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MEDICAID AMENDMENTS RELATING TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

October 10 (legislative day, September 28), 1978.—Ordered to be printed

Mr. Long, from the Committee on Finance,
submitted the following

REPORT

together with
ADDITIONAL VIEWS

[To accompany H.R. 9434]

The Committee on Finance to which was referred the bill (H.R. 9434) to amend the Social Security Act to increase the dollar limitations and Federal medical assistance percentages applicable to the medicaid programs of Puerto Rico, the Virgin Islands, and Guam, having considered the same, reports favorably thereon with an amendment and an amendment to the title, and recommends that the bill, as amended, do pass.

I. Summary

The bill as passed by the House of Representatives provides for increasing the dollar limitations and Federal medical assistance percentages applicable to the medicaid programs of Puerto Rico, the Virgin Islands, and Guam. The committee made changes in the House-passed bill and extended the proposal to include the Northern Mariana Islands. In addition, the committee added an amendment to the bill dealing with other medicare and medicaid matters.

Title I of the bill increases the ceiling on Federal funding for the medicaid programs in Puerto Rico, the Virgin Islands, and Guam, and deletes the existing 50-percent limit on the Federal medical assistance percentage rate applicable to these jurisdictions. The bill further provides for Federal matching to the new ceilings to be determined by a formula based on per capita income and extends the proposal to include the Northern Marianas.

Title II of the bill would amend title XIX of the Social Security Act (which establishes the medicaid program) to make additional children eligible for medicaid coverage; increase the proportionate share of the costs of health assessments and outpatient treatment for medicaid children which is paid for by the Federal Government; provide incentives for more successful operation of health assessment and follow-up programs by the States; assure that all types of eligible health care practitioners and agencies may serve as CHAP providers for medicaid children; and provide for penalties (in the form of reduced matching of administrative costs) for States which do not meet minimum performance standards in their child health assessment programs (CHAP), and bonuses, in the form of increased matching for medicaid administrative costs, for those that perform exceptionally well; and for other purposes.

Specifically, the legislation would do the following:

1. Require States to provide medicaid for all individuals age 6 and under who are financially eligible under the State welfare or medicaid income standard, regardless of whether they are members of an intact family. (Current law requires States only to cover children in families where one parent is absent or incapacitated). Additionally, it makes Federal matching available to cover all financially eligible individuals up to the age of 21 if a State elects to provide medicaid to persons in this age group. All of these children are eligible for the medicaid services normally included in the State plan, including assessment services. Once a child has been assessed, that child would also be eligible for all medically necessary services (with some exceptions) whether or not the State plan makes specific provision for them.
2. Provides a 4-month extension of eligibility for medicaid beyond the point when the income and resources of the family exceed the financial eligibility standard for the program for any child who has received a health assessment, in order to assure adequate time to receive necessary services.
3. Allows Federal matching for medicaid coverage for adopted children who have been in foster care, and who were hard to place for adoption because of a handicapping or medical condition requiring medical care, regardless of the income level of the adopting family. This coverage would be at the option of a State.
4. Allows children who are inmates of public institutions to remain eligible for medicaid if they were eligible before entry into the facility. (Current law provides that eligibility ceases when a person becomes an inmate of a public institution which is not a medical institution).
5. Provides that all children who have received a health assessment are eligible for all treatment and services which could be paid for under medicaid, whether or not such treatment is included in the State plan except that no State would be required to provide services for mental illness except as covered in the State plan, care for the mentally retarded in an intermediate care facility, or dental care which is not routine. An assessed child would not be required to make copayments for any medicaid service.
6. Provides for an increase in the Federal matching rate for assessments, and for all noninpatient services provided to children who have been assessed (and reassessed at appropriate intervals).

The new Federal matching rate is the greater of 75 percent or halfway between the current medicaid matching rate and 90 percent.

7. Requires a maintenance of effort by States relative to services for children, as a condition for receiving the higher Federal matching rate; that is, for a 2-year period, the receipt of the increased Federal matching would be conditioned on a State taking no action that would reduce both the scope and extent of Medicaid coverage and State share of spending for children.

8. Repeals (retroactive to original enactment) the penalty provision of current law for States which fail to meet certain requirements of the early and periodic screening, diagnosis, and treatment (EPSDT) program and replaces it with a provision for a 20-percent decrease in the Federal share of medicaid administrative costs for States which fail to meet certain minimum CHAP performance standards established by the Secretary. The Secretary would have the authority to delay imposition of the penalty for 6 months where he found a State was making a good faith effort to comply and to waive it if compliance is achieved in that time period. The legislation also provided for a bonus in the form of a 25-percent increase in matching for administrative costs for States which meet standards for outstanding performance.

9. Requires States to offer written agreements to all qualified health care providers who will agree to do assessments and necessary follow-up on terms as will reasonably be expected to elicit adequate provider involvement, including private practioners, public health departments, community health center, Head Start agencies, rural health clinics, and maternal and child health centers. Additionally, provision was made to allow States to sign agreements with college health centers and school systems which have made arrangements for assessments.

10. Requires providers who do assessments of medicaid children to provide them with information on available dental services dentists who participate in medicaid.

11. Requires States to designate a lead agency which must establish and maintain a health profile for each child so as to insure appropriate coordination and nonduplication in the provision of care and services to the child.

BACKGROUND AND NEED FOR THE LEGISLATION

CURRENT LAW

A. The Medicaid Program

Title XIX of the Social Security Act (Medicaid) provides for a program of medical assistance for certain low-income individuals and families. In its general structure, Medicaid is a financing program; it makes payments to providers of medical care for covered medical services for eligible persons.

With some minor exceptions (relating to the aged and disabled), a State Medicaid program is required to cover individuals and families who receive payments through the welfare programs, Aid to Families with Dependent Children (AFDC), and the Supplemental Security Income Program (SSI). A State may also provide Medicaid to these same categories of people (that is, aged, blind or disabled individuals, or members of families where one parent is absent, incapacitated, or unemployed) who have slightly too much money to be on welfare, but not enough to pay for their medical care. When a State provides this kind of coverage, it is said to have a program for the medically needy.

A State also has options available to it regarding who is covered in its AFDC program. A State is required only to cover families where one parent is absent or incapacitated. It may provide AFDC to families where one parent is unemployed. If these families are covered in the State AFDC program, they then become eligible for Medicaid.

Title III of the bill contains four miscellaneous amendments to the Social Security Act:

1. The bill provides for demonstration programs in up to 12 States to formally train AFDC recipients as homemakers and home health aides. These individuals would then be employed by public and nonprofit private agencies to provide supportive services to people, primarily the aged and disabled, who would reasonably be expected to require institutional care in the absence of these services. The services would be available to individuals whose income does not exceed 200 percent of the State's need standards. The program, authorized over a 5-year period, would be administered by the State health services agency designated by the Governor. Approved programs would receive 90 percent Federal funding.
2. The bill requires the Secretary of HEW to conduct a study of the problems faced by people with epilepsy or similarly incapacitating conditions in obtaining adequate health insurance coverage. The study would include an analysis of the advantages and disadvantages of covering such conditions under the medicare program. The Secretary is required to submit a report to the Congress by October 1, 1979.
3. The bill provides for the Administrator of the Health Care Financing Administration to be appointed by the President with the advice and consent of the Senate. The amendment would apply to anyone occupying that office on or after enactment.
4. The bill provides that health maintenance organizations (HMO's) contracting with States to provide health services under medicaid be required to have no more than 50 percent of their members covered under medicaid and/or medicare by no later than 3 years after the date the HMO is formally found qualified by HEW.

II. GENERAL EXPLANATION OF THE BILL

TITLE I—MEDICAID PROGRAMS IN PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND THE NORTHERN MARIANA ISLANDS

Section 101—Adjustments of dollar limitation on medicaid payments to Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands

The bill increases the ceiling on Federal funding for the medicaid programs in Puerto Rico, the Virgin Islands, and Guam. It further establishes a ceiling on Federal funding for the Northern Mariana Islands.

Under section 1108 of the Social Security Act, absolute ceilings are placed on Federal matching payments for medicaid programs in Puerto Rico, the Virgin Islands, and Guam. These fiscal year limits are $30 million for Puerto Rico, $1 million for the Virgin Islands, and $900,000 for Guam.

The original justifications for the limitation on Federal matching funds for the jurisdictions was based on their tax status. The Commonwealth of Puerto Rico has been exempt from Federal personal and corporate income taxes, and excise taxes have been rebated intact to the Commonwealth government. The Federal income tax laws apply to the territories of Guam, and the Virgin Islands; however, the Federal income tax revenues are rebated intact for the use of the territorial government.

The committee notes that the current ceilings on Federal expenditures have severely affected the amount of funds available to operate adequate medicaid programs in the jurisdictions, primarily because they have not been increased to reflect inflation in the economy in general and in medical care costs in particular. In fact, the amount of Federal dollars available in constant terms is less than 60 percent of what it was when the ceilings were established in 1972.

The committee bill increases the fiscal year ceiling on Federal funding for medicaid programs beginning in fiscal year '79 to $60 million for Puerto Rico, $2 million for the Virgin Islands, and $1.8 million for Guam. The bill also establishes a payment ceiling of $500,000 for the Commonwealth of the Northern Mariana Islands which is added to the medicaid program by section 102 of this bill.

Section 102—Elimination of special limitation on the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam

The bill deletes the existing limit on the Federal medical assistance percentage rate applicable to Puerto Rico, the Virgin Islands, and Guam and extends medicaid coverage to the Northern Mariana Islands.

The medicaid program is designed to provide relatively greater Federal assistance to areas which have limited resources. The Federal matching rate established under title XIX is determined by a statutory formula designed to provide a higher percentage of Federal matching to States with low per capita incomes, and a lower percentage of Federal matching to States with higher per capita incomes. No State may have a matching rate lower than 50 percent or higher than 83 percent. The rationale for the formula is to assist low income States in meeting the medical needs for their low income citizens through a greater infusion of Federal funds. However, the committee notes that the artificial 50-percent limitation on Federal matching for the jurisdictions has meant that they can not benefit from the variable Federal matching as States with low per capita incomes do.

The committee bill provides that after September 30, 1978, the Federal matching rate for the jurisdictions would be determined in the same manner as it is determined for the 50 States and the District of Columbia up to the new ceilings established under section 101 of the bill. This would allow Federal matching to be determined by a formula based on per capita income. Currently, this would provide for a Federal matching rate of 81.87 percent for Guam, 83 percent for Puerto Rico, and 74.6 percent for the Virgin Islands.

Under current law the Northern Mariana Islands are excluded from coverage under the medicaid program. The committee bill extends medicaid coverage to this jurisdiction.

TITLE II—CHILD HEALTH ASSESSMENT ACT

Title II of the committee bill amends title 19 of the Social Security Act to create a new child health assessment program (CHAP) under medicaid.

The primary purpose of the program is to increase the availability of quality health care for low income children. The aim of the child health assurance program is to enroll children in a program of health care which provides them comprehensive preventive services and needed subsequent care. Essentially, CHAP expands eligibility for the present early and periodic screening, diagnosis, and treatment (EPSDT) program, seeks to improve participation in the program, and increases the Federal matching rates.

Medicaid eligibility for poor and hard-to-place adopted children

Section 203 of the committee bill assures the eligibility of needy children age 6 or under for medicaid in all States regardless of the structure of the family of which the child is a member, provides for reasonable continuity of eligibility for children on medicaid, makes provision for a child to retain medicaid eligibility while in a public institution for juveniles, allows medicaid coverage for hard-to-place adopted children.

The committee bill requires all State medicaid programs to extend eligibility to children through age 6 who are determined to be needy regardless of whether that child is alone, is in a broken family, is in a family with an unemployed parent, or is in an intact family.

Eighteen States as well as Puerto Rico and the Virgin Islands now provide medicaid to all needy children under 21, however. It was not the intention of the committee to require any reduction of coverage for this group; in fact, throughout its deliberations the committee was intent on assuring that the legislation result in expansions of coverage, not cutbacks (see the section on maintenance of effort). The committee was particularly concerned that existing coverage of mental health care and dental care for children not be terminated or reduced. Therefore, the reported legislation specifically allows any State to provide coverage for needy children up to the age of 21. If a State elects this option, Federal matching will be available for all medical assistance provided. The committee expects that if the State opts for this broader coverage, any children age 7 to 21 brought into coverage would be eligible for the same services and under the same conditions as children age 6 and under covered under the State plan.

The bill allows medicaid coverage for children with special needs placed for adoption. The committee was concerned with the effect of the provision of the current medicaid program which allows a State to cover children in foster care, but does not allow coverage if these children are placed for adoption in a family with income even slightly higher than the medicaid standard.

HEW estimates that there are at least 100,000 children currently lingering in foster care who have not been adopted because of their special needs. A large number of these children have handicapping conditions—often multiple handicaps—which require continuing care and treatment. Although often eligible for medicaid while in foster care, these children frequently would lose such eligibility if adopted and probably would also be ineligible for coverage under the insurance policies of adoptive parents because their handicaps constitute a preexisting condition. The absence of medicaid coverage for such children following placement for adoption serves as a fiscal disincentive to finding permanent adoptive homes for these children and keeps them in foster care at public expense. The purpose of allowing States to cover these adopted children with special needs under medicaid is to encourage and facilitate their adoption.

It should be noted that the decision whether to cover these children would be the State's. The committee bill simply makes Federal matching funds available if they wish to do so.

The committee allows the State to determine whether to provide coverage for these children only until they find the need for the continuing medical care and services no longer exists, or up to the age of eligibility for children under the State plan. The committee believes the certainty of the time of coverage of the second option, and the greater ease of administering it, justifies providing this option to the States.

Required services

Section 204 of the committee bill clarifies the services which must be provided to children under the medicaid program by requiring comprehensive health assessments for all children and requiring that all services which are eligible for Federal matching under the medicaid program must be provided to assessed children if those services are necessary.

The committee bill provides that any individual under 21 who has received a timely periodic child health assessment is eligible for all care and services for which Federal matching funds are available under title XIX, without regard to whether such care and services are included in the State plan, and without regard to any limits on the amount, duration or scope of services included in the State plan, with exceptions. Entitlement to inpatient services in an institution for mental diseases, to inpatient services in an intermediate care facility for the mentally retarded, and to routine dental care is limited to the extent of coverage of those services in the State medicaid plan. States would not be required to provide services for mental illness nor inpatient care in an intermediate care facility for the mentally retarded except as covered in the State medicaid plan. Nor would States be required to provide other than routine dental care as defined in the bill.

The bill also provides for referral for appropriate care and services not available under title XIX.

The bill specifies that the making available of child health assessments and services beyond those covered in the State plan for assessed children shall not require that these services be available to all other persons eligible under the medicaid program.

The bill provides that all State medicaid plans must include the following required services: child health assessments, diagnosis, treatment, referral and medical case management of individuals under 21 who are included under the plan.

The bill defines a child health assessment as an assessment provided for an individual under 21 for such health problems and at such periods as the Secretary specifies in regulations, and provides that such assessments may only be provided by a health care provider who enters into a written agreement with the State medicaid agency. The written agreement must meet standards established by the Secretary and include an agreement that the provider will:

(1) provide timely and appropriate child health assessments,

(2) provide assessed individuals with basic diagnostic and treatment services (including immunizations) or refer assessed individuals to other health care providers for basic diagnostic and treatment services and follow-up to insure the services have been provided,

(3) refer assessed children to dentists, using a list provided by the State agency on dentists who will provide services to medicaid children,

(4) refer assessed children to other providers for any corrective treatment found to be necessary during the assessment which is not available directly from the provider doing the assessment, and follow-up to assure the services are received,

(5) take responsibility for the management of the medical care of each assessed child,

(6) be reasonably accessible on an ongoing basis to assessed individuals in order to provide continuing and available care,

(7) make such reports as are necessary.

The bill specifies that the term health care provider includes (but is not limited to) a private practitioner, public health department, community health clinic or center, primary care center, day care or Head Start program, rural health clinic, maternal and child health center, or college health centers, a school system, for purposes of doing assessments and carrying out other requirements of the CHAP program. Further the bill clarifies that providers carrying out assessments and providing other medical care and services to children are eligible for payment through the medicaid program whether such provider ordinarily bills other third party payors for the provision of similar services or not.

The committee intends the child health assessment program to move beyond a screening model where the emphasis is on conditions that can be found by a single, rapid test or procedure, in settings with large numbers of children. The intent is to introduce children to an ongoing source of primary care where they receive comprehensive health assessments (at regular intervals to be determined by their age) and subsequent care. The assessment should be individualized to the greatest extent possible. Parents of young children, in particular, should be involved in providing relevant health history and in receiving thorough counseling about the child's development and health needs.

Standards for the frequency and content of health assessments would be established by the Department. At a minimum, assessments should include the full array of assessment procedures recommended in current EPSDT guidelines plus counseling and the modified approach to developmental assessments as directed below by the committee. The Department should also establish standards for the frequency with which children of various ages should be assessed and the procedures necessary at each visit. The schedule is expected to be based on the American Academy of Pediatrics' "Master Schedule for Screening." A public comment period on proposed standards will provide ample opportunity for professional and other representatives or spokesmen to recommend any changes to revise standards in accordance with medical advances.

Several facts have convinced the committee to call for a "comprehensive health assessment" rather than a separate assessment for physical and mental problems: The opportunities for misclassifying children are great and have serious consequences for children; according to many professionals, we do not know how to assess children in the area of mental defects; and in many parts of the country there are not adequate resources to care for problems found through such a process. Therefore the committee intends that the assessment of a child's growth and development should be performed comprehensively in the context of routine assessment procedures. Growth and development should be evaluated through a thorough health history, physical examination and such observation of the child as is possible in the course of performing routine procedures. Such an approach will uncover common problems which impair development.

In replacing the separate "screening for mental defects" with a "comprehensive assessment," the committee in no way intends to limit the program's charge to identify and care for developmental problems. Rather, the committee has chosen this approach because it minimizes the danger of careless implementation which could result in damage to children. At the same time, it does not dilute the benefits children can derive from assessments of selected and better understood aspects of development and growth.

It is not the committee's intent to reduce services available to children in the area of mental health. The committee hopes that children will continue to receive at least current services.

Treatment of copayments for assessed children

Section 205 prohibits States from imposing cost-sharing charges on any individuals who have received a timely health assessment. The committee intends that no impediments be placed in the way of children who have received assessment services from obtaining health care needed to correct or ameliorate identified medical problems.

Continuation of eligibility

Section 206 of the committee bill provides that a child who has received a timely health assessment and then loses medicaid eligibility for any reason other than attaining the maximum age of coverage for children under the State plan will entitled to an additional four-months of eligibility under medicaid. The committee believes this provision can eliminate many of the problems of children going on and off medicaid eligibility which has in the past complicated program administration, burdened providers, and resulted in children not receiving the care their health assessments have shown to be necessary. The committee notes that for children in AFDC families, this extension of eligibility would operate in place of, not in addition to, the 4-month extension of eligibility for AFDC families who would otherwise lose medical eligibility because of employment.

Section 207—Federal reimbursements

Section 207 of the bill establishes increased matching rates for the costs of health assessments and all services (other than dental or inpatient care) provided to children who have been assessed and reassessed at appropriate intervals. It requires States to develop implementation plans. The section also requires the Secretary to establish standards for acceptable and outstanding performance for CHAP programs and to base penalties (if necessary) and bonuses, (where warranted) on the success of each State in achieving these standards. The section also includes a 2-year maintenance of effort provision.

The committee bill establishes an increased Federal matching rate for the costs of health assessments and all noninpatient services provided to children who have been assessed and reassessed at appropriate intervals. This higher matching rate, termed the Federal CHAP percentage, is the greater of 75 percent or halfway between the current medicaid matching rate and 90 percent.

The committee was concerned that some States have been slow to implement the EPSDT program because of a fear that, whatever its long-run savings, the program could result in a short-run increase in costs. This concern was believed to be a contributing factor to the inadequate outreach and screening efforts that have characterized some State programs. By making the increased match available only for noninpatient services for assessed children, it hopes to (a) encourage the use of ambulatory care wherever possible, and (b) provide a strong incentive to the States to assess as many medicaid children as possible.

The increase in the matching rate is shown in the following table.

CURRENT MEDICAID FEDERAL MATCHING RATES AND RATES UNDER CHAP, BY STATE

[Federal percentage]

State	For services		State	For services	
	Current law	Under CHAP [1]		Current law	Under CHAP [1]
Alabama	73	81	Montana	61	75
Alaska	50	75	Nebraska	53	75
Arkansas	72	80	Nevada	50	75
California	50	75	New Hampshire	63	75
Colorado	54	75	New Jersey	50	76
Connecticut	50	75	New Mexico	72	88
Delaware	50	75	New York	50	75
District of Columbia	50	75	North Carolina	68	75
Florida	57	75	North Dakota	51	75
Georgia	66	75	Ohio	55	75
Hawaii	50	75	Oklahoma	65	77
Idaho	64	77	Oregon	57	71
Illinois	50	75	Pennsylvania	55	75
Indiana	58	75	Rhode Island	57	79
Iowa	52	75	South Carolina	71	80
Kansas	52	75	South Dakota	64	77
Kentucky	70	80	Tennessee	69	79
Louisiana	70	80	Texas	61	76
Maine	70	80	Utah	69	79
Maryland	50	75	Vermont	68	79
Massachusetts	52	75	Virginia	57	75
Michigan	50	75	Washington	52	75
Minnesota	55	75	West Virginia	70	80
Mississippi	78	84	Wisconsin	59	75
Missouri	61	75	Wyoming	53	75

[1] Matching rate for health assessments, and for all outpatient services provided to a child who has been assessed (and reassessed) at appropriate intervals.

The committee bill requires States to develop and make available for public comment their plans for implementation of a child health assurance program.

The committee recognizes that unlike other medicaid services, CHAP's mandate includes assuring that children actually receive an array of health services. Therefore the committee has established a different planning mechanism than that used for other parts of medicaid. States will be expected to develop and continually revise a program plan for CHAP which demonstrates how the major requirements of the program will be met. In meeting the State plan requirements set out in the legislation, implementation plans should identify and make provision for written agreements with qualified providers on terms which can reasonably be expected to elicit their involvement in the program; assure coordination with other programs providing health care service to children; assure availability of appropriate support services including outreach and followup; and provide for the establishment and maintenance of health profiles on each eligible child.

It is clear that in order for the needs of CHAP children to be cared for properly, all qualified health resources must be utilized in the program. A recipient's right to "freedom of choice" among providers is an additional reason why we expect States to make vigorous efforts to elicit the participation of the range of providers in each community who are qualified to fulfill the responsibilities as set forth in the legislation and who agree to comply with the cost and service requirements of the program.

To effectuate the widest possible provider participation, the committee expects the States to work with provider organizations to educate them about the program, to determine the most effective way of identifying all qualified providers, and to establish contractual terms capable of eliciting broad provider participation. Contractual terms should include: reimbursement levels which reasonably cover the cost or are competitive with prevailing rates for all services provided (including reporting as well as outreach and followup services if given by the provider); reasonable reporting arrangements; and prompt payment of claims.

It is the committee's intent that the State plan describe how families will be informed of the program, what arrangements will be made to assist them in finding and getting an appointment with a qualified provider, how followup will be assured, and how necessary transportation will be arranged.

The committee bill requires the Secretary to establish standards for acceptable and superior performance for CHAP programs, and to base penalties (if necessary) and bonuses (where warranted) on the success of each State in achieving these standards.

The committee recognizes that the program requirements under EPSDT have often failed to extend the intended benefits to eligible children. In response to this deficiency, the committee has structured CHAP to place an emphasis on actually reaching needy children with assessments and subsequent care.

Much has been learned about what constitutes an effective EPSDT program. The committee believes that the considerable experience EPSDT has provided should serve as the basis for defining further the performance criteria and reasonable numerical standards. On the basis of past experience, performance criteria have been selected related to key CHAP services: informing families about the program; providing comprehensive health assessments and medical care for problems disclosed; bringing children up to date on immunizations; and assuring that providers offer services in accordance with agreed-upon terms. The intent is to enroll children in the CHAP program and assure they receive appropriate covered preventive and needed subsequent care.

These performance criteria will be used to determine superior performance worthy of the financial bonus as well as inadequate performance which warrants the financial penalty. Numerical standards should be set for each State for both minimum adequate performance and for exceptional performance regarding informing, assessing, treating and immunizing children. Because States vary widely now on the proportion of eligible children receiving such services, the committee expects that initially the exact numerical standards may vary by State. The standard, however, should represent a reasonable increase in performance each year, and within 5 years of enactment, it is expected that all States be required to operate at a uniform minimum level, and that at least 80 percent of eligible children should be enrolled in CHAP.

Regarding "informing families in a timely manner" of the availability of CHAP, the committee expects that eligible families will receive an explanation of what services are available, of the value of receiving them, and information on where and how to seek services.

Regarding the proportion of children who are provided assessments, as defined, in a timely fashion, the committee intends that a reasonable proportion of all eligible children receive preventive services as a result of CHAP.

Studies of EPSDT suggest that when services are provided properly (effective informing, assistance in using services) roughly 60 to 80 percent of families contacted will use services. Therefore the committee believes it is realistic to expect 80 percent of eligible children to be enrolled in CHAP or a program providing equivalent services 5 years after enactment of CHAP. At that time, 50 percent should be the standard for minimum acceptable performance and 90 percent should represent exceptional performance.

The outcome standard for CHAP assessments neither changes nor interferes with the voluntary nature of this program. Recipients retain the right to decline services and States are prohibited from using any form of coercion to get families to use services. The committee has included a standard for assessments because the experience of EPSDT shows that it is possible to establish an expected level of participation which accommodates the fact that some eligible families will decline service. Given the voluntary nature of CHAP, States found not to meet the minimum standard should not be penalized if they can show that, in spite of providing the requisite information and other forms of assistance, the nonmandatory nature of CHAP essentially accounted for the failure to reach the outcome standard.

Taking shortages of medical resources into account, the committee believes that in the majority of cases assessments and treatment can be provided within 120 days of a request for an assessment.

Regarding immunization, the Department, through its immunization initiative is committed to raising immunization levels among all children to above 90 percent by the fall of 1979. The committee believes that CHAP standards should be consistent with these Departmental goals and look to HEW to set timetables and numerical levels for CHAP.

Regarding compliance of providers with contractual terms, the committee expects States to monitor provider contracts so that every organized provider and a representative sample of providers in solo practice is audited at least once each year. It intends that providers who are not substantially adhering to the terms of the agreement will be decertified and that the State will take reasonable steps to identify providers with the capacity to care for children affected by decertification of providers.

The committee expects the Department to evaluate States' performance for purposes of the bonus or penalty through the use of standard reporting and random samples of client and provider records in each State. Samples should be statistically valid. We also expect the Department to monitor data reported on outcome standards to assure they accurately reflect the level of services provided in accordance with CHAP requirements.

The committee bill establishes standards for the frequency and timeliness of HEW determinations of State performance and the timely resolution of appeals. HEW is expected to review each State program at least twice a year to assure that all statutorily established performance standards are met. Reviews are expected to be completed promptly; the bill therefore requires their completion within 180 days of the close of the quarter under review. States desiring to appeal a finding of noncompliance must request a hearing within 60 days of the notice of noncompliance, and the review by an impartial party must be completed within 180 days of the State's filing its petition for review.

The committee bill is an opportunity for States to correct program deficiencies and thereby avoid imposition of the financial penalty. However, the committee intends that the correction period be used in a serious manner by States committed and able to achieve compliance within a reasonable time. To assure that the correction period not be used as a means of delay when little concrete progress is made, States requesting correction time should be expected to demonstrate to the Secretary a remedial plan capable of achieving compliance by the end of the correction period. The 6-month correction period should be granted based on the Secretary's judgment that the proposed plan will accomplish satisfactory performance and that the State is capable of carrying out the proposed plan. In opting for a correction period, a State is admitting it has deficiencies to correct. After seeking a correction period it is expected that States would generally not appeal HEW's finding of noncompliance.

The committee believes the program reporting failures in EPSDT which have made it impossible to assess the adequacy of the program, State by State, and nationally must be corrected. The guiding principle in devising reporting requirements should be to allow determination of the proportion of eligible children who receive program benefits (assessments and treatment for problems found in assessments as well as subsequent care) and the quality of care provided. Data should be reported:

(1) In terms of children, not procedures (that is number of assessments), as is currently the case;

(2) In a way that makes it possible to determine for any given period of time and portion of assessed children needing treatment who have received such treatment on a timely basis; and

(3) In a way that makes it possible to assure that children are moving in a timely fashion through the CHAP system.

Data on conditions found should be reported in sufficient detail to allow States to determine the adequacy of resources in an area with reference to the specific health needs uncovered through CHAP. Data on procedures performed during an assessment should be recorded in sufficient detail to allow audits by HEW and the States regarding the thoroughness of health assessments performed.

The committee is fully aware of the danger that excessive and irrational reporting demands could adversely affect providers' willingness to participate in CHAP. But the Department should devise and utilize only those reporting requirements which allow adequate program planning and monitoring without creating excessive burdens for providers. It is customary medical practice to keep thorough patient records on problems found and services provided, by date and by child. To meet the committee's requirements, providers would need to report to the State only selected data from these records so long as complete documentation is available locally for audit purposes. In addition, the committee intends that States establish reimbursement levels for providers which cover the reasonable costs of keeping adequate records and forwarding necessary information to the State on a regular basis.

The Secretary shall report to the Congress by February 1 of each year (beginning in 1981) on the actual levels of performance of each State's CHAP program in relation to the applicable performance standards.

The committee bill provides that during the first 2 years after enactment, a State will be ineligible for the increased Federal matching if it reduces both the scope and extent of medicaid coverage and the level of State spending for children. The committee does not intend that the increase in Federal matching be a windfall to States which then act to reduce their current program coverage. However, the committee did not want to lock States into any particular pattern of spending. For instance, if a State finds that a particular service which it is providing is not as useful or productive as it had anticipated or if a greater need for another service is found, the committee believes that the State should be free to make the appropriate adjustments in its program. Therefore, the reduced matching rate will come into play only if the level of State spending and scope and extent of coverage is reduced.

The 2-year limitation on the maintenance of effort requirement is included because of the committee's belief that once 2 years of expanded coverage at the higher match rate has passed, cutbacks are unlikely, and the consequent need for the provision with the administrative problems it would entail is so reduced as to make it unnecessary.

Repeal of penalty

Section 208 of the committee bill repeals section 403(g) of the Social Security Act which required a 1-percent reduction in the Federal share of medicaid funds for States failing to implement child health screening services under medicaid. A new penalty is authorized under section 207 of the committee bill.

Report on coordination of child health programs

Section 209 of the committee bill requires the Secretary of Health, Education, and Welfare to submit a report to Congress on the child health assessment program. The bill calls for a report (to be submitted to the Congress not later than July 1, 1979) on the coordination of services to children under titles V and XIX of the Social Security Act as well as on actions undertaken and to be undertaken to integrate services under other federally funded programs. Such a study then should target not only title V and XIX child health programs, but all federally funded child health programs. It should identify gaps in services as well as duplication of efforts between and among programs. It should recommend action to be taken by the Federal Government to coordinate and integrate child health programs.

Continuing medicaid eligibility for certain children placed in certain juvenile institutions

Section 210 of the committee bill provides that the provision barring Federal matching payments for care or services for any individual who is an inmate of a public institution (except a patient in a medical institution) shall not apply to individuals under 21 who are inmates of a public institution for juveniles if the individual was eligible for CHAP under the State plan before he entered the institution.

The committee was concerned that its intent to provide good health care to all needy children would be contradicted by the provision of current law which would terminate CHAP coverage for persons who become inmates of public institutions that are not medical institutions. This provision would result in denial of CHAP to children who are in State operated homes, detention or correctional facilities, halfway houses, and the like. The committee believes it is appropriate to allow coverage to continue for these children if they are in a public institution for juveniles, and either were eligible for CHAP when they entered the facility or would have been eligible if they remained in the family.

Effective dates

Section 211 specifies effective dates for the CHAP program. Except as otherwise provided the amendments included in the act shall apply to medical assistance provided on or after September 1, 1979. It further provides that if legislative action is required to change a State plan for medical assistance to meet the requirements of the act, the State plan will not be considered out of compliance with requirements of the law resulting from this act before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

The amendment relating to medicaid coverage for adopted children with special needs shall apply to individuals placed for adoption on or the date of enactment.

The section relating to the repeal of the penalty provision of current law is applicable to quarters beginning after June 30, 1974. Any individual under the age of 21 who has been screened pursuant to the requirements of the current law shall be deemed to have had a timely health assessment, in accordance with regulations established by the Secretary.

The Secretary shall establish final regulations to carry out the amendments made by the act not later than May 1, 1979.

TITLE III—MISCELLANEOUS PROVISIONS

Section 301—Demonstration projects for training and employment of AFDC recipients as homemakers and home health aides

The bill provides for demonstration programs in up to 12 States to formally train AFDC recipients as homemakers and home health aides. These individuals could then be employed by public and nonprofit private agencies to provide supportive services to people, primarily the aged and disabled, who would reasonably be expected to require institutional care in the absence of these services.

The committee bill is designed to deal with three major problems in the Nation's health and welfare programs, namely the need to provide alternative support services for individuals who would otherwise require institutionalization, to assist AFDC recipients to develop a marketable skill which will enable them to get off the welfare rolls, and to stem the increases in Federal and State costs for medicaid and welfare programs.

The committee bill establishes a means whereby many thousands of older and disabled people will be assisted in remaining at home rather than being moved into high-cost nursing homes and intermediate care facilities. It is estimated that as many as 40 percent or more of those in institutions do not necessarily have to be there—and would not be there if proper alternative supportive services were available. Most would prefer to live in familiar surroundings in which they can retain their sense of independence and dignity. The bill encourages the availability of support services by taking persons now on the welfare rolls, formally training them as homemakers and home health aides, and using them to provide supportive services.

The committee expects that the large majority of these trained people will ultimately be removed from the welfare rolls because they will have become gainfully and usefully employed members of the health professions. Properly implemented, enormous savings in medicaid and welfare costs should result as people leave the welfare rolls and others are kept out of high-cost nursing homes and other long-term care facilities.

The committee bill authorizes the Secretary of HEW to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers or home health aides. The committee intends that priority be given to those States which have demonstrated active interest and effort in supporting the concept and in developing and encouraging this proposal. Full responsibility for the program would be given to the State health services agency (which may be the State medicaid agency) designated by the Governor.

The committee expects that the Secretary will assign responsibility for implementation of this program to the Health Care Financing Administration as the agency responsible for the medicaid program.

The committee emphasizes that the program is completely voluntary; an AFDC recipient is under no obligation to enroll and does not risk loss of AFDC funds by refusing to participate. Persons eligible for training and employment would be only those who were continuously on the AFDC rolls for the 90-day period preceding application. Those who enter a training program would be considered to be participating in a work incentive program authorized under part C of title IV of the Social Security Act. During the first year such individual is employed under this program, he or she shall continue to retain medicaid eligibility and any eligibility he had prior to entering the training program for social and supportive services provided under part A of title IV. The individual will be paid at a level comparable to the prevailing wage level in the area for similar work. Federal funding will not be available for the employment of any eligible participant under the project after such participant has been employed for a 3-year period. After that period, the committee expects the individual to be able to obtain employment as an allied health worker.

The bill requires a State participating in a demonstration project to establish a formal training program, which is expected to be 10 to 12 weeks in duration. It is anticipated that the Secretary will assist States in developing the program where requested. The Secretary must approve the program as adequate to prepare eligible participants to provide part time and intermittent homemaker services and home health aide services to individuals, primarily the aged and disabled, who would, in their absence, be reasonably anticipated to require institutional care. The State shall provide for the full-time employment of those who have successfully completed the training program with one or more public agencies or by contract with nonprofit private agencies. The numbers of people in a State eligible for training and employment would be limited only by their ability to be trained and employed as well as by the number of those in need of home health and homemaker services. Thus, to the extent that a State can demonstrate increased capacity to train and utilize people, the numbers authorized in that State may be modified. The Secretary is expected to establish safeguards to assure that the program, as well as those trained and employed, are not improperly exploited. Such safeguards should include assurances that a nonprofit agency seeking to employ those trained under the program is a recognized bona fide nonprofit entity and not a pro forma nonprofit mechanism.

The committee bill provides that persons eligible to receive home health and homemaker services are the aged, disabled, or others, such as the retarded, who are in need of such services. They must be those for whom such services are not reasonably and actually available and who would otherwise reasonably be anticipated to receive institutional care. Participating States would be required to provide for independent professional review to assure that services are provided to individuals actually needing them.

The committee bill extends eligibility for services to individuals whose income is less than 200 percent of the State's need standard under the AFDC program for households of the same size. It is expected that the large majority of medicare beneficiaries would, because of this income standard, be potentially eligible for these homemaker and home health aide services. However, while medicare program costs should be moderated as a result, these services, unless otherwise qualified for reimbursement, would not be a regular medicare benefit. The eligibility level has been established above the State's need standard because of the high probability that an individual, even with income somewhat above this standard, would become a medicaid recipient when he required skilled nursing home or intermediate care. States may also make the services of those home health aides and homemakers available to individuals with incomes above these limits; in such cases fees would be charged on a sliding scale basis.

The committee bill specifies that the type of services included as homemaker and home health aide services include part time or intermittent: personal care, such as bathing, grooming, and toilet care; assisting patients having limited mobility; feeding and diet assistance; home management, housekeeping, and shopping; family planning services; and simple procedures for identifying potential health problems. The committee emphasizes that authorized services do not include any service performed in an institution or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services. It further notes that those trained under this program are not intended to be a reservoir of subsidized labor for hospitals. However, public and nonprofit hospitals might employ these people as outreach workers to facilitate timely discharge of hospitalized patients. Further, after they leave this program these individuals may subsequently be employed on a nonsubsidized regular basis, as occurred in New Mexico which pioneered this type of program.

The committee bill provides 90-percent Federal matching for the reasonable costs (less any related fees collected) of conducting the demonstration projects. Such amounts would be paid under the State's medicaid program. The committee anticipates no net cost since the reduction in medicaid costs resulting from the prevention or postponement of expensive care in institutions should more than offset the costs of training and provision of home health aide and homemaker services. It is anticipated that hospital stays may also be shortened—or even avoided—because of the availability of these services. The welfare burden should be eased to the extent that those trained ultimately find regular employment in the health care field—outside of this program.

The bill limits demonstration projects to a maximum of 4 years plus an additional period up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary is required to submit annual evaluation reports to the Congress and a final report not more than 6 months after he has received the final reports from all the participating States.

Consistent with responsible administration, the committee expects that the Secretary will act expeditiously in implementing this program with a minimum of regulatory delay and a maximum of formal and informal cooperative effort with the States which have demonstrated interest.

Section 302—Study of medicare coverage

The bill requires the Secretary of HEW to conduct a study of the problems faced by people with epilepsy or similarly incapacitating conditions in obtaining adequate health insurance coverage. The study shall include an evaluation of the present availability of health insurance and other means of coverage of health care costs. It shall also include an analysis of the advantages and disadvantages of covering such conditions under the medicare program. The Secretary is required to submit a report to the Congress by October 1, 1979.

Section 303—Appointment of the Administrator of the Health Care Financing Administration

The bill provides for the Administrator of the Health Care Financing Administration to be appointed by the President with the advice and consent of the Senate.

The Health Care Financing Administration (HCFA) is the agency in the Department of Health, Education, and Welfare responsible for administration, coordination, and policymaking for the medicare and medicaid programs. It was established by the Administration in early 1977 in order to provide the means for the orderly consolidation and coordination of these two major health programs.

The committee believes that the Administrator of this agency must be an individual experienced and knowledgeable in health care and health care financing with full awareness of the complexity of the issues involved. The committee notes that this position includes responsibility for both medicare and medicaid. The Administrator of the Social and Rehabilitation Service (an office now terminated) required appointment by the President and confirmation by the Senate primarily because of his responsibility for medicaid. The comparable position of the Commissioner of Social Security requires Presidential appointment and Senate confirmation.

Accordingly, the bill provides for the Administrator of the Health Care Financing Administration to be appointed by the President with the advice and consent of the Senate. The provision would apply to individuals who serve in the position on or after the date of enactment.

Section 304—Health maintenance organizations enrolling over 50 percent medicare or medicaid recipients

Present law prohibits a health maintenance organization (HMO), which contracts with a State to provide prepaid health services under medicaid, from having more than one-half of its members covered by medicaid and/or medicare. However, HMO's are given 3 years from the date of their contract with the State medicaid program to meet this condition.

Occasionally, because of administrative delays, an HMO may have difficulty signing up nonmedicaid/medicare members by the end of that 3-year period, and thus be forced to reduce its coverage of medicaid beneficiaries in order to achieve the 50–50 requirements.

This situation would be remedied under the committee bill by providing that HMO's contracting with States to provide health services under medicaid be required to have no more than 50 percent of their members covered under medicaid and/or medicare by no later than 3 years after the date the HMO is formally found qualified by the Department of Health, Education, and Welfare.

The date of qualification is essentially the date when the HMO can effectively solicit group plans from employers and is a more reasonable date from which to begin the requirement for the maximum 50-percent enrollment of medicaid/medicare beneficiaries than that in current law.

III. BUDGETARY IMPACT OF THE BILL

In compliance with section 252(a) of the Legislative Reorganization Act, and section 403 of the Congressional Budget Act, the following statements are made relative to the cost and revenue impact of the bill.

The following estimates are made by the committee after consultation with the Congressional Budget Office and the Department of Health, Education, and Welfare. No estimate pursuant to section 403 of the Congressional Budget Act has been received as of the time the bill is being reported.

Fiscal year expenditures	1979	1980	1981	1982	1983
Increased Federal medicaid assistance	32.4	32.4	32.4	32.4	32.4
Child health assessment program	30.0	373.0	510.0	667.0	835.0
Total outlays	62.4	405.4	542.4	699.4	867.4

IV. VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the bill. The bill was ordered favorably reported by voice vote.

V. REGULATORY IMPACT

In accordance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following statement of the regulatory impact of the bill is made.

In implementing the provisions of the bill, there will be an increase in Federal regulatory activity with respect to the child health assessment program due to the complexity of the program and extensive reporting requirements. It is not anticipated, however, that the legislation will impose an overly burdensome regulatory effect. It is anticipated that neither the increased matching for the territories nor the demonstration study to train AFDC recipients will impose a significant regulatory effect.

The increased regulatory activity under the CHAP program will have implications primarily for the agencies administering the program and would have minimal regulatory effect on eligible individuals. However, providers of services under the CHAP program will be subject to significant regulatory reporting requirements.

Since the bill would provide increased medicaid funds to provide services to eligible individuals, there would be a positive effect on those individuals as well as the entities providing services under the medicaid program.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, as reported).

VII. ADDITIONAL VIEWS

We feel it is most unwise to enact a major new program such as the child health assessment program in such a hasty and superficial way.

The measure, as reported by the Finance Committee, contains several substantial liberalizations with critical policy implications. The bill mandates medicaid (and broader CHAP) coverage to all children who meet State-set income standards up to age 6. Currently, States are only required to provide medicaid eligibility to children if their families receive payments under the welfare programs (AFDC and SSI); that is, if they are broken homes or families where one parent is incapacitated and family income is below the relevant State income standard. Thus, there are presently two tests of eligibility: deprivation and income. The bill completely does away with the first test and provides aid to intact families. This is a serious major new policy shift, with implications for so-called welfare reform and other proposals before the Congress; it thus far generally has rejected efforts to provide categorical aid to intact families where the only eligibility test is income. The only test which remains under this legislation is income, which is (or can be) subject to personal control and alteration in order to qualify.

The Congress long has been concerned with the work disincentive effects of the major welfare liberalizations of the last 15 years, and if this bill passes in its current form, we will have worsened severely that problem.

Moreover, like most major welfare liberalizations, this new program promises to be exceedingly costly. Even the most conservative estimates place the first year's price tag at $400 million or above. By the fifth year, the cost could well be in excess of $1 billion. Last minute changes in the bill were made to make it apply only in the last month of fiscal year 1979; this change, while it might escape the applicability of the Budget Act, does nothing to mitigate the major new welfare burden that is placed upon the Nation's taxpayers. Nor does the fact that the eligibility scope has been reduced from age 21 to age 6 do much to alter the bill's final cost; 70 percent of the bill's earlier cost is attributable to those children who remain covered under the version of the bill which was reported by the committee.

We fail to be convinced, as well, that sufficient need for this major new program has been demonstrated to justify its cost. Proponents of the bill argue that it is necessary to mandate a program (CHAP) upon States which thus far have not seen fit to implement on a broad scale its predecessor (early and periodic screening, diagnosis, and treatment, or EPSDT). Material provided by the proponents admits that:

> . . . it has been generally accepted that Federal and State performance under EPSDT has been . . . slow. . . . In fiscal year 1973, for example, fewer than 500,000 children were screened. By 1977, this number grew to approximately 2 million, representing only about 20 percent of the children eligible for screening because of their medicaid coverage.

Within the quoted statement is the following parenthetical clause: "In part, this has been due to State concern over the potential cost of the program." If the representatives of State taxpayers have been reluctant to implement the program on a broad scale, how is it justified for Federal representatives of the same taxpayers to force it upon them?

If the program envisioned only medical screening, that would be one thing. However, the bill continues eligibility for a broad scope of services, many of which exceed those which normally are available under medicaid. Required for any covered child who has received a timely assessment would be "all necessary care and services" (other than those for certain mental illnesses, mental retardation, and dental care which is not routine care)

> without regard to any limitation in the amount, duration, or scope of medical assistance, for which payment is available under this title, whether or not under the State plan for the State such care and services are provided to individuals who have not been so periodically assessed, and . . . for referral for all other necessary care and services. . . .

This amounts to a virtual blank check for benefits over which a State would have no control.

There were no hearings before the full committee on this bill. There was one brief cursory hearing in the Health Subcommittee, at which only proponents testified. The relationship with other major health programs, including the medicaid program itself, the maternal and child health program, and the teenage pregnancy legislation just adopted by the Senate, never have been explored adequately.

We fail to see, additionally, why we should undertake a major program expansion of this kind before the existing EPSDT and medicaid programs have been tested sufficiently to determine whether they can meet the perceived need—or if not, why not. We see the beginnings of another massive program, much like the end stage renal dialysis program or the food stamp program, which will swell to unmanageable proportions with massive additional tax demands in the near future, if this legislation is enacted. If additional incentive is needed for the States to implement the existing programs, a minor adjustment in the fiscal sharing formula should accomplish that task.

Debate over national health insurance is slated to begin anew in 1979. In all the flurry accompanying the very brief consideration of this bill in committee, it should be made clear that what is being done here is, in fact, the attempted establishment of national health insurance for all children up to age 6 who meet State-set income standards. That step, and its implications, should not be taken in the kind of haste and limited consideration that has accompanied this bill thus far.

We believe that if the screening and treatment of health needs of poor children is the issue, there are far better ways of meeting the goal, within the context of our present mix of public and private medicine, and it is totally unwise and unnecessary to enact those embodied in H.R. 9434.

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