree to which relatives, e.g., spouses or children, may be held responsible for the cost of an otherwise eligible person's care.

? Deeming restrictions ?, 1902(a)(17)(D)
Two purposes: protect relatives of persons needing long-term care; protect children from having their income and resources attributed to others in the family.

Lien restrictions, 1902(a)(18)/1917(a)
Protects spouses, children, other relatives left at home when someone enters an institution. Does not wipe out claim against recipient's estate.

Estate recovery restrictions, 1902(a)(18)/1917(b)
Protects spouse and children against being impoverished as part of collection of Medicaid claim.

Protections for community spouse & family, 1902(a)(51)/1924
Protects spouse and children against being impoverished as condition of disabled person's getting nursing home care.

h. Appropriate recovery of expenses from responsible third parties.

Assignment of rights, 1902(a)(45)/1912, with at least some limits on how broad a sanction for failing to assign may extend
Sanctions should penalize only parents, not children; 'good cause' exceptions are necessary.

State laws on medical child support, 1902(a)(60)/1908

Medicaid should not pay if absent parents are able to. All states should have similar standards because absent parents are often in a different state than the children.

State laws subrogating state to recovery against third party, 1902(a)(25)(B) and (I)

Neither third party nor beneficiary should get a windfall just because Medicaid pays the initial bills.

Participating provider may not refuse to serve eligible person simply because third party might be liable, 1902(a)(25)(D)

Recognizes that need for care is immediate but third-party payment might not be.

Pay and chase, as opposed to cost avoidance, with respect to prenatal and preventive pediatric care, 1902(a)(25)(E)

Some services are so important that Medicaid ought never to delay payment.

State laws forbidding discrimination by insurers, including ERISA plans, on basis of one's Medicaid coverage, 1902(a)(25)(H), 1903(o)

Unless there is a national policy against trying to make Medicaid a primary payor, insurers and states will try to do this.

* * *

Not vital: State plan mechanics and plan-changing and payment process [e.g., 1903(d)]; details of resolution of federal-state disputes; Federal control of state methods of administration [1902(a)(4)]; many details of optional eligibility categories & optional services; voc rehab coordination [1902(a)(11)]; blindness testing [1902(a)(12)]; Boren Amendment [1902(a)(13)]; hospice payment methodology [1902(a)(13)(D)]; **?cost-based reimbursement for FQHCs & RHCs? [1902(a)(13)(E)]**; simplicity/best interests hortatory stuff [1902(a)(19)]; consultative state services to help providers get paid [1902(a)(24)]; required contents of provider agreements [1902(a)(27)], **?nursing home administrator licensing? [1902(a)(29)/1908]**; utilization review, 1902(a)(30)(B) & (C)]; restrictions on to whom payments may be made [1902(a)(32); quality review agency [1902(a)(33)]; publicity of results of provider surveys [1902(a)(36)]; claims payment promptness standards [1902(a)(37)]; audits [1902(a)(42)]; IEVS exchange [1902(a)(46); ambulatory prenatal care option [1902(a)(47), 1921]; **? DSH payments for children ? [1902(a)(56)/1902(s)]**; physician list [1902(a)(59)/1902(v)]; required Medicaid fraud unit [1902(a)(61)/1903(q)]; AFDC maintenance of payment levels [1902(c)(1)]; PRO standards [1902(d)]; superfluous transitional Medicaid [1902(e)(1)]; option for HMO enrollee to continue in HMO after losing eligibility [1902(e)(2)]; QMB no-retroactive, time-of-reevaluation provisions [1902(e)(8)]; treble damages against person trying to double bill third party & Medicaid [1902(g)/1902(a)(25)]; American Samoa waiver authority [1902(j)]; **?(r)(2) methodologies? [1902(r)(2)]**; weird expenditure limits [1903(b)]; transition costs allowance for hospital closures [1903(e)], **? 133% of cash assistance payment restriction [1903(f)]**; Federal payment decrease for care in mental institutions [1903(g)]; miscellaneous federal payment limits [1903(i)(2)-(11), (13)-(15)]; technical assistance for states in contracting with HMOs [1903(k)];

federal/state/2d state payment divisions re medical support collections [1903(p)]; mechanized claims processing systems [1903(r)]; error rate calculations [1903(u)]; **? allow states to enroll recipients in group health plans ? [1906] (note: this becomes vital if it is interpreted to require this to be done at a recipient's request if the recipient shows it is cost-effective)**; hospitals providing LTC payment rates [1913]; recovery of Medicare overpayments from Medicaid providers [1914]; contracting & central lab provisions [1915(a)(1)]; cross reference to Federal subpoena authority [1918]; **?DSH adjustments? [1923]**; definitional cross references [1931].

What the heck? I never heard of this stuff -- 1902(a)(35)/1320a-3; 1902(a)(38)/1320a-7(b)(9); 1902(a)(40)/1320a(a).

WHY TITLE XIX'S FRAMEWORK IS IMPORTANT

Q. People say Medicaid is too complex. Why not scrap the Medicaid Act and start over?

A. At the core of the Medicaid Act are some crucial structural protections which must be preserved and could easily be lost if an entirely new statute replaces the Medicaid Act. These crucial protections include:

Accountability to the federal government:

- Because states must cover "all" eligible persons, they cannot undercut Federal guarantees of eligibility [1902(a)(8)];

- the federal government has a range of ways to prompt states to follow the Medicaid Act, while states have procedural protections against arbitrary federal actions [1904 and implementing regulations];

- under the Medicaid Act, a single state agency must be responsible for supervising the program [1902(a)(5)].

Accountability to the beneficiaries:

- The Medicaid Act prevents states from rationing eligibility or benefits by refusing to take new applications [1902(a)(8)];

- the Medicaid Act provides for notices of adverse action and for beneficiaries to take disputes to a fair hearing [1902(a)(4)];

- the Medicaid Act directs that decisions be made and that services be provided with reasonable promptness [1902(a)(3) and (8)];

- the Medicaid Act protects beneficiaries' confidentiality [1902(a)(7)].

Fairness among recipients:

- The program must be in effect in all political subdivisions [1902(a)(1)]; and

- the program must use reasonable standards for evaluating income and resources in determining eligibility [1902(a)(17)].

Recent history shows the danger of scrapping the Medicaid Act and starting over. None of these very basic protections appeared in the Medicaid portion of the Reconciliation bill, which purported to replace all of the Medicaid Act. None of these basic protections is mentioned in the National Governors' Association proposal. And note that the need for every one of these protections remains even if a state shifts over to comprehensive, mandatory managed care.