FROM NGA

MODIFICATIONS TO MEDICAID LEGISLATIVE LANGUAGE

Sent to the Hill on 3/21/96
Working from 3/7/96 10:21 p.m. draft

Definition of Disabilities (pg. 3, ln. 19-21)

Replace lines 19-21 with the following

'A state must choose one of the following.

1. A state may adopt its own disability definition. In doing so, the state could not define individuals as disabled if their impairment was less severe than SSI impairment criteria. The state would be subject to the set-aside percentage described in the policy. There would be Secretarial review of the definition as part of approval of the state plan.
2. A state could maintain its current SSI/209(b) definitions. The state would not be subject to the percentage set-aside requirements, and this definition would be deemed approved by the Secretary.
3. A state could adopt modified SSI standards (the modification would address alcoholics, substance abusers and modifications to address abuses of the children's definition, (i.e. Zebley vs. Sullivan). These modifications would be addressed in statute. The state would not be subject to the percentage set-aside requirements, and this definition would be deemed approved by the Secretary.'

Optional Eligibility (pg. 3.)

While there is no explicit language on optional eligibility (ostensibly, it's covered under the 275% number) we may need language to ensure continued optional eligibility for spend-down categories and Katie Beckett kids who might not meet the 275% test.)

Amount, Duration, and Scope of Services (pg. 4, ln. 1)

Add the following clarifications to amount, duration, and scope

- The state determines the amount, duration and scope of services. In making that determination, states may consider criteria including medical necessity, utilization review, and cost effectiveness of alternative covered services.
- With regard to guaranteed benefits to guaranteed populations only, the Secretary shall apply an objective standard when approving this portion of the state plan. The Secretary shall not be permitted to disapprove the amount, duration, or scope of any service if that level had been approved in a state in 1995.
- If the beneficiary has other medical coverage, Medicaid services constitute a 'wrap around' policy. For benefits covered by other medical coverage and Medicaid, the private coverage pays first. Medicaid amount, duration and scope applies only if the other coverage is less, and then only to make up the deficiency. Medicaid retains its status as payor of last resort.

Federally Qualified Health Centers (pg.4 ln.8-10)

FQHCs and RHCs are optional

Family Planning (pg.4, ln. 16-17 and pg. 112, ln. 14-15)

pg.4, ln. 16 and in pg. 112, ln. 14, Strike the word 'Prepregnancy'

AFDC pg 5

The bill seems to imply that states could drop their income standard for Medicaid coverage to the national average without making changes in eligibility. The agreement allowed states to roll back their AFDC standard and bring Medicaid back with it.

Welfare Reform and cost neutrality (pg. 6, ln. 3)

Replace the words 'this title' with 'the Act'. This change will permit welfare and other Social Security Act programs to be considered in determining cost neutrality.

Welfare Reform (pg. 6.)

There is no explicit provision for transition benefits as people come off of the welfare.

FQHC Reimbursement rates (pg. 9, ln. 11-23)

Replace with language that says that states may include in their state plan a strategy by which 100% cost reimbursement could ended by the 8th quarter following the establishment of a new program.

Assets Test Requirements (pg. 9, ln. 36)

Following the word 'resources', add the following '[NGA has no policy on this issue and has not reached resolution]'.

Residency Requirement (pg. 10, ln. 1)

Add 'Residency Requirements. With respect to individuals described under subsections (a) and (b) who are residents of the state for less than 180 days, the state may limit benefits under (a)(2) to the amount, duration, and scope of benefits available under the state plan of the individual's previous state of residence.'

Financial Risk (pg. 13)

It should be made clear that the solvency standards only apply to fully or partially capitated plans.

Premiums and Cost Sharing (pg. 14, ln 20 through pg. 15, ln. 32)

Strike everything between pg. 14, ln 20 and pg. 15, ln. 32 and add the following '[NGA has no policy on this issue and has not reached resolution]'

Public Comment on Capitation Rates (pg. 16)

Strike language that requires a public comment review period when setting capitated rates.

Personal Needs Allowance (pg. 23, ln. 21-26)

Return amounts to current law. On line 23, replace '$40' with '$30'. On line 24, replace '$80' with '$60'

Emergency Services for Nonlawful Aliens (pg. 35, ln. 1-6)

Permit states to include prenatal care within the definition of emergency services at state option. Insert on pg. 35, ln. 3 following the word 'including' add prenatal care, at state option.'

Annual Reporting (pg. 38)

Please clarify that financial reporting should be done annually according to the federal fiscal year, but state program reporting could be done by the state according to the state's fiscal year.

Nursing Home Reforms - General Rights (pg. 75, ln. 13-15)

The language needs to be clarified that this language does not preclude a state from using a managed care network where the person in the nursing home can choose from among physicians who are a part of that plan.

Nursing Home Reforms - Notice of Rights (pg. 77, ln. 25)

The language needs to be clear that if the resident is incompetent, notice of rights must be given to a person who is acting on the resident's behalf.

Nursing Home Reforms - Approval of a program (pg. 94, ln.31 through pg. 95, ln 12)

Strike pg. 94, ln.31 through pg. 95, ln 12. [drafters, we believe that these are unrelated to patient care. If so, please strike. Otherwise, strike only those provisions that do not relate to patient care.]

Nursing Home Reforms - Enforcement (pg. 103, ln. 17 though pg. 110, ln. 33)

Strike pg. 103, ln. 17 though pg. 110, ln. 33 and replace with language that states that as condition of participation in the program, the state plan must include enforcement strategies and the plan must be approved by the Secretary. [Drafters: It should also be made clear that administrative FFP is available to states for enforcement activities.]

Mental Health Services (pg. 112, ln. 20-23)

pg. 112, ln. 19 and again in line 22, strike 'in the case of a child'.

Abortion (pg. 113, ln. 3-5)

pg 113, ln. 3-5. Strike everything after the word 'Abortion' and insert '[NGA has no policy on this issue and has not reached resolution]'

EPSDT Modifications (pg. 115, ln. 17 through pg. 117 ln. 8)

pg. 115. Insert between lines 8 and 9 '[NGA has policy in support of modifying the treatment component of EPSDT but has not reached resolution on how that modification should be made.]'

Treatment of Indians (pg. 119, ln. 10-21)

Strike. The NGA policy calls for a special grant for American Indians using 100% federal funds. The NGA leaves it to the federal government to determine how that grant would be constructed.

Start Date (pg. 141, ln. 1-32)

Every state must begin the new program by 10/1/97. States may start earlier if they wish. Until a state starts the new program it continues to operate under current law.

Vaccines For Children Program

Restore to proposal. However, language should be simplified for program administration and states should determine which vaccines are in the program. This language should also retain the optional use clause.

Other Changes (I'm not sure if these are included or where they would go.)

Assets Transfer

1. In determining eligibility for long-term care, the look-back period would be extended, at state option, to 60 months.
2. The burden of proof would be on the beneficiary to show that a transfer was not done to shelter assets.
3. States would be permitted to break a trust if assets are sheltered in that trust.

Intergovernmental Funds Transfer

As in current law, states would be permitted to use inter-governmental funds transfers as part of the state share of the program.

Use of Local Funds

As in current law, states would be permitted to use local funds for up to 40 percent of their total state share.

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Community Based Services (pg 112, ln. 34)

Add after the word 'arrangements' the following 'assisted living arrangements, and transitional living arrangements in the community'.

Medicare/Medicaid Integration Projects

We would like to add Medicare/Medicaid integration projects with the following characteristics.

1. States should be granted waivers of Medicare and Medicaid law to support the development and implementation of innovative programs targeted to the dual eligibles. At a minimum, the Secretary should be required, under certain conditions with appropriate oversight, to grant flexibility to states in terms of oversight of Medicare funds, contracting authority to purchase both Medicare and Medicaid services for this population, oversight of contract administration and quality management, and administration of a single enrollment process.
2. States must be able to include all dual eligibles in their waivers including, but not limited to, the chronically ill. Ultimately, the real test of integrated systems will be whether they prevent or delay the onset of chronic illness; in order to test that hypothesis, states must be able to mix healthy and sick populations in single, integrated plans.
3. States must be able to exercise some Medicare lock-in for dual eligibles.
4. States should not be limited to contracting with Medicare-risk contractors. States must be allowed to enter into agreements with other entities or providers which are suited to the delivery of care and services under the waivers.
5. States should be permitted to share risk with the federal government and with providers and entities participating in the program, and to reinvest savings under this program in the form of expanded eligibility for lower income Medicare beneficiaries who do not qualify for Medicaid, but who are at risk of institutionalization and therefore likely to qualify for Medicaid. States should also be permitted to reinvest program savings in the form of expanded (i.e. nontraditional) services.
6. There should be no limit on the number of states permitted to apply for dual eligible waiver authority.
7. Waivers should be granted for five years, and if proven successful, be authorized to continue on a permanent basis.

Territories and Commonwealths

The NGA stongly encourages Congress to work with the Governors of Puerto Rico, Guam and other territories toward allocating equitable federal funding for their medical assistance programs.