

**SEQUENCE OF EVENTS
ROUNDTABLE WITH THE NATIONAL GOVERNORS' ASSOCIATION**

MONDAY, FEBRUARY 3, 9:30 - 11:00 AM

- **Press pool enters East Room**
- **The President delivers opening remarks**
- **Governor Bob Miller (D-NV; NGA Chair) delivers remarks**
- **Governor George Voinovich (R-OH; NGA Vice Chair) delivers remarks**
- **The Vice President delivers remarks**
- **Press departs**
- **The President delivers remarks on education**
- **The President leads discussion regarding education**
- **Governor Miller (D-NV; NGA Chair) summarizes the Governors' Agenda for the 105th Congress**
- **Governor Michael Leavitt (R-UT) leads a discussion on Medicaid**
- **Governor Tom Carper (D-DE) leads a discussion on welfare reform**
- **Governor Paul Patton (D-KY) leads a discussion on ISTEA**
- **Open question and answer period**

THE WHITE HOUSE
WASHINGTON

*Please Copy All
DPL Staff.*

January 28, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: KITTY HIGGINS *Kitty*

SUBJECT: HOT ISSUES -- NATIONAL GOVERNOR'S ASSOCIATION MEETING

NATION-WIDE ISSUES

Project XL: Announced in March 1996, Project XL is testing whether the nation can achieve better environmental results by providing greater regulatory flexibility in exchange for a commitment to superior environmental performance. Participants in four categories -- facilities, industry sectors, governmental agencies and communities -- are given the flexibility to develop common-sense, cost-effective strategies to achieve more environmental protection at a lower cost.

EPA is implementing three facility Project XL projects and is making progress on sixteen additional projects (including two with cities). Each Project XL agreement is developed through cooperative negotiations involving corporation officials, local citizens, state, local and federal government. Full stakeholder involvement is a critical component of the program.

The states may raise the following issues related to Project XL:

- 1) **Desire on the part of some states for EPA to "delegate" Project XL to them.** Because Project XL is only a limited set of experiments at new ways of doing business, not a new way of doing business, EPA believes delegation is inappropriate. Moreover, Project XL projects typically include grants of flexibility from federal regulations, necessitating a clear role for EPA. States, however, are full partners in every Project XL project. No project has gone forward without state approval.
- 2) **Concern that EPA is being too stringent, or not deferring to the states' judgment, in the level of environmental performance needed to approve a Project XL project.** EPA is working with a group of state environmental commissioners to develop a process for implementing common-sense reinvention ideas that are worthwhile, but do not rise to the level of Project XL.
- 3) **Request for Federal Project XL authorizing legislation.** By pushing the envelope of existing laws, so far EPA has been able to implement the XL projects submitted to date without new legislation. (EPA)

Proposed Air Quality Standards: EPA has recently published a proposal to set new air quality standards for ozone (smog) and particulate matter (soot). In the case of soot, the re-examination of the current standard is court-ordered. The proposed revised standards are health based and developed after rigorous scientific review. A number of Governors are interested in these proposed regulation changes.

The proposal is based on an extensive review of the most current scientific research which shows that the current air quality standards fail to provide adequate public health protection, especially for children. Ozone and particulate air pollution contribute to serious respiratory diseases, asthma attacks and even premature death. The proposed standards are expected to save 20,000 lives each year and reduce the incidences of significant respiratory illnesses.

The EPA is taking extensive public comment on the proposals. Last week, EPA sent letters to 284 mayors of areas that may be affected by the proposed standards, inviting their input. This week, EPA held 2-day public hearings on the proposals in Boston, Chicago and Salt Lake City that were widely attended by industry, environmentalists and other members of the public. EPA has also established a toll-free number and an e-mail address to receive comments. The public comment period closes on February 18, and EPA intends to finalize the proposed standards in June 1997.

As directed by Congress under the Clean Air Act, the proposed decision is based solely on scientific evidence. EPA, however, will take cost into account when implementing any new standard. No decisions concerning implementation of new standards have been made.

Governor Voinovich (R-Ohio) is leading the charge against the EPA proposal. He has called for all air quality health standards to be grounded in cost-benefit analysis. The Governors from the Northeastern states have been the most supportive, with *Governor Weld (R-MA)* and *Governor Whitman (R-NJ)* being the strongest supporters. *Governor Weld* testified in favor of the EPA proposal at a recent Boston, MA, public hearing. The only official position that differs from EPA is the request that the comment period, due to close on February 18, be extended for 60 days. (EPA)

State Enforcement of Pollution Laws: State enforcement of environmental statutes has recently received national attention as a result of several newspaper articles. Some governors might question EPA's position on state environmental enforcement efforts, particularly in light of recent IG findings of serious under-reporting of significant violations of the Clean Air Act in Pennsylvania, and as described in a recent front page *New York Times* article on enforcement. State enforcement of federal environmental laws has also been the focus of recent *Washington Post* and *New York Times* articles regarding Virginia. (EPA)

State Audit Legislation: Effective this January, EPA's audit policy greatly reduces and sometimes eliminates penalties for companies that discover, disclose and correct violations through voluntary audits or the compliance management program. It also includes safeguards for protecting the public and the environment from the most serious violations. EPA's policy rejects the concepts of corporate secrecy and immunity in favor of corporate accountability and the public's right-to-know. To date, approximately 19 states have passed legislation which provides some degree of privilege or immunity to violators. EPA is concerned about state audit legislation that could interfere with a

state's ability to conduct effective enforcement of Federal environmental requirements. The immediate issue concerns whether, and to what degree, EPA will delegate enforcement authority to states that have unacceptable immunity and privilege statutes. (EPA)

Funding Mandates: Many states have expressed concern regarding the mandates placed on the Byrne Formula Grant Program, especially those created by the Jacob Wetterling Act, Megan's Law, and the Pam Lynchner Act, and loss of funding for noncompliance. (DOJ)

Emergency Law Enforcement Assistance Program: There is only about \$500,000 in the account and the DOJ's Office of Justice Programs has already received almost \$3 million in claims (LA \$1.5 million; CA \$1 million; FL \$1.3 million). (DOJ)

ISTEA Reauthorization: Of major interest to the Governors will be the Administration's proposed funding levels for ISTEA reauthorization. Although budget proposals are not public, the Governors are concerned that the Administration will propose lower levels than they view as necessary and than the Highway Trust Fund can support. Once the budget is released, the Governors will have two related concerns:

- 1) The Department's proposal for FY98 and the remaining years of ISTEA reauthorization -- basically the enacted level for FY97 -- will be flat, not the increase in spending they would like to see. DOT's position is to maintain the substantial increase in federal investment in transportation infrastructure that has occurred in the first term.
- 2) The cash balance in the Highway Trust Fund will increase significantly under DOT proposals -- from \$23 billion at the end of this fiscal year to \$48 billion by the end of FY 2003, money they will view as user fees remaining unspent.

NGA has not yet reached a consensus on ISTEA. A December letter to DOT asks specifically for reauthorization without significant change, rejecting a major overhaul. The co-signers of that letter were from CT, DE, IL, MA, ME, MD, NH, NJ, NY, PA, PR, RI, UT, VT, WA, and WV. (DOT)

Gas Tax Turn Back: *Governors Voinovich of Ohio, Wilson of California, Engler of Michigan and Beasley of South Carolina* have endorsed a federal gas tax turn back proposal being championed by House Budget Committee Chairman Kasich which would rollback federal gas taxes and give the states the option to reinstate them as state taxes. This proposal, also sponsored by Senator Mack of Florida, would shift all but a small portion of surface transportation responsibilities back to the states and all but eliminate the revenue from this source. *Governor Chiles* has expressed interest in this concept as well. (DOT)

Aviation Funding: The Governors are concerned over the future of the Airport Improvement Program (AIP), particularly in light of the December 31, 1996, expiration of the aviation ticket tax and other aviation taxes. During the last year *Governor Edgar of Illinois* has been the lead for NGA in expressing concern that the airport trust fund may be depleted unless the aviation taxes are renewed or alternative funding measures are agreed to by Congress. According to DOT sources, the trust fund may be depleted by July. (DOT)

Lautenberg Amendment: The Lautenberg Amendment prohibits the possession of firearms and ammunition by persons convicted of misdemeanor crimes of domestic violence. This provision also applies to state and local police officers who have been convicted of domestic violence crimes. Several Members of Congress have objected to the interpretation of the DOJ and Treasury that the law applies retroactively to crimes of domestic violence that occurred before the statutes enactment. (Treas.)

Welfare Reform Legislation: As a result of Welfare Reform legislation passed earlier this year, up to 300,000 child disability beneficiaries and up to 1 million noncitizen beneficiaries will be reviewed to determine if they continue to qualify for SSI under the new law. Advocacy group interest remains strong. (SSA)

Drug Addicts and Alcoholics (DA&A): Approximately 92,000 individuals who receive Social Security and/or SSI disability benefits based primarily on drug addiction or alcoholism have had cash benefits and Medicare/Medicaid health care coverage stopped as of January 1. To date, there have been a small number of protests or office confrontations after DA&A beneficiaries did not receive their January checks. Also, some city officials and advocacy groups have raised the question in local media as to what public assistance, if any, these people will now receive. (SSA)

Entitlement Spending Down: HUD recently informed cities and states of their projected FY97 Consolidated Plan funding Community Development Block Grants, HOME Investment Partnership grants, Housing Opportunities for People with AIDS and Emergency Shelter Grants. Total city and state funding for most states dropped slightly from FY96. Due to demographic and economic changes, some states took significant reductions:

State	FY96 Total	FY97 Total	Difference
Alabama	82,610,000	81,482,000	-1,128,000
Arizona	72,046,000	71,260,000	-786,000
California	766,633,000	757,542,000	-9,091,000
Washington, D.C.	35,412,000	34,400,000	-1,012,000
Florida	262,839,000	259,537,000	-3,302,000
Illinois	296,904,000	292,859,000	-4,045,000
Maryland	91,683,000	89,675,000	-2,008,000
Michigan	224,437,000	220,809,000	-3,628,000
Ohio	265,315,000	261,242,000	-4,073,000
Pennsylvania	342,754,000	338,303,000	-4,451,000

STATE BY STATE ISSUES

ARIZONA

Governor Symington is under federal indictment for fraud charges and is awaiting trial. (DOJ)

CALIFORNIA

Non-Citizen Voting: The Orange County District Attorney has launched an investigation into charges that a local community based organization, *Hernandad Mexicana Nacional*, encouraged naturalization applicants who were not yet citizens to vote. DOJ has temporarily suspended off-site processing of citizenship seekers at *Hernandad's* Santa Ana office pending outcome of the investigation, and will initiate deportation for fraudulent voters under recent immigration law. (DOJ)

Governor Pushes Adoptions as Welfare Alternative: As part of his welfare reform proposals, *Governor Wilson* said that "welfare recipients, especially pregnant teenagers, should be offered every assistance in placing their children for adoption, recognizing that such a decision is courageous, wise and ultimately unselfish choice by the parent." Supporters contend that this will encourage adoption and that the position represents sound social policy which emphasizes improving the lives of children via traditional families. Critics said the proposal unfairly targets poor women. *Governor Wilson* has also suggested moving children on welfare into foster care to save the state and counties money. His proposals have drawn angry responses from children's advocacy groups around the state. California currently has more than 98,000 abused and neglected children in foster care, an increase of 10,000 in the past two years. In the past year, about 3,000 children were adopted. (HHS)

FLORIDA

Alien Inmates: *Governor Chiles* has requested that DOJ take custody of 32 non-United States citizens confined in Florida prisons. DOJ has no legal authority to house these inmates. (DOJ)

Reimbursement for Inmates: *Governor Chiles* has expressed concern about the administration of State Criminal Alien Assistance Program (SCAAP) Fiscal Year 1996 because not all Mariel Cubans incarcerated in Florida's prison system resulted in reimbursement. (DOJ)

Grant Request for Assistance to St. Petersburg: DOJ received an application from *Governor Chiles* requesting \$1.3 million in Emergency Law Enforcement Assistance Program (EFLEA) funds resulting from the St. Petersburg disturbances. No Emergency Law Enforcement Assistance Program funds are available at this time. (DOJ)

Witness Intimidation: On January 9, *Governor Chiles* wrote to the Attorney General requesting "assistance and guidance" on the issue of witness security. He asked that DOJ respond directly to the NGA. DOJ is currently reviewing this request to determine an appropriate response in light of DOJ's recent focus on overall witness intimidation issues. (DOJ)

Citrus Canker Eradication: USDA is reviewing options for increasing Federal funding and personnel for citrus canker eradication efforts following Florida's request for additional funding. While the quarantine area will soon be expanded, the disease has not reached commercial citrus-production areas. The State of Florida has filed a lawsuit against USDA for \$33 million in connection with our previous citrus canker eradication program, which ran from 1984-86. During recent meetings with Florida officials, USDA has made progress in negotiating the lawsuit's resolution. (USDA)

IOWA

Judge Blocks Abortion Notification Law: On January 3, a Federal judge issued a temporary restraining order blocking state officials from enforcing the State's abortion notification law. The law was challenged on the grounds that it creates unconstitutional barriers for minors seeking abortions. A hearing will be scheduled on the request for a preliminary injunction. (HHS)

LOUISIANA

Serial Murder Investigation: *Governor Foster* applied for the Emergency Law Enforcement Assistance Program (EFLEA) requesting \$1.5 million for New Orleans serial murder investigation; only about \$500,000 is available in the fund. (DOJ)

Investigation of State Attorney General: It has been widely reported in the Louisiana press that DOJ is investigating State Attorney General Richard P. Ieyoub in connection with his duties as Louisiana Attorney General. (DOJ)

Milk Prices: The State Agriculture Commissioner of Louisiana led a delegation of representatives from 16 state departments of agriculture, primarily from Southern states, to discuss options to help dairy farmers in light of falling milk prices paid to producers. USDA has received 800 letters asking for action to support struggling dairy farmers. (USDA)

MAINE

Tobacco Access Regulations: Secretary Shalala may contact *Governors King of Maine and Sundquist of Tennessee* to advise them that they have not yet fully complied with statutory obligations under the Synar regulations. The states would then have 30 days to come into full compliance. This statute calls for a 30 percent reduction of FY97 substance abuse funding for states that fail to meet the requirements for enforcing their existing State laws regarding access of tobacco products to minors. (HHS)

MASSACHUSETTS

Massachusetts Report Finds "Assault" on Poor: A study by University of Massachusetts-Boston researchers details major cuts in aid to homeless shelter and prevention programs, welfare, and food stamps. Authors call the cuts an "unprecedented assault" on the poor, driven by the "systemic destruction" of society's safety net. Examples include a 62 percent reduction in state rent subsidies

since 1990, and a 64 percent cut in emergency homeless assistance for families. Though the study concentrates on Massachusetts, it notes that federal policies, like continued disinvestment in subsidized housing and homeless programs, affect people nationwide. *Governor Weld's* administration responded that his cost controls and aggressive welfare policies help families move from dependency to self-sufficiency. (HUD)

Massachusetts Preservation Projects Lack Funding: In FY97, Congress provided \$175 million to subsidize the sales of certain HUD-insured, low-income multi-family developments to nonprofit organizations and resident groups. Unfortunately, that amount could not cover many proposed sales. Several projects in Massachusetts just missed the cutoff, meaning that owners may raise rents on the low-income residents. Sen. Kerry and Rep. Frank raised this issue with Secretary-designate Cuomo, and *Governor Weld* may have an interest in it as well. (HUD)

Crane Paper Company: Senators Kerry and Kennedy, *Governor Weld* and numerous federal, state and local officials have expressed concerns about the proposed open bidding for the paper that is used by the Bureau of Engraving and Printing (BEP) to print currency. For over 100 years, the Crane Company of Dalton, MA, has exclusively provided the paper to BEP. The FY97 appropriations law required BEP to seek an alternative source for currency paper and provided that BEP could assist another potential suppliers with start-up costs. Members of the Massachusetts delegation have expressed particular concern about the possibility of such assistance going to a foreign firm. (Treas.)

MICHIGAN

EdFlex and Technology Challenge Grants: DOEd will be contacting the state in the next few days to inform them that their current Technology Challenge Grant proposal will not be approved due to the imminent expiration of the state's own technology plan. DOEd will also be making a determination on the state's EdFlex application within the next few days. Many states are interested in participating in the EdFlex program, under which states are released from most DOEd regulations as long as they meet agreed performance-based standards. (DOEd)

Limited English Proficiency Civil Rights Case: DOEd's Office for Civil Rights (OCR) has determined that approximately 20,000 national origin minority students in Michigan are not receiving adequate English language instruction. OCR has proposed a remedial action plan, which Michigan argues it does not have the authority, the resources or the responsibility to implement. OCR will respond to the state's claims by January 31. (DOEd)

NEBRASKA

Farm Bill Concerns: *Governor Nelson* may express his concerns about the impact of the 1996 farm bill on family farms in Nebraska. Because the state does not permit corporate farming, federal farm bill changes have a large impact on small farmers. He has also been pressing NGA to support granting inspectors at state inspected meat plants the same authority as federal meat inspectors. (USDA)

Potential Integration of VA Medical Centers: VA is reviewing consolidation plans for facilities in Grand Island and Lincoln. There has been considerable local opposition, largely centered on the concern that any change would result in the closing of the only rural VA medical center in Nebraska. Secretary Brown met with Congressman Bill Barrett on January 22. (VA)

NEW HAMPSHIRE

Goals 2000: Currently 16 districts in New Hampshire receive Goals 2000 funds directly from DOEd, an option made available through amendments in the 1996 budget bill. *Governor Shaheen* made Goals 2000 one of her top priorities and is now considering options for state participation in the program; three state school board members who opposed participation have recently resigned. (DOEd)

NEW JERSEY

Welfare Reform May be Delayed: NJ may not be able to implement its welfare reform plan on February 3, as originally anticipated, due to a delay in State Assembly action on two of *Governor Whitman's* four bills. While the Assembly is expected to vote on January 29, even if the bills are approved that day, the legislation would not take effect until a month from the day it is signed. Issues holding up Assembly action include abolishing municipal welfare agencies and turning their cases over to the counties and workers' compensation for welfare recipients injured on the job. (HHS)

NEW MEXICO

Waste Isolation Pilot Plant (WIPP): DOE is in the process of evaluating environmental impacts and seeking regulatory approval for the nation's first nuclear waste repository in southeastern New Mexico, 26 miles east of Carlsbad. Should the EPA approve the safety of the site, the WIPP will be used to permanently dispose of transuranic radioactive waste left from the research and production of nuclear weapons. DOE-sponsored public meetings have drawn a lot of attention. It will take the EPA approximately one year to review DOE's application. A recent comprehensive review by the National Research Council study validates the project as a viable solution for the permanent, safe disposal of transuranic waste. Attorney General Udall has indicated that a suit will be filed against the state if the state proceeds with hearings on the permit prior to the certification being received by EPA. (DOE)

NEW YORK

Decrease in Medical Care budget: VA facilities in New York and New Jersey are projected to lose \$148 million over the next three years. State and local officials have expressed concern as they are also cutting back funding for health and mental health care. (VA)

Inmate Reimbursements: *Governor Pataki* is concerned about the administration of State Criminal Alien Assistance Program because not all Mariel Cubans incarcerated in their prison system resulted in reimbursement to New York. DOJ has no plans to seek any legislative modifications. (DOJ)

New York Hospital Subsidy Controversy: State hospital authorities and the New York congressional delegation weighed in against an OMB proposal to change budget policy regarding the credit subsidy for HUD's Section 242 hospital mortgage insurance program. New York hospitals account for 85 percent of all Section 242 mortgages. OMB proposed to change the credit subsidy from a negative to a positive one, citing concerns about trends in the New York health care system that could affect hospital revenues. State agencies and Members of Congress argue that the change is unnecessary, and could have a profound effect on the amount of financing available to hospitals. *Governor Pataki's* office has remained quiet on this issue. The governor has stated his desire to cut both health care costs and the oversupply of hospital beds. (HUD)

NORTH CAROLINA

Bluff Mountain: Overruling nearly 100 citizen appeals, Forest Service officials upheld their highly controversial decision last November to cut timber on Bluff Mountain in North Carolina. (USDA)

OHIO

Central State University: DOEd has a long-standing civil rights case involving Ohio's only historically black school focusing on funding disparities between Central State and Ohio's other public universities. The school is in the midst of a severe fiscal crisis, and some Central State officials have been critical of a recent DOEd proposal for improvements in the university's fiscal condition. DOEd determined in October 1995 that the school must repay \$482,000 for mismanaging federal financial aid, and other programs are under review by the DOEd. Outside state counsel plans to forward a proposed resolution regarding the civil rights issues during the week of January 20. (DOEd)

Proficiency Test: DOE's Office for Civil Rights (OCR) expects to release a letter to the Ohio Department of Education by January 31 notifying it that OCR has determined that Ohio has failed to implement a settlement agreement relating to ODE's Ninth Grade Proficiency test and the nondiscrimination standards of Title VI. Under the agreement, Ohio was to have implemented by March 1, 1996, a set of measures to ensure that children have access to sufficient instruction to meet state standards. (DOEd)

SOUTH CAROLINA

Church Burnings: A member of the Ku Klux Klan recently pled guilty to arson charges at Macedonia Baptist Church and Mt. Zion AME Church and the burning of a migrant camp. (DOJ)

TEXAS

Local Law Enforcement Block Grant: DOJ was sued by Dallas and Harris counties regarding funding eligibility under the Local Law Enforcement Block Grant. Pursuant to the judge's injunction, funds are now frozen to these counties, including cities therein. Specifically, counties are shorted at the expense of cities. The formula was established by Republicans in Congress over Administration objections. (DOJ)

Houston City Council: The media in Houston has reported that the DOJ Criminal Division's Public Integrity Section and the FBI are conducting an investigation into allegations that four current and former members of the Houston City Council have accepted unlawful payments in return for their support of a \$150 million hotel development project. The local media has further reported that the investigation has involved the use of an FBI undercover company posing as an investment group seeking a share of the hotel project. DOJ is not making any public statements concerning the ongoing investigation. (DOJ)

Seeks to Privatize Eligibility Determination: The Texas Health and Human Services Commission has submitted a proposal to privatize the eligibility determination for several public assistance programs under the Texas Integrated Enrollment System (TIES). The proposal includes cash assistance, Medicaid, and food stamps as well as several other programs. The Health Care Financing Administration has expressed concerns regarding the degree to which the State is willing to transfer its responsibility to make eligibility determinations to a non-governmental entity. State public employee unions and a recipient's advocacy group have also expressed opposition to the proposal. (HHS)

VIRGINIA

Goals 2000: *Governor Allen* announced January 10 that Virginia will participate in Goals 2000. His action marks a major reversal from his firm stand against the state's participation and makes Virginia the 50th Goals 2000 state. (DOEd)

From: Kenneth S. Apfel on 01/31/97 06:15:23 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Gene B. Sperling/OPD/EOP, Marcia L. Hale/WHO/EOP, John L. Hilley/WHO/EOP

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

Subject: Talking Points on NGA's Job Training Proposal

We developed talking points in response to the NGA proposal for a job training block grant. The points below could be incorporated into other talking points being developed for anyone meeting with NGA or working on their proposal.

Administration's Response to Governors' Request for a Job Training Block Grant

The original G.I. Bill proposal. In the 1995 State of the Union message and FY 1996 through 1997 Budgets, the President proposed a ■G.I. Bill for America's Workers■ to collapse nearly 70 federal programs, and ■not give the money to the States, but give the money directly to the American people.

Bills in the 104th Congress. In the fall of 1995, training reform bills passed both Houses of Congress. However, Republican conferees excluded the Administration and the minority from the negotiations. The partisan conference produced a bill that resembled the Senate bill's block grant approach; it failed to gain the Administration's support or the vote of any minority conferee. The conference bill never reached a floor vote.

Governors want a training block grant. The Governors want to resuscitate the flawed training conference bill, arguing they need the flexibility of a block grant to implement welfare reform.

The President wants to help States implement welfare reform, but not through a training block grant.

He has proposed a \$3.4 billion Welfare-to-Work Jobs Challenge -- including employer tax credits, incentives for investment in distressed communities, and a \$3 billion Welfare-to-Work Jobs Initiative to move one million of the hardest-to-employ welfare recipients

A block grant to the Governors does not fulfill the G.I. Bill principles of:

Skill grants. For the past two years, the President has proposed a G.I. Bill for America's workers to empower adults with Skill Grants (i.e. vouchers) so that they, not bureaucracies, choose where to get training.

- Skill grants are an innovative, market-based tool to make training providers accountable to customers.
- Block grants are business as usual, with bureaucrats and contractors making job training decisions for adults.

Accountability. The President believes job training programs must be fully accountable to taxpayers for results.

- The G.I. Bill proposes strong gatekeeping and consumer reporting provisions to protect against fraudulent and incompetent training providers.
- Since Federal funds support training programs, the Federal government must be a full partner in establishing performance goals and approving plans.

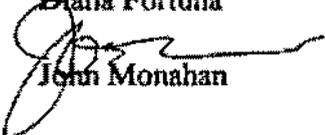
Message Copied To:

Emily Bromberg/WHO/EOP
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Jill Pizzuto



January 29, 1997

NOTE TO: Bruce Reed ✓
Marcia Hale
Emily Bromberg
John Emerson
Diana Fortuna

FROM: 
John Monahan

SUBJECT: Briefing Materials for 1997 NGA Winter Meeting

Attached are briefing materials prepared by the Department of Health and Human Services (HHS) for the upcoming National Governors' Association Winter Meeting, February 1-4. The following items will be of special interest:

Update on Welfare Reform Implementation

- chart showing status of certifications for state plans for Temporary Assistance to Needy Families (TANF) program
- map indicating states whose TANF plans have been certified as complete
- chart indicating major elements of state TANF plans
- Secretary Shalala's letter to the governors pledging continued collaboration with states in welfare reform implementation

Health Care Reform Waivers Update

- status report on Medicaid section 1115 research and demonstration and section 1915 program waiver applications
- map indicating states in which the Clinton Administration has approved a Medicaid section 1115 research and demonstration waiver
- talking points on "problem" waivers
- letters to governors with pending Medicaid research and demonstration waiver or

significant program waiver applications updating them on the status of HHS review of their applications

Major Issues

Issues that governors may raise relating to HHS include:

1. Bifurcation: Whether state-only spending under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) must comply with TANF regulations. As you know, the Administration is in the process of clarifying this issue.
2. Medicaid: Governors will likely pass a resolution opposing the caps on Medicaid spending, including per-capita cap proposals similar to that under consideration by the Administration.
3. Perinatal HIV Transmission: State public health officials have raised concerns about HHS's failure to promulgate guidelines relating to CDC's annual survey of child-bearing women. Key members of Congress have raised ethical issues concerning this survey, and it was halted in 1995.

In addition, I would like to call to your attention some of the major issues involving particular Governors:

Alaska Governor Tony Knowles - Governor Knowles' Washington office has contacted us for assistance with several issues including:

1. Additional funding for the Low Income Home Energy Assistance Program (LIHEAP) - Alaska is suffering through one of the coldest winters on record. Hearing of the President's recent announcement for increased funding for North Dakota and South Dakota, Alaska officials have asked the Governor's office to press for similar relief. We are not aware of an official request from the State for assistance, but we are advising the Alaska-Washington office of the process for making such a request.
2. Concerns with technical corrections to Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) - Alaska has raised concerns about a provision in the technical corrections package that would require funds for the new Temporary Assistance to Needy Families program be provided directly to the State's 226 Native Alaskan tribes, rather than to 12 Native Alaskan corporations established to provide social services to the tribes. Governor Knowles' office claims that having to work with all the tribes rather than the corporations will impose a major administrative burden on the State social services agency. The Justice Department has indicated to us that constitutionally, the federal government is required to deal directly with the

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tribes. We have scheduled a meeting with the Governor's Washington office on February 5 to discuss this issue.

Florida Governor Lawton Chiles - may raise concerns about the status of his state's 1915(c) waiver request for home and community-based services. We are working closely with the State to resolve this issue (please see letter to Governor Chiles in the attached briefing book).

Georgia Governor Zell Miller - recently wrote the Secretary requesting favorable action on his state's application for a child welfare demonstration project. Our Department has statutory authority to grant up to 10 waivers. To date we have approved 4 (Delaware, Illinois, Oregon, and North Carolina). Waivers for Ohio and possibly Maryland will be announced on February 14. HHS staff is still working with Georgia to sharpen the focus of the state's proposal, but we remain hopeful about the state's application.

Maryland Governor Parris Glendening - may raise concerns about the status of his state's child welfare waiver request. We expect this waiver to be approved February 14, perhaps in conjunction with a White House event. We are telling state officials that a final decision is expected shortly.

Massachusetts Governor William Weld - may raise concerns about the status of his state's TANF application which was submitted in September 1996. It will be approved this week.

Minnesota Governor Arne Carlson - may raise concerns about the status of his Medicaid waiver. Please see the talking points in the attached briefing book.

New Mexico Governor Gary Johnson - may raise concerns regarding the status of his 1915(b) Medicaid waiver. Please see the talking points in the attached briefing book.

New York Governor Pataki - as indicated in the "Problem Waiver" talking points, Governor Pataki may be concerned about the length of time involved in our review of his state's Medicaid program waiver.

Utah Governor Mike Leavitt - may raise concerns regarding the status of his state's 1115 Medicaid waiver. We have been working closely with staff and expect a resolution shortly. Please see the talking points included in the attached briefing book.

Please call me at 690-6060 or Jim Mason of my staff at 401-5639 if you have any questions about this material.

Attachment

**National Governors' Association
1997 Winter Meeting
February 1 - 4, 1997**

HHS Briefing Materials

I. Welfare Reform Implementation

- State TANF Certifications (as of 1/29/97)
- Map of TANF States
- State TANF Plan Elements
- Secretary's Letter to the Governors

II. Health Reform Waivers

- Clinton Administration Medicaid Waiver Record
- Map of Medicaid Waiver States
- Medicaid Waiver Status Report
- "Problem Waiver" Talking Points
- Waiver Status Letters

III. National Governors' Association Policy Resolutions

Faint, illegible text, possibly a list or index, running vertically down the page.





STATES WITH SUBMITTED TANF STATE PLANS

as of 1/29/97 2:00 p.m.

Source: U.S. Dept. of Health & Human Services/Administration for Children & Families

states submitted: 41
states certified: 35
states pending: 6

Tribes/territories submitted: 2
Tribes/territories certified: 0
Tribes/territories pending: 2

<u>state</u>	<u>submission date</u>	<u>certified complete</u>	<u>state</u>	<u>submission date</u>	<u>certified complete</u>
Wisconsin	8/22/96	9/30/96	New Jersey	10/15/96	1/29/97
Michigan	8/27/96	9/30/96	Wyoming	10/16/96	12/23/96
Ohio	9/19/96	11/1/96	New York	10/17/96	12/13/96
Florida	9/20/96	10/8/96	Nevada	10/18/96	12/24/96
Vermont	9/20/96	11/18/96	North Carolina	10/18/96	1/10/97
Massachusetts	9/23/96	1/28/97	Montana	11/1/96	
Maryland	9/27/96	1/10/97	Georgia	11/15/96	1/21/97
Oregon	9/27/96	11/1/96	Iowa	11/15/96	1/21/97
Arizona	9/30/96	11/1/96	West Virginia	11/27/96	
Kentucky	9/30/96	11/18/96	District of Columbia	12/4/96	
Maine	9/30/96	12/27/96	Virginia	12/6/96	
Oklahoma	9/30/96	11/1/96	Washington	12/12/96	1/14/97
Tennessee	9/30/96	12/20/96	Delaware	1/22/97	
Utah	9/30/96	12/13/96	Pennsylvania	1/22/97	
Alabama	10/1/96	12/7/96			
Connecticut	10/1/96	1/22/97			
Indiana	10/1/96	11/1/96			
Kansas	10/1/96	11/27/96			
Louisiana	10/1/96	1/10/97			
Mississippi	10/1/96	11/27/96			
Missouri	10/1/96	12/23/96			
Nebraska	10/1/96	12/7/96			
New Hampshire	10/1/96	11/12/96			
South Dakota	10/1/96	12/7/96			
Texas	10/1/96	11/26/96			
California	10/9/96	12/7/96			
South Carolina	10/12/96	1/3/97			

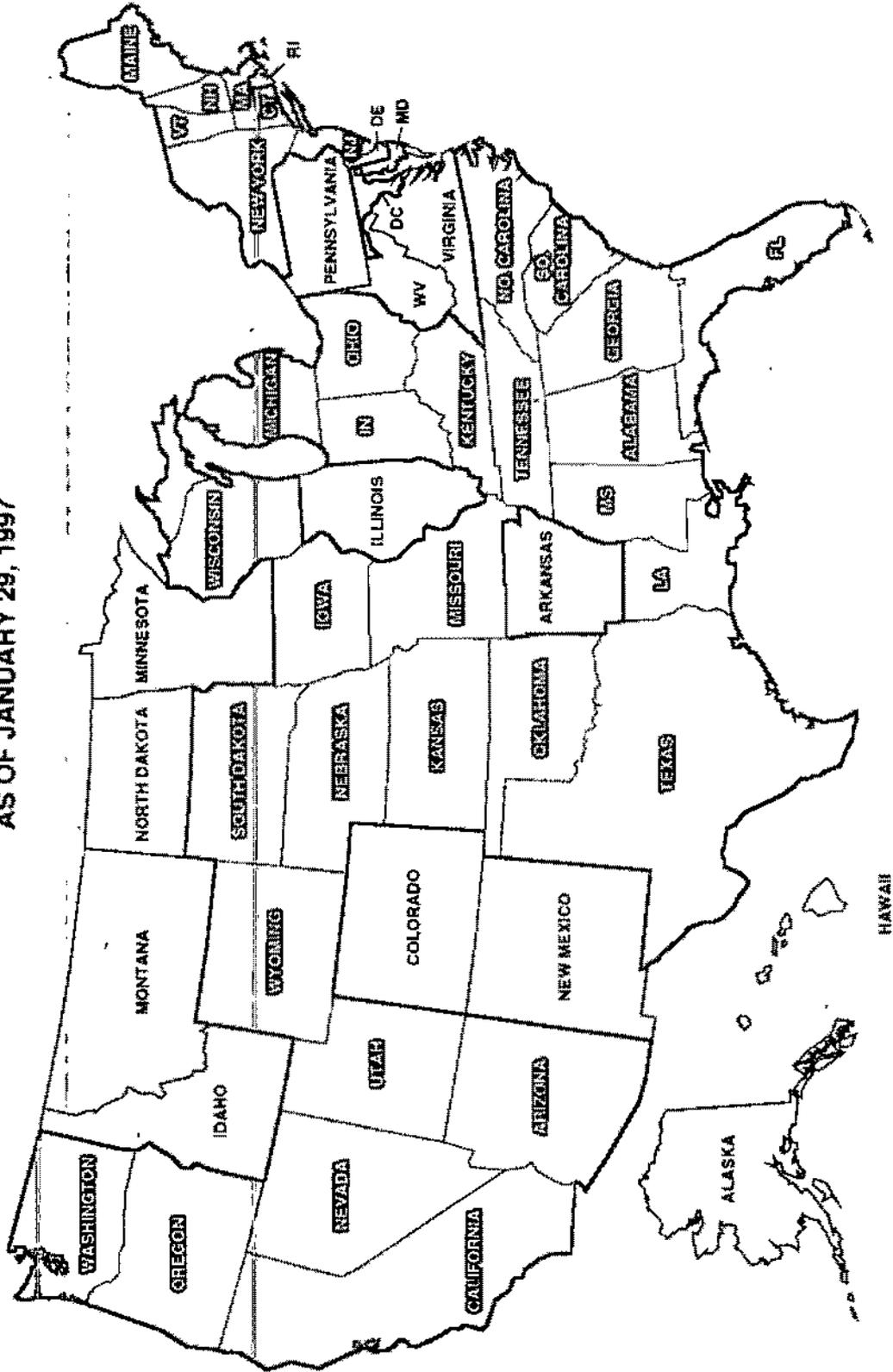
<u>Tribes/territories</u>	<u>submission date</u>	<u>certified complete</u>
Red Cliff Band of Lake Superior Chippewas (WI)	10/2/96	
Guam	1/9/97	

Note: this information is available on the World Wide Web at <http://www.acf.dhhs.gov/news/welfare/stplans.htm>



COMPLETE TANF STATE PLANS

AS OF JANUARY 29, 1997





DRAFT - DRAFT
 Selected Provisions of TANF Programs V
 For Internal Use Only

Total # of TANF plans submitted as of January 28, 1997:
 States: 41
 Territories: 1

Total # of TANF plans certified complete as of January 28, 1997:
 States: 34
 Territories: 0

State	Reskin Waiters	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Sanctions For Noncompliance With Work Requirements	Employment Subsidy Components	Individual Responsibility Plan	Family Cap	2-Tier	Screen for Domestic Violence ?	Benefits to ABES	Other Selected Options
ALABAMA Received: 10/01/96 Subject to TANF: 11/15/96	All (in 3 consultation)	Consistent with 407	Immediate	As defined in 407	Reduction of Termination	Not specified	Yes	Not specified	No	Yes	No	Participation by Noncustodial Parent (ASSETS)
ARIZONA Received: 09/30/96 Subject to TANF: 10/01/96	All	24 max of 60 for each household members	Individual	As defined in 407	Reduction	Yes	Yes	Yes	No	Not specified	Yes	Individual Development Accounts
CALIFORNIA Received: 10/09/96 Subject to TANF: 11/26/96	All	Not specified	24 if received job in 21 of the last 24 months	Job Search, Unsubsidized or Subsidized Employment, Education, OJT or Work Experience	Reduction	Not specified	Yes	Yes	Yes	Yes	Yes	Individual Development Accounts, Learnsafe
CONNECTICUT Received: 10/01/96 Subject to TANF:	All	21	Immediate for job search (Upon entering the time-limited program, all recipients must participate in work activation activities)	Work is defined by the State as employment or any other required activity which seeks to either place recipients into employment or prepare them for employment as possible. Activation includes those defined in 407.	Reduction of Termination	Not specified	Yes (Employment Plan)	Yes	No	Not specified	Yes	Learnsafe, Individual Development Accounts

State	Retain Waivers	Time Limit (Months)	Time Frame for Work (Months)	Major Work Activities	Successful Noncompliance With Work Requirements	Employment Stability Component	Individual Responsibility Plan	Family Cap	2 Yr	Screen for Domestic Violence ?/	Benefits to Aliens	Other Selected Options
DELAWARE Revised: 01/22/97	All	24 for adults; if not able to locate job, 24 additional months pay after performance	Immediate	Work Readiness/ Life Skills, Job Search/Job Placement, Job Retention, Work Experience/OJT, Vocational Skills Training, Remedial/Basic Skills Training	Reduction	Not specified	Yes	Yes	No	Yes (certified)	Yes	Learn/are Participated by Noncompliant Parents; Convicted Drug Felons are Not Eligible; Individual Derangement Accounts
DISTRICT OF COLUMBIA Revised: 12/05/96	Not specified	60	Not specified	In accordance with 407	Reduction	Not specified	Yes	Not specified	Yes	Not specified	Yes	
FLORIDA Revised: 09/29/96 Subject to TANY: 10/01/96	All	(1) 24 out of 60 with lifetime of 40; (2) 36 out of 72 with lifetime of 40	Immediate	As defined in 407	Termination, Preemptive Payoff for Children Under 12 Years Old	Yes	Yes	Yes	Yes/	Yes (certified)	Yes	Enroll/are Participated by Noncompliant Parents; Require Immunizations; Community Service After 3 Months
GEORGIA Revised: 11/15/96 Subject to TANY: 01/01/97	All (children determined within 90 days)	48	When determined able to engage in work or 24 months whichever comes first	As defined in 407	Reduction or Termination	Not specified	Yes	Yes	Yes	Yes (certified)	Yes	Require Immunizations; Learn/are Participated by Noncompliant Parents to Enroll/are Participated; Convicted Drug Felons are Not Eligible
GUAM Revised: 01/09/97	Not applicable	60	Immediate	In accordance with 407	Reduction	Not specified	Yes (team)	Not specified	No	Yes (certified)	No	Community Service After 2 Months
INDIANA Revised: 10/01/96 Subject to TANY: 06/01/96	All	24	24	Job Search, Subsidized Work, and Community Work Experience (Public Service)	Reduction	Not specified	Yes	Yes	Yes	Yes	Yes	

State	Resain Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Sanctions Noncompliance With Work Requirements	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	2 Tier	Screen for Domestic Violence ?	Beneficial to Aliens	Other Selected Options
IOWA Revised: 11/15/96 Subject to TANF: 01/01/97	All	Individuals Not to Exceed 60	When determined able to engage in work or 24 months, whichever occurs first	As defined in 407	Reduction or Termination	Not specified	Yes	Not specified	No	Yes (certified)	Yes	Individual Development Accounts
KANSAS Revised: 10/01/96 Subject to TANF: 10/01/96	Not specified	60	Immediate	As defined in 407	Not specified	Not specified	Yes	Not specified	No	Not specified	Yes	
KENTUCKY Revised: 05/20/96 Subject to TANF: 10/01/96	Not applicable	60	6	Unsubsidized Work, Subsidized Private Sector, Community Service, Workfare, Retention Assistance, Family Health Care Providers, and Registered Child Care Providers	Reduction, Retention Grant Paid to Provider Payor	Yes Tax credits to employers	Yes	Not specified	No	Yes	No	Upfront Diversion; Individuals Committed of Drug Felony are Not Eligible; Reentry; Imposition; Parole paid by Monetary Aid; Parents
LOUISIANA Revised: 10/01/96 Subject to TANF: 01/01/97	Terminatory	24 out of 60	Not Specified	Unsubsidized Employment, Subsidized Private Sector, Subsidized Public Sector, Job Search and Job Readiness Assistance, Community Service, Vocational Education, Job Skills Training, Directly Related to Employment, Provision of Child Care Services to an individual who is participating in a Community Service Program	Termination	Not specified	Not specified	Not specified	No	Yes	Yes	

State	Retain Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Sanctions/Noncompliance With Work Requirements	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	Tier	Screen for Domestic Violence ?	Benefits to Alphas	Other Selected Options
MAINE Received: 10/31/96 Subject to LANT: 11/01/96	Unlimited	60	When determined able to engage in work or 24 months, whichever occurs first	OJT, Apprenticeships, Self-Employment, Other Non-Traditional Employment, and Full-Time Work	Reduction in Tuition Party Payments	Yes	Yes	Not specified	No	Not specified	Yes	
MARYLAND Received: 09/27/96 Subject to TANY: 11/09/96	Terminated FY97, Retain FY except cash component	60	Not specified	Job Search and Other Unspecified Activities	Reduction w/ Termination	Not specified	Yes	Yes	Yes	Yes (certified)	Yes	Learnfare
MASSACHUSETTS Received: 09/21/96 Subject to LANT: 09/26/96	All	24 out of 60 consecutive months	60 days	Job search, Job Readiness, Job Skills Training, Education, the Full Employment Program (FEFP), Supported Work, Community Services, Subsidized or Unsubsidized Job, Two-Year Community College Programs, Vocational Education, Secondary Education, Attendance at Secondary School, Child Care Services to Other Participants in Work Activities	Reduction, Termination, Mandated Part-time in Community Service	Yes	Yes	Yes	No	Yes	Yes	Learnfare/Requires Incentivizations
MICHIGAN Received: 08/27/96 Subject to TANY: 09/26/96	All	60	60 days	High School Completion, GED, Basic/Remedial Education, English Proficiency, Job Skills Training, Job Readiness Activities, Job Development Placements	Reduction	Yes	Yes	Not specified	No	Decide Later	Yes	Learnfare

State	Retain Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Sanctions Noncompliance With Work Requirements	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	2 Tier	Screen for Domestic Violence 2/	Benefits to Aliens	Other Selected Options
MISSISSIPPI Received: 10/01/96 Subject to TANF: 10/01/96	All	60	24	As defined in 407	Full Family Sanction or Termination	Yes	Yes	Yes	No	Yes	Yes	Learnsfare; Require Immunizations; Community Service After 2 Months; Individual Development Accounts
MISSOURI Received: 10/01/96 Subject to TANF: 12/01/96	All	24/48	24	As defined in 407	Reduction	Yes	Yes	Not specified	No	Yes	Yes	
MONTANA Received: 11/01/96	All	18 two parents; 24 single parent	Not specified	State sets parameters but communities have been given flexibility to determine appropriate work activities. These activities are based on Montana's JOBS program, waiver authority, and local community operating plans.	Reduction	Not specified	Yes	Not specified	No	Yes (certified)	Yes	Learnsfare; Community service for individuals who have used Pathways benefits but not achieved self-sufficiency
NEBRASKA Received: 10/01/96 Subject to TANF: 12/01/96	All (in 5 counties)	24 out of 48	Immediate	Job Search, Education, Job Skills Training, Job Readiness, Microbusiness Enterprise, Work Experience, OJT, Employment, and CWEP.	Full Family Sanction or Termination	Not specified	Yes	Yes	No	Yes (certified)	Yes	Learnsfare
NEVADA Received: 10/18/96 Subject to TANF: 12/03/96	Not applicable	60 (will submit change to 24)	When determined able to engage in work or 24 months, whichever comes first	Unsubsidized/ Subsidized Private or Public Sector Employment, Work Experience, OJT, Job Search, Job Readiness, Community Service, Vocational Education, and Child Care Services	Reduction	Not specified	Yes	Not specified	No	Yes	Yes	

State	Retain Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Severely Noncompliance With Work Requirements	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	Tier	Screen for Domestic Violence ?/	Benefits to Aliens	Other Selected Options
NEW HAMPSHIRE Received: 10/01/96 Subject to TANF: 10/01/96	All	60	When determined able to engage in work or 24 months, whichever comes first	OJT, Alternate Work Experience, Job Search, Job Skills Training, Education	Reduction or Termination	Not specified	Yes	Not specified	No	Yes	Yes	
NEW JERSEY Received: 10/15/96	Terminates	60	When determined able to engage in work or 24 months, whichever comes first	As defined in 407	Reduction	Yes	Yes	Yes	No	Not specified	Yes	Convicted Drug Felons are Not Eligible
NEW YORK Received: 10/17/96 Subject to TANF: 12/02/96	Not specified	Not specified	When determined able to engage in work or 24 months, whichever comes first	As defined in JOBS State Plan	Reduction or Termination	Not specified	Not specified	Not specified	Not specified	Not specified	Yes	3 Month Community Service
NORTH CAROLINA Received: 10/22/96 Subject to TANF: 01/01/97	All	24/60	Immediate	As defined in 407	Reduction or Denial	Yes (Caldwell County)	Yes	Yes	No	Will Develop Standards	Yes	Require Humanities, Learning, Upbeat, Extension
OHIO Received: 09/19/96 Subject to TANF: 10/01/96	All	36 out of 60	24 months	Alternative Work Experience, Community Work Experience, Work Supplementations, OJT, and Postsecondary Education	Reduction or Termination	Yes	Yes	Not specified	No	Yes	Yes	2 Month Community Services, Learning

State	Keats Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Sanctions/Noncompliance With Work Requirements	Employment Subsidy Components	Individual Responsibility Plan	Family Cap	2 Tier	Screen for Domestic Violence ?	Benefits to Aliens	Other Selected Options
OKLAHOMA Received: 09/25/96 Subject to TANT: 10/01/96	Terminable MAAFS Continuing Learnfare	60	Immediate	Activities designed to assist in becoming employable or in obtaining employment; Alternative Work Experience, Job Search, Job Readiness Training, Job Skills Training, Job Corps, QJT	Not specified	Not specified	Not specified	Not specified	No	Yes	Yes	Learnfare
OREGON Received: 09/27/96 Subject to TANT: 10/01/96	All	24 and 64	Immediate	As defined in 407	Restoration or Termination	Yes	Not specified	Not specified	No	Yes	Yes	Individual Development Accounts
PENNSYLVANIA Received: 01/23/97		60	Immediate	Job Search, Job Readiness/Preparation, Subsidized Employment, Work Experience, QJT, Workfare, Community Services, Vocational Education, General Education, ESL, Job Skills Training, Any Employment or Training Funded/Approved by Department	Ineligible	Not specified	Yes	Not specified	Yes	Yes (certified)	Yes	Require Immunizations; Individual Development Accounts; Accountants; Convicted Drug Felons are Not Eligible; Learnfare
SOUTH CAROLINA Received: 10/12/96 Subject to TANT: 10/12/96	Some	24 60 90	Applicable Immediate or works job search; Recipients When Determined able to engage in work or 24 months, 60 months, 90 months whichever comes first	Work Experience, QJT, Vocational Training, Technical Schools, Literacy Classes, Adult Education, OED, Family Life Skills, and Job Club Activities	Termination	Not specified	Yes	Yes	No	No	No	Learnfare; Individual Development Accounts

State	Retain Waivers	Time Limit (Months)	Time Frame For Work (Months)	Major Work Activities	Selections/ Requirements With Work	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	2 Tier	Screen For Domestic Violence 2/	Benefits to Aliens	Other Selected Options
SOUTH DAKOTA Received: 10/01/96 Subject to TANY: 12/01/96	Some	60	24	As defined in 407; additionally, Pre-Employment Training, Secondary Education, Vocational Education and College Education	Terminally ill individual; Pre-Employment Training; Research Grant	Not specified	Yes	Not specified	No	Yes	Yes	Upfront Diversion; Loan/Grant; Royalty; Immunizations
TENNESSEE Received: 09/30/96 Subject to TANY: 10/01/96	All	12/24/00	Immediate	Unemployment; Community Services; Job Search; GED	Transition	Not specified	Yes	Yes	No	Yes (certified)	Yes	Individual Dependence Accounts
TEXAS Received: 10/01/96 Subject to TANY: 11/01/96	All	12/24/96 in individual	Immediate	Education or Literacy Training; Employment Skills Training; Vocational Training; Life Skills Training; Parent Skills Training; Community Work Program or Other Work Program Approved by the State; A. Boudreau Internship Subsidized Employment; Self-Employment Assistance	Reduction	Not specified	Yes	No	No	Not specified	Yes	Upfront Diversion; Loan/Grant; Royalty; Immunizations; Individual Dependence Accounts
UTAH Received: 09/30/96 Subject to TANY: 09/01/96	All	36	24	Employment; Job Search; Mental Health Treatment; Training	Provision or Termination	No	Yes	No	No	Yes (certified)	Yes	Upfront Diversion
VERMONT Received: 09/30/96 Subject to TANY: 09/20/96	All	60	Immediate	Unemployment; Job Search; Community Services; Jobs; Grant Extension	Vendor Payments	Yes	Yes	No	No	Not specified	Yes	

State	Retain Waivers	Time Limit (Months)	Time For Work (Months)	Major Work Activities	Sanctions Noncompliance With Work Requirements	Employment Subsidy Component	Individual Responsibility Plan	Family Cap	Tier	Screen for Domestic Violence 2/	Benefits to Aliens	Other Selected Options
VIRGINIA Received: 12/06/96	All	34 out of 60	32 for CWEP	Unsubsidized, Subsidized, Private/Public, Work Experience, OJT, Job Search, Job Skills Training, Job Development	Full Family Sanction	Yes	Yes	Yes	No	No	Yes	Upfront Diversion; Learnfare; Individual Devolvement Accounts; Require Immunization
WASHINGTON Received: 12/12/96 Subject to TANF: 01/10/97	All	48 out of 60 Benefits reduced	24	As defined under JOBS	Reduction	Not specified	Yes (Income) Employment Plan (subsidy)	Not specified	No	Yes (certified)	Yes	
WEST VIRGINIA Received: 11/26/96	Not specified	60	24	Unsubsidized, Job Search, CWEP, Vocational Skills, Training, Secondary Education (for 1 year parents)	Reduction or Termination	Yes	Yes	No	No	Yes (certified)	U	Upfront Diversion
WISCONSIN Received: 09/22/96 Subject to TANF: 09/30/96	All	60	Immediate	As defined in 407	Reduction	Yes	Not specified	Yes	Yes	No, specified	Yes	Learnfare; Individual Devolvement Accounts
WYOMING Received: 10/07/96 Subject to TANF: 01/01/97	Terminate	60	Immediate Under Pay AB or Performance	Work Experience, Community Service, Educational/Vocational Training	Termination	Not specified	Yes	Not specified	No	No	No	Participation by Noncustodial Parent

Footnotes:

1/ Shading indicates plan determined complete by DHS.

2/ Includes States that certified that the State will screen for domestic violence, as well as States that did not certify but included a description in their plan.

3/ For individuals who have moved from another state and have lived in Florida for less than 12 months, the time limit for temporary assistance shall be the shorter of the time limitations in the two states, and months in which assistance was received in any state shall count towards the 48-month cumulative benefit limit. Otherwise, new residents are treated the same as other residents.





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

JAN 29 1997

The Honorable Fob James, Jr.
Governor of Alabama
Montgomery, Alabama 36130-2175

Dear Governor James:

In his inaugural address last week, President Clinton laid out his vision for America -- a nation with stronger communities, a country fully committed to investing in our families and children. I am honored that the President asked me to continue to help him carry out his vision by continuing to serve as Secretary of Health and Human Services. And I am proud of the work our Department has already done in forging a stronger partnership with states to improve the lives of our citizens.

Of course, we have many challenges ahead. First, nothing is more crucial than successful implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which the President signed last August. We both know how significantly this law changed the roles and responsibilities of states in administering programs to aid poor families and children in this country. Let me again pledge my Department's assistance to you as your state makes the transition to the new Temporary Assistance for Needy Families (TANF) program. In fewer than five months since enactment of the welfare reform law, the Department of Health and Human Services (HHS) has certified as complete over 30 states' TANF plans. As you know, these certifications allow states to begin drawing down funds under the new block grant in support of their new assistance programs.

We also are in regular consultation with the National Governors' Association, National Conference of State Legislatures, American Public Welfare Association, and numerous individual state officials as we examine important issues relating to implementation of the new welfare reform law. Please be assured that we are deeply committed to close consultation with our state partners as the TANF program is implemented, particularly with respect to the development of regulations and other guidance.

Second, in the coming weeks President Clinton will outline his agenda for health care improvement, including initiatives to improve Medicaid and expand access for uninsured workers and children. I am confident that you will find these proposals contain substantial state flexibility that builds upon the work we have done with so many states to expand Medicaid coverage, control costs, and improve quality. I look forward to working

page 2 - The Honorable Fob James, Jr.

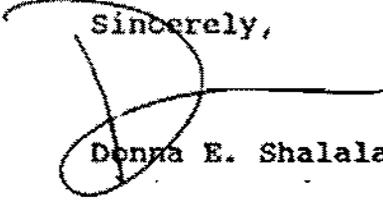
with each of you to explore ways in which our federal-state partnership can provide quality health care to American families who need it.

Third, over the next four years, I look forward to many other opportunities for us to work together on a range of health and human services issues, from child care to services for the aging. These issues are important to all of us, and I am eager to work with you as we address them with the common goal of strengthening our families and our communities.

I will always welcome your thoughts on these issues, and if I can ever be of assistance to you on these or other matters, please do not hesitate to contact me or my Director of Intergovernmental Affairs, John Monahan. John can be reached on (202) 690-6060.

Best wishes on the exciting year ahead, and for the upcoming Winter Meeting of the National Governors' Association.

Sincerely,



Donna E. Shalala



MEDICAID WAIVERS APPROVED DURING THE CLINTON ADMINISTRATION
(January 21, 1993-January 22, 1997)

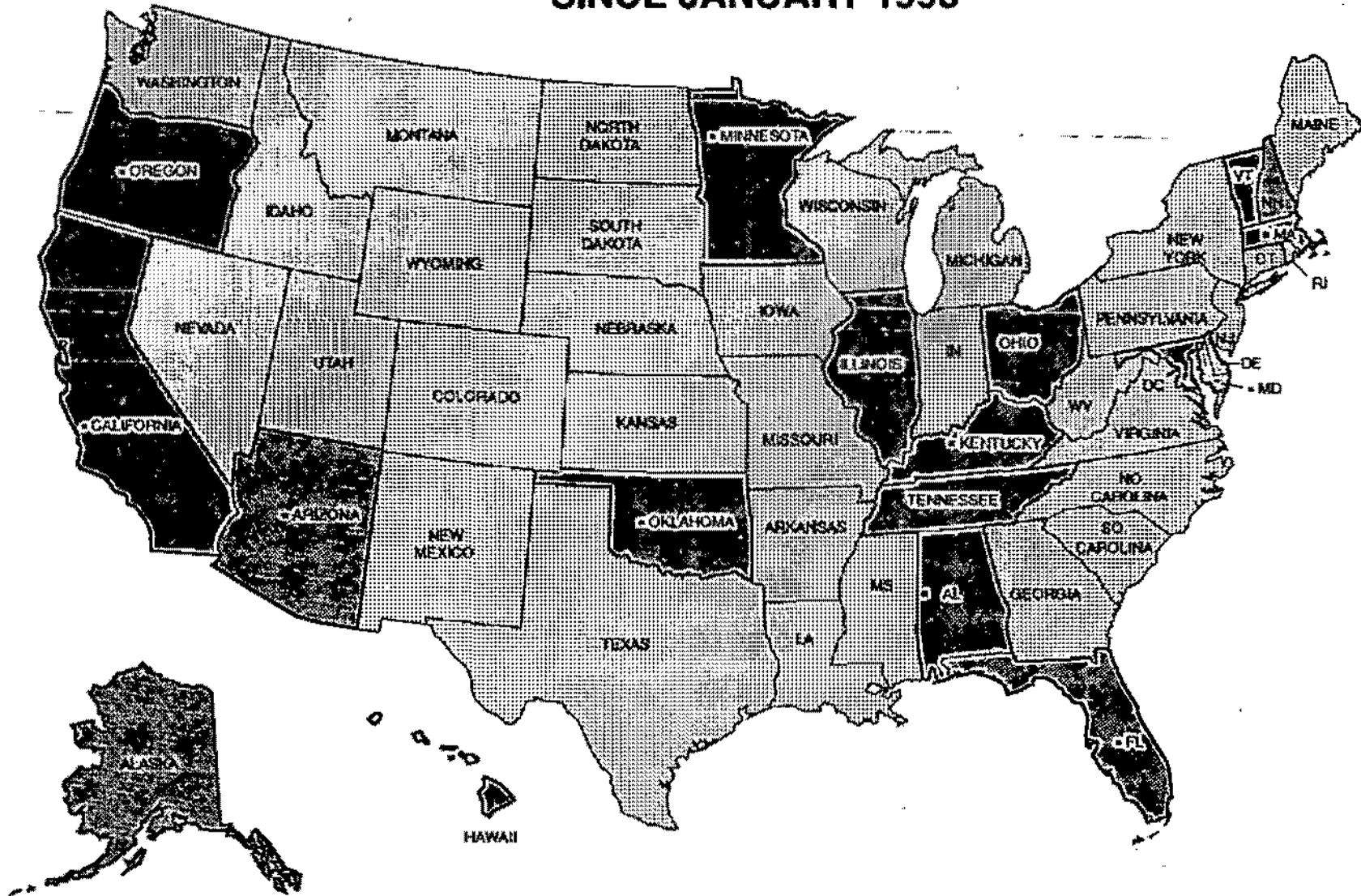
STATE	1115 STATEWIDE HEALTH CARE REFORMS Permit states to: -restructure eligibility and coverage under Medicaid; -acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating state health programs.	1915(b) FREEDOM OF CHOICE WAIVERS* Permit states to: -waive beneficiaries' rights to free choice of providers in order to, for example, implement a primary care case management system or a speciality physician services arrangement; -require Medicaid beneficiaries to receive services from specified providers, generally on a negotiated rate contract basis.	1915(c) HOME AND COMMUNITY-BASED WAIVERS * Permit states to: -provide a broad array of home and community-based services (excluding room and board) not otherwise covered under the Medicaid program as an alternative to institutional care.
Alabama	✓	✓(5)	✓(14)
Alaska			✓(16)
Arizona			
Arkansas		✓(4)	✓(10)
California		✓(19)	✓(11)
Colorado		✓(4)	✓(18)
Connecticut		✓(1)	✓(10)
Delaware	✓		✓(6)
D.C.		✓(2)	✓(2)
Florida	✓	✓(5)	✓(19)
Georgia		✓(5)	✓(6)
Hawaii	✓		✓(4)
Idaho		✓(2)	✓(6)
Illinois			✓(15)
Indiana		✓(3)	✓(27)
Iowa		✓(4)	✓(25)
Kansas		✓(3)	✓(9)
Kentucky	✓	✓(4)	✓(7)
Louisiana		✓(3)	✓(13)
Maine		✓(3)	✓(12)
Maryland	✓	✓(4)	✓(7)

Massachusetts	✓	✓(3)	✓(4)
Michigan		✓(6)	✓(12)
Minnesota	✓	✓(2)	✓(20)
Mississippi		✓(6)	✓(5)
Missouri		✓(3)	✓(13)
Montana		✓(4)	✓(5)
Nebraska		✓(3)	✓(14)
Nevada		✓(1)	✓(10)
New Hampshire			✓(8)
New Jersey		✓(3)	✓(14)
New Mexico		✓(3)	✓(6)
New York		✓(9)	✓(16)
North Carolina		✓(4)	✓(14)
North Dakota		✓(5)	✓(7)
Ohio	✓	✓(3)	✓(11)
Oklahoma	✓	✓(1)	✓(11)
Oregon	✓	✓(4)	✓(3)
Pennsylvania		✓(10)	✓(15)
Rhode Island	✓		✓(8)
South Carolina	**	✓(2)	✓(12)
South Dakota		✓(3)	✓(8)
Tennessee	✓		✓(18)
Texas		✓(14)	✓(28)
Utah		✓(4)	✓(8)
Vermont	✓		✓(8)
Virginia		✓(3)	✓(7)
Washington		✓(14)	✓(16)
West Virginia		✓(5)	✓(4)
Wisconsin		✓(5)	✓(17)
Wyoming		✓(1)	✓(7)
TOTALS	15**	192	566

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



STATES WITH APPROVED SECTION 1115 AND 1915(b) PROGRAMS SINCE JANUARY 1993



APPROVED 1915(b)



APPROVED 1115

* State also has approved 1915(b)



NO 1915(b) OR 1115 PROGRAMS

* State has 1115 approved prior to 1993





STATUS OF OTHER STATE MEDICAID INITIATIVES

January 23, 1997

INTERNAL DOCUMENT

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL RECEIVED	APPROVED	DISAPPROVED	ACCEPTANCE OF T&C	IMPLEMENTATION	NEW ACTIVITY
AR		10/12/95	6/18/96				
CO		6/3/93					
CO		9/28/95					
DC		3/17/94	10/13/95/10/19/95		10/95	12/15/95	
IA		4/5/93		12/23/93			
ME		4/93		7/13/93			
MD		2/8/93	8/9/93		09/93	10/93	
MD		6/11/94	12/5/94		12/94	1/95	
MI		3/95					
MN		4/18/94	4/27/95		5/25/95	1/97	
MN		10/14/93		4/7/94			
NES	X						
NH		12/6/93		4/19/94			
NM		12/9/94					
RI		4/5/94					
SC		6/23/93 4/26/96 (Amendment)	12/7/93		02/3/94	7/94	X
WVA	X						
WI		2/28/96					

**SECTION 1115 WAIVER ACTIVITY
OTHER MEDICAID INITIATIVES
January 23, 1997**

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
<p>ARKANSAS (Approved)</p>	<p>Arkansas was awarded a waiver demonstration project that will extend Medicaid coverage for family planning services. The goal of this project is to reduce the number of unintended pregnancies in Arkansas, thereby reducing the number births covered by Medicaid. Currently in Arkansas, Medicaid covers pregnant women with incomes at or below 133 percent of the FPL. Over 85 percent of these women lose their coverage 60 days after delivery. The State proposes to allow these women to have Medicaid-covered family planning services for 5 years or the length of the proposed project. Women will be notified by mail that they are eligible for pregnancy prevention services. The application process will be streamlined and a media campaign will be conducted to enhance outreach.</p>	<p>Waiver was approved on 6/18/96.</p> <p>At this time, the State has not responded to HCFA award letter.</p> <p>HCFA and the State are renegotiating the special terms and conditions.</p>	<p>Proposal received 10/12/95.</p> <p>Questions sent 11/22/95.</p> <p>State response received 2/7/96.</p> <p>Draft terms and conditions sent 6/96.</p> <p>Award letter sent 6/18/96.</p>
<p>COLORADO (Received)</p>	<p>Colorado has submitted an application for a section 1115 project to demonstrate that certain home health services could appropriately be provided in settings which are alternative to the home.</p>	<p>A decision package is nearing completion and will be sent forward as soon as budget neutrality calculations are finalized.</p>	<p>Proposal received 6/3/95.</p> <p>Questions sent 9/28/95.</p> <p>State responded to questions on 10/20/95, and submitted revised material on 7/19/96.</p>
<p>COLORADO (Received)</p>	<p>Colorado submitted a section 402 and section 1115 waiver proposal to combine preventive, primary, acute, and long-term care services into a coordinated system of managed care for all Medicaid eligibility groups. Existing funding from Medicare (for dual eligibles) and Medicaid will be used to fund the medical, social, and supportive services that will be available under this project. The State intends to begin this project with a single site demonstration in Mesa County, Colorado. The State will contract with Rocky Mountain HMO (the only HMO in Mesa County) to organize and provide integrated care services to over 7,000 Medicaid eligible beneficiaries including dual eligibles</p>	<p>On 8/2, a letter was sent to the State which outlined issues that must be resolved before proceeding with negotiating special terms and conditions. The issues include: budget neutrality, Medicare payment rates, and the Medicare service system.</p> <p>The State responded to HCFA's letter on 9/4/96.</p> <p>On 9/26, a conference call was held to discuss outstanding issues. HCFA is awaiting the submission of Medicare and Medicaid historical data for budget neutrality calculations and rate-setting.</p>	<p>Proposal received 9/28/95.</p> <p>Questions sent 2/22/96.</p> <p>State response received 5/16/96.</p>

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
DISTRICT OF COLUMBIA (Approved/ Implemented)	The District of Columbia was granted an 1115 waiver demonstration that implements a specialized managed care program, targeted to the needs of its SSI eligible disabled children. Eligibles are enrolled into a newly-formed health plan, Health Services for Children with Special Needs, Inc. (HSCSN) on a voluntary basis. HSCSN receives monthly capitation payments, but maintains a risk-sharing arrangement with the District.	A staggered 6-month notification and enrollment schedule was recently completed. Enrollment cannot be finalized until HSCSN has completed a health assessment for each new member. To date, HSCSN has completed approximately 1409 assessments.	Proposal received 3/17/94. Review panel was held 5/17/94. Waiver approved 10/13/95. Acceptance of special terms and conditions 10/19/95. Implemented 12/15/95.
IOWA (Disapproved)	The proposal requested waivers of the transfer of assets requirements. Iowa sought to extend the look-back and penalty periods from 30 to 60 months, as well as implement other changes related to the penalty periods.		Proposal received 4/5/93. Disapproved 12/23/93.
MAINE (Disapproved)	Maine requested 1115 waivers in order to eliminate two optional categories for Title XIX recipients through changes in their State plan: medically needy with incomes greater than \$1302 per month and categorically needy with incomes between \$434 and \$1302 per month. Maine needed 1115 waivers in order to grandfather individuals in these two categories residing in nursing homes before 7/1/93.		Proposal received 4/93. Disapproved 7/13/93.
MARYLAND (Approved)	Maryland has been given waivers to establish a preventive and primary care program for children whose income is below 185 percent of the FPL. Waivers have been approved for a 5-year period, beginning 10/1/93, to cover children under Medicaid who meet the following criteria: born after 9/30/93; between 1 and 19 years of age; not currently eligible for the Medicaid program; and living in families whose income does not exceed 185 percent of the FPL, with no resource limitation. Maryland intends to demonstrate that access to basic primary care and preventive services increases the utilization of such services, improves health outcomes, and is cost effective by preventing acute and chronic medical conditions. No hospital inpatient, outpatient, or emergency room coverage will be provided under the demonstration.	The program is currently operating. Enrollment in the project is lower than anticipated.	Proposal received 2/8/93. Waivers approved 8/9/93. Acceptance of special terms and conditions 9/93. Implemented 10/93. Continuation award letter sent 9/24/96.

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
MARYLAND (Approved)	Maryland will implement an 1115 waiver demonstration that will establish limited Medicaid eligibility and provide family planning and related preventive reproductive services to women who have just delivered under the Medicaid pregnant woman and children category. Under the program, pregnant women, whose incomes are at or below 185 percent of the FPL (and who are not eligible for Medicaid otherwise), are eligible to receive Medicaid for a 5-year period.	<p>C/n 7/11/96, HCFA received the first quarterly report of Year 2.</p> <p>On 9/19/96, HCFA received the second quarterly report of Year 2.</p> <p>On 1/7/97, HCFA received the third quarterly report of Year 2.</p> <p>On 12/10/96, a letter offering suggestions for improving the cover letter and survey instrument, together with a revised mocked up survey was faxed to the State. A follow-up conference call will be held to answer any questions concerning the revised survey instrument.</p> <p>Questions were sent to the State with the continuation application. Responses to these questions will be used to evaluate continuance of the demonstration project.</p>	<p>Proposal received 6/1/94.</p> <p>Waivers approved 12/5/94.</p> <p>Acceptance of terms and conditions 12/94.</p> <p>Implemented 1/95.</p> <p>Continuation application received 1/17/96.</p> <p>Continuation application approved 3/1/96.</p>
MICHIGAN (Received)	The State is seeking approval to extend Medicaid benefits for family planning services to all women of child bearing age with income below 185 percent of FPL. This will create a Medicaid population of 346,500 women eligible for family planning services. The extended family planning benefit includes the existing family planning services and adds home visits, outreach services, and paraprofessional support to overcome the typical barriers to service utilization.	<p>HCFA is negotiating with the State on budget neutrality issues.</p> <p>Discussions continue on budget neutrality issues.</p> <p>Clearance package is being prepared for signatures.</p>	<p>Proposal received 3/95.</p> <p>Questions sent 6/13/95.</p> <p>State response received 8/18/95.</p> <p>Review panel was held 9/19/95.</p>
MINNESOTA (Approved)	The Senior Health Options Project integrates long-term care and acute care services under combined Medicare and Medicaid capitation payments for elderly dual eligibles.	<p>HCFA staff conducted a pre-implementation site visit the week of 11/18/96.</p> <p>HCFA staff are preparing an approval letter for the implementation of the "Senior Health Options Project."</p>	<p>Proposal received 4/18/94.</p> <p>Review panel was held 5/24/94.</p> <p>Waivers approved 4/27/95.</p> <p>Acceptance of special terms and conditions 5/25/95.</p> <p>RFP issued 2/26/96.</p> <p>Expected implementation 1/97.</p>

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
MINNESOTA (Disapproved)	The State submitted a request to waive Sections 1902(a)(51)(B) and 1917(c) of the SSA. This section 1115 waiver proposal would permit the State to: (1) increase from 36 to 60 months for Medicaid nursing facility eligibility the length of the look-back period for asset transfers; (2) treat the uncompensated transfers of excluded assets in the same manner as non-excluded assets; and (3) apply any resulting penalty period to the loss of coverage of all Medicaid services, not just long term care services.		Proposal received 10/14/93. Disapproved 4/07/94.
NEW ENGLAND STATES (Anticipated)	The States of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont are collaborating in the development of an application that would seek Medicare and Medicaid waivers to implement a State-administered purchasing arrangement in which integrated health networks would bid to deliver services for dually eligible Medicare and Medicaid elderly and disabled beneficiaries. The proposal will incorporate concepts previously submitted in Massachusetts' "Senior Care Plan."	An application is expected to be submitted 3/97. Preliminary concept documents have been received.	<u>Proposal expected 3/97.</u>
NEW HAMPSHIRE (Disapproved)	New Hampshire requested a waiver to develop Project TOOTH, "The Project Toward Occupational Opportunity Through Health." Project TOOTH will provide comprehensive dental treatment for approximately 200 AFDC/JOBS program participants whose disfiguring dental status is the major impediment to their employment following jobs training. The State requested funding and the waiving of comparability requirements to create a group of Medicaid recipients eligible for comprehensive dental care.		Proposal received 12/6/93. Disapproved 4/19/94.
NEW MEXICO (Received)	New Mexico requests 1115 waivers to provide Medicaid family planning services to all women of child-bearing age with incomes at or below 185 percent of the FPL. The program will be statewide; however, participants in four community/county areas selected as pilot areas will receive enhanced services in addition to those covered under Medicaid.	On 12/9/96, the State responded to questions sent to them regarding budget neutrality issues. HCFA and the State will resume negotiating budget neutrality issues.	Proposal received 12/9/94. Questions sent 3/95. State responses received 9/95. Review panel was held 11/26/95.

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
RHODE ISLAND (Received)	Rhode Island submitted a proposal entitled "CHOICES", an acronym for Citizenship, Health, Opportunities, Interdependence, Choices and Supports. This program proposes to consolidate all current State and Federal funding streams for adults with developmental disabilities under one "managed care/managed competition" Title XIX waiver program. CHOICES consolidates into a single program with a single set of rules the following separate Title XIX programs: ICF/MR, Home and Community Based Waivers, State Plan Rehabilitation Services, and Acute/Medical Care.	HCFA has awarded the State a developmental grant to help with the development of this project. The State intends to submit a revised application. It is HCFA's understanding that the workgroups have completed their work on aspects of the "CHOICES" project. The information developed by the workgroups has been incorporated into a revised draft application. This draft application will be reviewed by Rhode Island Staff. After additional review by providers and consumers it will be submitted to HCFA in January.	DRAFT proposal received 9/23/93. Proposal received 4/5/94. Review panel was held 5/16/94. Developmental grant approved 6/2/95. Acceptance of special terms and conditions 6/22/95.
SOUTH CAROLINA (Approved)	South Carolina was given waivers to extend Medicaid family planning services to Medicaid-eligible pregnant women beyond the 60-day post partum period.	The State submitted an amendment to include all women up to 185 percent of FPL and to extend benefits to this population for the duration of the project. <u>The State amendment was approved on 1/3/97. HCFA is waiting for the State to accept the terms and conditions.</u>	Proposal received 6/23/93. Amendment received 4/26/96. Waiver approved 12/7/93. Acceptance of special terms and conditions 2/3/94. Implemented 7/94. Continuation application submitted 10/31/95. Amendment received 5/95. Questions sent 7/5/95. State responses received 8/14/95. <u>Amendment approved 1/3/97.</u> Continuation application approved 3/14/96.
WEST VIRGINIA (Anticipated)	West Virginia is requesting a section 1115 waiver to extend Medicaid coverage to post-partum women with incomes at or below 150 percent of FPL for 2 years after delivery.		Concept paper received 2/1/96.

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
<p>WISCONSIN (Received)</p>	<p>The State submitted Medicaid section 1115 waiver request to implement the "Wisconsin Partnership Program" in specific counties of the State.</p> <p>This program will test two innovative models of care, one for frail elderly and one for persons with disabilities, utilizing a multi-disciplinary team to manage care. The team is to include the participant, a nurse practitioner, the physician's choice of primary care physician, and a social worker or independent living Coordinator. Consumer choice of care, settings and the manner of service delivery is a key component of the program. The demonstration will result in research into the use of consumer-defined quality indicators to measure and improve the quality of service delivery to people who are elderly and people with disabilities.</p>	<p>The Wisconsin proposal is under review.</p> <p>On 7/12, a letter and questions were sent to the State.</p> <p>The State is preparing their response to questions sent by HCFA.</p>	<p>Proposal received 2/28/96.</p>

1915(b)
Freedom Of Choice Waivers
Bi-Weekly Tracking Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	First 90 Day	90th Day	Start Date
AL	AL04.M01	RCCM/ Patient 1st	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment: Susceptible AFDC, SSI and Other Medical RCCM 775 1915(b) (1) 115,000 Mandatory Enrollment	First 90 Day	03/18/1997		
AR	AR03	Mental Health Program	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment: Susceptible AFDC, SSI and Other Behavioral Phy Custodial 1915(b) (1),(3) Mandatory Enrollment	Additional Info Requested			08/22/1993
CA	CA04.M03	Health Plan of San Mateo	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment: County AFDC and SSI Medical RCCM and Other Mixed 1915(b) (1) Mandatory Enrollment	Additional Info Requested			08/16/1996
CA	CA11.R04	Santa Barbara Health Initiative	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment: County AFDC and SSI Medical NIO Mixed 1915(b) (1) Voluntary Enrollment	First 90 Day	04/05/1997		

1915(b)
Freedom Of Choice Waivers
Bi-Weekly Tracking Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Additional Info Requested	12/07/1996	12/20/1996
CA	CA15.001	Solomon Partnership Health Plan	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment:	County: AFDC, SSI and Other Medical: HMO: Capitated: 1915(b) (1),(2),(4) Mandatory Enrollment:				
CA	CA23	Medi-Cal Specialty Mental Health Serv. Consolidation	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment:	Statewide: AFDC and SSI Behavioral: PHP: Medicaid: 1915(b) (4) Mandatory Enrollment:		Additional Info Requested		
DC	DC01.001	DC Medicaid Managed Care Waiver	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment:	Statewide: AFDC: Medical: HMO: Capitated: 1915(b) (1),(2),(4) 93.822 Mandatory Enrollment:		Additional Info Requested		
FL	FL01.002.002	Florida Medicaid	Geographic Area: Population: Services: Program Structure: Reimbursement: Authority: Projected Enrollments: Type of Enrollment:	Statewide: AFDC and SSI Medical: HMO and PHP: Managed: 1915(b) (1) Mandatory Enrollment:	File 90 Day			01/28/1997

1915(b)
Freedom Of Choice Waivers
BI-Weekly Tracking Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Status Date
GA	GA05	Georgia Behavioral Health Plan	Geographic Area: Statewide Population: AFDC and SSI Services: Behavioral Program Structure: Other Reimbursement: FFS Authority: 1915(b) (4) Projected Enrollments: Mandatory Enrollment Type of Enrollment:	Additional Info Requested	02/28/1997	11/14/1995
IA	IA04.803	Managed Health Care	Geographic Area: County Population: AFDC Services: Medical Program Structure: HMO and PPO Reimbursement: PPO Authority: 1915(b) (1),(4) Projected Enrollments: Mandatory Enrollment Type of Enrollment:	Second 90 Day	04/20/1997	
IA	IA05.801	Managed Mental Health Program	Geographic Area: Statewide Population: AFDC, SSI and Other Services: Behavioral Program Structure: PIP Reimbursement: 1915(b) (1),(3),(4) Authority: 105,000 Projected Enrollments: Mandatory Enrollment Type of Enrollment:	First 90 Day	04/20/1997	
KS	KS01.806	Medicaid Managed Care	Geographic Area: Statewide Population: AFDC and SSI Services: Medical Program Structure: Other Reimbursement: Capitated Authority: 1915(b) (1) Projected Enrollments: Mandatory Enrollment Type of Enrollment:	Additional Info Requested		12/31/1996

1915(b)
 Freedom Of Choice Waivers
 BI-Weekly Tracking Report
 Covering 1/1/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Status Date
KY	K803	Kentucky Medicaid Managed Care Plan for Substance Abuse	Geographic Area: Statewide Population: AFDC and SSI Services: Other Program Structure: PCCM Reimbursement: Mixed Authority: 1915(b) (1),(4) Projected Enrollments: Mandatory Enrollment Type of Enrollment:	Additional Info Requested	03/08/1997	01/02/1997
KY	KY06	Kentucky ACCESS	Geographic Area: Statewide Population: Other Services: Other Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1),(3),(4) Projected Enrollments: 87,000 Type of Enrollment: Mandatory Enrollment	Second 90 Day	03/08/1997	
ME	ME02.R01	PrimeCare	Geographic Area: Other Population: AFDC and Other Services: Medical Program Structure: PCCM Reimbursement: FFS Authority: 1915(b) (1) Projected Enrollments: Mandatory Enrollment Type of Enrollment:	First 90 Day	03/01/1997	
ME	ME01.M01	HMO Choice Initiative	Geographic Area: County Population: AFDC Services: Medical Program Structure: HMO - Capitated Reimbursement: 1915(b) (1),(2),(4) Authority: 115,346 Projected Enrollments: Mandatory Enrollment Type of Enrollment:	Additional Info Requested		02/09/1996

1915(b)
Freedom Of Choice Waivers
BI-Weekly Tracing Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Start Date
MI	M011	Michigan HMO Program	Geographic Area: Statewide Population: AFDC and SSI Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (4) Projected Enrollments: Mandatory Enrollment Type of Enrollment: Mandatory Enrollment	Additional Info Requested	02/17/1997	12/13/1996
MO	M003.M02	Managed Care + Plus	Geographic Area: County Population: AFDC Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1),(2),(4) Projected Enrollments: Mandatory Enrollment Type of Enrollment: Mandatory Enrollment	Second 90 Day	04/05/1997	
MO	M003.M03	Managed Care + Plus	Geographic Area: County Population: AFDC Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1),(2) Projected Enrollments: Mandatory Enrollment Type of Enrollment: Mandatory Enrollment	Second 90 Day	04/16/1997	
MO	M003.M04	Managed Care + Plus	Geographic Area: County Population: AFDC Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1),(2) Projected Enrollments: Mandatory Enrollment Type of Enrollment: Mandatory Enrollment	First 90 Day	04/16/1997	

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1915(b)
 Freedom Of Choice Waivers
 BI-Weekly Trading Report
 Covering 1/7/97 through 01/21/1997

State	County Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Status Date
NC	NC01.R01.M01	North Carolina Alternatives	<p>Geographic Area: Statewide</p> <p>Population: AFDC Behavioral and Other HI-MO and PIP Mixed</p> <p>Program Structure: 1915(b) (1),(4)</p> <p>Reimbursement: Mandatory Enrollment</p> <p>Authority: Projected Enrollment: Type of Enrollment:</p>	Additional Info Requested		12/18/1995
NM	NM02	SALLID	<p>Geographic Area: Statewide</p> <p>Population: AFDC and SSI Medical, Dental and Behavioral</p> <p>Program Structure: 1915(b) (4)</p> <p>Reimbursement: Mandatory Enrollment</p> <p>Authority: Projected Enrollment: Type of Enrollment:</p>	First 90 Day	03/05/1997	
NY	NY12.M02	Westchester County	<p>Geographic Area: County</p> <p>Population: AFDC and SSI Medical</p> <p>Program Structure: HI-MO Capitalized</p> <p>Reimbursement: 1915(b) (1)</p> <p>Authority: Projected Enrollment: Type of Enrollment: Mandatory Enrollment</p>	First 90 Day	04/14/1997	
NY	NY13	N.Y. Managed Care Program	<p>Geographic Area: County</p> <p>Population: AFDC and Other</p> <p>Program Structure: Medical, Behavioral and Other HI-MO and PIP Capitalized</p> <p>Reimbursement: 1915(b) (2),(3),(4)</p> <p>Authority: Projected Enrollment: Type of Enrollment: Mandatory Enrollment</p>	Second 90 Day	03/17/1997	

1915(b)
Freedom Of Choice Waivers
BI-Weekly Tracking Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Status Date
SC	SC01.R04.M01	South Carolina High Risk Challenging Project	Geographic Area: Statewide Population: Other Program Structure: Medical Reimbursements: Other Authority: 1915(b) (1),(2),(4) Programs/Enrollments: PPS Type of Enrollments: Mandatory Enrollment	First 90 Day	02/23/1997	
UT	UT05.R02	Pre/ild Mental Health Plan	Geographic Area: County Population: AFDC, SSI and Other Program Structure: Behavioral Reimbursements: Other Authority: 1915(b) (4) Programs/Enrollments: Mixed Type of Enrollments: Mandatory Enrollment	Additional Info Requested		11/08/1996
VA	VA01.R02	Mediation Program	Geographic Area: Statewide Population: AFDC Program Structure: Medical Reimbursements: MCOH Authority: PPS Programs/Enrollments: 1915(b) (1) Type of Enrollments: Mandatory Enrollment	Additional Info Requested		12/20/1996
WA	WA08.R01.M01	Manual Health Services	Geographic Area: Other Population: AFDC and SSI Program Structure: Behavioral Reimbursements: PIP and Other Authority: Caseload Programs/Enrollments: 1915(b) (1),(4) Type of Enrollments: Mandatory Enrollment	First 90 Day	03/16/1997	

1915(b)
Freedom Of Choice Waivers
Bi-Weekly Tracking Report
Covering 1/7/97 through 01/21/1997

State	Control Number	Waiver Name	Waiver Description	Waiver Status	90th Day	Status Date
WA	WA05.R01.M01	Healthy Options	Geographic Area: County Population: SSI Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1), (4) Projected Enrollments: 72,000 Type of Enrollments: Mandatory Enrollment	Second 90 Day	03/13/1997	06/14/1995
WV	WV04	Behavioral Health	Geographic Area: Statewide Population: AFDC and SSI Services: Behavioral Program Structure: PCOM Reimbursement: FFS Authority: 1915(b) (1), (4) Projected Enrollments: Mandatory Enrollment Type of Enrollments: Mandatory Enrollment	Additional Info Requested		
WV	WV05.M01	Minority Care	Geographic Area: County Population: AFDC and SSI Services: Medical Program Structure: HMO Reimbursement: Capitated Authority: 1915(b) (1) Projected Enrollments: Mandatory Enrollment Type of Enrollments: Mandatory Enrollment	First 90 Day	03/11/1997	
WY	WY01.M01	Hospital Based Selective Contracting Program	Geographic Area: Statewide Population: Other Services: Other Program Structure: Other Reimbursement: FFS Authority: 1915(b) (4) Projected Enrollments: Mandatory Enrollment Type of Enrollments: Mandatory Enrollment	Second 90 Day	03/16/1997	



NEW YORK SECTION 1115 DEMONSTRATION PROPOSAL
(INTERNAL USE ONLY)

TALKING POINTS

- We understand that the review process for "The Partnership Plan" has been lengthy. This project is, by far, one of the largest and most complicated that the Department has had to review. We appreciate the cooperation and patience that State officials and staff have exhibited.

BACKGROUND

- New York submitted "The Partnership Plan" on March 20, 1995. The State seeks to fundamentally redesign its Medicaid program to incorporate managed care and better meet the needs of special populations. The State is proposing to move approximately 2.7 million currently eligible individuals and approximately 300,000 Home Relief (General Assistance) recipients from a primarily fee-for-service delivery system to managed care. Such a large-scale movement into managed care results in massive administrative and structural changes that require careful planning and implementation.
- During the proposal review, HCFA has coordinated with reviewers from the Department and OMB, submitted major issues and questions to the State for clarification, and has remained in regular contact with State officials and their staffs through ongoing conversations and negotiating sessions.
- State delays in submitting necessary budget neutrality information slowed down the initiation of budget neutrality negotiations.
- During late August and throughout September 1996, HCFA and the State met to review and reach agreement on the language for specific draft terms and conditions. HCFA accepted the State's suggested language in many areas and continues to discuss outstanding programmatic issues with the State.
- Since receiving the State's budget neutrality counterproposal (dated October 15, 1996), staff from HCFA, the Department and other Federal agencies have been weighing various policy options in response to points raised by New York. Considerable Federal resources are devoted to developing a budget neutrality methodology that is both fair to the State, and protects the Federal budget from the risk of increased expenditures under a demonstration. Because of the complex nature of The Partnership Plan and the number of beneficiaries involved, particular attention has been given to developing a budget neutrality formula that meets all of these objectives.

- New York's past problems with implementing a voluntary managed care program and concerns about the State's ability to implement future managed care programs have necessitated a more careful and thorough review of their proposal and responses to our questions. It has also resulted in a more comprehensive list of special terms and conditions which has extended the negotiation process with the State.
- Because of the complexity of New York's proposal, the State's past record in implementing managed care, and the enormous influx of comments from beneficiaries and advocates, HCFA would not have met its obligation to protect beneficiaries and assure access to high quality care by accelerating the review.
- HCFA remains committed to working with New York to ensure that beneficiaries are guaranteed access to quality services through a well-designed and implemented demonstration.

STATUS

- Outstanding issues include: the phase-in approach to implementation; budget neutrality; the milestone approach to the development of special needs plans; provisions for seriously mentally ill individuals; and financial protection of safety net providers.
- We hope to reach agreement in principle with the State as soon as possible, perhaps as early as mid-February.

WISCONSIN WORKS (W-2)
TITLE XIX ISSUES
(INTERNAL USE ONLY)

Attachment:
- 9/30 letter to ~~state~~ ^{US}
- 10/25 letter in Dec.

TALKING POINTS

- This Administration remains committed to maintaining a Federal guarantee of comprehensive, high-quality health care benefits enforceable through Federal law for low-income persons. Because of this commitment, we were not able to approve Wisconsin's original title XIX requests in the "Wisconsin Works (W-2)" proposal. However, we are willing to work with the State on a mutually agreeable plan that can expand Medicaid coverage to low-income persons.

BACKGROUND

- On May 28, 1996 Wisconsin submitted their "Wisconsin Works" (W-2) proposal which requested title XIX, title IV-A, and Food Stamp waivers. *(Wisconsin (we've done with many other states) to expand Medicaid coverage to low-income families in a manner consistent with the ~~the~~ Adm's commitment to preserving the guarantee of coverage.)*
- Department staff identified issues relevant to title XIX, including: 1) the elimination of the Medicaid entitlement for AFDC-related groups which included the poverty level groups of pregnant women and children; 2) the reduced benefit package for current eligibles; 3) cost-sharing requirements for current eligibles; and 4) budget neutrality.
- The State was informed in a September 30 letter that their Medicaid proposal is not approvable in its current form because it runs counter to the Administration's commitment to maintain an enforceable federal guarantee of health care for low-income persons.
- On October 10, 1996 HCFA met with the State to discuss specific concerns that the proposal raised. At that time, the State agreed to submit additional information to HCFA supporting the objectives of W-2.
- In a November 25 conference call, the State was informed that the additional information did not provide the rationale to approve W-2 in its current format because the proposal remained counter to the Administration's commitment to preserving the Medicaid entitlement for current eligibles. Under W-2, current eligibles would lose Medicaid eligibility, have their benefits package reduced, and be subject to cost-sharing requirements (i.e., premiums).
- During the same conference call, HCFA also informed the State that more latitude could be granted for an expansion population under section 1115 demonstration authority in terms of the type of benefit package offered and the requirements for cost-sharing. However, HCFA would not approve a reduction of the Medicaid entitlement under section 1115 demonstration authority for a

State Option group of low income pregnant women and children. If the State wants to reduce the entitlement for this population, a State Plan Amendment (SPA) would be required. The State informed HCFA that these decisions would not allow them to implement W-2. In response, the State asked HCFA to address a number of questions (listed below.) HCFA responded to the questions on December 9, 1996, as follows:

- Q./ Eligibility: Could a State Option group that has lost Medicaid eligibility through a SPA process, but has become eligible again through a title XIX expansion under Section 1115 demonstration authority, be offered a reduced benefit package and be subject to cost-sharing provisions?

A./ HCFA response: We will not use demonstration authority to expand eligibility to a population who lost their Medicaid entitlement through a SPA process.

- Q./ Budget neutrality: Under budget neutrality, is HCFA willing to consider an aggregate cap that does not include an offset for a decrease in the number of Medicaid eligibles resulting from the implementation of TANF?

A./ HCFA response: Any determination of an aggregate budget neutrality cap must be based on realistic assumptions regarding Medicaid eligibility and costs under TANF.

- Q./ Welfare reform savings: Can savings from earlier welfare reform demonstration waivers be used to fund a program expansion under the new demonstration?

A./ HCFA response: Title IV-A savings cannot be used to fund a purely Medicaid program. HCFA reaffirmed its willingness to be flexible if the State wants to expand Medicaid eligibility and to work with them at their pace in the waiver review process.

- Q./ Impact of TANF: The State questioned if approval of the title XIX waivers in W-2 are subject to the deadlines outlined in the new welfare reform legislation (TANF).

A./ HCFA response: TANF will allow the State to indefinitely continue title IV-A waivers affecting Medicaid eligibility if the waivers were approved by the Department by July 1, 1997. However, the title XIX waivers in their W-2 proposal were not subject to this deadline because the continuation of waivers for Medicaid eligibility only applies to income and resource standards and methodologies and deprivation standards.

STATUS

- The State said they would consider our comments in their proposal; however, no time frame was provided. We have not heard back from the State since that December 9 call.

ALABAMA SECTION 1115 DEMONSTRATION
(INTERNAL USE ONLY)

TALKING POINT

- We are pleased that Alabama has accepted the terms and conditions of its recently-approved section 1115 demonstration. The State has requested an adjustment of the budget neutrality expenditures limit to recognize the increased cost of protease inhibitor drugs to treat the symptoms of HIV/AIDS. This request is under consideration by HCFA, the Department and OMB.

BACKGROUND

- "The Alabama Better Access for You (BAY) Health Plan" proposal was submitted on July 10, 1995, and was approved on December 6, 1996. The demonstration will enroll current Medicaid beneficiaries into managed care and offer enhanced family planning benefits up to 24 months to low-income women. The State will initially implement the demonstration in Mobile County with possible expansion to other counties.
- As the Alabama demonstration was in the final stages of approval, HCFA, the Department and OMB were reaching a final decision regarding the State of Maryland's request to include the cost of protease inhibitors in budget neutrality calculations. Because this issue had not been considered in the Alabama negotiations, the State was given the option of proceeding with the approval of their demonstration or waiting for a decision on Maryland to determine if Alabama would want to revise its budget neutrality agreement accordingly. Alabama decided to move forward with the approval.
- Subsequently, HCFA and Maryland reached agreement to count the costs of protease inhibitor drugs and viral load testing services as an expenditure against the overall expenditure limit in the Maryland demonstration. However, because the net cost of the drugs may place an onerous burden on the State that is not accounted for in the without-waiver baseline, HCFA will study the net costs and adjust the without-waiver baseline in all five years of the demonstration, as appropriate. In the terms and conditions of the demonstration award, Maryland has agreed to submit a report to HCFA on the net title XIX cost of including protease inhibitor therapy, using service utilization and drug therapy data for the first two years of the demonstration.
- Alabama has requested the same budget neutrality agreement for protease inhibitors as Maryland and has indicated that they can meet all the necessary reporting requirements.

STATUS

The State's budget neutrality request is under review by HCFA, the Department and OMB. The State's projected implementation date is May 1, 1997. We anticipate that the State will be able to meet that date.

**MICHIGAN WELFARE REFORM
1996 AMENDMENT
(INTERNAL USE ONLY)**

TALKING POINT

- This Administration remains committed to preserving the guarantee of health care coverage for Medicaid-eligible individuals. We were concerned that the amendment you submitted in June 1996 to your existing welfare reform demonstration, "To Strengthen Michigan Families," would have a negative impact on beneficiaries in that it would cause some individuals to lose eligibility. On August 21, 1996, we discussed these concerns with State staff and asked the State to consider withdrawing the waivers that reduced eligibility. We are waiting to receive a response from the State.

BACKGROUND

- On June 27, 1996, Michigan submitted an amendment to their existing welfare reform demonstration (known as "To Strengthen Michigan Families") requesting numerous waivers from AFDC, Food Stamps and Medicaid. As a result of the recently enacted welfare reform legislation, the AFDC waivers are no longer needed.
- The objectives of most of the Medicaid provisions in the proposal are to simplify eligibility and reduce the administrative burden the program has on the State.
- Some of the provisions clearly expand Medicaid eligibility, while others clearly reduce eligibility. The State estimates that approximately 18,000 people would lose eligibility. Because of this negative impact on beneficiaries, the State has decided to re-think what provisions they actually wanted to implement. HCFA has opposed taking Medicaid benefits away from recipients.
- On August 21, 1996, we informed Michigan that its request to reduce eligibility for current eligibles was not approvable. The State indicated that they would reconsider whether they wanted the requested waivers. We have not heard from the State since August.

STATUS

- HCFA is awaiting the State's response.

NEW HAMPSHIRE SECTION 1115 DEMONSTRATION PROPOSAL
(INTERNAL USE ONLY)

TALKING POINT

- We are working with the State to address a number of issues and anticipate the negotiation of the special terms and conditions soon.

BACKGROUND

- Community Care Systems, submitted on June 5, 1996, aims to create a comprehensive integrated service delivery system that will provide capitated, managed acute care services that are coordinated with specialty and support services not included in the health plan service package. The current waiver request is for phase one, which will enroll AFDC and AFDC-related children and families. Phases two and three are planned as separate waiver amendments in conjunction with the New England Dual Eligible coalition and will enroll the elderly population and adults and children with disabilities.
- Phase one will include some severely disabled children who live with their families. Many of these families have expressed concerns about the effect of enrollment in managed care on their ability to obtain the specialized services their children need.
- The State has requested, as a part of phase one, waivers to extend a Medicaid buy-in option to non-Medicaid adults and families. The State estimates that there are almost 67,000 uninsured children and adults between 100 percent and 200 percent of poverty in the State.

STATUS

- HCFA and the State are working to resolve several programmatic and budget neutrality issues before negotiating specific terms and conditions for the demonstration.
- The State is still developing the proposal for the buy-in option.

UTAH SECTION 1115 DEMONSTRATION PROPOSAL
(INTERNAL USE ONLY)

TALKING POINT

- We are proceeding with budget neutrality discussions with the State and anticipate that we will have remaining programmatic issues resolved in the near future.

BACKGROUND

- Utah submitted its section 1115 demonstration proposal on June 28, 1995. A letter outlining the major issues was sent to the State on October 1 and technical questions followed on October 4, 1995. HCFA received responses to the technical questions on January 18, 1996 and budget neutrality on May 24, 1996. In September and November 1996, HCFA requested additional clarification material on budget neutrality issues. HCFA has received the additional requested information and is engaged in discussions with the State.
- Between September and December 1996, several briefing papers were prepared for the Department to address policy issues regarding Medicaid eligibility under Utah's waiver.

STATUS

- We are engaged in budget neutrality discussions with the State. Both HCFA and IHS are preparing a paper for the Department regarding cost-sharing requirements for American Indians and Alaskan Natives under a title XIX expansion, which is relevant to Utah's proposal. We expect a formal decision from the Department by the end of January.

ILLINOIS SECTION 1115 DEMONSTRATION PROPOSAL
(INTERNAL USE ONLY)

TALKING POINT

- The Department is currently reviewing the Operational Protocol and Request for Proposal for Managed Care Entities. We have received extensive comments from a number of provider groups, hospitals, and advocates and will take them into account in our review of the documents and discussions with the State. In addition, we are meeting with all interested parties to discuss their concerns.
- We have informed the State that we will continue to provide technical assistance to them in their efforts to correct current performance deficiencies with the health benefit's broker. One of the factors that we will be looking at prior to giving our approval for implementation of the demonstration is the vendor's ability to perform their responsibilities satisfactorily.

BACKGROUND

- The Illinois demonstration was approved on July 12, 1996. It included Special Terms and Conditions specifying that implementation could not occur until HCFA approved the operational protocol and RFPs soliciting managed care.
- The State submitted for approval the Operational Protocol and draft Request for Proposal (RFP) for managed care entities (MCEs) on November 26, 1996. Several sections of the documents require further clarification and development. In addition, inconsistencies between the documents themselves, the State rules, and Special Terms and Conditions have been identified.
- The State has tentative plans to release the RFP the first week of February. Several provider groups, hospitals, and advocates have submitted comments on the documents as well as expressed strong reservations about the feasibility of the demonstration, largely due to the number of services that will be carved-out of the demonstration, or provided on a fee-for-service basis outside of the MCE's control.
- During the approval process, we agreed to consider continued use of the health benefits broker that was being utilized in the voluntary program provided the State submitted the contract for comments and approval 180 days prior to implementation of the demonstration. On December 16, we received the contract for the health benefits broker; however, the State had not made any changes to reflect added responsibilities, standards, etc. under MediPlan Plus. Further, the State and Regional Office have identified a number of performance problems with the current vendor (HRDI-WHP Partners) under the voluntary program.

STATUS

- The Operational Protocol and MCE RFP are currently under review in the Department. Meetings are being held with all interested parties to discuss their concerns and comments. The State has been informed that there will be a number of areas that need to be addressed prior to HCFA approving the documents, or permitting release of the RFP.
- The State was notified on January 7, 1997 that the Special Terms and Conditions were amended to allow additional time to submit a revised contract for the health benefits broker that encompasses the added responsibilities under MediPlan Plus. In addition, the State was informed that the Regional Office staff will closely monitor the performance of the health benefits broker in the voluntary program to ensure that deficiencies are corrected prior to implementation of MediPlan Plus.

CALIFORNIA SECTION 1115 DEMONSTRATION PROPOSALS
(INTERNAL USE ONLY)

TALKING POINTS

- We are willing to review any 1115 demonstration that California submits on behalf of a county and remain available to provide technical assistance to the State in their endeavors.

BACKGROUND

- On April 15, 1996, HCFA approved the "Medicaid Demonstration Project for Los Angeles County." At that time, 28 additional counties expressed interest in operating a similar demonstration, with all of the financial provisions granted to Los Angeles County.
- On May 20, 1996, HCFA sent a letter to the State that outlined the key components (submitted by the State, presence of a public hospital, fundamental restructuring, budget neutrality, and public notice) that had to be present for HCFA to consider granting an 1115 demonstration.
- On August 14, 1996, the State issued a letter to all county officials that included this criteria, and additional State criteria (advisory board, financial data, reporting requirements, and State access to records). Further, the letter informed county officials that they had until October 1, 1996, to submit a letter of intent to the State.
- In September, Department and State representatives met with county officials to provide guidance on submitting an 1115 demonstration application and to answer questions. During this meeting, the State provided the counties with additional time to submit a concept paper.

STATUS

- Ten counties informed the State that they intend to submit an applications for an 1115 demonstration.
- On November 20, 1996, the State submitted a concept paper for a section 1115 demonstration for Alameda County. In early January, HCFA informed Alameda and State representatives that the financial plan submitted as part of the concept paper was unacceptable. On January 13, Department, State, and County officials met to begin discussing an alternative approach.
- We received concept papers for San Francisco and Monterey in January 1997.

**MINNESOTA PROPOSAL TO EXPAND ITS SECTION 1115 DEMONSTRATION
USING NEWLY-APPROVED WELFARE REFORM PROGRAM AUTHORITY
(INTERNAL USE ONLY)**

TALKING POINTS

- We are working closely with Minnesota to try to approve the State's request to expand its Prepaid Medical Assistance Program+ (PMAP+) demonstration program to cover all adult members of uninsured families with children whose income does not exceed 275% of the Federal poverty level under Medicaid.

BACKGROUND

- In July 1994, Minnesota applied for a health care reform demonstration authority which would have covered all families in the State's MinnesotaCare program under Medicaid. Because we could not reach agreement with the State on the trend rates to be used for the purposes of determining budget neutrality, Medicaid coverage was only expanded to include children under age 21, when this demonstration was approved on April 27, 1995, and implemented on July 1 of that year.
- On August 16, 1996, the Administration for Children and Families approved a statewide expansion of Minnesota's Welfare Reform Waiver. Subsequently, the State approached HCFA wishing to use this authority to expand Medicaid eligibility.
- Following a number of discussions between state and HCFA staff on this issue, on December 11, 1996, Minnesota submitted a formal request to expand its Medicaid population, combining waivers granted under the State's welfare reform program with the liberalization of income standards permitted under newly enacted section 1931(b) and (d) of the Social Security Act.

STATUS

- We are considering approving Minnesota's request on the basis that these individuals could have been eligible for Medicaid under section 1931(b) and (d) of the Act, in order to avoid the budget neutrality issues that arose in our discussions of the original Minnesota health care reform waiver request.
- We are currently discussing this approach with the Office of Management and Budget, and will be contacting Minnesota as soon as these discussions are completed.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
(INTERNAL USE ONLY)

TALKING POINTS

- I want to take this opportunity to update you on the status of your two proposals: 1) to expand eligibility to individuals below 100 percent of the Federal poverty level; and 2) to provide managed care for on-reservation Indians.
- Regarding the eligibility expansion, AHCCCS has indicated that they plan to submit a revised request in early 1997. The legislature needs to pass implementing legislation.
- With respect to the on-reservation proposal, we recognize that the plan is innovative, but it raises complex legal issues relating to whether the Indian Health Service can accept risk under the Anti-Deficiency Act.
 - HCFA sent issues and questions to the State on March 21, 1996. Both HCFA and IHS are currently reviewing the State's response, which we received on June 26, 1996.
 - HCFA will work closely with the State and IHS to determine if the issues regarding the Anti-Deficiency Act can be resolved.

BACKGROUND

- AHCCCS has been operating as a Statewide managed care demonstration since 1982.
- Eligibility expansion:
 - The primary issue remains whether the State will be able to meet budget neutrality requirements. Arizona estimates that they can cover approximately 60% of the proposed expansion group by liberalizing eligibility for Medicaid, as permitted under welfare reform. This should make it easier to achieve budget neutrality.
 - The Governor's legislative request failed to receive approval in the 1995 and 1996 sessions. However, the proposal was passed overwhelmingly by the voters as a referendum initiative in November 1996. AHCCCS is preparing legislation. A Governor's task force is being assembled, and a special session of the legislature may be convened.

• Managed care for on-reservation Indians:

-In May 1994, Arizona submitted a waiver request to conduct a managed care demonstration for American Indians who reside on-reservation. The State proposes to make capitation payments for both on-reservation and off-reservation services authorized by IHS/tribes.

-HCFA shared the proposal with IHS, who was particularly concerned that placing IHS at risk through capitation payments could violate the Anti-Deficiency Act.

-In May 1995, HCFA sent the State a list of draft questions on some preliminary issues raised by IHS. The State responded on June 7, 1995, and indicated a willingness to be flexible in order to address anti-deficiency issues. On June 13, 1995, IHS provided formal comments on the proposal.

-On June 28, 1995, the then-State Medicaid Director informed HCFA staff that the on-reservation managed care demonstration was her lowest priority.

-At the NGA meeting in February 1996, the Governor requested an update and HCFA promised to send the State questions. The questions were sent on March 21, 1996.

-The State's response to these questions was received on June 26, 1996, and addressed only the Anti-Deficiency Act issue. It was reviewed by HCFA and IHS. Following consultation with the IHS Area Offices that would be affected by this proposal, the IHS Central Office indicated in a letter to HCFA dated September 9, 1996, that they would like to schedule a conference call with AHCCCS to discuss Anti-Deficiency Act concerns and possible alternatives to overcome these concerns. We will work with IHS to schedule the call.

STATUS

• HCFA will move forward with a review of the eligibility expansion proposal if/when the State submits a revised waiver request.

• HCFA, IHS and the State will work together to resolve the Anti-Deficiency Act issue in the on-reservation proposal. Pending this resolution, other issues can be addressed.





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

JAN 29 1997

The Honorable Lawton Chiles
Governor of Florida
State Capitol
Tallahassee, Florida 32399-0001

Dear Lawton:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

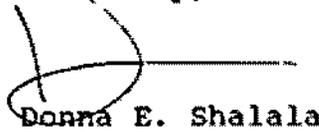
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of Florida's request for a section 1915(c) home and community-based services (HCBS) waiver to provide Medicaid services to individuals aged 65 and over, which was received in HHS on October 15, 1996. On January 10, 1997, HCFA requested additional information relating to providers' participation in the HCBS program. The additional information will help us determine whether the waiver request meets statutory and regulatory requirements specific to HCBS waiver programs and if the waiver will permit Medicaid beneficiaries the freedom to choose providers. We look forward to receiving the State's reply and to working with your staff to address any further pending issues expeditiously.

page 2 - The Honorable Lawton Chiles

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

A handwritten signature in black ink, appearing to be 'D. Shalala', written over a horizontal line.

Donna E. Shalala



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

JAN 29 1997

The Honorable Zell Miller
Governor of Georgia
203 State Capitol
Atlanta, Georgia 30334

Dear Zell:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

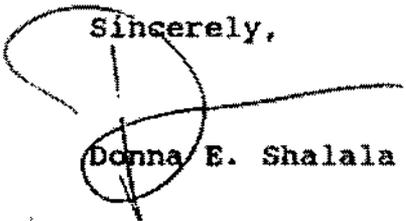
In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "Georgia Behavioral Health Plan," submitted on September 1, 1995. As you know, the plan combines section 1115, 1915(b), and 1915(c) waivers into a fully integrated system of managed care for mental illness, mental retardation, and substance abuse. At your request, the Health Care Financing Administration (HCFA) agreed to track the three waiver proposals as a single package, even though each waiver will be processed separately. In November 1995, HCFA sent questions regarding the section 1115 portion of the proposal to the State agency and has not yet received a response. HCFA also notified the State in a letter on June 5, 1996, that we cannot proceed with the proposal review without the State's response and offered to provide assistance as necessary. State staff recently indicated that internal discussions are ongoing and that all three waiver

page 2 - The Honorable Zell Miller

requests are on hold. We remain willing to assist you and your staff in any way that we can.

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,



Donna E. Shalala



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

JAN 29 1997

The Honorable Bill Graves
Governor of Kansas
State Capitol
Topeka, Kansas 66612

Dear Governor Graves:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

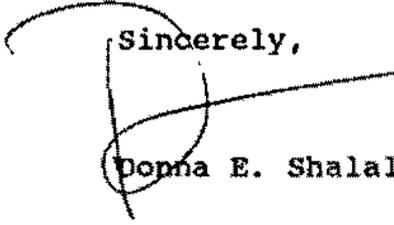
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "Community Care of Kansas," submitted on March 23, 1995. As you know, the plan has goals of fostering the development of managed care in rural and small urban communities, and improving health outcomes by assuring a continuum of care. The Health Care Financing Administration (HCFA) sent draft programmatic terms and conditions to the State agency staff in March 1996 and budget neutrality terms and conditions in July 1996. State staff have indicated that their negotiations with managed care organizations in Kansas are ongoing. Once those negotiations are completed, we remain committed to moving forward with you on this proposal.

page 2 - The Honorable Bill Graves

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,


Donna E. Shalala



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

JUN 29 1997

The Honorable John Engler
Governor of Michigan
P.O. Box 30013
Lansing, Michigan 48909

Dear Governor Engler:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1915(b) application, entitled "Michigan's HMO Program," which was submitted on September 20, 1996. As you know, the proposal would permit the State to selectively contract with HMOs in Genesee, Macomb, Oakland, Wayne, and Washtenau Counties. Beneficiaries residing in these counties would be required to select one of the designated HMOs to obtain their medical care. The Department has received numerous letters from providers and advocacy groups in Michigan inquiring about access to, and payment for, FQHC services under the waiver. To address these issues raised during our review of your proposal, the Health Care Financing Administration forwarded a request for additional information to the State on December 13, 1996. We look forward to receiving the State's reply and working with your staff to address any issues

page 2 - The Honorable John Engler

expeditiously.

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

Donna E. Shalala



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

JUN 29 1997

The Honorable Mel Carnahan
Governor of Missouri
P.O. Box 720
Jefferson City, Missouri 65101

Dear Governor *Mel* Carnahan:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1915(b) waiver modification request, entitled "Managed Care +Plus," which was submitted to HCFA on September 12, 1996. This waiver would expand the existing "Managed Care +Plus" 1915(b) waiver into the western and northwestern regions of Missouri. The State's reply to the Health Care Financing Administration's additional information request was received on January 6, 1997. We are currently reviewing these materials and expect to have a final decision on your request before the 90-day statutory review period expires on April 5, 1997.

page 2 - The Honorable Mel Carnahan

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,



Donna E. Shalala



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

JAN 20 1997

The Honorable Jeanne Shaheen
Governor of New Hampshire
State House
Concord, New Hampshire 03301

Dear Governor Shaheen:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

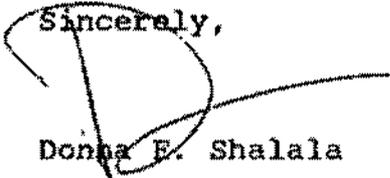
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In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "Community Care Systems," submitted on June 5, 1996. As you know, the plan would provide acute care services, and coordination of specialty and support services, for Aid to Families with Dependent Children (AFDC) and AFDC-related children and families under a capitated managed care system. The Health Care Financing Administration (HCFA) sent technical questions to the State on August 22, 1996, and the State responded on September 19, 1996. Since that time, HCFA and State staffs have been actively involved in discussing programmatic and budget neutrality aspects of the proposal. We remain committed to working with your staff to continue our progress on this proposal and any other initiatives you may be considering for your new administration.

page 2 - The Honorable Jeanne Shaheen

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,



Donna E. Shalala



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

JAN 29 1997

The Honorable Gary Johnson
Governor of New Mexico
State Capitol
Santa Fe, New Mexico 87503-0001

Dear Governor Johnson:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

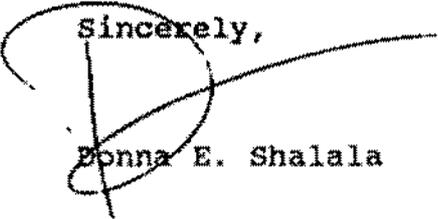
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In that light, I would like to take this opportunity to update you on the status of your pending section 1915(b) waiver application, entitled "New Mexico Salud," which was received on December 4, 1996. As you know, this waiver would implement a statewide mandatory Medicaid managed care program for both Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) beneficiaries. The Department has received letters from numerous groups and organizations in New Mexico that raise issues relating to the sufficiency of the infrastructure necessary to implement the waiver in many areas of the State and the impact of accelerated implementation on people with chronic illnesses or disabilities. HCFA is in the early stages of our review of your proposal, but will provide a decision to your State or request additional information required to process your waiver before expiration of the 90-day statutory review period on March 5, 1997.

page 2 - The Honorable Gary Johnson

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,



Donna E. Shalala



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

... 20 1997

The Honorable George Pataki
Governor of New York
State Capitol
Albany, New York 12224

Dear Governor Pataki:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled New York Partnership Plan, submitted on March 20, 1995. As you know, the Partnership Plan is by far the largest and most complicated waiver of its type ever received by HHS. The plan would enroll the Medicaid and Home Relief population into managed care programs and establish new health plans to meet the needs of special populations. HCFA forwarded draft Terms and Conditions to State officials on August 13, 1996. Department and State staff are actively negotiating programmatic and budget neutrality issues relating to the Terms and Conditions. We expect that these outstanding issues can be resolved soon.

New York has also submitted a section 1915(b) waiver, entitled the "New York Managed Care Program." The waiver would require

page 2 - The Honorable George Pataki

Aid to Families with Dependent Children (AFDC), AFDC-related, and Home Relief Children up to age 21 who reside in 31 counties of the state to enroll in managed care programs. On December 18, 1996, HCFA received the State Health Department's reply to our request for additional information. My staff is currently reviewing these materials and will make a decision on your application before the 90-day statutory review period expires on March 17, 1997. Of course, we will work closely with your staff to coordinate consideration of the 1915(b) proposal with your statewide 1115 demonstration.

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

Donna E. Shalala



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

The Honorable James B. Hunt, Jr.
Governor of North Carolina
State Capitol
Raleigh, North Carolina 27603

-Dear Jim:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

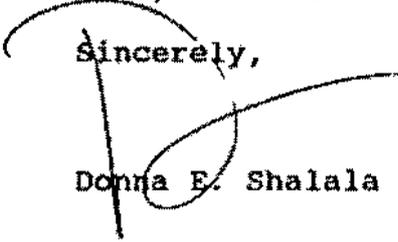
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending 1915(b) waiver application entitled "North Carolina Alternatives," which was submitted to the Health Care Financing Administration (HCFA) in October 1995. Since that time, HCFA staff have been working with your staff. Several outstanding issues remain to be addressed. These issues include the need for a State plan to perform financial reviews of "North Carolina Alternative" contractors and the need to establish a baseline for measuring cost-effectiveness during the waiver period. HCFA will be sending your staff a letter which outlines the remaining issues.

page 2 - The Honorable Jim Hunt

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,



Donna E. Shalala



The Honorable George W. Bush
Governor of Texas
P.O. Box 12428
Capitol Station
Austin, Texas 78711

Dear Governor Bush,

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

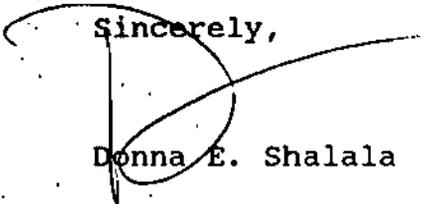
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "State of Texas Access Reform (STAR)," submitted on September 6, 1995, and revised on November 5, 1996. As you know, the plan would restructure the Medicaid program through the use of managed care systems and expand eligibility to children ages 6-18 with incomes below 133 percent of the Federal poverty level. On January 24, 1997, the Health Care Financing Administration sent technical questions to your State regarding several issues, and we look forward to working with your staff.

page 2 - The Honorable George W. Bush

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,


Donna E. Shalala



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

JUN 29 1997

The Honorable Michael O. Leavitt
Governor of Utah
210 State Capitol
Salt Lake City, Utah 84114

Dear Governor *Leavitt*:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

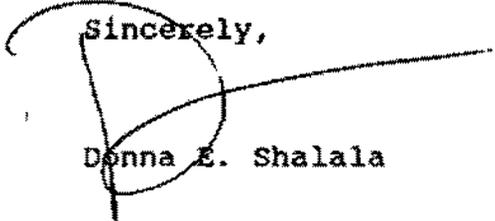
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "Utah Medicaid Reform," submitted on July 7, 1995. As you know, the plan would extend Medicaid eligibility to individuals under 100 percent of the Federal poverty level, utilize managed care systems, and encourage small employers to provide health care coverage for low-income employees. In September and November 1996, HCFA requested additional materials from the State to clarify budget neutrality issues. We have since received the materials and remain committed to working with your staff to resolve any outstanding issues in the near future.

page 2 - The Honorable Michael O. Leavitt

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,


Donna E. Shalala



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

April 23 1997

The Honorable Gary Locke
Governor of Washington
Legislative Building
Olympia, Washington 98504

Dear Governor Locke:

As we begin the second term of the Clinton Administration, let me assure you that the President and I remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your pending section 1115 demonstration proposal, entitled "Healthy Options," submitted on October 2, 1996. As you know, the plan would implement Medicaid managed care statewide for the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) populations and test innovations in encounter data, Medicaid Health Plan Employer Data and Information Set (HEDIS), and quality measures for the disabled. The Health Care Financing Administration (HCFA) sent questions for clarification to State officials on December 12, 1996. We look forward to working with your staff when we receive responses to these questions. We stand ready to work with you on any other initiatives under consideration in your new administration.

page 2 - The Honorable Gary Locke

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

Donna E. Shalala



THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20301

JAN 29 1997

The Honorable Tommy G. Thompson
Governor of Wisconsin
State Capitol, 115 East Avenue
Madison, Wisconsin 53707

Dear Governor Thompson:

As we begin the second term of the Clinton Administration, let me assure you that the President and our Department remain committed to working with states to test innovative reforms in health and human services.

Since President Clinton first took office over four years ago, the Department of Health and Human Services (HHS) has approved 79 welfare reform demonstrations for 43 states. I am pleased that these welfare reform demonstrations have expanded our collective knowledge about successful strategies for moving welfare recipients to work and laid the groundwork in so many states for implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

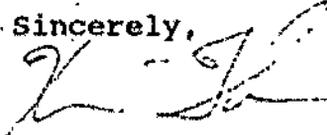
At the same time, we are continuing to work just as hard with states seeking additional flexibility for health care innovations through research and demonstration waivers or program waivers under the Social Security Act. Since 1993, our Department has approved 15 statewide Medicaid health reform demonstrations and hundreds of other waivers to assist states in pursuing mandatory managed care and in establishing home and community-based alternatives for persons in need.

In that light, I would like to take this opportunity to update you on the status of your request to waive certain Medicaid requirements as set forth in your proposal entitled, "Wisconsin Works (W-2)," submitted on May 28, 1996. I wish to be clear that the Administration shares Wisconsin's desire to expand coverage for low-income, uninsured persons, especially those who are leaving welfare for work. As we have done with many other states and as we indicated in our correspondence of September 30, 1996, we would be pleased to work with you to design a Medicaid demonstration that expands coverage to those families working under W-2. However, any such demonstration must be consistent with the Administration's policy to guarantee coverage for eligible families and assure budget neutrality for federal taxpayers. We remain committed to working with your staff to resolve the outstanding issues in the near future.

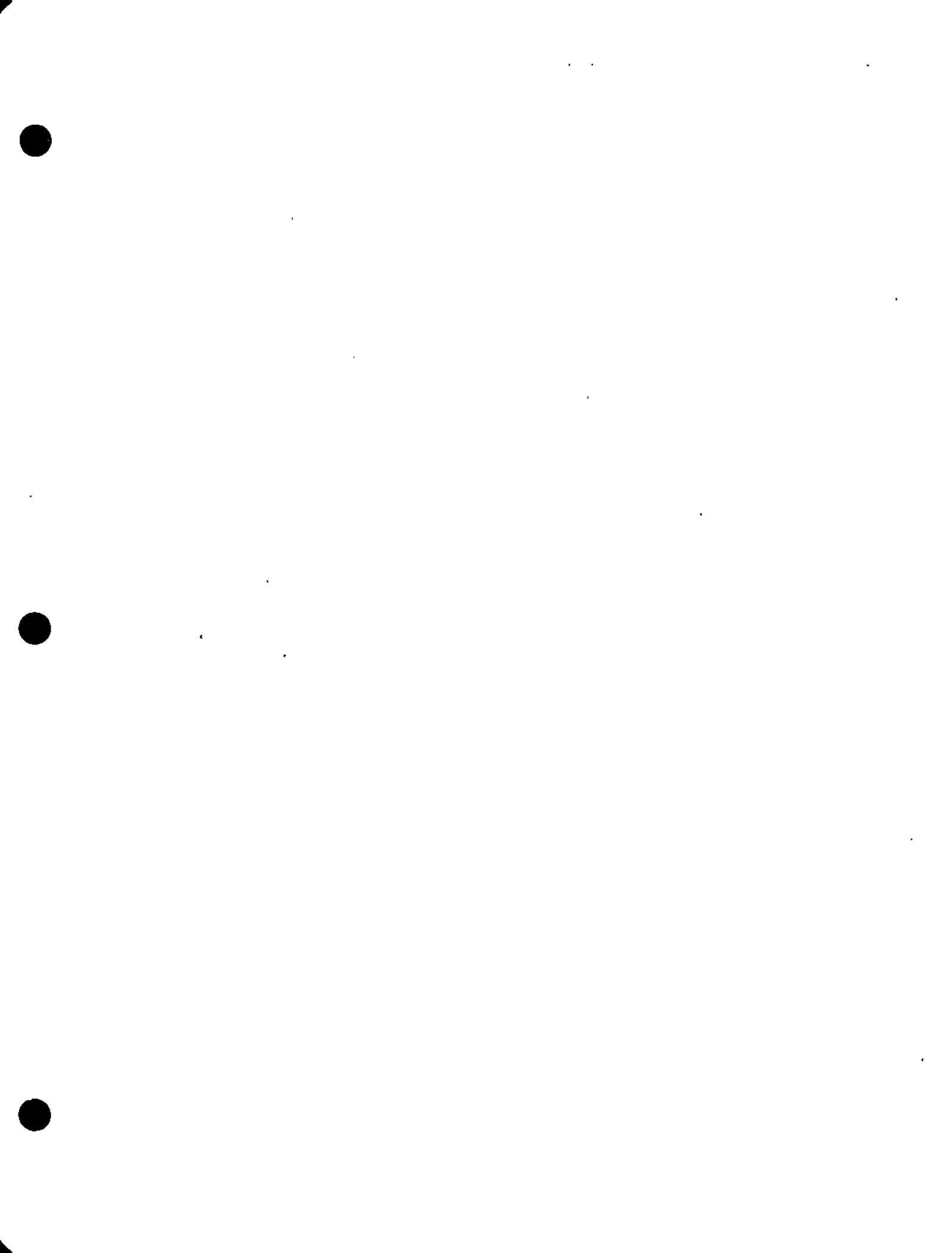
page 2 - The Honorable Tommy Thompson

If you have any questions about our review process or about the status of your State's demonstration proposal, please do not hesitate to contact me or John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

A handwritten signature in dark ink, appearing to read "Kevin Thurm", written over a light-colored background.

Kevin Thurm



EC-7. LONG-TERM CARE

7.1 Preamble

The U.S. population is aging; people are living longer and improvements in medical technology have extended life for many with severe disabilities. These demographic trends and technological advances, when considered together, suggest that the need for long-term care will continue to grow for the next half century. As this demand grows, so will the demand for well-designed private savings and long-term care insurance instruments, carefully integrated with responsive, publicly funded programs. Typically, the frail elderly and people with disabilities require basic support for normal everyday activities. This long-term care may be provided either through A VARIETY OF HOME- AND COMMUNITY-BASED CARE SERVICES OR institutions (i.e., nursing homes, residential facilities for people with mental illness, and residential facilities for people with mental retardation), ~~or a variety of home and community-based care services.~~ It also is important to appreciate that there is a significant amount of family and other private caregiving on behalf of many chronically ill and functionally impaired individuals that should be acknowledged and supported, rather than necessarily replaced, as both public and private policy options for long-term care are developed.

Among publicly funded long-term care programs, there are four primary populations served—the frail elderly, INDIVIDUALS WITH PHYSICAL DISABILITIES, INDIVIDUALS WITH CHRONIC MENTAL ILLNESSES, AND INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES. ~~the physically disabled, the chronically mentally ill, and the developmentally disabled.~~ Because of a long tradition of developing public programs around certain population categories, the funding streams and delivery systems for these populations are distinct and tend to reflect the unique needs of individuals in each subpopulation.

Virtually all publicly financed long-term care programs are administered at the state or local level, with the largest share funded by the Medicaid program. To pay for services, states often use a combination of funds from Medicaid, the Supplemental Security Income (SSI) program, the Social Services Block Grant, the Older Americans Act, the Community Mental Health Services Block Grant, and the Developmental Disabilities Assistance and Bill of Rights Act, as well as state general revenues. Because people who need long-term care also may need specialized housing assistance, states also use Housing and Urban Development (HUD) resources, as well as SSI, to pay for care in facilities (such as board and care) that does not meet institutional Medicaid definitions.

Although a variety of public programs provide long-term care, most, including Medicaid, are available only to those with limited income and assets. Unfortunately, with a high demand for these services and severe limits on state and federal funding, many Americans do not qualify for care. As such, the burden and the cost of long-term care primarily fall on individuals and their families. Most Americans become aware of the prohibitive costs of prolonged institutional or community-based long-term care only when confronted by family illness. Few alternatives exist to help pay for institutional care; even fewer alternatives exist to pay for home- and community-based care. In most cases, the high costs of care ultimately force people to spend their life savings and then turn to Medicaid for financial assistance.

Current federal policies are fragmented and emphasize institutional care. Although institutional care must be available to and affordable for those who need it, federal policies must be redesigned to

encourage availability of a continuum of services, including home- and community-based care, with the goal of preventing or delaying admission into an institution for as long as possible. The independence of the individual must be maintained and enhanced to the maximum extent possible; family efforts to assist the individual also must be supported. Moreover, federal policy must encourage Americans to plan for their long-term care needs. In addition to public programs, the federal government should coordinate with states to stimulate viable, private sector long-term care insurance products and other means to assist individuals and families in securing private sources of protection against at least part of the potential costs of long-term care.

7.2 A Comprehensive Long-Term Care System

ONE OF THE MOST IMPORTANT PRIORITIES OF THE 105TH CONGRESS WILL BE ENSURING THE CONTINUED FINANCIAL VIABILITY OF MEDICARE. MEDICARE FACES SIGNIFICANT CHALLENGES RELATED TO THE SHORT-TERM FINANCIAL STATUS OF THE HOSPITAL TRUST FUND, AS WELL AS LONGER-TERM DEMANDS TIED TO THE AGING OF THE BABY BOOMER GENERATION. FROM THE PERSPECTIVE OF THE GOVERNORS, THE NEEDS OF MEDICAID AND MEDICARE MUST BE CONSIDERED TOGETHER, BECAUSE THE TWO PROGRAMS ARE FUNDAMENTALLY INTERRELATED DEMOGRAPHICALLY, PROGRAMMATICALLY, AND FINANCIALLY.

REGARDLESS OF WHETHER CONGRESS AND THE WHITE HOUSE DECIDE TO ADDRESS MEDICARE REFORM DIRECTLY OR THROUGH A COMMISSION, MEDICAID LONG-TERM CARE SHOULD BE PART OF THE DISCUSSION. BY EXAMINING THE NEEDS OF THE TWO PROGRAMS JOINTLY, REFORM OFFERS THE POTENTIAL OF CREATING A MORE COORDINATED AND COST-EFFECTIVE SYSTEM OF CARE. TO UNDERTAKE MEDICARE REFORM WITHOUT CONSIDERATION OF THE IMPACT OF CHANGES ON MEDICAID EXPOSES MEDICAID TO THE RISK OF COST SHIFTING AND MISSES AN OPPORTUNITY TO FUNDAMENTALLY IMPROVE AN INEFFICIENT STATUS QUO.

7.2.1 NURSING HOME CARE AND HOME- AND COMMUNITY-BASED CARE. ~~In recent years, a number of federal proposals would have established a new federal publicly-financed home- and community-based services program. Such a program would fill a major gap in the financing of long-term care and would offer consumers an alternative to nursing homes. Although a new program would go a long way toward addressing an unmet demand, the need for a comprehensive approach that integrates community-based and institutional long-term care remains.~~

EXISTING DISTINCTIONS BETWEEN MEDICARE AND MEDICAID POLICIES RELATED TO COVERAGE OF AND ELIGIBILITY FOR NURSING HOME CARE AND HOME- AND COMMUNITY-BASED CARE ARE PARTICULARLY COMPLICATED. SIMPLIFICATION WOULD BE AN IMPORTANT COMPONENT OF A MORE RATIONAL LONG-TERM CARE SYSTEM, PROMOTING COORDINATION OF CARE ACROSS SERVICE SETTINGS. The most comprehensive approach to SIMPLIFICATION WOULD BE AN INTEGRATED MODEL, WHICH ~~such integration~~ would offer a choice of services in a range of settings and would provide a UNIFIED plan of care. ~~to all in need. A reformed system could combine individual resources, private resources,~~

~~and public financing streams and remove the bias toward institutional care. Under this comprehensive approach, states would receive funding from a single source—Medicaid, or a new program that incorporates Medicaid long-term care services—to integrate nursing facility and home and community-based services in a single program. States would have the flexibility to use this new funding stream to support care provided to people who live in nursing homes, in other congregate settings, or in their own homes. States could administer the program as one integrated program serving all populations in need or through two or more state agencies serving specific populations.~~ To accommodate such a strategy, Congress, the administration, and the states should work together to:

- encourage a consumer-focused system of long-term health care;
- eliminate the institutional bias of current long-term care programs;
- increase the supply of long-term care options, including a range of community-based and in-home services;
- integrate delivery systems for institutional, residential, and community and in-home services;
- ensure that adequate consumer protections are established for beneficiaries;
- emphasize cost-effective treatment in the least restrictive setting;
- integrate federal, state and, where possible, **PERSONAL RESOURCES, INCLUDING PRIVATE SECTOR LONG-TERM CARE INSURANCE POLICIES,** ~~private financing streams~~ to provide continuity of care;
- integrate health **AND** social service, ~~and housing~~ funding streams; and
- stimulate development of a viable private long-term care insurance product market **AND ENCOURAGE INDUSTRY DEVELOPMENT OF STRATEGIES TO ATTRACT YOUNGER BUYERS OF LONG-TERM CARE INSURANCE.**

~~The system must be available to individuals of all ages who need assistance in their activities of daily living, and it must be capable of providing a broad range of services, including home and community-based care.~~

7.2.2 **Managed Care and Long-Term Care**

THE MOST OBVIOUS CATEGORICAL CONNECTION BETWEEN THE MEDICAID AND MEDICARE PROGRAMS IS THE DUALY ELIGIBLE POPULATION. THE DUALY ELIGIBLE QUALIFY FOR BOTH PROGRAMS AND RECEIVE A FULL PACKAGE OF BENEFITS FROM EACH. BECAUSE THE TWO PROGRAMS ARE SO CLOSELY LINKED, CHANGES MADE IN ONE DIRECTLY IMPACT THE OTHER. FOR EXAMPLE, REDUCTIONS IN MEDICARE REIMBURSEMENT RATES FOR HOSPITALS COULD LEAD TO EARLIER HOSPITAL RELEASES, RESULTING IN INCREASED NURSING HOME ENROLLMENT. FOR THE DUALY ELIGIBLE, THAT LEADS TO A TRANSITION FROM MEDICARE COVERAGE OF HOSPITAL BENEFITS TO MEDICAID COVERAGE FOR NURSING HOME CARE.

SUCCESSFUL MANAGEMENT OF THE PROGRAMMATIC CONNECTIONS BETWEEN MEDICAID AND MEDICARE WOULD RESULT IN THE CREATION OF A MORE SEAMLESS

SYSTEM OF BENEFITS FOR RECIPIENTS, MAKE HOME- AND COMMUNITY-BASED CARE A MORE VIABLE ALTERNATIVE TO INSTITUTIONAL PLACEMENTS, AND REDUCE COST SHIFTING. ONE MANAGEMENT STRATEGY MANY GOVERNORS WOULD LIKE THE FLEXIBILITY TO PURSUE IS MANDATORY MANAGED CARE FOR THE DUALY ELIGIBLE.

~~With the proliferation of networks of care, the next likely area for the development of integrated health care networks is in long-term care.~~ Three general strategies exist for the application of managed care practices to long-term care. The first is the integrated care model, which attempts to combine both primary and preventive care, as well as home- and community-based and institutional care, into a single integrated system. The second is the primary/acute care model, which focuses solely on primary and preventive care but excludes long-term care services. This model, while technically not long-term care, is extremely important because health care networks do not have much experience providing primary and preventive care to the frail elderly and people with developmental or physical disabilities—individuals with unique and demanding health care needs. The third strategy is the long-term care model, which focuses on integration of home- and community-based care and institutional care but excludes primary and preventive care. Common to all three models is the goal of providing quality and cost-efficient care in the MOST APPROPRIATE ~~least-restrictive~~ setting.

~~Although in its infancy,~~ States and the federal government HAVE BEGUN ~~are conducting~~ demonstrations to assess the efficacy of each of these three general approaches. HOWEVER, A NUMBER OF SIGNIFICANT OBSTACLES, BOTH STATUTORY AND ADMINISTRATIVE, HAVE ARISEN TO CONDUCTING EFFECTIVE MANAGED CARE EXPERIMENTS. THE GOVERNORS CALL UPON CONGRESS AND THE ADMINISTRATION TO PERMIT INTERESTED STATES TO EXPERIMENT WITH MANDATORY MANAGED CARE PILOT PROJECTS FOR THE DUALY ELIGIBLE. THIS AUTHORITY TO EXPERIMENT COULD BE CLARIFIED EITHER THROUGH AN EXPLICIT LEGISLATIVE SANCTION OF MANDATORY MANAGED CARE PROGRAMS FOR THE DUALY ELIGIBLE OR THROUGH THE CREATION OF SUBSTANTIAL MEDICARE WAIVER AUTHORITY SIMILAR TO THE WAIVER OPTIONS THAT CURRENTLY EXIST IN MEDICAID.

MEDICAID FILLS THE GAPS IN MEDICARE COVERAGE FOR LOW-INCOME SENIOR CITIZENS AND CERTAIN PEOPLE WITH DISABILITIES. WHEN A MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION IS NOT AVAILABLE OR DOES NOT OFFER PRESCRIPTION DRUG COVERAGE, MEDICAID ASSUMES THE COST OF PROVIDING THIS IMPORTANT BENEFIT. AS CONGRESS AND THE ADMINISTRATION MAKE DECISIONS REGARDING MEDICARE HMO RATES, SPECIAL CONSIDERATION SHOULD BE GIVEN TO THE DISPARITIES THAT EXIST BETWEEN THE RATES PAID TO HMOS IN RURAL AND URBAN AREAS AND THE IMPACT OF THOSE DISPARITIES ON THE RANGE OF OPTIONS

provisions. IN ADDITION, ~~For example,~~ they often have high lapse rates, require medical underwriting, AND are unavailable to people with existing disabilities. ~~—or—are—not—protected—against~~ inflation. Also, some insurers have not been forthcoming in paying out benefits. LONG-TERM CARE INSURANCE POLICIES ~~In addition,~~ they are often so expensive to purchase that they are unaffordable for a large segment of the general population. HOWEVER, HIPA CONTAINS SEVERAL PROVISIONS THAT SHOULD MAKE POLICES MORE AFFORDABLE, INCLUDING TAX DEDUCTIBILITY AND INFLATION PROTECTION. THE GOVERNORS HOPE THESE PROVISIONS WILL MAKE LONG-TERM CARE INSURANCE POLICIES BROADLY ACCESSIBLE.

The Governors, with the state insurance commissioners, will work with the insurance industry, Congress, and consumer groups to ensure that coverage is available for home- and community-based services, that model consumer protection standards are adopted and followed, that policies are available that are reasonable in cost, that effective outreach is conducted regarding these policies, and that public education programs are available regarding the importance of early individual planning for long-term care needs.

The Governors recognize that private long-term care insurance is not a panacea for the nation's long-term health care problems. In light of the longevity of the population, the growing need for home- and community-based care, the average length of stay for institutional care, and the fixed incomes of those most at risk of needing long-term care, the Governors further recognize that a solution is not easily achievable and that interventions that provide appropriate care, real protections, and fiscal guarantees must be crafted.

7.4

Conclusion

As the BABY BOOM GENERATION BEGINS TO RETIRE IN 2010, ~~nation-enters-the-twenty-first-century,~~ the population needing long-term care will ~~continue-to~~ grow DRAMATICALLY. Federal and state action is needed now to plan for this certainty. Some time remains to develop and assess policies that could lead to cost-efficient, quality medical and support services. However, if this time is not used wisely, the costs in terms of quality of life for individuals and their families, and in state and federal spending, could be quite substantial.

Time limited (effective WINTER MEETING 1997-WINTER MEETING 1999). ~~Winter Meeting 1995-~~
~~Winter Meeting 1997~~
Adopted Winter Meeting 1995.

AND SERVICES AVAILABLE TO BENEFICIARIES. ADJUSTMENTS TO HMO PAYMENT METHODOLOGIES SHOULD BE CONSIDERED THAT ENCOURAGE EXPANSION OF MEDICARE MANAGED CARE IN STATES WHERE LOW PAYMENTS HAVE RESTRICTED OPTIONS AND SERVICES AND HAVE LED TO LOW PARTICIPATION. ~~The Governors call on Congress and the administration to ensure that there is sufficient flexibility in federal Medicare and Medicaid statutes so that continued testing of these models can occur. Moreover,~~

The Governors are committed to working with Congress, the administration, and health care providers and beneficiaries to ensure that networks of care are practical and viable for people with developmental and physical disabilities, AS WELL AS FOR PEOPLE WITH CHRONIC MENTAL ILLNESSES. ALL INTERESTED PARTIES MUST BUILD ON THE LESSONS LEARNED FROM EXISTING PILOT PROJECTS TO DESIGN INTEGRATED SERVICE DELIVERY MODELS TO MEET THE SPECIAL NEEDS OF THESE POPULATIONS.

7.3 Private Long-Term Care Insurance

In recent years, there has been growth in the availability of private long-term care insurance. Although the growth of this market has been slow and has had mixed success, for those who have access to and can afford such coverage, it may represent a reasonable alternative to public financing. Of particular interest are new efforts in some states to create a private-public partnership for long-term care insurance that allows individuals to purchase state-certified private policies and then have a portion of their assets protected once the private benefits are paid out and public financing becomes necessary. CURRENTLY, FOUR STATES ARE OPERATING THESE PROGRAMS, BUT FURTHER EXPANSION HAS BEEN RESTRICTED. THESE EXISTING public-private partnerships must be permitted to continue, and federal barriers must be eliminated. In addition, authority to implement such programs must be expanded to all states.

Although public-private initiatives must be supported, the Governors have been remain concerned about the quality of many of the private long-term care policies that are currently available. HOWEVER, THE PASSAGE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPA) EXTENDS IMPORTANT QUALITY PROTECTIONS TO THE LONG-TERM CARE INSURANCE MARKET. THE GOVERNORS CALL UPON THE FEDERAL GOVERNMENT TO WORK CLOSELY WITH STATES WHEN IMPLEMENTING THESE QUALITY STANDARDS TO ENSURE THAT BENEFICIARIES RECEIVE THE BENEFITS THEY HAVE PURCHASED WHEN THEY NEED THEM.

DESPITE THE REAL IMPROVEMENTS SET FORTH IN HIPA, THE GOVERNORS CONTINUE TO HAVE SEVERAL CONCERNS REGARDING LONG-TERM CARE INSURANCE. Often, the policies have limited coverage for home care. ~~and lack adequate consumer protection~~



EC-8. MEDICAID

8.1 Preamble

The Medicaid program is a state/federal program that serves as the primary source of acute health care coverage and long-term care for the poor. Because it is a national program serving more than 37 30 million beneficiaries, the Governors believe that quality services must be provided as efficiently and effectively as possible.

In 1996 1994 approximately \$164 \$141 billion WAS will be spent in the Medicaid program. Of that amount, about \$71 \$60 billion WAS will be state funds. Medicaid is now one of the largest components of state budgets, comprising 20 48 percent of state spending. ~~Not only is Medicaid SPENDING HAS GROWN growing in both absolute and relative terms, AND AS A RESULT OF THIS GROWTH, MEDICAID IS NOW THE SECOND-LARGEST EXPENDITURE IN STATE BUDGETS. it remains the fastest growing state expenditure.~~ As a result, states are experiencing great difficulty in finding the money to fund Medicaid. Even more important, perhaps, is that increased Medicaid spending makes it difficult, if not impossible, to increase funding for other priorities, such as education. Finding ways to control Medicaid spending is a major priority for the Governors.

Medicaid financing and administration are shared jointly by the federal government and the states. THIS FEDERAL-STATE PARTNERSHIP OF FINANCIAL RESPONSIBILITY MUST BE MAINTAINED WITHOUT FURTHER COST SHIFTS FROM THE FEDERAL GOVERNMENT TO THE STATES AND WITHOUT EXPANSIONS OF FEDERAL PROGRAMMATIC MANDATES THAT INCREASE STATE COSTS OR LIMIT STATE FLEXIBILITY. IN RECENT ~~Over the past five~~ years, federal policymakers have narrowed the administrative flexibility of states and made legislative and regulatory changes that mandate greatly increased state expenditures. As a result, states increasingly view their relationship with the federal government not as a partnership, but as a relationship in which states have been forced to accept federal mandates that have great impact on state budgets and health policy initiatives.

States must have relief from the real and pressing problems presented by the Medicaid program if they are to move forward with long-term solutions. DESPITE THE FAILURE OF FUNDAMENTAL MEDICAID REFORM EFFORTS IN PREVIOUS CONGRESSES, THE GOVERNORS CONTINUE TO BELIEVE THAT URGENT CHANGES ARE NEEDED TO PROMOTE EFFECTIVENESS AND EFFICIENCY. Therefore, the Governors call on Congress and the administration to work to immediately address the problems with this program. Included among those solutions must be an overall reduction in the federal statutory and regulatory micro-management that has typified the program in the last decade.

8.2 FEDERAL FINANCING

8.2.1 **Impose No Unilateral Caps for Federal Spending on Medicaid Entitlements.** AS THE PRESIDENT AND CONGRESSIONAL LEADERS DEVELOP THEIR POLICY AGENDAS FOR THE 105TH CONGRESS, IT APPEARS THAT THE MEDICAID REFORM DEBATE WILL BE VERY DIFFERENT THAN IT WAS IN THE 104TH CONGRESS. THE DEBATE LIKELY WILL FOCUS MORE ON IMPROVEMENTS TO THE EXISTING MEDICAID PROGRAM THAN ON A FUNDAMENTAL RECONSIDERATION OF BASIC PROGRAM DESIGN. GIVEN THIS PREMISE, GOVERNORS ARE EAGER TO WORK WITH CONGRESS AND THE ADMINISTRATION TO MAKE NEEDED IMPROVEMENTS AND PROMOTE EFFICIENCIES IN THE MEDICAID PROGRAM AS LISTED IN THIS POLICY.

AT THE SAME TIME, MEDICAID WILL BE INCLUDED IN EFFORTS TO BALANCE THE BUDGET. GOVERNORS ALREADY HAVE CONTRIBUTED TO SIGNIFICANT BUDGETARY SAVINGS BY CONTROLLING MEDICAID GROWTH RATES. IN THE LATE 1980S AND EARLY 1990S, MEDICAID SPENDING GREW AT AN ANNUAL AVERAGE OF MORE THAN 20 PERCENT. IN 1995 AND 1996, MEDICAID GROWTH HAS BEEN HELD TO AN AVERAGE OF LESS THAN 4 PERCENT. REVISIONS IN THE MEDICAID BASELINE AND MEDICAID GROWTH RATES WILL PRODUCE SCORABLE DEFICIT REDUCTION.

THESE REDUCTIONS IN GROWTH RATES WERE MADE POSSIBLE BY TAKING ADVANTAGE OF THE LIMITED FLEXIBILITY CURRENTLY AFFORDED BY THE MEDICAID PROGRAM TO CONTAIN COSTS. HOWEVER, ECONOMIC PRESSURES AND OTHER FACTORS BEYOND STATE CONTROL WILL CONTINUE TO BE DRIVING FORCES PROPELLING MEDICAID SPENDING GROWTH. THEREFORE, STATES WILL NOT BE ABLE TO ABSORB ANY MEDICAID CUTS WITHIN EXISTING PROGRAM PARAMETERS. ADDITIONAL FLEXIBILITY WILL BE NEEDED TO MOVE BEYOND THE RESULTS ALREADY ACHIEVED.

THE GOVERNORS WOULD WELCOME THE OPPORTUNITY TO WORK WITH CONGRESS AND THE ADMINISTRATION TO DEVELOP EQUITABLE AND EFFECTIVE COST-CONTAINMENT STRATEGIES, BECAUSE THE GOVERNORS STRONGLY BELIEVE THAT THE FEDERAL BUDGET MUST NOT BE BALANCED BY SHIFTING COSTS TO STATES. IN ADDITION, GOVERNORS WOULD OPPOSE COST-CUTTING STRATEGIES THAT UNFAIRLY BURDEN STATES.

[Note: The following language is unresolved pending discussion between members of the Medicaid Task Force. Two suggestions have been set forth.]

[Option A]

IN THE CONTEXT OF A MEDICAID PROGRAM THAT RETAINS THE INDIVIDUAL ENTITLEMENT, THE GOVERNORS ADAMANTLY OPPOSE CAPS ON FEDERAL MEDICAID SPENDING IN ANY FORM. ANY ~~A unilateral federal cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. The Governors adamantly oppose a cap on federal Medicaid spending.~~ If Congress is serious about reducing the costs of the program, it must reexamine the authorizing legislation that has brought the program to the condition it is in today and restructure the program to make it consistent with congressional spending strategies.

[Option B]

IN THE CONTEXT OF A MEDICAID PROGRAM THAT RETAINS THE INDIVIDUAL ENTITLEMENT, THE GOVERNORS CAN ONLY SUPPORT COST-CONTAINMENT INITIATIVES THAT ARISE FROM SPECIFIC, SIGNIFICANT PROGRAMMATIC CHANGES THAT ARE DEVELOPED WITH THE DIRECT PARTICIPATION OF GOVERNORS AND THAT PROVIDE STATES THE TOOLS THEY NEED TO REDUCE MEDICAID COSTS. THE GOVERNORS WILL OPPOSE CAPS ON FEDERAL MEDICAID SPENDING THAT WOULD SIMPLY SHIFT COSTS TO STATES. ~~A unilateral federal cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. The Governors adamantly oppose a cap on federal Medicaid spending. If Congress is serious about reducing the costs of the program, it must reexamine the authorizing legislation that has brought the program to the condition it is in today and restructure the program to make it consistent with congressional spending strategies.~~

8.2.2 **MEDICAID MANDATES.** THE UNFUNDED MANDATES REFORM ACT OF 1995 IS DESIGNED TO PROTECT STATES FROM THE COST SHIFTS THAT OCCUR WHEN THE FEDERAL GOVERNMENT REQUIRES STATES TO ENACT EXPENSIVE NEW POLICIES BUT FAILS TO PROVIDE THE FUNDING NECESSARY FOR IMPLEMENTATION. THE GOVERNORS UNEQUIVOCALLY OPPOSE UNFUNDED FEDERAL MANDATES AND APPLAUD THE PROTECTION AFFORDED BY THE NEW LAW. STATE MEDICAID PROGRAMS HAVE HISTORICALLY BEEN VULNERABLE TO UNFUNDED MANDATES AND SHOULD PARTICULARLY BENEFIT FROM MANDATE RELIEF.

8.2.3 **MEDICAID AND MEDICARE.** AS CONGRESS AND THE ADMINISTRATION DEBATE POSSIBLE MEDICARE REFORMS, THE IMPACT OF THOSE CHANGES ON MEDICAID PROGRAMS MUST BE CAREFULLY CONSIDERED. THE GOVERNORS CANNOT SUPPORT MEDICARE REFORM STRATEGIES, SUCH AS INCREASED COST-SHARING OBLIGATIONS FOR THE DUALY

ELIGIBLE, THAT RESULT IN COST SHIFTS TO THE STATES. THE LONG-TERM FINANCIAL NEEDS OF MEDICAID AND MEDICARE MUST BE CONSIDERED JOINTLY TO SUCCESSFULLY PREPARE EACH PROGRAM FOR THE INCREASED DEMANDS THAT WILL ACCOMPANY THE AGING OF THE BABY BOOMER GENERATION. THE GOVERNORS ALSO SUPPORT EXPERIMENTATION WITH MANDATORY MANAGED CARE PILOT PROJECTS FOR THE DUALY ELIGIBLE, AS DISCUSSED IN NGA'S LONG-TERM CARE POLICY, EC-7.

8.2.4 DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM. MEDICAID'S DSH FUNDS ARE AN IMPORTANT PART OF STATEWIDE SYSTEMS OF HEALTH CARE ACCESS FOR THE UNINSURED. THE GOVERNORS STRONGLY BELIEVE THAT DSH FUNDS MUST CONTINUE TO BE DISTRIBUTED THROUGH STATES TO ENSURE THAT THE PROGRAM EFFECTIVELY COMPLEMENTS OTHER FEDERAL AND STATE SOURCES OF HEALTH CARE FUNDING.

8.3 PROGRAMMATIC RECOMMENDATIONS

8.3.1 Allow States Greater Flexibility to Establish Managed Care Networks. There is a national trend in health care service delivery toward organized systems of care. These systems or networks have been shown to provide cost-efficient, quality care while ensuring that the patient has a reliable place from which to seek primary care and to which specialty care can be directed. Systems of coordinated care have particular benefits for Medicaid beneficiaries. These systems ensure a medical home for beneficiaries, encourage primary and preventive care, and discourage the use of emergency rooms and specialists for routine medical care.

Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. Although the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed. TO ENSURE CONTINUITY AND QUALITY OF CARE AND TO REDUCE ADMINISTRATIVE COSTS, STATES SHOULD HAVE THE OPTION TO REQUIRE MEDICAID BENEFICIARIES TO STAY IN AN HMO FOR A PERIOD OF UP TO TWELVE MONTHS. STATES ALSO SHOULD BE ALLOWED TO GUARANTEE ENROLLMENT FOR CERTAIN MEDICAID BENEFICIARIES IN HMOS FOR A PERIOD OF UP TO TWELVE MONTHS.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. The Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care.

CONGRESS SHOULD CLARIFY THAT UNDER FEDERAL LAW, THE STATES' OBLIGATION TO PROVIDE SERVICES IS SATISFIED IF THE STATE ENTERS INTO A CONTRACT WITH A PROVIDER OR HMO THAT COVERS THE NECESSARY BENEFITS. BEYOND THAT, ANY DISPUTE BY A CLIENT REGARDING COVERED SERVICES SHOULD BE RESOLVED AS A CONTRACTUAL MATTER BETWEEN THE CLIENT AND THE PROVIDER OR HMO UNDER STATE LAW. MANY STATES HAVE ALTERNATIVE DISPUTE RESOLUTION PROCESSES THAT SHOULD BE EXHAUSTED BEFORE RECOURSE TO THE STATE COURT SYSTEM. THERE SHOULD BE NO PRIVATE RIGHT OF ACTION FOR PROVIDERS OR HEALTH PLANS REGARDING PAYMENT RATES.

8.3.2 **WAIVERS.** CURRENTLY, EACH STATE MUST PRODUCE AND DEFEND WAIVER REQUESTS EVEN IF OTHER STATES HAVE ALREADY RECEIVED APPROVAL TO IMPLEMENT SIMILAR WAIVERS. OBTAINING REDUNDANT FEDERAL APPROVAL IS AN INEFFICIENT USE OF RESOURCES AT BOTH THE STATE AND FEDERAL LEVEL. STATES SHOULD BE ALLOWED TO IMPORT ANY WAIVER IN PLACE IN ANOTHER STATE WITHOUT SECURING ADDITIONAL FEDERAL APPROVAL.

8.3.3 **Give States Greater Leeway in Containing the Cost of Hospital and Long-Term Care. Through the Boren Amendment.** The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. The courts have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment. The nation's Governors believe that any coherent approach to IMPROVING OUR NATION'S HEALTH CARE SYSTEM national health care reform must address the inflexible provider reimbursement standard of the Boren Amendment. The Governors CALL FOR support repeal of the Boren Amendment IN ITS ENTIRETY.

8.3.3.1 **ALTERNATIVE Statutory and Regulatory Changes.** IN THE ABSENCE OF A FULL REPEAL OF THE BOREN AMENDMENT, THE GOVERNORS WOULD and urge alternative statutory protections for states. They believe that a statutory change is a necessary tool to bring Medicaid institutional costs under control. Therefore, the Governors WOULD urge the administration and Congress to REPLACE THE BOREN AMENDMENT WITH adopt these changes or other strategies that will give states the relief they need.

The Governors agree that RESTRUCTURED standards for establishing adequate reimbursement rates for hospitals, nursing facilities, and intermediate care facilities for people with mental retardation must be designed to promote access to care for Medicaid patients, quality of services, cost containment, and efficient service delivery. The Governors support a strategy that would replace the current cost-efficiency-based standard in the Boren Amendment with provisions that establish "safe harbor" standards, where a state meeting any of these safe harbor provisions would satisfy the statute. SUCH OPTIONS Standards might include the following.

- The payment rate is equal to the Medicare-based upper payment limit.
- The payment rate is no less than the rate agreed to by the facility for comparable services paid for by another payer (e.g., payment rates for Medicaid patients would not have to be higher than rates paid by any large managed care plans or large businesses).
- Regarding nursing facilities, the aggregate number of participating licensed and certified nursing home beds in the state (plus resources devoted to home- or community-based care for the elderly) is at least equal to a specified percentage of the population age 65 or over.
- The reimbursement rate is sufficient to cover at least 80 percent of the allowable costs of all facilities in the class in the state in the aggregate or is sufficient to cover the allowable costs of 50 percent of all facilities in the class in the state.
- The reimbursement rate is equal to a benchmark rate plus inflation, no less than the rate of inflation for the overall economy according to a general index (national or state) such as the consumer price index or the gross domestic product. The benchmark rate would be the approved rate as of the date of enactment of the statute or the current rate approved by the Health Care Financing Administration (HCFA). This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.

The Governors also believe that the Boren Amendment is not applicable when a hospital engages in rate negotiations as part of its participation in a network serving Medicaid beneficiaries.

The Governors also believe that the procedural requirements in the current Boren Amendment must be streamlined.

Finally, the Governors support strategies that would reduce or eliminate the costs of prolonged and costly litigation.

8.3.3.2 **BOREN-LIKE PROVISIONS. THE SAME AMBIGUITY THAT HAS CAUSED PROBLEMS FOR STATES IN THE BOREN AMENDMENT EXISTS IN OTHER PARTS OF THE MEDICAID STATUTE AS WELL. FOR EXAMPLE, SECTION 1902(A)(30) ALLOWS STATES TO SET REIMBURSEMENT RATES TO SAFEGUARD AGAINST UNNECESSARY UTILIZATION OF CARE AND TO ENSURE THAT PAYMENTS ARE "CONSISTENT WITH EFFICIENCY, ECONOMY, AND QUALITY OF CARE."** TO CLARIFY THIS UNDEFINED TERMINOLOGY, COURTS HAVE BEGUN TO ESTABLISH PARAMETERS FOR REIMBURSEMENT RATES. GIVEN THE GROWING PROBLEM OF COURT INTERPRETATIONS OF "BOREN-LIKE" PROVISIONS IN STATUTE, SECTION 1903 (M)(2)(A)(III) ALSO APPEARS VULNERABLE TO LITIGATION. THIS SECTION AMBIGUOUSLY REQUIRES STATE CONTRACTS WITH HMOS TO BE MADE ON AN "ACTUARIALLY SOUND BASIS." THE GOVERNORS RECOMMEND THAT ALL SUCH REIMBURSEMENT PROVISIONS BE CLARIFIED TO PRECLUDE ANY LITIGATION OVER PROVIDER OR HEALTH PLAN PAYMENT RATES. IN ALL INSTANCES,

PROVISIONS SHOULD INCLUDE THE OPPORTUNITY TO ALLOW THE MARKET TO ESTABLISH RATES, AS THROUGH THE COMPETITIVE BIDDING PROCESS OR DIRECT NEGOTIATION.

8.3.4 Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program By Providing Services Within Their State Medicaid Plan and Selecting Less Costly Alternatives for Diagnosis and Treatment Without Risking Quality. Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. The U.S. Department of Health and Human Services SHOULD WORK WITH THE STATES TO DEVELOP AND FINALIZE ~~needs-to-issue~~ rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

8.3.5 Ensure that States Will Not Be Expected to Implement Any Medicaid Program Changes Until the Health Care Financing Administration Has Published Final Regulations to Guide Program Administration. In too many cases, HCFA has failed completely to publish regulations associated with statutory changes in the Medicaid program or has done so after many years of delay. Too often, states have had to implement statutory changes and in some cases, have been held financially accountable for unclear laws, even though HCFA failed to provide clarification through implementing regulations. LACK OF TIMELY ACTION BY HCFA IN ISSUING REGULATIONS HAS RESULTED IN PARTICULAR DIFFICULTIES IN THE AREA OF SPOUSAL IMPOVERISHMENT PROTECTION.

8.3.6 Promote Cost Control and Efficiency. States should be encouraged to continue innovations in provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain Medicaid providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement strategies should be repealed.

~~In addition, with respect to three particularly troublesome mandates over the last four years, the Governors call upon Congress and the administration to make the following specific, programmatic changes:~~

8.3.7 Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries Who Are Not Otherwise Medicaid-Eligible. Since the passage of the Medicare catastrophic legislation in 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary Program). The Medicare program is a federal program and the federal government should bear all of its costs. CURRENTLY, MEDICAID IS RESPONSIBLE FOR MEETING THE MEDICARE COST-SHARING OBLIGATIONS OF LOW-INCOME BENEFICIARIES. SHOULD MEDICARE NOT ASSUME FULL FINANCIAL RESPONSIBILITY, CONGRESS SHOULD AT A MINIMUM CLARIFY THAT COPAYMENTS MAY BE REIMBURSED AT MEDICAID, RATHER THAN MEDICARE, RATES. PAYING AT MEDICAID RATES PRESERVES EQUITY AND ACCESS AMONG ALL MEDICAID CLIENTS.

8.3.8 **Reconsider the Nursing Home Reform Mandates in the Omnibus Reconciliation Act of 1987.** Congress mandated extensive new quality assurance measures for the Medicaid nursing home program. The statutory language permits limited state flexibility and puts Congress in the position of micro-managing the program. In addition, Congress should repeal the preadmission screening and ~~Annual Resident Review (PASARR)~~ requirements. Since enactment, states have found PREADMISSION SCREENING PASARR to be extremely cost-inefficient and have developed other strategies to ensure the appropriate placement of individuals with disabilities. ~~In addition, the specialized annual resident review for mental illness and mental retardation is duplicative of existing annual review processes.~~

8.3.9 **Make Audit and Disallowance Policies More Equitable.** Under current law, federal audit and disallowance requirements do not discriminate between violations of "obscure policies" and those that have direct harm to beneficiaries. The statute should be revised to prohibit federal practices that impose heavy penalties when the violation constitutes no beneficiary harm. STATES SHOULD BE HELD HARMLESS AGAINST POSSIBLE PENALTIES OR DISALLOWANCES FOR REASONABLE INTERPRETATIONS OF LAW BASED ON DEPARTMENTAL GUIDANCE PRIOR TO THE ISSUANCE OF REGULATIONS.

8.3.10 **Allow Greater Flexibility in Medicaid Home- and Community-Based Care (HCBC) Programs.** Home- and community-based care is an important alternative to institutional care for the elderly and people with chronic and disabling conditions. Currently, every state in the country has at least one HCBC program. Existing Medicaid statutes require states to establish and administer these programs through waivers. The statutes must be revised to give states the authority to administer HCBC programs through a plan amendment process. However, states must be able to retain the authority to limit the number of beneficiaries receiving Medicaid home- and community-based care. Finally, Congress and the states must work together to restructure the Medicaid program to eliminate the incentive to place beneficiaries in institutional care when community care would be more appropriate and possibly more cost-efficient.

8.3.11 **MANAGED CARE AND QUALITY STANDARDS. GOVERNORS ARE COMMITTED TO ENSURING THAT EVERY MEDICAID RECIPIENT RECEIVES HIGH-QUALITY HEALTH CARE, AND MANAGED CARE HAS BEEN AN EFFECTIVE STRATEGY FOR MEETING THAT GOAL. MEDICAID MANAGED CARE HAS DELIVERED HIGH-QUALITY, COST-EFFECTIVE HEALTH CARE SERVICES TO MILLIONS OF RECIPIENTS.**

GIVEN THE EXPERTISE STATES HAVE DEVELOPED WITH MEDICAID MANAGED CARE, THE GOVERNORS WOULD LIKE TO WORK CLOSELY WITH CONGRESS AND THE ADMINISTRATION AS QUALITY ISSUES ARE DEBATED. ALTHOUGH THERE CAN BE NO DISAGREEMENT THAT INDIVIDUALS ENROLLED IN MANAGED CARE NETWORKS SHOULD HAVE THEIR HEALTH CARE NEEDS MET WITH QUALITY SERVICES, THE GOVERNORS ARE CONCERNED THAT EFFORTS TO ENSURE QUALITY, IF NOT UNDERTAKEN CAREFULLY, COULD RESULT IN RIGID GUIDELINES THAT DICTATE STATE

CONTRACTUAL RELATIONSHIPS OR FAIL TO KEEP UP WITH TECHNOLOGICAL INNOVATIONS.

ANY TIME CONGRESS MANDATES COVERAGE OF A PARTICULAR BENEFIT OR SETS REQUIREMENTS AROUND THE TERMS OF THAT BENEFIT, CAREFUL CONSIDERATION MUST BE GIVEN TO THE FISCAL IMPACT OF THE CHANGE ON MEDICAID. EVEN REQUIREMENTS LIMITED TO THE PRIVATE SECTOR CAN HAVE A STRONG MEDICAID IMPACT THROUGH CONTRACTUAL RELATIONSHIPS WITH HMOS. GOVERNORS WILL VIEW ANY CHANGES IN THE HEALTH CARE MARKET IN A CONTEXT FRAMED BY OPPOSITION TO UNFUNDED MANDATES.

8.3.12 CHILDREN ELIGIBLE FOR MEDICAID. RECENTLY THERE HAS BEEN A GREAT DEAL OF ATTENTION FOCUSED ON THE POPULATION OF CHILDREN ELIGIBLE FOR MEDICAID BUT NOT CURRENTLY ENROLLED IN THE PROGRAM. GOVERNORS AGREE THAT HEALTH CARE IS ESSENTIAL TO THE WELL-BEING OF CHILDREN. ACCORDINGLY, CHILDREN ENTITLED TO MEDICAID BENEFITS SHOULD RECEIVE THOSE BENEFITS. IN THIRTY-FOUR STATES, MEDICAID ELIGIBILITY FOR CHILDREN HAS BEEN EXPANDED BEYOND FEDERALLY MANDATED MINIMUM REQUIREMENTS.

EXACT ESTIMATES OF THE NUMBER OF CHILDREN WHO ARE MEDICAID-ELIGIBLE BUT NOT ENROLLED ARE DIFFICULT TO DEVELOP. ELIGIBLE CHILDREN MAY NOT BE ENROLLED IN MEDICAID FOR A NUMBER OF REASONS. FOR EXAMPLE, A CHILD MAY HAVE HEALTH INSURANCE COVERAGE THROUGH A NONCUSTODIAL PARENT. MANY STATES ALREADY HAVE IMPLEMENTED A RANGE OF INNOVATIVE OUTREACH STRATEGIES TARGETED TO THOSE WHO NEED BENEFITS BUT MAY NOT BE AWARE OF THEIR MEDICAID ELIGIBILITY, INCLUDING ENROLLMENT CENTERS LOCATED OUT IN COMMUNITIES, "ONE-STOP SHOPS," AND SIMPLIFIED PRESUMPTIVE ELIGIBILITY PROCESSES.

SHOULD THE FEDERAL GOVERNMENT CONSIDER ADDITIONAL STRATEGIES TO REACH OUT TO FAMILIES OF CHILDREN ELIGIBLE FOR MEDICAID BUT NOT RECEIVING BENEFITS, THOSE STRATEGIES MUST BE DEVELOPED IN CONJUNCTION WITH THE STATES. UNCOORDINATED OUTREACH EFFORTS WOULD BE ADMINISTRATIVELY CUMBERSOME AND WOULD FAIL TO ACHIEVE THE DESIRED RESULTS. OUTREACH EFFORTS ALSO MUST BE DESIGNED IN A WAY THAT DISCOURAGES EMPLOYERS FROM DISCONTINUING PRIVATE SECTOR INSURANCE COVERAGE FOR CHILDREN. THE GOVERNORS BELIEVE STRONGLY THAT NO MEDICAID OUTREACH STRATEGY SHOULD

CREATE AN OPPORTUNITY FOR SHIFTING PRIVATE SECTOR INSURANCE COSTS TO THE PUBLIC SECTOR.

BECAUSE THE GROUP OF CHILDREN CURRENTLY ELIGIBLE FOR MEDICAID BUT NOT ENROLLED HAS PROVED DIFFICULT TO ACCURATELY QUANTIFY AND HAS BEEN RESISTANT TO PREVIOUS OUTREACH EFFORTS, THE GOVERNORS WOULD OPPOSE TYING RECEIPT OF MEDICAID FUNDS TO ACHIEVING INCREASED ENROLLMENT TARGETS.

Time limited (effective WINTER MEETING 1997-WINTER MEETING 1999). ~~Winter Meeting-1995-~~
~~Winter Meeting-1997~~
Adopted Winter Meeting 1995.



HR-2. IMMIGRATION AND REFUGEE POLICY**2.1 Immigration Policy****2.1.1**

Preamble. The nation's Governors recognize the important contribution immigrants have made and continue to make to our nation. Although the federal government has the primary role in directing overall policy regarding immigration and refugees, the effects of such policy on local communities present challenges that cannot be ignored by the states. These challenges include demands for education, job training, social and health services, and other assistance designed to promote the integration of immigrants into our communities.

Decisions regarding the admission and placement of legal immigrants and refugees rest solely with the federal government. Similarly, the illegal entry of other individuals also is a direct responsibility of the federal government. ~~When these decisions are coupled with federal mandates to serve both legal and undocumented immigrants and refugees in joint federal-state categorical assistance programs, the consequence is a significant increase in the state share of these program costs.~~

The federal government's unwillingness to provide adequate funding for refugee resettlement and immigrant assistance services has resulted in a dramatic shift of program costs from the federal government to state and local taxpayers. This reduced federal commitment has strained the states' ability to provide the programs and services necessary to promote economic self-sufficiency within the immigrant and refugee community. GOVERNORS RECOGNIZE CONGRESS' WELL-INTENTIONED EFFORTS AND AGREE THAT SPONSORSHIP REQUIREMENTS CAN HELP PREVENT IMMIGRANTS FROM BECOMING PUBLIC CHARGES. HOWEVER, THE PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 THAT DENY CERTAIN BENEFITS TO THIS POPULATION, BOTH RETROACTIVE AND PROSPECTIVE, REPRESENT A COST TRANSFER TO STATE AND LOCAL GOVERNMENTS. THE GOVERNORS ARE PARTICULARLY CONCERNED ABOUT THE EFFECT OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 ON IMMIGRANTS WHO WERE IN THE UNITED STATES ON THE DATE OF ENACTMENT, BUT WHO CANNOT MEET THE CITIZENSHIP REQUIREMENTS BECAUSE OF AGE OR DISABILITY. THESE INDIVIDUALS SHOULD NOT BE BARRED FROM FEDERAL SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS AND FOOD STAMPS.

EVEN THOUGH MANDATES HAVE BEEN TERMINATED AND STATES HAVE BEEN PROVIDED THE OPTION TO ESTABLISH ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), MEDICAID, AND SOCIAL SERVICES, IT IS NOT CLEAR THAT THE JUDICIAL SYSTEM WILL PERMIT STATES TO BAR REFUGEES AND OTHER LEGAL IMMIGRANTS WHO ARE IN NEED FROM CRITICAL SERVICES PROVIDED TO OTHER RESIDENTS OF THE STATE. AT THE LEAST, DURING AN INITIAL PERIOD OF JUDICIAL DELIBERATION, STATES COULD BE REQUIRED TO SUSTAIN BENEFITS. FURTHER, THOSE INDIVIDUALS WHO ARE RECEIVING FEDERAL BENEFITS AND WHO HAVE SUBMITTED AN APPLICATION TO NATURALIZE SHOULD CONTINUE TO BE ELIGIBLE TO RECEIVE THESE

BENEFITS WHILE THEY ARE PARTICIPATING IN THE APPROXIMATE SIX- TO NINE-MONTH NATURALIZATION PROCESS.

Because immigration and refugee policy is under the sole jurisdiction of the federal government, the Governors believe that the federal government must be prepared to bear the costs of such policy.

2.1.2

Principles. Because immigration decisions have a broad influence upon our society and involve the states, the Governors urge Congress to consider the following principles in the deliberation and formulation of immigration policies.

- The decision to admit immigrants is a federal one that carries with it a firm federal commitment to shape immigration policy within the parameters of available resources we as a nation are determined to provide.
- The fiscal impact of immigration decisions must be addressed by the federal government. The states, charged with implementing federal policy, have shared and are sharing in the costs; however, there should be no further shift of costs to the states.
- Immigration policy shall be developed within the context of our national interest, which takes into consideration preservation of the family, demographic trends, economic development, labor market needs, and humanitarian concerns.
- Immigration decisions shall not discriminate against nor give preference to potential immigrants because of their nationality, race, sex, or religion.
- A basic responsibility of the federal government is to collect and disseminate timely and reliable statistical information on immigration and its consequences for the United States.
- ~~The increase of the social and economic strength of our hemispheric neighbors is an efficient method to reduce migration.~~
- Immigration policies and administrative systems should be modernized and reviewed periodically to ensure that they are fair and workable.
- FEDERAL IMMIGRATION POLICIES SHOULD ENSURE THAT NEW IMMIGRANTS DO NOT BECOME A PUBLIC CHARGE TO FEDERAL, STATE, OR LOCAL GOVERNMENTS.
- A TRANSFERRED PRISONER'S EARLY RELEASE BEFORE THE BALANCE OF THE STATE-IMPOSED MAXIMUM SENTENCE IS SERVED SHOULD BE CALCULATED AND GOVERNED UNDER THE LAWS OF THAT STATE AND NOT THE PRISONER'S COUNTRY OF ORIGIN.
- THE FEDERAL GOVERNMENT MUST PROVIDE ADEQUATE INFORMATION TO AND CONSULT WITH STATES ON ISSUES CONCERNING IMMIGRATION DECISIONS THAT AFFECT THE STATES.
- STATES SHOULD NOT HAVE TO INCUR SIGNIFICANT COSTS IN IMPLEMENTING FEDERAL LAWS REGARDING IMMIGRATION STATUS AS A CONDITION OF BENEFITS.

2.1.3

Immigration Ceiling and Preference System. The National Governors' Association supports control of legal immigration at a level consistent with our national interest and resources, under a ceiling adjusted periodically by Congress as conditions warrant. The ceiling should continue to exclude immediate relatives of United States citizens, refugees, asylees, and aliens whose adjustment of status is not subject to immigration quotas under current or future laws.

The ceiling should provide for the separation of the two major types of immigrants—families and independent immigrants—into distinct admission categories. In designing the preference system, the principle of family unity should be preserved and the independent immigration system should reflect economic and labor market needs.

2.1.4 Prohibition on the Hiring of Illegal Immigrants. THE GOVERNORS AGREE THAT to help control illegal immigration, the employment of illegal immigrants should be prohibited. TO THIS END, ENFORCEMENT MECHANISMS AND VERIFICATION SYSTEMS MUST BE ENHANCED. The appropriate federal agencies selected to enforce this prohibition should have the resources necessary to carry out their task. EMPLOYERS SHOULD HAVE ACCESS TO A RELIABLE VERIFICATION SYSTEM THAT WILL ASSIST THEM IN COMPLYING WITH THE LAW. SUCH A SYSTEM SHOULD ~~The federal government should develop enforcement mechanisms that will~~ minimize the administrative burdens on employers and SHOULD ~~that do not~~ discriminate against the employment of workers and potential workers.

THE GOVERNORS ALSO SUPPORT THE DEVELOPMENT OF METHODS TO PREVENT IDENTIFICATION DOCUMENT FRAUD. HOWEVER, THE GOVERNORS DO NOT SUPPORT THE DEVELOPMENT OF THOSE METHODS THAT UNNECESSARILY INVADE THE PRIVACY OF INDIVIDUALS, INFRINGE UPON AREAS THAT TRADITIONALLY HAVE BEEN UNDER THE SCOPE OF STATE AND LOCAL AUTHORITY, OR DIRECTLY OR INDIRECTLY CREATE UNFUNDED MANDATES TO STATE AND LOCAL GOVERNMENTS.

2.1.5 Legalization AND NATURALIZATION. The Governors urge the following.

- ~~The federal government must provide full and timely reimbursement to state and local governments for costs incurred as a consequence of the legalization program. The Governors call upon the federal government to make available without further deferral the state legalization impact assistance funds (SLIAG) promised the states under the Immigration Reform and Control Act of 1986 (IRCA).~~
- States require maximum flexibility in determining and allocating resources to meet the needs of newly legalized aliens.
- THE IMMIGRATION AND NATURALIZATION SERVICE MUST BE DILIGENT IN ITS EFFORTS TO ENSURE THAT FELONS ARE NOT NATURALIZED AND BEING GIVEN THE BENEFITS OF CITIZENSHIP RATHER THAN BEING DEPORTED.
- THE NATURALIZATION PROCESS SHOULD BE STREAMLINED TO BE MORE EFFICIENT AND ACCESSIBLE TO ELIGIBLE APPLICANTS WISHING TO BECOME CITIZENS, WITH ALL THE RIGHTS AND RESPONSIBILITIES THEREOF. IN ADDITION, AS CONGRESS ALLOWED EXEMPTIONS TO NATURALIZATION TESTS FOR PHYSICALLY AND MENTALLY DISABLED APPLICANTS, THERE SHOULD BE AN EXEMPTION FOR THOSE INDIVIDUALS WHO ARE ELIGIBLE FOR NATURALIZATION EXCEPT FOR THE INCAPACITY TO COMMUNICATE THE DESIRE TO NATURALIZE.

- ~~The current legalization program provides the opportunity for illegal immigrants to become lawful residents. Because of insufficient national and community outreach efforts resulting from a compressed timetable as required by law, application deadlines should be extended.~~

- 2.1.6 **Supplemental Worker Program.** In implementing any supplemental worker programs, the federal government must conduct timely labor certifications to ensure labor availability in the event of labor shortages. This program should not cause displacement of American workers.
- 2.1.7 **Cooperation with Western Hemisphere Countries.** A workable immigration program must recognize and involve the major sending countries. The federal government must work cooperatively with Mexico and other western hemisphere countries in the development of mutually beneficial policies. The Governors believe that trade and investment policies are critical elements to reduce illegal immigration.
- 2.1.8 **Research and Data Collection.** Congress should direct the federal government to develop a reliable data system and strengthen the research capacity on migration and its consequences to the United States, especially concerning the immigration flow, estimate of illegal migration, and impact of immigration on states and local communities. To do so, better coordination of federal agencies is needed.
~~Congress should implement the findings of the panel on immigration statistics convened by the National Research Council in 1985.~~
- In order to provide the necessary information on immigration flows and secondary migration, alien registration by the federal government must be reinstated. In addition, data collected should be analyzed and disseminated to the states in a timely manner for the purpose of planning, implementing, and evaluating immigration policy.
- 2.1.9 **LEGAL Immigration Law Enforcement.** The federal government should provide sufficient funding to the Immigration and Naturalization Service and other appropriate agencies to enforce the immigration laws, modernize management, and provide for an adequate and reliable data collection system.
- 2.1.10 **Exclusion/Asylum Proceedings.** Individual claims for asylum should be handled in a fair and expeditious manner. Prompt efforts should be made to address the current backlog problems.
- 2.1.11 **Emergency Authority and Contingency Plan.** As the President has contingency planning authority, the federal government must develop a contingency plan to deal with unanticipated flows of refugees, PAROLEES, or asylum applicants. The states expect an immediate federal government response to such a situation. The Governors must be consulted in determining the role of the states. The states anticipate full federal reimbursement of any state and local costs.
- 2.1.12 **IMPACT AID. SPECIAL IMPACT AID TO STATE AND LOCAL GOVERNMENTS SHOULD BE PROVIDED TO MEET UNUSUAL BURDENS ON COMMUNITIES. IMPACT AID SHOULD BE PROVIDED IN THE EVENT THAT ANY OF THE FOLLOWING OCCUR:**
- A REFUGEE FLOW IS UNEXPECTEDLY LARGE OR SUDDEN;
 - THE RESETTLEMENT AREA IS HIGHLY CONCENTRATED BY INITIAL PLACEMENT OF REFUGEES, INCLUDING SECONDARY MIGRANTS;
 - THE RESETTLEMENT AREA HAS UNFAVORABLE ECONOMIC CONDITIONS; OR
 - THE REFUGEE POPULATION HAS SPECIAL NEEDS.
- ~~2.1.12 **Coordination with States.** The Governors are concerned about the lack of information and adequate consultation on issues concerning immigration that affect the states. Federal agencies must develop~~

~~ongoing communication mechanisms to inform and consult with states on both legal and illegal immigration matters.~~

1.2 ILLEGAL IMMIGRATION

2.2.1 **LAW ENFORCEMENT.** RECOGNIZING THE NEED FOR STRONGER ENFORCEMENT AGAINST ILLEGAL IMMIGRATION, CONGRESS SHOULD CONTINUE TO PROVIDE SUFFICIENT FUNDING FOR THE IMMIGRATION AND NATURALIZATION SERVICE (INS) AND OTHER APPROPRIATE AGENCIES TO CONTROL OUR NATION'S BORDER AND TO REMOVE CRIMINAL ALIENS FROM THE UNITED STATES. THE GOVERNORS STRONGLY SUPPORT PROVISIONS IN THE ILLEGAL IMMIGRATION REFORM AND IMMIGRANT RESPONSIBILITY ACT OF 1996 THAT WILL DOUBLE THE NUMBER OF BORDER PATROL AGENTS BY 2001, ENHANCE INVESTIGATIVE AND ENFORCEMENT AUTHORITY FOR ALIEN SMUGGLING AND DOCUMENT FRAUD, AND STREAMLINE THE PROCESS OF REMOVAL OF CRIMINAL ALIENS AND ALIEN TERRORISTS. THE GOVERNORS CALL ON THE FEDERAL GOVERNMENT TO EFFECTIVELY USE THE RESOURCES PROVIDED FOR THESE PURPOSES.

THE GOVERNORS ALSO ARE CONCERNED ABOUT THE INCREASE IN DRUG TRAFFICKING BY ILLEGAL IMMIGRANTS ALONG THE BORDERS OF THE STATES AND TERRITORIES. CONTROL OF THE FLOW OF DRUGS ACROSS OUR BORDERS IS A FEDERAL RESPONSIBILITY, AND SMUGGLING DRUGS INTO THE UNITED STATES IS A FEDERAL FELONY. THE GOVERNORS ARE CONCERNED THAT THE FEDERAL GOVERNMENT'S CURRENT DRUG-SMUGGLING POLICY IS ALLOWING A LARGE NUMBER OF PEOPLE CAUGHT SMUGGLING ILLEGAL DRUGS INTO THE UNITED STATES TO BE RETURNED TO MEXICO WITHOUT PROSECUTION. THE GOVERNORS URGE THE FEDERAL GOVERNMENT TO REVERSE THIS POLICY AND TO VIGOROUSLY ENFORCE OUR DRUG CONTROL LAWS.

2.2.2 **Prosecution and Removal of Undocumented Felons.** According to a recent study published by the Urban Institute, the seven states most impacted by illegal immigration housed more than 21,000 adult CRIMINAL illegal aliens in their state prisons in March 1994, at an annual cost of nearly \$500 million. These figures do not include the cost of incarcerating CRIMINAL illegal aliens in youth facilities or supervising paroled CRIMINAL illegal aliens.

THE GOVERNORS ARE CONCERNED ABOUT THE LACK OF RESOURCES IN THE IMMIGRATION AND NATURALIZATION SERVICE DEVOTED TO THE EARLY IDENTIFICATION OF CRIMINAL ALIENS IN STATE CRIMINAL JUSTICE SYSTEMS. CURRENTLY, A LARGE NUMBER OF CONVICTED UNDOCUMENTED FELONS DO NOT COME TO THE ATTENTION OF THE INS AND ESCAPE FORMAL DEPORTATION BECAUSE

OF A LACK OF PRESENCE OF INS OFFICIALS IN LOCAL FACILITIES. THE GOVERNORS BELIEVE THAT PROGRAMS LIKE THE EARLY IDENTIFICATION PILOT PROGRAMS CURRENTLY OPERATING IN SEVERAL STATES SHOULD BE EXPANDED SIGNIFICANTLY TO ENSURE THAT UNDOCUMENTED FELONS ARE FORMALLY DEPORTED.

IN ADDITION, THE GOVERNORS BELIEVE THAT GREATER EFFORTS SHOULD BE MADE BY THE FEDERAL GOVERNMENT TO FACILITATE THE TRANSFER OF CRIMINAL ALIEN FELONS TO THEIR HOME COUNTRIES TO SERVE THEIR SENTENCES. CURRENT TRANSFER TREATIES ARE UNWORKABLE BECAUSE THEY REQUIRE THE CONSENT OF THE PRISONER AND THEY PROVIDE LITTLE INCENTIVE FOR THE COUNTRY OF ORIGIN TO COOPERATE WITH THE UNITED STATES IN THE ENFORCEMENT OF TRANSFER TREATIES. ALTHOUGH THE ILLEGAL IMMIGRATION REFORM AND IMMIGRANT RESPONSIBILITY ACT OF 1996 ECHOES THESE CONCERNS, CURRENT FEDERAL ACTION IN THIS AREA CONTINUES TO BE LACKING.

FOR THIS REASON, THE GOVERNORS CONTINUE TO CALL ON THE FEDERAL GOVERNMENT TO NEGOTIATE AND RENEGOTIATE PRISONER TRANSFER TREATIES TO EXPEDITE THE TRANSFER OF CRIMINAL ALIENS IN THE UNITED STATES WHO ARE SUBJECT TO DEPORTATION OR REMOVAL. THE NEGOTIATIONS FOR SUCH AGREEMENTS SHOULD FOCUS ON:

- ENSURING THAT THE TRANSFERRED PRISONERS SERVE THE BALANCE OF THEIR STATE-IMPOSED PRISON SENTENCE;
- REMOVING ANY REQUIREMENT THAT THE PRISONERS CONSENT TO BE TRANSFERRED TO THEIR COUNTRIES OF ORIGIN;
- STRUCTURING THE PROCESS TO REQUIRE THAT THE PRISONERS SERVE THE REMAINDER OF THEIR ORIGINAL PRISON SENTENCE IF THEY RETURN TO THE UNITED STATES; AND
- CONSIDERING ECONOMIC INCENTIVES TO ENCOURAGE COUNTRIES OF ORIGIN TO TAKE BACK THEIR CRIMINAL CITIZENS.

ADDITIONALLY, THE GOVERNORS BELIEVE THE FEDERAL GOVERNMENT SHOULD:

- INCREASE THE USE OF INTERIOR REPATRIATION WITH COUNTRIES CONTIGUOUS TO THE UNITED STATES;
- PLACE INS OFFICIALS IN STATE AND LOCAL FACILITIES FOR EARLY IDENTIFICATION OF POTENTIALLY DEPORTABLE ALIENS—NEARER THE POINT

OF THEIR ILLEGAL ENTRY—TO ENSURE FORMAL DEPORTATION PRIOR TO RELEASE; AND

- UPON THE REQUEST OF A STATE GOVERNOR, PLACE INS OFFICERS IN STATE COURTS TO ASSIST IN THE IDENTIFICATION OF CRIMINAL ALIENS PENDING CRIMINAL PROSECUTION.

FINALLY, THE GOVERNORS ARE CONCERNED ABOUT THE LARGE NUMBER OF DEPORTED FELONS THAT ARE RETURNING TO THE UNITED STATES. A SIGNIFICANT NUMBER OF THE CRIMINAL ALIEN FELONS HOUSED IN STATE PRISONS AND LOCAL JAILS ARE PREVIOUSLY CONVICTED FELONS WHO REENTERED THE UNITED STATES AFTER THEY WERE DEPORTED. IN CALIFORNIA, FOR EXAMPLE, REPORTS INDICATE THAT MORE THAN 300 PREVIOUSLY DEPORTED PAROLEES ARE ILLEGALLY REENTERING THE COUNTRY EACH MONTH AND COMING INTO CONTACT WITH LAW ENFORCEMENT OFFICIALS. CRIMINAL ALIEN REENTRY IS A VIOLATION OF FEDERAL LAW PUNISHABLE BY UP TO TWENTY YEARS IN FEDERAL PRISON AND SHOULD BE ENFORCED FOR ALL STATES.

THE GOVERNORS URGE THE FEDERAL GOVERNMENT TO PROVIDE SUFFICIENT FUNDS FOR PROVEN POSITIVE IDENTIFICATION SYSTEMS, LIKE CALIFORNIA'S CRIMINAL ALIEN FLAGGING PROJECT AND THE AUTOMATED FINGERPRINTING IDENTIFICATION SYSTEM (AFIS) SYSTEM, TO ALLOW FOR THE EXPANDED USE OF THE SYSTEM IN THE REST OF THE NATION.

~~A significant number of the illegal alien felons housed in state prisons and local jails are previously convicted felons who re-entered the United States after they were deported. Though illegal alien re-entry is a violation of federal law—punishable by up to fifteen years in federal prison—it is rarely enforced by the federal government.~~

~~In addition, the Governors are concerned about the lack of resources in the Immigration and Naturalization Service (INS) devoted to early identification of illegal aliens in state criminal justice systems. Because a large number of convicted undocumented felons serve time in local facilities or are placed on probation, they do not come to the attention of INS and thus, escape formal deportation. Formal deportation is necessary to ensure that convicted aliens who re-enter can be prosecuted under federal law.~~

~~Finally, the Governors believe that more efforts should be made by the federal government to facilitate the transfer of illegal alien felons to their home countries to serve their sentences. Current transfer treaties are unworkable because they require the consent of the prisoner. Also, there is little incentive for the country of origin to cooperate with the United States in the enforcement of transfer treaties. The Governors note that economic incentives from the federal government to these countries can be more cost effective than federal incarceration or reimbursement to state and local governments.~~

~~In response to these concerns, the federal government should undertake the following initiatives:~~

- ~~increasing enforcement of federal laws pertaining to the re-entry of illegal aliens, especially those that apply to previously convicted felons;~~
- ~~identifying potentially deportable aliens earlier in the process to ensure formal deportation prior to release from state or local facilities;~~

- ~~renegotiating prisoner transfer treaties and the removal of the requirement that prisoners consent to be transferred to their countries of origin; and~~
- ~~considering economic incentives to encourage countries of origin to take back their criminal citizens.~~

~~2.1.13 Incarceration and Deportation Costs of Undocumented Alien Felons. Under Section 501 of IRCA, the federal government is authorized to reimburse state and local governments for the costs associated with the incarceration of undocumented alien felons. The Governors repeatedly have called on the federal government to appropriate the funds authorized under Section 501; however, no funds have ever been appropriated to assist the states and thus fulfill this federal obligation, despite rising costs in many states. The Governors believe Section 501 has proven to be an ineffective mechanism for fulfilling the federal government's responsibility to pay the correctional costs of undocumented felons.~~

~~The Governors call on the federal government to replace or amend Section 501 so that the federal government takes custody of undocumented felons convicted of state crimes. If federal incarceration is infeasible, the Governors call on the federal government to establish a billing mechanism to allow state and local governments to bill the federal government directly for the incarceration of undocumented felons.~~

2.2.3 Education Costs of Undocumented Aliens. The Governors are concerned about the COSTS ASSOCIATED WITH presence of ever-larger numbers of undocumented children in our school systems. In a number of states, this has led to classroom overcrowding and has seriously exacerbated the funding crunch faced by public school systems. Because of the federal government's failure to provide funding for the education of undocumented children, Governors have had to cut back on other vital public services.

In the case of Plyler v. Doe, the U.S. Supreme Court upheld a lower court ruling striking down as unconstitutional a state law that denied educational services to undocumented children. The Court's narrow 5-4 decision was based in part on the absence of any "identifiable congressional policy" on the subject and "absent any contrary indication fairly discernible in the legislative record," the Court could "perceive no national policy that supports the state." The Court's dissenting opinion noted that the majority was "making no attempt to disguise that it is acting to make up for Congress' lack of effective leadership in dealing with the serious national problems caused by the influx of uncountable millions of illegal aliens across the border."

The Governors believe the Plyler decision was in fact a call for Congress to legislate in this area. Yet, since that ruling, the federal government has done nothing to set a national policy regarding the education of undocumented children. Instead, the federal government disingenuously cites Plyler as the final word. Meanwhile, state and local governments are forced to devote scarce resources to comply with a constitutional mandate born of federal inaction and irresponsibility.

The Governors are not advocating the denial of educational services to undocumented persons. HOWEVER, SOME GOVERNORS BELIEVE THAT EACH STATE SHOULD HAVE THE RIGHT TO DECIDE WHETHER IT WILL PROVIDE FREE EDUCATIONAL SERVICES TO UNDOCUMENTED PERSONS, WHILE SOME GOVERNORS BELIEVE THAT ALL CHILDREN ARE GRANTED THIS RIGHT UNDER THE U.S. CONSTITUTION. The Governors oppose being a captive source of funding for the costs of educating millions of undocumented children. Therefore, the Governors call on the federal government to recognize its exclusive responsibility for costs associated with THE UNFUNDED MANDATE THAT IS THE RESULT OF failed immigration policies by establishing a direct billing mechanism to ensure that any educational services provided to undocumented children are financed entirely by the federal government.

2.2.4 **Study of Costs of Citizen Children.** Governors across the country are providing education, health, and social services to citizen children of undocumented immigrants at extremely high costs. However, the true costs are not known, as no systematic survey has been undertaken to examine these costs and the fiscal impacts on states of providing services to citizen children of undocumented immigrants. The Governors call upon Congress and the administration, working jointly with state budget officers, to undertake a study of these costs and to report back within one year, so that an accurate assessment can be made.

2.3 **Refugee Policy**

2.3.1 **PREAMBLE. INTERNATIONAL POLITICAL CONDITIONS OVER THE PAST TWO DECADES HAVE FORCED NUMBERS OF PEOPLE TO LEAVE THEIR HOMES AND SEEK REFUGE IN OTHER COUNTRIES. THE UNITED STATES HAS PROVIDED LEADERSHIP TO THE WORLD COMMUNITY IN ADDRESSING THE NEEDS OF REFUGEES AND DISPLACED PERSONS. THE NATION'S GOVERNORS ARE SUPPORTIVE OF THIS EFFORT TO ASSIST THOSE INDIVIDUALS WHO HAVE BEEN DISPLACED BECAUSE OF THEIR BELIEFS AND SUPPORT OF U.S. POLICY.**

~~Federal Responsibility. The National Governors' Association has supported and will continue to support the domestic resettlement of refugees as defined by the Refugee Act of 1980, as amended. WE~~ The Governors believe that refugee issues are an international responsibility and that resettlement must be shared as equitably as possible. Further, there must be a genuine effort to protect refugees worldwide.

STATES PLAY A MAJOR ROLE IN REFUGEE RESETTLEMENT. THEY MUST WORK WITH THE REFUGEES TO ASSIST IN THEIR ADJUSTMENTS TO AMERICAN LIFE AND TO EXPEDITE THEIR ECONOMIC SELF-SUFFICIENCY. EFFECTIVE RESETTLEMENT OF REFUGEES REQUIRES THE DEVELOPMENT OF SYSTEMS THAT PROVIDE CULTURALLY APPROPRIATE SERVICES TO MEET THE NEEDS OF ETHNICALLY DIVERSE COMMUNITIES, AS WELL AS EXTENSIVE NETWORKING WITH EXISTING HUMAN SERVICE SYSTEMS.

THE GOVERNORS RECOGNIZE THAT RESETTLEMENT IS NOT A ONE-TIME EVENT, BUT A PROCESS OF ADJUSTMENT THAT MAY TAKE MONTHS OR YEARS. IN ORDER FOR THIS PROCESS TO BE SUCCESSFUL, FEDERAL, STATE, AND LOCAL OFFICIALS MUST WORK TOGETHER WITH THE PRIVATE SECTOR AND LOCAL VOLUNTARY AGENCIES TO BUILD A SEAMLESS CONTINUUM OF SERVICES FROM INITIAL RECEPTION THROUGH LONGER TERM NEEDS, LEADING THE WAY TO SELF-SUFFICIENCY.

2.3.2 **FEDERAL RESPONSIBILITY.** ~~For those who are resettled in this country,~~ THE states are committed to working toward the rapid integration of refugees into our communities. However, the federal government has the total responsibility to meet the basic needs of refugees and entrants (e.g., cash, medical, social services, and special educational costs) for the initial three years. The federal

government also has the total responsibility for determining and accounting for secondary migration to areas of saturation.

If the federal government is unwilling to sufficiently fund the necessary services, then it is incumbent upon the federal government to decrease the flow of refugee admissions. Under no circumstances should there be any further shift of costs to state and local governments.

In recent years, there have been significant funding reductions in refugee programs. These budget reductions represent a major federal policy change that shifts fiscal responsibility for meeting the basic needs of refugees and entrants from the federal government to states and localities. This fiscal policy change occurs at a time when state and local resources have experienced significant cuts in human service programs because of federal budget balancing. Because the states do not have the authority to set immigration quotas or limit secondary migration, they are unable to effectively control the additional costs incurred because of this change in policy.

AGED AND DISABLED REFUGEES SHOULD NOT BE BARRED FROM FEDERAL SUPPLEMENTAL SECURITY INCOME BENEFITS AND FOOD STAMPS AFTER FIVE YEARS OF RESIDENCE. THE NEW WELFARE LAW NO LONGER PROVIDES FEDERAL BENEFITS TO THIS POPULATION AFTER FIVE YEARS, AND SHIFTS THE RESPONSIBILITY TO STATES TO DECIDE WHETHER TO PROVIDE STATE BENEFITS TO THESE REFUGEES ADMITTED TO THE U.S. BY FEDERAL POLICY. THE AGED REFUGEES, IN PARTICULAR, CONFRONT EXTRAORDINARY DIFFICULTIES IN BECOMING NATURALIZED CITIZENS, E.G. INABILITY TO PASS THE TESTS, OR LOSS OF DOCUMENTS. UNLIKE LEGAL IMMIGRANTS, REFUGEES DO NOT HAVE SPONSORS. EVEN THOSE REFUGEES ABLE TO NATURALIZE WOULD BE IN JEOPARDY FOR A SIX- TO NINE-MONTH PERIOD DURING THE PROCESS OF APPLYING FOR CITIZENSHIP.

RECENTLY, EFFORTS TO PRIVATIZE REFUGEE RESETTLEMENT HAVE BEEN UNDER DISCUSSION. UNDER THE WILSON-FISH AMENDMENT TO THE REFUGEE ACT, STATES HAVE THE OPTION OF IMPLEMENTING PRIVATIZED RESETTLEMENT PROGRAMS. THE GOVERNORS SUPPORT MAINTAINING THE CURRENT PREMISE THAT THE DECISION TO PRIVATIZE SHOULD BE LEFT UP TO EACH INDIVIDUAL STATE.

~~Underlying the implementation of the Refugee Act of 1980 was the recognition that if refugee resettlement programs are to be successful, they must be developed in concert with the states and communities most directly affected by federal refugee admission decisions. The Governors are committed to working with the federal government to develop new ways of implementing resettlement programs in order to reduce reliance on public assistance programs, including increased utilization of private voluntary agencies in the service delivery process. However, any new program revisions must address the increasing fiscal burden that has been unfairly placed on the states as a result of the federal government's unwillingness to appropriate funds sufficient to support the number of refugees being admitted.~~

~~Program changes currently being implemented by the Office of Refugee Resettlement are not in the best interest of the states or the refugee population. The Governors call on the administration to place an immediate moratorium on the implementation of these changes and to work with states, local governments, and voluntary agencies to develop an effective resettlement program based on the partnership that was envisioned in the Refugee Act of 1980.~~

Principles. IN KEEPING WITH THE ABOVE PRECEPTS, GOVERNORS SUPPORT THE REAUTHORIZATION OF THE REFUGEE ACT OF 1980, WITH THE FOLLOWING PRINCIPLES AS GUIDANCE FOR DEVELOPING NEW LEGISLATION. ~~In addition, the Governors emphasize that the following principles are important components of a federal domestic assistance program:~~

- The goal of resettlement assistance efforts is to help refugees achieve self-sufficiency as quickly as possible. The key to economic self-sufficiency is entry into unsubsidized employment at a living wage at the earliest possible time with concurrent removal from dependency on public aid.
- Social services are vital to reaching the goal of self-sufficiency, and federal funding should not be decreased as a means of reducing the federal refugee or entrant budget.
- UNDER THE FASCELL/STONE AMENDMENT (SECTION 501 OF THE REFUGEE EDUCATION ASSISTANCE ACT OF 1980), CONGRESS INTENDED FOR CUBAN AND HAITIAN ENTRANTS TO BE TREATED AS REFUGEES FOR THE PURPOSES OF FEDERAL BENEFITS. CUBAN AND HAITIAN ENTRANTS SHOULD CONTINUE TO RECEIVE SIMILAR "REFUGEE" STATUS AS A TEMPORARY MEANS TO SELF-SUFFICIENCY.
- THE FEDERAL GOVERNMENT HAS REDUCED THE PERIOD OF ELIGIBILITY FOR REFUGEE SERVICES FROM THIRTY-SIX MONTHS TO EIGHT MONTHS. AT LEAST TWELVE MONTHS ARE REQUIRED TO ASSIST REFUGEES IN ACQUIRING BASIC LANGUAGE SKILLS, HOUSING, AND WORK TO ACHIEVE RUDIMENTARY SELF-SUFFICIENCY. THE FEDERAL GOVERNMENT SHOULD PROVIDE ADEQUATE RESOURCES TO ENSURE A FULL TWELVE MONTHS OF ACCESS TO REFUGEE BENEFITS.
- Stability of federal funding is crucial if states are to implement an effective resettlement program. In addition, the timely provision of funding is essential to enable states to discharge their administrative responsibilities in an expeditious manner, relative to funding decisions and program planning.
- States must be consulted in a timely manner when changes in the current program are being considered. A process for ongoing state participation in program review should be incorporated into the federal administrative structure.
- The federal government should synchronize ADMISSIONS AND APPROPRIATION CYCLES TO ALLOW FOR MORE EFFECTIVE MANAGEMENT OF THE PROGRAM. ~~the funding cycles and streamline its administrative and reporting requirements for the states to allow for more cost-effective management of the program, while maintaining state flexibility.~~
- Because the refugee program is state-administered, it is essential that all funding should flow to the states to allow for centralized program planning, administration, accountability, and coordination of local planning efforts.
- Although the states are willing to consider changes in the current program that would improve the efficiency or effectiveness of the program, the Governors would oppose any attempt to convert funding for the program to a block grant.

2.3.4

Coordination and Consultation. The Governors continue to be concerned about the lack of adequate consultation on the part of the voluntary agencies (VOLAGs) and their local affiliates in the initial placement of refugees and on the part of the federal government in the equitable distribution of refugees and entrants.

States have continually urged the federal government to establish a mechanism to ensure appropriate coordination and consultation. However, significant progress has not been made and the following mechanisms need to be considered to address this problem.

- There should be a requirement in the State Department/VOLAG contract to limit placement to areas conducive to resettlement. In addition, VOLAGs and their local affiliates should be required to have a letter of agreement that specifies that there has been consultation and planning for the initial placement of refugees and sets forth the continuing process of consultation. The requirement in the State Department/VOLAG contract to limit placement to areas conducive to resettlement should include concurrence by the state.
- INS, THE U.S. DEPARTMENT OF STATE (DOS), AND THE OFFICE OF REFUGEE RESETTLEMENT (ORR) SHOULD COORDINATE WITH STATES RECEIVING ENTRANTS AND REFUGEES. ENTRANTS SHOULD BE MADE ELIGIBLE FOR DOS ASSISTANCE FOR THIRTY DAYS, OR ANOTHER MECHANISM SHOULD BE DEVELOPED TO ALLOW FOR A SMOOTH TRANSITION OF ENTRANTS INTO A COMMUNITY. THE CURRENT SYSTEM, IN WHICH AN ENTRANT SIMPLY ARRIVES IN THE UNITED STATES WITHOUT ANY KNOWLEDGE OF THE STATE, CREATES A TREMENDOUS BURDEN ON THE COMMUNITY, LEAVES GAPS IN THE PROVISION OF SERVICES, AND PROVIDES NO FOUNDATION FOR PLANNING PURPOSES.
- ~~The State Department should enter into agreements with the states for the purpose of planning and consultation on refugee placement strategies within available federal resources. This should include state participation in identifying appropriate areas for resettlement.~~
- There should be a continued requirement that sponsors not be on welfare. The sponsorship program should be modified, and existing sponsorship obligations should be more strictly enforced.

~~It is essential that the U.S. Coordinator for Refugee Affairs actively coordinate the resettlement of refugees and provide Governors with relevant information on activities within their states. In addition, there needs to be a clear delineation of the roles of the U.S. coordinator, the State Department's Bureau of Refugee Affairs, and the Department of Health and Human Services' Office of Refugee Resettlement.~~

An advisory committee should be established, representing state and local government officials, VOLAGs, and the refugee community, to examine and advise Congress and federal agencies on a full range of refugee resettlement issues.

The Governors should be closely involved in the congressional consultation process through which new refugee admissions levels are determined to ensure that program funding is provided to support the level of refugee admissions.

2.3.5

Impact Aid. Special impact aid to state and local governments should be provided to meet unusual burdens on communities. Impact aid should be provided in the event that any of the following occur:

- a refugee flow is unexpectedly large or sudden;
- the resettlement area is highly concentrated by initial placement of refugees, including secondary migrants;
- the resettlement area has unfavorable economic conditions;
- the refugee population has special needs; or
- **THERE IS A CONTINUING STREAM OF REFUGEES TO ONE GEOGRAPHIC AREA.**

2.4

Habitual Residents

For clarification purposes, the immigration and refugee policy provisions also pertain to habitual residents, as defined in the compacts of free association.

Time limited (effective WINTER MEETING 1997-WINTER MEETING 1999). ~~Winter Meeting 1995-~~

~~Winter Meeting 1997~~

Adopted Winter Meeting 1988; revised Winter Meeting 1992, Winter Meeting 1993, Winter Meeting 1994, and Winter Meeting 1995 (formerly Policy C-14).



ACF (P)

HR-22. CHILD CARE

22.1 PREAMBLE

AS AMERICA'S MOST VALUABLE HUMAN RESOURCE, CHILDREN DESERVE A SAFE AND HEALTHY CHILD CARE ENVIRONMENT. THE GOVERNORS RECOGNIZE THAT PARENTS ARE CHILDREN'S FIRST AND PRIMARY NURTURERS, AND GOVERNMENT POLICIES SHOULD ACKNOWLEDGE AND SUPPORT THE FAMILY AS THE PRIMARY CHILD CARE UNIT. OVER THE PAST TWO DECADES, MAJOR ECONOMIC AND SOCIAL CHANGE HAS RESULTED IN GROWING NUMBERS OF PARENTS AT ALL INCOME LEVELS SEEKING QUALITY CARE OPPORTUNITIES FOR CHILDREN. THE CHALLENGE TO PUBLIC AND PRIVATE ENTITIES IS TO RESPOND TO THIS NEED AND PRESERVE FOR PARENTS THE FUNDAMENTAL CHOICE OF HOW TO BEST MEET THE CHILD CARE NEEDS OF THEIR CHILDREN.

GOVERNORS, THE FEDERAL GOVERNMENT, THE PRIVATE SECTOR, AND FAMILIES ALL HAVE A VESTED INTEREST IN ENSURING THAT OUR NATION'S CHILD CARE SYSTEM IS PROVIDING THE SERVICES AND RESOURCES THAT WORKING FAMILIES NEED. GOVERNORS BELIEVE THAT THE PRIVATE SECTOR IS AN IMPORTANT PARTNER IN THIS EFFORT.

THE GOVERNORS BELIEVE THAT THE EXPANSION OF SAFE, AFFORDABLE, AND ACCESSIBLE CHILD CARE OPPORTUNITIES IS VITAL TO THE ECONOMIC GROWTH OF THE NATION AND CRUCIAL FOR THE WELL-BEING OF THE NATION'S FAMILIES AND CHILDREN. THE GOVERNORS ALSO RECOGNIZE THAT DRAMATIC AND ONGOING CHANGES IN OUR SOCIETY WILL CONTINUE TO FUEL A GROWING DEMAND FOR SAFE, AFFORDABLE, AND ACCESSIBLE CHILD CARE OVER THE NEXT DECADE. FOR EXAMPLE, WITH THE PASSAGE OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996, P.L. 104-193, TOUGH WORK REQUIREMENTS AND TIME-LIMITED ASSISTANCE WILL GREATLY INCREASE THE DEMAND FOR AFFORDABLE AND ACCESSIBLE CHILD CARE OVER THE NEXT SEVERAL YEARS, AS GROWING NUMBERS OF FAMILIES TRANSITION OFF WELFARE AND OTHER FAMILIES REMAIN AT RISK OF WELFARE DEPENDENCY, CHILD CARE FOR LOW-INCOME WORKING FAMILIES ALSO WILL NEED TO BE EXPANDED.

22.2 RECOMMENDATIONS

THE GOVERNORS BELIEVE THAT ADEQUATE FUNDING FOR CHILD CARE IS ABSOLUTELY ESSENTIAL IF STATE WELFARE REFORM INITIATIVES ARE TO BE SUCCESSFUL IN HELPING FAMILIES MAKE THE TRANSITION FROM WELFARE AND

DEPENDENCY TO WORK AND SELF-SUFFICIENCY. CONGRESS MUST PROVIDE FUNDING FOR CHILD CARE FOR BOTH THE DISCRETIONARY AND MANDATORY FUNDING STREAMS AT THE FULL LEVELS AUTHORIZED IN THE WELFARE LAW. ADDITIONALLY, BECAUSE THE SOCIAL SERVICES BLOCK GRANT (SSBG) IS USED IN MANY STATES TO FUND CHILD CARE FOR WORKING POOR FAMILIES, FUNDING FOR THIS PROGRAM ALSO MUST BE MAINTAINED. GOVERNORS STRONGLY OPPOSE ANY ATTEMPTS TO FURTHER REDUCE FUNDING FOR SSBG.

22.2.1 OPERATE A SEAMLESS CHILD CARE SYSTEM. THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 ACHIEVED THE CONSOLIDATION RECOMMENDED BY THE GOVERNORS BY COMBINING TITLE IV-A CHILD CARE FUNDING (AID TO FAMILIES WITH DEPENDENT CHILDREN, AT-RISK CHILD CARE, AND TRANSITIONAL CHILD CARE) WITH THE CHILD CARE DEVELOPMENT BLOCK GRANT TO CREATE A SINGLE CHILD CARE SYSTEM. THE NEW CHILD CARE BLOCK GRANT TO STATES WILL FACILITATE THE OPERATION OF A SEAMLESS SYSTEM OF CHILD CARE, ENABLING STATES TO SERVE FAMILIES MORE SMOOTHLY AND EFFECTIVELY WITHOUT CHANGES IN SERVICES AS FAMILIES' SITUATIONS CHANGE. CHILD CARE WILL BE PROVIDED THROUGH A SINGLE STATE AGENCY AND STATES WILL HAVE TOTAL FLEXIBILITY TO SET PAYMENT RATES FOR PROVIDERS AND PROVIDE DIFFERENT REIMBURSEMENT RATES FOR DIFFERENT CATEGORIES OF CARE AND IN DIFFERENT GEOGRAPHIC SETTINGS.

22.2.2 INCREASE STATE FLEXIBILITY. GIVEN THE INCREASED DEMAND FOR CHILD CARE SERVICES, FLEXIBILITY WILL BE KEY AS STATES PROVIDE CHILD CARE SERVICES UNDER THE BLOCK GRANT. AS MORE WELFARE RECIPIENTS MOVE INTO THE WORKFORCE, STATES WILL NEED TO EXPAND CHILD CARE DURING NONTRADITIONAL HOURS AND IN ALTERNATIVE SETTINGS, SUCH AS SCHOOLS AND THE WORKPLACE. STATES WILL NEED FLEXIBILITY IN SETTING CHILD CARE RATES, SUCH AS PROVIDING A "FAMILY BENEFIT" RATHER THAN A FLAT RATE PER CHILD TO FURTHER STRETCH CHILD CARE RESOURCES. THE GOVERNORS URGE THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN WRITING REGULATIONS, TO HONOR THE CONGRESSIONAL INTENT TO ACCORD STATES MAXIMUM FLEXIBILITY.

22.2.3 IMPROVE PROGRAM ADMINISTRATION. THE GOVERNORS APPRECIATE THAT SEVERAL SET-ASIDES HAVE BEEN MODIFIED OR ELIMINATED. THEY CONSIDER THE EXPANSION OF AFFORDABLE AND ACCESSIBLE CHILD CARE TO BE A PRIORITY, BUT ARE CONCERNED THAT THE 5 PERCENT ADMINISTRATIVE CAP MAY LIMIT A STATE'S ABILITY TO CREATE INNOVATIVE AND EFFECTIVE PROGRAMS. ELIGIBILITY

DETERMINATION, CHILD CARE PLACEMENT, RECRUITMENT, LICENSING, INSPECTIONS, TRAINING, COMPUTERIZED SYSTEMS, FRONT-LINE WORKERS, AND FIELD STAFF SHOULD NOT BE CONSIDERED ADMINISTRATIVE COSTS. ALL COSTS RELATED TO MANAGEMENT INFORMATION SYSTEMS AND ONGOING DATA COLLECTION AND ANALYSIS REQUIRED UNDER THE LAW SHOULD BE OUTSIDE OF THE ADMINISTRATIVE CAP. ADDITIONALLY, STATES NEED THE FLEXIBILITY TO USE SOME PORTION OF THEIR FUNDS TO EXPAND CAPACITY THROUGH RENOVATION AND CONSTRUCTION.

22.2.4 USE STATE STANDARDS. STATES ARE COMMITTED TO TARGETING CHILD CARE TO THOSE MOST IN NEED AND DO NOT NEED PRESCRIPTIVE FEDERAL REQUIREMENTS. THE CHILD CARE BLOCK GRANT REQUIRES STATES TO DEVELOP HEALTH AND SAFETY STANDARDS THAT ALL PROVIDERS MUST MEET. THESE STANDARDS ARE RELATED TO PREVENTING AND CONTROLLING INFECTIOUS DISEASES, ENSURING THE SAFETY OF BUILDINGS AND PHYSICAL PREMISES, AND PROVIDING MINIMUM HEALTH AND SAFETY TRAINING. IN SOME CASES, THESE STANDARDS MAY BE INAPPROPRIATE TO THE PROVIDER SETTING. THE GOVERNORS BELIEVE THAT THE STATES ARE IN THE BEST POSITION TO SET HEALTH AND SAFETY STANDARDS AND RECOMMEND THAT FEDERALLY FUNDED PROVIDERS BE REQUIRED TO COMPLY WITH HEALTH AND SAFETY STANDARDS AS PRESCRIBED UNDER STATE LAW. THE GOVERNORS ALSO URGE THE ELIMINATION OF THE 85 PERCENT STATE MEDIAN INCOME CAP REQUIREMENT FOR ELIGIBILITY. AS CONGRESS MONITORS THE IMPLEMENTATION OF THE LAW AND OPPORTUNITIES ARISE TO MAKE MODIFICATIONS, THE GOVERNORS ASK THAT THESE CHANGES BE CONSIDERED.

22.1 Preamble

~~As America's most valuable human resource, children deserve a safe and healthy child care environment. The Governors recognize that parents are children's first and primary nurturers, and government policies should acknowledge and support the family as the primary child care unit. Over the past two decades, major economic and social change has resulted in parents seeking quality care opportunities for children. The challenge to all levels of government is to respond to this need and preserve for parents the fundamental choice of how to best meet the child care needs of their children.~~

~~The Governors believe that the expansion of quality child care opportunities is vital to the economic growth of the nation and crucial for the well-being of the nation's families and children. The Governors also recognize that dramatic and ongoing changes in our society will continue to fuel a growing demand for quality child care over the next decade.~~

~~In response to this growing need, the states and the federal government have created programs to provide quality child care opportunities for low-income families. One of the federal initiatives, the Child Care Development Block Grant (CCDBG) distributes funds to states to provide child care services for low-income families, as well as to support activities to improve the overall quality and supply of child care in the state. No state match is required under this program.~~

The Governors believe that CCDBG is a highly successful program that together with state and local initiatives has substantially increased the supply and the quality of child care services for low-income families and support its reauthorization:

11.2 Recommendations for Modifying Federal Child Care Programs

Based on the experiences and interests of states in providing high-quality child care services, the Governors offer the following recommendations to the administration and Congress in addressing issues of child care in the first session of the 104th Congress:

11.2.1 Create a Seamless Child Care System. The Governors urge Congress to move toward a more seamless system incorporating all of the federal child care programs. In general, they believe that CCDBG should be the foundation for that seamless system and that other federal child care programs, such as the Title IV-A and At-Risk Child Care programs, should be consolidated with CCDBG to form a single child care system operated by the states.

Such a consolidation would permit states to better coordinate state and federal child care programs at the state level and therefore operate a more seamless child care system. Based on the CCDBG requirements, the U.S. Department of Health and Human Services should work with states to develop a standardized reporting form that can be used by states for reporting on the use of federal child care funds.

In addition, the Governors call for the elimination of the 75 percent of state median income cap requirement for CCDBG eligibility and instead permit states to determine eligibility as under the At-Risk Child Care program. The Governors are committed to targeting child care programs to those families most in need. Therefore, as part of the state plan, the state can describe to the secretary of the U.S. Department of Health and Human Services its definition of an eligible family in the context of its own child care initiatives and overall child care needs in the state.

11.2.2 Increase State Flexibility. The Governors recommend that states be given total flexibility to set payment rates for providers. This will permit states to serve more families with limited CCDBG dollars and allow them to respond in the most appropriate manner based on their unique needs.

States also should be given the flexibility to set different statewide limits for different categories of care. Some categories of care, such as before school, evening, or part-time care, often are in shorter supply and therefore can be more expensive than traditional full-time day care. By permitting states to set different statewide limits for different categories of care, states can purchase higher cost care without paying inflated rates for traditional care. In addition, states should have the option to pay providers more than the local market rate for higher quality care. This will provide an incentive for providers to increase the quality of care available in all types of categories.

The Governors call for the greatest flexibility possible in the allocation of funds for 1) the provision of child care services and activities to improve the quality and availability of child care; and 2) activities to improve the quality of child care and to increase the availability of early childhood development and before and after school child care services. Under the current CCDBG, funds are allocated between these two basic categories, and additional set-asides are included within the second category. The Governors believe the states are in the best position to assess the child care needs of their residents and call for the elimination of inflexible federal funding categories and set-asides. If the federal government is committed to maintaining basic funding categories, the Governors call for the greatest flexibility possible to reallocate funds between categories.

11.2.3 Improve Program Administration. In an effort to reduce the costs of administering CCDBG, the Governors call for enhanced federal funding to automate child care tracking and payment systems. Such an automated system could be used not only to administer child care programs, but also to coordinate child care services with other federal programs that support children and their families.

The Governors also call for greater flexibility for the states in terms of what is considered an allowable administrative expense, especially in the area of licensing and provider monitoring. Greater state administrative flexibility and the reduced costs of administering CCDBG would free up funds that would be used to expand the availability of child care.

~~11.2.4 Use State Standards. The Child Care Development Block Grant includes health and safety standards that all providers must meet. These standards are related to the prevention and control of infectious diseases, building and physical premises safety, and minimum health and safety standards appropriate to the provider setting. In some cases, these standards exceed what is required by current state law. The Governors believe the states are in the best position to set health and safety standards and recommend that providers funded by CCDBG be required to comply with health and safety standards as prescribed under state law.~~

Time limited (effective WINTER MEETING 1997-WINTER MEETING 1999). ~~Winter Meeting 1995-~~

~~Winter Meeting 1997~~

Adopted Winter Meeting 1995.



HR-36. IMPLEMENTATION OF WELFARE REFORM

36.1 PREAMBLE

THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996, P.L. 104-193, REALLOCATES RESPONSIBILITIES BETWEEN THE FEDERAL GOVERNMENT AND THE STATES AND PROVIDES STATES WITH THE OPPORTUNITY AND FLEXIBILITY TO RESTRUCTURE WELFARE AS A TRANSITIONAL PROGRAM THAT WILL ENABLE RECIPIENTS TO BECOME PRODUCTIVE, SELF-SUFFICIENT, WORKING MEMBERS OF SOCIETY. THE WELFARE LEGISLATION INCORPORATED MANY OF THE RECOMMENDATIONS SUPPORTED BY THE NATION'S GOVERNORS, INCLUDING INCREASED FUNDING FOR CHILD CARE, A CONTINGENCY FUND TO ASSIST STATES DURING PERIODS OF ECONOMIC DOWNTURN, AND A FUND TO REWARD HIGH PERFORMING STATES. THE GOVERNORS BELIEVE THAT GREATER FLEXIBILITY, BEYOND THAT PROVIDED IN THE LAW, WOULD FACILITATE IMPLEMENTATION AND ENABLE GOVERNORS TO ACCOMMODATE THE UNIQUE NEEDS OF THEIR OWN STATE'S ECONOMY AND WELFARE POPULATION.

STATES NOW FACE THE CHALLENGE OF IMPLEMENTING SWEEPING CHANGES WITHIN A LIMITED PERIOD OF TIME. THE GOVERNORS ARE COMMITTED TO ENSURING SUCCESSFUL IMPLEMENTATION OF THE LEGISLATION TO ACHIEVE THE FOLLOWING GOALS:

- INCREASE SELF-SUFFICIENCY BY MOVING FAMILIES INTO WORK AND OFF WELFARE;
- INCREASE THE SUPPORT OF BOTH PARENTS FOR THEIR CHILDREN;
- PREVENT AND REDUCE OUT-OF-WEDLOCK BIRTHS; AND
- ENCOURAGE THE FORMATION AND MAINTENANCE OF TWO-PARENT FAMILIES.

IN ORDER TO MEET THESE GOALS, THE FLEXIBILITY EMBODIED IN THE BILL MUST BE RETAINED THROUGH THE REGULATORY PROCESS AND ANY SUBSEQUENT LEGISLATIVE MODIFICATIONS TO THE BILL. THE GOVERNORS PLEDGE TO CONTINUE TO WORK WITH CONGRESS AND THE FEDERAL GOVERNMENT THROUGHOUT THE IMPLEMENTATION PROCESS SO THAT ANY PROBLEMS CAN BE IDENTIFIED EARLY AND REDRESSED QUICKLY THROUGH LEGISLATION OR REGULATION.

36.2 PRINCIPLES AND RECOMMENDATIONS FOR WELFARE REFORM IMPLEMENTATION

THE GOVERNORS BELIEVE THAT THE IMPLEMENTATION AND MONITORING OF WELFARE REFORM MUST BE COLLABORATIVE EFFORTS AMONG FEDERAL, STATE, AND LOCAL GOVERNMENTS AND THE PRIVATE SECTOR. GOVERNORS MUST BE INVOLVED IN

FEDERAL TANF DOLLARS—SUCH AS THE WORK REQUIREMENTS, DATA COLLECTION REQUIREMENTS, AND ASSIGNMENT OF CHILD SUPPORT RIGHTS—ALSO MAY BE IMPOSED ON STATE MAINTENANCE-OF-EFFORT DOLLARS. THE GOVERNORS STRONGLY BELIEVE THAT STATE DOLLARS SPENT TO MEET THE MAINTENANCE-OF-EFFORT REQUIREMENT—EITHER WITHIN THE STATE PROGRAM CREATED BY THE BLOCK GRANT OR IN SEPARATE STATE-ONLY FUNDED PROGRAMS—SHOULD NOT BE SUBJECT TO FEDERAL RESTRICTIONS, LIMITATIONS, OR REQUIREMENTS. THE IMPOSITION OF FEDERAL REQUIREMENTS ON STATE DOLLARS IS INCONSISTENT WITH THE PRINCIPLES OF FEDERALISM THAT UNDERLIE BLOCK GRANTS. SIMILARLY, ANY BONUS A STATE RECEIVES, EITHER FOR HIGH PERFORMANCE OR FOR REDUCING OUT-OF-WEDLOCK BIRTHS, SHOULD NOT BE SUBJECT TO TANF REQUIREMENTS. STATES SHOULD HAVE THE FLEXIBILITY TO REINVEST THESE FUNDS IN INNOVATIVE WAYS TO MEET THE GOALS OF WELFARE REFORM. ALL STATE-ONLY FUNDS SPENT BY A STATE TO MEET THE OBJECTIVES OF THE TANF PROGRAM SHOULD COUNT TOWARD THE STATE MAINTENANCE-OF-EFFORT REQUIREMENT.

36.2.4 PROVIDE TIME-LIMITED CASH ASSISTANCE TO FAMILIES. THE GOVERNORS BELIEVE THAT CASH ASSISTANCE TO FAMILIES WITH CHILDREN SHOULD BE AVAILABLE ONLY FOR A TIME-LIMITED PERIOD. DURING THIS PERIOD, ACTIVITIES SHOULD OCCUR TO HELP THESE INDIVIDUALS MAKE THE TRANSITION FROM WELFARE TO WORK. STATES SHOULD HAVE THE ABILITY TO EXTEND OR WAIVE THE TIME LIMIT IN APPROPRIATE CIRCUMSTANCES AS IS PERMITTED BY THE 20 PERCENT HARDSHIP EXEMPTION IN THE LAW. CASH ASSISTANCE, AND NOT ANY OTHER ACTIVITIES OR SERVICES PROVIDED UNDER TANF, SHOULD COUNT AGAINST THE TIME LIMIT. STATES SHOULD NOT BE PROHIBITED FROM PROVIDING NONCASH SERVICES WITH TANF FUNDS TO FAMILIES THAT HAVE REACHED THE SIXTY-MONTH TIME LIMIT.

36.2.5 LIMIT OTHER TANF REQUIREMENTS TO CASH ASSISTANCE. IN ADDITION TO THE TIME LIMIT, IT APPEARS THAT IF A FAMILY RECEIVES ANY TYPE OF ASSISTANCE UNDER TANF, THAT FAMILY WILL ALSO BE SUBJECT TO THE TWO-YEAR WORK REQUIREMENT, BE INCLUDED IN THE CALCULATION OF THE WORK PARTICIPATION RATE AND THE DATA COLLECTION REQUIREMENTS, AND BE REQUIRED TO ASSIGN THEIR CHILD SUPPORT RIGHTS TO THE STATE. THESE REQUIREMENTS WILL INHIBIT STATES' ABILITY TO PROVIDE PREVENTION-ORIENTED AND SUPPORT SERVICES THAT ARE ALLOWABLE UNDER TANF. AS WITH THE IMPOSITION OF THE TIME LIMIT, THE GOVERNORS BELIEVE THAT THE FEDERAL REQUIREMENTS AND PROHIBITIONS

EDUCATIONAL ACTIVITIES TOWARD THE WORK REQUIREMENT, REMOVING TEEN PARENTS FROM THE 20 PERCENT VOCATIONAL EDUCATION LIMIT, AND PERMITTING DRUG AND ALCOHOL TREATMENT TO COUNT TOWARD THE WORK REQUIREMENT. THE CALCULATION OF PARTICIPATION RATES SHOULD INCLUDE ALL HOURS OF WORK ACTIVITY FOR ALL ACTIVE PARTICIPANTS DURING THE REPORTING MONTH.

36.2.8 PROVIDE SUITABLE CHILD CARE AND RETAIN FULL FUNDING. AN ADEQUATE SUPPLY OF SAFE, AFFORDABLE, AND ACCESSIBLE CHILD CARE IS ONE OF THE ESSENTIAL COMPONENTS OF SUCCESSFUL WELFARE REFORM. SUITABLE CHILD CARE IS NECESSARY IF PARENTS ARE TO WORK. CONGRESS AND THE ADMINISTRATION MUST HONOR THEIR COMMITMENT TO FUND CHILD CARE AT THE LEVELS PROVIDED FOR IN P.L. 104-193.

36.2.9 ADDRESS INFORMATION SYSTEM REQUIREMENTS. THE LAW CREATES EXTENSIVE NEW DATA COLLECTION, REPORTING, TRACKING, AND MONITORING REQUIREMENTS UNDER THE TANF, CHILD CARE, CHILD SUPPORT ENFORCEMENT, AND FOOD STAMP PROGRAMS THAT WILL BE COSTLY AND DIFFICULT FOR STATES TO MEET. STATES DO NOT CURRENTLY HAVE THE CAPACITY TO MEET THE NEW SYSTEM REQUIREMENTS. THEREFORE, THE GOVERNORS MAKE THE FOLLOWING RECOMMENDATIONS.

- CONGRESS SHOULD STREAMLINE AND REDUCE THE REPORTING REQUIREMENTS IN THE TANF, CHILD CARE, CHILD SUPPORT ENFORCEMENT, AND FOOD STAMP PROGRAMS.
- HHS REGULATIONS SHOULD EXCLUDE FROM THE DEFINITION OF ADMINISTRATION FOR TANF ALL COSTS ASSOCIATED WITH INFORMATION TECHNOLOGY AND COMPUTERIZATION; ONGOING COSTS ASSOCIATED WITH MEETING THE DATA COLLECTION, REPORTING, TRACKING, AND MONITORING REQUIREMENTS; AND ANY EVALUATIONS REQUIRED IN LAW OR EXISTING WAIVERS.
- THE FEDERAL GOVERNMENT SHOULD PROVIDE TECHNICAL ASSISTANCE TO STATES IN DEVELOPING SYSTEMS AND FACILITATE INTERSTATE COORDINATION, PARTICULARLY IN THE TRACKING OF TIME LIMITS. STATES SHOULD NOT BE HELD RESPONSIBLE OR PENALIZED FOR FAILURE TO ENFORCE THE FIVE-YEAR LIFETIME LIMIT AND OTHER PROHIBITIONS THAT ARE DEPENDENT ON INTERSTATE SYSTEMS IF THE FEDERAL GOVERNMENT IS NOT WILLING TO PROVIDE FUNDING TO CREATE AND OPERATE AN INTERSTATE TRACKING SYSTEM.

THE WELFARE REFORM DEBATE. CONGRESS ADOPTED THE GOVERNORS' RECOMMENDATION OF PROVIDING \$2 BILLION IN THE CONTINGENCY FUND FOR FISCAL 1997 THROUGH FISCAL 2001. THE GOVERNORS ARE CONCERNED, HOWEVER, THAT RESTRICTIONS CONTAINED IN THE FINAL BILL DIMINISH THE VALUE OF THE FUND AND WILL RESULT IN STATES DRAWING DOWN FEWER DOLLARS. THESE RESTRICTIONS INCLUDE LIMITING THE AMOUNT A STATE MAY ACCESS IN ANY MONTH TO ONE-TWELFTH OF 20 PERCENT OF ITS TANF GRANT, IMPOSING A VERY NARROW DEFINITION OF WHAT COUNTS TOWARD MEETING THE 100 PERCENT MAINTENANCE-OF-EFFORT REQUIREMENT, AND EFFECTIVELY REDUCING THE FEDERAL MATCH RATE THROUGH AN END-OF-THE YEAR RECONCILIATION PROVISION. THE GOVERNORS URGE CONGRESS TO CONSIDER SOME MODIFICATIONS IN THESE AREAS.

36.2.13 **MEASURE PERFORMANCE.** GOVERNORS SUPPORT THE PERFORMANCE BONUS THAT WILL REWARD STATES FOR MEETING THE GOALS OF P.L. 104-193, INCLUDING REDUCING WELFARE DEPENDENCY BY INCREASING EMPLOYMENT AND EARNINGS. GOVERNORS STRONGLY URGE THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES TO WORK CLOSELY WITH NGA AND THE AMERICAN PUBLIC WELFARE ASSOCIATION, AS INSTRUCTED IN THE LEGISLATION, TO DEVELOP THE CRITERIA AND FORMULA FOR THE AWARD OF PERFORMANCE BONUSES.

THE WORK PARTICIPATION RATE THAT STATES MUST MEET IN ORDER TO RECEIVE FULL TANF FUNDING IS A PROCESS RATHER THAN AN OUTCOME MEASURE AND DOES NOT MEASURE THE NUMBER OF INDIVIDUALS WHO HAVE LEFT WELFARE FOR WORK OR WHO HAVE BEEN DIVERTED FROM THE WELFARE ROLES. STATES ARE ACTUALLY GIVEN MORE CREDIT FOR KEEPING SOMEONE IN A SUBSIDIZED JOB AND ON WELFARE THAN FOR PLACING THAT PERSON IN A JOB WITH A SUFFICIENT INCOME SO THAT THEY NO LONGER ARE ELIGIBLE FOR CASH ASSISTANCE. ALTHOUGH THE PRO RATA REDUCTION IN THE WORK REQUIREMENT ATTEMPTS TO ADDRESS THIS ISSUE BY REWARDING A STATE FOR REDUCING ITS CASELOAD, IT WILL NOT BENEFIT A STATE IF ITS CASELOAD INCREASES DURING AN ECONOMIC DECLINE, EVEN IF THE STATE IS CONTINUING TO MOVE INDIVIDUALS INTO THE WORKFORCE.

THE GOVERNORS SUPPORT MOVING TOWARD AN OUTCOME-BASED SYSTEM THAT WOULD ALLOW A STATE TO USE PERFORMANCE MEASURES TO ASSESS ITS PROGRESS TOWARD MEETING BENCHMARKS AND GOALS ESTABLISHED BY THE STATE.

36.2.14 **REPEAL THE MAINTENANCE-OF-EFFORT REQUIREMENT FOR SUPPLEMENTAL SECURITY INCOME (SSI) STATE SUPPLEMENTS.** ALTHOUGH STATES ARE GIVEN A GREAT DEAL OF FLEXIBILITY UNDER TANF, STATES ARE STILL MANDATED TO MEET

THEY ARE PARTICIPATING IN THE APPROXIMATE SIX- TO NINE-MONTH NATURALIZATION PROCESS.

EVEN THOUGH MANDATES HAVE BEEN TERMINATED AND STATES HAVE BEEN GIVEN THE OPTION TO ESTABLISH ELIGIBILITY FOR TANF, MEDICAID, AND SOCIAL SERVICES, IT IS NOT CLEAR THAT THE JUDICIAL SYSTEM WILL PERMIT STATES TO BAR REFUGEES AND OTHER LEGAL IMMIGRANTS WHO ARE IN NEED FROM CRITICAL SERVICES PROVIDED TO OTHER RESIDENTS OF THE STATE. STATES COULD BE REQUIRED TO SUSTAIN BENEFITS, AT LEAST DURING AN INITIAL PERIOD OF JUDICIAL DELIBERATION.

AGED AND DISABLED REFUGEES SHOULD NOT BE BARRED FROM FEDERAL SSI BENEFITS AND FOOD STAMPS AFTER FIVE YEARS OF RESIDENCE. THE NEW WELFARE LAW NO LONGER PROVIDES FEDERAL BENEFITS TO THIS POPULATION AFTER FIVE YEARS AND SHIFTS THE RESPONSIBILITY TO STATES TO DECIDE WHETHER TO PROVIDE STATE BENEFITS TO THESE REFUGEES ADMITTED TO THE COUNTRY BY FEDERAL POLICY. THE AGED REFUGEES, IN PARTICULAR, CONFRONT EXTRAORDINARY DIFFICULTIES IN BECOMING CITIZENS, E.G., INABILITY TO PASS THE TESTS OR LOSS OF DOCUMENTS. UNLIKE LEGAL IMMIGRANTS, REFUGEES DO NOT HAVE SPONSORS. EVEN THOSE REFUGEES ABLE TO NATURALIZE WOULD BE IN JEOPARDY FOR A SIX- TO NINE-MONTH PERIOD DURING THE PROCESS OF APPLYING FOR NATURALIZATION.

BECAUSE IMMIGRATION AND REFUGEE POLICY IS UNDER THE SOLE JURISDICTION OF THE FEDERAL GOVERNMENT, THE GOVERNORS BELIEVE THAT THE FEDERAL GOVERNMENT MUST BE PREPARED TO BEAR THE COSTS OF SUCH POLICY.

36.3 PROGRAMS TO SUPPORT WELFARE REFORM

36.3.1 EARNED INCOME CREDIT (EIC). THE GOVERNORS HAVE SUPPORTED EFFORTS TO MORE NARROWLY TARGET EIC. THE EARNED INCOME CREDIT SHOULD BE ADJUSTED OVER TIME SO THAT WITH FOOD STAMPS, A FAMILY OF FOUR WITH A FULL-TIME, YEAR-ROUND WORKER WILL BE BROUGHT UP TO THE POVERTY LINE. ADMINISTRATION OF EIC SHOULD BE SIMPLIFIED, OUTREACH AND EDUCATION TO ENSURE FULL PARTICIPATION SHOULD BE EXPANDED, AND WORKER CHOICE REGARDING THE FREQUENCY OF PAYMENT SHOULD BE PRESERVED. EMPLOYERS SHOULD BE ENCOURAGED TO ADVANCE EIC TO QUALIFIED EMPLOYEES. STATES SHOULD BE ALLOWED TO ADVANCE EIC TO THOSE ELIGIBLE INDIVIDUALS, INCLUDING THOSE ON PUBLIC ASSISTANCE.

36.3.2 JOB DEVELOPMENT/JOB CREATION. AS JOBS ARE CREATED IN THE ECONOMY THROUGH VARIOUS MEANS, EVERY EFFORT SHOULD BE MADE TO ENSURE THAT

SUPREME COURT ON BLESSING V. FREESTONE. THE GOVERNORS URGE CONGRESS TO MOVE SWIFTLY TO ADOPT AN AMENDMENT TO CLARIFY THAT NO PRIVATE RIGHT-OF-ACTION EXISTS UNDER THE SOCIAL SECURITY ACT. THE GOVERNORS ARE NOT OPPOSED TO CITIZEN SUITS BUT BELIEVE SUCH SUITS SHOULD BE BROUGHT AGAINST THE LEVEL OF GOVERNMENT ENACTING THE LAW, IN THIS CASE, THE FEDERAL GOVERNMENT.

Time limited (effective Winter Meeting 1997-Winter Meeting 1999).



ASPE, HCFA

HR-37. PRIVATE SECTOR HEALTH CARE REFORM

EC 3. ~~HEALTH CARE REFORM~~

37.1 Preamble

The health of our nation depends on the health of our people. ~~And today,~~ The United States has the most sophisticated and technologically advanced health care system in the world. However, the technological excellence of our system has come with a price. Growth in the American health care industry has exceeded growth in the overall economy for almost every one of the last thirty years, ~~ALTHOUGH RECENTLY THERE HAS BEEN AN ENCOURAGING MODERATION IN MEDICAL INFLATION. OVER THE LAST YEAR, HEALTH CARE COST INCREASES WERE IN LINE WITH GENERAL INFLATION, THANKS IN LARGE PART TO THE COST CONTROLS AND MANAGEMENT EFFICIENCIES IMPLEMENTED IN MEDICAID AND OTHER STATE HEALTH PROGRAMS BY GOVERNORS.~~

~~The cost of this extraordinary growth continues to concern government, businesses, and individuals.~~ A growing number of Americans, INCLUDING CHILDREN AND ADOLESCENTS, are without PRIVATE SECTOR health coverage, with even basic care beyond the reach of many. With health care costs HAVING EXCEEDED ~~exceeding~~ general economic growth FOR DECADES, coverage HAS DECLINED ~~declining~~, and costs HAVE SHIFTED ~~shifting~~ to a smaller percentage of Americans who can afford to pay. Affordable quality care is becoming more elusive. The challenge that we face is to extend access to affordable quality care to all Americans, including those in underserved and rural areas, while containing costs.

The last several years have seen intense federal efforts to develop a consensus on national health care reform. ALTHOUGH EFFORTS TO ENACT FUNDAMENTAL NATIONAL REFORM HAVE BEEN UNSUCCESSFUL THUS FAR, IMPORTANT PROGRESS HAS BEEN MADE WITH THE PASSAGE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT. ~~Thus far, these efforts have been unsuccessful. By contrast,~~ IN ADDITION, the reform efforts of Governors and state legislators have been much more successful THAN FEDERAL ATTEMPTS AT FUNDAMENTAL REFORM. The emphasis of Governors today is to develop state-based health care reform efforts.

In almost every state, strategies have been implemented to improve the quality and availability of health care. In most states, the reform efforts have been focused to address a specialized problem. In several notable cases, the state is engaged in a comprehensive effort that is likely to provide near-universal coverage for its citizens. In general, states are testing strategies to restructure both the health care market and the public programs that support the most vulnerable citizens.

37.1.1 **Private Market.** Within the private insurance market, states have acted to enhance access and improve equity for both employers and employees. In some states, for example, limits have been placed on preexisting conditions exclusions for certain market segments. Some states HAVE IMPLEMENTED

REFORMS SETTING FORTH ~~are experimenting with~~ guaranteed issue, WHICH REQUIRES INSURERS IN THE SMALL GROUP MARKET TO ACCEPT EVERY SMALL EMPLOYER WHO APPLIES FOR COVERAGE, and portability of coverage, THROUGH WHICH ~~where~~ individuals can be ensured access to coverage after changing jobs. And within the small group insurance market, a number of states are establishing modified community rating systems, while two states have moved to a pure community rating.

More than EIGHTEEN ~~sixteen~~ states are experimenting with tax incentives to increase coverage. Included among THESE strategies are transitional tax credits to small businesses and medical savings accounts. These STATE EXPERIMENTS ~~strategies~~ are applicable only to state taxes and do not affect federal tax laws.

Finally, Some states are encouraging the establishment of purchasing alliances or group purchasing pools. By spreading risk and encouraging competition among health networks and insurers, alliances are able to offer affordable coverage to individuals, those who are self-employed, and people who work in small businesses—those who find it most difficult to purchase affordable coverage. Although these programs are still in their earliest stages, the results look promising. THE GOVERNORS CONTINUE TO BE CONCERNED ABOUT FEDERAL PREEMPTION OF STATE LAW IN THE REGULATION OF HEALTH CARE NETWORKS, AS DISCUSSED IN AN NGA LETTER DATED SEPTEMBER 28, 1995.

BY EXPERIMENTING WITH A NUMBER OF INNOVATIONS WITHIN THE PRIVATE INSURANCE MARKET, STATES HAVE TAKEN THE LEAD IN DEVELOPING AND IMPLEMENTING REFORMS DESIGNED TO EXPAND AFFORDABLE ACCESS TO INSURANCE COVERAGE WHILE CONTROLLING COSTS. THE EXPERIENCE GAINED THROUGH STATE REFORM EFFORTS LAID THE GROUNDWORK FOR THE PASSAGE OF THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

~~37.1.1 Public Programs. The Medicaid program remains the only national health care program for those who are poor. Although the program serves more than 30 million beneficiaries annually, many extremely poor people do not qualify for care.~~

~~Several states have acted to eliminate this inequity by restructuring their Medicaid program. Provisions of the Social Security Act, of which Medicaid is one part, allow states to experiment with the program so that individuals not otherwise eligible for the program may become so. These provisions also have been used to ensure that Medicaid beneficiaries receive care through systems of managed care.~~

37.2 Federal Support for State-Based Health Care Reform

States have made significant progress in reforming their health care systems; however, much more needs to be done. The nation's Governors call upon the President and Congress to work with states to facilitate and accelerate the development of state reform efforts.

37.2.1 **Employee Retirement Income Security Act.** Although the Governors are extremely sensitive to the concerns of large multistate employers, the fact remains that one of the greatest barriers to some state reform initiatives is the Employee Retirement Income Security Act (ERISA).

ERISA was enacted in 1974 and applies to employee benefits plans, including employee health plans. ERISA provides for a complete federal preemption of state laws that "relate to" employee health

plans. Under the McCarran-Ferguson Act, states retain the ability to regulate insurance carriers, such as indemnity plans and health maintenance organizations. However, states are powerless to regulate or otherwise affect employee health plans that "self-insure" under ERISA rather than buy insurance.

Self-insurance was very rare when ERISA was enacted, but it now covers 51 PERCENT almost half of the employees in the United States who receive health benefits. This proliferation of self-insurance, coupled with the federal courts' broad interpretation of the reach of ERISA preemption, has made ERISA a formidable barrier to states wishing to implement certain health care reform.

ERISA preempts all self-insured health plans from state regulations and subjects those plans only to federal authority. As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- **REQUIRING ALL HEALTH PLANS TO PROVIDE STATES WITH INFORMATION CRUCIAL TO DEVELOPING A COMPREHENSIVE UNDERSTANDING OF THE STATUS OF THE STATE'S HEALTH CARE ACCESS AND DELIVERY SYSTEMS;**
- ~~developing standard data collection systems applicable to all state health plans;~~
- ~~developing uniform administrative processes, including standardized claim forms;~~
- ~~establishing all-payer rate setting systems;~~
- establishing a statewide employer mandate;
- imposing a level playing field through premium taxes on self-insured plans; and
- **OVERSEEING QUALITY IN SELF-FUNDED HEALTH PLANS AND ESTABLISHING CONSUMER PROTECTIONS.**
- ~~imposing a level playing field through provider taxes where the tax is interpreted as having an impermissible direct or indirect impact on self-insured plans.~~

THE DECISION IN NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS V. TRAVELERS INSURANCE COMPANY AFFIRMED STATES' ABILITY TO ESTABLISH ALL-PAYER RATE-SETTING SYSTEMS. THE SAME CASE INDICATED THAT PROVIDER TAXES WOULD BE PERMISSIBLE, BUT CONCERNS REMAIN THAT THESE TAXES COULD BE PREEMPTED BY ERISA THROUGH EVOLVING JUDICIAL INTERPRETATION.

37.2.1.1 Strategy for Reform. A multidimensional approach to reform could be taken that includes flexibility for states directly in the ERISA statute, and through new waiver authority.

- **Statutory Flexibility.** Congress may act quickly to help states by including flexibility directly in statute. This may be accomplished through statutory directives to the federal executive branch regarding national uniformity. Specifically, a state would be permitted to impose requirements on self-funded plans if the state was willing either to adopt and build upon minimum national standards or work within some type of federal framework. The federal executive branch would be instructed to work with states to identify and define those standards.

This approach has the potential for broad applicability but is most relevant to ~~administrative simplifications and insurance reform. For example, states and the business community generally agree on the need for uniform claims and data reporting procedures. In order to encourage uniformity in health plan administrative requirements, the U.S. Secretary of Labor, in consultation with the U.S. Secretary of Health and Human Services and the states, could be directed to compile, publish, and publicize existing national standards for claims processing formats and procedures for data reporting. If a state selected one of the existing~~

standards, it would be permitted to implement that standard and include self-funded plans. This type of directive also could be extended to quality and utilization review procedures.

To facilitate the process, the legislation should be structured to rely on existing national standards. Where none exist, the legislation could direct the executive branch to develop them. However, if the executive branch finds it necessary to develop a national standard, states should be given limited flexibility during the development period so that they can move ahead with their innovations.

- **Waiver Authority.** In addition to direct statutory flexibility, Congress should establish direct waiver authority in ERISA. Waiver authority would be most applicable for states that wish to develop alternative financing and cost-control strategies that are now precluded by the statute. Waiver authority could have the following parameters.
 - The secretary of the U.S. Department of Labor would have the authority to review and grant ERISA waivers.
 - There would be no prohibition against replicating other state ERISA waivers. However, each state would have to submit a waiver application.
 - Waivers would be approved for an initial five-year period with five-year renewals thereafter.
 - Waiver applications would be submitted by the Governor.
 - As a condition for waiver approval, the state would have to demonstrate that the strategy has the support of the state's legislature.
 - For states making requests for exemptions in the areas of financing or cost control, the state's waiver application would have to include a plan for expanding coverage and **MAINTAINING QUALITY, AND** a strategy for documenting the state's progress toward achieving **THESE GOALS** that goal.

37.2.2

The Health Insurance Market. With the enactment of the McCarran-Ferguson Act in the 1930s, a state's prerogative to regulate health insurers has been recognized by federal law. However, since ERISA's enactment in 1974, that delineation of state and federal responsibilities has been blurred. ERISA provides that self-funded single employer or Taft-Hartley jointly administered plans are exempt from state regulation. States cannot establish minimum solvency and capital requirements for these self-funded plans. They cannot ensure that employees and dependents in self-funded plans receive the basic consumer protections that are offered to those in commercial state-regulated plans; nor can they ensure that those in self-funded plans have remedies available when problems arise over coverage decisions and other matters. ~~States, attempting to make the private insurance market more stable and equitable, are prohibited from imposing guaranteed issue or limitations on preexisting conditions exclusions requirements on self-funded plans.~~ As such plans proliferate, they represent a growing share of the total health care market and greatly erode the ability of states to regulate the private health care market. The federal government must act to rectify the situation.

The nation's Governors call on the federal government to correct these inequities by adopting one or more of the following options.

- Congress should **WORK WITH THE STATES TO** establish national health care standards for self-funded plans that are similar to those imposed by states on commercial plans. If Congress is unwilling to define legislative standards in ERISA, the U.S. Department of Labor, **IN CONSULTATION WITH THE STATES,** should be given the authority to develop regulations that, at the very least, establish essential consumer protections and remedies standards for self-funded plans.
- Anecdotal evidence suggests that consumer protections problems are more likely to arise in small self-funded plans. Congress could limit self-funding authority to businesses above a certain size. Businesses below that limit would be required to follow state laws. The

U.S. Department of Labor would need to enforce standards for those plans that remain under its jurisdiction.

~~The Governors also support standards that result in portability of coverage, guaranteed renewability of policies, limitation on both medical underwriting and preexisting conditions exclusions, and opportunities for states to establish meaningful and equitable rating systems.~~

If Congress chooses to set minimum national standards, they should be developed with state officials in consultation with representatives of affected small businesses, insurers, and consumers.

37.2.2.1

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS. THE GOVERNORS SUPPORT EFFORTS DESIGNED TO ENABLE SMALL EMPLOYERS TO JOIN TOGETHER TO PARTICIPATE MORE EFFECTIVELY IN THE HEALTH INSURANCE MARKET. IN FACT, STATES HAVE TAKEN THE LEAD IN FACILITATING THE DEVELOPMENT OF SUCH PARTNERSHIPS AND ALLIANCES. HOWEVER, THESE PARTNERSHIPS MUST BE CAREFULLY STRUCTURED AND REGULATED BY STATE AGENCIES. MANY STATES HAVE EXPERIENCED EXTENSIVE AND WELL-DOCUMENTED PROBLEMS WITH FRAUDULENT MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS) IN RECENT YEARS. IN MANY CASES, STATE LEGISLATION HAS BEEN ADOPTED TO PROTECT AGAINST FURTHER ABUSE.

THE GOVERNORS STRONGLY OPPOSE CONGRESSIONAL REFORMS THAT WOULD EXTEND ERISA STATUS TO MEWAS OR OTHERWISE LIMIT STATE OVERSIGHT. STATE INSURANCE REGULATION IS CRUCIAL TO ENSURING THAT SMALL BUSINESS ALLIANCES RECEIVE RELIABLE AND SECURE COVERAGE. BEFORE ANY CHANGE IS MADE IN FEDERAL STATUTE WITH REGARD TO MEWAS, THE IMPACT OF THE SMALL MARKET REFORM CHANGES SET FORTH BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 SHOULD BE CAREFULLY ANALYZED.

37.2.3

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996. WITH THE PASSAGE OF THIS IMPORTANT NEW LAW, THE FEDERAL GOVERNMENT HAS MADE PROGRESS TOWARD EXTENDING BASIC MARKET REFORMS TO ERISA PLANS. ALTHOUGH GOVERNORS RECOGNIZE THE IMPORTANCE OF NATIONAL PROTECTIONS AND APPLAUD THE EXTENSION OF THOSE PROTECTIONS TO ERISA PLANS, IT IS IMPORTANT TO REMEMBER THAT STATES HAVE PRIMARY RESPONSIBILITY FOR INSURANCE REGULATION. THAT ROLE MUST BE PRESERVED.

THE GOVERNORS LOOK FORWARD TO WORKING CLOSELY WITH THE FEDERAL GOVERNMENT AS IMPLEMENTATION DECISIONS ARE MADE. IN PARTICULAR, GOVERNORS WILL BE FOLLOWING VERY CAREFULLY THE PROCESS FOR DETERMINING WHETHER STATE ALTERNATIVES FOR THE REGULATION OF THE INDIVIDUAL INSURANCE MARKET ARE DEEMED ACCEPTABLE BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). THE STATUTE PROVIDES EXAMPLES OF WHAT

CONSTITUTES AN ACCEPTABLE ALTERNATIVE, AND GOVERNORS DO NOT WANT STATE FLEXIBILITY TO BE DIMINISHED THROUGH THE REGULATORY PROCESS.

THE GOVERNORS ALSO BELIEVE STATES SHOULD BE CONSULTED EXTENSIVELY AS HHS DEVELOPS STANDARDS FOR THE ADMINISTRATIVE SIMPLIFICATION PROVISIONS IN THE NEW LAW. NATIONAL STANDARDS WILL BE ADOPTED AND ENACTED WITHIN TWENTY-FOUR MONTHS OF PROMULGATION REGARDING TRANSACTIONS, DATA ELEMENTS FOR SUCH TRANSACTIONS, AND STANDARDS FOR THE ELECTRONIC TRANSMISSION OF CERTAIN HEALTH INFORMATION. STATE PARTICIPATION IS NEEDED TO ENSURE THAT STATE DATA NEEDS ARE ADDRESSED AND THAT PATIENT PRIVACY IS PROTECTED.

~~37.2.3 Acute Care Services for Low-Income Individuals and Families. Irrespective of the health care reform strategy, a public sector role will remain in the financing and delivery of services to the poor, the elderly, and people with disabilities. The Medicaid program is the vehicle currently used to finance such care. Today, Medicaid struggles to serve a widely diverse population with a broad array of services. It is not only difficult to effectively administer, but also prohibitively expensive.~~

~~The Governors believe that the Medicaid system has become a rigid and overly complex program. Its bias toward institutional care prevents states from providing preventive and primary care in settings most appropriate for its beneficiaries, and eligibility for the program is dominated by arcane rules that penalize all who interact with it.~~

~~Therefore, the Governors envision a strategy that would allow the states to manage public resources in a more efficient and effective manner than is currently possible through Medicaid.~~

~~37.2.3.1 Program Structure. Many states believe they can make better use of their Medicaid dollars by restructuring their Medicaid programs. Specifically, some states would rather offer a core benefits package to low-income people without tying the program to eligibility for categorical programs. This may be a better approach than the current Medicaid structure, which provides a very comprehensive package to those who are categorically eligible, but leaves many low-income people without any insurance at all. In addition, some states would like to offer sliding scale subsidies so that low-income people can purchase health insurance according to their ability to pay. The federal government should encourage these innovations.~~

~~37.2.3.2 Entitlements and Financing. States and the federal government should share in financing this program. States should be given the option to operate this program as an individual entitlement or as an entitlement to states. As an individual entitlement, the program would operate in a manner similar to the current Medicaid program and anyone qualifying for the program would have to be served.~~

~~As an entitlement to states, the federal government's financial exposure would be established by an upper limit on available federal dollars. State contributions to this program also would be limited by the federal upper limit. In operating it as an entitlement to states, individuals could qualify for the program; however, participation would be limited by available state and federal funds. It must be clear that under this structure, the choice of an entitlement to states would be made by each individual state and not by Congress.~~

~~States could not operate these programs with funds that are subject to annual federal appropriations. Rather, the financing structure should appear in statute and be treated as a permanent appropriation.~~

~~Finally, in order to operate this program effectively, states must be given significant flexibility in program design and implementation. Moreover, the Governors can support the "entitlement to states" option only if states are given substantial statutory flexibility in defining benefits packages, eligibility requirements, payment rate setting, and other administrative requirements.~~

~~37.2.3.3 Statutory Changes to the Social Security Act. States have begun to look seriously at comprehensive systems of health care where the artificial categorical barriers of Medicaid are removed and where they can establish statewide networks of care for Medicaid beneficiaries. Unfortunately, there~~

are no provisions in the Social Security Act that can be used to establish such programs on an ongoing basis.

Currently, states have been developing these more comprehensive networks through the research and demonstration provisions of Section 1115(a) of the Social Security Act. Section 1115(a), however, was designed for research purposes and has some important limitations. States must demonstrate, through the application process, that they are testing an innovation. The law requires an evaluation that, in some cases, requires control groups. Projects approved under the 1115(a) process are approved for a limited time period, usually three to five years at the discretion of the administration, and require special statutory changes to go beyond the demonstration period. Finally, these projects must be cost neutral over the life of the project. Section 1115(a) is essential to ensure the testing of alternative health and social policies.

However, the current statute falls short by requiring states who want to continue a successful effort to continually reapply for and renew their waivers. In short, once a state has proven that its research project works, it cannot continue without pursuing demonstration goals and waiver renewals for a programmatic effort or without special treatment in federal laws undertaken by Congress. Existing Section 1115(a) waivers should be grandfathered into this new system.

The Governors support changes to the Social Security Act to permit these types of programs to be approved in a manner similar to the "plan amendment process" under Medicaid, where the state describes the plan and, once approved, it becomes a permanent program subject to routine federal oversight. If this strategy is not chosen, the waiver application process must be streamlined, there must be no research and demonstration requirements, and the waivers must be approved for five years and be renewable no less than every five years. Moreover, the executive branch must be instructed to streamline the waiver oversight process and shorten review and approval periods.

- 37.2.4 **Medical Tort Reform.** Reform of the medical tort system should be undertaken with a view toward achieving high-quality and appropriate care. Ideally, medical tort reform will reduce the cost of defensive medicine and provide appropriate levels of compensation for patients injured by medical negligence. Toward that end, the federal government should establish national minimum tort and liability standards. States could establish more restrictive standards if they so choose. The federal government, working with states, also must consider alternative dispute resolution strategies that could be used to reduce the costs of litigation.
- 37.2.5 **Antitrust.** More and more Americans are receiving their care through health delivery networks. Establishing these networks requires new approaches to cooperation among providers and businesses that heretofore have been competitors. Congress and the administration must work with the states to accommodate this new health care environment while ensuring that competition remains in the marketplace.
- 37.2.6 **Outcome and Quality Standards.** If meaningful choices are ever to be made in health care, research must be supported to develop outcomes and quality standards for use by providers, PURCHASERS, and consumers alike. Also, information systems must be developed that include price and quality information for all providers and consumers of health care services in a given geographic area. The federal government, and the states, AND THE PRIVATE SECTOR (BOTH PURCHASERS AND PROVIDERS) must cooperate in the development and implementation of such standards. DATA MEASURES MUST PROVIDE INFORMATION RELEVANT TO STATE PROGRAMMATIC DECISIONS AND CONSUMER CHOICE. THE COLLABORATIVE PROCESSES OF STANDARD DEVELOPMENT AND MEASUREMENT MUST BE DESIGNED IN SUCH A WAY THAT THEY DO NOT CREATE UNREASONABLE ADMINISTRATIVE BURDENS WITHOUT YIELDING USEFUL RESULTS.

37.2.7 **Administrative Simplifications.** The administrative complexity of the current system must be reduced. THE GOVERNORS SUPPORT THE REFORMS SET FORTH IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT TO MOVE the nation must move toward uniform claims forms and uniform standards for electronic data interchange. HOWEVER, STATES MUST BE CLOSELY INVOLVED IN THE DEVELOPMENT OF THE NATIONAL STANDARDS TO ENSURE THAT STATE DATA NEEDS ARE MET AND INDIVIDUAL PRIVACY RIGHTS ARE PROTECTED.

37.2.8 **Public Sector Health Care Delivery.** Although the Governors support the delivery of care through the private health care system, A PUBLIC SYSTEM OF SERVICES, FUNDED BY THE STATE AND FEDERAL GOVERNMENTS, HAS ARISEN TO ADDRESS NEEDS UNMET BY THE PRIVATE SECTOR. (SEE THE GOVERNORS' PUBLIC HEALTH SERVICES POLICY, HR-7.) ~~there are some areas in the country that have an inadequate number of health care providers or services. In other areas; the private system does not provide services to low-income individuals and families, and these people seek care through public clinics. In these circumstances, federal and state governments have provided for the delivery of personal health care services. The Governors believe that this public health care system should be considered in any budget strategy and coordinated with the private health care sector, wherever possible.~~

37.2.9 **Enhance Opportunities for Primary Care Practice.** DESPITE THE RECENT INCREASE IN THE PERCENTAGE OF MEDICAL STUDENTS CHOOSING TO PURSUE CAREERS IN GENERAL MEDICINE, the medical education system STILL is not preparing the providers that are needed for a health care system with a focus on preventive and primary care. States are currently experimenting with a wide variety of initiatives that address the critical ISSUES issue of increasing primary care practice AND IMPROVING THE DISTRIBUTION OF PRIMARY CARE PROVIDERS, especially in rural and urban medically underserved areas. These initiatives include data collection to better understand the distribution of, and need for, providers in specific locations; loan repayment programs to practitioners who practice in underserved areas; and technical assistance programs to enhance primary care delivery systems in underserved locations.

Therefore, the Governors recommend that the federal government recognize, review, and support programs currently underway in states that are successfully addressing the issue of increasing and preserving access to primary care physicians in medically underserved and rural areas. Moreover, the Governors recommend that the federal government provide incentives for students, physicians, and mid-level health professionals to serve in primary care professions, particularly in rural and underserved areas.

37.2.10 **MANAGED CARE AND QUALITY.** SEE THE GOVERNORS' MEDICAID POLICY, EC-8.

37.3

Conclusion

In many states, Governors have begun to meet the challenge of reforming their health care systems and are beginning to learn about the successes and failures. The federal government should support states as they demonstrate different approaches to achieve universal access to affordable health care and should evaluate creative comprehensive approaches to health care reform.

Time limited (effective WINTER MEETING 1997-WINTER MEETING 1999). ~~Winter Meeting 1995-~~

~~Winter Meeting 1997~~

Adopted Winter Meeting 1994; revised Winter Meeting 1995.



HR-38. EC-6. HIV/AIDS**38.1 Preamble**

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are critical public health problems. No state has been untouched by the devastating human and economic costs of HIV and AIDS. U.S. Public Health Service and worldwide projections of future incidence are startling. THROUGH JUNE 1996, 548,102 AIDS CASES HAVE BEEN REPORTED IN THE UNITED STATES. SINCE THE BEGINNING OF THE EPIDEMIC, 343,000 PEOPLE HAVE DIED OF AIDS IN THIS COUNTRY. ~~In September 1994, more than 425,000 active cases of AIDS were reported in the United States. In 1991 and 1992 alone, more than 220,000 people died of AIDS. State and local governments have allocated significant financial resources to this problem. In fiscal 1992, states spent \$401.9 million on HIV/AIDS programs and services beyond those programs funded through the Medicaid program. In a number of states, state and local funds far exceed federal support. ALTHOUGH ENCOURAGING PROGRESS HAS BEEN MADE IN SLOWING THE SPREAD OF THE DISEASE, the Governors strongly believe, therefore, that the magnitude of the HIV/AIDS epidemic calls for strong action by all levels of government, including CONTINUED SUPPORT FOR HIV/AIDS PREVENTION AND TRACKING AND FOR THE REAUTHORIZED reauthorization of the Ryan White CARE Act.~~

38.2 Education, Prevention, Counseling, and Testing

The Governors recognize that the federal government has made a significant contribution toward funding HIV/AIDS ~~research and prevention activities. Although SIGNIFICANT scientific progress has been made, an effective vaccine or a cure for the disease remains years away. In the absence of a vaccine or a cure, prevention efforts such as education, public information, HIV/AIDS counseling and testing, and personal responsibility are the most effective means available to prevent the disease from spreading further.~~

~~In recent years, State health departments have assumed the primary role in planning and coordinating HIV/AIDS prevention efforts. All states are engaged in HIV Prevention Community Planning with support from the U.S. Centers for Disease Control and Prevention (CDC). SINCE Beginning in 1994, state and territorial health departments have been required to implement a planning process through which they collaborate with their communities to identify unmet needs and establish priorities for HIV/AIDS prevention programming. WITH In general, federal support for prevention efforts, THIS PLANNING PROCESS HAS GIVEN THE has been helpful; however, states must be given sufficient time to implement prevention strategies that evolve from these planning activities. Moreover, states must have the flexibility to design and implement TARGETED prevention programs at the state and local level that meet STATE AND LOCALLY DETERMINED needs and are consistent with community values. FEDERAL RESTRICTIONS OR REQUIREMENTS ON THE USE OF~~

AVAILABLE FUNDING INTERFERE WITH THE ABILITY OF STATES TO DEVELOP COMPREHENSIVE PREVENTION STRATEGIES.

Preventive efforts directed at young people—before they reach the age when they may engage in behaviors that place them at risk of infection—also are important. The nation's youth should be MADE aware of the risk of the possible spread of HIV/AIDS through SEXUAL ACTIVITY AND THE HARM POSED BY CONTAMINATED NEEDLES—~~injection of drugs~~. Information about HIV/AIDS should be an integral part of substance abuse prevention efforts.

IT IS ALSO IMPORTANT TO RECOGNIZE THE INTERRELATIONSHIPS BETWEEN HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES AND COMBINE EFFORTS TO COMBAT FURTHER SPREAD OF DISEASE. ALTHOUGH THE GOVERNORS HAVE INITIATED A VARIETY OF SEXUALLY TRANSMITTED DISEASE PREVENTION STRATEGIES, WHEN HIV/AIDS IS TRANSMITTED SEXUALLY, SEXUAL ABSTINENCE IS THE ONLY 100 PERCENT EFFECTIVE MEANS OF PREVENTION AND SHOULD BE STRONGLY REINFORCED AMONG MINORS AS A WAY TO REDUCE THE RISK OF CONTRACTING HIV/AIDS.

Finally, special education efforts must be made to ensure that all members of the medical and health care community are knowledgeable and have current information about HIV/AIDS prevention. Health providers must be more diligent in identifying people who are at risk or who are infected with HIV, particularly in populations such as women and adolescents who are not as frequently recognized as at risk. GOVERNORS ALSO RECOGNIZE THE IMPORTANCE OF EDUCATING PROVIDERS ON THE APPROPRIATE USE OF EMERGING TREATMENTS AND PRIMARY PREVENTION AND CARE SERVICES WITHIN THE MANAGED CARE SETTING.

Counseling and testing have been important components of the national education and prevention effort. Access to counseling services should be an integral part of the HIV/AIDS testing effort, both before and after testing and regardless of the test results. Counseling and testing represent major opportunities to encourage, on a one-to-one basis, the behavior changes required to stop further spread of the HIV virus. Although counseling and testing remain important strategies to address this epidemic, the nation must continue to seek any and all strategies that will successfully reduce the transmission of HIV/AIDS. IN ORDER TO INCREASE EARLY ACCESS TO NEW HIV/AIDS TREATMENTS, IT IS CRITICAL THAT COUNSELING AND TESTING PROGRAMS HAVE THE ABILITY TO LINK INDIVIDUALS TO PRIMARY CARE SERVICES AS SOON AS POSSIBLE. FEDERAL LAWS SHOULD NOT CHALLENGE OR SUPERSEDE STATE LAWS AND PREFERENCES WITH RESPECT TO ISSUES SURROUNDING TESTING AND REPORTING.

The social stigma associated with HIV/AIDS has created a particular problem for the prevention and control of the disease. Out of fear of discrimination, individuals with HIV and AIDS worry about being identified. Within the context of sound public health policy, states are encouraged to review their

medical information and privacy laws and, where necessary or appropriate, update these statutes to safeguard the rights of tested individuals.

The Governors are concerned that individuals who test positive for HIV/AIDS may face discrimination, despite the fact that all medical evidence to date shows that HIV cannot be transmitted through casual contact. PROGRESS HAS BEEN MADE IN ENDING AIDS DISCRIMINATION, BUT clarification of or modifications in laws should be made where necessary to protect HIV-infected individuals from inappropriately being denied opportunities in areas such as employment and housing.

IN ADDITION TO THE RANGE OF VERY IMPORTANT PREVENTION STRATEGIES ALREADY UNDERWAY ACROSS THE COUNTRY, PREVENTION ACTIVITIES CENTERED AROUND SUBSTANCE ABUSE AND PERINATAL TRANSMISSION ARE EMERGING AS PARTICULAR PRIORITIES.

38.2.1 SUBSTANCE ABUSE. TRANSMISSION TIED TO INJECTING DRUG USE CONTINUES TO BE A MAJOR CAUSE OF HIV INFECTION. THIRTY-SIX PERCENT OF THE TOTAL NUMBER OF AIDS CASES REPORTED TO CDC ARE LINKED TO INJECTING DRUG USE. A key factor in containing the spread of HIV/AIDS is reducing the use of injection drugs. Programs should strive to eliminate the significant waiting time frequently facing both those wishing to receive treatment for drug abuse, and those desiring HIV testing and counseling. Yet the vast majority of drug users are not seeking treatment. Consequently, outreach should be extended to drug users who are not currently in treatment in order to get them into treatment, encourage them to be counseled and tested, and educate them about the dangers of high-risk behaviors. Additionally, appropriate models to attract drug users to treatment should be developed, WITH A PARTICULAR EMPHASIS ON FINDING EFFECTIVE METHODS FOR REACHING OUT TO LONG-TERM ABUSERS.

38.2.2 PEDIATRIC AIDS. THE MAJOR CAUSE OF PEDIATRIC HIV/AIDS TODAY IS PERINATAL TRANSMISSION OF INFECTION, ALTHOUGH DRAMATIC PROGRESS HAS ALREADY BEEN MADE IN REDUCING TRANSMISSION RATES. RECENT FINDINGS RELEASED BY CDC DEMONSTRATE A 27 PERCENT REDUCTION IN PERINATAL TRANSMISSION BETWEEN 1992 AND 1995. THE GOVERNORS APPLAUD THIS REDUCTION AND THE SCIENTIFIC ADVANCES AND VOLUNTARY PREVENTION STRATEGIES THAT MADE IT POSSIBLE.

THE RYAN WHITE CARE ACT AS REAUTHORIZED IN 1996 INCLUDES A NUMBER OF PROVISIONS FOCUSED ON REDUCING PERINATAL TRANSMISSION, INCLUDING TARGETED CASELOAD REDUCTIONS. FAILURE TO COMPLY WILL CAUSE A STATE'S ALLOCATION OF TITLE II FUNDING TO BE ELIMINATED. VITAL TREATMENT FUNDING WILL BE JEOPARDIZED AS A RESULT OF PREVENTION MANDATES. GOVERNORS STRONGLY OPPOSE EFFORTS TO TIE RECEIPT OF FEDERAL FUNDS TO MANDATORY TESTING LAWS.

GOVERNORS ARE STRONGLY COMMITTED TO REDUCING AND ELIMINATING HIV/AIDS IN CHILDREN THROUGH IMPLEMENTATION OF UNIVERSAL HIV COUNSELING AND VOLUNTARY TESTING GUIDELINES FOR PREGNANT WOMEN. BUT MANDATORY POSTPARTUM TESTING, AS SET FORTH IN THE RYAN WHITE CARE ACT, WILL NOT IN AND OF ITSELF REDUCE THE SPREAD OF HIV/AIDS TO NEWBORNS. IN FACT, SOME STATES FEAR THAT MANDATORY TESTING COULD DISCOURAGE AT-RISK WOMEN FROM SEEKING NEEDED HEALTH CARE. INSTEAD OF THIS FOCUS ON MANDATORY TESTING, GOVERNORS ENCOURAGE FEDERAL SUPPORT FOR THE USE OF AZT DURING PREGNANCY, WHEN INFECTION CAN BE PREVENTED.

IN AN EFFORT TO COMPLY WITH THE TARGETED PERINATAL CASELOAD REDUCTIONS MANDATED BY THE RYAN WHITE CARE ACT, EVERY STATE WILL BE FORCED TO REDIRECT FUNDS FROM OTHER EQUALLY VITAL AND MORE EFFECTIVE HIV/AIDS PREVENTION ACTIVITIES. STATES WILL NO LONGER BE ABLE TO DEVELOP COMPREHENSIVE PREVENTION STRATEGIES TO MEET THE PARTICULAR NEEDS OF THEIR COMMUNITIES. INSTEAD, FEDERAL MANDATES WILL REQUIRE STATES TO FOCUS AVAILABLE RESOURCES ON ONE PARTICULAR CATEGORY OF NEED. UNFORTUNATELY, THE SCIENCE OF PREVENTION IS NOT SO EXACT THAT THERE IS ANY GUARANTEE THAT ANY LEVEL OF INTERVENTION WILL PRODUCE THE DESIRED RESULT IN ANY STATE. GOVERNORS WOULD LIKE TO WORK CLOSELY WITH CONGRESS AND THE ADMINISTRATION TO DEVELOP PREVENTION STRATEGIES THAT ACHIEVE THE GOAL WE ALL SUPPORT OF KEEPING BABIES HEALTHY, WITHOUT JEOPARDIZING FUNDING FOR OTHER IMPORTANT HIV/AIDS PREVENTION AND TREATMENT EFFORTS.

THE GOVERNORS SUPPORT EFFORTS TO REDUCE THE TRANSMISSION OF HIV/AIDS. WE DO NOT SUPPORT THE NEW PERINATAL TRANSMISSION MANDATE IMPOSED BY CONGRESS. IN ADDITION, GOVERNORS ARE SPECIFICALLY CONCERNED THAT BECAUSE AN ALTERNATIVE MEASURE AS REQUIRED BY THE LEGISLATION HAS NOT BEEN DETERMINED BY CDC, IT WILL BE VIRTUALLY IMPOSSIBLE STATISTICALLY FOR LOW-INCIDENCE STATES AS DEFINED BY CDC TO REALIZE THE REQUIRED 50 PERCENT REDUCTION IN PERINATAL TRANSMISSION. FOR THAT REASON, GOVERNORS BELIEVE THAT WHILE MOVING TOWARD A MORE WORKABLE PERINATAL TRANSMISSION PREVENTION STRATEGY FOR ALL STATES, LOW-INCIDENCE STATES SHOULD BE HELD HARMLESS FROM THE CASELOAD REDUCTION REQUIREMENTS OF THE RYAN WHITE CARE ACT. GOVERNORS ALSO BELIEVE THAT FUTURE FEDERAL RESOURCES MADE AVAILABLE TO REDUCE PERINATAL TRANSMISSION SHOULD BE TARGETED TO HIGH-INCIDENCE STATES.

38.3 Research

A comprehensive national education and prevention program, with significant federal leadership, must be a central component of the nation's fight against HIV/AIDS. At the same time, resources must be devoted to research—both to find a vaccine for HIV/AIDS as well as to develop EFFECTIVE, ACCESSIBLE, AND AFFORDABLE ~~a-treatment~~ TREATMENTS and A cure for present and future HIV/AIDS patients. The federal government has the primary role to play in funding HIV/AIDS-related research activities. The Governors urge that money appropriated for HIV/AIDS research be used expeditiously and that funding provided for HIV/AIDS research not be made at the expense of other public health priorities.

In addition to the substantial commitment made by the federal government, PRIVATE SECTOR HIV/AIDS RESEARCH HAS LED TO DRAMATIC BREAKTHROUGHS. GOVERNORS APPLAUD THE PHARMACEUTICAL INDUSTRY FOR THE RESEARCH AND DEVELOPMENT EFFORTS THAT HAVE RESULTED IN THE CREATION OF PROTEASE INHIBITORS AND OTHER USEFUL DRUG THERAPIES. ~~some states have provided leadership by funding AIDS research with state dollars.~~ The Governors urge increased coordination between federal and PRIVATE SECTOR EFFORTS ~~state initiatives in this area~~ to ensure the most efficient use of research dollars. The Governors also urge the speedy dissemination of research results to the scientific community, as well as practitioners, to ensure that research findings can be applied as expeditiously as possible. THE FOOD AND DRUG ADMINISTRATION'S EXPEDITED DRUG APPROVAL PROCESS HAS HELPED MAKE NEW TREATMENTS AVAILABLE MORE QUICKLY THAN IN THE PAST AND SHOULD BE CONTINUED.

38.4 Treatment

Over the next few years, the growing number of HIV/AIDS and ~~AIDS-related~~ cases will place an increasing strain on the nation's health care delivery system. The estimated cost of treating a person with HIV/AIDS from the time of infection to death is \$119,000. ~~For those who receive no treatment until a diagnosis of AIDS is made, the cost is estimated at \$69,000.~~ Now is the time to begin the fiscal and capacity planning required to address these future health care delivery needs. This should include an assessment of the appropriate burden of HIV/AIDS health care costs that should be borne by the public and private sectors.

At the same time, we need to provide appropriate services to those individuals presently suffering from HIV/ ~~infections or~~ AIDS. TREATMENT NEEDS ARE CHANGING WITH THE ADVENT OF PROMISING MULTIDRUG COMBINATION THERAPIES, WHICH ARE HELPING MANY HIV/AIDS PATIENTS LIVE LONGER AND HEALTHIER LIVES. TREATMENT PROTOCOLS RELATING TO CHRONIC DISEASE MANAGEMENT OF HIV/AIDS, DEVELOPED IN

PARTNERSHIP BETWEEN FEDERAL, STATE, AND PRIVATE EFFORTS, WILL LEAD TO CHANGES IN EXISTING SYSTEMS OF CARE.

Adequately addressing PATIENTS' the health care needs of AIDS patients requires establishment of a "continuum of care," including inpatient and outpatient hospital services, care in nursing home and alternative residential settings, home care, hospice care, psychosocial support services, and case management services. Many state and local governments have led the way in providing health care services for people with HIV/AIDS; however, more research is required to determine the most humane and cost-effective way of providing HIV/AIDS-related care. ~~The federal government has funded several demonstration projects to determine models for providing services to AIDS patients. Such demonstrations should continue.~~ Finally, as the nation moves toward networks of health care, efforts are needed to ensure that the prevention and treatment needs of people at risk for or infected with HIV/AIDS are adequately addressed in managed care settings. In addition, strategies must be developed that ensure that those in managed care arrangements also have access to other support services, such as social supports and home- and community-based services, so that the continuum of care is maintained.

38.5 Ryan White CARE Act

The Governors strongly SUPPORTED support the reauthorization of the Ryan White CARE Act. Funds provided through the act support a network of health care, and support services in cities and states, AND PRESCRIPTION DRUGS for people living with HIV infection and AIDS, especially the uninsured who would otherwise be without care. This program is a critical element in HIV/AIDS prevention, education, and treatment efforts by states.

HOWEVER, DESPITE STRONG SUPPORT OF THE RYAN WHITE CARE ACT AS A WHOLE, CERTAIN PROVISIONS OF THE ACT ARE OF CONCERN TO GOVERNORS. AS PREVIOUSLY MENTIONED, THE PERINATAL TRANSMISSION MANDATE RESTRICTS STATE FLEXIBILITY TO ALLOCATE LIMITED FEDERAL FUNDING. IN ADDITION, THE AIDS DRUG ASSISTANCE PROGRAM (ADAP) FUNDING MADE AVAILABLE THROUGH THE RYAN WHITE CARE ACT HAS NOT KEPT UP WITH THE INCREASING COSTS OF THE EXPENSIVE NEW DRUG THERAPIES. ACCORDINGLY, AN INCREASING PERCENTAGE OF THE COST OF THE NEW THERAPIES IS SHIFTING FROM THE FEDERAL GOVERNMENT TO THE STATES. GOVERNORS CALL UPON THE FEDERAL GOVERNMENT TO WORK IN PARTNERSHIP WITH STATES AND THE PRIVATE SECTOR TO REDUCE THE COSTS OF TREATMENT AND TO MAINTAIN FUNDING THAT ADEQUATELY REFLECTS THE GROWING COST OF DRUG THERAPIES.

ADAP SERVICES CURRENTLY ARE DELIVERED BY STATES IN A NUMBER OF DIFFERENT, COST-EFFECTIVE WAYS, SUCH AS MINNESOTA'S SUCCESSFUL HIGH-RISK

INSURANCE POOL FOR HIV/AIDS PATIENTS. GOVERNORS BELIEVE THAT WHILE MANY OF THESE STRATEGIES ARE COST EFFECTIVE, FURTHER STUDY IS NEEDED TO HELP STATES IDENTIFY AND LEARN FROM THE BEST PRACTICES IN THE FIELD.

GOVERNORS ALSO BELIEVE THAT CDC AND THE HEALTH RESOURCES AND SERVICES ADMINISTRATION SHOULD WORK VERY CLOSELY WITH STATES WHEN DETERMINING WHETHER A GOOD-FAITH EFFORT HAS BEEN MADE TO COMPLY WITH THE NEW MANDATE IN THE RYAN WHITE CARE ACT REQUIRING STATES TO NOTIFY THE SPOUSES OF INDIVIDUALS WITH HIV INFECTION. GOVERNORS FEEL STRONGLY THAT NO STATE SHOULD LOSE ACCESS TO THEIR RYAN WHITE CARE ACT FUNDS AS THIS NEW MANDATE IS IMPLEMENTED.

IN IMPLEMENTING THE RYAN WHITE CARE ACT AND IN CONFRONTING THE HIV/AIDS EPIDEMIC MORE GENERALLY, GOVERNORS BELIEVE THAT THE BEST RESULTS WILL BE ACHIEVED IF THE FEDERAL GOVERNMENT, THE STATES, PRIVATE INSURERS, THE MEDICAL AND PHARMACEUTICAL INDUSTRIES, AND INTERESTED MEMBERS OF OUR COMMUNITIES WORK TOGETHER IN CLOSE PARTNERSHIP.

Time limited (effective WINTER MEETING 1997-MEETING 1999). ~~Winter Meeting 1995-Winter Meeting 1997~~
Adopted Annual Meeting 1987; reaffirmed Winter Meeting 1992; revised Winter Meeting 1995 (formerly Policy C-17).

'97 FEB 2 PM9:30

**PRESIDENT WILLIAM J. CLINTON
NATIONAL GOVERNOR'S ASSOCIATION
ROUNDTABLE MEETING
THE EAST ROOM
FEBRUARY 3, 1997**

Good morning, Governor Miller, Governor Voinovich, and good morning to all the governors. Welcome back to the White House. It was wonderful to see all of you here last night, and I thank you for returning today for this important meeting.

My friends, a new era is upon us -- a time of fleeting opportunity to prepare our nation for the 21st century. To meet the challenges of this new era, we must be partners. And we must act now.

That is why tomorrow night in my State-of-the-Union address, I will do more than call upon Congress to act, as so many Presidents have before me. I will call on all of us -- every level of government, every community, and every American -- to work together to meet our common goals.

Given the new opportunities and the new challenges we face, we must forge a special partnership. This is especially true when it comes to our paramount challenges of educating our people for the new global economy, the Information Age, and lifting all our people from the underclass into our growing middle class. So that we can go forward together, I would like to invite each of you to be there with me at the Capitol tomorrow night, to participate in this call to action.

Today, we're here to talk about the role each of us has to play, and the responsibility each of us has to give our people the tools to make the most of their own lives. I know that many of you have concerns about critical matters that we must resolve, like welfare reform, Medicaid spending, education and the environment. I am committed to addressing your concerns, beginning today at this meeting, but continuing in the months and years ahead.

Working together, we have achieved a great deal in the last 4 years; but we all know that there is much more to be done. And it is not just a job for Washington; it is a job for all of us.

And now, I'd like to start our discussion.

National Governors' Association Winter Meeting

Saturday:

DGA Meeting: Erskine Bowles Tentative
 Frank Raines Tentative

SAT PM
 (BWR/CJ)

Talking Pts.
 - Line up supporters on Educ.

Sunday:

Opening Plenary: Erskine Bowles 10:00am
 NGA Dinner: The President 7:30pm
 All Governors

Monday:

White House Roundtable (1 1/2 hours):
 The President
 Cabinet Members
 Plenary Session: The Vice President (Follows Senator Lott) 2pm
 DGA Reception: The President Brief Remarks
 DGA Dinner: The Vice President

BR
 9:30am - Educ, WR, visit your state

Ice T, EPA, UC, WR
 Educ WR

(→ FMLA
 → Georgia)

→ Hope mtg.

1) Mtg on Feb 5th / Hope
 2) Assign Fran Lewis
 3) Schedule NGA stuff
 4) Call K. Skeltone & D. Pink
 5) S. Waldman
 6) Lynn - reviews

**DEMOCRATIC GOVERNORS' ASSOCIATION****MEMORANDUM**

TO: BRUCE REED

FROM: Katie Whelan
Bob Rogan
Doug Richardson

RE: DGA Meeting

DATE: January 30, 1997

The purpose of this memorandum is to brief you in preparation for your appearance at the Democratic Governors' Association winter political meeting on Saturday, February 1, 1997, in the Skyroom, top floor, Hotel Washington, 515 15th St. N.W., Washington, D.C.

At this meeting, Democratic Governors meet with leaders from the Administration and Capitol Hill for a private and frank discussion of pressing issues, the national political climate and ways in which Governors can help their Democratic allies in Washington.

Vermont Governor Howard Dean, the DGA Chairman, and Puerto Rico Governor Pedro Rossello, the DGA Vice Chair, are looking forward to your appearance and the chance for Governors to get to know you and White House Chief of Staff Erskine Bowles.

This meeting will be attended by 17 Democratic Governors, many of their spouses, key Governors' staff and invited guests.

An agenda and a list of Governors attending are attached. We wanted to call your attention to these highlights:

- 2 p.m. Democratic Governors news conference on health care for children and education, Hotel Washington lobby.
- 2:30 p.m. DGA Political Meeting, Skyroom, Hotel Washington. Closed to Press.

DGA Meeting**Page 2**

- 2:35 p.m. **The View From Capitol Hill: What To Expect From the 105th Congress**
Senate Democratic Leader Tom Daschle
House Democratic Leader Dick Gephardt
Congressman Steny Hoyer
- 3:20 p.m. **The Clinton Administration: Agenda for 105th Congress and President's Second Term**
White House Chief of Staff Erskine Bowles
Office of Management and Budget Director Franklin Raines
Domestic Policy Adviser Bruce Reed
Doug Sosnik, Counselor to the President
- 4:15 p.m. **National Governors' Conference: Winter Meeting Preview**
Governor Bob Miller, Nevada, NGA Chair

During your portion of the program, the Governors would very much like to hear you and the other members of the Administration team outline the President's priorities -- as they will be detailed in the State of the Union on February 4 and in the President's budget proposal on February 6. The Governors want to be helpful in reinforcing the Administration's message for these two events, and will likely press you for details about both the speech and the budget message.

You can also expect the Governors to be very forthright in expressing their opinions and asking for your comments on several issues, including Medicaid, welfare reform bill revisions, health care for children, education, the balanced budget process and the proposed balanced budget amendment.

Governor Dean will introduce the Clinton Administration panel, including you, for a part of the program that is tentatively scheduled to last approximately 45 minutes -- divided among your presentations, discussion and question-and-answer.

Thank you very much for agreeing to join the Governors for this important meeting. They are looking forward to seeing you.



DEMOCRATIC GOVERNORS' ASSOCIATION

DGA WINTER POLITICAL MEETING
Saturday, February 1, 1997
2 p.m. to 5 p.m.
Hotel Washington

Welcome

Governor Howard Dean, Vermont
1997 DGA Chair

The 105th Congress: A Preview

Senate Democratic Leader Tom Daschle
House Democratic Leader Dick Gephardt
Congressman Steny Hoyer

The White House: The Year Ahead

Erskine Bowles, White House Chief of Staff
Franklin Raines, Director, Office of Management and Budget
Bruce Reed, Domestic Policy Advisor
Doug Sosnik, Counselor to the President

NGA: The Year Ahead

Governor Bob Miller, Nevada
NGA Chairman



DEMOCRATIC GOVERNORS' ASSOCIATION

DGA WINTER BUSINESS MEETING

Monday, February 3, 1997

7:30 a.m. to 9 a.m.

J.W. Marriott Hotel

Welcome

**Governor Howard Dean, Vermont
1997 DGA Chair**

DGA Financial Report

Mark Weiner, DGA Treasurer

DGA: 1997-1998 Prospectus

Governor Dean

Governor Pedro Rossello, Puerto Rico

1997 DGA Vice Chair

Democratic National Committee: The New Regime

Governor Roy Romer, DNC General Chairman

Steven Grossman, DNC National Chairman

Doug Sosnik, Counselor to the President

Craig Smith, Co-Executive Director, Presidential Inaugural Committee

NGA Update

Governor Bob Miller, Nevada

NGA Chair

POLITICAL MEETING
SATURDAY, FEBRUARY 1
2:30 - 5:00 PM
Sky Room, Hotel Washington

GOVERNORS ATTENDING:

- TONY KNOWLES AND SUSAN - ALASKA
- ROY ROMER AND BEA - COLORADO
- THOMAS CARPER AND MARTHA - DELAWARE
- LAWTON CHILES AND RHEA - FLORIDA
- ZELL MILLER AND SHIRLEY - GEORGIA
- FRANK O'BANNON AND JUDY(?) - INDIANA
- PAUL PATTON AND JUDI - KENTUCKY
- MEL CARNAHAN AND JEAN - MISSOURI
- BEN NELSON - NEBRASKA
- BOB MILLER - NEVADA
- JEANNE SHAHEEN AND BILL - NEW HAMPSHIRE
- JIM HUNT AND CAROLYN - NORTH CAROLINA
- PEDRO ROSELLO AND MAGA(?) - PUERTO RICO
- HOWARD DEAN - VERMONT
- GARY LOCKE AND MONA LEE - WASHINGTON
- CARL GUTIERREZ - GUAM

**BUSINESS MEETING
MONDAY, FEBRUARY 3
7:30 - 9:00 AM
SALON 1, JW MARRIOTT**

GOVERNORS ATTENDING:

- TONY KNOWLES - ALASKA
- ROY ROMER AND BEA - COLORADO
- THOMAS CARPER - DELAWARE
- LAWTON CHILES - FLORIDA
- ZELL MILLER AND SHIRLEY - GEORGIA
- FRANK O'BANNON AND JUDY - INDIANA
- PAUL PATTON AND JUDI(?) - KENTUCKY
- PARRIS GLENDENING - MARYLAND
- MEL CARNAHAN AND JEAN - MISSOURI
- BEN NELSON - NEBRASKA
- BOB MILLER - NEVADA
- JEANNE SHAHEEN AND BILL - NEW HAMPSHIRE
- JIM HUNT AND CAROLYN - NORTH CAROLINA
- JOHN KITZHABER - OREGON
- PEDRO ROSELLO AND MAGA(?) - PUERTO RICO
- HOWARD DEAN - VERMONT
- GARY LOCKE-WASHINGTON
- CARL GUTIERREZ - GUAM

WORK TOGETHER! - wouldn't be here w/o you

COMMON AGENDA: STATE OF THE STATE

TOP PRIORITIES (along w/BB + CFR) → EDUC + WR

① EDUC

- BC + RILEY → Hunt, Rans, Miller

- HOPE → Georgia on Wed

- Stds, Educ. Tech, Charters, Teachers, & 3

② WR

- Choles, Carper, Carnahan (KC)

- Move Im WTW

- ~~CA~~ Carbide - down 2.25m

- Indiana + OR down 40%

③ HC - the heart (Dear mother)

ONE THING: BENEFITS FOR LEGAL IMMIG.

- We can get GOP on the run - don't let off the hook

- We can win if bipartisan

- Anybody wants cover, PERS going to give them

- CHILES

THE WHITE HOUSE
WASHINGTON

January 29, 1997

MEMORANDUM FOR ERSKINE BOWLES, FRANKLIN RAINES, BRUCE REED

cc: Sylvia Mathews; Vicky Radd; Doug Sosnik; Chris Jennings

FROM: Marcia Hale and John Emerson *je*

SUBJ: DGA Meeting: Saturday, February 1

Attached is a memorandum from DGA staff regarding your appearance before the DGA Winter Meeting on Saturday, in the Skyroom of the Hotel Washington. Your discussion is set to commence at 3:20pm, and will follow presentations by Tom Daschle and Dick Gephardt. The format will be relatively informal, with the three of you seated at a Roosevelt Room sized table along with the attending governors. Approximately 100 other people, including governors' staff and various friends of the DGA, will be seated in folding chairs around the room. Marcia, Doug, John, Emily Bromberg and Chris Jennings will also be there. The session is closed to the press.

Governor Howard Dean, who chairs the DGA, will introduce the three of you and turn the meeting over to Erskine. While the governors would like to hear a preview of the State of the Union and the Budget, this meeting is as much designed for them to develop personal relationships with you and to let you know who they are. Expect a wide open discussion.

We suggest that Erskine open up by telling them a bit about himself, introducing his team at the White House, and reiterating how important the Democratic governors are to the President, both in formulating policy and in advocating his agenda.

Erskine should thank them for all their help during last year's budget battle and campaign, and stress his intention of continuing the valuable working relationship the Democratic governors have had with the White House. He should also mention the significance of Roy Romer's appointment as General Chair of the DNC, and acknowledge the importance of the 1998 election cycle (when three quarters of the nation's governors are up), perhaps stating that it is no coincidence that we now have a governor as DNC chair.

Next, Erskine should briefly outline the highlights of the State of the Union, the Budget, and the President's agenda for 1997. The governors will be particularly interested in how they can help with the roll-out of next week's events, both in the media and on the Hill. [We are currently awaiting guidance from Gene Sperling on roll-out plan.]

Finally, he should turn the discussion over to Frank Raines, for a more detailed presentation on the budget, and then open it up for discussion and advice. [Note: Erskine should preview his comments to the NGA on Sunday.]

During the discussion, expect comments on medicaid, welfare reform, education, the balanced budget amendment, and the budget process. Bruce Reed and Chris Jennings will be there to answer any detailed questions on welfare reform and medicaid. You can also expect a plea for Presidential and Vice-presidential time for DGA fundraisers during 1997.

Governors attending will be:

Tony Knowles	(Alaska)
Tauese Sunia	(American Samoa)
Roy Romer	(Colorado)
Tom Carper	(Delaware)
Lawton Chiles	(Florida)
Zell Miller	(Georgia)
Carl Gutierrez	(Guam)
Frank O'Bannon	(Indiana--elected '96)
Paul Patton	(Kentucky)
Parris Glendening	(Maryland)
Mel Carnahan	(Missouri)
Ben Nelson	(Nebraska)
Bob Miller	(Nevada--NGA Chair)
Jeanne Shaheen	(New Hampshire--elected '96)
Jim Hunt	(North Carolina)
Pedro Rossello	(Puerto Rico--DGA Vice-chair)
Howard Dean	(Vermont--DGA Chair)
Gary Locke	(Washington--elected '96)

Not attending:

Ben Cayetano	(Hawaii)
John Kitzhaber	(Oregon)

DEMOCRATIC GOVERNORS' ASSOCIATION

DGA WINTER POLITICAL MEETING

Saturday, February 1, 1997

2 p.m. to 5 p.m.

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The 105th Congress: A Preview

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