

RECENT CMS PROPOSALS RELATED TO MEDICAID FINANCIAL MANAGEMENT

CMS has recently increased its scrutiny of Medicaid financing arrangements. In January, CMS' plans to begin prospectively reviewing state Medicaid budgets became public. Soon afterward, the Administration made proposals in the President's Budget to institute new Medicaid program integrity activities, saving the federal government \$1.5 billion in FY 2005 and \$23.5 billion over 10 years. This package contains some of the available documents describing CMS' plans, along with a letter from the National Association of State Medicaid Directors responding to some of the potential changes:

- Sections of the President's Budget and the HHS budget description, released February 2, that describe new CMS program integrity proposals;
- A draft letter to state Medicaid directors CMS has been developing that would require prospective financial management of state Medicaid budgets;
- A January 7 *Federal Register* notice announcing changes to the CMS Form-37, which would make operational the changes described in the CMS draft state Medicaid director letter. This notice was withdrawn on February 20.
- A January 27 letter from David Parrella, Chair of the Executive Committee of the National Association of State Medicaid Directors, outlining NASMD's concerns about the CMS draft letter and *Federal Register* notice.
- A response letter from HHS Secretary Tommy Thompson to Governor Kempthorne in his capacity as Chairman of the National Governors Association agreeing that the comment period for CMS-37 was not sufficient and committing to republishing the notice after consultation with NGA and NASMD.

CMS is likely to continue its focus on Medicaid financial management. It plans to begin consultations with states about its plan to prospectively review state Medicaid budgets, after which plans to move forward with the January proposal or something similar to it. CMS is also more aggressively reviewing state plan amendments and waivers to ensure that these meet CMS' financial management goals. At the same time, CMS may introduce legislation to implement the program integrity proposals in the President's Budget.

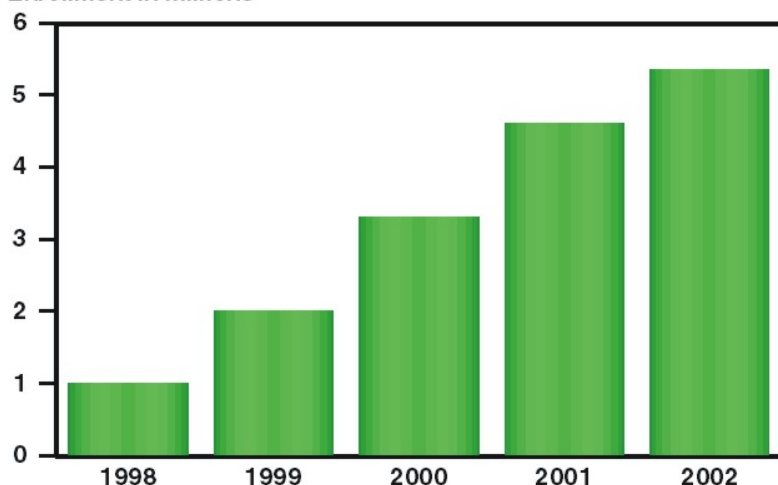
Medicaid and the State Children's Health Insurance Program Overview

Medicaid. Close to 42 million individuals were enrolled in Medicaid in 2003. Medicaid covers approximately one-fourth of the Nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services in the United States. In 2003, the elderly and those with disabilities represented approximately 30 percent of Medicaid beneficiaries but accounted for two-thirds of its spending. Total Medicaid spending will be an estimated \$322 billion (\$182 billion Federal share) in 2005.

State Children's Health Insurance Program (SCHIP). SCHIP was established in 1997 to make available approximately \$40 billion over 10 years for States to provide health care coverage to low-income, uninsured children. SCHIP gives States broad flexibility in program design while protecting beneficiaries through Federal standards. Since the beginning of the Administration, enrollment in SCHIP has grown by over 1 million children, to approximately 5.3 million in 2002.

SCHIP Enrollment

Enrollment in millions



Source: Centers for Medicare and Medicaid Services.

The SCHIP redistribution law (P.L. 108-74), signed by the President in August 2003, prevented over \$2 billion in unspent SCHIP funds from expiring and helped alleviate the effect of declining SCHIP funding allocations between 2002 and 2004 for States ramping up their programs. This law will allow States to continue coverage for children who are currently enrolled.

Medicaid and SCHIP Modernization. Over the past year, the Administration has held productive discussions with stakeholders on ways to modernize the Medicaid and SCHIP programs based on an Administration proposal included in the 2004 Budget. A common complaint among States is that the complex array of Medicaid laws, regulations, and administrative guidance is confusing, overly burdensome, and serves to stifle State innovation and flexibility. The creation of the SCHIP program created new opportunities for States, but because rules governing Medicaid and SCHIP differ in significant respects, coordination of the two programs has proven difficult. As a result, States frequently request waivers to tailor their Medicaid and SCHIP programs to their specific insurance markets or to expand eligibility to the uninsured beyond mandatory groups.



A mother accompanies her daughter to a doctor's visit.

States' years of experience with implementing home- and community-based waiver programs, waiver programs to extend Medicaid coverage to higher income and non-traditional populations, and the SCHIP program provide States with a wealth of knowledge and a multitude of strategies to design more efficient and effective programs. Further, in August 2001, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. Eight States currently have HIFA waivers. Approximately 175,000 people are currently covered under these waivers with another 585,000 people anticipated to be enrolled. These experiences give States knowledge of the flexibility they need to design tailored, innovative approaches to increase access to health insurance coverage for the uninsured. The Administration remains committed to enacting legislation, which will reform Medicaid and SCHIP to give States as much flexibility as possible with predictable financing.

As with last year, all Medicaid and SCHIP funding would be combined and provided to States selecting this option. The allotment option requires States to provide a specified benefit package for current Medicaid beneficiaries whose coverage is mandated by law.

Medicaid and SCHIP Program Integrity. One of the Administration's continuing priorities for Medicaid and SCHIP is ensuring their fiscal integrity. The 2005 Budget proposes to build on past efforts to improve Federal oversight of these programs and to ensure that Federal taxpayer dollars for Medicaid are going to their intended purpose.

- *Financial Management.* In 2005, HHS will continue to devote more resources to Medicaid and SCHIP financial management. This effort will include increasing the number of audits and evaluations of State Medicaid programs, measuring improper payments, and elevating the importance of financial management oversight at CMS. The Budget proposes to allocate \$20 million from the Health Care Fraud and Abuse Control program to help finance this initiative.
- *Intergovernmental Transfers and Upper Payment Limits.* Medicaid's open-ended financing structure encourages efforts to draw down Federal matching funds in any way possible, some of which are not appropriate. These financing practices undermine the Federal-State partnership and jeopardize the financial stability of the Medicaid program.

In 2001 and 2002, the Congress and the Administration took steps to curb the "upper payment limit" loophole. Through this loophole, States made excessive Federal Medicaid payments to local government-owned hospitals and nursing homes without a corresponding State contribution. In many cases, the providers

returned all or a portion of the payments to the State via an intergovernmental transfer (IGT). IGTs are money transfers from one level of government to another; for example, from a county hospital to a State government. Once the funds are returned to the State they may be used for other purposes, such as paying for non-Medicaid or even non-health related activities.

The Administration proposes to further improve the integrity of the Medicaid matching rate system by proposing steps to curb IGTs that are in place solely to avoid the legally-determined State financing.

The Administration also proposes to cap Medicaid payments to individual government providers to no more than the cost of providing services to Medicaid beneficiaries. Under current law and regulation, States continue to have ample opportunities to make excessive payments to individual government providers far above their costs for the purpose of leveraging additional Federal dollars. Limiting Federal reimbursement to no more than cost would curb excessive payments and still preserve a State's ability to pay reasonable rates to such providers. These actions would help promote fiscal integrity and ensure that Federal taxpayer dollars are being used appropriately to serve the important mission of Medicaid.

Improving Options for People with Disabilities and Long-Term Care Needs. The Budget includes several policies that promote home- and community-based care options for people with disabilities and appropriate planning for an individual's long-term care needs. Many of these policies build on the New Freedom Initiative announced by the President on February 1, 2001. The New Freedom Initiative is part of a nationwide effort to integrate people with disabilities more fully into society.

In July 2003, the Administration submitted the New Freedom Initiative Medicaid Demonstrations Act of 2003 legislation.



A senior goes for a walk.

- *New Freedom Initiative.* This initiative comprises four demonstrations to promote home- and

community-based care for children and adults with disabilities. Two of the demonstrations provide respite care for caregivers of disabled children and adults. The third demonstration will test the effectiveness of providing home- and community-based alternatives to psychiatric residential treatment for children enrolled in Medicaid. The fourth demonstration will continue to test ways to alleviate workforce shortages of direct care workers in the community.

- *“Money Follows the Individual” Rebalancing Demonstration.* This five-year demonstration would finance Medicaid services for individuals who transition from institutions to the community. Federal grant funds would pay the full cost of home- and community-based waiver services for one year, after which the participating States would agree to continue care at the regular Medicaid matching rate.
- *Protecting Medicaid Coverage for Spouses of Certain Workers with Disabilities.* States would be given the option to continue Medicaid eligibility for the spouses of individuals with disabilities who return to work. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse’s Medicaid eligibility. This proposal would extend to spouses the same Medicaid coverage protection offered to workers with disabilities.
- *Presumptive Eligibility for Home and Community Based Care Services.* This proposal establishes a State option allowing Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community.
- *Systems Change Grants.* The Budget proposes \$40 million to continue the Real Choice Systems Change grants to provide financial assistance for States to develop systems that support community-based care alternatives for people with disabilities who require an institutional level of care.
- *Consumer Direction.* In addition to the above proposals, the Budget includes a new proposal that would give States the option of allowing individuals who self-direct all of their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income (SSI). Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid or SSI.
- *Long-Term Care Options.* The Budget would promote the use of long term care (LTC) insurance by eliminating the ban on LTC Partnership programs. Through Partnership programs, consumers who purchase and use Partnership-approved insurance can become eligible for Medicaid services after their insurance coverage is exhausted without having to divest all of their assets, as is typically required.

Continuity of Coverage for Special Populations. The Budget includes policies to improve or continue health coverage already available through certain programs.

- *Transitional Medical Assistance (TMA).* TMA provides health coverage for former welfare recipients after they enter the workforce. TMA extends up to one year of health coverage to families who lose Medicaid eligibility because of employment earnings.

The Budget proposes to extend TMA for five years with statutory modifications, including a State option to eliminate TMA reporting requirements and provide 12 months of continuous eligibility regardless of changes in families’ financial status. In addition, the Budget proposes a waiver of the TMA requirement for States that currently provide health benefits for families at 185 percent of the Federal poverty level, which is the statutorily mandated income eligibility level. These changes will allow for consistent enrollment of TMA beneficiaries while easing the administrative burden on States.

- *Premium Assistance for Low-income Medicare Beneficiaries.* Medicare beneficiaries whose income falls between 120 and 135 percent of poverty and who meet the asset test are eligible to have their Part B premiums covered by the Medicaid program. These premiums rose by 13.5 percent in 2004, to \$800 per year (\$66.60 per month), a considerable amount for these individuals. The Administration proposes

to extend this program for one year. States receive 100 percent Federal funding for these benefits.



A young child waits for her vaccination shot.

- *Vaccines for Children (VFC)*. The VFC program provides free vaccine to four groups of categorically-eligible children: Medicaid recipients, American Indians and Native Alaskans, the uninsured, and the underinsured (those whose insurance does not cover vaccinations). VFC covers all childhood vaccinations recommended by the Advisory Committee on Immunization Practices.

The Administration is proposing legislation to change two provisions of VFC. Both changes will improve vaccine access for VFC-eligible children. First, the Administration proposes to lift the price cap on the tetanus-diphtheria booster, which will facilitate its availability at no cost to VFC-eligible children. Second, the Administration is proposing to allow underinsured children to receive VFC-funded vaccines at State and local health clinics, rather than only at Federally Qualified Health Centers and Rural Health Centers, as is currently required.

Helping the Uninsured

The Administration has worked to give more Americans affordable, high-quality insurance coverage through a number of proposals.

Health Savings Accounts (HSAs). When the President signed the Medicare reform legislation into law, Americans gained access to health savings accounts. HSAs allow individuals to buy less expensive high-deductible plans and to save pre-tax dollars for out-of-pocket medical expenses. In addition to these savings, under a new Administration proposal, individuals participating in HSAs would be allowed to deduct their premiums for the high-deductible insurance plan from their taxable income. HSAs are available to everyone who has a high-deductible plan, which is defined as having an annual deductible of at least \$1,000 for individual coverage and at least \$2,000 for family coverage. Individuals, their employers, or both can contribute funds up to the amount of the deductible, subject to a cap of \$2,600 for individuals and \$5,150 for families. The money not spent would stay in the account and earn interest tax-free. People over age 55 can contribute additional money to the account without penalty. These accounts will help more American families get the health care they need at a price they can afford.

Trade Adjustment Assistance Reform Act of 2002 (TAA) Tax Credit. The Trade Adjustment Assistance Reform Act of 2002 provides assistance to Americans who lose their jobs because of trade. Individuals certified to receive TAA benefits and individuals between the ages of 55 and 64 receiving benefits from the

Table S-8. Mandatory Proposals
(In millions of dollars)

	2004	2005	2006	2007	2008	2009	Total	
							2005-2009	2005-2014
Agriculture:								
Forest Service Recreation Fee Proposal	—	—	-17	-12	-7	-2	-38	—
Extend expiring National School Lunch Act provisions	11	18	—	—	—	—	18	18
Subtotal, Agriculture	11	18	-17	-12	-7	-2	-20	18
Education:								
Reform the Federal Student Loan Programs to Help Students Afford College:								
Expand Teacher Loan Forgiveness	—	227	50	52	54	57	440	763
Retain Variable Interest Rates	—	—	103	200	198	175	676	1,783
Increase Loan Limits for First-Year Students from \$2,625 to \$3,000	—	20	58	75	78	82	313	775
Standardize FFEL and DL Extended Repayment Plans	—	184	112	-33	41	86	390	1,022
Additional Benefits to Students	—	251	286	373	293	287	1,490	3,062
Subtotal	—	682	609	667	664	687	3,309	7,405
Standardize Guaranty Agency Insurance Premium	—	-497	-352	-337	-339	-341	-1,866	-3,952
Eliminate Rollover	—	-490	-448	-418	-430	-456	-2,242	-4,949

of Tax-Exempt Special Allowance								
Other Student Loan Reforms	—	116	-65	-92	-95	-90	-226	-807
Subtotal, Education	—	-189	-256	-180	-200	-200	-1,025	-2,303
Energy:								
Reclassification of Nuclear Waste Disposal Fees as discretionary	—	749	754	757	767	767	3,794	7,655
Arctic National Wildlife Refuge (ANWR), lease bonuses	—	—	-1,200	—	—	—	-1,200	-1,200
Subtotal, Energy	—	749	-446	757	767	767	2,594	6,455
Health and Human Services (HHS):								
Medicaid/State Children's Health Insurance Program:								
Medicaid proposals	175	889	846	959	1,098	1,252	5,044	7,863
Program Integrity	—	-1,542	-1,737	-1,924	-2,120	-2,327	-9,650	-23,553
Temporary Assistance for Needy Families Reauthorization	96	279	328	337	350	361	1,657	3,390
Healthy Marriages:								
Healthy Marriage and Family Formation Initiative	-118	-59	13	38	40	40	72	272
State-based	9	30	45	49	50	50	224	474

CENTERS FOR MEDICARE & MEDICAID SERVICES

Mission: *The Centers for Medicare & Medicaid Services' mission is to assure health care security for beneficiaries.*

The FY 2005 budget request for the Centers for Medicare & Medicaid Services (CMS) is \$482.1 billion in net outlays. The request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and CMS operating costs. This budget reflects an increase of \$29.1 billion over FY 2004.

On December 8, 2003, President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) into law. This is the most significant overhaul of the Medicare program since its inception in 1965, adding a long overdue prescription drug benefit and expanded health choices

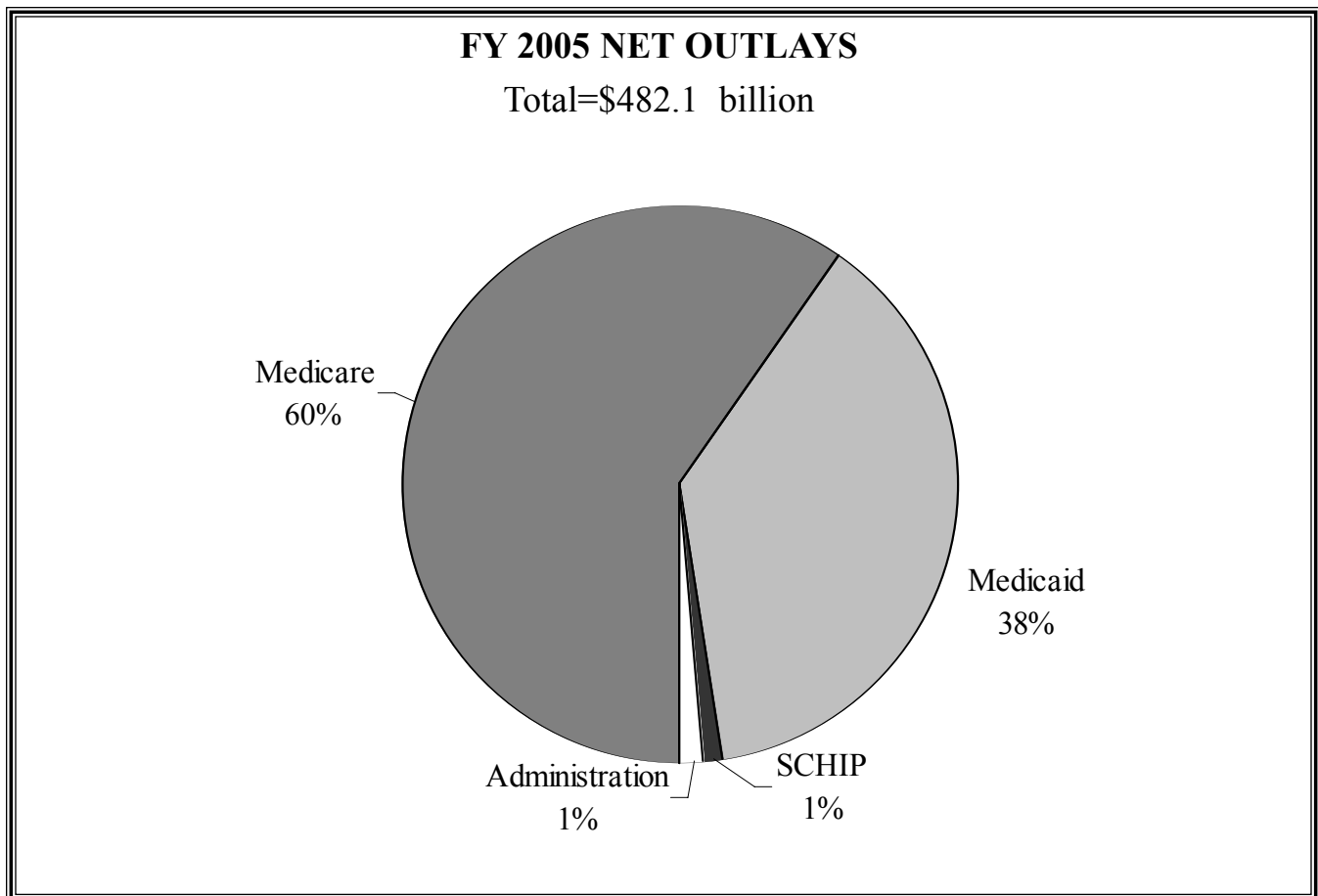
for seniors. A top priority for CMS and HHS will be the timely implementation of the sweeping changes in the law, starting with providing Medicare beneficiaries a discount prescription drug card by June 2004.

Building upon the success of the Health Insurance Flexibility and Accountability (HIFA) and Pharmacy Plus waivers, the Administration plans to work diligently with the Congress to develop a Medicaid modernization plan. This plan would introduce more State flexibility and fiscal stability into the program. As under last year's proposal, States will have the option of receiving their SCHIP and Medicaid funding together in an allotment. The allotment option requires States to provide a

specified benefit package for current Medicaid beneficiaries whose coverage is mandated by law.

The budget also includes significant new efforts to extend services to the disabled and those in need of long-term care services through the New Freedom Initiative. In addition, it provides assistance to vulnerable populations transitioning from welfare to work through the extension of the Transitional Medical Assistance Program.

Finally, the budget proposes to restrict the use of certain intergovernmental transfers and cap Federal payments to individual State and local providers. This will improve program integrity and help stem the tide of rising costs in the Medicaid program.



grow by \$2.4 billion, or 13 percent, between FY 2004 and FY 2005. The State-estimated increase for prescription drugs accounts for 41.2 percent of the total FY 2005 benefit growth.

Waivers: States have sought waivers under section 1115 of the Social Security Act to expand health care coverage to low-income, uninsured populations and to test innovative approaches in health care service delivery. Many of the demonstrations include the Temporary Assistance for Needy Families (TANF) and related populations, and some include the elderly and the disabled. Although demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care for the Medicaid population.

To date, CMS has approved 27 Statewide comprehensive health care reform demonstrations in 23 States. CMS has also approved two sub-State health reform demonstrations and 12 demonstrations specifically related to family planning.

Health Insurance Flexibility and Accountability (HIFA): In August 2001, President Bush announced the Health Insurance Flexibility and Accountability (HIFA) demonstration, a new section 1115 initiative. HIFA enables States to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income, uninsured individuals, with a focus on those with incomes at or below 200 percent of the Federal Poverty Level.

A more in-depth discussion of HIFA waivers is included in the SCHIP section.

Pharmacy Plus: The Administration developed the Pharmacy Plus waivers under section 1115 to help low-income seniors and people with disabilities who need assistance with prescription drug costs. Pharmacy Plus is directed to Medicare beneficiaries

and other low-income seniors and people with disabilities with income of 200 percent or less of the Federal Poverty Level (FPL) who are not eligible for full Medicaid benefits. Four states have approved Pharmacy Plus demonstrations (Florida, Illinois, South Carolina, and Wisconsin) and Maryland has revised its Statewide 1115 demonstration to add a pharmacy benefit.

The Administration is working to address how the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) will effect the management of the Pharmacy Plus initiative.

MEDICAID AND SCHIP REFORM

The past year has witnessed increasing dialogue on the subject of Medicaid and SCHIP modernization. States have continued to express concerns about the complexity of administering the Medicaid program. Federal regulation of the Medicaid program is an increasing burden on the ability of the States to address the unique needs of their low-income uninsured residents. The Secretary is encouraged by the current discussion and will look for new and innovative ways to address these concerns in the coming year. Building on the foundation of last year's Medicaid and SCHIP modernization proposal, the Secretary will work with Congress to pass an option for States to receive Medicaid and SCHIP funds in the form of flexible allotments. This strategy will provide States with the greatest potential for innovation and stability of funding.

MEDICAID LEGISLATIVE PROPOSALS

New Freedom Initiative Demonstrations: The President's Budget repropose three demonstration projects under the New Freedom Initiative. Each promotes at-home care as an alternative to institutionalization. The demonstrations are:

- ◆ Respite services to the caregivers of disabled adults.
- ◆ Respite services to caregivers of children with severe disabilities.
- ◆ Home and community-based services for children currently residing in psychiatric residential treatment facilities.

These three demonstrations will cost \$13 million in FY 2005, and \$256 million over five years. They will be funded out of mandatory Medicaid dollars.

There is a fourth demonstration project that addresses shortages of community direct care workers. This project is funded out of the CMS Research, Demonstrations, and Evaluation budget and costs \$2.9 million in FY 2005.

Money Follows the Individual Rebalancing Demonstration: The Administration is also committed to promoting the use of at-home care as an alternative to nursing homes for elderly and disabled Americans. Under the "Money Follows the Individual" demonstration, at-home care combines cost effective benefits with increased independence and quality of life for the beneficiary.

In this five-year demonstration project, Federal grant funds would pay for home and community-based waiver services for individuals who move from institutions into at-home care. These costs would be funded at a matching rate of 100 percent for the first year of each individual's participation. As a condition of receiving the enhanced match, the participating State would agree to continue care after the first year at the regular Medicaid matching rates and to reduce institutional long-term care. This demonstration will have no cost in FY 2005 and will cost \$500 million over five years.

Living with Independence, Freedom, and Equality (LIFE) Accounts: Under this proposal, States would have the option of

allowing individuals who self-direct all of their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income (SSI). Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid or SSI. This legislative proposal is estimated to be cost neutral.

Spousal Exemption: This proposal extends eligibility for Medicaid benefits to the spouses of individuals with a disability individuals entering the workforce. The lack of spousal coverage is a significant impediment to employment for many low-income individuals with a disability, and this exemption smooths the road to independence. The Federal government will invest \$17 million in this program for FY 2005 and \$102 million over five years.

Presumptive Eligibility for Community-Based Services: This proposal will establish a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community. This will increase the number of Medicaid beneficiaries who receive home and community-based services rather than institutional care. This proposal will have no effect on the Medicaid budget.

Extension and Simplification of Transitional Medical Assistance (TMA): TMA was created to provide health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare benefits due to earnings from work. This provision was enacted along with welfare reform and was scheduled to sunset in September 2001. Congress has extended this program under PL 108–89 through March 31, 2004.

In addition to this extension, the 2005 President's Budget includes proposals to simplify eligibility for TMA benefits to the low-income working poor. There are three provisions to the proposal.

- ◆ States will be given the option to offer 12 months of continuous coverage to eligible participants.
- ◆ States may waive income reporting requirements for beneficiaries.
- ◆ States that offer Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements.

This proposal will cost \$558 million in FY 2005 and \$3.24 billion over five years.

Partnership for Long Term Care:

This proposal would eliminate the legislative prohibition on developing more Partnership programs. The Partnership for Long Term Care (LTC) was formulated to explore alternatives to current long-term care financing by blending public and private insurance. Four States (California, Connecticut, Indiana, and New York) currently have these partnerships whereby private insurance is used to cover the initial cost of LTC. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria. This proposal has no costs associated with it.

Extension of Premium Assistance to Qualified Individuals (QI): Under the QI program, Medicaid pays Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent of poverty. Currently Part B premiums cost about \$799 a year. The Administration recognizes the economic burden these premiums

place on low-income beneficiaries and proposes to extend the QI benefit through FY 2005. States will continue to be fully reimbursed for the cost of the program. This extension is estimated to cost \$136 million in FY 2005.

Disability Determination Proposal:

The Social Security Administration has proposed a management improvement that has a Medicaid impact. The proposal requires that 50 percent of all favorable adult disability benefit decisions be reviewed to verify eligibility. The program will save money in the Medicaid program by insuring that only legally disabled individuals are eligible for Medicaid services due to their SSI status. The proposal saves the Medicaid program \$3 million in FY 2005.

Improvements to the Vaccines for Children (VFC) Program:

VFC is a CDC administered, Medicaid funded program that administers free vaccines to eligible children. The Administration is proposing two legislative changes to the program. First, the President's Budget proposes to lift the price cap on the tetanus-diphtheria booster, thereby increasing access for VFC eligible children. Second, the President's Budget would allow under-insured children to receive VFC administered inoculations at State and local health departments in addition to Federally Qualified Health Centers and Rural Health Centers. These proposals will cost an additional \$165 million in FY 2005.

Medicaid Program Integrity:

Throughout the life of the Medicaid program, States have used intergovernmental transfers (IGT) as a means of inappropriately drawing down inordinate amounts of Federal Medicaid funding. Past State funding mechanisms that manipulated the Medicaid Upper Payment Limit, Disproportionate Share

Hospital payments, and provider taxes and donations would have been impossible without the use of intergovernmental transfers. The FY 2005 President's Budget proposes to further improve the fiscal integrity of Medicaid by curbing IGTs that are in place solely to undermine the statutorily determined Federal matching rate. The budget proposes to cap Medicaid payments to individual State and local government providers at the cost of providing services to Medicaid beneficiaries and restrict the use of certain intergovernmental transfers. This proposal will save the Federal Government \$1.5 billion in FY 2005 and \$9.6 billion over five years.

Child Support Enforcement

Proposals: The Administration for Children and Families (ACF) has proposed two changes that have an effect on the Medicaid baseline. Both proposals affect the Child Support Enforcement program. The first proposal would allow States to seek medical child support for children from both the custodial and non-custodial parent. States would also be able to enforce these support orders against the custodial parent. ACF expects this change to increase children's access to private sources of health care.

The second legislative change mandates that all States review child support orders for Temporary Assistance for Needy Families (TANF) families every three years. Under current law, States review child support orders every three years if instructed to do so by the custodial parent or at the State's own discretion. This change would mandate that States undertake these reviews. ACF believes that required reviews would result in the discovery of increased levels of private health insurance among non-custodial parents. This increased access to private health insurance would lead to a decrease in Medicaid costs among TANF families.

These two proposals will be budget neutral in FY 2005, but will save the Federal Government \$50 million over five years.

Refugee and Asylee Exemption

Extension: Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date are not eligible for SSI until they have resided in the country for five years or have obtained citizenship. Refugees and asylees on SSI are currently exempted from this ban for the first seven years they reside in the United States. Procedural delays and asylee waiting lists have created a situation in which seven years may not be enough for these groups of immigrants to gain American citizenship. To assure that refugees and asylees have ample time to complete the citizenship process, the President's Budget proposes extending the current seven year exemption to eight years. The policy would continue through 2007. The proposal will cost the Federal Government \$29 million in FY 2005 and \$132 million over five years.

Temporary Assistance for Needy Families (TANF) Cost Allocation

Adjustment: This FY 2005 appropriations language proposal will reduce the Federal reimbursement for administrative costs of Medicaid by \$300 million to reflect the share assumed in the Temporary Assistance for Needy Families (TANF) block grant and will prohibit States from using TANF funds to pay these costs during FY 2005. In the past, costs common to AFDC, Medicaid and Food Stamps were charged to the former AFDC program and included in each State's TANF base year. This proposal allows the recovery of amounts that were funded in the TANF block grant that States now charge to Medicaid. This one time reduction will eliminate the dual payment to States for certain administrative costs in the administration of the Medicaid

program that was created by the TANF welfare reform legislation. This proposal will be in effect for only FY 2005, and will save approximately \$300 million for the Federal Government.

Reduce the Enhanced Federal Matching Rate for Information and Claims Management Systems:

Under current law States receive a 90 percent matching rate on all expenditures related to the design, development, and implementation of Medicaid claims processing and information retrieval systems. A new proposal, included in the FY 2005 Medicaid appropriations request, would reduce this matching rate to 75 percent, which is consistent with other enhanced matching rates. This one-year change will save the Federal Government approximately \$80 million in FY 2005.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations

SMDL #03-

DRAFT

Dear State Medicaid Director:

Over the last decade states have initiated a number of financing mechanisms to enhance the allowable Federal funding for their Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General reviews of these programs have resulted in the identification of a number of potential disallowances of Federal funds involving billions of dollars that have accumulated over the years. The large amount of the funding in question has made it difficult for CMS to recover the improperly spent funds and correct the issues involved.

CMS' financial management oversight has traditionally been performed through reviews of historical claims. Specifically, funds were advanced to a state at the beginning of each quarter, but CMS would generally not review expenditures to identify improper payments until after a financial management review was completed on the state's quarterly expenditure report. Since this review was generally retrospective, states were faced with repaying large amounts of Federal funding. These repayments resulted in states experiencing disruptions in state budgets, problems in maintaining provider payments, and concerns over continued availability of services to beneficiaries.

To address these long standing problems, CMS will implement a prospective financial management review process. This new process will establish a stable funding mechanism for the State Medicaid programs as well as assure accountability, prospective predictability and public confidence in the financing processes for the Medicaid program. Specifics of this new prospective oversight program follow.

Beginning with state fiscal year 2005 each state will submit to the appropriate CMS Regional Office, at least 150 days prior to the commencement of each state fiscal year, its preliminary Medicaid budget (i.e. services and administration). At a minimum this submission will include:

- The total budget for medical assistance expenditures of the single state agency (including the identification of Federal and non-Federal funding sources);
- Budgets for medical assistance expenditures made by other state agencies, which will be the basis for claims for Federal matching funds;

- Budgets for medical assistance expenditures made by non-state governmental units (e.g., public hospitals, County Health Departments), which will be the basis for claims for Federal matching funds; and
- Budgets for administrative costs either directly charged or allocated to the Medicaid program under approved cost allocation plans.

Each submission should also include a listing and estimated amounts of all of the state funding sources for the non-Federal share of expenditures pursuant to the Medicaid budget. “State funding sources” refers to all sources for the non-Federal share of Medicaid expenditures. Funding sources can include the state general fund, separately maintained trust funds, other state appropriations and non-state public expenditures. State funding sources also include revenues (whether deposited in the General Fund or other funds) derived from health care providers, or from governmental units on account of health care expenditures, as well as interagency or intergovernmental transfers related to health care expenditures or from an entity related to health care. The state shall provide information on all funding sources reasonably related to the non-Federal share of Medicaid expenditures

All budgets should list expenditures in the same categories that are reported on the CMS-64 forms. Each source of state revenue that meets the definition of a health-care related tax or a provider-related donation under section 1903(w) of the Social Security Act (the Act) will be separately identified and should be accompanied by a showing to support its treatment under the principles set forth in section 1903(w) of the Act and the implementing regulations.

Upon request, the state will provide additional documentation reasonably requested by CMS to facilitate its review of the state’s submission. Update reports will be provided every 30 days to CMS on the status of the budget. These updates will include any significant new expenditure categories or state funding sources under consideration. Once the final state budget is adopted, the State will submit a final Medicaid budget for CMS review, including the estimated amount of each funding source and a description of each of the funds and funding sources expected to finance the non-Federal share of the Medicaid expenditures.

CMS will advise the state no later than 45 days after receipt of the state’s submission of its final Medicaid budget of any proposed state-funding source that CMS believes is not allowable under Federal law and regulations. If necessary, CMS and the state will meet and discuss issues raised with respect to any funding source that CMS had questioned. If after review and negotiation, CMS adheres to a determination that a state funding source is not compliant with Federal law and regulations, CMS will defer and disallow claims related to budget items, including funding sources, that have not been reviewed and accepted by CMS in the financial review process. As a consequence, states may need to modify their budget and funding sources.

As part of its prospective review CMS will provide the state with a written determination of any proposed expenditure which it believes lacks outstanding state plan authority, waiver authority or other authority for Federal financial participation (FFP), or that the expenditure is otherwise not

subject to FFP. If the state continues to believe that there is authority for the proposed expenditure and that it is subject to FFP, the state may retain the expenditure in the Medicaid

Budget, but CMS will be free to utilize any authority in statute or regulation to question or withhold FFP.

The state may submit to CMS supplemental budget amendments to incorporate any previously unbudgeted expenditure. Supplemental budget amendments may be based on:

- Service utilization changes;
- Increases in eligibles;
- Increases in the number of providers; and
- And/or increases in cost of services or administration.

The state's supplemental budget submission will also show the funding sources from which the non-Federal share of the cost of the increased expenditures will be obtained. CMS will review the non-Federal funding sources and notify the state within 45 days of any state funding sources that it believes does not comply with applicable Federal law. CMS will then defer or disallow any claims that are based on unacceptable state funding sources.

The supplemental budget amendment may be submitted at any time but would normally be submitted at the same time that a supplemental budget request is made to the state legislature. CMS will approve any supplemental budget amendment provided that it covers allowable expenditures and the state has demonstrated a valid funding source for the non-Federal share of the expenditures.

The prospective financial management review process will establish the framework for allowable expenditures for purposes of drawing FFP. Federal grants will be predicated on the level of expenditures contained in the approved state submissions. The current process for grant awards, draws of Federal funds, and reporting expenditures shall continue to be employed. However, the state will not draw any Federal funds to cover new expenditures, including those that would require a new state plan amendment, waiver amendment or new contracts, unless and until the expenditures are approved and the state funding sources are accepted through the supplemental budget process and applicable state plan or other Federal authorization process.

Current Federal cash management protocols will be applicable to the state's draw and use of Federal funds.

The state plan and waiver submission processes contained in existing statutes and regulations will be utilized. The supplemental budget process will be used for the state to submit the funding sources to cover the non-Federal share of the additional expenditures. The state will not claim expenditures under any state plan amendments until they are approved by CMS. The state, however, remains free to pay for services covered by pending state plan amendments with state-only funds, pending approval of the plan amendment and the Medicaid budget amendment by CMS. At which time the state will be entitled to draw Federal funds for the Federal share of all expenditures covered by the approved amendment from the time of its approved effective date.

The CMS recognizes the desirability of avoiding, where possible, challenges to state expenditures that could result in retroactive recoveries of previously spent Federal funds or that are based on technical grounds rather than on substantive Federal law limitations. This prospective financial management review processes is not intended to limit the ability of CMS to question the entitlement of the state to receive FFP for any expenditure, and to apply prospectively any determination as to the availability of FFP. CMS does not intend, however, to seek to recover such FFP, through disallowance, deferral or other actions, unless the ground of ineligibility of the specific expenditure for FFP has been clearly established in law, regulation, or policy issuance available to the state prior to the time the expenditure was made. A state can exercise all rights available to it under Federal law or regulations in the event CMS takes any deferral, disallowance, or other action with respect to a claim for FFP in Medicaid expenditures.

I look forward to working with you to implement this new prospective oversight process which will ultimately enhance the effectiveness of the Medicaid program. I believe this new process will reduce the magnitude of financial disputes between states and the Federal government, ensure the financial integrity of the Medicaid program and allow us all to focus our attention on meeting the needs of beneficiaries.

If you have any questions or need additional assistance, please contact

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

State Program Integrity Directors

Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association

Page 5 – State Medicaid Directors

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Mathews
Senior Health Policy Analyst
Council of State Governments

FEDERAL RESERVE SYSTEM**Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies**

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than January 20, 2004.

A. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63166-2034:

1. *Marantz Group, LP*, Springfield, Illinois and its general partner, Tom E. Marantz, Springfield, Illinois; to retain voting shares of Staun Bancorp, Inc., Staunton, Illinois, and thereby indirectly retain voting shares of First Community State Bank, Staunton, Illinois.

2. *Joseph Thomas McLane*, Poplar Bluff, Missouri; to become a trustee of Midwest Bancorporation Inc. and Affiliates Employee Stock Ownership Plan, Poplar Bluff, Missouri, and thereby indirectly gain control of Midwest Bancorporation, Inc., Poplar Bluff, Missouri, First Midwest Bank of Carter County, Van Buren, Missouri, First Midwest Bank of Dexter, Dexter, Missouri, and First Midwest Bank of Piedmont, Piedmont, Missouri.

Board of Governors of the Federal Reserve System, December 31, 2003.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 04-249 Filed 1-6-04; 8:45 am]

BILLING CODE 6210-01-S

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Center for Medicare and Medicaid Services**

[Document Identifier: CMS-37]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

Agency: Center for Medicare and Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Center for Medicare and Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We are, however, requesting an emergency review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR Part 1320. We cannot reasonably comply with the normal clearance procedures because of possible public harm.

CMS is proposing to minimize disruption to State operations and the reduction of unnecessary expenditures to the Federal government by modifying the collection requirements associated with the CMS-37 information collection package. In particular, CMS will begin to require the States to submit up-front documentation to support the budget and expenditure information currently captured on the CMS-37 "Medicaid Program Budget Report". This will enable CMS to identify and resolve any potential funding and/or expenditure

issues with the States prior to the budget actually being formulated and/or implemented and the expenditures actually paid and claimed by the States.

CMS is requesting OMB review and approval of this collection by January 9, 2004, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by January 8, 2004.

Type of Information Collection Request: Revision of a currently approved collection; *Title of Information Collection:* Medicaid Program Budget Report; *Form No.:* CMS-37, OMB # 0938-0101; *Use:* The Medicaid Program Budget Report is prepared by the State Medicaid Agencies and is used by CMS for (1) developing National Medicaid Budget estimates, (2) qualification of Budget Assumptions, (3) the issuance of quarterly Medicaid Grant Awards, and (4) collection of projected State receipts of donations and taxes; *Frequency:* Quarterly; *Affected Public:* State, local, and/or tribal governments; *Number of Respondents:* 56; *Total Annual Responses:* 224; *Total Annual Hours:* 8,064.

We have submitted a copy of this notice to OMB for its review of these information collections. To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Jburke3@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-4194.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below, by January 8, 2004:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Julie Brown, CMS-37, Room C5-16-03, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

and
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395-6974 or (202) 395-5167, Attn: Brenda Aguilar, CMS Desk Officer (CMS-37).



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

January 27, 2004

Dennis Smith, Acting Director
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Dennis:

First of all, let me express my long overdue congratulations on your well-deserved elevation to the head of CMS. It gives me particular satisfaction to know that someone who made their career working in Medicaid is now the head of Medicare. I hope that the discussions that we participated in last spring on the importance of the dual eligibles in any Medicaid reform proposal will help shape future policy on the roles and responsibilities of the two programs that you now administer.

Unfortunately, I am not encouraged about the future for the states in the light of the recent decisions on the CMS regulatory agenda that appeared recently in the Federal Register. I am referring to the "Semiannual Regulatory Agenda" that appeared in the Register on December 22, 2003 and the notice on the prospective budget review process that appeared on January 7, 2004.

As you know, NASMD has urged you to develop regulations with a full opportunity for public comment to reflect any change in the historical policies on issues such as Inmates of Public Institutions, Targeted Case Management, Home and Community-Based Services, and ICF/MRs. We have expressed our concern that any move by your agency to curtail the availability of federal financial participation for these services could have a disastrous impact on state Medicaid programs that continue to struggle with rising costs and slowly recovering revenues.

I would like to believe that the removal of these items from the regulatory agenda means that any re-thinking of the federal financial role has been set aside for now pending a larger discussion of a broader agenda for reform. As you know, I continue to personally support such a reform initiative. However, I fear that their removal from the regulatory agenda signals a return to an over-reliance on the "Dear State Medicaid Director" letter series, with little or no opportunity for consultation and review by the National Association of State Medicaid Directors (NASMD).

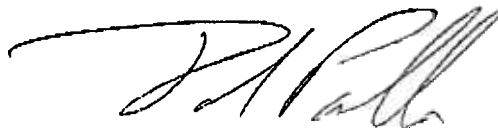
Our concerns with public process may prove to have been well-founded based on the notice published on January 7 with a breathtakingly brief comment period of 24 hours, justified by the need to reduce "paperwork". As I understand it, you are now saying that CMS may withhold federal funds pending a review of our proposed state budgets, a kind of "five questions" in advance.

The process described here sounds like an over-reaching on the part of CMS into the legislative process that confronts the states. Nor do I think that this tactic is the best way to move the states towards a goal that we both share, namely a fundamental re-thinking of the roles and limits on state and federal involvement in the financing of health care. Offering the states a capped appropriation as a way out of difficult conversations about their state share is not a federal/ state partnership.

Medicaid Directors and the Governors that they serve approach the idea of reform from a broad array of perspectives across the ideological spectrum. But I can assure you that they will all view with concern any administrative measure that makes fiscal reform an inescapable, if unpalatable choice.

Understanding the great demands on your time, I urge you to open a dialogue with my colleagues on the Executive Committee on these recent publications. I look forward to beginning that dialogue no later than our next face-to-face meeting of the Executive Committee at the end of March. I am available at your convenience to discuss these matters in advance of that meeting.

Sincerely,



David Parrella, Director
Medical Care Administration

Chair, Executive Committee
National Association of State Medicaid Directors

cc: NASMD Executive Committee
Kathy Kotula, APHSA



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

FEB 20 2004

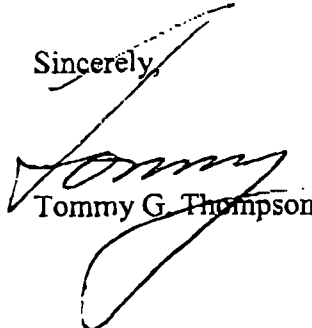
The Honorable Dirk Kempthorne
Governor of Idaho
Chairman, National Governors Association
444 North Capital Street, Suite 267
Washington, DC 20001-1512

Dear Governor Kempthorne:

Thank you for your letter concerning the January 7 *Federal Register* notice regarding Medicaid budget and expenditure implementation. This notice proposes revisions to the CMS-37 form that would enable prospective review by the Centers for Medicare & Medicaid Services (CMS) of key Medicaid budget and expenditure information.

I agree that the comment period provided for in the *Federal Register* notice was not sufficient to receive all the necessary input on the proposal. Therefore, I intend to enter into consultations on the proposal with the States through the National Governors Association and the National Association of State Medicaid Directors. Once those consultations are complete, I intend to republish the notice in the *Federal Register* and provide for a 60-day formal comment period. In this way, I believe that everyone will be afforded sufficient time to appropriately respond to the proposal. I can assure you that this proposal will not be implemented until this process is complete, and look forward to our consultations.

Sincerely,



Tommy G. Thompson