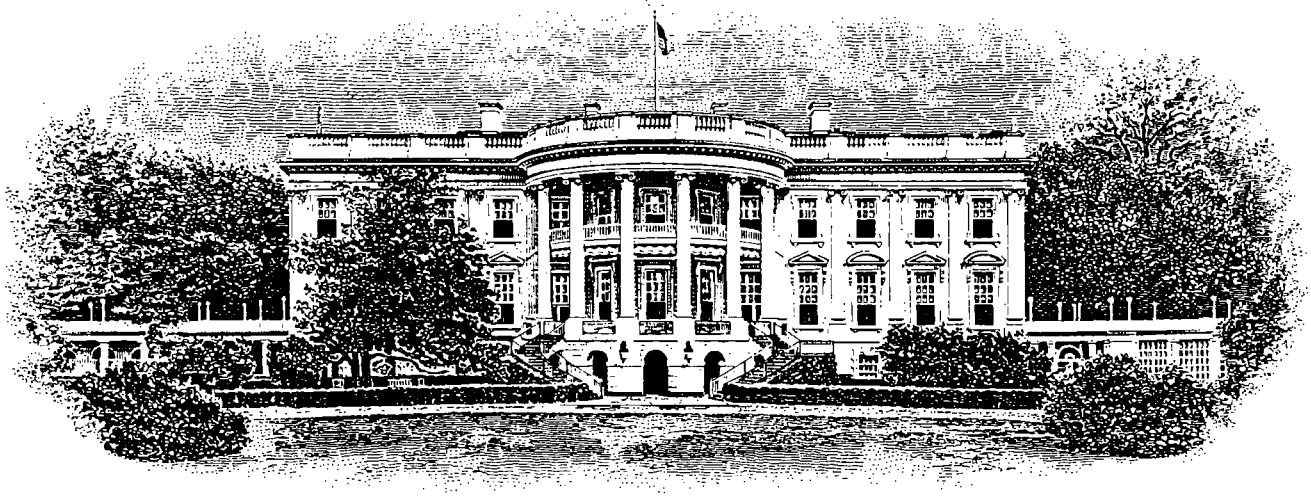
The White House



POTUS BRIEFING MEMO
POTUS REMARKS
TALKING POINTS ON:

- tobacco recoupment
- social security
- welfare and Medicaid rolls

NGA ~~RESOLUTIONS~~ &
RESPONSES

BACKUP ON

- cost allocation
- 1115 waivers
  - approved since 1992
  - details on problem states
- CHIP plans approved
- TANF & Medicaid enrollment

THE WHITE HOUSE

WASHINGTON

February 19, 1999

REMARKS AND ROUNDTABLE DISCUSSION WITH THE NATIONAL GOVERNORS' ASSOCIATION

DATE: February 22, 1999
LOCATION: East Room
TIME: 9:30 to 11:15 AM
FROM: Mickey Ibarra
Bill White

I. PURPOSE

To host nation's governors, the Vice President, and several Cabinet Members for a roundtable discussion on education accountability, Ed-Flex legislation, and tobacco recoupment. In addition, we have agreed to respond to a question on livability and federalism.

II. BACKGROUND

The National Governors' Association (NGA) is gathering in Washington for their annual Winter Meeting from February 20-23, 1999. Governor Tom Carper (D-DE) is the Chair and Governor Mike Leavitt (R-UT) is the Vice Chair of the NGA. For their meeting, the NGA has adopted the theme, "Progress Through Partnership," and will focus on education, states and the new economy, electronic commerce, energy, and smart growth.

With the economy booming and state treasuries flush, it is a good time to be a governor. Last year, governors cut taxes by $7 billion while raising spending by 6.3 percent. This year, with state tax collections running 3.9 percent above last year's level, more than 30 states plan tax cuts. Only two states, Alaska and Hawaii, are running deficits.

The Administration has compiled a strong record of accomplishments on issues of importance to the NGA including: Welfare Reform, TEA 21, Children's Health Insurance Program (CHIP), Internet Taxation, Clean Water Act, Community Oriented Policing Services (COPS), and Workforce Development. Our FY 2000 Budget is also state friendly, with full funding for Social Services Block Grants, increases in Head Start and COPS, and no Medicaid program cuts. But with 32 Republican Governors, NGA has been cautious in offering praise for our budget proposal and forceful in highlighting our differences on tobacco recoupment, Indian Gaming, and the Federalism executive order.

In your remarks, you will highlight the Administration's successful partnership with states during the past six years, outline why our budget is a win for states, and discuss a partnership with governors on strengthening education accountability so that students are prepared for the 21st Century economy. Governor Carper, Governor Leavitt, and the Vice President will also follow with brief remarks.

The press will then depart for the roundtable discussion, where the two most contentious issues will be; (1) tobacco recoupment; the governors are supporting legislation to prevent the federal government from recouping Medicaid dollars, and (2) education accountability; the governors support the concept of accountability but some see the initiative as an attempt to "federalize" education policy. This past week, COS Podesta, Secretary Riley, and Bruce Reed talked with the Democratic Governors to advocate unity on our education message.

Governor Carper will moderate the roundtable discussion. Governor John Rowland (R-CT) will present the governors' views on tobacco recoupment. The discussion will then move to education, with Governor Frank O'Bannon (D-IN) on Ed-Flex legislation; and Governors Jim Hunt (D-NC) and Tom Ridge (R-PA) on education accountability. Time permitting, Governors Parris Glendening (D-MD) and Ed Schafer (R-ND) will ask about the Administration's livability initiative; and Governor John Engler (R-MI) will raise the Federalism executive order. On each topic, you will respond, and if you choose, call upon an Administration participant to elaborate. (Briefing material on each topic is attached.)

The governors arrive on Saturday, February 20, and participate in an opening news conference and a task force meeting on information technology. Also on Saturday, the Democratic Governors' Association (DGA) and Secretary Riley will do a press conference on education. John Podesta, Secretary Shalala, and Bruce Reed will also make presentations to the DGA. On Saturday evening, the governors attend a reception at the Japanese Embassy. The Democratic governors attend a dinner with the Vice President at the Naval Observatory.

On Sunday, February 21, the NGA Winter Meeting includes panels on the new economy, implementing TEA-21, promoting electronic commerce, mentoring, and smart growth. Secretaries Daley, Glickman, and Richardson, as well as General McCaffrey, all participate in sessions with the governors on Sunday.

On Monday afternoon, after the governors depart the White House, the NGA holds a session on education, including a discussion of technology, accountability, and extra learning opportunities.

On Tuesday, the governors meet with Senators Lott and Daschle, Speaker Hastert, and Representative Gephardt. In the afternoon, Governors Carper and Leavitt participate with you at the Children's Health Insurance Program (CHIP) event.

III. PARTICIPANTS

Pre-Brief Participants:
Mickey Ibarra
Fred DuVal
Bill White
Bruce Reed
Sally Katzen
Paul Glastris
Secretary Riley

Event Participants:
See Attached List.

IV. PRESS PLAN

Pool press for your opening remarks and those of the Vice President, Governor Carper, and Governor Leavitt. Closed press for the Roundtable discussion. Following the event, Governors Carper and Leavitt take questions from the press at stakeout.

V. SEQUENCE OF EVENTS

- o You and the Vice President are announced into East Room and you proceed to lectern.
- o You deliver opening remarks from lectern and introduce Governor Tom Carper.
- o Governor Tom Carper (D-DE; NGA Chair) delivers remarks and introduces Governor Mike Leavitt.
- o Governor Mike Leavitt (R-UT; NGA Vice Chair) delivers remarks and introduces the Vice President.
- o The Vice President delivers remarks.
- o The press departs.
- o You ask Governor Tom Carper to moderate the discussion session.
- o Governor John Rowland (R-CT) leads a discussion on tobacco recoupment.
- o Governor Frank O'Bannon (D-IN) leads a discussion on education flexibility.
- o Governors Jim Hunt (D-NC) and Tom Ridge (R-PA) lead a discussion on education accountability.
- o Governors Parris Glendening (D-MD) and Ed Schafer (R-ND) ask a question on livability.
- o Governor John Engler (R-MI) asks a question about the Federalism Executive Order.
- o Governor Tom Carper thanks you and closes session.

VI. REMARKS

To be provided by Speechwriting.

VII. ATTACHMENTS

Tab A:	NGA Roundtable Participants
Tab B:	Seating Chart
Tab C:	Briefing Material for Roundtable Discussion Topics
Tab D:	Possible Questions and Answers

PARTICIPANTS
NGA Round Table --February 22, 1999

Democrats

Governor Don Siegelman *	Alabama
Governor Ton Knowles	Alaska
Governor Tauese Sunia	American Samoa
Governor Gray Davis *	California
Governor Tom Carper	Delaware
Governor Roy Barnes *	Georgia
Governor Carl Gutierrez	Guam
Governor Ben Cayetano	Hawaii
Governor Frank O'Bannon	Indiana
Governor Tom Vilsack *	Iowa
Governor Paul Patton	Kentucky
Governor Parris Glendening	Maryland
Governor Mel Carnahan	Missouri
Governor Jeanne Shaheen	New Hampshire
Governor Jim Hunt	North Carolina
Governor John Kitzhaber	Oregon
Governor Pedro Rossello	Puerto Rico
Governor Jim Hodges *	South Carolina
Governor Howard Dean	Vermont
Governor Charles Wesley Turnbull *	Virgin Islands
Governor Gary Locke	Washington

Republicans

Governor Jane Dee Hull	Arizona
Governor Mike Huckabee	Arkansas
Governor Bill Owens *	Colorado
Governor John Rowland	Connecticut
Governor Jeb Bush *	Florida
Governor Dirk Kempthorne *	Idaho
Governor George Ryan *	Illinois
Governor William Graves	Kansas
Governor Paul Cellucci	Massachusetts
Governor John Engler	Michigan
Governor Kirk Fordice	Mississippi
Governor Marc Racicot	Montana
Governor Michael Johanns *	Nebraska
Governor Kenny Guinn *	Nevada
Governor Christy Todd Whitman	New Jersey
Governor Gary Johnson	New Mexico
Governor George Pataki	New York

Governor Ed Schafer	North Dakota
Governor Froilan Tenorio	Northern Mariana Islands
Governor Bob Taft *	Ohio
Governor Frank Keating	Oklahoma
Governor Tom Ridge	Pennsylvania
Governor Lincoln Almond	Rhode Island
Governor Don Sundquist	Tennessee
Governor George W. Bush	Texas
Governor Mike Leavitt	Utah
Governor Jim Gilmore	Virginia
Governor Cecil Underwood	West Virginia
Governor Tommy Thompson	Wisconsin
Governor Jim Geringer	Wyoming

Independent

Governor Angus King	Maine
Governor Jesse Ventura *	Minnesota

Not Attending

Governor Mike Foster	Louisiana (R)
Governor Bill Janklow	South Dakota (R)

* *Denotes new Govenor elected for the first time in 1998.*

Cabinet

Secretary Richard Riley	Department of Education
Secretary William Daley	Department of Commerce
Secretary Rodney Slater	Department of Transportation
Secretary Dan Glickman	Department of Agriculture
Secretary Donna Shalala	Department of HHS
Administrator Carol Browner	EPA
Director Jack Lew	OMB

White House Staff

John Podesta	Chief of Staff
Mickey Ibarra	Intergovernmental Affairs
Bruce Reed	Domestic Policy Council
Gene Sperling	National Economic Council

1999 NGA ROUNDTABLE SEATING CHART 02/19/9

Gov. Hodges	Gov. Cellucci	Gov. Barnes	Gov. Ridge	Gov. Leavitt	The Vice President	The President	Gov. Carper	Gov. Rowland	Gov. Glendening	Gov. Whitman
Gov. Gilmore										Gov. Shaheen
Gov. Hunt										Gov. Pataki
Gov. Dean										Gov. Almond
Gov. Sundquist										Gov. Patton
Secy Riley										John Podesta
Gov. Fordice										Gov. Taft
Gov. Siegelman										Gov. O'Bannon
Gov. Carnahan										Gov. Ryan
Mickey Ibarra										Gov. King
Gov. Engler										Gov. Huckabee
Gov. Bush (TX)										Gov. Bush (FL)
Gov. Thompson										Bruce Reed
Secy Slater										Gov. Vilsack
Gov. Ventura										Gov. Davis
Gov. Graves										Gov. Kitzhaber
Gov. Guinn										Gov. Underwood
Secy Glickman										Secy Shalala
Gov. Owens										Gov. Johanns
Secy Daley										Gov. Schafer
Gov. Locke										Gov. Racicot
Gov. Geringer										Gov. Kempthorne
Gene Sperling										Adm. Browner
Gov. Keating	Gov. Hull	Gov. Cayetano	Gov. Rossello	Gov. Turnbull	Jack Lew	Gov. Tenorio	Gov. Sunia	Gov. Gutierrez	Gov. Knowles	Gov. Johnson

Paul D. Glastris
02/19/99 04:34:05 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: draft of Mon. NGA meeting speech

Draft 02/19/99 4:30 p.m.
Paul Glastris

PRESIDENT WILLIAM J. CLINTON
REMARKS FOR NGA MEETING
EAST ROOM, THE WHITE HOUSE
February 22, 1999

Acknowledgments: VP Gore; Gov. Tom Carper; Gov. Mike Leavitt; Secretaries Riley, Slater, Glickman; EPA Adm. Browner; John Podesta; Bruce Reed; Gene Sperling; Mickey Ibarra; Fred DuVale

For twenty years I have been coming to NGA meetings, and every year I take delight in seeing old friends and making new ones. But I want to take a moment to remember an old friend who is not here: Gov. Lawton Chiles. As I said at his funeral last month, Lawton was a man with light in his eyes, steel in his spine, and love in his heart. Long before many of us, he saw where his state, and our nation, needed to go on everything from education, to immigration, to reinventing government to the need for fiscal discipline. There are many examples in history of governors who went on to become elected officials in Washington. Lawton was one of the few who went the other way. He brought a national perspective, and a sense of national mission, to the governing of his state, and in so doing inspired us all.

One thing Lawton understood is that it is hard to make dramatic positive change by the federal government acting alone, or by each state acting alone, or by myriad local governments acting alone. Only when all levels of government are pulling in the same direction do we make the greatest amount of headway against our nation's greatest challenges. And I think everyone in this room will agree that we face no greater challenge today than to providing all of our children with the world class educations they need to succeed in the global economy. I believe we can give them that education, if we all pull together in the direction of what we know works.

We have a rare moment of opportunity to pull together. As I said in my State of the Union address last month, America is stronger, healthier, and more prosperous than ever before. But I also said we have an historic responsibility to use the prosperity we have created

to meet the challenges of the 21st Century, like education. And rarely has there been a moment when we have had such wide agreement about the scope and nature of the education problems we face. Every one of us in this room knows that too many of our schools are overcrowded and in need of repair. Every one of us knows that our 53 million school children come from more diverse backgrounds and speak more different languages than at any time since the turn of the century. Every one of us knows that there is a crying need for more and better teachers.

That is why, in my State of the Union Address last month, I set out an ambitious plan to renew our public schools, by investing more in what works--and to stop investing in what doesn't. The budget I sent Congress this month calls for spending $1.4 billion to help states and school districts hire new, better-trained teachers. That's a 17 percent increase over the budget I signed last fall and it moves us closer to our goal of hiring 100,000 new teachers over seven years. It calls on Congress to build or modernize 5000 schools. It triples our budget for after school and summer school programs to $600 million, enough to keep a million children in the school house and off the street during the hours when parents work and juvenile crime soars.

But let us be blunt: The key to fixing our schools is not to spend more money, though I believe we must. The federal government is already investing $15 billion a year in the public schools. The key is to change the way we invert that money--to reward what we know works, and to stop rewarding what we know does not work. That is the idea behind my Education Accountability Act, which I will send to Congress next month. It says that every state and school district accepting federal money must do five things: end social promotion...turn around failing schools... ensure teachers know the subjects they are teaching...have reasonable discipline codes...and empower parents with report cards on their schools.

Now, we did not dream up these five ideas in Washington. We learned them from you. We learned them from states like North Carolina, where Governor Hunt has led the way to improve teacher quality, with performance assessments for new teachers and incentives for veteran teachers to become even more proficient. We learned them from Pennsylvania, where Governor Ridge is improving school safety with effective discipline codes. We learned them from Delaware, where Governor Carper is putting an end to social promotion by insisting that students pass state tests before they move to the next grades. We learned them from California, where Governor Davis has called on the state legislature to turn around failing schools with a new accountability plan. We learned them from Michigan, where Governor Engler is supporting greater accountability in schools by requiring school districts to send parents report cards on how well schools are doing.

These five ideas represent the best practices in education reform today, practices invented and proven to work by you, out in the great laboratories of democracy. Many of you proposed one or more of these accountability ideas in your State of the State addresses. In his State of the State address, Gov. Engler said he agreed with all five of these ideas, and that he didn't understand how

anyone could disagree.

I'm with Gov. Engler. I don't understand how anyone can disagree with these ideas. But this being Washington, some people are already trying to frame this in partisan ideological terms and force everybody to take sides when we ought to be coming together.

You'll hear people say, the federal government should not be getting involved in public education, that's a state and local prerogative. Tell that Founding Fathers. In 1787 they declared that all new territories set aside land for public schools, establishing at the very birth of our republic the principle that public education, though a state and local responsibility, is a national priority. At key moments in our history the federal government has similarly taken the lead in education. In 1862 Abraham Lincoln created the land grant college system to educate a nation of farmers. In 1917 Woodrow Wilson mandated vocational training in public high schools to educate a nation of factory workers. In 1958, in response to the Soviet' s launch of Sputnik, Dwight Eisenhower created a new federal program to help public school teachers improve their math and science instruction. None of these federal actions undermined the abilities of state and local governments to run their schools. But each was a necessary response to the challenges the nation faced at the time. I believe we are at a moment when the federal government must once again lead in response to the challenges of a new time. And it should lead in the direction you all have pointed out--towards what works.

You'll hear some people say the federal government should be giving states more flexibility, not demanding more accountability. This is a classic example of a false choice. You all know from your own interactions with local governments that flexibility and accountability can and must go hand in hand. I was a governor and I understand your need for maximum flexibility. My administration has cut regulations in our elementary and secondary education programs by two-thirds, and granted dozens of waivers so that states and school districts can have the flexibility to try new approaches. The federal government has no business telling you who to hire, what to teach, how to teach it, what kind of climate or philosophy of education you want. But let's not kid ourselves: we're not doing our children any favors by saying it should be a local option to hire bad teachers; a local option to pass students from grade to grade without teaching the anything; a local option to allow the same schools to fail year after year after year. We have a moral responsibility to do what is right for our children's education, and to stop doing what's wrong.

You'll hear people say, there's no need for the federal government to insist on these accountability measures because states and school districts are doing it on their own. I have no doubt that these ideas will eventually spread to every state and school district in America. The question is, how long can we afford to wait for that to happen? Our federal system is great at inventing and testing new ideas. It

is not so great at spreading the best of those ideas around in a timely manner. It took over a hundred years for laws mandating compulsory free elementary education to spread from few states to the whole nation. That pace of change might have been ok back in the 19th Century, when it more or less matched the pace at which the U.S. economy was changing from agricultural to industrial. But in this day and age, with a highly competitive, fast-paced, information-based global economy bearing down on all of us, we simply do not have the luxury of waiting a hundred years before all of our nation's schools are fixed.

We must fix our schools, all of them, now. We can no longer afford to have whole groups of children and whole areas of the country to fall behind in education. If we fail to fix to do this, and do it quickly, we are going to lose another generation of children to low expectations, low educational achievement, and low prospects of moving ahead in life. There is a saying among governors today that "the state with the best schools wins." Let me tell you, the stakes are higher than that. The nation with the best schools wins. State governments have shown us the way to improve our schools. Now the federal government has a responsibility to lead the nation by following the direction you have pointed out. If we can all manage to pull in the same direction, we can give all our children the world-class educations they need to thrive in the 21st Century.

Thank you and God bless you.

Message Sent To:

Michael Waldman/WHO/EOP
Joshua S. Gottheimer/WHO/EOP
Cathy R. Mays/OPD/EOP
Bruce N. Reed/OPD/EOP
Tanya E. Martin/OPD/EOP
Tracy Pakulniewicz/WHO/EOP
Mickey Ibarra/WHO/EOP
Fred DuVal/WHO/EOP
Linda Ricci/OMB/EOP

TOBACCO RECOUPMENT
NGA Roundtable February 22, 1999

Governors Who Will Discuss:

Governor John Rowland (R-CT)
Governor Paul Patton (D-KY)

Administration Experts Present:

Bruce Reed
Secretary Shalala

What Governors Will Say:

The NGA's top legislative priority for the 106th Congress is the Hutchison-Graham bill, which protects tobacco settlement funds awarded to states from claims by the federal government. The Governors will argue that there is no basis for federal recoupment because (1) the states assumed all the burden and risks of litigation and (2) much of the settlement money is for non-Medicaid claims. In an NGA statement, Governors Carper and Leavitt said, "After bearing all the risks initiating the suits and all the expense of years of arduous negotiations and litigation, states are now entitled to all of the funds awarded to them in the tobacco settlement without federal seizure. States should not be hindered from using the settlement funds for programs to promote the health, education, and welfare of their citizens."

Administration Talking Points:

- The state tobacco settlement is a real step in the right direction and I congratulate you.

- I know we all share a commitment to reducing youth smoking. Every day, 3,000 children become regular smokers and 1,000 have their lives shortened as a result.

- We also all share a commitment to protecting tobacco farmers. I am pleased that the states and industry were able to negotiate a package to compensate farmers and I remain committed to doing more to protect tobacco farmers and their communities.

- While the state settlement is a great first step, I believe we must do more to protect children and reduce youth smoking. I will continue to push for legislation to increase the price of cigarettes so fewer young people start to smoke, hold the tobacco companies accountable for their youth marketing practices, and reaffirm the Food and Drug Administration's authority to regulate tobacco products. In addition, as you know, the federal government is bringing suit to recover from the tobacco companies the health care costs incurred by Medicare and other federal programs as a result of smoking.

- On the question of tobacco recoupment, we have an obligation under current Medicaid law to recoup the federal share of the tobacco settlement. As you know the federal government pays an average of 57 percent of Medicaid costs, and states routinely reimburse us for the federal share of Medicaid collections. I realize that there is some debate about how much of the settlement represents Medicaid damages, but both the Justice Department and HHS have analyzed this question and concluded that the bulk of the settlement is for Medicaid.

- But I want you to know that as I have said all along, I am committed to working with you and members of Congress to change the law, to enact legislation to settle the federal government's claims in exchange for a commitment by the states to use tobacco money to prevent youth smoking, protect tobacco farmers, improve public health, and assist children. My budget specifically assumes no recoupment until FY 2001 so that we can reach an agreement this year. I hope we can start work on this kind of agreement as soon as possible.

- I will, however, vigorously oppose any legislation which would completely give up the federal share of the states' tobacco settlement -- without any commitment by the states to use these monies to prevent youth smoking, protect tobacco farmers, improve public health, or assist children. I know that most of you want to do the right thing with this money, but I also know that Governors and legislatures will come under tremendous pressure to spend this on things that have nothing whatsoever to do with children or tobacco farmers or reducing youth smoking. Look at what happened in the Congress debate last year. It would be a national tragedy if this landmark state settlement went by without any real assurance that we are going to do everything we can to reduce youth smoking and help tobacco farmers.

Tobacco Questions & Answers:

Q: Why are you trying to recoup state funds when you are filing a federal lawsuit to obtain reimbursement for federal tobacco-related costs?

A: These two claims are separate and distinct. Under current law, the federal government cannot pursue Medicaid claims directly; states are under a legal obligation to pursue them and the federal government must recoup its share from the states. The Justice Department litigation will seek reimburse for federal claims outside of Medicaid, including tobacco-related health costs in Medicare, the Federal Employee Health Benefits program, military and veterans benefits, and the Indian Health Service.

Q: You say you want a commitment from the states to spend the federal share of the state tobacco settlement on certain shared national and state priorities. What exactly do you have in mind?

A: I am seeking a commitment from the states to use tobacco money to prevent youth smoking, protect tobacco farmers, improve public health, and assist children. I want to work with you and Congress to devise a specific menu which meets these purposes, as we were able to do last year in the McCain legislation. We will have to rethink some issues this year -- for example the McCain bill had other spending for tobacco prevention and farmers and thus the menu did not include those items. The important thing is that we work together as we did before to construct a menu that works for all of us.

Q: Our state has agreed to spend all the tobacco funds we receive from the settlement to prevent youth smoking and promote public health. Why should we have to change our plans to fit a bill written here in Washington?

A: I want to enact legislation that will enable states like yours to continue your efforts to reduce youth smoking and improve public health. I just want some assurance that every state will use these funds for these important purposes -- that is, to prevent youth smoking, protect tobacco farmers, improve public health, or assist children.

Q: Our legislature is meeting now and will have to make appropriations over the next two months. We can't wait for months for this legislation to be finished!

A: I understand your concerns, and I couldn't agree more that we should reach agreement and enact this legislation as soon as possible.

Q. Isn't it contradictory to bring suit against the tobacco companies and try to protect farmers?

A. I have repeatedly reaffirmed my commitment to protecting tobacco farmers and their communities and I believe we can reduce youth smoking and also protect tobacco farmers. I am encouraged that the states and industry were able to agree recently upon a $5 billion package to compensate farmers. I will continue to work with all parties to ensure the financial well-being of tobacco farmers, their families, and their communities. Farmers who never marketed cigarettes to children and worked hard to sell a legal crop should be protected. If we are successful in this suit, we could use some of the money to make sure farmers are protected.

SOCIAL SECURITY
NGA Roundtable February 22, 1999

FRAMEWORK FOR ANSWER:

- **Clearly An Idea That Is On The Table, But Pros and Cons Need to Be Weighed.** This proposal has been included in many reform plans. But before we reach any conclusions, we need to study carefully the pros and cons.

Advantages of This Proposal Are:

- **Social Security Coverage Has Expanded Significantly.** Since the Social Security Act of 1935, coverage has expanded from workers in business and industry to almost all Americans.

- **State and Local Government Workers Are Final Group Not Covered.** Many people have argued that state and local government employees are the final sizable group of workers not universally covered (nonetheless, about 70 percent of state and local workers receive benefits for various reasons). Being covered under Social Security would allow state and local workers to move from one job to another without losing coverage. Proposals are to cover newly hired state and local workers, not existing workers.

Disadvantages of This Proposal Are:

- **But Impact on Existing State and Local Programs Needs to Be Carefully Examined.** I know that the impact of the proposal would vary greatly across the nation, and that some people are concerned about its effect on existing state and local retirement programs. So we will need to look carefully at this and other proposals over the coming year, to figure out which changes are best as part of a comprehensive Social Security reform.

BACKGROUND:

- Since the Social Security Act of 1935, coverage has expanded from workers in business and industry to include the self-employed, nonprofit groups, agricultural and household workers, the Armed Services, Congress, and all other Federal employees hired after 1983. In 1998, 96 percent of all workers are covered under Social Security -- up from 55 percent in 1939.

- State and local government employees are the final sizable group of workers not universally covered by Social Security. If such workers are mandatorily covered under a state or local public pension system, they are not mandatorily covered under Social Security. Roughly 25 percent of state and local workers are not covered under Social Security. Many of these workers are in California, Ohio, New York, and Texas. In New Mexico, about 17 percent of state and local government employees are not currently covered by Social Security.

- Many proposals would expand mandatory Social Security coverage to state and local government workers hired after a certain date. Such proposals would close roughly 0.2 percent of the current 2.19 percent gap. Moving newly hired workers out of the state and local programs that would otherwise cover them could put financial pressure on some state and local programs -- a gradual phase-in could attenuate any such pressures.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Medicaid Coverage

QUESTION:

There are claims that welfare reform is causing families to lose their Medicaid benefits unfairly. With so many States like New York operating welfare diversion programs, what are you doing to ensure that low- income families get the Medicaid benefits they need and to which they are entitled?

ANSWER:

- We are doing everything possible to maximize both the number of people with health insurance and the number of people moving from welfare to work. The delinking of Medicaid from welfare means that States need to pay careful attention to their eligibility and enrollment processes. That's why we have worked with States to ensure that people leaving welfare and working families know that they may be eligible for Medicaid benefits.

- We are also working with States to identify model outreach strategies, program operations, coverage expansions and Medicaid policies to ensure that Medicaid-eligible folks actually receive it. Additionally, the President has pushed for a major new outreach effort to help States enroll eligible people in Medicaid and the new Children's Health Insurance Program.

- This Administration has demonstrated an unprecedented commitment to reduce the number of uninsured people and to move people from welfare to work. Since taking office in 1993, we have led the reform efforts by granting waivers to 43 States. In each waiver, the Administration insisted that States continue health coverage for all eligible people, while also promoting work. This reflected our commitment to expanding health coverage. More recently, the President eliminated the so-called "100 hour rule" easing States' ability to extend coverage to families working their way off welfare.

- At the President's urging, the 1996 welfare reform law preserved the Medicaid entitlement for low-income children, the disabled, pregnant women and the elderly – so they can receive the health care they need. Like child care, housing assistance, and transportation, Medicaid is a crucial work support for single parents trying to move from welfare to work.

CHIP State Plans

February 16, 1999

Approved

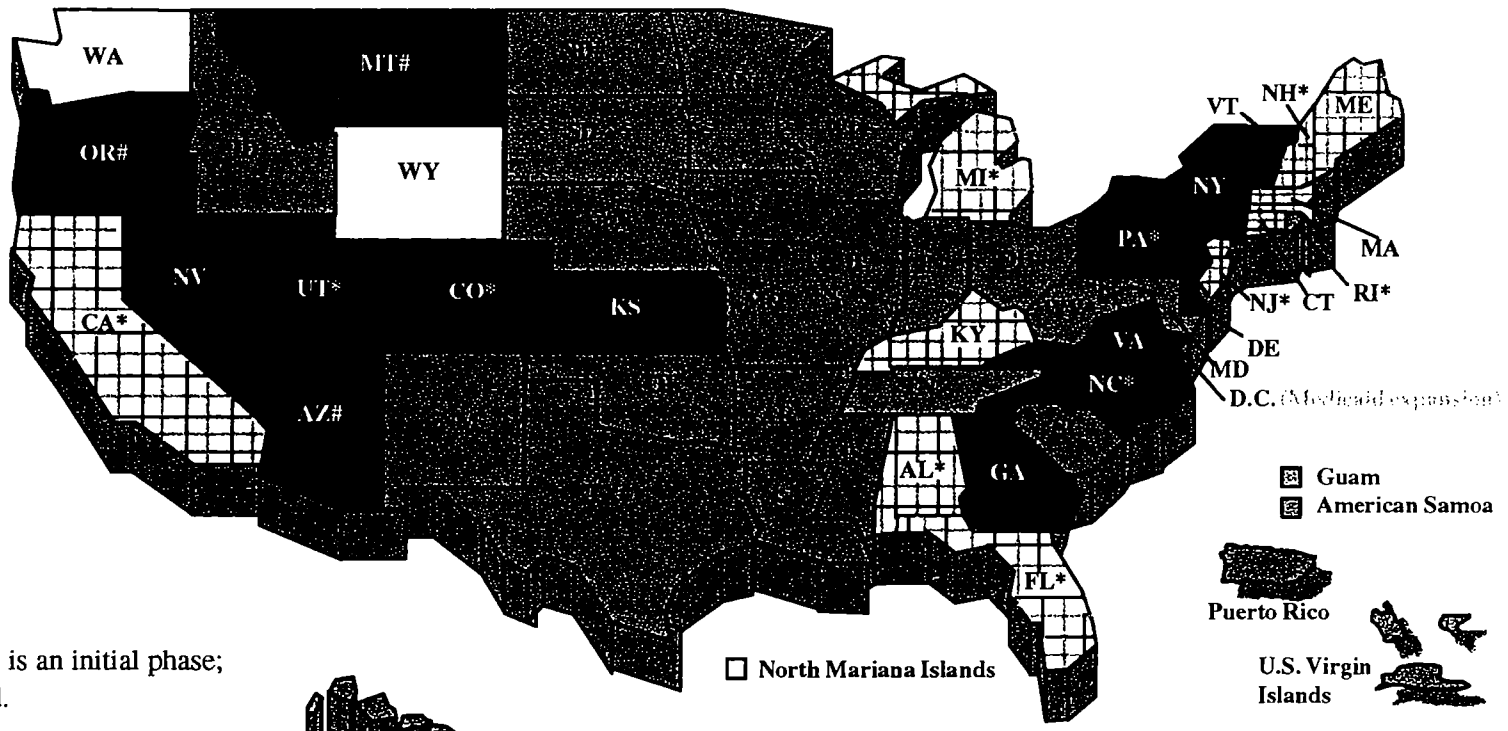
- Separate State Child Health Plan
- Medicaid Expansion
- Combination

Pending

- Separate State Child Health Plan
- Medicaid Expansion
- Combination

No Submission

- Not Submitted



* State Plan Amendment

\# State has indicated submission is an initial phase; plan amendment is anticipated.

http://www.hcfa.gov/init/chip-map.htm

Summary Information (in order of submission/approval)

Number of Plans Submitted: 53
(AL, CO, SC, FL, OH, CA, IL, NY, MO, PA, MI, TN, RI, MA, CT, OK, NJ, ID, OR, NV, WI, VT, TX, PR, UT, MT, IN, MN, MD, DC, AR, NC, NE, ME, NM, GA, NH, IA, SD, KY, VA, AZ, WV, DE, VI, KS, ND, MS, LA, AK, HI, GU, AS)

Number of Plans Approved: 50
(AL, CO, SC, FL, OH, CA, IL, NY, MI, CT, NJ, MO, RI, OK, MA, PA, WI, OR, ID, TX, PR, IN, UT, NC, MN, MD, AR, ME, NE, NV, SD, DE, IA, KS, GA, MT, NH, WV, AZ, DC, VI, ND, LA, VA, MS, KY, AK, VT, NM, HI)

Number of Separate State Child Health Plans: 14
(CO, NY, PA, OR, NV, UT, MT, NC, GA, VA, AZ, DE, KS, VT)

Number of Medicaid Expansions: 29 (SC, OH, IL, MO, TN, RI, OK, ID, WI, TX, PR, IN, MN, MD, DC, AR, NE, NM, IA, SD, WV, VI, ND, MS, LA, AK, HI, GU, AS)

Number of Combination Plans: 10 (FL, CA, MA, CT, NJ, ME, NH, KY, MI, AL)

Number of Amendments Approved: 12
(CA, MI, AL, FL, MO, NE, PA, ID, NC, WI, RI, MS)

Number of Amendments Under Review: 10
(IL, FL-2nd amendment, AR, WV, NH, OK, CA-2nd amendment, UT, CO, ...)

HR-16. MEDICAID

16.2.1 The Federal Commitment to the Medicaid Program

NGA is concerned about proposals to reduce the Federal match for or cap the Federal commitment to the Medicaid program, since they believe that there is no way to reduce funds without jeopardizing patient protections and other critical program functions. In addition, NGA feels strongly that Medicaid expenditures should not be cut as part of efforts to balance the budget.

Analysis

The Administration does not support either a cap on Federal Medicaid spending or any Federal matching rate reductions. The President's FY 2000 budget proposal reduces Medicaid administrative payments to offset the overall rise in Medicaid administrative costs as States shift costs that were previously charged to AFDC to Medicaid.

16.2.2 Medicaid Mandates

NGA is calling on Congress to enact statutory language to clarify that a cut or a cap on the Medicaid program without new or expanded flexibility is an unfunded mandate.

Analysis

Although we support the goals of the Unfunded Mandate Act, it is not clear that it should be extended to affect any change in Medicaid policy. All Medicaid spending is matched at some rate by the Federal government. This Administration has both given states significant flexibility in Medicaid and made appropriate policy changes to ensure the fiscal integrity of this program. Thus, this extension does not appear to be needed.

16.2.3 Medicaid and Medicare

NGA would like additional flexibility to integrate Medicaid and Medicare funding streams, benefit packages, and delivery systems in order to improve on fragmented systems of care.

Analysis

This Administration has been a strong proponent of budget-neutral demonstrations to improve the effectiveness of Medicare service delivery. This Administration shares States' commitment to integrating care for dual eligibles and we have demonstrated this commitment by working closely with States to

develop creative ways to utilize both Medicaid and Medicare to serve vulnerable populations in a way that is consistent with the statute.

16.2.4 Disproportionate Share Hospital Program

NGA is opposed to any further cuts in DSH payments.

Analysis

There is no change in DSH payments in the President's FY 2000 budget.

16.2.5 Budget Neutrality

NGA would like to call our attention to the fact that expenditures in one program often realize savings in others. NGA would like States to have the flexibility to consider budget neutrality across Federal programs, not just for individual programs.

Analysis

The current way that budget neutrality is determined for Medicaid waivers reflects an agreement made with the NGA in 1993. We have since heard states' concerns about the narrowness of the determination, but are concerned that broadening budget neutrality to include other programs would create additional Federal liabilities. Although we are willing to hear how states propose that budget neutrality can be broadened, without the details, we have serious concerns about this resolution.

16.3.1 Allow States Greater Flexibility to Establish Managed Care Networks

Although NGA is appreciative of the added flexibility that the BBA provided in the design and development of Medicaid managed care networks, they believe that the regulations that HCFA is promulgating would create so many barriers to full implementation of these networks that the option is not really valid. They also want Congress to clarify that, under Federal law, if the State enters into a contract with a provider or HMO that covers the necessary benefits, the State's obligation to provide services is satisfied. Any dispute regarding covered services should be resolved as a contractual matter between the client and provider under State law.

Analysis

The Administration supports States in their efforts to expand mandatory managed care programs consistent with BBA. HHS is currently in the process of reviewing comments from Governors, Medicaid agencies, managed care organizations and other stakeholders on the proposed regulation, and will give them full

consideration.

16.3.2 Managed Care Quality Standards

NGA believes that the HCFA regulations governing grievance procedures in Medicaid managed care are overly proscriptive, and that many States have specific grievance and appeal procedures in their plan contracts that are as effective as the Federal approach.

Analysis

The Administration intends to continue to work in partnership with the States to continuously improve the quality of care for Medicaid beneficiaries. When developing the regulation, HCFA was guided by three principles: the preservation of State flexibility wherever possible and appropriate; consistency with the Medicare program; and incorporation of the recommendation of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

16.3.3 Waivers

NGA believes that States should not have to produce and defend waivers that are "similar to" previously-approved ones in other States. NGA argues that developing and securing approval for similar waivers is a waste of both Federal and State resources. Therefore, a State should be able to import any previously approved waiver in place without securing additional Federal approval.

Analysis

Although states often implement similar programs through waivers, no two state waiver programs are the same. Each state's goals, desired changes, budget neutrality, etc. are unique and thus distinct waivers are required. Thus, we cannot support this resolution. However, this Administration has eliminated the need for managed care waivers, and through eligibility simplification, allowed states to cover new categories of people without waivers (e.g., two-parent families, working families, people with disabilities who return to work). Any additional approvals should serve to broaden our knowledge about health care delivery to Medicaid enrollees.

16.3.4 Boren-like Provisions

NGA believes that the same ambiguity that caused problems for States in the Boren amendment exists in other parts of the Medicaid statute governing reimbursement to providers and urges Congress to repeal them in order to preclude any litigation over provider or health plan payment rates.

Analysis

We are reviewing this issue and look forward to learning more about your concerns as we continue to work with Governors and Medicaid agencies.

16.3.5 Managing Costs in EPSDT

NGA believes that current policy should be modified to allow States to limit the range and cost of services required under EPSDT.

Analysis

Recognizing states' concerns about costs, the BBA authorized a study to determine whether and how much EPSDT raises costs. Thus, we do not support this resolution pending the results of this study.

16.3.6 Ensure that States will not be Required to Implement Medicaid Program Changes Until HCFA has Published Final Regulations to Guide Program Administration

NGA believes that States should not be held liable for operating under State law or State interpretation of Federal statute until the Federal regulations are adopted. In addition, NGA feels that States should not be bound by informal policy directives that are issued in violation of the formal rulemaking process.

Analysis

The Administration is sensitive to the desire of States to be guided by final regulations that are complete, consistent, and reflect the input of governors and other stakeholders. HHS will give comments from governors full consideration as it drafts the Medicaid managed care final regulations.

16.3.7 Promote Cost Control and Efficiency

NGA believes that mandatory reasonable cost reimbursement strategies should be repealed.

Analysis

The Administration is committed to carrying out the intent of the Congress to phase out cost-based reimbursement for Federally qualified health centers and rural health clinics through the gradual process outlined in the BBA. We will work with States and these community based providers throughout this process to ensure that the delivery of high quality care is not interrupted or impaired.

16.3.8 Assume Full Financial Responsibility for All Low Income Medicare Beneficiaries Who Are Not Otherwise Medicaid-Eligible

NGA believes that the Federal government should assume the full responsibility for meeting the Medicare cost sharing obligations for low income beneficiaries and for providing the full Medicaid benefit package to these beneficiaries when applicable, since Medicare is a Federal program and the Federal government should bear all of its costs.

Analysis

The Administration is committed to ensuring that low income beneficiaries receive the medical care they require. While we understand rationale for the NGA recommendation, we are committed to maintaining at least the current level of assistance to low income Medicare beneficiaries. In addition, any proposed increase in Federal spending would need to be considered in the context of a balanced budget.

16.3.9 Make Audit and Disallowance Policies More Equitable

NGA believes that the Medicaid statute should be revised to prohibit heavy Federal penalties when the State violation does not result in direct harm to beneficiaries. States should be held harmless against possible penalties or disallowances for reasonable interpretations of law prior to the issuance of Federal regulations.

Analysis

Part of the Federal government's fiduciary responsibility for overseeing the Medicaid program is to employ disallowances for violations such as unauthorized or inappropriate payments, and so we do not agree that penalties should be limited to those violations that directly harm patients. However, we share the State's concerns that the size of a disallowance be in proportion to the significance of the State violation; however, this would require a statutory change.

16.3.10 Allowing Greater Flexibility in Medicaid Home and Community-based Programs

NGA requests the authority to administer Home and Community-based care programs through Medicaid State Plan Amendments rather than through waivers. However, the States would like to retain the ability to limit the number of beneficiaries served under this program. In addition, the States would like to eliminate the current incentives in the Medicaid program to place beneficiaries in institutional care.

Analysis

The Administration's FY 2000 budget proposes to eliminate the institutional bias in Medicaid by implementing an equal eligibility standard (300% of SSI) for all institutional home and community based services program, and we are extremely supportive of State efforts in this area. However, the Administration could not support allowing States to implement home and community based services programs that provided services to only a portion of those who would qualify under equal eligibility criteria, as this would fundamentally change the entitlement nature of Medicaid.

16.3.11 Children who are eligible for Medicaid

NGA is opposed to tying receipt of Medicaid funds to achieving increased program enrollment rates.

Analysis

The Administration has not proposed to link receipt of Medicaid funds to increased program enrollment rates.

16.3.12 Flexibility for Optional Eligibility Groups

NGA believes that States should have the flexibility to customize a package of optional benefits to meet the particular needs of optional eligibility groups, acknowledging that this would require waiving comparability and statewideness.

Analysis

The Administration could not support a program that would change the entitlement nature of Medicaid by providing services to only a portion of those who would qualify under equal eligibility criteria. We are committed to working with the States through the waiver programs to allow for additional program flexibility while demonstrating improvements in service delivery and cost-efficiency.

16.3.13 The Americans With Disabilities Act

NGA believes that recent court decisions have interpreted the ADA in such a way that home and community based services will become an open ended entitlement for people with disabilities. They would like constructive clarification of the parameters of State requirements under the ADA.

Analysis

The Administration supports State flexibility in designing a range of institutional and home and community based services to serve Medicaid beneficiaries with disabilities. We are committed to working closely with States to ensure the civil rights protections found in the ADA while affording States the flexibility to provide services to each beneficiary in the setting most appropriate to their needs.

HR 17 MEDICARE

17.1 Improving the Coordination of Acute, Primary, and Long Term Care

NGA believes that the lack of coordination between the Medicare and Medicaid programs causes fragmented service delivery and poor clinical outcomes. NGA suggests that the way to end this fragmentation is full integration of funding and care delivery.

Analysis

The Administration is extremely interested in working with States to develop programs for the integration of acute and long term care. However, the BBA outlined broad parameters for the expansion of Medicare managed care, and we believe that State integrated care demonstrations should stay within this framework. We are also committed to beneficiary choice within the Medicare program, and believe that Medicare beneficiaries should retain the choice as to whether or not to join a managed care program.

17.1 Eliminating Institutional Bias

NGA believes that current Federal policy related to long term care is very complicated and results in care management based on reimbursement instead of need.

Analysis

The Administration shares NGA's commitment to developing community based care options for the disabled. We believe that there is significant flexibility within Medicaid's current structure through the personal care option and the home and community care waiver program to allow recipients access to a comprehensive range of home and community based services. The Administration's FY 2000 budget proposes to eliminate the institutional bias in Medicaid by implementing an equal eligibility standard (300% of SSI) for all institutional home and community based services program, and we are extremely supportive of State efforts in this area.

*	Final State Food Stamp Proposal	Recommended Food Stamp Adjustment	F State Medicaid Proposal	Recommended Medicaid Determination	Total Final State Submission	Total Proposed Determination
ıa	$1.37	$1.37	$1.37	$1.37	$2.74	$2.74
	$0.00	$1.05	$0.00	$1.05	$0.00	$2.10
ıiz	$5.68	$5.68	$5.68	$5.68	$11.36	$11.36
rkansas	$1.61	$1.61	$1.61	$1.61	$3.22	$3.22
alifornia	$58.85	$58.85	$68.80	$68.80	$127.65	$127.65
olorado	$0.79	$2.77	$0.00	$2.77	$0.79	$5.54
onnecticut	$0.91	$2.73	$4.75	$4.37	$5.66	$7.10
elaware	$0.00	$1.00	$0.00	$1.00	$0.00	$2.00
lorida	$1.41	$14.41	$27.40	$14.41	$28.81	$28.82
eorgia	$0.00	$0.00	$0.00	$12.82	$0.00	$12.82
lawaii	$0.00	$0.00	$0.00	$0.99	$0.00	$0.99
daho	$0.00	$1.50	$0.00	$1.50	$0.00	$3.00
llinois	$9.50	$9.16	$10.99	$14.39	$20.49	$23.55
ndiana	$0.95	$1.11	$3.25	$4.61	$4.20	$5.72
owa	$0.98	$0.98	$0.00	$0.00	$0.98	$0.98
Kansas	$0.99	$1.60	$0.99	$1.60	$1.98	$3.20
Kentucky	$0.00	$4.30	$0.00	$4.30	$0.00	$8.60
ouisiana	$0.00	$1.10	$0.00	$1.10	$0.00	$2.20
Maine	$0.60	$0.60	$0.76	$0.76	$1.36	$1.36
Maryland	$1.19	$1.19	$5.38	$5.38	$6.57	$6.57
Massachusetts	$2.58	$2.08	$6.90	$9.84	$9.48	$11.92
Michigan	$0.16	$4.78	$10.12	$11.06	$10.28	$15.84
Minnesota	$1.22	$2.38	$1.53	$2.24	$2.75	$4.62
Mississippi	$0.98	$2.10	$0.00	$2.10	$0.98	$4.20
Missouri	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a	$0.16	$0.65	$0.29	$0.65	$0.45	$1.30
N	$0.00	$0.55	$0.00	$0.55	$0.00	$1.10
Nev	$0.00	$1.78	$0.00	$1.78	$0.00	$3.56
New Hamp	$0.76	$0.88	$0.76	$0.88	$1.52	$1.76
New Jersey	$8.67	$9.13	$13.02	$14.61	$21.69	$23.74
New Mexico	$0.00	$1.42	$0.00	$1.42	$0.00	$2.84
New York	$55.60	$63.33	$46.74	$53.79	$102.34	$117.12
N Carolina	$0.00	$0.00	$5.38	$12.99	$5.38	$12.99
N Dakota	$0.31	$0.31	$0.64	$0.64	$0.95	$0.95
Ohio	$0.21	$5.84	$0.33	$5.84	$0.54	$11.68
Oklahoma	$0.00	$4.12	$0.00	$4.12	$0.00	$8.24
Oregon	$2.48	$5.37	$1.03	$5.37	$3.51	$10.74
Pennsylvania	$0.10	$0.10	$0.00	$0.00	$0.10	$0.10
Rhode Island	$0.00	$0.09	$0.00	$1.37	$0.00	$1.46
S Carolina	$0.45	$1.78	$0.43	$1.72	$0.88	$3.50
S Dakota	$0.18	$0.18	$0.67	$0.67	$0.85	$0.85
Tennessee	$2.26	$2.26	$2.51	$2.51	$4.77	$4.77
Texas	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utah	$1.14	$1.14	$1.14	$1.14	$2.28	$2.28
Vermont	$0.00	$0.44	$0.00	$0.44	$0.00	$0.88
Virginia	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Washington	$2.28	$2.28	$6.24	$6.24	$8.52	$8.52
West Virginia	$0.00	$0.57	$0.00	$0.57	$0.00	$1.14
Wisconsin	$0.00	$0.00	$6.96	$6.96	$6.96	$6.96
V ng	$0.38	$0.39	$0.38	$0.39	$0.76	$0.78
L ol	$0.63	$1.62	$0.63	$1.62	$1.26	$3.24
Tc	$165.38	$226.58	$236.68	$300.02	$402.06	$526.60

* dollar amts in millions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary

Washington, D.C. 20201

Lt #2

FEB - 4 1999

Ms. Janet Clarke, Director
State of Alaska - Department of Health and Social Services
Division of Administrative Services
P.O. Box 110650
Juneau, Alaska 99811-0650

Dear Ms. Clarke:

The Agricultural Research, Extension, and Education Reform Act of 1998 requires the Department of Health and Human Services to determine the amount of funds in each State's base year for the Temporary Assistance for Needy Families (TANF) block grant that was charged to the former Aid to Families with Dependent Children (AFDC) program for common administrative costs that could have been allocated to Food Stamps and Medicaid. In her letter dated January 15, 1999, Secretary Shalala advised your Governor of her decision (copy enclosed).

As noted in that decision, the Secretary's determination differed with the State's proposal. Enclosed is an analysis of the State's proposal and the rationale for the Department's decision. In accordance with the Act, the State may appeal the Food Stamp, Medicaid or both determinations under procedures outlined in the letter to the Governor.

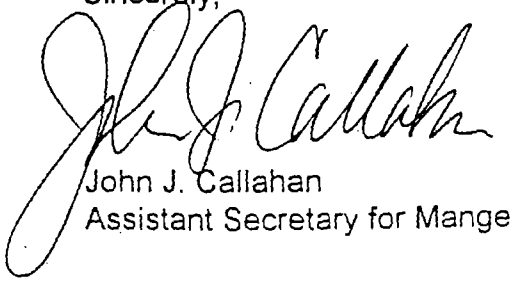
The January 15, 1999, letter to the Governor advised that the State may file an appeal of the determinations to an HHS Administrative Law Judge within 60 days of the receipt of that notice. The Department has determined to extend your appeal time so that any appeal must be filed within 60 days of the receipt of this letter transmitting our rationale. The reason for extending your appeal time is so that your State may have adequate opportunity to review the rationale for the Department's decision before deciding whether or not to file an appeal.

Your State must file an appeal in accordance with the extension of time noted above to preserve your statutory appeal rights. Your appeal may include a request for mediation. Mediation is a voluntary process, entered into by the parties' mutual agreement in an effort to achieve a negotiated resolution of the dispute. The mediator facilitates an agreement. The parties are bound only to outcomes that are reduced to a written agreement. Mediation discussions are confidential under the requirements of the Administrative Dispute Resolution Act which governs this process. Nothing from the mediation process will be added to the record in the appeal unless both parties agree. Neither party is precluded from returning to the appeal process before the Administrative Law Judge and the Departmental Appeals Board should there not be a mediated resolution.

I recognize that your staff had only a limited amount of time to complete this legislatively mandated project. We are fully aware that this was not an easy task in that it required the reconstruction of dated documents and data. Your efforts are greatly appreciated.

Should you or your staff have any questions, please contact Joseph E. Cook, Jr., Director of Audit Resolution and Cost Policy, (202-401-2804), Room 522E HHH Building, 200 Independence S.W., Washington, D.C. 20201 or Ronald Speck, Senior Cost Policy Officer (202-401-2751).

Sincerely,



John J. Callahan
Assistant Secretary for Mangement and Budget

Enclosures

cc: Abigail Nichols, Director, PAD/FNS
Chuck Seed, Director, DCA/HHS

Ltr #1

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

JAN 15 1999

The Honorable Don Siegelman
Governor of Alabama
Montgomery, Alabama 36130

Dear Governor Siegelman:

The Agricultural Research, Extension, and Education Reform Act of 1998 requires the Department of Health and Human Services to determine the amount of funds in each State's base year for the Temporary Assistance for Needy Families (TANF) block grant that was charged to the former Aid to Families with Dependent Children (AFDC) program for common administrative costs that could have been allocated to Food Stamps and Medicaid.

Based on our review of your State's proposal, HHS concurs with the proposed determinations of $1,368,000 for Food Stamps and $1,368,000 for Medicaid as the amounts that were charged to the AFDC program for administrative costs common to determining eligibility for those programs in the State's base year. The Act stipulates that the amounts determined for Food Stamps will be reduced annually from the allowable Federal share of Food Stamp administrative claims beginning on or after October 1, 1998, and through September 30, 2002. The Secretary of Agriculture will subsequently advise you as to how and when these adjustments will be made. While the Act required HHS to determine the amounts applicable to Medicaid, there is no current statutory requirement to make a similar adjustment for that program.

In accordance with the Act, the State may appeal these determinations to an HHS Administrative Law Judge within 60 days of this notice. Such an appeal should be sent to:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division
637D HHH Building.
200 Independence Ave. SW
Washington, DC 20201

Not later than 60 days after the record is closed (i.e, no additional information is required from either party), the Administrative Law Judge will issue a final decision. Within 30 days after the receipt of that decision, the State may appeal the decision to the HHS Departmental Appeals Board.

I wish to thank the Alabama staff for their assistance in meeting the compressed deadlines and data requirements imposed by this legislation. I look forward to our staffs working cooperatively to resolve any outstanding issues.

Sincerely,

Donna E. Shalala

cc: The Honorable Dan Glickman, Secretary of Agriculture
Mr. James D. Connell, Director, Finance Division, DHR

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN -7 1999

To: The Secretary

Thru: DS

COS

ES

From: John J. Callahan
Assistant Secretary for Management and Budget

Subject: State-by-State Determinations for Food Stamp Administrative Costs under Public Law 105-185 – Action

Issue. The Agricultural Research, Extension, and Education Reform Act of 1998 (P.L. 105-185) was signed by the President on June 23, 1998. It requires HHS to determine the amounts that were charged to the former AFDC program in each State's and the District of Columbia's TANF base year that could have been allocated to Food Stamps and Medicaid. The purpose of the legislation is to effectively recover, with respect to Food Stamps, the amounts that were funded in the TANF block grant that States can now charge to Food Stamps - in effect, a duplication of funding or reimbursement. The amounts determined for Food Stamps are to be recovered each year from FY 1999 - FY 2002.

This office, working with the Division of Cost Allocation of the Program Support Center, and in consultation with the Department of Agriculture, has developed for your "determination" (i.e. approval), a compilation of those amounts (see attachment).

Background. Giving rise to the passage of the Act was the realization that the TANF welfare reform legislation created a dual payment to the States for certain administrative costs inherent in the administration of the AFDC, Medicaid and Food Stamp programs. The Congressional Budget Office estimated this dual payment to be approximately $500 million. Public Law 105-185 included language to adjust this dual payment anomaly and required these State-by-State determinations to be made within 180 days of enactment.

Following passage of the Act, we sent a guide to the States and the District of Columbia to assist them in estimating and proposing the amounts to be adjusted. Leading up to this point, we had worked extensively with the National Governors' Association and other organizations, as well as State officials themselves, in developing the guidance. The guidance allowed the States a fair measure of flexibility in proposing the amounts, while recognizing final determination authority rests with the Secretary of HHS.

The States proposed adjustments for Food Stamps of $165 million. Based upon the DCA and ASMB review and analysis of these proposals, we have determined adjustments of $227 million--a net increase of $62 million. The States identified $237

million for Medicaid and we have determined $300 million–an increase of $63 million. There is no legislation currently pending to make Medicaid adjustments.

→ The Food Stamp adjustments will begin this April and are effective for the following three fiscal years (i.e. through FY 2002). We agreed with twenty-two of the State proposals, seven of which required no Food Stamp offsets. Of these, we reduced the amounts initially proposed by two of the States. With respect to the remaining twenty-nine States (including the District of Columbia), our adjustments were less than a million dollars in fifteen.

The cause of the $62 million variance between the State proposals for Food Stamps and our determinations fall primarily into three categories. First, nineteen States submitted "zero" proposed adjustments. Of these, we identified only seven that were correct in taking this position. States falling into this category accounted for $13.8 million.

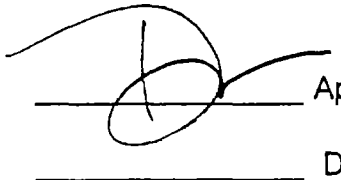
The second cause for the variance arose where States did not include all activities and costs that were subject to the adjustment. These ran the gamut from a failure to include indirect costs to excluding the local office income maintenance workers in the calculations. These States accounted for $24.6 million of the variance.

Lastly, several States, while correctly computing the amounts for both Food Stamps and Medicaid, offset the amounts determined for Food Stamps by other adjustments outside the scope of the legislation and unrelated to the issue being addressed. We adjusted $15 million for these States, of which Florida accounted for $13 million.

New York was an anomaly in that $6.2 million of our increasing adjustment of $7.7 million fell outside the above categories. The State's initial proposal was $62.2 million. In the process of providing additional documentation to the DCA, the State revised its proposal downward to $55.6 million. The State's revision was based on technical arguments of "Federal reimbursements" in the base year vs. "amounts claimed." As the expenditures were subsequently allowed, paid, and included in the TANF base year used to compute the block grant, we took the position that they were subject to the adjustment. The remaining $1.5 million upward adjustment that we made was attributable to activities omitted from the State's original submission.

The States have appeals rights to an Administrative Law Judge and then to the Departmental Appeals Board. We anticipate that where our differences with States are based on a lack of information which resulted in the imposition of a formula[1] for your determinations, we will have opportunities to reach negotiated settlements through mediation prior to administrative hearings.

Recommendation. On Thursday, December 17, 1998, we met with the Deputy Secretary and key departmental officials to review the requirements of the Act and the amounts proposed for the State-by-State determinations. On December 30, 1998 I held a follow-up meeting with IGA, ASPA and ACF to share this package with them, as revised by the guidance provided at the Deputy Secretary meeting. It is my recommendation, and the consensus of the officials consulted, that you approve these amounts. If you agree with this recommendation, as well as with the format of the letters by which these determinations will be conveyed to the governors, please indicate below, as well as sign the actual letters to California and New York, following which we will provide the remaining 49 letters to be signed.



_____ Approve

_____ Date

_____ Disapprove

JAN 14 1999 Date

Attachments

[1]In lieu of performing an in depth analysis, States were given the option of using a formula to compute the amounts for both Food Stamps and Medicaid. The formula was suggested by California during the aforementioned exposure process. As the formula was similar to the one we used to formulate our original estimates, it was incorporated into the guidance as an option. Four States opted for the formula, including California, which we accepted.

MEDICAID DEMONSTRATIONS AND WAIVERS APPROVED DURING THE CLINTON ADMINISTRATION

(January 21, 1993-February 18, 1999)

STATE	1115 HEALTH CARE REFORM DEMONSTRATIONS Permit states to: -restructure eligibility and coverage under Medicaid; -acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating state health programs.	1915(b) FREEDOM OF CHOICE WAIVERS* Permit states to: -waive beneficiaries' rights to free choice of providers in order to, for example, implement a primary care case management system or a speciality physician services arrangement; -require Medicaid beneficiaries to receive services from specified providers, generally on a negotiated rate contract basis.	1915(c) HOME AND COMMUNITY-BASED WAIVERS * Pemit states to: -provide a broad array of home and community-based services (excluding room and board) not otherwise covered under the Medicaid program as an alternative to institutional care.
Alabama	✓	✓ (7)	✓(15)
Alaska			✓(21)
Arizona			
Arkansas	✓	✓(6)	✓(18)
California	✓	✓(34)	✓(13)
Colorado		✓(6)	✓(26)
Connecticut		✓(1)	✓(12)
Delaware	✓		✓(9)
D.C.		✓(3)	✓(5)
Florida	✓	✓(11)	✓(29)
Georgia		✓(7)	✓(10)
Hawaii	✓		✓(8)
Idaho		✓(2)	✓(10)
Illinois	✓		✓(21)

Indiana		✓(3)	✓(39)
Iowa		✓(14)	✓(38)
Kansas		✓(5)	✓(18)
Kentucky	✓	✓(8)	✓(11)
Louisiana		✓(8)	✓(15)
Maine		✓(4)	✓(17)
Maryland	✓	✓(3)	✓(8)
Massachusetts	✓	✓(1)	✓(8)
Michigan		✓(6)	✓(14)
Minnesota	✓	✓(2)	✓(28)
Mississippi		✓(4)	✓(7)
Missouri	✓	✓(8)	✓(18)
Montana		✓(6)	✓(7)
Nebraska		✓(5)	✓(18)
Nevada		✓(1)	✓(10)
New Hampshire			✓(11)
New Jersey	✓	✓(4)	✓(17)
New Mexico		✓(4)	✓(8)
New York	✓	✓(12)	✓(20)
North Carolina		✓(5)	✓(18)
North Dakota		✓(7)	✓(9)

Ohio	✓	✓(3)	✓(13)
Oklahoma	✓	✓(1)	✓(20)
Oregon	✓	✓(2)	✓(7)
Pennsylvania		✓(13)	✓(25)
Rhode Island	✓		✓(12)
South Carolina	**	✓(3)	✓(16)
South Dakota		✓(5)	✓(10)
Tennessee	✓		✓(21)
Texas		✓(16)	✓(40)
Utah		✓(7)	✓(12)
Vermont	✓		✓(12)
Virginia		✓(9)	✓(9)
Washington		✓(18)	✓(20)
West Virginia		✓(6)	✓(5)
Wisconsin		✓(4)	✓(22)
Wyoming		✓(3)	✓(11)
TOTALS	**20**	**277**	**792**

*The numbers indicated include new waivers, renewals, and modifications. **Only framework for SC's plan was approved.

Rhode Island

- I would like to take this opportunity to update you on the status of the Rhode Island CHOICES section 1115 demonstration, which will allow the developmentally disabled to have more choice and control over the acute and long-term care services that they receive.

- A planning grant from the Department assisted with the development of this proposal, a final version of which was received by HCFA on May 15, 1997.

- Currently, the Department and the Office of Management and Budget are reviewing the demonstration proposal, and will be in regular contact with your staff to resolve outstanding issues.

- We look forward to continuing the progress we have made on the CHOICES demonstration, which promises disabled beneficiaries the opportunity to make informed decisions about the care that they require.

- I would also like to take this opportunity to congratulate you on the recent approval of the amendment to your Title XXI plan.

- As you know, the amendment will allow Rhode Island to expand health care coverage to additional uninsured children. We look forward to continuing to work with your staff as Rhode Island implements this important new program.

Maryland

- The Department remains committed to working in partnership with your staff to realize our common goal: improving the coordination of care for low-income vulnerable populations.

- Currently, we are in receipt of your proposed amendment to your Section 1115 demonstration. This proposal would add certain substance abuse treatment services to the benefit package for demonstration individuals who are recipients of Temporary Cash Assistance (TCA).

- Very soon, the Department will send some questions and clarifications regarding the amendment, and we will look forward to receiving your responses.

- I would also like to extend my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on July 29 of last year. We look forward to continuing to work with your staff as Maryland implements this important new program.

Wisconsin

- I would like to extend my sincere congratulations on the approval of Wisconsin's BadgerCare program, which will expand health care coverage to low-income children and their parents.

- Using section 1115 demonstration authority for Medicaid and Title XXI Children's Health Insurance Program (CHIP) funding, we were able to realize your goal of insuring low-income families under BadgerCare.

- Yours has been a state that is eager to test innovative approaches to providing services to lower-income individuals. The Department looks forward to an ongoing partnership with Wisconsin as it implements the expanded BadgerCare program.

- We are currently reviewing your amendment regarding coverage of foster care children, and expect to be able to give you an answer shortly.

- Throughout negotiations on the BadgerCare proposal, your staff agreed with the Department to deal separately with the issue of coverage for foster parents of children in BadgerCare. The Department has continued to discuss this Medicaid reimbursement issue with your staff, and we appreciate your willingness to address this issue outside of the process of approving your Medicaid demonstration and Title XXI plan.

Hawaii

- The Department remains committed to working in partnership with your staff to realize our common goal: improving access to health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.

- We are in receipt of your proposed amendment to QUEST, your Section 1115 demonstration. This proposal would enroll the aged, blind, and disabled populations in QUEST, building upon the achievements of your existing demonstration.

- The Department continues to work with Hawaii to assure that the review process for this amendment is expeditious.

- I would also like to extend my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on January 19, 1999. We look forward to continuing to work with your staff as Hawaii implements this important new program.

Minnesota

- The Department remains committed to working in partnership with your staff to realize our common goal: improving access to health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.

- The amendment to the Prepaid Medical Assistance Plan Plus (PMAP+), which would implement Phase II of MinnesotaCare is under review in the Department. We will continue to work with your staff to address issues related to this amendment and hope to be able to notify you of a decision in the near future.

- In addition, this month we also received the latest amendment to PMAP+, a proposal to implement a county-based prepaid medical assistance program.

- We have assured your staff that we will do our utmost to ensure an expeditious review of this amendment, while simultaneously working toward resolution on the Phase II amendment.

Vermont

- The Department remains committed to working in partnership with your staff to realize our common goals: improving access to and coordination of health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.

- We have been working with your staff on the behavioral health services component of your Medicaid program. Your state proposed five amendments to your current section 1115 Medicaid demonstration the Vermont Health Access Plan (VHAP), which would improve access to and coordination of care in a variety of ways.

- Amendments to VHAP include a coordinated care program for long-term behavioral health services; expanded eligibility in the number of parents and caretaker relatives of Medicaid-eligible children; an extended and enhanced benefits package; and reductions in cost-sharing for beneficiaries.

- We anticipate announcing a decision on four of these amendments very soon, and understand that you would like to have them approved by March 1. Furthermore, we will continue to work with State staff to ensure a very expeditious approval of the outstanding amendment pertaining to long-term behavioral health services.

- I would also like to reiterate my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on December 15, 1998. We look forward to continuing to work with your staff as Vermont implements this important new program.

Declining Medicaid Rolls

Introduction

This memo presents preliminary findings concerning welfare reform and dynamics in both welfare caseload and Medicaid enrollment. The findings are based on analyses of program data and the Current Population Survey (CPS) from 1995 through 1997, and on research on the subject and reports from the field.

Attachment 1 is a table that displays the data used for the analysis presented here. Attachment 2 outlines research that is underway or planned, and describes the efforts the Department and other parties are making to improve Medicaid outreach and increase participation among eligible children and families.

Background

Until passage of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA), eligibility for Medicaid was automatic for those receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. PRWORA replaced AFDC with a new program of block grants to the states – Temporary Aid to Needy Families (TANF) – and severed the historical linkage between welfare and Medicaid eligibility for families. Also, together with sweeping changes in immigration law, PRWORA restricted the eligibility of new immigrants for Medicaid and welfare.

In a specific effort to preserve Medicaid coverage for those affected by welfare reform, PRWORA required states, under a new *section 1931*, to continue to provide Medicaid to families who meet the AFDC eligibility criteria that were in effect on July 16, 1996[1] – regardless of whether they are eligible for cash under their states' new TANF programs. Thus, states must, at a minimum, maintain their old AFDC eligibility criteria for purposes of determining Medicaid eligibility, even though they apply different eligibility criteria for TANF. However, under section 1931, states also have flexibility to expand Medicaid coverage beyond previous levels.

Acknowledging the new administrative burden on states that resulted from delinking Medicaid from cash receipt, PRWORA provided $500 million in enhanced matching funds to help states cover the increased costs associated with outreach and Medicaid eligibility determinations in the new environment. The law also gave states two new Medicaid options -- presumptive eligibility for children and 12-month continuous eligibility -- to improve coverage among poor families. Since PRWORA passed, HCFA, the Department, and others have undertaken substantial efforts to improve Medicaid outreach and increase the participation of eligible children and families at risk of losing Medicaid -- or never enrolling -- as a consequence of welfare changes. Further, the Children's Health Insurance Program (CHIP) provides a new mechanism for finding Medicaid-eligible children.

Current Findings

State variation in the timing and character of welfare reform, and variation in Medicaid policies and economic conditions, pose a formidable challenge to research aimed at defining or modeling the impact of welfare reform on Medicaid enrollment dynamics. Also, the state and national data necessary for such analysis are only gradually becoming available. For all these reasons, research is still at an early stage. Nonetheless, the following important preliminary findings can be drawn from data on poverty, welfare, and Medicaid (see Attachment 1).

- *Raw Poverty Numbers are Down* -- Between 1995 and 1997, the total population in poverty fell by 800,000 (2.3%). A drop of 600,000 in the number of poor children made up a significant share of the decline. These declines continued a downward trend in poverty numbers that began with this Administration. Since 1993, the number of poor adults has fallen by almost 4 million (9%) and the number of poor children has fallen by 1.6 million (10.3%).

- *But Poverty Rates Have Changed Little* -- Although the number of poor fell between 1995 and 1997, the poverty rate among adults fell only from 13.8% to 13.3% in this period, and the poverty rate among children fell by just under one point, from 20.8% to 19.9%. Nonetheless, these declines in the poverty rate continue a trend that began under this Administration: in 1993, the poverty rate among adults was 15.1% and the poverty rate among children was 22.7%.

- *Welfare Rolls Are Falling Much Faster than Poverty* -- From 1995 to 1997, when the population in poverty fell by 800,000, the average monthly welfare caseload dropped by 3 million -- a 23% decrease. The data show that the drop in welfare caseload appears to be accelerating rapidly: from 1995 to 1996, caseload fell by about 1 million; from 1996 to1997 caseload fell by an additional 2 million; and the newest available data, from 1997 to June 1998, show that the welfare caseload fell by another 2 million.

- *Medicaid Enrollment Is Dropping Much Less than Welfare Caseload* -- In contrast to the 3 million (23%) drop in welfare caseload from 1995 to 1997, the number of people enrolled in Medicaid fell by 1.1 million (2.7%) over this period. Although the number of adults and children receiving welfare-related Medicaid fell by about 25%, the number who receive non-welfare-related Medicaid rose by 23%. Because the increase in non-welfare-related Medicaid was not large enough to completely offset the decrease in welfare-related Medicaid, there were 600,000 fewer adults and 700,000 fewer children on Medicaid in 1997 than in 1995.

- *The Uninsured Rate and the Private Coverage Rate Among the Poor Have Both Increased* -- Despite the overall drop in the number of poor people since 1995, the number of poor adults and children who have private coverage rose by 200,000 and

100,000 respectively. At the same time, the number of poor adults and children who are uninsured increased by about 250,000 each.

Discussion

It appears from the data that many low-income families -- especially children -- who can qualify for Medicaid through eligibility groups that are not tied to welfare are now being covered under such other categories. However, the net loss of 1.1 million people enrolled in Medicaid still warrants attention to ensure that those whose economic status has not improved, but who have been affected by welfare reform, make the transition from welfare-related to non-welfare-related Medicaid coverage.

It is unlikely that the 1.1 million-person decrease in the Medicaid rolls translated strictly into coverage losses among the poor. While the number of poor adults and children who were uninsured did indeed rise over this period (by 250,000 each), so did the number with private coverage (by 200,000 and 100,000, respectively). In addition, some of those no longer covered by welfare-related Medicaid could have been among the 800,000 people lifted out of poverty altogether; in that case, we can only speculate about whether they obtained private coverage or became uninsured as a result.

In short, the data suggest that despite the changes in welfare, the availability of Medicaid through non-welfare-related routes preserved coverage to a substantial extent. The Medicaid caseload drop in the poorest group bears watching, and closer study of the transitions experienced by this population since welfare reform is critical to better identification of gaps and better targeting of outreach. The 2.7% drop in total Medicaid enrollment also warrants notice, as net increases in Medicaid caseload might have been expected over this period if the phase-in of poverty-level children continued to add children to the rolls, and if section 1931 maintained enrollment of families, as intended.

The apparent acceleration of welfare caseload declines -- the rolls dropped by 1 million between January 1997 and June 1998 alone -- argues for careful monitoring with regard to Medicaid enrollment dynamics. Because the availability of Medicaid data lags behind welfare data, it remains to be seen whether non-welfare-related Medicaid eligibility continued to preserve coverage for the increasing numbers of people not on welfare, as well as it appeared to between 1995 and 1997.

Other Study Findings

The data findings of Medicaid coverage declines and rising uninsurance among the poor are consistent with the results of various studies that have specifically examined Medicaid enrollment and participation in relation to changes in welfare and immigration policy, as follows.

Medicaid caseload analysis

- In an analysis for the Urban Institute's *Assessing the New Federalism* (ANF) project, Ellwood and Ku analyzed Medicaid caseload changes between 1995 and 1996. They found a net decline of nearly 2 percent in Medicaid enrollment of children and non-disabled adults – the first downturn in nearly a decade of eligibility expansions and rising Medicaid participation rates.[2]

- Analyzing state Medicaid enrollment data from five states, Ellwood found enrollment drops from January 1995 to January 1998 of 12 to18 percent in New York, California, and Florida, and 29 percent in Wisconsin. Only Minnesota showed an increase, of 1 percent. However, this study did not track the insurance status of those who left Medicaid to determine what proportion found private coverage and what proportion became uninsured.

- An analysis of administrative data from Los Angeles County generated important findings regarding immigrants. Applications for Medicaid and welfare benefits by non-citizen-headed families declined sharply following enactment of PRWORA, while approvals of citizen cases did not change. Approvals of non-citizen-headed cases fell by 52% between January of 1996 and 1998, explaining the entire 23% drop in total approvals over the period. Non-citizen applications for Medicaid-only benefits also declined. Finally, the number of citizen children of non-citizen parents applying for Medicaid and welfare declined sharply -- approved applications dropped by 48% between January of 1996 and 1998, compared to a 6% increase for citizen children of citizen parents during the period.

Studies of welfare "leavers"

- Preliminary 1997 results from the National Evaluation of Welfare-to-Work Strategies (formerly the JOBS evaluation) indicate that as members of both experimental and control groups left AFDC in increasing numbers, health coverage among both groups declined. Evaluation sites that experienced greater impacts on employment and welfare receipt typically also had greater reductions in health coverage among the treatment group, despite increasing rates of employer sponsored insurance (ESI), because more families lost Medicaid than gained ESI. These findings will be addressed in greater detail in a forthcoming report.

- In a widely cited 1989-92 analysis of families leaving welfare, uninsurance among mothers exiting welfare was found to rise over the three years they were followed, from 23 to 45 percent. The study findings highlight the particular exposure of mothers, who are not protected by poverty-related Medicaid eligibility, and also the importance of Medicaid during the early period following exit, when low-wage work without ESI is typical.[3]

- A May 1997 GAO study of three states showed that, despite continued eligibility for Medicaid, participation plummeted in households where welfare benefits were terminated. Before termination, Medicaid participation ranged from 84 to 100 percent across the three states; after termination, the rates ranged from 26 to 61 percent.[4]

- The finding of decreased Medicaid enrollment is also typical of states' own studies of their welfare "leavers." ESI increases have not offset these reductions in Medicaid enrollment.[5]

Effects of Re-engineering Welfare

Welfare reform profoundly changed both the administration of welfare and welfare "culture" in the states. The major restructuring of the welfare system and related operational challenges, and transformation in public attitudes toward welfare, may cause reduced participation in Medicaid as well as welfare during this period of fundamental transitions.

- As welfare offices are transformed into "job centers" and former caseworkers are re-trained as "job counselors," the new emphasis on job placement and reducing dependency may be eclipsing any focus on determining eligibility for medical (and food) assistance, despite their importance as work supports.

- Former welfare caseworkers, who in their new role, become front line Medicaid eligibility workers, may actually have little or no training or experience making Medicaid eligibility determinations. They may not understand that, unlike before, Medicaid eligibility for applicants does not flow strictly from receipt of cash benefits, and that applicants who do not qualify for TANF must be evaluated separately for Medicaid eligibility under section 1931.

- The profound changes in public attitudes toward welfare and in welfare itself (e.g., time limits) may result in fewer people entering welfare/job offices. Non-participation in welfare may cause non-participation in Medicaid as well if those who decline to apply for TANF do not make contact with the Medicaid program otherwise.

- Reports from the field provide mounting evidence that misinformation, confusion, and discouraging messages also contribute to suppressed Medicaid enrollment among eligible children and families, including immigrants.

- The New York Times recently reported that welfare offices in New York City, which are actively discouraging application for welfare, are also systematically failing to provide and process applications for Medicaid (and Food Stamps) promptly, despite clear federal policy guidance that they do so. City statistics show that while 53 percent of the people

who asked to apply for welfare, food stamps and Medicaid were successful in the past, about 25 percent receive benefits at the city's new "job centers."

Conclusion

The net results of the latest data and research in this area counsel both concern and optimism. Medicaid enrollment is down overall during a period when increases might have been expected. Moreover, the fact that the net drop results from the decline in enrollment in the poorest Medicaid coverage group implies a need for more outreach to those who have dropped from the welfare caseload but remain eligible for Medicaid.

At the same time, the data indicate that the drop in Medicaid enrollment is nowhere near the level that many worried would result from welfare reform. A significant number of those no longer qualifying for welfare-related Medicaid appear to be finding their way into Medicaid through other eligibility pathways. Some of those who do not show up on the Medicaid rolls are families whom the economy has boosted out of poverty and/or into jobs with insurance. Some, like many young adults, do not realize the importance of having health insurance for themselves and their children. But clearly, some leaving the welfare-related Medicaid rolls, and some who do not show up in Medicaid as a result of the immigrant policy changes, are becoming uninsured.

The data findings should be considered preliminary and tentative and some caveats should be noted. The data sets analyzed measure different periods of time and they measure in substantially different ways. Furthermore, the data instruments are not sensitive to volatility in income, employment, and coverage within a year that undoubtedly complicate the results. Finally, the data cover only two years; as data from subsequent years become available, the longer series will provide a more reliable picture of trends in poverty and program participation.

Especially given reservations about the data currently available for analysis, other research and reports from the field are important sources of information and insight, and should help guide future study and monitoring efforts. It is clear from a mounting body of such work that confusion about eligibility, both in the public and among eligibility workers in state and local offices, is a consequence of the delinkage of Medicaid from welfare. The separate processing of Medicaid applications for those who are denied welfare benefits may not occur promptly or automatically. Formal and informal welfare diversion programs probably produce diversion from Medicaid as well, because while the programs are decoupled, many continue to believe that eligibility for them remains linked. If eligible families fail to become enrolled in Medicaid for any of these reasons, then the work support offered by transitional Medicaid will also remain unrealized. Finally, the welfare and immigration changes that have transformed the program have also changed the larger "culture," sending new messages that discourage participation, not only in welfare but also in other public benefits. Those who decline to apply for welfare may either decline to apply separately for Medicaid, or simply fail to.

The importance of health insurance for low-income families and children, and its importance as a work support, both suggest that dynamics in coverage among this population should be a critical focus of monitoring for the Department. In particular, we need to monitor states' implementation of welfare reform as it affects Medicaid, and their implementation of section 1931, so that we can more narrowly identify the obstacles to Medicaid participation and better design outreach efforts.

ATTACHMENT 1

Changes in Poverty and Program Caseload Between 1995 and 1997				
	1995	1997	Difference	Percent Change
CPS Poverty Data				
Total Population in Poverty	36.4 m	35.6 m	-800,000	-2.3%
Adults	21.8 m	21.5 m	-300,000	-1.4%
Children	14.7 m	14.1 m	-600,000	-3.8%
ACF Welfare Data				
Total AFDC/TANF Caseload	13.4 m	10.4 m	-3 m	-22.6%
HCFA Medicaid Data				
Total Medicaid Enrollment	41.4 m	40.3 m	-1.1 m	-2.7%
Non-Disabled Adults	9 m	8.4 m	-600,000	-6.3%
Welfare Related	5.4 m	4.0 m	-1.4 m	-26.0%
Non-Welfare Related	3.6 m	4.5 m	+800,000	+23.0%
Non-Disabled Children	20.4 m	19.6 m	-700,000	-3.5%
Welfare Related	11.2 m	8.4 m	-2.8 m	-25.0%
Non-Welfare Related	9.2 m	11.3 m	+2.1 m	+22.6%
CPS Insurance Data				
Poor Uninsured Adults	11 m	11.2 m	+250,000	+2.2%
Poor Uninsured Children	3.1 m	3.4 m	+250,000	+7.4%
Poor Adults w/ Private Coverage	8.1 m	8.3 m	+200,000	+1.8%
Poor Children w/ Private Coverage	2.7 m	2.8 m	+100,000	+4.1%

Note: Non-Disabled Adults + Non-Disabled Children do not add to Total Medicaid enrollment because Total Medicaid Enrollment includes SSI groups and the elderly.

ATTACHMENT 2

Further Research

Numerous research efforts currently underway or in development focus specifically on the impact of welfare reform on Medicaid participation.

- HCFA has awarded a major contract to analyze national trends in Medicaid utilization, expenditures, duration and continuity of enrollment, shifts across eligibility categories, and the profile of enrolled children and families, and to attempt to disentangle the effects of welfare reform from other effects.[6]

- Phase Two of the 1998 DHHS-funded study of formal welfare diversion programs, which is now underway, entails case studies in five states focused on the implementation of diversion policies. A specific emphasis of these case studies is the manner in which Medicaid eligibility and enrollment are handled in processing applicants who are diverted from TANF.[7]

- ASPE has awarded grants totaling $2.9 million to 13 states and counties to study the outcomes of families who leave or are diverted from welfare.[8] All the grantees will link Medicaid and TANF files, as well as collect health insurance information via survey. Nearly all other states are conducting their own welfare "leavers" studies as well.

- The GAO plans a study of four to five states to explore the extent to which Medicaid enrollment trends are due to state-specific welfare variables.[9]

- The Kaiser Family Foundation (KFF) recently funded eight focus groups in California to learn more about how well low-income families with uninsured children understood their Medicaid eligibility. KFF plans to fund a national survey of low-income people to profile eligible-but-not-enrolled individuals, document the reasons for non-participation, describe state policies and practices that pose barriers to enrollment, and identify promising outreach and enrollment strategies.

- Building on their earlier effort under *Assessing the New Federalism*, Ellwood and colleagues will conduct in-depth case studies in five states, focusing on state administrative procedures and practices for assuring that people leaving the welfare rolls are enrolled in Medicaid-only coverage. Analysis of longitudinal data on enrollees will supplement the work, and will have a sub-focus on use of transitional Medicaid for adults going to work.[10]

In addition to studies focused narrowly on welfare reform and its impacts, community studies with broader research interest may provide valuable data and information concerning health

insurance coverage of low-income populations, and a needed contextual framework for considering findings in this area:

Community Tracking Study, funded by the Robert Wood Johnson Foundation (RWJ), will collect extensive information on changes in health insurance coverage over several years.

"Cherlin project," a multi-disciplinary longitudinal study of low-income families in selected metropolitan areas, is focused primarily on the implications of welfare reform for child well-being. An HHS-funded supplement will explore how welfare reform affects the well-being of persons with disabilities.

Los Angeles Study of Families and Children (LASFC), conducted by RAND with over $7 million from NICHD, is a four-year longitudinal survey of children, their families, and their neighborhoods in LA. The study will bring together extensive survey information and administrative data that may illuminate the effects of welfare reform at the neighborhood level. ASPE is considering funding a supplement to obtain richer data on health insurance coverage.

Outreach

Both the public and private sectors are taking steps aimed at improving health insurance coverage for low-income families affected by welfare reform. These outreach initiatives entail identifying eligible children and families, as well as ensuring that they are enrolled.

Department Efforts: DHHS and its agencies are engaged in numerous activities to promote outreach. They include:

- efforts to educate state officials about Medicaid and CHIP outreach obligations and opportunities;
- bringing state officials together to share experiences and provide state perspectives;
- developing a "Working Families Initiative," which will include proposals to increase Medicaid coverage for low-income working families; and
- coordinating the Interagency Task Force on Children's Health Insurance Outreach.

Private Sector Efforts: Private sector groups have also directed substantial resources to examining potential problems for Medicaid resulting from welfare reform and to expanded outreach efforts.

- RWJ is creating a grant program to promote the development of state-wide coalitions of state welfare, Medicaid, and CHIP officials, to address outreach and enrollment, eligibility simplification, and coordination across health insurance programs.
- The Center on Budget and Policy Priorities has published several issue papers identifying problematic state welfare policies and promoting approaches that may help states extend Medicaid coverage to low-income working families.
- Families USA is seeking to support work by state groups that will focus on the impact of welfare reform on the insurance status of low-income families.

Endnotes

1. Section 1931 also gives States limited authority to use more restrictive eligibility criteria than those in place for AFDC as of July 16, 1996, and broad flexibility to use more liberal eligibility criteria.

2. Marilyn Ellwood and Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, Health Affairs (May/June1998).

3. Moffitt and Slade, *Health Care Coverage for Chldren Who are On and Off Welfare*, The Future of Children, Spring 1997.

4. General Accounting Office, *Welfare Reform: States Early Experiences with Benefit Termination* (1997).

5. For a discussion of the state studies (covering various periods between 1996 and 1998), see generally Mark Greenberg, Issue Paper: *Participation in Welfare and Medicaid Enrollment*, Kaiser Commission on Medicaid and the Uninsured (September 1998).

6. Embry Howell, Marilyn Ellwood et al., *The Impact of Welfare Reform on Medicaid Populations*, Mathematica Policy Research (Expected completion October 2000).

7. Kathleen Maloy et al., *Diversion as a Work-Oriented Welfare Reform Strategy: The Experiences of Five Local Communities*, The Center for Health Policy Research, George Washington University (Expected completion December 1998).

8. For brief descriptions of the grants awarded, see <http://aspe.os.dhhs.gov/hsp/isphome.htm>

9. General Accounting Office, *The Impact of Welfare Reform on Medicaid Enrollment,* by request for Reps. Coyne and Levin (Expected completion Spring/Summer 1999).

10. Marilyn Ellwood, et al., *Moving from Welfare/Medicaid to Medicaid Only Coverage for Families*, Mathematica Policy Research (Expected completion January 1999).