NATIONAL CONFERENCE OF STATE LEGISLATURES

444 NORTH CAPITOL STREET, N.W. SUITE 515 WASHINGTON, D.C. 20001
202-624-5400 FAX: 202-737-1069

DANIEL T. BLUE, JR.
SENIOR HOUSE MINORITY LEADER
NORTH CAROLINA
PRESIDENT NCSL

THOMAS R. TEDCASTLE
DIRECTOR, BILL DRAFTING
AND GENERAL COUNSEL
FLORIDA
STAFF CHAIR, NCSL

WILLIAM POUND
EXECUTIVE DIRECTOR

November 17, 1998

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

The balanced budget agreement of 1997 produced numerous substantive and fiscal changes that have greatly benefited states. The National Conference of State Legislatures has lauded that agreement for the historic part it has played in bringing about a federal budget surplus. As you know, the 1997 agreement imposes a new set of constraints on the administration and Congress in building the FY2000 budget. NCSL supports the objectives of the agreement—that is, preserving and augmenting the surplus. We also hope that the state-federal partnership and the success of current state-federal programs will be major criteria that you use in preparing a budget to submit to Congress early next year.

In particular, we urge your consideration of the following.

(1) **Budget process changes and modifications are needed to ensure continued funding for key discretionary and mandatory program priorities.** It appears that several billion in discretionary spending reductions must be imposed to align a FY2000 budget with the spending ceilings set in the 1997 budget agreement. This has been further complicated by some of the spending decisions reached in the omnibus FY1999 appropriations bill, H.R. 4328, recently signed into law. NCSL's concerns are twofold. First, we fully support staying on a course that ensures a balanced federal budget. That has been our long-held policy. Second, we are committed to preserving state-federal programs that have proven benefits for particular populations. These include programs sustaining services for low-income individuals and families, such as the Social Services Block Grant, and the Low Income Home Energy Assistance Program (LIHEAP). These also include programs addressing a particular state-federal partnership need, such as drinking water and clean water state revolving fund investments. We firmly believe that circumstances compel budget process and budget agreement modifications to maintain joint commitments to proven programs. We are prepared to work with you to discuss spending reductions in program areas where there appears to be questionable or uncertain merit for continued funding.

(2) **State-federal entitlement and mandatory programs, such as Medicaid, child welfare and child support enforcement, should not be reduced or capped without concurrent statutory changes that would protect states against burdensome cost shifts. We must avoid arbitrary reductions in administrative match monies for Medicaid and other entitlement programs.** These reductions, such as were proposed in your FY1999 budget and embraced in never-resolved Congressional budget resolutions, are direct cost shifts--unless accompanied by administrative or programmatic relief. Furthermore, capping entitlement programs would likely lead to nothing more than a cost-shift to state governments, an outcome that could seriously undermine state-federal relations.

(3) **The Social Services Block Grant (Title XX) must be funded at its authorized level of $2.38 billion per annum.** Title XX was designed to give states the flexibility to provide a critical range of services to the elderly, disabled and children and families who are struggling to achieve self-sufficiency. Recent cuts to the block grant strike at the very heart of devolution and represent a retreat from federal commitment to block grants. As critical as the dollar amounts, however, are the resulting programmatic losses and service reductions to the elderly, the disabled, children and families if Title XX is further diminished.

Title XX should be an integral part of any child care initiative that we hope you will advance with your FY2000 budget, whether that is accomplished through programmatic increases, tax changes or a combination of both. **To continue addressing the challenges of welfare reform, child care services must be expanded. This is particularly true in light of the growing number of working poor families who are unable to access child care services.** We are obliged to respond to these public demands. There are many ways to address child care needs, such as through increased funding for the Child Care and Development Block Grant and the Social Services Block Grant. Both programs are vibrant and effective. Additional funding for both should be deemed a priority in order to complement notable efforts that states have made with child care. We also recommend that you and your key policy advisors meet soon with state legislators and NCSL staff to determine how we can collectively fashion a federal initiative that will enhance our collaborative efforts to address child care needs.

(4) NCSL applauds your efforts to start the discussion on reforming and protecting the social security system. Your leadership on this matter is critical, particularly as it regards preservation of social security and ensuring flexibility for individuals utilizing other retirement options. **As a first step, we urge you to invite state legislators to your December 8-9, 1998 summit on social security.**

State and local government retirement plans must be fully preserved. As you well know from your service as a governor and attorney general, there are many state employees who participate in state pension and retirement plans and not in social security. However, there have been many proposals made since the 1980s, all which have been dropped, that would mandate that all state and local government workers contribute to social security. Endorsing these proposals now would be a grave error. It would definitely upset the standing of state and local pension plans supported by employee contributions. It would subsequently compel a hike in contribution levels for these employees. It would likely lead to a reduction in benefits, such as health care. We understand the immediate fiscal appeal of such an option, but maintain that it would totally uproot state and local government retirement plans and in the long run further strain social security. These systems effectively manage retirement funds on behalf of public employees and are models for effective retirement savings that should be studied for best practices, not raided as a short term fix to extend social security for a limited number of years. It would also be unfair to employees who have earned these benefits, who have negotiated and bargained for these benefits and who have made contributions towards these benefits. State and local government retirement plans provide flexible coverage by grouping employees, such as firefighters and police officers, who would otherwise be ill-served by social security.

(5) **NCSL believes that if we are to meet the goals to which we mutually agreed to regarding welfare reform and children's health, both the Temporary Assistance for Needy Families (TANF) and the Children 's Health Insurance Program (CHIP) should be funded at levels equivalent to FY1999.**

(6) **The guaranteed funding for our nation's highways, mass transit systems and public safety programs included in the TEA-21 legislation must be fully protected.** To undermine the agreements reached in H.R. 2400 would only serve to delay needed investments in our nation's transportation infrastructure. Furthermore, NCSL long sought to restore full integrity to the transportation trust funds. We feel TEA-21 has restored confidence in those trust funds through the guaranteed annual funding that now accompanies them.

Mr. President, the nation's state lawmakers would welcome any opportunity to work with you to assist with your preparation of a FY2000 budget. I am hopeful that NCSL's priorities are also yours. A balanced federal budget, that maintains a commitment to individuals and families who are served by funding of key programs, should be crafted.

Thank you for your consideration of the views of the National Conference of State Legislatures. Please have your staff contact either Michael Bird (202-624-8686) or Gerri Madrid (202-624-8670) for further details and information.

Sincerely,

Representative Daniel T. Blue
President, NCSL

Cc: Vice President Al Gore
Jack Lew, Director, OMB
Gene Sperling, Director, National Economic Council
Bruce Reed, Domestic Policy Advisor
Donna Shalala, Secretary of Health & Human Services
Rodney Slater, Secretary of Transportation

NRHA ADVOCACY

NATIONAL RURAL HEALTH ASSOCIATION

1998 LEGISLATIVE AND REGULATORY AGENDA

L - Requires Legislative Action ***R*** - Requires Regulatory Action

■ ACCESS TO HEALTH CARE SERVICES

Medicare regulation of managed care organizations (MCOs) should ensure that these MCOs meet quality assurance, accreditation and consumer protection standards. The Secretary of Health and Human Services (HHS) should clarify that MCOs provide enrollees reasonable access to services by including primary care services within the *lessor* of 30 minutes or 30 miles from their place of residence if they live in a rural area. Additionally, MCOs should be required to provide beneficiary education on health plans and benefits. ***R***

■ ACCESS TO HEALTH INSURANCE FOR CHILDREN

Federal regulations should require that state health plans implementing the expansion of health insurance coverage for children included in the Balanced Budget Act (BBA) should specifically address the unmet needs of children in rural, underserved areas. ***R***

■ ADJUSTED AVERAGE PER CAPITA COST (AAPCC)

The NRHA supports mechanisms to ensure that enhanced funding received by managed care organizations as a result of changes in the AAPCC made by the BBA be utilized to provide additional preventative and other services which will improve the health status of beneficiaries, and to support and improve the rural health care infrastructure, including the utilization of appropriate local services and eliminating geographical inequities in provider payment. ***R***

The NRHA supports the separate identification of the Disproportionate Share Hospital (DSH) component from the AAPCC. ***L***

■ HEALTH PROFESSIONALS SHORTAGE AREA (HPSA) AND MEDICALLY UNDERSERVED AREA (MUA) DESIGNATIONS

Proposed changes in the HPSA and MUA designations should not harm and unintentionally remove access to care in rural, underserved areas. The NRHA believes state and local input is crucial in the designation process. ***R***

■ MEDICARE COMMISSIONS

The NRHA strongly supports practical rural membership on the Medicare Payment Advisory Commission (MedPAC) and the National Bipartisan Commission on the Future of Medicare. Additionally, both commissions should adequately address the rural health care delivery system as part of their considerations and recommendations. ***L / R***

■ MEDICARE DEPENDENT HOSPITAL PROGRAM

As the Medicare Dependent Hospital program is reinstated by the Health Care Financing Administration (HCFA), the NRHA supports reducing the eligibility percentage for Medicare discharges or patient days from the current 60 percent to 50 percent. In addition to the 1982 or 1987 updated hospital specific rate base, the NRHA supports the current audited base year as an option. The same capital-related payments as those allowed for sole community providers should be permitted. ***L***

■ MEDICARE FEE SCHEDULE

Eliminate the differences in payment that are based on geographic designation as urban or rural. ***L / R***

Physicians assistants, nurse practitioners, and clinical nurse specialists in underserved and rural areas should be reimbursed at a 100 percent level of the fee schedule for primary care physicians, and direct reimbursement to such providers should be protected. ***L***

Eliminate and prohibit an urban/rural differential based on the geographic payment cost index for rural Federally Qualified Health Centers (FQHCs). ***L / R***

The NRHA supports increasing the current 10 percent Medicare bonus payment in rural HPSAs to 20 percent for all primary care providers including physician assistants, nurse practitioners, and nurse mid-wives. ***L***

■ MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

The NRHA supports inclusion of professional services as part of cost-based reimbursement provided by HCFA. ***L / R***

■ NATIONAL HEALTH SERVICE CORPS

In light of the continuing shortages of primary health care professionals in rural and other underserved areas, the NRHA strongly supports making available additional federal resources to the National Health Service Corps (NHSC) to allow the program to expand its efforts in placing providers in rural, underserved areas, including expanded field resources. ***L***

The NRHA supports a change in the Internal Revenue Code to exclude from gross income any amounts received under the tuition and related expenses portion of the NHSC scholarship program. ***L***

■ POST-ACUTE CARE TRANSFERS

Due to the net effect on low-volume providers, the NRHA opposes the expansion of post-acute care transfers to 10 diagnostic-related groups (DRGs) as defined by the BBA. As a result of the expansion of post-acute care transfers, such providers may suffer disproportionately because of their narrower scope of service, resulting in significant reductions in reimbursement. ***L / R***

■ REGULATORY EQUITY

Eliminate all duplicative regulation and surveys for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) facilities that have long-term care, home health, hospice, skilled-nursing, and ambulatory clinics, and insure that these facilities receive "deemed status." ***R***

The NRHA supports continued review and appropriate clarifications and revisions of federal regulations, including the Clinical Laboratory Improvement Amendments (CLIA) and Stark II self-referral prohibitions, to improve the effectiveness of health care delivery in underserved areas. ***R***

■ RURAL DEFINITION

The NRHA supports the use of a definition of rural in all federal health service and demonstration programs that includes rural portions of counties designated as metropolitan statistical areas (MSAs). ***L / R***

■ RURAL HEALTH CLINICS (RHCs) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

Develop mechanisms to allow provider-based RHCs cost reporting under reimbursement caps to remain a part of cost reporting processes for the parent organization, in a simplified and integrated manner. ***R***

The NRHA opposes the phase out of required payments by Medicaid to RHCs and FQHCs, and believes the phase-out methodology contained in the BBA is problematic in that it automatically reduces reimbursement below the cost of providing those services no matter how reasonable the costs may be. The NRHA strongly supports the continuation of Medicaid reimbursement to these providers that covers their reasonable costs. Recognizing the importance of these safety net providers in insuring access to health care, including Medicare recipients, the NRHA supports federal action in this area either by requiring state to make these payments or through a significantly enhanced match for these payments. ***L***

The NRHA supports requiring Medicare MCOs to contract with established RHCs and FQHCs in rural areas, and a mandatory wrap around payment by Medicare for RHCs and FQHCs. ***L***

■ RURAL HIV/AIDS

The NRHA supports the Health Resources and Services Administration's (HRSA) monitoring of the yearly and cumulative funding distributions of Titles II, III, and Part F SPNS of the Ryan White Program to rural areas. Additionally, a revised formula should be developed for Title II that distributes more appropriate funding into rural areas. ***R***

The Centers for Disease Control and Prevention should provide HIV/AIDS data by county and non-metropolitan statistical area. ***R***

■ STATE OFFICES OF RURAL HEALTH

The NRHA fully supports the continuation of federal funding for state offices of rural health so that they can continue to provide technical assistance to rural communities and providers, and help develop more efficient and collaborative systems of care in rural areas. ***L***

■ TELEHEALTH

Reimbursement for telemedicine services should be made based upon medical effectiveness and utilization, and not based upon or limited to particular delivery platforms. ***L / R***

Telemedicine payment methodology should model those in place for conventionally delivered services such that a professional fee is paid to the provider of the service and a technical fee is available to the facility to cover costs associated with the technology at rates to be determined by the Secretary of HHS and related to costs of equipment, space, personnel, and communications costs. ***L / R***

The NRHA urges that Congress expeditiously consider expansion of eligibility for telemedicine reimbursement included in the BBA beyond the current limitation to residents of HPSAs to include all beneficiaries residing in all rural areas including rural portions of counties designated as MSAs. ***L***

The NRHA supports the ability of the Rural Health Corporation to provide outreach to rural health care providers on the universal service provisions contained in the Telecommunications Act of 1996. ***R***

■ TORT REFORM

The NRHA supports meaningful tort reform in an effort to decrease cost and improve access to needed care. ***L***

■ TRAINING RURAL HEALTH CARE PROVIDERS

Ambulatory care entities which train medical residents should receive reimbursement for indirect, as well as direct, costs of training. Such reimbursement will require development of a new formula for estimation of the indirect costs of training in the ambulatory setting, apart from those used to support other aspects of the academic medical center. Additionally, the NRHA urges the Secretary of HHS to interpret broadly the definition of rural ambulatory sites eligible for Graduate Medical Education (GME) reimbursement through Medicare. ***L / R***

The NRHA supports the Medicare program's continued reimbursement for all approved family practice residencies up to the number of positions for which they are accredited. Additionally, the NRHA supports enhanced reimbursement for those family practice residencies in rural communities and those that include the rural training as part of their curriculum or those that have a history of placing graduates in rural practices. Training opportunities which place graduates in rural and underserved areas should be increased in number. The NRHA urges the Secretary to use broad discretion in authorizing new residency programs that serve rural constituents. ***L / R***

■ WAGE INDEX

PPS wage indices should reflect the cost of hiring an average mix of employees. The wage data used must be occupationally mix adjusted. Only wage relevant to acute care delivery should be part of the wage index calculation. ***L / R***

For further information, please contact:

Darin E. Johnson, Government Affairs Director
National Rural Health Association
1320 19th Street, N.W. Suite 350
Washington, D.C. 20036-1610

Telephone: (202) 232-6200
Fax: (202) 232-1133
E-mail: johnson@nrharural.org

National Coalition for the Homeless

1012 14th Street, NW
Suite 600
Washington, DC 20005
(202) 737-6444 – phone
(202) 737-6445 – fax
nch@ari.net – e-mail
http://nch.ari.net – website

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

P.O. Box 68019
Nashville, TN 37206
(615) 226-2292 – phone
(615) 226-1656 – fax
hch@nashville.net – e-mail
www.nashville.net/~hch – website

September 17, 1998

Mr. Chris Jennings
Deputy Assistant to the President for Health Care Policy
Executive Office of the President
Old Executive Office Building, Room 216
Washington, DC 20502

Dear Mr. Jennings:

We are writing on behalf of the National Coalition for the Homeless and the National Health Care for the Homeless Council to thank the Clinton Administration for taking a leadership role in expanding children's enrollment in the Medicaid. We are particularly pleased with your proposal to expand the presumptive eligibility provision of the Medicaid program.

The National Coalition for the Homeless (NCH) is a national network of homeless persons, state and local homeless coalitions, housing, health and other service providers, and others committed to ending homelessness. The National Health Care for the Homeless Council (NHCHC) is a membership organization comprised of 300 individuals and 25 agencies providing health services to homeless people.

We are requesting the Administration to make a critical improvement to your presumptive eligibility proposal—whether it is taken up by Congress this session or is proposed again in the FY 2000 budget—in order to assure that states may also be able to utilize the extensive network of providers of emergency shelter, food assistance, and other services for homeless children, youth, and families when implementing their Medicaid outreach and enrollment initiatives.

Homeless children and youth experience health problems at extremely high rates. Young people without permanent housing have high incidences of both acute and chronic diseases and health complications—including upper respiratory infections, asthma, anemia, obesity, mental health disorders, developmental delays, substance abuse, and sexually transmitted diseases. Their significantly comprised health status is a predictable consequence of a living situation consisting of extreme financial deprivation, tremendous residential instability, frequent family crises, and a lack of access to even basic health care.

While the number of homeless children and youth without health insurance has not been quantified, providers of health services to homeless families and children have long reported a lack of any health insurance—even Medicaid—among the homeless population. Virtually all homeless children and youth are eligible for Medicaid, but many have not been enrolled, due mainly to barriers their families face in accessing this vital program. Such hurdles include their family's lack of a fixed address for receiving enrollment notifications, documentation requirements that cannot be fulfilled for those without a place to store basic records, inability to apply for services at enrollment centers because of the need to seek shelter and employment during business hours, lack of transportation to fixed enrollment sites, and enrollment waiting periods after which the family can not be traced.

The provisions in the Balanced Budget Act of 1997 and the Administration's FY 1999 budget request to increase Medicaid enrollment of children through a presumptive eligibility process are laudable. Regrettably, homeless families face the same barriers to those entities currently designated or proposed to be designated as presumptive eligibility sites—Medicaid providers, Child Health Insurance Program (CHIP) offices, and Head Start, WIC, child care, child support, temporary assistance, education, and housing agencies—as they do to Medicaid offices themselves. For many homeless families and their children, emergency shelter and food assistance programs may be the only programs with which they have contact. Thus, it is critical that Congress and the Administration amend the Medicaid presumptive eligibility provision to add homeless shelters, food assistance programs, and other homeless service providers to the list of qualified entities.

Homeless shelters, food assistance programs, and other homeless service providers have the capacity to gather family income information for the purpose of determining eligibility for Medicaid. In fact, those providers that receive federal homeless assistance funding have a special responsibility for determining a family's eligibility for federal assistance—in this case homeless funds. Three programs that provide the bulk of federal funding to public and community-based homeless service providers are: the Department of Housing and Urban Development's Stewart B. McKinney Homeless Assistance Act programs (Emergency Shelter Grant, Supportive Housing, Shelter Plus Care, and Section 8 Moderate Rehabilitation for Single Room Occupancy Dwelling programs [Title IV of the Stewart B. McKinney Homeless Assistance Act]), the Federal Emergency Management Agency's Emergency Food and Shelter National Board program (Title III of the McKinney Act), and the Department of Health and Human Services' (HHS) Runaway and Homeless Youth Act programs (Title III, Part A and Title III, Part B of the Juvenile Justice and Delinquency Prevention Act). Many of these programs expect the service providers to make an income assessment prior to providing the requested service or as a component of their case management. Those that do not instead require an assessment of homelessness, which is understood to be indicative of income status except in rare cases. Given that federally-funded homeless service providers are currently entrusted with decision-making authority regarding eligibility for federal programs—like those presumptive eligibility entities designated in current law or in the Administration's proposal—we see no compelling justification for excluding them from the list of Medicaid presumptive eligibility qualified entities.

It is important to emphasize that neither current law, the Administration's proposal, nor our proposed amendment would compel states to use homeless service providers for Medicaid presumptive eligibility determination if they do not wish to do so. Furthermore, current law allows a state to deny presumptive eligibility privileges to any provider that it finds is not capable of determining a family or child's income status. Current law also allows HHS to issue regulations to prevent fraud and abuse in the program. These protections are sufficient for assuring that only those homeless service providers with the actual capacity to determine income are authorized to make presumptive eligibility determinations.

In summary, homeless children and youth are among those most in need of health services and least enrolled in the only health insurance program available to them. Homeless shelter, food assistance, and other service providers are the first, if not the only, organizations with whom homeless families, children, and youth have contact . Thus, they should be allowed to become presumptive eligibility sites if a state chooses to make such arrangements. Federally funded homeless service providers have already been entrusted with eligibility determination for other federal funds and should be further entrusted once again.

Mr. Jennings, we ask for your leadership in expanding the Administration's current proposal on Medicaid presumptive eligibility and ensuring it is reintroduced in the FY 2000 budget so that the nation's homeless children and youth will have an increased opportunity to receive the health care to which they are entitled . Please have a member of your staffs contact Bob Reeg, NCH Health Policy Analyst, at 202/737-6444, x. 314 if we can be of any assistance to you in advancing the expansion of presumptive eligibility determination for Medicaid.

Sincerely,

Mary Ann Gleason

Mary Ann Gleason
Executive Director
National Coalition for the Homeless

Sincerely,

John Lozier
Executive Director
National Health Care
for the Homeless Council

cc: Tom Freedman
Director for Policy Planning
Domestic Policy Council

1. Medicare
2. Social Security

AMERICAN NURSES ASSOCIATION

Site group

TO: Barbara Woolley

FROM: Marjorie Vanderbilt
Director, Government Affairs, 202-651-7085

Rose Gonzalez
Associate Director, Government Affairs, 202-651-7098

CRNA provision not on list

DATE: November 20, 1998

RE: ANA's priorities in the President's FY 2000 Budget

Per our previous discussions, the following is a list of ANA's priorities for inclusion in the President's Fiscal Year 2000 Budget recommendations to Congress. These four items are all top priorities for ANA.

- **Support legislation to provide reimbursement for services of all nurse practitioners and clinical nurse specialists, regardless of geographic location or practice setting, under Medicaid.** (In Medicare)

  In the President's FY 1997 Budget to Congress, the Administration showed its recognition of the fact that advanced practice nurses are a proven and valuable resource for providing needed primary and specialty care services, particularly to underserved populations. ANA appreciates the Administration's previous support for direct Medicare reimbursement for all nurse practitioners and clinical nurse specialists, regardless of geographic location or practice setting, which was included in both the President's FY 1997 Budget Proposal and the Balanced Budget Act of 1997 (Public Law 105-33). ANA requests that the Administration will demonstrate continued support of nurse practitioners and clinical nurse specialists through inclusion of Medicaid reimbursement for these advanced practice nurses in its FY 2000 Budget recommendation to Congress.

- **Provide support in the FY 2000 Budget for funding of nursing education, including funding for the Nurse Education Act Programs. Support for continuation and funding of the Division of Nursing at HRSA and the National Institute for Nursing Research.**

  The rapidly evolving changes in our health care system call for the fullest utilization possible of the multi-disciplinary providers who care for patients and families in an ever-increasing array of settings; hospitals; subacute care facilities, long term care facilities, schools and universities; workplaces and communities. Adequate Federal support for nursing education through the Nurse Education Act programs, is critical to meeting the health care needs of this country, particularly its primary health care needs. Support for

nursing and health care research are also critical components of addressing this country's continued heath care needs.

- **Support reauthorization of the Community Nursing Organization (CNO) project.**

  As the nation moves further toward managed care, there is serious examination of the potential for safe, high quality, cost-efficient care in a capitated context. The Community Nursing Organization project, a Medicare demonstration project, serves Medicare beneficiaries through capitated, nursing services, in four sites across the county. Preliminary reports are exciting, and indicate that nurses are ideally situated to serve as independent providers for managed care enrollees. There is a very high record of patient satisfaction in all four CNO sites. The CNO project deserves to be continued and expanded, and ANA requests Administration support for efforts to extend it beyond its current December 31, 1999 expiration date.

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