

More Than Half the Nation Enacting Welfare Reform Under the Clinton Administration

The Clinton Administration has approved 50 demonstrations in 35 states, launching welfare reform for thousands of families in more than half of the states, more than the two previous Administrations combined. In an average month, the welfare demonstrations cover over 9.9 million people, representing over 69 percent of all recipients. All of the waivers which have been granted build on many of the central principles of President Clinton's vision for welfare reform, including:

States	Principles				
	<p><i>WORK:</i> States are helping people move from welfare to work, from receiving welfare checks to earning paychecks, by increasing education and training opportunities and creating public/private sector partnerships.</p>	<p><i>Time Limited Cash Assistance:</i> States are making welfare a transitional support system, rather than a way of life, by providing opportunity, but demanding responsibility in return.</p>	<p><i>Child Support Enforcement:</i> States are strengthening child support enforcement and sending a clear message that both parents must be responsible for their children.</p>	<p><i>Making Work Pay:</i> States are providing incentives and encouraging families to work, not stay on welfare, so they can achieve and maintain economic self-sufficiency.</p>	<p><i>Parent Responsibility:</i> States are promoting parental responsibility by encouraging education, or limiting benefits for families who have another child while on AFDC.</p>
Arkansas					
Arizona	✓	✓	✓	✓	✓
California				✓	✓
Colorado		✓		✓	✓
Connecticut	✓	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓
Florida	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	✓
Hawaii	✓	✓	✓	✓	✓
Illinois	✓	✓		✓	✓
Indiana	✓	✓	✓	✓	✓
Iowa		✓		✓	
Maryland	✓	✓	✓	✓	✓
Massachusetts	✓		✓	✓	✓
Michigan	✓	✓	✓	✓	✓
Missouri	✓	✓	✓	✓	✓
Mississippi	✓	✓	✓	✓	✓
Montana	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓
New York			✓	✓	✓
North Dakota	✓	✓	✓	✓	✓
Ohio	✓		✓	✓	✓
Oklahoma	✓	✓	✓	✓	✓
Oregon	✓		✓	✓	
Pennsylvania	✓	✓	✓	✓	✓
South Carolina	✓	✓		✓	✓
South Dakota	✓	✓	✓	✓	✓
Texas					✓
Utah	✓	✓	✓	✓	✓
Vermont	✓	✓	✓	✓	✓
Virginia	✓	✓	✓	✓	✓
Washington		✓		✓	
West Virginia	✓	✓	✓	✓	✓
Wisconsin	✓	✓	✓	✓	✓
Wyoming	✓	✓	✓	✓	✓

MEDICAID WAIVERS APPROVED DURING THE CLINTON ADMINISTRATION
 (January 21, 1993-January 25, 1996)

State	1915 Statewide Health Care Reform	1915(b) Freedom of Choice Waivers*	1915(c) Home and Community-Based Waivers*
Alabama		✓(1)	✓(11)
Alaska			✓(12)
Arizona			
Arkansas		✓(3)	✓(8)
California		✓(15)	✓(7)
Colorado		✓(4)	✓(17)
Connecticut		✓(1)	✓(7)
Delaware	✓		✓(6)
D.C.		✓(2)	
Florida	✓	✓(1)	✓(16)
Georgia		✓(4)	✓(6)
Hawaii	✓		✓(4)
Idaho		✓(1)	✓(4)
Illinois			✓(12)
Indiana		✓(2)	✓(22)
Iowa		✓(4)	✓(20)
Kansas		✓(2)	✓(7)
Kentucky	✓	✓(2)	✓(5)
Louisiana		✓(2)	✓(12)
Maine		✓(2)	✓(12)
Maryland		✓(2)	✓(6)
Massachusetts	✓	✓(3)	✓(3)
Michigan		✓(4)	✓(8)

State	1915 Statewide Health Care Reforms	1915(b) Freedom of Choice Waivers*	1915(c) Home and Community Based Waivers*
Minnesota	✓	✓(1)	✓(17)
Mississippi		✓(3)	✓(5)
Missouri		✓(3)	✓(9)
Montana		✓(2)	✓(4)
Nebraska		✓(2)	✓(9)
Nevada		✓(1)	✓(9)
New Hampshire			✓(7)
New Jersey		✓(1)	✓(13)
New Mexico		✓(2)	✓(4)
New York		✓(6)	✓(13)
North Carolina		✓(3)	✓(13)
North Dakota		✓(3)	✓(3)
Ohio	✓	✓(3)	✓(9)
Oklahoma	✓	✓(1)	✓(9)
Oregon	✓	✓(3)	✓(2)
Pennsylvania		✓(5)	✓(10)
Rhode Island	✓		✓(6)
South Carolina	**	✓(1)	✓(11)
South Dakota		✓(2)	✓(7)
Tennessee	✓		✓(15)
Texas		✓(5)	✓(18)
Utah		✓(3)	✓(7)
Vermont	✓		✓(6)
Virginia		✓(3)	✓(5)
Washington		✓(12)	✓(16)

State	1115 Statewide Health Care Reforms	1915(b) Freedom of Choice Waivers*	1915(c) Home and Community Based Waivers*
West Virginia		✓(3)	✓(3)
Wisconsin		✓(4)	✓(14)
Wyoming		✓(1)	✓(7)
TOTALS	12**	128	456

*The numbers indicated include new waivers, renewals, and modifications.

**Only the framework for South Carolina's plan was approved.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATE WELFARE DEMONSTRATIONS

Under section 1115 of the Social Security Act, HHS is authorized to grant states waivers of current laws governing the AFDC and Medicaid programs. This authority is intended to give states the flexibility to demonstrate alternatives that better match their residents' needs.

The Clinton administration is committed to supporting state flexibility and innovation in welfare programs. Under President Clinton, HHS has given more than two-thirds of the states the opportunity to test new welfare approaches -- granting waivers to more states than all previous administrations combined. In an average month, these welfare demonstrations will cover more than 9.9 million people, representing approximately 69 percent of all AFDC recipients.

Since January 1993, HHS has approved welfare demonstration projects in the following 35 states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

Welfare reform demonstrations granted under President Clinton's leadership have begun the move toward a new welfare system. As President Clinton has said, "We won't have ended welfare as we know it until its central focus is to move people off welfare and into a job so that they can support themselves and their families." National reform, embodying the principles of work and responsibility and building on the successes of state demonstrations, will truly offer hope and opportunity for millions of families and children.

Under demonstrations approved by this administration, states are implementing projects with the following goals:

Requiring Work

Twenty-seven states are helping people move from welfare to work, from receiving welfare checks to earning paychecks, by increasing education and training opportunities and creating public/private sector partnerships.

Some states have expanded the Job Opportunities and Basic Skills Training (JOBS) work and training program by narrowing the criteria for exemptions from JOBS participation or extending job search requirements. In addition, many states have expanded case management services to complement their employment and training initiatives.

Several states also have programs to secure private sector jobs for welfare recipients by providing wage subsidies and forging new private/public sector partnerships. In other states, employers are providing workplace mentoring for participants and contributing to special accounts that recipients can later use to increase their education and training.

Arizona, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming

Time-limiting Assistance

Twenty-two states are making welfare a transitional support system, rather than a way of life, by providing opportunity, but demanding responsibility in return.

As under the administration's Work and Responsibility Act, many of these approaches require recipients to develop personal employability plans and self-sufficiency agreements containing specific goals and deadlines, enforcing the agreements with sanctions that include reduction or denial of benefits. In return, states may offer additional services such as counseling, training, employer subsidies, and extended Medicaid and child care coverage.

Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Vermont, Washington, Wisconsin

Making Work Pay

Thirty-two states are providing incentives to encourage families to move from welfare to work.

Many states have increased current resource limits and earnings disregards under AFDC to encourage individuals to work and save money so that they may achieve and maintain self-sufficiency. In fact, more states have increased the resources and earned income a family can keep than have implemented any other type of reform.

Recognizing the need for transitional support as individuals move from welfare to work, some states are also extending child care and/or Medicaid benefits to families after they leave the welfare rolls.

Other states have initiated programs to prevent individuals from going on welfare in the first place. These states provide, on a voluntary basis, a one-time payment in lieu of AFDC to meet a temporary need of assistance.

Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Improving Child Support Enforcement

Eighteen states are strengthening child support enforcement, sending a clear message that both parents must be responsible for their children.

Under its child support enforcement program, this administration has required all states to establish hospital-based paternity programs and has substantially increased Federal spending on child support enforcement. States are also experimenting with new strategies to ensure that both parents contribute to the economic well-being of their children. For example, several states are experimenting with "pass through" arrangements that allow families to collect a larger percentage of child support payments, thus increasing incentives to obtain and enforce court orders.

Arizona, Connecticut, Delaware, Georgia, Indiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, New York, North Dakota, Ohio, Oregon, Vermont, Virginia, Wisconsin

Encouraging Parental Responsibility

Twenty-eight states are promoting parental responsibility by encouraging education, or by limiting benefits for families who have another child while on AFDC. Some states require minors to live at home or with a responsible adult in order to receive assistance, and many use incentives to encourage teen parents to regularly attend and graduate from high school. Several states also require children to attend school, be immunized, and receive regular health check-ups.

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Wisconsin, Wyoming

Attached is a list and brief description of the state welfare reform demonstration projects granted by the Clinton administration.

ARIZONA:

EMPOWER (Employing and Moving People Off Welfare and Encouraging Responsibility) establishes a time limit on adult AFDC benefits of 24 months in any 60-month period. Additional AFDC benefits will not be provided to families for children conceived while on AFDC or conceived within 12 months after leaving AFDC, if the family later reapplies for benefits.

Families can put aside \$100 a month in Individual Development Accounts, up to \$9000, for training and education. Transitional Child Care and Medicaid will be extended from 12 months as currently allowed to 24 months after leaving AFDC.

An additional three-year pilot project will operate in the Casa Grande, Eloy and Coolidge areas of Pinal County. The pilot will provide work experience by placing participants in subsidized jobs for 9 to 12 months, funded by AFDC grants and cashed-out food stamp allotments; months spent in a subsidized job will not count toward the time limit. All child support collections will be passed through to the family, without affecting eligibility.

Arizona's waiver was received on Aug. 3, 1994 and approved on May 22, 1995.

ARKANSAS:

Under Arkansas' demonstration, AFDC parents age 16 or younger will be required to attend school regularly or face reductions in benefits if they fail to do so. If appropriate, teen-age parents can meet the requirement by attending an alternative educational program.

In addition, Arkansas will implement a policy of not increasing AFDC benefits when additional children are born into a family receiving welfare. Family planning and group counseling services focusing on the responsibilities of parenthood will be included in the demonstration.

Arkansas' application was received on Jan. 14, 1993, and granted on April 5, 1994.

CALIFORNIA:

California's "Work Pays Demonstration Project" demonstration will encourage teen-age AFDC parents to regularly attend school by paying them a \$100 cash bonus for maintaining a C average, and \$500 for ultimately graduating from high school. Teen-age parents who fail to maintain a D average can have their AFDC payments reduced by up to \$50 a month for two months.

The demonstration will also permit AFDC families to accumulate \$2,000 in assets and have \$4,500 equity in a car. In addition, families will be able to deposit \$5,000 into savings so long as the funds are used to purchase a home, start a business or finance a child's post-secondary education or training.

Finally, the demonstration will allow recipients who work -- but who have low AFDC benefits -- to opt out of the program. They will remain eligible for health care under Medi-Cal as well as other services, such as child care, which are available to AFDC recipients.

California's waiver request was received on Sept. 29, 1993, and granted March 1, 1994.

A second waiver, "AFDC and Food Stamp Compatibility Demonstration Project," makes rules for welfare and food stamp eligibility more compatible. Both AFDC and food stamp recipients with self-employment income can deduct 40 percent of that income when determining eligibility and benefit amounts. Participants in both programs will also be able to exclude college assistance and work-study funds from the resource limit, and up to \$100 in gift income each quarter.

AFDC participants are able to deduct \$4,500 from the equity value of a vehicle when figuring resources, and California counties now have more flexibility in determining the method of setting the equity value.

California's second waiver request was received on Dec. 28, 1994, and approved on April 11, 1995.

A third waiver, "California's Incentives to Self-Sufficiency Project," an amendment to "Work Pays Demonstration Project," provides transitional child care benefits to families that become ineligible for further AFDC benefits because of marriage. It also allows greater penalties for specific types of fraud and increases work Community Work Experience Program activities.

California's third waiver request was received on Dec. 28, 1994, and approved on Sept. 11, 1995.

A fourth waiver, "School Attendance Demonstration Project," requires the dependent teen-age children of AFDC recipients in San Diego County to attend school or participate in job search and training.

California's fourth waiver request was received on Dec. 5, 1994, and approved on Dec. 6, 1995.

COLORADO:

Colorado is initiating a "Personal Responsibility and Employment Program" which includes a number of major revisions to the state's AFDC program. The demonstration will operate in five counties. Under the demonstration, parents who are able to work or able to participate in a training program must do so after receiving AFDC benefits for two years. Individuals who refuse to perform the assignments can face a loss of AFDC benefits.

Additionally, the demonstration will "cash out" Food Stamps for participants, meaning that the value of the coupons will be added to the monthly AFDC payment. Participants will be encouraged to work through a new formula which will enable families to keep more of the money they earn. Asset levels and rules pertaining to ownership of an automobile will also be changed so that participants will be permitted to own a car regardless of its value or their equity in it.

Finally, the demonstration provides for payment of financial bonuses when participants stay in school and graduate from a secondary (high school) or GED program, and permits financial penalties to be assessed when parents fail to have their children immunized.

Colorado's waiver request was received on June 30, 1993, and granted on Jan. 13, 1994.

CONNECTICUT:

Connecticut's "A Fair Chance" initiative is designed to increase supports, incentives, and work expectations for AFDC recipients. It has two components, Pathways and Family Strength.

Pathways requires AFDC recipients to work a minimum of 15 hours a week after two years of AFDC, 25 hours a week after three years, and 35 hours a week after four years. Pathways will also help families leaving welfare increase their incomes by paying the difference between the non-custodial parent's child support payments and a state-established minimum. Family Strength provisions raise the resource limit for AFDC eligibility from \$1000 to \$3000 and extend transitional child care and medical benefits, an additional year, to a total of two years.

Family Strength will be implemented statewide and Pathways will be implemented in the New Haven and Manchester areas.

Connecticut's application was received on Dec. 30, 1993, and approved on Aug. 29, 1994.

Connecticut's second project, "Reach for Jobs First," limits Aid to Families with Dependent Children (AFDC) payments to 21 months for employable adults, with extensions for good-faith efforts. Recipients must spend at least 12 weeks in jobs search and can keep all that they earn while on AFDC, up to the Federal poverty line for the family's size. Those subject to the time limit are given priority for participation in JOBS, and non-custodial parents may also participate.

Minor parents are required to live in an adult-supervised setting, with the AFDC benefit issued to the adult. The amount of additional AFDC benefits for additional children born to families is reduced by half. Transitional child care and Medicaid are available to those who become employed within six months of losing AFDC eligibility for any reason. Medicaid coverage is provided for 24 months and child care for as long as the family's income is less than 75 percent of the State's median income. There are progressive sanctions for failure, without good cause, to comply with JOBS or child support requirements, including elimination of benefits to the full family for a third offense. The state is also making administrative changes to simplify eligibility procedures.

Connecticut's second waiver was received Aug. 10, 1995 and approved Dec. 18, 1995.

DELAWARE:

Under Delaware's "A Better Chance" demonstration, all AFDC participants will be required to sign and comply with a Contract of Mutual Responsibility. The contract will specify employment-related activities as well as other activities leading to self-sufficiency.

The demonstration sets a time limit of 24 months on cash benefits for able-bodied adults over 19 years old. It also requires teen parents to live in an adult supervised setting, attend school, participate in parenting and family planning education, and immunize their children. Incentives include a \$50 bonus paid to teens who graduate from high school and the receipt of an additional 12 months of transitional child care and Medicaid benefits to help parents move to work.

Gradual sanctions can lead to the family losing benefits if participants fail to meet education and employment requirements.

Parents will not receive an increase in AFDC payments for additional children conceived while the family is on assistance. In addition, participants who do not cooperate with child support enforcement will be denied benefits.

"A Better Chance" will operate for seven years. Delaware's application was received on Jan. 30, 1995 and approved on May 8, 1995.

FLORIDA:

Florida is implementing a "Family Transition Program" for AFDC recipients in two counties. Under the plan, most AFDC families will be limited to collecting benefits for a maximum of 24 months in any five-year period.

Individuals who exhaust their transitional AFDC benefits but are unable to find employment will be guaranteed the opportunity to work at a job paying more than their AFDC grant. The demonstration also provides a longer period of eligibility -- 36 months in any six-year period -- for families at a high-risk of becoming welfare dependent.

Medicaid and child care benefits will be available in the demonstration. Local community boards will play a large role in overseeing the program.

Other elements of the demonstration include an increase in the earnings disregard formula and asset ceilings, as well as a statewide requirement that AFDC parents must ensure that their children have been immunized.

Florida's waiver request was received on Sept. 21, 1993, and granted on Jan. 27, 1994.

Florida's first demonstration implemented a "Family Transition Program" for AFDC recipients in Escambia and Alachua Counties. The "Family Transition Program Expansion," which extends the project to six additional counties, was the first to be reviewed under a "fast track" 30-day period. Counties eligible for participation are Lee, Duval, Pinellas, St. Lucie, Orange, and Volusia Counties. It will operate for eight years.

Florida's second waiver request was received on August 2, 1995, and granted on September 6, 1995.

GEORGIA:

Georgia is initiating the "Personal Accountability and Responsibility Project" (PAR) which strengthens federal work requirements that must be met in order to receive cash benefits. Georgia's welfare agency will now be able to exclude from an AFDC grant any able-bodied recipient between the age of 18 to 60 who has no children under the age of 14 and who willfully refuses to work or who leaves employment without good cause. The rest of the family will continue to be eligible for AFDC benefits.

The plan will also allow the state to deny additional cash benefits for additional children born after a family has been on welfare for at least two years if the child was conceived while the family was on welfare. However, PAR would allow recipients to "learn back" the denied benefits through the receipt of child support payments or earnings.

Georgia's second project has two components. Under Work for Welfare, in effect in ten counties, adults who have received AFDC payments for 24 of the previous 36 months are required to work up to 20 hours per month at an assigned job in local, state or Federal government, or at a non-profit agency. If work is not available, time may be spent in job search. Courts may order non-custodial parents who are delinquent in child support payments to also take part.

Failure to participate can result in the loss of the individual's benefits for one month the first time, 3 months the second, and 2 years the third. Benefits to children are not affected, and participation is not required if transportation is not available. The ten counties are Bibb, Cook, Crisp, Dooly, Irwin, Jenkins, Lowndes, Walker, Wayne, and White.

A second component, implemented statewide, allows a family to have a vehicle of any value if it is used to commute to work or school. It also disregards the earnings of children attending school full-time, through age 18.

Georgia's second project request was received on July 6, 1994 and approved on October 6, 1995.

Medicaid and Food Stamps eligibility will continue for all family members. In addition, Georgia will offer family planning services and instruction in parental skills to AFDC recipients. Georgia's waiver request was received on May 18, 1993, and granted on Nov. 2, 1993.

HAWAII:

Under Hawaii's "Creating Work Opportunities for JOBS Families" (CWOJF) programs, job-ready JOBS recipients who would otherwise expect to wait at least three months to be placed in a regular education or training activity are required to pursue job leads developed by JOBS program specialist. The positions are part-time (up to 18 hours per week), private sector jobs at minimum wage, and will allow participants to gain work experience, develop their skills, and better target training needs. The demonstration will operate for five years.

Hawaii's application was received on Nov. 3, 1993, and granted on June 24, 1994.

ILLINOIS:

The Work Pays component, added to the previously approved Project Fresh Start, encourages employment and thereby self-sufficiency by enabling recipients to keep more of their earnings than is normally allowed. The State will disregard two of each three dollars earned for as long as they continue working.

Illinois waiver request was received Aug. 2, 1993, and granted on Nov. 23, 1993.

A second Illinois project, Work and Responsibility, will operate statewide and include a 2-year time limit on AFDC when the youngest child in the family is 13 or older, with good cause extensions. Any month in which the family has earned income will not count toward the time limit. Those who fail to find employment within the first year must accept up to 60 hours per month of work subsidized by the AFDC grant. Families that reach the time limit and do not qualify for extensions will be ineligible to reapply for further assistance for two years. New applicants with children 5-12 years of age must participate in job search and employment and will be assigned to community service if they have not found a job by the end of six months.

Under this second project, all recipients must develop a Self Sufficiency Plan for moving from welfare to independence as a condition of eligibility. There will be no increased benefits for the birth of children conceived while receiving AFDC.

A third project, School Attendance, operates in areas that have contracted with social service providers to provide assistance to families with truant children. Recipients must cooperate with efforts to improve school attendance or face fiscal sanctions.

The second and third waiver requests were received July 18, 1995 and approved October 2, 1995.

INDIANA:

Under the Indiana Manpower Placement and Comprehensive Training Program (IMPACT), at any point in time, up to 12,000 job-ready individuals will be assigned to a "Placement Track" and receive help in job search and placement. Once on this track, AFDC benefits will be limited to 24 consecutive months. The time limit applies to adult benefits only; children's benefits will not be affected. Case management and supportive services will continue for a period after AFDC benefits end.

For all recipients who become employed, earnings will be disregarded in determining Food Stamp benefits for the first six months. There will be increased sanctions for quitting a job or for failure to comply with program requirements. There will also be fewer exemptions from current JOBS participation requirements. Another provision will extend subsidies to employers who hire welfare recipients for a maximum of 24 months.

A family benefit cap provision will disallow additional AFDC benefits for children conceived while on AFDC although the child will be eligible for Medicaid. Children will be required to attend school and be immunized. IMPACT will operate for seven years.

Indiana's request was received June 21, 1994, and granted Dec. 15, 1994.

IOWA:

Iowa is implementing a reform plan that will encourage AFDC and Food Stamp recipients to take jobs and accumulate assets through a program of "Individual Development Accounts." Funds deposited in an account can only be withdrawn to pay for education, training, home ownership, business start-up or family emergencies. The current law which limits each family's assets to \$1,000 will be changed to allow each applicant to have up to \$2,000 in assets and each AFDC family to possess up to \$5,000 in assets. Additionally, the vehicle asset ceiling will rise from \$1,500 to \$3,000.

Recipients will also be encouraged to work under a new formula which disregards 50 percent of their earnings in the calculation of benefits. For recipients lacking in significant work histories, all income will be disregarded during the first four months on AFDC. A Family Investment Program will be created for most AFDC parents, requiring them to participate in training and support services as a condition of AFDC receipt. Only parents with a child under 6 months old at home, those working at least 30 hours per week, and the disabled are exempt. Individuals who choose not to participate in the Family Investment Agreement will have their AFDC benefits phased out over six months and will not be able to reapply for another six months.

Iowa's request was received April 29, 1993, and granted Aug. 13, 1993.

MARYLAND:

Maryland's "Family Investment Program" (FIP), under a pilot demonstration in Anne Arundel and Prince George's counties and parts of Baltimore, requires able-bodied AFDC applicants to participate in job search as a condition of eligibility. After six months of non-compliance, the case will be closed, resulting in denial of AFDC benefits for the entire family. Closed cases can be reopened only if applicant complies with JOBS for 30 days. Closed cases may receive up to three months of non-cash transitional assistance through a third party, such as a non-profit organization.

Also under the pilot, the income of dependent children will not be counted in determining AFDC eligibility, and the resource and vehicle value limits will be raised to \$5,000. The principal wage earner in two-parent families can work more than 100 hours a

month, and individuals sanctioned by Child Support Enforcement will be required to participate in JOBS. Families facing a short-term financial crisis can receive a one-time payment equal to three months of benefits rather than applying for AFDC.

Statewide, FIP eliminates automatic benefit increases for additional children conceived while receiving AFDC. The family can retain child support payments for the additional child, however, and the State will issue voucher payments for the purchase of goods for the child, up to the amount of increase the family would otherwise receive. Unmarried minor parents must reside with a parent or guardian and must attend family health and parenting classes.

Maryland's application was received March 1, 1994, amended in May, 1995, and approved August 14, 1995.

MASSACHUSETTS:

"Welfare Reform '95" provides jobs for recipients who cannot find work by combining AFDC and cashed-out Food Stamp benefits to be used for up to 12 months to subsidize private sector jobs. Employers will contribute to Individual Asset Accounts that will help recipients transition to non-subsidized employment. Earned income disregards and resource limitations will be increased, and transitional Medicaid benefits will be extended.

Teen parents without high school diplomas must attend school, and must generally live with their parents. There are sanctions for parents who do not ensure that their children attend school or receive appropriate immunizations. There are no increases in AFDC benefits for additional children. There are stricter requirements for paternity establishment and child support, and sanctions for non-compliance.

Massachusetts' request was received April 3, 1995 and approved August 4, 1995.

MICHIGAN:

This expansion of Michigan's "To Strengthen Michigan Families" welfare demonstration requires AFDC recipients to participate in either the Job Opportunities and Basic Skills Training Program (JOBS) or Michigan's "Social Contract" activities that encourage work and self-sufficiency. Michigan is also testing the requirement that AFDC applicants participate in job search, by actively seeking employment while eligibility for AFDC is being determined.

The demonstration also requires that pre-school-age children be immunized and disregards the value of one vehicle in determining eligibility. Additionally, in two counties, Michigan will evaluate mediation services to determine if this increases compliance with child support. The demonstration will extend previously approved waivers until October 1999.

Michigan's request was received March 8, 1994, and granted Oct. 5, 1994.

MISSISSIPPI:

Mississippi's reform plan promotes health and education for children receiving welfare assistance and supports work efforts by their parents. The demonstration includes a wide component and two projects, "Work First" in six counties, and "Work Encouragement" in two counties.

The wide component requires all children aged six through 17 to attend school and all children under age six to be immunized and receive regular health checkups. It also extends AFDC eligibility for two-parent families by allowing mothers or fathers to work more than 100 hours a month.

The "Work First" component provides subsidized, private-sector employment for job-ready participants. A special fund created from participants' AFDC and food stamp benefits will reimburse employers' wages. The State will provide supplemental payments to recipients when their total income is less than the combined AFDC and Food Stamp benefits they would otherwise receive. In addition, each "Work First" participant will have an "individual development account" for family savings, to which employers will contribute one dollar per hour of work. The State will also pass on to the family all the child support payments it collects on its behalf.

The "Work Encouragement" component allows recipients to keep more of their earnings and still receive AFDC, by raising the earned income limit from 60 to 100 percent of state-established need levels. Time limits on income disregards will also be waived.

The "Work First" component will be implemented in Adams, Harrison, Jones, Lee, Hinds and Washington Counties. The "Work Encouragement" component will be implemented in Leflore and Oktibbeha counties. Under both the "Work First" and "Work Encouragement" components, courts may require unemployed, non-custodial fathers to participate in the JOBS program to meet child support obligations.

The demonstration will be in effect for five years. The request was received Dec. 10, 1993, and granted Dec. 22, 1994.

Mississippi's second demonstration, New Direction Demonstration Project, denies additional AFDC benefits to children conceived while the family is receiving welfare. The child will be eligible for Medicaid and any income the family receives on behalf of the child will not be counted in determining the family's eligibility for AFDC. The benefit cap does not apply to first-born children or to children conceived as a result of rape, sexual assault, or incest.

This second project provides incentives for school attendance and immunization and makes more two-parent families eligible for benefits. In six counties, AFDC and food stamp benefits can be used to supplement wages in private sector jobs, and in two other counties, higher income ceilings allow recipients to earn more before they lose their AFDC eligibility.

The application for Mississippi's first demonstration, in effect for five years, was received Dec. 10, 1993, and granted Dec. 22, 1994. The application for Mississippi's second project, which will operate until the year 2000, was received Feb. 17, 1995, and approved on Sept. 1, 1995.

MISSOURI:

"Missouri Families - Mutual Responsibility Plan" requires AFDC recipients to sign and fulfill a self-sufficiency agreement that establishes a plan for work and places a two-year time limit on benefits. An additional two years may be allowed, if necessary, to achieve self-sufficiency.

Individuals who are not self-sufficient by the end of the time limit must participate in job search or work experience programs. Those who have received AFDC benefits for 36 months or more and have completed their agreement by leaving AFDC will not be eligible for further benefits, with certain good cause exceptions. Children's benefits will not be affected.

Minor parents must live with their parents or guardians to receive benefits. If they attend school full-time and work, they may keep all employment income. In some counties, non-custodial parents who volunteer for the state's JOBS program can receive credit against past-due child support.

For two-parent families with at least one parent under 21, the limit will be waived on the number of hours the principal wage earner can work. The resource limits will be increased for all families, and they may own one automobile, without regard to its value.

Missouri's application was received in two parts, on Aug. 15, 1994, and Jan. 30, 1995, and was approved on April 18, 1995.

MONTANA:

Montana's "Families Achieving Independence" has three components: the Job Supplement program, AFDC Pathways program, and Community Services program.

The Job Supplement program helps at-risk families avoid becoming welfare dependent by providing a one-time payment of as much as three times the monthly AFDC payment the family would otherwise be eligible to receive. Child support collections will also be passed directly on to the custodial parent.

Other AFDC applicants must enroll in the AFDC Pathways component and sign a Family Investment Agreement that limits benefits to 24 months for one-parent families and 18 months for two-parent families, with some exceptions. Income disregards and asset limits will be raised, and recipients must participate in JOBS, comply with child support enforcement provisions, and obtain medical screenings and immunizations for their children. Adults who do not leave AFDC by the end of the time limit must enroll in the Community Services program and perform 20 hours of community work per week. Children's AFDC benefits will not be time-limited, and they will continue to be eligible for Medicaid and food stamps.

All participants must also choose between a reduced Medicaid benefit package and a partial premium payment towards a private health insurance policy. Full Medicaid coverage will be provided on an emergency basis if certain services are needed for employment purposes.

Montana's application was received April 19, 1994 and approved on April 18, 1995.

NEBRASKA:

Under Nebraska's demonstration project, most welfare recipients will be given a choice between two time-limited welfare plans. One program will offer slightly lower benefits, but will enable recipients to retain more benefits when they begin to earn income from work. An alternative benefit program will offer slightly higher benefits, but the level of benefits will decrease more quickly when recipients begin to earn employment income. A non-time-limited program will remain in place, but could only be chosen by recipients exempted by the state from enrolling in one of the time-limited programs.

Under all three programs, a recipient must develop a self-sufficiency contract with a caseworker. There will be no additional benefits for children conceived while the mother is receiving AFDC; resource limits will be raised to \$5,000; benefits will be reduced by \$50 for each minor child who fails to attend school; and minor parents who live at home will be expected to receive support from their parent(s) if the parent's income exceeds 300 percent of the federal poverty rate. In addition, under the two time-limited programs, cash assistance will be provided for a total of 24 months in a 48-month period; food stamps will be cashed out; AFDC payments will be slightly reduced; and all adult wage earners must work or participate in job search, education, or training. Two years of transitional Medicaid and child care will be available for recipients who leave welfare for work. The project will be implemented in two counties on July 1, 1995, and will be expanded statewide the following year. It will operate for seven years.

Nebraska's waiver request was received on Oct. 4, 1994, and granted on Feb. 27, 1995.

NEW YORK:

New York's "A Jobs First Strategy" gives applicants alternatives to welfare, provides new incentives for recipients to find work and create businesses, and encourages the formation and preservation of two-parent families.

The demonstration allows applicants otherwise eligible for Aid to Families with Dependent Children the option to receive child care or JOBS Training program services in place of AFDC. The program will also provide one-time cash assistance or other services necessary to remedy a temporary emergency which has resulted, or may result, in job loss or impoverishment.

The demonstration allows children in AFDC families to receive AFDC for up to two years after a caretaker parent marries and the new spouse's income makes the family ineligible, so long as the household's income does not exceed 150 percent of the federal poverty guidelines. It extends to a full year transitional child care benefits for employed recipients who leave the rolls because of child support payments. In addition, clients are encouraged to develop their own business enterprises by excluding certain business income and resources, including vehicles.

The demonstration will be implemented in six sites in four counties (Broome, Onondaga, Erie and up to three sites in Brooklyn), and will operate for five years.

The request was received June 7, 1994, and granted Oct. 19, 1994.

NORTH DAKOTA:

North Dakota's demonstration will provide federal AFDC matching funds to the state for low-income women during the initial six months of pregnancy with their first child. Such payments are usually not available until the last trimester of the pregnancy.

In addition, the demonstration links AFDC to a requirement that individuals enroll in the state's welfare-to-work program and pursue education or training activities both during the first six months of pregnancy and after their child is 3 months of age.

North Dakota's waiver application was received on Aug. 19, 1993, and granted on April 11, 1994.

A second project, "Training, Education, Employment and Management" (TEEM), operates in 10 North Dakota counties. TEEM combines Aid to Families with Dependent Children (AFDC), Food Stamps and the Low Income Home Energy Assistance Program (LIHEAP) into a single cash benefit and establishes simpler and more uniform eligibility rules. It requires recipients to develop a personal responsibility contract with a time limit for attaining self-sufficiency. Failure to comply with the contract brings progressive sanctions, up to and including loss of AFDC benefits for the entire family.

Under TEEM, families may earn more money and accumulate more assets before losing benefits. They may also own one vehicle, regardless of value, to get to and from work. Health screenings and appropriate immunizations are required for all children. To encourage family formation, income of a stepparent is not counted for the first six months. The 10 counties where the project operates are Adams, Cass, Ransom, Richland, Sargent, Stark, Steele, Stutsman, Traill, and Williams.

The waiver request was received September 13, 1994, and approved September 28, 1995.

OHIO:

The Ohio demonstration has three components: Families of Opportunity, Children of Opportunity, and Communities of Opportunity.

Communities of Opportunity will operate in up to five sites, primarily in Empowerment Zone/Enterprise Community areas. In these sites, the state will work with local business, industry and community leaders to generate up to 2500 wage-supplemented jobs during the five-year life of the demonstration. These jobs are expected to pay at least \$8 per hour and provide the economic stability for a family to leave welfare permanently. Wages will be supplemented with Food Stamp allotments and AFDC grants.

Families of Opportunity expands eligibility for two-parent families, extends transitional child care for up to 18 months, and increases the amount of earnings a family can retain before losing AFDC eligibility. It will operate in ten counties.

Children of Opportunity will operate in two counties and will focus on education. Under this component, dependent children between 6 and 18 will be required to attend school regularly.

Case management services will be available for families with attendance problems, and there will be financial penalties for failure to comply.

Ohio's first request was received on May 28, 1994 and granted on March 7, 1995. The project will operate for five years.

The "Learning, Earning, and Parenting" (LEAP) Program, Ohio's second demonstration, to be in operation for six and a half years, builds on the accomplishments of the original waiver by adding a statewide emphasis on work. The State requires AFDC recipients, who are either pregnant or parents under the age of 20, to attend school or a program leading to a high school diploma or equivalent. The modification also allows LEAP participants to meet this requirement through approved training or work activities, if educational activities are not appropriate. Bonuses, originally included in LEAP, now include a one-time \$62 grade-completion bonus for each subsequent grade (except grade 12) completed in high school or alternative school. A one-time \$200 bonus will be granted to those who graduate from

high school or obtain a GED. Fiscal sanctions will be imposed for non-compliance.

Ohio's second request was received on June 19, 1994, and granted on September 6, 1995.

OKLAHOMA:

Oklahoma's demonstration seeks to encourage welfare recipients to regularly attend school and ultimately graduate from a high school or equivalent educational program.

The demonstration provides that AFDC recipients between the ages of 13 and 18 need to remain in school or face a reduction in benefits if they drop out. The plan applies to teen-age parents as well as children.

Oklahoma's request was received Dec. 28, 1992, and granted Jan. 25, 1994.

In addition, under Oklahoma's "Mutual Agreement--A Plan for Success" (MAAPS) work incentives are increased by allowing recipients to keep some of their earnings without losing AFDC benefits. MAAPS also waives the requirement that the principal wage earner in a two-parent family work fewer than 100 hours per month to qualify for AFDC, and it raises the allowance for an automobile, from \$1500 to \$5000.

After receiving AFDC benefits for three years in any five-year period, recipients still unable to find a job are required to work at least 24 hours a week in a subsidized job. MAAPS also provides intensive case management for three targeted groups: teen parents, long-term recipients and those with a continuing cycle of dependence on welfare. An agreement between the recipient and the state assesses abilities and outline rights, responsibilities and consequences.

MAAPS operates in six counties: Creek, Grady, Jackson, McCurtain, Okmulgee and Seminole. It will operate for five years and include a rigorous evaluation.

For this waiver, Oklahoma's application was received on Feb. 24, 1994, and granted March 13, 1995.

OREGON:

Oregon's JOBS Plus demonstration provides individuals with short-term (up to nine months) subsidized public or private employment at minimum wage or better. The state will provide supplemental payments if an individual's income is less than the combined Aid to Families with Dependent Children and Food Stamp benefits.

Participants will continue to be eligible for Medicaid and will receive workplace mentoring and support services. The state also will pass on to the family all the child support payments it

collects on the family's behalf.

Each JOBS Plus participant will also have an Individual Education Account (IEA), to which employers will contribute one dollar per hour of work. After a participant begins working in a non-subsidized position, the state will transfer the IEA to the State Scholarship Commission. The commission will then make funds available to the participant or the immediate family for continuing education and training at any state community college or institution of higher learning.

Oregon's request was received on Oct. 28, 1993, and granted Sept. 19, 1994.

PENNSYLVANIA:

Pennsylvania's "Pathways to Independence" project provides incentives and support for single and two-parent families moving from welfare to self-sufficiency. It increases earned income disregards so that recipients can keep more of what they earn before they become eligible for public assistance. Additionally, it raises AFDC resource limits, including the value of a family's vehicle, and increases the time that a family is eligible for transitional child care and Medicaid after the family leaves welfare due to earnings. It will operate in Lancaster County. To further aid the transition to work, Pathways extends case management counseling and referral services to up to one year after the family leaves welfare. Families will be able to deposit money into retirement savings and education accounts without penalty. Furthermore, after two months of employment, recipient families can also choose to receive cash payment of their monthly Food Stamp benefit. The demonstration will operate for five years.

The request was received on Feb. 18, 1994, and granted Nov. 3, 1994.

SOUTH CAROLINA:

South Carolina's Self-Sufficiency and Personal Responsibility Program sets work requirements and provides transitional assistance for program participants. After completing Individual Self-Sufficiency Plans (ISSP's) to help prepare them to become self-sufficient, AFDC recipients have 30 days to find a job in a designated vocational area. If they fail to secure such employment, recipients receive an additional 30 days on AFDC to find any private sector job, after which time they must participate in a community work experience program in order to continue to receive AFDC benefits. Progressive sanctions for non-compliance, up to and including removal of the entire family from assistance, are components of this program.

To aid in the transition to work, recipients who would otherwise no longer be eligible for AFDC because of employment can receive reduced benefits for up to 12 months. Families remain eligible

for Medicaid and child care during this phase-down period, and regular transitional Medicaid and child care benefits begin at the end of this period.

The program also raises resource limits to \$3,000 and exempts the cash value of life insurance policies, one vehicle and interest and dividend payments. Children of recipients are required to attend school regularly and obtain appropriate immunizations.

The demonstration will operate in Berkeley, Dorchester, Charleston, and Barnwell Counties for a period of five years.

South Carolina's request was received on June 13, 1994, and granted on Jan. 9, 1995.

SOUTH DAKOTA:

South Dakota is initiating its "Strengthening of South Dakota Families Initiative" that encourages welfare recipients to undertake either employment or education activities. The program assigns AFDC participants to either an employment or education track that enables them to move from dependency to self-sufficiency. Individuals enrolled in the employment track will receive up to 24 months of AFDC benefits; those participating in the education track will receive up to 60 months of AFDC benefits.

Upon completion of either track, participants will be expected to find employment, or failing that, will be enrolled in approved community service activities. Individuals who refuse to perform the required community service without good cause will have their benefits reduced until they comply. In addition, in conformance with the food stamp program, AFDC benefits can be denied to any family in which an adult parent quits a job without good cause. The sanction period will last three months, or until the parent acquires a comparable job.

The demonstration also enacts new rules pertaining to the employment and earnings of children receiving AFDC. Under current law, income earned by children can reduce the family's overall AFDC payment. The South Dakota demonstration will disregard such earnings for children who are attending school at least part-time. Children will be permitted to have a savings account of up to \$1,000.

South Dakota's request was received Aug. 6, 1993, and granted March 14, 1994.

TEXAS:

"Promoting Child Health in Texas" requires the parents or guardians of children receiving Aid to Families with Dependent Children to show proof of age-appropriate immunizations, or face benefit reductions.

The state is also expanding opportunities for children to receive vaccinations in Department of Human Services' offices.

Texas' waiver was received on April 11, 1995, and approved on July 31, 1995.

UTAH:

Utah is extending its "Single Parent Employment Demonstration" project (SPED), which mandates greater participation in work preparation program, allows recipients to retain higher monthly earnings without affecting their welfare cash benefits, and allows a one-time payment for basic or special needs to prevent people from needing to rely on welfare.

Another provision allows a family's AFDC cash benefits to be terminated if, after repeated efforts to encourage compliance and gradual sanctions, parents fail to comply with education, training and work preparation requirements. It also extends transitional services and some Food Stamp benefits from one to two years after leaving AFDC for work.

Utah's waiver request was received on May 17, 1995, and approved on July 31, 1995.

VERMONT:

Vermont's "Family Independence Project" (FIP) promotes work by enabling AFDC recipients to retain more income and accumulate more assets than is normally allowed. FIP also requires AFDC recipients to participate in community or public service jobs after they have received AFDC for 30 months for most AFDC families, 15 months for families participating in the unemployed parent component of AFDC. Current child support payments will now go directly to families entitled to them.

Vermont's request was received Oct. 27, 1992, and granted April 12, 1993.

VIRGINIA:

Virginia's first demonstration, the "Welfare Reform Project," encourages employment by identifying employers who commit to hire AFDC recipients for jobs that pay between \$15,000 and \$18,000 a year and by providing additional months of transitional child care and health care benefits. A second statewide project will: enable AFDC families to save for education or home purchases by allowing the accumulation of up to \$5,000 for such purposes; encourage family formation by changing the way a stepparent's income is counted; and allow fulltime high school students to continue to receive AFDC benefits until age 21. Further, in up to four counties, AFDC recipients who successfully leave welfare for work may be eligible to receive transitional benefits for child and health care for an additional 24 months, for a total of

36 months. In one location, Virginia will offer a guaranteed child support "insurance" payment to AFDC families who leave welfare because of employment to assist the family in maintaining economic self-sufficiency.

Virginia's request was received July 13, 1993, and granted Nov. 23, 1993.

To keep families in crisis from going on welfare, the "Virginia Independence Program" (VIP), the state's second demonstration, will offer AFDC-eligible applicants up to 120 days worth of benefits in one payment with the stipulation that they cannot receive any more AFDC benefits for at least 160 days. The state also will require unmarried minor parents to live with a parent or responsible adult, will deny additional benefits to children born to a family on AFDC, and will impose financial sanctions on families whose children do not receive preschool immunizations or comply with school attendance standards. If a caretaker relative does not assist in establishing paternity for a child born out-of-wedlock, the family's entire AFDC benefit can be terminated until the relative cooperates with the state.

VIP also contains two components: "Virginia Initiative for Employment Not Welfare" (VIEW) and "Full Employment Program" (FEP). The VIEW program, to be phased in over four years, applies only to cases with non-exempt adult recipients. Such recipients must sign an Agreement of Personal Responsibility or risk the termination of AFDC cash benefits. Cash benefits will be limited to 24 cumulative months for cases headed by employable caretakers. During this period, adults must participate in training of employment-related activities. Earned income will be disregarded if earnings plus the AFDC allotment do not exceed the Federal Poverty Guidelines.

VIEW participants who cannot find unsubsidized employment can take part in FEP, which allows the state to fund private sector subsidized employment by combining AFDC benefits with cashed-out food stamp benefits.

The request for Virginia's second demonstration, which will operate for eight years, was received Dec. 2, 1994, amended March 28, 1995, and approved July 1, 1995.

WASHINGTON:

Washington's "Success Through Employment Program" (STEP), sets time limits on Aid to Families with Dependent Children (AFDC) by progressively reducing benefits after a family has received assistance for four years in a five year period. After four years, the grant will be reduced by 10 percent, and by another 10 percent for each additional year thereafter.

To encourage two-parent families to obtain employment, STEP will waive the requirement that the principal wage earner in a two-parent family work fewer than 100 hours per month for the family to qualify for AFDC.

Washington's waiver request was received February 1, 1995, and approved September 29, 1995.

WEST VIRGINIA:

West Virginia's "Joint Opportunities for Independence" (JOIN) program helps adults in two-parent families gain work experience with private employers and provides a travel expense stipend and an income disregard. Employers who provide work experience positions to JOIN participants would pay individuals \$1.00 per hour for work and travel expenses.

The state will provide child care when both parents participate in program activities. Fiscal sanctions will be imposed on families who fail to participate in JOIN.

West Virginia's application was received on April 11, 1995, and approved on July 31, 1995.

WISCONSIN:

Wisconsin's reform plan, "Work Not Welfare," will require that most AFDC recipients either work or look for jobs. The plan provides case management, employment activities and work experience to facilitate employment. Receipt of AFDC benefits will be limited to 24 months in a four-year period, except under certain conditions, such as an inability to find employment in the local area due to a lack of appropriate jobs. Upon exhaustion of benefits, recipients become ineligible for 36 months.

With exceptions, children born while a mother receives AFDC will not be counted in determining a family's AFDC grant. In addition, child support will now be paid directly to the AFDC custodial parent in cases where the funds are collected by the state.

Wisconsin's request was received July 14, 1993, and granted Nov. 1, 1993.

In addition, under Wisconsin's AFDC Benefit CAP (ABC) Demonstration Project, no additional benefits will be provided to existing Aid to Families with Dependent Children cases due to the birth of a child, with exceptions, although additional children will remain eligible for Medicaid benefits and food stamps. All AFDC recipients will be offered family planning services and instructions on parenting skills. The new rule goes into effect ten months after the demonstration is implemented.

For this waiver, Wisconsin's application was received on Feb. 9, 1994, and approved on June 24, 1994.

Under Wisconsin's statewide "Pay for Performance" (PFP) project, AFDC applicants must meet with a financial planning resource specialist to explore alternatives to welfare. Failure to do so

without good cause results in denial of eligibility for AFDC benefits for all members of the family.

Individuals who still want to apply for AFDC after meeting with the financial planning resource specialist must complete 60 hours of JOBS activities prior to approval for AFDC. At least 30 of the 60 hours must include contact with employers. Not completing this requirement without good cause will result in denial of AFDC benefits for all members of the family.

Recipients who do receive AFDC will be required to participate in JOBS for up to 40 hours per week. For each hour of non-participation, the AFDC grant will be reduced by the Federal minimum wage. If the AFDC grant is fully exhausted, the remaining sanction will be taken against the Food Stamp allotment. If hours of participation fall below 25% of assigned hours without good cause, no AFDC grant will be awarded and the Food Stamp amount will be \$10.

Wisconsin's waiver was requested April 18, 1995 and approved August 14, 1995.

WYOMING:

Wyoming's reform plan will encourage AFDC recipients to enroll in school, undertake a training program, or enter the workforce. Wyoming's plan will allow AFDC families with an employed parent to accumulate \$2,500 in assets, rather than the current ceiling of \$1,000.

Wyoming will promote compliance with work and school requirements with tough penalties: AFDC minor children who refuse to stay in school or accept suitable employment could have their monthly benefit reduced by \$40; and adult AFDC recipients who are required to work or perform community service, but refuse to do so, face a \$100 cut in their monthly benefit. Also, Wyoming will severely restrict eligibility for adults who have completed a post-secondary educational program while on welfare, and will deny payment to recipients who have confessed to or been convicted of program fraud until full restitution is made to the state.

Unemployed, non-custodial parents of AFDC children who are not paying child support can now be ordered, by the courts, into Wyoming's JOBS program.

Wyoming's request was received May 20, 1993, and granted Sept. 7, 1993.

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HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

January 1996

Contact: HCFA Press Office
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STATE MEDICAID DEMONSTRATIONS

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad discretion to waive certain laws pertaining to Medicaid, in order to conduct experimental, pilot or demonstration projects. This allows states, and the federal government, to pursue Medicaid projects which test new and innovative ideas relating to benefits and services, eligibility requirements and processes, program payment, and service delivery.

These demonstrations are frequently aimed at serving more low-income and uninsured people while saving money through new program efficiencies.

HHS is fully committed to assisting states in using this waiver authority to test well designed and creative approaches to health care. Significant strides have been made to make the waiver review process more efficient and straightforward, and HHS continues to seek improvement.

- o Since January 1993, HHS has approved 12 comprehensive health care reform demonstration projects, and the framework of one additional demonstration.*
- o In addition, 14 states have received Medicaid waivers since January 1993, as part of larger welfare reform projects. These complementary Medicaid waivers enable states to continue providing essential health care services while encouraging independence from welfare.*
- o Finally, 24 sub-state Medicaid demonstration projects have been approved affecting smaller components of state Medicaid programs.*

In the years 1988-1992, no statewide health care reform projects were approved, four states received welfare-related Medicaid waivers, and 16 sub-state demonstrations were granted. Demonstrations are monitored by HHS' Health Care Financing Administration.

COMPREHENSIVE HEALTH CARE REFORM DEMONSTRATIONS

Comprehensive Demonstrations Approved

DELAWARE: The Diamond State Health Plan expands Delaware's existing Medicaid program to provide comprehensive health coverage to poor adults and children with incomes up to 100 percent of the federal poverty level (FPL) through a managed care delivery system. It will incorporate Delaware's Nemours Child Plan, as well as the state's case managed program for adults receiving general assistance. HCFA will monitor implementation of the program throughout the five-year period.

Submitted: July 29, 1994

Approved: May 17, 1995

FLORIDA: The Florida Health Security Program is a voluntary, employer-based, discounted premium program designed to provide access to private health insurance for employed but uninsured Floridians. The program will use a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250 percent of the FPL. Health plans (indemnity and HMO) will be offered by Accountable Health Partnerships and administered by Community Health Purchasing Alliances. The State is working on required state legislation.

Submitted: February 9, 1994

Approved: September 15, 1994

HAWAII: Health QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided), Hawaii's statewide demonstration project, creates a public purchasing pool that will arrange for health care through capitated managed care plans. The Hawaii QUEST program provides seamless coverage to those persons previously covered through Federal and State programs and those who are uninsured by building on the State's unique exemption to the Employee Retirement Income Security Act (ERISA) granted by Congress in 1983. This is accomplished through expansion of the Medicaid income eligibility level to 300 percent of the FPL and elimination of categorical requirements and asset tests. HCFA will monitor implementation of the program throughout the 5-year period.

Submitted: April 19, 1993

Approved: July 16, 1993

Page 3 - Medicaid Demonstrations

KENTUCKY: Kentucky did not receive the necessary state legislation to implement the Kentucky Medicaid Access and Cost Containment demonstration, which was approved on December 9, 1993. On June 19, 1995, the State submitted an amendment to their proposal, entitled the Kentucky Health Care Partnership Plan (The Partnership). Under The Partnership, the State will be divided into eight managed care regions with a network consisting of public and private providers. The standard Kentucky Medicaid benefit package will be available through each partnership. The State plans to enroll all non-institutional Medicaid beneficiaries currently enrolled. Enrollment will be phased-in beginning on July 1, 1996, on a region-by-region basis. All of the partnerships will be fully implemented within 18 months.

Submitted: June 19, 1995
Approved: October 12, 1995

MASSACHUSETTS: The Massachusetts MassHealth demonstration is designed to improve access to health insurance and stimulate the private offering of affordable coverage. The program will provide access to an expansion group of 400,000 individuals, consisting of the uninsured, the unemployed, and low-income workers at risk of losing their insurance. The MassHealth program specifically targets the unique needs of key groups within the uninsured population, such as low-income children, families and disabled; working disabled adults and children; the low-income short-term unemployed; and the long-term unemployed. In addition, tax credits will be provided for employers who have historically not offered health insurance coverage to their employees, but who now contribute at least 50 percent of the cost of purchasing a state-defined basic benefit package for their low-income employees. The program will also subsidize the employee share of the premium.

Submitted: April 15, 1994
Approved: April 24, 1995

MINNESOTA: Minnesota has enacted several health care reform measures to improve health care quality and create a seamless system of care for its population. The MinnesotaCare Acts of 1992, 1993, and 1994 call for specific changes in the health care delivery and financing systems, and Phase I involves the integration of low income and uninsured programs and the expansion of managed care by building on the existing Prepaid Medicaid Demonstration. The Prepaid Medical Assistance Program Plus (PMAP+) will allow the State to proceed with Phase I of MinnesotaCare and the previous Medicaid demonstration will be expanded in both size and scope, by expanding to nine additional counties and expanding eligibility to approximately 68,000 new eligibles. HCFA is working with Minnesota to develop Phase II of the project, which would further streamline all publicly funded health care programs in the State.

Submitted: July 27, 1994
Approved: April 27, 1995

Page 4 -- Medicaid Demonstrations

OHIO: OhioCare is a statewide program that will expand Medicaid eligibility to individuals with incomes up to 100 percent of the federal poverty level (FPL), eliminate categorical requirements and asset tests, and enroll the eligible population in managed care plans for basic health services. OhioCare's basic benefit plan includes the health services currently provided under Ohio's Medicaid program. OhioCare will also utilize managed care for certain special health related services, such as mental health and drug and alcohol addiction services. The State estimates OhioCare could enroll up to 500,000 additional beneficiaries.

Submitted: March 2, 1994

Approved: January 17, 1995

OKLAHOMA: Oklahoma's SoonerCare will increase access to primary care for beneficiaries through a managed care infrastructure in urban and rural areas. To guarantee the development of managed care in rural areas, key incentives will be provided to urban plans who undertake linkage efforts with rural providers.

Submitted: January 6, 1995

Approved: October 12, 1995

OREGON: Oregon's demonstration program expands Medicaid eligibility and shifts delivery of Medicaid services into fully and partially capitated plans and primary care case management programs. The State utilized a public prioritization process to establish the service package provided under the Medicaid demonstration. Oregon's Medicaid Reform Project expands Medicaid coverage to 100 percent of the FPL. This expands coverage to 126,300 additional low-income Oregonians. HCFA is monitoring implementation of the program throughout the 5-year period.

Submitted: August 15, 1991

Approved: March 19, 1993

RHODE ISLAND: Rhode Island's Rite Care is a statewide initiative that seeks to increase access to primary and preventive health care services for all Aid to Families with Dependent Children recipients and certain low income women and children. The Rite Care program provides coverage to pregnant women and children up to 6 years of age with family incomes at or below 250 percent of the FPL; women who would otherwise lose Medicaid eligibility post-partum will remain eligible for family planning services. Approximately 3,500 additional people will receive coverage over the course of the waiver. Individuals eligible for the program are required to enroll in prepaid health plans which contract with the State to provide comprehensive health services for a fixed cost per enrollee per month. Each health plan will offer medical, dental and mental health benefits, and enhanced outreach services. HCFA will monitor implementation of the program throughout the 5-year period.

Submitted: July 20, 1994
Approved: November 4, 1993

TENNESSEE: TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured state residents, and those whose medical conditions make them uninsurable. All TennCare enrollees receive services through capitated managed care plans that are either health maintenance organizations or preferred provider organizations. Enrollment will be capped at 1,300,000 including approximately 400,000 previously uninsured. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled. TennCare's benefits are more generous than those offered under current Medicaid for acute care, and the plan emphasizes preventive care. HCFA will monitor implementation of the program throughout the 5-year period.

Submitted: June 16, 1993
Approved: November 18, 1993

VERMONT: The Vermont Health Access Plan will provide comprehensive health care coverage to approximately 90,500 individuals, including 26,500 previously uninsured with incomes up to 150 percent of the FPL. Also included in the Health Access Plan is a Medicaid pharmacy benefit for the state's lower-income Medicare beneficiaries, and mental health and chemical dependency benefits.

Submitted: February 24, 1995
Approved: July 28, 1995

Comprehensive Demonstration Framework Approved
(Award of Waivers Pending):

SOUTH CAROLINA: South Carolina's Palmetto Health Initiative (PHI) seeks to expand Medicaid eligibility to individuals with incomes up to 100 percent of the FPL, and children up to age 18 in families with incomes up to 133 percent FPL. Each enrollee would select either a fully capitated health plan, or a partially capitated primary physician plan, thereby giving each enrollee direct access to a primary care provider. PHI also seeks to streamline the eligibility process and reduce administrative overhead. South Carolina anticipated an additional 280,000 individuals could be provided health care under the waiver. South Carolina also proposes to implement a managed care program, with a focus on home and community-based services, for persons requiring or at risk of requiring, placement in a nursing facility.

While the framework of this project was approved in November 1994, the State has decided to indefinitely postpone proceeding with the developmental phase of the project.

Submitted: March 1, 1994

Concept Approval: November 18, 1994

MEDICAID WAIVERS IN SECTION 1115 WELFARE REFORM DEMONSTRATIONS

Since January 1993, HCFA has approved Medicaid waivers for welfare demonstrations in 14 states. Medicaid waivers are pending approval in an additional 9 states. In addition to the following demonstrations, which require Medicaid waivers, there are a number of welfare reform demonstrations that do not require Medicaid waivers, but do result in demonstrations in which AFDC-related waivers given by the Administration for Children and Families permit the case to remain AFDC-eligible with higher earnings or resources. When a case is AFDC-eligible, all members are automatically Medicaid-eligible.

Approved Medicaid Waivers in Welfare Demonstrations

ARIZONA: Arizona's "Employing and Moving People Off Welfare and Encouraging Responsibility (EMPOWER)" demonstration gives an extended 24-month transition benefit with the case losing eligibility when income exceeds 185 percent of the federal poverty level (FPL). *Submitted: August 3, 1994. Approved: May 22, 1995.*

COLORADO: Colorado's "Personal Responsibility and Employment Program" permits cases who have been on AFDC less than 3 of the previous 6 months, and lose AFDC eligibility due to earnings, to receive the one-year Medicaid transition benefit. The quarterly income reporting during the transition is eliminated, but recipients are required to report income increases, and the case loses the remainder of the transition benefit when income exceeds 185 percent of the FPL. *Submitted: June 30, 1994. Approved: January 15, 1994.*

CONNECTICUT: Connecticut's "A Fair Chance" demonstration gives cases who lose AFDC eligibility due to earnings a 2-year Medicaid transition benefit, regardless of income, but requires the recipients to report on the availability of employer group health insurance. *Submitted: December 10, 1993. Approved: August 29, 1994.*

DELAWARE: Delaware's "A Better Chance" demonstration gives an extended 24-month transition benefit, with the second year provided to those cases not covered under the Medicaid Managed Care waiver, if their income does not exceed a level to be established by the State at or above 100 percent of the FPL. *Submitted: January 30, 1995. Approved: May 8, 1995.*

FLORIDA: Florida's "Family Transition Program" eliminates the quarterly income report requirement during the twelve months the Medicaid transition benefit is given to recipients who lose AFDC eligibility due to earnings. However, recipients are required to report income increases, and lose the remainder of the transition benefit when income exceeds 185 percent of the FPL. *Submitted: September 21, 1993. Approved: January 27, 1994.*

ILLINOIS: Illinois' "Homeless Families Stabilization" demonstration gives a 2-year Medicaid transition benefit, regardless of income, to cases who lose AFDC eligibility due to earnings. *Submitted: October 6, 1992. Approved: May 6, 1993.*

MONTANA: Montana's "Families Achieving Independence in Montana (FAIM)" demonstration allows the state to limit optional Medicaid benefits for current AFDC-related eligibles. Able-bodied Medicaid beneficiaries will be required to choose between a limited services Medicaid managed care package or a limited services fee-for-service option. Optional payment of part of the premium for a private health insurance policy will be available beginning in the second year of the demonstration. As part of the FAIM demonstration, the State has received a waiver of certain Medicaid confidentiality provisions to enable the State to share eligibility information (demographics only) with contractors and other state and local agencies providing services to this population. All entities receiving this information will be required to comply with state confidentiality regulations. *Submitted: April 19, 1994. Approved: April 18, 1995.*

NEBRASKA: Nebraska's Welfare Reform Demonstration Project permits the state to limit employable adults to a maximum of 24 months of AFDC and Medicaid in any 48-month period, and requires that they participate in employment-related activities, with more stringent sanctions for non-cooperation. In the Time-Limited Program, cases who lost AFDC eligibility due to earnings will receive an extended 24-month Medicaid transition benefit, with the case losing eligibility when income exceeds 185 percent of the FPL, and the state may impose copayments in months 7-24 of the transition period. *Submitted: October 4, 1994. Approved: February 27, 1995.*

NEW YORK: New York's "A Jobs First Strategy" demonstration gives cases who lose AFDC eligibility due to earnings a 1-year Medicaid transition benefit regardless of income, but requires recipients to report on the availability of employer group health insurance. *Submitted: June 7, 1994. Approved: October 19, 1994.*

PENNSYLVANIA: Pennsylvania's "Pathways to Independence" demonstration permits cases who have been on AFDC less than 3 of the previous 6 months to receive the Medicaid transition benefit. The benefit is given to cases who lose AFDC eligibility due to the collection of child support, as well as to those who lose eligibility due to earnings. Recipients are required to submit quarterly income reports, and they lose the remainder of the transition benefit if their income exceeds 235 percent of the FPL. *Submitted: February 18, 1995. Approved: November 3, 1994.*

SOUTH CAROLINA: South Carolina's "Self-Sufficiency and Parental Responsibility program" gives cases who lose AFDC eligibility due to earnings a phased-down, partial AFDC grant for up to 12 months, with Medicaid eligibility continuing during that period. The Medicaid transition benefit will begin when the phased-down, partial AFDC grant ends. Cases are required to submit income reports semi-annually during the transition benefit when their income exceeds 185 percent of the FPL. *Submitted: July 13, 1994. Approved: January 9, 1995.*

VERMONT: Vermont's "Family Independence Project" gives cases who lose AFDC eligibility due to earnings a 3-year Medicaid transition benefit with semiannual income reporting. The case loses the remainder of the transition benefit when income exceeds 185 percent of the FPL. *Submitted: October 27, 1992. Approved: April 12, 1993.*

Page 9 -- Medicaid Demonstrations

VIRGINIA: Virginia's welfare reform demonstration gives cases who lose AFDC eligibility due to earnings a 3-year Medicaid transition benefit in four localities and a 2-year transition benefit in the rest of the State. Cases are required to report income quarterly and lose the remainder of the transition benefit if income exceeds 185 percent of the FPL in the first year or 150 percent of the FPL in the second or third year. *Submitted: July 13, 1993. Approved: November 23, 1993.*

WISCONSIN: Wisconsin's "Work Not Welfare" demonstration limits the Medicaid transition benefit to a maximum of 12 months within a 48-month period. The state may require recipients to pay a premium for health insurance at any time during the transition benefit, and the premium may exceed 3 percent of income. *Submitted: July 14, 1993. Approved: November 1, 1993.*

NON-COMPREHENSIVE MEDICAID DEMONSTRATIONS

CALIFORNIA: The Program for All-Inclusive Care for the Elderly (PACE) -- California (Sutter SeniorCare, Sacramento)

The PACE program is a managed care service delivery system for the frail elderly who live in the community but are certified for institutionalization in a nursing home. Most of the 300 participants are dually eligible for Medicare and Medicaid, and all are being assessed for eligibility for nursing home placement according to state standards. *Submitted: July 14, 1993. Approved: May 1, 1994.*

DISTRICT OF COLUMBIA: The Health Services for Children with Special Needs program is a specialized managed care program, targeted to the needs of Medicaid-eligible disabled children, with mandatory enrollment. The District has been given a 1-year grant to help further develop the model proposed in its application.

Submitted: March 25, 1994

Approved: October 12, 1995

DELAWARE: Nemours Childrens Program

The State has developed a public/private managed care system which enrolls, on a capitated basis, Medicaid-eligible children in pediatric clinics. The Nemours Foundation developed the clinics and is subsidizing a portion of the service cost. *Submitted: October 13, 1992. Approved: July 27, 1993.*

FLORIDA: Preconception Project

This project is a demonstration and evaluation of a preconceptional intervention program.

Resource mothers will guide high-risk clients, during home visits, through various risk reduction activities over a 2-year period. The objective is to significantly reduce the incidence of low birth weight infants in the target population. *Submitted: July 31, 1991. Approved: June 28, 1994.*

MARYLAND: Primary and Preventive Care for Kids

Maryland has developed a primary and preventive care program that expands Medicaid eligibility for those services provided to children born after September 30, 1983, with family incomes below 185 percent of the FPL. *Submitted: February 8, 1993. Approved: August 9, 1993.*

MARYLAND: Demonstration Project for Family Planning and Reproductive Services

Maryland will extend Medicaid eligibility for family planning and preventive reproductive services for a 5-year period to women who are Medicaid eligible due to their pregnancy and remain Medicaid eligible 60 days postpartum. *Submitted: April 18, 1994. Approved: April 27, 1995.*

Minnesota: Long Term Care Options Project

Minnesota's project will provide integrated services to approximately 4,000 elderly beneficiaries in the seven-county Minneapolis/St. Paul metro area and St. Louis County. These beneficiaries, who are eligible for both Medicare and Medicaid will be offered a comprehensive benefit package which will include coverage for both long term care and acute care services in a single package combining Medicare benefits with the current benefits under the PMAP program. Enrollment is expected to begin in June 1996. *Submitted: April 18, 1994. Approved: April 27, 1995.*

SOUTH CAROLINA: Family Planning Project

South Carolina's project extends Medicaid eligibility for family planning services to all women with incomes below 185 percent of the FPL who have had one or more Medicaid reimbursed pregnancies. *Submitted: June 23, 1993. Approved: December 7, 1993.*

Multi-State Demonstrations Approved

MASSACHUSETTS, NEW YORK, SOUTH CAROLINA, WASHINGTON: Improving Access to Care for Pregnant Substance Abusers

These demonstrations seek to increase the number of Medicaid-eligible pregnant substance abusers who receive coordinated perinatal care services, substance abuse treatment, and other relevant services to promote better health outcomes for themselves and their offspring. The projects selected for funding presented strong perinatal and substance abuse treatment systems, strong research designs, rich sources of data, and other innovative components, including creative (e.g., culturally sensitive) methods of outreach. Features common to these projects include case-finding, case management, provider training, community outreach, and other ancillary services (e.g., parenting education, nutrition counseling, transportation). In addition, Massachusetts, New York and Washington requested waivers to provide services in Institutes for Mental Diseases. *Submitted: 1991. Waivers Approved: July 1, 1993.*

KANSAS, MAINE, MISSISSIPPI, NEW YORK, SOUTH DAKOTA, TEXAS: Multi-State Nursing Home Case-Mix and Quality Demonstration

These demonstrations test a combined Medicare and Medicaid nursing home payment and quality monitoring system. The system significantly enhances the quality assurance process in skilled nursing facilities. Data for measuring quality of care will come from an expanded version of the standardized resident assessment instrument currently used by states for all nursing home residents. The same tool is used to determine Medicare and Medicaid payment. The instrument, which measures residents needs, strengths and preferences, is used in care planning. In the developmental phase of the demonstration, data from the assessment instruments were used to create 30 facility-level quality indicators. Under the demonstration, these indicators will help facilities benchmark their own performance and help Medicare and Medicaid target nursing home surveys. *Submitted: Winter 1989. Approved: December 1994 (after lengthy developmental period).*

SOUTH CAROLINA, WASHINGTON: Health Access Plan

This project tests the effects of eliminating categorical eligibility requirements and raising the financial eligibility limits (to 150 percent of the FPL in South Carolina and 200 percent of the FPL in Washington) on individuals' access to and cost of health care. *Submitted: Spring 1991 (developmental period required). Waivers Approved: February 1993. (The South Carolina demonstration will end in February 1996 and Washington's will end in March 1996.)*

**ARKANSAS, CALIFORNIA, FLORIDA, NEW JERSEY, NEW YORK, VIRGINIA:
Medicaid Direct Purchase Vaccine Program**

The Medicaid Direct Purchase Vaccine Program streamlines the reimbursement process for childhood vaccine, by allowing states to directly reimburse manufacturers for vaccines. Vaccine manufacturers send to each private physician who treats children on Medicaid a shipment of vaccines on consignment at no cost to the physician. Physicians then bill Medicaid for the office visit when they inoculate children, but not for the cost of the vaccine. The Medicaid program reimburses the manufacturer at a discounted rate, according to the number of vaccines administered. The manufacturer then sends quantities of the vaccines to the private physicians to replace the amounts used. *Submitted: January - April 1993. Approved: June - July 1993. Implemented (California only): August 1993 - September 1994 (ended). [These demonstrations were superseded by enactment of the national Vaccines for Children program.]*

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

JAN 31 1996

The Honorable Fob James, Jr.
Governor of Alabama
Montgomery, Alabama 36104

Dear Governor James:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on your section 1115 demonstration proposal entitled "Bay (Better Access for You) Health Plan." The Health Care Financing Administration (HCFA) staff and your staff will continue working to resolve major issues in the State's proposal as discussed in the State's response to our issues letter. In addition, HCFA sent a list of questions to the State on December 18, 1995, and is awaiting your response to those questions.

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

Sincerely,

Donna E. Shalala



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

JAN 31 1996

The Honorable Fife Symington
Governor of Arizona
Phoenix, Arizona 85007

Dear Governor Symington:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to express my appreciation for your ground breaking efforts with your longstanding 1115 waiver, "The Arizona Health Care Cost Containment System (AHCCCS)." The Health Care Financing Administration (HCFA) staff has been working cooperatively with your staff to consider several proposed modifications to the existing demonstration. We will continue to explore with State officials any options that strengthen the ability of the existing project to serve its beneficiaries.

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

Sincerely,

Donna E. Shalala



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

FEB 2 1996

The Honorable Pete Wilson
Governor of California
Sacramento, California 95814

Dear Governor Wilson:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the Department's activity regarding your State's waiver requests.

Regarding your State's welfare initiatives, we approved four California demonstration proposals, including two projects in the past few months, the California Incentives to Self-Sufficiency (CISS) Project in September, and the San Diego School Attendance Demonstration Project in December. I am pleased that, to the extent possible, we are making good progress on your three remaining pending welfare proposals. We are committed to working with your staff at the California Department of Social Services (DSS) in moving forward as quickly as possible with these applications.

1. My staff at the Administration for Children and Families (ACF) received a proposal on March 14, 1994, to amend the previously approved and operating California Work Pays Demonstration Project. DSS asked us to hold our review of the proposed amendment, which would progressively reduce the level of AFDC benefits to families, because the State legislature had not passed relevant authorizing legislation. Last November, DSS sent us a letter modifying the proposed amendment and told us to expect a response early in 1996 to the issues we had sent the State in July 1994. We are currently awaiting that response.
2. ACF staff has also had a number of discussions with DSS staff toward resolving issues and questions which arose out of a federal review of the application for waivers received August 26, 1994 to amend the Assistance Payments Demonstration Project. These amendments were sought following a decision in Beno v. Shalala by the Ninth District Court of Appeals requiring that the Department of Health and Human

Services reconsider its approval of the waivers. Earlier this week, we sent DSS a letter outlining the terms and conditions under which we would make a prompt decision to regrant the waiver that had been granted by the previous Administration.

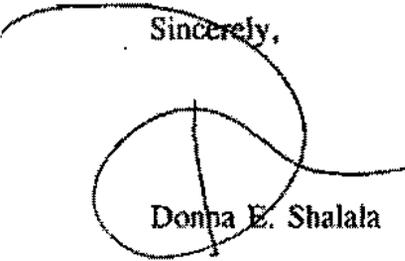
3. On November 9, 1994, ACF received an additional request to amend the California Work Pays Demonstration Project by allowing the State not to increase benefits to families receiving AFDC due to the birth of a child conceived while receiving AFDC. Earlier this week, we sent DSS a letter describing the terms and conditions under which we would make a prompt decision about this waiver request.

Regarding your Medicaid initiatives, I would also like to update you on the status of the pending renewal request for the California 1915(c) AIDS home and community-based services waiver, received by the Health Care Financing Administration (HCFA) on September 12, 1995. Since receipt of the waiver, HCFA has continued to work with your staff to resolve quality assurance and other issues that were identified in your State's submission. The State promptly responded to our request for additional information by submitting a draft response to the Regional Office on January 19, 1996. We are now awaiting California's formal response to our additional information request. HCFA will make a decision within 90 days of receipt of the State's formal response.

In addition, the Department is also working with Los Angeles County and the State on the development of a section 1115 proposal to restructure the health care system in Los Angeles County. Most recently, HHS staff met with County and State officials on January 18-19, and we remain committed to working with your State to address the urgent health care situation in Los Angeles County.

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

Sincerely,



Donpa E. Shalala



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

JAN 31 1996

The Honorable Roy Romer
Governor of Colorado
Denver, Colorado 80203-1792

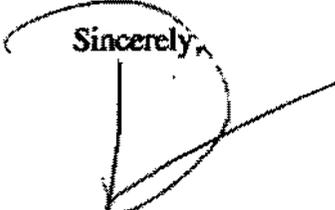
Dear Roy:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your request to institute a 2-year 1915(b) waiver under which Colorado would selectively contract with providers to provide lung, heart, liver and bone marrow transplant services to Medicaid beneficiaries. Your revised proposal was received by the Health Care Financing Administration on November 8, 1995. Since that time, we have met with State officials to discuss several concerns impacting the cost effectiveness of the waiver. On January 19, 1996, we met with State officials to address, among other things, specific concerns involving the methodology to be used in calculation of payment rates. We expect to provide a final decision on the waiver by February 6, 1996.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable Lawton Chiles
Governor of Florida
Tallahassee, Florida 323999-0001

Dear Lawton:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes both the approval of Florida's Family Transition Program and its later expansion to six additional counties and the Florida Health Security Program. We look forward to continuing this valuable work with the States.

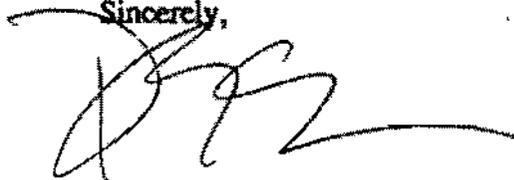
As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Family Responsibility Act. My staff at the Administration for Children and Families (ACF) received this proposal on October 4, 1995. Unfortunately, the Federal shutdown caused almost a month of delay in processing the application. However, on January 22, 1996, shortly after returning from the shutdown, ACF sent the Florida Department of Health and Rehabilitative Services (HRS) a list of issues and questions which resulted from a Federal review of the application. If HRS's response provides sufficient clarification and resolves significant issues, ACF will promptly submit draft terms and conditions to HRS.

I would also like to update you on the status of your 1915(b) waiver request to institute a mental health managed care program under State's Medicaid plan. As you know, the proposal would require Medicaid beneficiaries residing in five counties to receive all Medicaid-covered mental health services from a designated prepaid capitated mental health plan. The Health Care Financing Administration has been working with State staff to address specific concerns regarding the cost effectiveness of the waiver and the methodology for calculating savings. We expect to have a final decision on the waiver in the near future.

Page Two - The Honorable Lawton Chiles

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, 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 31 1996

The Honorable Zell Miller
Governor of Georgia
Atlanta, Georgia 30334

Dear Zell:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of two projects in Georgia, the Personal Accountability and Responsibility Project and the Work for Welfare Project. We look forward to continuing this valuable work with the States.

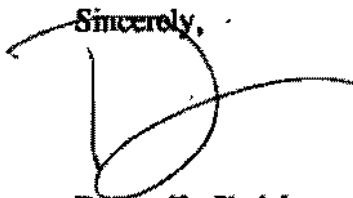
As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Jobs First Project. My staff at the Administration for Children and Families (ACF) received this proposal on July 5, 1995 and sent the Georgia Department of Human Resources (DHR) a list of issues and questions on January 19, 1996 which resulted from a Federal review of the application. If their response provides sufficient clarification and resolves significant issues, ACF will promptly submit draft terms and conditions to DHR.

I would also like to update you on the status of the Georgia Behavioral Health Plan (GBHP). At your request, the Health Care Financing Administration (HCFA) is tracking the three waiver proposals that comprise the GBHP as a single package, although each waiver is being processed by separate offices. Your proposal would combine section 1115, 1915(b), and 1915(c) waivers into a fully integrated system of managed care for mental illness, mental retardation, and substance abuse. In November 1995, questions regarding the section 1115 portion of the proposal were sent to the State and we are awaiting the State's response.

Page Two - The Honorable Zell Miller

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

Sincerely,

A handwritten signature in black ink, appearing to be 'D. Shalala', with a large, sweeping flourish that extends to the right and loops back under the name.

Donna E. Shalala



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

JAN 3 | 1996

The Honorable Benjamin J. Cayetano
Governor of Hawaii
Honolulu, Hawaii 96813

Dear Governor Cayetano:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of Hawaii's Creating Work Opportunities for JOBS Families Project and Health QUEST. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for Families are Better Together. My staff at the Administration for Children and Families (ACF) received this proposal on May 22, 1995 and sent the Hawaii Department of Human Services (DHS) a list of issues and questions on July 6, 1995 which resulted from a Federal review of the application. Following discussions with State staff concerning these issues, ACF sent draft terms and conditions to the Hawaii DHS on August 17, 1995. Subsequently, DHS asked us to put a hold on our processing of the application while additional welfare reform provisions were being considered by the State. We understand that you will shortly be submitting a new proposal. My staff and I look forward to receiving your application and working with you further to help facilitate your welfare reform initiative.

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

Sincerely,

Donna E. Shalala



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

JAN 31 1996

The Honorable Jim Edgar
Governor of Illinois
Springfield, Illinois 62706

Dear Jim:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of three projects in Illinois: the Work Pays Project, the Work and Responsibility Demonstration, and the School Attendance Demonstration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Six Month Paternity Establishment Demonstration. My staff at the Administration for Children and Families (ACF) received this proposal on July 18, 1995. We have had a number of discussions with staff of the Illinois Department of Public Aid (DPA) concerning the proposal. Unfortunately, the Federal shutdown caused almost a month of delay in processing this and other applications. We are now hopeful that, as a result of a teleconference between ACF and DPA staff earlier this week, we will soon be able to mutually resolve our concerns about how to structure an agreement that meets the State's objectives for this project. Upon reaching a resolution we should be able to promptly send DPA draft terms and conditions for review.

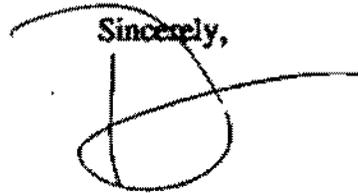
We have also had a number of discussions with DPA staff concerning adding an additional provision to Illinois' recently approved Work and Responsibility Demonstration (WRD) related to cross-matching income security records of AFDC recipients. Again, we are hopeful that we will soon mutually resolve our concerns about how to structure an agreement that meets the State's objectives for this project. Upon reaching a resolution we should be able to promptly send DPA staff draft terms and conditions amending WRD for their review.

Page Two - The Honorable Jim Edgar

I would also like to update you on the status of your statewide section 1115 demonstration for MediPlan Plus. On December 18, 1995, the Health Care Financing Administration forwarded draft terms and conditions to the State for consideration. Pending review by your staff and resolution of any outstanding issues, we could reach a final decision promptly.

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

Sincerely,

A handwritten signature in black ink, appearing to be "D. Shalala", written over the word "Sincerely,".

Donna E. Shalala



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

JAN 31 1996

The Honorable Evan Bayh
Governor of Indiana
Indianapolis, Indiana 46204

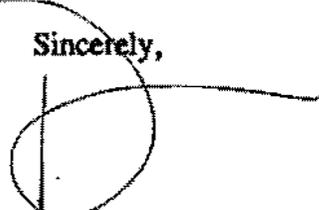
Dear Evan:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of Indiana's Impacting Families Welfare Reform Demonstration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take the opportunity to update you on the status of your State's waiver request for amendments to the Impacting Families Welfare Reform Demonstration. The Administration for Children and Families (ACF) received the application for this project December 14, 1995. Unfortunately, the Federal shutdown caused almost a month of delay in processing this and other applications. However, we have now begun our review of these proposals and expect to send the Indiana Family and Social Services Administration a list of issues and questions which result from this review by the end of February.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable Terry E. Branstad
Governor of Iowa
Des Moines, Iowa 50319-0001

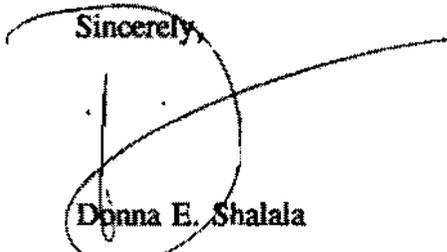
Dear Terry:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

I would like to take this opportunity to update you on the status of Iowa's 1915(c) waiver request to provide home and community-based services to individuals with traumatic brain injury. On November 11, 1995, HCFA held a conference call with State staff to discuss those issues which presented a barrier to approval. At Iowa's request, we provided technical assistance to the State to help address those issues. Because of this situation, the State agreed to stop the 90-day review clock. On January 10, 1996, HCFA forwarded a formal information request to the State concerning the outstanding issues surrounding the waiver request. We are currently awaiting the State's response and, upon receiving that response, anticipate approval of the waiver as early as Spring of 1996.

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

Sincerely,


Donna E. Shalala



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

JAN 3 1996

The Honorable Bill Graves
Governor of Kansas
Topeka, Kansas 66612-1590

Dear Governor Graves:

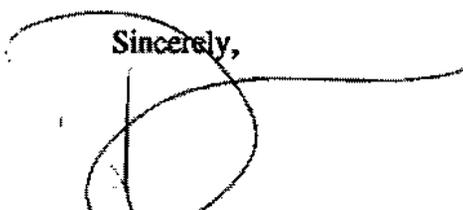
Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Actively Creating Tomorrow for Families program. My staff at the Administration for Children and Families (ACF) received this proposal on July 26, 1994. After a series of discussions with staff of the Kansas Department of Social and Rehabilitation Services (DSRS), ACF sent DSRS proposed terms and conditions of approval on April 14, 1995. It is my understanding you are currently reconsidering the demonstration provisions. Consequently, we are awaiting your final decision before we proceed.

I would also like to inform you of the status of the "Community Care of Kansas" section 1115 Medicaid demonstration proposal. Since receipt of your request on March 23, 1995, we have worked with the State to resolve our major concerns involving competitive bidding and beneficiary choice. I am pleased that we have reached agreement on these issues. HCFA anticipates that a final decision will be made in the near future.

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

Sincerely,



Donna E. Shalala



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

JAN 3 1 1996

The Honorable Mike Foster
Governor of Louisiana
Baton Rouge, Louisiana 70804-9004

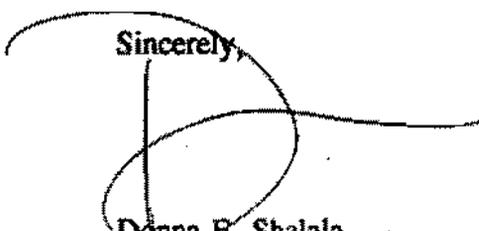
Dear Governor Foster:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Individual Responsibility Project. My staff at the Administration for Children and Families (ACF) received this proposal on September 22, 1995. ACF sent draft terms and conditions to the Louisiana Department of Social Services (DSS) on November 21, 1995 and received comments from DSS on January 23, 1996. On January 25, we faxed DSS revised draft terms and conditions. When we receive their response, we should be able to issue a final decision promptly.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1995

The Honorable Angus S. King, Jr.
Governor of Maine
Augusta, Maine 04333

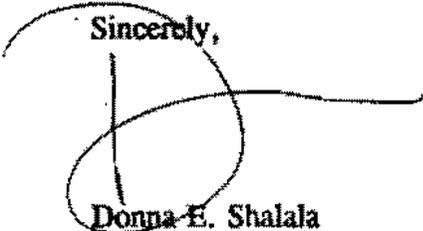
Dear Governor King:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Welfare to Work Demonstration. My staff at the Administration for Children and Families (ACF) received this proposal on September 20, 1995. On October 19, 1995 ACF sent the Maine Department of Human Services (DHS) both: 1) a list of issues and questions which resulted from a Federal review of the application; and 2) a key portion of draft terms and conditions for the proposed demonstration. If DHS's response provides sufficient clarification and resolves significant issues, ACF will promptly submit complete draft terms and conditions to DHS.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1995

The Honorable Kirk Fordice
Governor of Mississippi
Jackson, Mississippi 39205

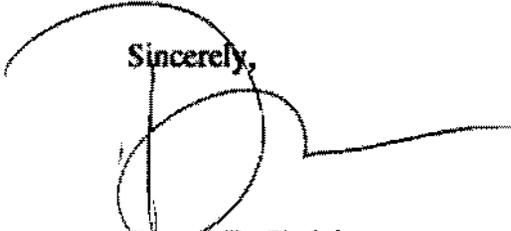
Dear Governor Fordice:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of both Mississippi's New Direction Demonstration Project and subsequent amendments to that project. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request to further amend the New Direction Demonstration Project. On November 20, 1995, the Administration for Children and Families (ACF) received your proposal. Since that time we have had a number of discussions with Mississippi Department of Human Services (DHS) staff and, despite the Federal shutdown causing almost a month of delay in processing this and other applications, we expect to send DHS within the next two weeks draft terms and conditions amending the project for review and comment. When we receive their response, we should be able to issue a final decision promptly.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable Mel Carnahan
Governor of Missouri
Jefferson City, Missouri 65102

Dear Governor Carnahan:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your statewide section 1115 waiver, "Making Health Care More Responsive and Efficient," originally received by the Health Care Financing Administration (HCFA) on June 30, 1994 and amended by the State in March 1995. We continue to work closely with State staff on issues relating to budget neutrality and hope to resolve any outstanding matters as promptly as possible.

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

Sincerely,

Donna E. Shalala



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

JAN 25 1996

The Honorable Stephen Merrill
Governor of New Hampshire
Concord, New Hampshire 03301

Dear Governor Merrill:

When President Clinton took office, he committed this Administration to providing states with the flexibility they need for innovation in their health and welfare programs. In partnership with states, the Department of Health and Human Services has been working hard to improve and streamline the waiver process. And, so far, the Clinton Administration has approved 50 welfare reform waivers for 35 states and 12 major health care reform waivers. This compares with 11 welfare reform waivers and no statewide health reform waivers approved in the previous Administration.

As you know I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your state's waiver requests:

1. Our Administration for Children and Families (ACF) received your proposal for the "Earned Income Disregard Demonstration" on September 20, 1993. After several staff conversations and an exchange of relevant information with the New Hampshire Department of Health and Human Services (NHDHHS), we were able promptly to resolve outstanding questions and issues. We sent NHDHHS draft terms and conditions under which the project could be approved on October 28, 1993. Since then, your staff has indicated that the State does not want to move ahead with this project at this time.
2. ACF received the "New Hampshire Employment Program and Family Assistance Program" on September 18, 1995. A quick initial review of this proposal by our staff identified work-related reform provisions that could be approved under the expedited review procedures announced by President Clinton last August. Under this Fast Track process, we are committed to reaching a final agreement with a state within 30 days of the receipt of a request that employs one or more of five established strategies for moving welfare recipients to work and maintains basic standards for evaluation.

As a result of our discussions, on October 6, 1995, New Hampshire submitted a separate application to implement those parts of your proposal that could be expedited under our Fast Track procedures. We faxed NHDHHS draft terms and

conditions on October 19, 1995. Late in October NHDHHS staff indicated that they were not prepared to move to a final decision on the Fast Track request, because they were considering possible changes to the application. On January 24, 1996, we received the State's response to our October 19 draft terms and conditions and ACF will be in contact with NHDHHS staff to discuss clarifications and to resolve remaining issues. We stand ready to immediately issue a separate final decision on your Fast Track submission at such time as you wish to proceed.

In addition, our staffs have resumed discussions regarding a federal review of the other aspects of your application we received on September 18, 1995. Unfortunately, the federal shutdown caused almost a month of delay in processing the application. Nevertheless, within a few days of our staff's return to work, on January 19, 1996, we faxed to NHDHHS a list of issues and questions for discussion.

3. New Hampshire submitted a section 1115 statewide health reform demonstration proposal entitled the "Granite State Partnership for Access and Affordability in Health Care" to the Health Care Financing Administration (HCFA). On June 20, 1995, your staff sent us a revised proposal and met with HCFA Administrator Bruce Vladeck, to discuss various health reform options available to the state. Based on these discussions, your staff proposed a health reform concept paper that was shared with us on September 25, 1995. Within one month we sent your staff a letter outlining issues that we identified in their concept paper. This week HCFA staff plans to visit with State officials to continue developing your State's concept paper on health care reform.

As you can see, we have been working closely with your State agencies on a number of health and welfare reform projects. On those matters where we are awaiting further information from the State, please be assured we will continue to respond promptly. We have resolved similar issues in many of the other 50 waiver demonstrations that have been approved. Therefore if NHDHHS's response indicates resolution of these issues, ACF will promptly submit draft terms and conditions of a waiver approval for your staff's review.

If you have any questions about our process or about the status of your waiver proposals, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060.

Sincerely,

A handwritten signature in dark ink, appearing to read "Donna E. Shalala". The signature is stylized with a large, sweeping loop at the top and a vertical line through the center.

Donna E. Shalala



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

JAN 31 1996

The Honorable George E. Pataki
Governor of New York
Albany, New York 12202

Dear Governor Pataki:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your statewide 1115 waiver proposal, the "Partnership Plan," submitted to Health Care Financing Administration (HCFA) on March 20, 1995. DHHS, HCFA, and State staff have held substantial discussions regarding various aspects of your State's proposal, and I expect them to continue in a constructive fashion. Currently, we have focused on the State's implementation timeline, the possibility of establishing milestones to measure the development of special needs plans, and budget neutrality.

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

Sincerely,

Donna E. Shalala



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

JAN 31 1995

The Honorable John A. Kitzhaber
Governor of Oregon
Salem, Oregon 97310

Dear Governor Kitzhaber:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of Oregon's JOBS Plus demonstration and the Oregon Health Plan. We look forward to continuing this valuable work with the States.

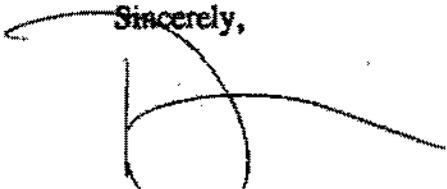
As you know, your staff at the Oregon Department of Human Resources (DHR) has requested that two earlier waivers applications – one increasing the motor vehicle asset limit and another expanding transitional child care – be folded into Oregon's pending waiver request, for the Oregon Option, which we received on July 10, 1995. Staff at the Administration for Children and Families (ACF) travelled to Oregon to assist in this innovative effort and have held considerable discussions of the proposal with DHR staff. After putting review of the proposal on hold, at DHR's request, pending developments in federal welfare reform legislation, ACF received a letter in November from DHR seeking to reopen discussions. ACF has recently responded to DHR's letter, and we are eager to continue discussions to resolve the significant remaining issues in your application.

I would also like to inform you of the status of your request to amend the Oregon Health Plan section 1115 demonstration to reduce eligibility and services as well as modify requirements regarding premiums and copayments. The Health Care Financing Administration (HCFA) approved the imposition of premiums on November 21, 1995, effective December 1, 1995. HCFA staff and other representatives from our Department are discussing with the State protections for beneficiaries who are unable to pay premiums. On January 11, 1996, HCFA also approved the State's request to change the funding line to reduce the number of conditions/treatments provided under the demonstration.

Page Two -- The Honorable John A. Kitzhaber

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable James B. Hunt, Jr.
Governor of North Carolina
Raleigh, North Carolina 27603-8001

Dear Jim:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's two waiver requests. My staff at the Administration for Children and Families (ACF) received the Work First Program proposal September 20, 1995 and sent the North Carolina Department of Health and Human Resources (HHR) a list of issues and questions on October 26, 1995 which resulted from a Federal review of the application.

ACF also received the Cabarrus County Work Over Welfare Demonstration Project proposal on October 5, 1995 and sent HHR a list of issues and questions on November 30, 1995 which resulted from a Federal review of the application. ACF received a response from HHR to these issues and questions on January 19, 1996.

ACF staff met with HHR staff on January 24, 1996 and were able to discuss and resolve a number of issues related to both projects. We have begun to draft terms and conditions and expect, following additional telephone conversations with your staff, we should be able to send you draft terms and conditions within the week on the statewide project for review and comment. When we receive their response, we should be able to issue a final decision promptly.

Page Two - The Honorable James B. Hunt, Jr.

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

Sincerely,

A handwritten signature in black ink, consisting of a large, stylized 'D' with a vertical line through it, and a horizontal line extending to the right.

Donna E. Shalala



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

JAN 31 1996

The Honorable George V. Voinovich
Governor of Ohio
Columbus, Ohio 43266-0601

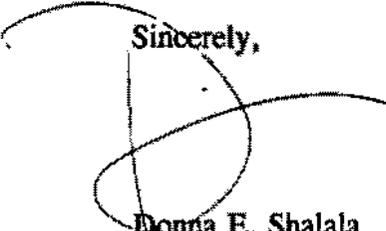
Dear George:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of two welfare reform demonstrations for Ohio: the State of Opportunity project and the extension and modification for the Learning, Earning and Parenting project, and a statewide health care demonstration: OhioCare. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Ohio First Project. My staff at the Administration for Children and Families (ACF) received this proposal on October 27, 1995. Unfortunately, the Federal shutdown caused almost a month of delay in processing the application. However, on January 25, 1996, shortly after returning from the shutdown, ACF sent the Ohio Department of Human Services (DHS) both 1) a list of issues and questions which result from a Federal review of the application; and 2) a key portion of draft terms and conditions for the proposed demonstration. If their response provides sufficient clarification and resolves significant issues, ACF will promptly submit complete draft terms and conditions of approval to DHS.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable Frank Keating
Governor of Oklahoma
Oklahoma City, Oklahoma 73105

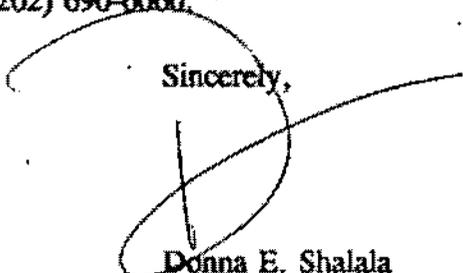
Dear Governor Keating:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of two welfare reform demonstrations for Oklahoma: the Learnfare Program and the Mutual Agreement, A Plan for Success project, and one statewide health care demonstration: SoonerCare. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take the opportunity to update you on the status of your State's waiver request. The Administration for Children and Families (ACF) received the application for this project on October 27, 1995. Unfortunately, the Federal shutdown caused almost a month of delay in processing the application. However, on January 26, 1996, shortly after returning from the shutdown, ACF sent the Oklahoma Department of Human Services (DHS) a list of issues and questions which result from this review. If their response provides sufficient clarification and resolves significant issues, ACF will promptly submit draft terms and conditions to DHS.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1995

The Honorable Tom Ridge
Governor of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Ridge:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

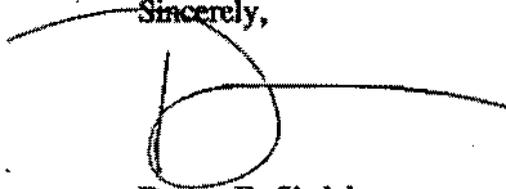
As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver requests for the School Attendance Improvement Program and the Savings for Education Program. The Administration for Children and Families (ACF) received the School Attendance Improvement Program proposal on September 12, 1994, and sent the Pennsylvania Department of Public Welfare (DPW) a list of issues and questions in November which resulted from a Federal review of the application. The Pennsylvania DPW provided ACF a partial response to these questions in April 1995, and ACF sent a preliminary partial draft of terms and conditions to DPW on May 3, 1995. We understand the State is reconsidering this proposal. If you choose to move forward with the project and DPW's response to the remaining issues and to the preliminary draft terms and conditions provides sufficient clarification, ACF will promptly submit complete draft terms and conditions to DPW.

ACF also received the Savings for Education Program proposal on December 29, 1994. We have informed DPW staff that, depending on how this program is structured, Pennsylvania may be able to implement this program without waiver authority. We understand that DPW is currently looking at this suggested approach. My staff stands available to assist DPW in achieving their objectives for this project.

Page Two - The Honorable Tom Ridge

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

Sincerely,

A handwritten signature in black ink, consisting of a large, stylized 'D' with a horizontal line extending to the right and a vertical line extending downwards from the top of the 'D'.

Donna E. Shalala



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

JAN 31 1996

The Honorable Lincoln Almond
Governor of Rhode Island
Providence, Rhode Island 02903

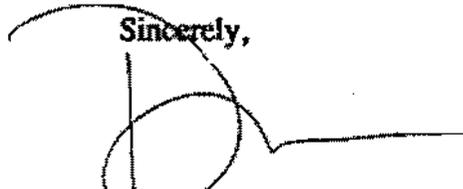
Dear Governor Almond:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes our earlier approval of Rhode Island's RItE Care demonstration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's request to modify the "RItE Care" section 1115 demonstration to expand the covered populations to include children up to age eight in families with income up to 250 percent of poverty. Approximately 400 additional children would be added by this change. The Health Care Financing Administration is reviewing your proposal and will provide a decision in the next few days.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable David M. Beasley
Governor of South Carolina
Columbia, South Carolina 29211

Dear Governor Beasley:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Family Independence Program which we received June 12, 1995. On August 7, 1995, the Administration for Children and Families (ACF) sent the Department of Social Services (DSS) a list of issues and questions which arose out of the Federal review. Through discussions with DSS staff we have been able to resolve a number of issues, though a few key issues remain. On December 1, 1995, ACF sent DSS draft terms and conditions for the proposed demonstration reflecting our position on still unresolved issues. DSS provided us proposed language revisions to certain sections of the draft terms and conditions on January 16, 1996 which we are now reviewing. Despite the fact that the Federal shutdown has delayed progress in processing a number of applications, we expect to be able to respond to DSS concerning these proposed revisions within the next two weeks. We are hopeful that we can reach an agreement in the near future.

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

Sincerely,

Donna E. Shalala



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

JAN 31 1995

The Honorable Don Sundquist
Governor of Tennessee
Nashville, Tennessee 37423-0001

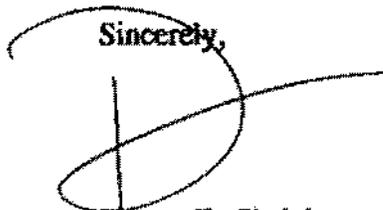
Dear Governor Sundquist:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes approval of Tennessee's TennCare demonstration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your proposal to make two modifications in the TennCare section 1115 demonstration project. On June 30, 1995, we received your request to raise the premium amounts for enrollees who have income over 100 percent of the Federal poverty level (FPL) and to charge premiums to enrollees below 100 percent of the FPL. A second amendment to pay on a capitation basis for services to the severely and persistently mentally ill (SPMI) was received on October 2, 1995. We have approved your premium plans for individuals above the poverty level, and we are working to resolve the premium issue for individuals below the FPL. With respect to the SPMI issue, HCFA staff will meet with the State on February 1 and expect to discuss the outstanding questions and concerns.

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

Sincerely,



Donna E. Shalala



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

JAN 31 1996

The Honorable George W. Bush
Governor of Texas
Austin, Texas 78711

Dear Governor Bush:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of Texas' Promoting Child Health in Texas project. We look forward to continuing this valuable work with the States.

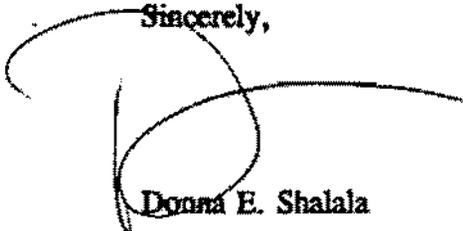
As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request for the Achieving Change for Texans Project. My staff at the Administration for Children and Families (ACF) received this proposal on October 6, 1995. Unfortunately, the Federal shutdown caused almost a month of delay in processing the application. However, on January 18, 1996, shortly after returning from the shutdown, ACF sent the Texas Department of Human Services (DHS) a list of issues and questions which resulted from a Federal review of the application. If their response provides sufficient clarification and resolves significant issues, ACF will promptly submit draft terms and conditions to DHS.

I would also like to update you on the status of your section 1115 statewide health care reform demonstration to restructure Texas' Medicaid program through the use of managed care systems. Since receipt of your proposal on September 6, 1995, the Department has been working with State staff to address several issues. The Health Care Financing Administration submitted a formal information request to the State on December 18, 1995. Once we receive your staff's responses, we will work closely with them to resolve any outstanding issues.

Page Two - The Honorable George W. Bush

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

Sincerely,

A handwritten signature in black ink, appearing to be "Donna E. Shalala", written over a printed name. The signature is stylized with a large loop and a long horizontal stroke.

Donna E. Shalala



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

JAN 31 1996

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

Dear Mike:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. This includes the approval of amendments to Utah's Single Parent Employment Demonstration. We look forward to continuing this valuable work with the States.

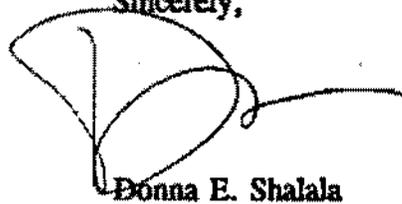
As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on the status of your State's waiver request to exclude the value of a vehicle for AFDC recipient families after initial eligibility has been determined. The Administration for Children and Families (ACF) received this application on October 3, 1995. In discussions with staff of the Utah Department of Human Services (DHS), ACF staff suggested how this proposal might best be implemented as an amendment to Utah's currently operating Single Parent Employment Demonstration. DHS is currently considering this approach. Should they agree, ACF will be ready to promptly submit draft terms and conditions for such an amendment to DHS.

I would also like to update you on the status of the "Utah Medicaid Reform" section 1115 demonstration, received in the Department on July 7, 1995. The State's response to our request for additional information was received by the Health Care Financing Administration on January 18, 1996. Our staff has already been in contact with State officials regarding outstanding issues, and we expect to continue working closely with your State's staff to resolve these issues.

Page Two - The Honorable Michael O. Leavitt

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

Sincerely,

A handwritten signature in black ink, appearing to be "Donna E. Shalala". The signature is stylized with a large loop and a long horizontal tail extending to the right.

Donna E. Shalala



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

JAN 31 1996

The Honorable Howard Dean, M.D.
Governor of Vermont
Montpelier, Vermont 05609

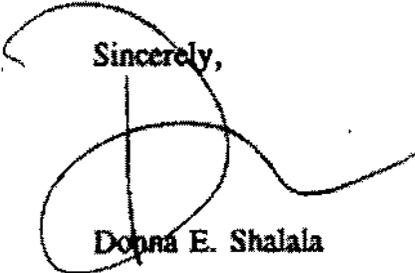
Dear Howard:

Since the beginning of his Administration, President Clinton has been committed to providing States with the flexibility they need to develop and test innovative practices in their health and welfare programs. Along with the National Governors' Association, the Department of Health and Human Services has worked hard to strengthen our intergovernmental partnership by improving and streamlining the waiver process. As a result of our efforts, the Administration has approved 50 welfare reform waivers for 35 States and 12 major health reform waivers to date, far more than any previous administration. We look forward to continuing this valuable work with the States.

As you know, I have regularly written the Nation's governors regarding our progress in encouraging State innovations in health and welfare reform. I would like to take this opportunity to update you on recent decisions we have made impacting enrollment and eligibility under the "Vermont Health Security Plan" demonstration project. As you know, the plan extends health care to uninsured Vermonters with incomes under 150 percent of the Federal poverty level and implements a managed care system. We have informed the State staff that the Department will permit the expansion population to be enrolled into a single managed care plan. We have also informed the State by telephone of our approval of a waiver to permit guaranteed eligibility under the demonstration for six months. This action will help facilitate the coordination of care provided under the managed care plans. We will follow up with a letter in the next few days.

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

Sincerely,



Donna E. Shalala



AUG 11 1993

Mr. Raymond Scheppach
Executive Director
National Governors' Association
444 North Capital Street, Suite 250
Washington, D.C. 20001

Dear Mr. Scheppach:

Enclosed is a copy of the new policy principles the Department is planning to issue that will guide our Department's consideration of waivers pursuant to Section 1115 of the Social Security Act. These principles reflect the commitment President Clinton made to the nation's governors to streamline the waiver process and to establish procedures by which federal agencies can work constructively with the states to facilitate testing of new policy approaches to social problems. The Department has already started to embrace the new policy principles and within the next 12 months hopes to complete a set of changes which will streamline and simplify the waiver process.

Our discussions with the National Governors' Association have been enormously helpful in the development of these policies. We recognize the historic and essential role of the states in the testing of new ideas and programs and look forward to a fruitful partnership with states in addressing the significant social problems facing us.

Sincerely,

John Monahan
Director, Intergovernmental Affairs

Enclosure

DISCUSSION DRAFT
POLICY PRINCIPLES FOR SECTION 1115 WAIVERS

Approval Criteria

Under Section 1115, the Department is given latitude, subject to the requirements of the Social Security Act, to consider and approve research and demonstration proposals with a broad range of policy objectives. The Department desires to facilitate the testing of new policy approaches to social problems. The Department will:

- o work with states to develop research and demonstrations in areas consistent with the Department's policy goals;
- o consider proposals that test alternatives that diverge from that policy direction; and
- o consider, as a criterion for approval, a state's ability to implement the research or demonstration project.

While the Department expects to review and accept a range of proposals, it reserves the right to disapprove or limit proposals on policy grounds. The Department also reserves the right to disapprove or limit proposals that create potential violations of civil rights laws or equal protection requirements or constitutional problems. The Department seeks proposals which preserve and enhance beneficiary access to quality services.

Within that overall policy framework, the Department is prepared to:

- o grant waivers to test the same or related policy innovations in multiple states, (replication is a valid mechanism by which the effectiveness of policy changes can be assessed);
- o approve waiver projects ranging in scale from reasonably small to state-wide or multi-state, and
- o consider joint Medicare-Medicaid waivers, such as those granted in the Program for All-Inclusive Care for the Elderly (PACE) and Social Health Maintenance Organization (SHMO) demonstrations, and Aid to Families with Dependent Children (AFDC)-Medicaid waivers.

Duration

The complex range of policy issues, design methodologies, and unanticipated events inherent in any research or demonstration makes it very difficult to establish a single Department policy on the duration of 1115 waivers. However, the Department is committed, through negotiations with state applicants, to:

- o approve waivers of at least sufficient duration to give new policy approaches a fair test. The duration of waiver approval should be congruent with the magnitude and complexity of the project -- for example, large-scale statewide reform programs will typically require waivers of five years;
- o provide reasonable time for the preparation of meaningful evaluation results prior to the conclusion of the demonstration; and
- o recognize that new approaches often involve considerable start-up time and allowance for implementation delays.

The Department is also committed, when successful demonstrations provide an appropriate basis, to working with state governments to seek permanent statutory changes incorporating those results. In such cases, consideration will be given to a reasonable extension of existing waivers.

Evaluation

As with the duration of waivers, the complex range of policy issues, design methodologies, and unanticipated events also makes it very difficult to establish a single Department policy on evaluation. This Department is committed to a policy of meaningful evaluations using a broad range of appropriate evaluation strategies (including true experimental, quasi-experimental, and qualitative designs) and will be more flexible and project-specific in the application of evaluation techniques than has occurred in the past. This policy will be most evident with health care waivers. Within-site randomized design is the preferred approach for most AFDC waivers. The Department will consider alternative evaluation designs when such designs are methodologically comparable. The Department is also eager to ensure that the evaluation process be as unintrusive as possible to the beneficiaries in terms of implementing and operating the waived policy approach, while ensuring that critical lessons are learned from the demonstration.

Cost Neutrality

Our fiduciary obligations in a period of extreme budgetary stringency require maintenance of the principle of cost neutrality, but the Department believes it should be possible to maintain that principle more flexibly than has been the case in the past.

- o The Department will assess cost neutrality over the life of a demonstration project, not on a year-by-year

basis, since many demonstrations involve making "up-front" investments in order to achieve out-year savings.

- o The Department also recognizes the difficulty of making appropriate baseline projections of Medicaid expenditures, and is open to development of a new methodology in that regard.
- o In assessing budget neutrality, the Department will not rule out consideration of other cost neutral arrangements proposed by states.
- o States may be required to conform, within a reasonable period of time, relevant aspects of their demonstrations to the terms of national health care reform legislation, including global budgeting requirements, and to the terms of national welfare reform legislation.

Timeliness and Administrative Complexity

The Department has begun to implement procedures that will minimize the administrative burden on the states and reduce the processing time for waiver requests. Among the steps taken by the Health Care Financing Administration (HCFA) so far are:

- o expanding pre-application consultation with states;
- o setting, and sharing with applicants, a well-defined schedule for each application, with established target dates for processing and reaching a decision on the application;
- o maintaining a policy of one consolidated request for further information;
- o sharing proposed terms and conditions with applicants before making final decisions; and
- o establishing concurrent, rather than sequential, review of waivers by HCFA components, other units of the Department and the Office of Management and Budget. The success of this strategy is evident in the approval of the major health reform proposal from Hawaii in under three months. The Department is committed to making an expedited waiver process the rule and not the exception to the rule.

HCFA will complete the following steps to simplify and streamline the waiver process:

- o expand technical assistance activities to the states;
- o reallocate internal resources to waiver projects; and
- o develop multi-state waiver solicitations in areas of priority concern, including integrated long-term care system development, services for adolescents, and services in rural areas.

Many of these procedures have been in place for some time for AFDC waivers at the Administration for Children and Families (ACF), where response times are usually short. ACF will continue to work to streamline the AFDC waiver process and respond to state concerns.

"NCA Policy
Resolutions"

NATIONAL GOVERNOR'S ASSOCIATION 1996 WINTER RESOLUTIONS
UNDOCUMENTED IMMIGRANTS

RESOLUTION: The provision of health care to undocumented immigrants must remain a fundamental federal responsibility financed exclusively with federal dollars.

HHS POSITION: In large part, the current structure for health treatment of undocumented immigrants would remain in place, with additional funding of \$3.5 billion over 5 years for states. Deterring illegal immigration is the best long-term solution to protect states from costs associated with illegal immigration. This Administration has taken unprecedented steps and invested the most resources ever to deter undocumented immigration.

- The President's budget would not alter current legal requirements that health care providers must treat anyone coming to them for emergency care.
- Federal and state Medicaid funds would continue to compensate providers for emergency care for undocumented people.
- The President's budget would provide an additional \$3.5 billion of 100 percent federal funds over 5 years to states with the largest number of undocumented immigrants to assist in paying for emergency care provided to undocumented immigrants.
- Community and migrant health centers would continue to provide primary care for uncovered people.
- We believe that the combination of the Medicaid payments for emergency services, additional federal assistance to the states, and an aggressive campaign to curb undocumented immigration should help to offset the costs of providing emergency medical services to undocumented individuals.

EC-4. HEALTH CARE FOR UNDOCUMENTED IMMIGRANTS

The Governors recognize that every individual in the United States and U.S. territories must continue to have access to emergency and other public health care services. However, since the U.S. Constitution requires that our nation's immigration policy be placed under the exclusive jurisdiction of the federal government, all costs resulting from immigration policy should be paid by the federal government. The Governors believe that under no circumstances should state, territorial, and local governments be required to share in costs resulting from federal policy decisions that would provide health care and other federal entitlements to undocumented individuals.

~~The Governors believe that the President and Congress should use the ongoing debate over national health care reform as an opportunity to consider what health benefits are to be provided by the federal government directly to undocumented immigrants, and to determine a payment structure under which the federal government will pay directly for these benefits.~~

The Governors oppose state, territorial, and local governments being forced to subsidize federal immigration policy. Therefore, the Governors call on the President and Congress to recognize the federal government's sole responsibility in immigration policy by repealing all current federal mandates that require that state, territorial, and local funds be used to provide health care and other public services to undocumented individuals. In its place, the Governors call upon Congress and the administration to develop a direct billing system to ensure that emergency or public health care needs that are provided to undocumented immigrants be financed fully by the federal government. The provision of health care to undocumented immigrants must remain a fundamental federal responsibility, financed exclusively with federal dollars, not an unfunded mandate or a cost shift to states, territories, local governments, or health care professionals.

Time limited (effective WINTER MEETING 1996-WINTER MEETING 1998 ~~Winter Meeting 1994-Winter Meeting-1996~~).

Adopted Winter Meeting 1994.

Public Health Services

Resolution Summary

The resolution outlines the services of public health and sets forth responsibilities of federal, state, and local levels in implementing those services. It outlines principles that should form the base for federal assistance to state and local governments, retaining major responsibility for public health at the state government level. It also defines the respective federal and state roles for coordination of public health services with managed care, block grant programs related to public health, maternal and child health services, health promotion and prevention, and disease prevention and control.

Summary of Administration Position

The Governors should be commended for addressing public health in their policy resolutions. The draft resolution outlines a definition of states' roles that is generally consistent with Administration policies; however, it does not sufficiently address appropriate federal roles as defined by our proposed Performance Partnership Grant legislation and other current public health policies and activities. For example:

- It does not adequately recognize that public health services are necessary for protection and improvement of the health of the entire population, as well as assuring access to health care for vulnerable and under-served populations.
- It fails to include essential federal responsibilities for defining, collaboratively with states, consistent public health policies and standards to ensure nationwide health protection, such as in areas safeguarded through Food and Drug Administration regulations.
- It does not address mental health and substance abuse prevention and treatment programs as necessary parts of public health.
- It does not include prevention of injury as a component of federal-state partnerships in health promotion and prevention.
- It does not recognize the key role of public health as guarantor of quality, especially in publicly funded managed health care for vulnerable populations.

In addition, the resolution fails to describe important characteristics of any federal health grant program. For example, the resolution in 8.4.2 calls for authority to transfer funds among block grant programs, which is not consistent with the necessity for accountability in the allocation and use of federally appropriated funds. While the Administration strongly endorses performance measures for health block grant programs, our position is that those measures must be mutually agreed upon between federal and state agencies, also to assure accountability..

In summary, while the resolution is an appropriate statement of the state role in public health, it is not an adequate description of federal responsibilities in public health services, as defined by Administration policies and legislative proposals.

HR-8. PUBLIC HEALTH SERVICES

8.1

PREAMBLE

EFFECTIVE PUBLIC HEALTH SERVICES ENSURE ACCESS TO COMMUNITY-BASED PREVENTIVE AND PRIMARY HEALTH CARE FOR VULNERABLE AND MEDICALLY UNDERSERVED POPULATIONS. SUCH SERVICES IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS. AT A TIME WHEN GOVERNMENT HEALTH CARE EXPENDITURES ARE CONSUMING A GREATER PROPORTION OF FEDERAL AND STATE BUDGETS, THE GOVERNORS BELIEVE THAT A RENEWED EMPHASIS ON PREVENTIVE COMMUNITY-BASED PUBLIC HEALTH SERVICES WILL BE A COST-EFFECTIVE WAY TO IMPROVE HEALTH STATUS.

8.2

CORE PUBLIC HEALTH SERVICES

THE GOVERNORS ENCOURAGE SUPPORT FOR THE CORE PUBLIC HEALTH FUNCTIONS. CORE FUNCTIONS ARE THOSE ACTIVITIES ROUTINELY CARRIED OUT BY PUBLIC HEALTH AGENCIES THAT PROMOTE COMMUNITY-BASED HEALTH SERVICES. CORE PUBLIC HEALTH ACTIVITIES INCLUDE:

- PREVENTING EPIDEMICS;
- PROTECTING THE ENVIRONMENT, WORKPLACES, HOUSING, FOOD, AND WATER;
- PROMOTING HEALTHY BEHAVIOR;
- MONITORING THE HEALTH CONDITIONS OF THE POPULATION;
- MOBILIZING COMMUNITIES FOR ACTION WHERE THERE ARE THREATS TO HEALTH;
- RESPONDING TO DISASTERS;
- ENSURING THAT MEDICAL SERVICES ARE OF HIGH QUALITY AND ARE NECESSARY;
- TRAINING SPECIALISTS IN INVESTIGATING AND PREVENTING DISEASES; AND
- DEVELOPING POLICIES TO PROMOTE HEALTH.

EFFECTIVE PUBLIC HEALTH SYSTEMS THAT INCLUDE THESE CORE FUNCTIONS IMPROVE THE HEALTH OF OUR CITIZENS AND PREVENT ILLNESS.

RESULTING IN LOWER MEDICAL SERVICES EXPENSES. CONVERSELY, AN INADEQUATE PUBLIC HEALTH INFRASTRUCTURE CAN RESULT IN INCREASED HEALTH CARE COSTS, SUBSTANTIAL ECONOMIC LOSS, UNNECESSARY SUFFERING, AND PREMATURE DEATH.

8.3

FEDERAL, STATE, AND LOCAL RESPONSIBILITIES

SINCE THE ENACTMENT OF THE FIRST QUARANTINE LAW, THE DELIVERY OF PUBLIC HEALTH SERVICES HAS BEEN A RESPONSIBILITY OF STATE AND LOCAL GOVERNMENTS. THE DELIVERY OF PUBLIC HEALTH SERVICES IS BEST CARRIED OUT BY STATES, WHICH CAN ALLOCATE RESOURCES AND DEVELOP POLICIES THAT RESPOND TO THEIR UNIQUE NEEDS AND HEALTH PROBLEMS. THE GOVERNORS, HOWEVER, BELIEVE THAT THE FEDERAL GOVERNMENT HAS A RESPONSIBILITY TO PROVIDE FINANCIAL AND TECHNICAL ASSISTANCE TO THE STATES AND, IN TURN, TO LOCAL GOVERNMENTS FOR THE DELIVERY OF PUBLIC HEALTH SERVICES. THE FEDERAL GOVERNMENT'S ROLE IS FINANCING PUBLIC HEALTH DELIVERY, COLLECTING INFORMATION ON A NATIONAL LEVEL, AND TAKING THE LEAD ON CERTAIN PUBLIC HEALTH FUNCTIONS THAT ARE NATIONAL IN SCOPE.

FEDERAL ASSISTANCE TO STATE AND LOCAL GOVERNMENTS SHOULD BE BASED ON THE FOLLOWING PRINCIPLES.

- THE RESPONSIBILITY FOR THE DELIVERY OF PUBLIC HEALTH SERVICES MUST REMAIN WITH STATE AND LOCAL GOVERNMENTS.
- FEDERAL FINANCIAL ASSISTANCE SHOULD BE BROAD-BASED ENOUGH TO PERMIT STATES TO TARGET AVAILABLE RESOURCES ON THE HIGHEST PRIORITY HEALTH PROBLEMS AFFECTING THE CITIZENS OF EACH STATE.
- STATE GOVERNMENT, THROUGH A STATE HEALTH PLAN, SHOULD BE RESPONSIBLE FOR THE DESIGN OF PUBLIC HEALTH PROGRAMS.
- ALL PUBLIC HEALTH ACTIVITIES FINANCIALLY ASSISTED BY THE FEDERAL GOVERNMENT WITHIN A STATE SHOULD BE UNDER THE SPONSORSHIP OF AGENCIES SPECIFIED BY THE STATE.
- THE FEDERAL GOVERNMENT SHOULD ESTABLISH POLICIES FOR THE SURVEILLANCE OF ENVIRONMENTAL THREATS TO THE PUBLIC HEALTH AND FOR MONITORING HEALTH TRENDS AND IDENTIFYING

THE LONG-TERM CHRONIC HEALTH EFFECTS OF EXPOSURE TO TOXIC SUBSTANCES AND OTHER ENVIRONMENTAL CONTAMINANTS.

- THE FEDERAL GOVERNMENT, IN CONCERT WITH STATE AND LOCAL GOVERNMENTS, SHOULD PROVIDE THE LEADERSHIP NECESSARY TO ESTABLISH NATIONWIDE HEALTH PROMOTION EFFORTS SUCH AS THOSE FOCUSED ON CHILDHOOD IMMUNIZATION, HIV/AIDS PREVENTION, AND THE HAZARDS TO MINORS OF SMOKING.
- THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PROVIDE LEADERSHIP ON HEALTH AND MEDICAL CARE RESEARCH THROUGH THE NATIONAL INSTITUTES OF HEALTH.

8.4 COORDINATION OF SERVICES

THE GOVERNORS BELIEVE THAT COOPERATIVE FEDERAL, STATE, LOCAL, AND PRIVATE INITIATIVES BASED ON THESE PRINCIPLES WILL ASSIST THE DEVELOPMENT OF A COORDINATED DELIVERY SYSTEM FOR PUBLIC HEALTH SERVICES. THE DEVELOPMENT OF A COORDINATED SYSTEM OF PUBLIC HEALTH SERVICES CAN HELP ENSURE THAT OUR CITIZENS HAVE THE OPTIMAL OPPORTUNITY TO LEAD HEALTHY LIVES IN AN ENVIRONMENT THAT MINIMIZES EXPOSURE TO HAZARDOUS PRACTICES, ENVIRONMENTS, AND PRODUCTS.

- 8.4.1 MANAGED CARE. MANY STATES ARE USING MANAGED CARE AS A PRIMARY STRATEGY FOR CONTAINING HEALTH CARE COSTS AND SHIFTING RESPONSIBILITY FOR SERVICE DELIVERY TO PRIVATE SECTOR PROVIDERS. THESE CHANGES ARE RESHAPING THE RESPONSIBILITIES OF PUBLIC HEALTH AGENCIES AND WILL REQUIRE THAT PUBLIC HEALTH PROFESSIONALS DEVELOP NEW SKILLS NECESSARY TO SUPPORT PRIVATE SECTOR EFFORTS AND TO ADDRESS THE PUBLIC HEALTH NEEDS OF THE ENTIRE POPULATION.

THE GOVERNORS ENCOURAGE PUBLIC HEALTH AGENCIES AND PRIVATE SECTOR PROVIDERS TO CLEARLY DEFINE THEIR RESPECTIVE RESPONSIBILITIES AND DEVELOP COMPLEMENTARY STRATEGIES FOR THE EFFECTIVE USE OF THE STRENGTHS AND RESOURCES OF EACH SYSTEM TO MAINTAIN AND IMPROVE HEALTH.

- 8.4.2 HEALTH SERVICES BLOCK GRANTS. BLOCK GRANTS CONTINUE TO BE AN IMPORTANT SOURCE OF FUNDING FOR MANY CRITICAL PUBLIC HEALTH PROGRAMS. THE GOVERNORS BELIEVE THAT THESE FEDERAL GRANTS MUST

CONTINUE IN ORDER TO MEET PUBLIC HEALTH NEEDS. HOWEVER, THEY ALSO BELIEVE THAT THESE GRANTS SHOULD BE BASED ON PERFORMANCE. STATES SHOULD BE GIVEN THE AUTONOMY TO SET THEIR OWN OBJECTIVES, TO TARGET RESOURCES, AND TO TAILOR PROGRAMS BASED ON THEIR INDIVIDUAL PERFORMANCE OBJECTIVES. PROVIDING FOR MORE STATE FLEXIBILITY IN EXISTING HEALTH SERVICE BLOCK GRANTS, SPECIFICALLY BY REMOVING COMPLEX ALLOCATION AND SET-ASIDE REQUIREMENTS AND BY ALLOWING FOR INTERBLOCK TRANSFER, IS ESSENTIAL.

8.4.3 MATERNAL AND CHILD HEALTH SERVICES. THE GOVERNORS BELIEVE THAT IMPROVING THE HEALTH STATUS OF AMERICA'S CHILDREN SHOULD BE A TOP PRIORITY OF ALL LEVELS OF GOVERNMENT. TO HELP MEET THIS PRIORITY, FEDERAL SUPPORT FOR MATERNAL AND CHILD HEALTH SERVICES AND NUTRITION PROGRAMS SUCH AS THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) SHOULD BE MAINTAINED. SINCE ITS CREATION IN 1972, WIC HAS PROVIDED SUPPLEMENTAL FOOD, NUTRITION EDUCATION, AND HEALTH CARE REFERRAL SERVICES TO MILLIONS OF LOW-INCOME PREGNANT WOMEN, INFANTS, AND CHILDREN. WIC IS AN EFFECTIVE ENTREPRENEURIAL PROGRAM WITH A PROVEN TRACK RECORD. THE PROGRAM SHOULD BE FURTHER IMPROVED BY REDUCING PRESCRIPTIVE AND BURDENSOME REGULATIONS ON STATE AND LOCAL AGENCIES AND BY GIVING STATES GREATER FLEXIBILITY TO ADMINISTER THE PROGRAM.

8.4.4 HEALTH PROMOTION AND PREVENTION. THE GOVERNORS CONTINUE TO LOOK TO THE FEDERAL GOVERNMENT FOR LEADERSHIP IN PROVIDING FOR HEALTH EDUCATION AND PROMOTION PROGRAMS THAT ENCOURAGE PREVENTION AND LEAD TO HEALTHIER LIFESTYLES. FOR EXAMPLE, FEDERAL EFFORTS, WITH STATE SUPPORT, HAVE MADE THE PUBLIC AWARE OF THE IMPORTANCE OF BREAST CANCER SCREENING PROGRAMS THAT COULD LEAD TO EARLY DETECTION AND TREATMENT OF BREAST CANCER. IN MANY INSTANCES, HEALTH EDUCATION AND PROMOTION PROGRAMS CAN PLAY AN IMPORTANT ROLE IN MODIFYING UNHEALTHY PRACTICES AND CAN REDUCE THE INCIDENCE OF CANCER, HEART DISEASE, STROKE, AND COMMUNICABLE DISEASES.

FEDERAL FINANCIAL ASSISTANCE SHOULD BE MADE AVAILABLE TO STATES FOR PUBLIC HEALTH SERVICES THAT CAN BE DEMONSTRATED TO REDUCE NET FEDERAL EXPENDITURES BY PREVENTING ILLNESS AND EXPENSIVE HOSPITALIZATION AND THAT ARE DEMONSTRATED TO BE OF

SPECIAL NEED IN THE AFFECTED STATES. ALLOCATIONS OF SUCH FUNDING SHOULD RECOGNIZE THE IMPORTANCE OF ATTAINABLE PERFORMANCE OBJECTIVES AS WELL AS A STATE'S NEED.

IN ADDITION, THE FEDERAL GOVERNMENT SHOULD ENSURE THE CAPACITY OF FEDERAL AGENCIES THAT WORK IN CONCERT WITH STATES TO MAINTAIN HIGH LEVELS OF CHILDHOOD IMMUNIZATION, REDUCE CHRONIC AND COMMUNICABLE DISEASES, AND RESPOND TO PUBLIC HEALTH EMERGENCIES.

8.4.5 DISEASE PREVENTION AND CONTROL. PROVIDING FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASES IS AN IMPORTANT PUBLIC HEALTH ACTIVITY. CURRENT FEDERAL EFFORTS TO SUPPORT AND COORDINATE STATE PROGRAMS FOR STRONG SURVEILLANCE, INVESTIGATION, REPORTING, AND OTHER DISEASE PREVENTION AND CONTROL ACTIVITIES SHOULD BE MAINTAINED.

~~8.1~~ Preamble

~~Effective community based public health services improve the health of our citizens and prevent illness that results in the use of expensive medical services. The National Governors' Association is concerned that the current cost and institutional bias of the major publicly financed medical care programs has diminished our capacity to provide community based public health services. Public health services are particularly critical for low income individuals and families who are not eligible for Medicaid or other health care financing coverage. The Governors therefore believe that renewed emphasis on the provision of community based public health services should be an integral element of cooperative federal/state initiatives to improve the health of our nation's citizens and the efficiency of our delivery systems.~~

~~8.2~~ Federal, State, and Local Responsibilities

~~Since the enactment of the first quarantine law, the delivery of public health services has been a responsibility of state and local governments. States continue to be in a better position to allocate resources and develop policies that respond to differing local needs and health care characteristics. The Governors, however, believe that the federal government has a responsibility to provide financial assistance to state and, in turn, local governments for the delivery of public health services. They also call on the federal government, in cooperation with state and local governments, to assume more responsibility for certain public health functions that are primarily national in nature. Federal assistance to state and local governments should be based on the following principles.~~

- ~~• The responsibility for the delivery of public health services must remain with state and local governments.~~
- ~~• Federal financial assistance must be flexible enough, preferably in the form of broad-based grants, to permit states to target available resources on the highest priority health problems affecting the citizens of each state.~~
- ~~• State government, through a state health plan, should be responsible for the design of public health programs that reflect national priorities, while focusing on local needs.~~

- All public health activities financially assisted by the federal government within a state should be under the sponsorship of agencies specified by the state.
- The federal government should establish policies for the surveillance of environmental threats to the public health and the establishment of health registries to monitor health trends and identify the long-term chronic health effects of exposure to toxic substances and other environmental contaminants.
- The federal government, in concert with state and local governments, should provide the leadership necessary to establish nationwide health promotion efforts such as those focused on childhood immunization and the hazards of smoking.

~~8.3~~ Coordination of Services

The Governors believe that cooperative federal, state, and local initiatives based on these principles will assist the development of a coordinated intergovernmental delivery system for public health services. The development of a coordinated system of public health services can help to ensure that our citizens have the optimal opportunity to lead healthy lives in an environment that minimizes exposure to hazardous practices, environments, and products. Toward this end, the Governors call on the President and Congress to review and expand on the following elements of federal public health services assistance.

~~8.3.1~~ Health Services Block Grants. Although the Governors continue to strongly support the block grant concept, states have been forced to adjust to severe reductions at the time of initial program consolidation. The Governors oppose additional federal fund reductions, even if associated with further consolidation of federal public health programs. The establishment of the three health services block grants in the Omnibus Reconciliation Act of 1981 has enhanced the states' ability to target limited federal resources. However, NGA believes that the effectiveness of the block grants could be greatly improved by

- removing the remaining categorical elements, such as the complex allocation and set-aside requirements in the alcohol, drug abuse, and mental health services block grant;
- establishing uniform reporting requirements; and
- establishing uniform provisions for transferring funds between block grants.

The association also believes that any increased state responsibility for federal programs should be accompanied by adequate federal financial assistance.

~~8.3.2~~ Maternal and Child Health Services. The health status of American children has improved dramatically over the last two decades. Federal programs such as Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps have contributed significantly to this improvement, and the Governors recognize the important link between health care and income security. As a result, the Governors are concerned that millions of children living below the federal poverty level are not covered by Medicaid or lack access to a regular source of health care or adequate income assistance.

The Governors believe that meeting the health care needs of underserved or unserved children should be a priority as well as a responsibility of all levels of government. Federal support for maternal and child health services and nutrition programs such as the Supplemental Food Program for Women, Infants, and Children (WIC), should be increased. A Harvard University study concluded that every dollar spent in WIC services resulted in three dollars of Medicaid savings. Despite these savings, the current level of federal support will enable far less than half of the potentially eligible women and infants to participate in the WIC program.

~~8.3.3~~ Health Promotion and Prevention. The Governors call on the federal government to expand its health promotion activities and encourage critical state preventive health initiatives and programs. Most health care professionals believe that personal behavior and habits such as smoking, exercise, diet, and alcohol and drug abuse are major determinants of morbidity and mortality. In many instances, health education and promotion programs can play an important role in modifying unhealthful practices. Federal financial assistance should be made available to states on a flexible basis for public health services that can be demonstrated to

~~reduce net federal expenditures by preventing illness and expensive hospitalization and are demonstrated to be of special need in the affected state.~~

~~In addition, the federal government should enhance the capacity of federal agencies, such as the Centers for Disease Control, that work in concert with state public health officials to maintain high levels of childhood immunization, reduce chronic diseases, and respond to public health emergencies.~~

Time limited (effective WINTER MEETING 1996-WINTER MEETING 1998 ~~Winter Meeting 1994 Winter Meeting 1996~~).

Adopted Annual Meeting 1980; revised Annual Meeting 1981, Winter Meeting 1982, Annual Meeting 1984, Winter Meeting 1986, Annual Meeting 1986, Winter Meeting 1988, Winter Meeting 1989, Annual Meeting 1989, Winter Meeting 1990, and Winter Meeting 1994 (formerly Policy C-5).

HR 31 INDIAN HEALTH SERVICE

Resolution Summary

The resolution describes the federal trust responsibility for Indian people to include the provision of health care, the federal funding and administration of the health care through the Indian Health Service (IHS), and special Medicaid provisions under which the Federal government assumes responsibility for the full costs of care provided through IHS facilities. It defines the respective federal and state government roles in the provision of health care to American Indians/Alaskan Natives (AI/ANs) exclusively in terms of treaty-based trust responsibilities which obligates the Federal government, not States, to provide health care to AI/ANs. It concludes that states have no role in the financial support or operation of IHS facilities.

Summary of Administration Position

The draft resolution correctly identifies the federal responsibility for the funding and provision of health care to AI/ANs. However, it overlooks the right of AI/ANs, as state citizens, to access state-funded health services on the same basis as other citizens. The resolution fails to acknowledge state responsibility for its AI/AN citizens by tying governmental responsibility for Indian health care exclusively to treaty obligations. Federal Indian law and policy does not preempt state responsibility under Federal Medicaid law to provide health services to all eligible citizens including its AI/ANs citizens.

The Administration agrees that reform of publicly funded health care programs like Medicaid must not affect federal and state responsibilities for Indian health services which are based either on treaties or citizenship. It is important to remember that AI/ANs possess dual citizenship. They are citizens of their tribes, as well as citizens of their state. The Administration supports the preservation of the individual federal entitlement to health care coverage for all low-income families with children, elderly and disabled.

The Administration is committed to fulfilling the Federal obligation to provide health care to AI/ANs and preserving the 100 percent reimbursement for Medicaid services for eligible AI/ANs receiving care in IHS facilities. However, the Administration cannot advance or support policies which make the Federal government the sole provider of health care to AI/ANs and abrogate the right of AI/ANs to participate in state funded services on the same basis as any other state citizen.

In summary, the resolution defines roles and responsibilities of the federal and state governments with regard to the provision and financing of Indian health care in a manner that is inconsistent with the longstanding legal rights of AI/ANs as citizens.

HR-31. INDIAN HEALTH SERVICES

31.1 PREAMBLE

THE U.S. GOVERNMENT HAS A TRUST RESPONSIBILITY FOR INDIAN PEOPLES, AND THIS TRUST RESPONSIBILITY EXTENDS TO THE PROVISION OF HEALTH CARE. THE FEDERAL GOVERNMENT HAS ESTABLISHED AND FINANCIALLY SUPPORTS THE INDIAN HEALTH SERVICE AND HAS MADE SPECIAL PROVISIONS IN THE CURRENT MEDICAID PROGRAM TO ENSURE THAT THE FEDERAL GOVERNMENT BEARS ALL OF THE COSTS OF CARE PROVIDED THROUGH INDIAN HEALTH SERVICE FACILITIES. STATES DO NOT HAVE TREATY-BASED TRUST RESPONSIBILITIES TO PROVIDE HEALTH CARE TO NATIVE AMERICAN PEOPLES AND, CONSEQUENTLY, HAVE NO PROPER ROLE IN THE FINANCIAL SUPPORT OR OPERATION OF INDIAN HEALTH SERVICE FACILITIES.

31.2 RECOMMENDATIONS

RECENT CONGRESSIONAL PROPOSALS TO RESTRUCTURE PUBLICLY FUNDED HEALTH CARE IN THE UNITED STATES MAY AFFECT THIS LONG-STANDING BALANCE OF ROLES AND RESPONSIBILITIES AMONG FEDERAL, TRIBAL, AND STATE GOVERNMENTS WITH REGARD TO THE PROVISION AND FINANCING OF HEALTH CARE FOR NATIVE AMERICANS. TOWARD THAT END, THE GOVERNORS REAFFIRM OUR BELIEF THAT:

- STATES NOT BE REQUIRED TO SUBSIDIZE THE U.S. GOVERNMENT TRUST RESPONSIBILITY;
- THE INDIAN HEALTH SERVICE AND TRIBAL GOVERNMENTS BE DIRECTLY FUNDED BY THE U.S. GOVERNMENT AT A LEVEL THAT DOES NOT REQUIRE A STATE SUBSIDY TO PROVIDE HEALTH SERVICES;
- IF STATES CONTINUE TO BE INVOLVED IN THE PROVISION OF HEALTH SERVICES TO INDIVIDUALS COVERED BY THE FEDERAL TRUST RESPONSIBILITY, 100 PERCENT FEDERAL FUNDS BE MADE AVAILABLE TO STATES FOR SUCH MEDICALLY NECESSARY CARE WITHOUT REGARD TO THE PROVIDER OF THE SERVICE; AND
- THE DISBURSEMENT OF FEDERAL FUNDS FOR HEALTH CARE SERVICES ON BEHALF OF INDIVIDUALS COVERED BY THE FEDERAL TRUST

RESPONSIBILITY NOT COUNT AGAINST ANY ALLOTMENT LIMIT THAT
MAY BE IMPOSED ON STATE MEDICAID PROGRAMS.

Time limited (effective Winter Meeting 1996-Winter Meeting 1998).

NGA POLICY RESOLUTION

Low Income Home Energy Assistance Program

Summary: The proposed new policy supports federal energy assistance to low-income households to meet home heating and cooling needs. It calls for continued advance funding for the program and for emergency funds available upon the request of the President in the event of natural disasters, increases in energy prices, and other emergencies.

HHS View: ACF has no concerns with the proposed policy resolution.

HR-33. LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

33.1 PREAMBLE

THE GOVERNORS BELIEVE THAT THE FEDERAL LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) IS AN IMPORTANT FEDERAL ASSISTANCE PROGRAM. THEY BELIEVE THAT LIHEAP SHOULD BE MAINTAINED. LIHEAP PROVIDES ENERGY ASSISTANCE TO LOW-INCOME HOUSEHOLDS TO MEET HOME HEATING AND COOLING NEEDS. THE PROGRAM CURRENTLY SERVES CLOSE TO 6 MILLION PRIMARILY ELDERLY, DISABLED, AND WORKING POOR HOUSEHOLDS. THE AVERAGE HOUSEHOLD INCOME OF MOST RECIPIENTS IS LESS THAN \$8,000 PER YEAR. LIHEAP ALSO ACTS AS A LEVER, HELPING TO ENCOURAGE UTILITIES AND OTHER SOURCES TO ESTABLISH FUEL FUNDS AND OTHER SOURCES OF ASSISTANCE TO HELP LOW-INCOME HOUSEHOLDS PAY THEIR FUEL BILLS.

33.2 STATE RESPONSIBILITY

UNDER CURRENT LAW, STATES HAVE MAXIMUM FLEXIBILITY TO ALLOCATE LIHEAP RESOURCES, SET ELIGIBILITY LEVELS, AND DETERMINE ADMINISTRATIVE STRUCTURES. ONE INDICATION OF THE SUCCESS OF THIS APPROACH IS THAT STATES ARE ABLE TO ALLOCATE FUNDS USING A LIMITED ADMINISTRATIVE FUNDING LEVEL OF 10 PERCENT.

33.3 IMPLEMENTATION

THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PROVIDE ADVANCED FUNDING FOR LIHEAP. WITHOUT ADVANCED FUNDING, THE POTENTIAL FOR DELAY IN PROGRAM APPROPRIATIONS CAN CREATE SEVERE PROBLEMS IN STATES WHERE THE WINTER HEATING SEASON CAN BEGIN AS EARLY AS OCTOBER.

33.4 CONTINGENCY FUND

EMERGENCY FUNDS SHOULD CONTINUE TO BE AVAILABLE UPON THE REQUEST OF THE PRESIDENT IN THE EVENT OF UNFORESEEN INCREASES IN ENERGY PRICES, NATIONAL DISASTERS, AND OTHER EMERGENCIES.

Time limited (effective Winter Meeting 1996-Winter Meeting 1998).

NGA POLICY RESOLUTION

Head Start

Summary: NGA is seeking to reaffirm an existing policy calling for Head Start to be better integrated into statewide comprehensive service initiatives for young children. The State Collaboration Grant program should be expanded and states allowed to assign responsibility for administering the grants.

HHS View: ACF has no concerns with the reaffirmation of this policy resolution.

HR-9. HEAD START

9.1 Preamble

The Governors recognize the essential role that Head Start plays in providing comprehensive child development and support services to young children and their families with incomes at or below the poverty level. As Governors take a greater leadership role in orchestrating comprehensive services for young children, the National Governors' Association believes that much can be learned from the Head Start experience, not only in providing comprehensive services, but also in educating policymakers and the public about the need to invest in young children.

Although several states are integrating the Head Start program into larger comprehensive service initiatives for children, the Governors believe that additional steps should be taken at both the state and federal levels to develop stronger ties between Head Start programs and other state and federal resources that support at-risk children and their families. The Governors applaud the efforts of the Advisory Committee on Head Start Quality and Expansion to encourage such linkages at the federal, state, and local levels.

9.2 State Role

At the state level, the Head Start community should be included in policy development and implementation of statewide comprehensive service initiatives for young children. Head Start can serve as a bridge or link for at-risk children and their families for care and services beyond Head Start. State-level barriers to providing comprehensive services should be identified and eliminated.

9.3 Federal Role

In reauthorizing the Head Start program, Congress should ensure that the Head Start program of the 21st century is built on the concept of collaboration with other state and federal programs that provide services and resources to at-risk children and their families. The State Collaboration Grant program should be expanded and states should be allowed to assign responsibility for administering the grants to ensure the highest level of commitment to building and operating comprehensive service programs for young children and their families. The collaboration grant and all collaborative activities should be recognized as affecting the early childhood community overall and should serve as advocates for comprehensive services for young children and their families. Federal-level barriers to providing comprehensive services should be identified and eliminated. Although more than twenty states currently support collaboration projects, other mechanisms to strengthen state-level linkages and encourage state investment in early childhood programs should be developed.

Time limited (effective WINTER MEETING 1996-ANNUAL MEETING 1996 ~~Winter Meeting 1994-Winter Meeting 1996~~).

Adopted Winter Meeting 1994.

"Tobacco Information"

CLINTON ADMINISTRATION RECORD ON TOBACCO

President Clinton's initiative is clearly aimed at preventing children from smoking cigarettes and using chewing tobacco. That's the only issue for the Clinton Administration -- protecting our children's health and future. The Administration is not proposing a ban on tobacco products, it is not denying adults the right to buy and use tobacco products.

We are facing a major public health crisis with our children and grandchildren. Each day, 3,000 young people become regular smokers and nearly 1,000 of them will die prematurely from cancer, heart disease, emphysema and other diseases caused by tobacco use.

It's getting worse. The most recent studies show smoking rates are climbing among our teenagers. In 1995, smoking rates increased among 8th, 10th and 12th graders. These are our children and grandchildren, we're talking about.

Here are the numbers and they tell us we are in trouble:

- among 10th graders, 27.9% had smoked within 30 days and 16.3% smoked every day
- among 12th graders, 33.5% had smoked within 30 days, and daily smoking was up to 21.6%
- and among our youngest children, 8th graders: 19.1% had smoked within 30 days, and 9.3% smoked every day

We have to act now, and President Clinton is showing real leadership -- tackling this head-on in a number of ways. From the Synar amendment to the Food and Drug Administration's proposals, President Clinton is showing how to work with states on a tough national issue.

Those of you fighting this fight at the state level have told us how you appreciate this leadership. Twenty-seven (27) state attorneys general wrote a letter in support of President Clinton's initiative and the Food and Drug Administration's proposals to implement that initiative.

Here's what the AGs said: "We believe that the proposed rule, which emphasizes reducing access and limiting the appeal of tobacco products, should be a crucial component of a national effort by federal, state and local officials to help our youngest generation of Americans avoid suffering preventable disease and premature death from the use of tobacco products."

The FDA proposals make sense: Reduce kids' access to these products and limit the appeal of these products. You have to do both if you're going to make progress. All the experts tell us that: reduce supply, reduce demand.

This is a national problem and the FDA approach gives us a national solution -- and then allows the individual states to take additional steps that make sense for their communities.

Requiring age verification and face-to-face sales, eliminating mail order sales and free samples, removing vending machines, and stopping the sale of single cigarettes or the so-called "kiddie packs," packages with less than 20 cigarettes -- this is just good, common sense.

We know our kids think smoking is cool or sexy or hip. That's the message from \$6 billion worth of tobacco industry advertising and promotion.

So, the President says keep billboards away from playgrounds and schools, make the advertising in magazines our kids read less attractive by making it black-and-white text only, and let's keep our kids from becoming walking billboards with caps and t-shirts and gym bags emblazoned with the cigarette and chewing tobacco brand names. That's common sense.

Mike Synar, the late Congressman from Oklahoma, was a great fighter to protect our children from the death and disease of tobacco use.

President Clinton said it all in a letter to Mr. Synar's family: "The Synar regulation is an integral component of our country's childhood tobacco control efforts. The regulations will enlist all state governments in a campaign to stop illegal tobacco sales and discourage thousands of young people from striking the first match of a lifelong, life-threatening addiction."

The Synar Amendment requires states to have laws to prevent kids from buying cigarettes and chewing tobacco, and the Synar regulation just announced by the Department of Health and Human Services tells states how they should comply with this law.

Together with the FDA proposals, Synar puts in place a comprehensive, common sense strategy to protect our children.

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