

MEMORANDUM

TO: Distribution

April 3, 1995

FR: Chris J.

RE: GAO Medicaid Waiver Report

Attached is our latest and final draft reply to the GAO Medicaid waiver report. Nancy Ann just gave it to me, and informed me that some Q's & A's will shortly be forwarded to us.

Diana, I hope I am not duplicating and intruding upon your work. Knowing of the interest in this among us, I wanted to get out as soon as I received any information from her.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

March 31, 1995

The Honorable Charles A. Bowsher
Comptroller General of the
United States
General Accounting Office
Washington, DC 20548

Dear Mr. Bowsher:

Enclosed is the Administration's response to the draft GAO report, "MEDICAID: Spending Pressures Drive States Toward Program Reinvention." We appreciate the opportunity to review this draft report and provide our comments on it.

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce C. Vladeck", with a long horizontal flourish extending to the right.

Bruce C. Vladeck
Administrator

Enclosure

The Administration's Response to Draft GAO Report, "MEDICAID: Spending Pressures Drive States Toward Program Reintervention"

The Administration's budget neutrality methodology

There is no such thing as a State-specific Medicaid baseline. Thus, in reviewing State projections of without-waiver expenditures, the Administration generally compares State historical expenditure growth to the benchmark of baseline growth in the Medicaid program for the nation as a whole. In so doing, the Administration recognizes that there has historically been dramatic variation in State Medicaid programs, e.g., differences in the use of disproportionate share funding, etc. These factors (as well as the geographic variation in practice style) have resulted in radically different levels of expenditures and growth rates across the states.

Further, it is important to recognize that the Administration determines budget neutrality on the basis of current federal law, which is also the basis used in the President's Budget to project baseline Medicaid expenditures. Therefore, in its review of waiver proposals, the Administration acknowledges that under current Federal law States are able to engage in program changes.

Waiver review policy changes under this Administration

The GAO report suggests that this Administration's waiver review policies are different than previous Administration's policies. It is important to note that prior to the Clinton Administration taking office in 1993, only one comprehensive Statewide section 1115 Medicaid waiver had been granted. Recognizing the desire and the need of states to have greater flexibility in reforming their Medicaid systems, upon taking office the Clinton Administration encouraged states to design innovative health delivery systems tailored to each State's unique circumstances, while preserving and enhancing access to quality care. To facilitate these aims, the Clinton Administration developed a more flexible approach to reviews of waiver proposals submitted under section 1115 of the Social Security Act. The Administration announced the principles that would guide its review of such proposals in the Federal Register on September 27, 1994, stating its desire to "facilitate the testing of new policy approaches to social problems" and pledging, among other things, to:

- work with states to develop research and demonstrations in areas consistent with the Department's policy goals;
- consider proposals that test alternatives that diverge from that policy direction;

- consider, as a criterion for approval, a State's ability to implement the research or demonstration project;
- grant waivers to test the same or related policy innovations in multiple States as a mechanism by which the effectiveness of policy changes can be assessed;
- compute budget neutrality over the life of the waiver, since many demonstrations involve making "up-front" investments in order to achieve out-year savings;
- recognizing the difficulty of making appropriate baseline projections of Medicaid expenditures, remain open to development of a new methodology in that regard; and
- in assessing budget neutrality, the Department will not rule out consideration of other budget neutral arrangements proposed by States.

The Administration articulated these principles for reviewing waiver request in part as a response to State concerns about arbitrary spending limits, e.g., the inherent limitations in projections of future spending, the lack of consistently reliable data, and past State experience showing that even the best planning can be overwhelmed by unforeseen effects.

GAO'S use of the national current services baseline to establish budget neutrality

The Administration disagrees with GAO's preliminary analysis of the financing provisions of four Statewide Medicaid demonstrations discussed in the draft report. GAO applies a uniform budget neutrality methodology to each State, without a discussion of the advantages and disadvantages of that approach. GAO compares the baseline costs and growth rates of the approved projects to a "current services" baseline, and finds that three of the four States may not be budget neutral. We believe that each demonstration is budget neutral and take issue with GAO's assumption that their rigid methodology is appropriate for all States. Recognizing that States and their Medicaid programs vary significantly, as discussed above, we have used a more flexible approach to ensure that each project is budget neutral.

There are several conceptual and technical problems with the GAO's approach to using the national current services baseline to establish budget neutrality in all states:

The GAO uses as a standard for Federal budget neutrality a current services baseline, which they define to include expenditures needed to finance the program assuming laws and policies that are in place at the State level today. Nevertheless, the GAO applies this current services standard to a current law baseline (the President's Budget does not differentiate between the two, essentially applying a current law approach to estimates of current services baseline expenditures). The GAO does not construct a true current services baseline for their analysis.

Conceptually, current services is the wrong baseline to adjudicate budget neutrality. In granting waivers, the federal government determines budget neutrality on the basis of current federal law -- the basis also used to project baseline Federal expenditures. Under current federal law states are able to engage in program expansions and contractions. Thus, establishing a state-specific budget neutrality baseline at a minimum must involve some judgement regarding states' behavior under current law. (See further discussion of hypotheticals below).

The report spends considerable time (Summary, page 2) relating the dramatic variation in state Medicaid programs, i.e., difference in the mix of eligible populations, the mix of services offered, provider payment rates, and the use of disproportionate share funding. All of these factors (as well as the geographic variation in practice styles) have resulted in radically different levels of expenditures and growth rates across the states. However, this variation is ignored in selecting their budget neutrality approach.

The report (Summary, page 3) asserts that the determination of the without-waiver baseline is in considerable "dispute." Yet in asserting its methodology, GAO offers no discussion of pros and cons of its approach or alternative methods. The GAO should at least attempt an analysis of budget neutrality using state-specific data.

Waivers involve subsets of the Medicaid population and services. GAO applies the President's Budget Current Services Medicaid baseline to establish its budget neutrality baseline. It is unclear how GAO measured the services used by "populations covered by the waiver."

For the four waiver states for which GAO provided its estimates of year-by-year with and without baselines, based on the President's Budget baseline for FY 1996, we note that across the four waivers, the federal government actually realizes small savings (0.1% relative to total Federal Medicaid outlays for the FY 1994 to FY 1998 period).¹

The Inclusion of 1902(r)(2) expansion populations in State demonstration baselines

The report criticizes the Administration's decision to allow states to include in their demonstration baselines the cost of extending coverage to optional groups under section 1902(r)(2) of the Social Security Act. We believe this decision is consistent with a current law approach and reflects the priorities of the Administration and Congress to extend coverage to pregnant women and children. We would also emphasize that, to be counted in the "without waiver" baseline costs, the expanded populations must also be covered under the demonstration.

¹The four states are Tennessee, Florida, Oregon, and Hawaii.

Entitlement growth played minor role in Medicaid's high growth

We concur with GAO's finding that entitlement growth was not the major cause of the 17% cost growth experience in the Medicaid program between 1985 and 1993. However, we believe it is misleading to compare this growth rate with growth in the federal budget of 3.8% over the same time period, as on page 4 of the summary.

Waivers used to do more than contain costs and expand program coverage

GAO's report suggests that the objectives of section 1115 are limited to containing costs and expanding coverage. While these objectives are important -- and we believe they are achieved in section 1115 waivers discussed in this report -- the Administration believes this focus is too narrow.

First, in addition to containing costs and expanding coverage, section 1115 demonstrations allow states to experiment with innovative delivery and payment systems for their Medicaid or low-income populations.

Second, we do not agree with the statement that "whether the comprehensive scope of the demonstrations can be characterized as experimental is controversial." HCFA considers each of the statewide demonstrations as having unique components that are worth testing under a demonstration and has awarded two contracts to evaluate the innovative features of each implemented program.

April 3, 1995



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to: Nancy-Ann Min

Through: Barry Clendenin *BC*
Mark Miller *MM*

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Subject: Questions/Answers for Mike
McCurry Press Conference on
GAO's Medicaid Waiver Report

With informational copies for:

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From: Parashar Patel *P.P.P.*
Andy Allison *AA*

Attached are questions and answers on GAO's report, "MEDICAID: Spending Pressures Drive States Toward Program Reinvention".

**Qs and As for Draft GAO Report -- "MEDICAID: Spending Pressures Drive States
Toward Program Reinvention"**

Q. The Draft GAO report indicates that while section 1115 Medicaid waivers allow for greater flexibility to contain state spending, the federal government would not likely realize cost efficiencies because waiver approval in some States also permits coverage expansions. The Draft report also finds that some States' section 1115 Medicaid demonstration waivers could increase federal spending. **Have these waivers increased federal spending?**



A. We believe that each demonstration is budget neutral and disagree with GAO's preliminary analysis of the financing provisions of four Statewide Medicaid demonstrations discussed in the draft report.

GAO applies a uniform budget neutrality methodology to each state. The Administration takes issue with GAO's assumption that their rigid methodology is appropriate for all States. In our response to the Draft GAO report, we noted several conceptual and technical problems with GAO's approach to using the national current services baseline to establish budget neutrality in all States. Recognizing that States and their Medicaid programs vary significantly, the Administration has used a more flexible approach to ensure that each project is budget neutral.

We also note that for the four waiver States for which GAO provided its estimates of year-by-year, with and without waiver spending, based on the President's Budget baseline for FY 1996, across the four waivers, the federal government actually realizes small savings (0.1% relative to total Federal Medicaid outlays for the FY 1994 to FY 1998 period). The Federal Government realizes savings because, using GAO's methodology and data, Federal savings under Tennessee's waiver are greater than the additional Federal costs in the three other waiver States.¹

Q. **One of GAO's principal findings is that entitlement growth played a minor role in Medicaid's high growth rate. Do you agree?**

A. We agree with GAO's finding that entitlement growth was not the major cause of the high cost increases in the Medicaid program between 1985 and 1993.

Rather factors such as increases in the disproportionate share reimbursement program for hosp. fees and

¹The other three waiver States are Hawaii, Florida, and Oregon.

have been more significant.

Q. GAO indicates that until 1993 section 1115 waivers were limited in scope and that all section 1115 waivers approved since have been approved as statewide demonstrations. GAO notes that questions have arisen as to whether the comprehensive scope of these demonstrations can be characterized as experimental. **Are these waivers experimental?**

A. GAO's Draft report suggests that the objectives of section 1115 are limited to containing costs and expanding coverage. While these objectives are important -- and we believe they are achieved in section 1115 waivers discussed in this report -- the Administration believes this focus is too narrow.

First, in addition to containing costs and expanding coverage, §1115 demonstrations allow States to experiment with innovative delivery and payment systems for their Medicaid or low-income populations.

Second, we do not agree with the statement that "whether the comprehensive scope of the demonstrations can be characterized as experimental is controversial." The Administration considers each of the statewide demonstrations as having unique components that are worth testing under a demonstration and has awarded two contracts to evaluate the innovative features of each implemented program.

Q. Many of the States that have received approvals for section 1115 demonstration programs use capitated managed care arrangements to provide services for Medicaid recipients. While such arrangements can increase access, some advocates argue that such care also means that quality of care and access problems can go undetected without adequate beneficiary education and vigorous state and federal oversight. **Given the recent problems with Medicaid HMOs in Florida and the problems with Tennessee's waiver as outlined in the GAO report, what steps has the Administration taken to ensure quality care?**

A. Quality and access to quality care are a high priority for the Administration. We carefully evaluate each proposal to determine whether the State has developed a performance-based quality improvement program and can guarantee access to critical health services. We work particularly closely with States to develop agreements on monitoring, quality assurance activities, and access standards.

Q. GAO says that since 1993 the Administration has applied the test of budget neutrality in such a way as to allow States more flexibility in showing that their proposed projects would be budget neutral. **Why did the Administration change its test of budget neutrality?**



A. It is important to note that prior to the Clinton Administration taking office in 1993, only one Statewide section 1115 Medicaid waiver had been granted. Recognizing the desire and the need of States to have greater flexibility in reforming their Medicaid systems, upon taking office the Clinton Administration encouraged States to design innovative health delivery systems tailored to each State's unique circumstances, while preserving and enhancing access to quality care. To facilitate these aims, the Clinton Administration developed a more flexible approach to reviews of waiver proposals submitted under section 1115 of the Social Security Act. We believe that each demonstration waiver is budget neutral.

The Administration announced the principles that would guide its review of such proposals in the Federal Register on September 27, 1994. The Administration articulated these principles for reviewing waiver requests in part as a response to State concerns about arbitrary spending limits, e.g., the inherent limitations in projections of future spending, the lack of consistently reliable data, and past State experience showing that even the best planning can be overwhelmed by unforeseen effects.

Q. According to the GAO, each of the waiver agreements ensures some limits on federal spending and holds some financial risks for the States. If there are cost overruns, the federal government, under each of the waivers, has limited its liability for such cost overruns. However, the States will not receive federal assistance in paying for costs in excess of the agreed-upon limits. But in fact, as GAO points out, the impact of higher than anticipated costs on federal funding depends on the specific waiver agreement and HCFA's enforcement. **Given the fact that the Administration has allowed States to expand coverage and incur liability for additional costs, what will the Administration's response be if States cannot meet their caps?**

A. All of the waiver agreements include explicit enforcement mechanisms, including reporting requirements and sanctions for non-compliance.

Q. **Has HCFA ever approved or will they ever approve a waiver with growth rates below the national average?**

A. Allowable growth under Tennessee's waiver is below the national growth rate expected at the time the waiver was approved.

I assume that if you have had a chance to read this report, you realize that it criticizes the Administration's handling of 1115 waivers. It states that there has been a change in policy under the Clinton administration and that policy is less fiscally responsible than the Bush Administration policy. Some of the more critical statements are:

WAIVERS ARE NOT BUDGET NEUTRAL

"...the administration has allowed states to make adjustments and determine a new baseline... In contrast, we believe a more rigorous test of budget neutrality measures spending using a current services baseline. Thus, we consider the demonstrations to add to federal costs..."

CONGRESS IS BEING BYPASSED

"In essence, states will have used Medicaid to finance state health reform without the opportunity for congressional consent or debate."

CLINTON ADMINISTRATION POLICY IS LESS FISCALLY RESPONSIBLE

"Four states..sucessfully argued that their baselines should include the costs of extending coverage to optional eligibility groups that could have been, but were not then, served by the state's Medicaid program" "That a policy change occurred in 1993 is underscored by the fact that, according to one Oregon official, the state was unsuccessful in making its argument to the previous administration."

"Federal Medicaid expenditures could increase substantially if all states successfully made the 1902(r)(2) argument. The Urban Institute estimates that annual state and federal [Medicaid] spending could increase by between \$5.5 billion and \$23 billion."

"Another policy change since 1993 is to allow demonstrations to show budget neutrality over the life of the waiver, but not require it year by year."

We have drafted some criticisms of the GAO report in general and their application of a national growth standard specifically. As you know, OMB staff have considered national growth standards in the past, and in fact the most recent waiver negotiations (IL, DE) reflect national growth rates. When we send over our comments on the GAO report, we will also send over a discussion of moving toward a methodology like GAOs.

The GAO report is being done at the request of the House Budget Committee. The report will be released Arpil 4th, at which time the GAO will testify. They have asked for comments from OMB and HHS by COB Monday. Also recall that in addition to GAO, CBO has been asked to comment on this issue. If they choose to comment, we can expect CBO to point-out that one of the main differences between their Medicaid baseline and the Administration's is that CBO assumes that these 1115 waivers are not necessarily saving the federal government money.

We strongly recommend the following actions:

- 1) inform Jack Lew and Bob Damus of this draft report's conclusions [I can do this if you want me to];
- 2) raise this report to the Director's attention--we may want to brief her on its contents and provide her with possible responses; and
- 3) coordinate with HHS on our responses [I spoke with D. Chang and Barb Cooper on Friday night--they have started the review but they did not sound like they were moving very fast "we will put it in the review process"--you may want to contact Judy F. to assure that this report gets HHS/HCFA's prompt attention.]

**Draft GAO Report:
"MEDICAID: Spending Pressures Drive States
Toward Program Reinvention"**

- GAO was scheduled to release the report today in a Kasich hearing.
- The report looks at the Administration's approval of section 1115 waivers for states to expand their Medicaid programs.
- The report concludes that in 3 out of 4 specific instances where waivers have been used, they are not budget neutral -- that is, they are costing the federal government money.
- We disagree with this conclusion and have serious questions about GAO's technical approach.
- The report also implies that the Administration has used a different policy in reviewing the waivers from previous Administrations.

Q. According to the draft GAO report, section 1115 Medicaid waivers may have increased federal spending. Have they?

A. No. We believe that each waiver is budget neutral and disagree with GAO's preliminary analysis of the four Medicaid demonstrations discussed in the draft report.

GAO used a uniform method to determine if federal costs had increased. The Administration does not believe that GAO's rigid methodology is appropriate for all states. We also have technical concerns about GAO's methodology.

I might point out that, for the four waiver states GAO analyzed, even assuming GAO's methodology is correct -- the federal government actually realizes savings. (That's because, using GAO's methodology and data, Federal savings under Tennessee's waiver are greater than the additional Federal costs in the three other waiver states.)

Q. The GAO says the Clinton Administration has used a different policy in reviewing section 1115 waivers. Is that true?

A. From day one of this Administration, the President has made clear that he wanted to encourage state innovation while preserving access and quality for Medicaid beneficiaries. Before this Administration, only one of these waivers had ever been granted -- to Arizona in the early 1980s. The 7 waivers we've granted are covering almost 500,000 more people while saving the states money and not costing the federal government any more than it would have spent.

"Medical waivers"

Current Enrollment in Approved Section 1115 Demonstrations (As of 9/1/96)

<u>State</u>	<u>Current Eligibles</u>	<u>Expansion Eligibles</u>
AZ	480,024*	-----
DE	54,990	4,000
HI	Approx. 135,000 total	
MN	142,200	86,000
OH	295,861	-----
OK	125,133	-----
OR	255,742	108,207
RJ	68,943	2,424
TN	848,933	315,099
VT	-----	3,088
Subtotal		653,818

Projected Enrollment in Approved Demonstrations Not Yet Implemented

FL	-----	1,079,294
IL	1,500,000	-----
KY	493,108	-----
MA	480,000	434,000

TOTAL APPROVED WAIVERS:

2,167,112

X

Source: Health Care Financing Administration

* includes 457,798 in acute care program and 22,226 in long term care program

Chris - Official # that we use is 2.2 million

Medicaid Section 1115 Demonstration Waivers

As Medicaid reform legislation has stalled, states are increasingly using the section 1115 Medicaid demonstration waiver authority to pursue major statewide health reform initiatives. In order to further control costs and sometimes to expand eligibility beyond the upper limits in Medicaid law, states apply for these waivers of Medicaid law. OMB plays a major role in the negotiation of these waivers with HHS and the states, especially in the area of "budget neutrality."

History

- Since the original Medicaid legislation was passed in 1965, §1115 of the Social Security Act has given the Secretary of HHS the authority to waive certain requirements of the Medicaid program to support "an experimental, pilot or demonstration project."
- The §1115 authority allows the Secretary to waive more aspects of Medicaid law than the more limited §1915(b) waiver authority (known as a freedom of choice waiver) which states use even more frequently to move their eligible populations into managed care.
- The Administration has approved 12 statewide §1115 waivers and is in the process of evaluating 11 more. Prior to the Clinton Administration, only Arizona had received approval for a statewide §1115 waiver in 1984. Montana's behavioral health waiver application was disapproved. New Jersey and Washington are expected to submit waiver proposals this summer. Tab A includes a list of all the waivers with their approval or disapproval dates and waivers yet to be approved:
- Of the 13 approved statewide waivers, 9 states have implemented their programs. Florida, Kentucky, Massachusetts and Ohio have yet to obtain approval for their program from the state legislatures.
- In FY 95 acute care spending in States with approved waivers comprised 14% of total Medicaid spending. Acute care spending in states with pending §1115 waivers comprised 23% of total Medicaid spending. Since most demonstrations do not incorporate all State Medicaid acute care spending, these figures probably overstate the percentage of Medicaid expenditures attributable to the §1115 waivers.
- When all of the currently approved demonstrations are implemented, nearly 2.2 million individuals who did not receive Medicaid coverage will be eligible for services.

- States typically use the §1115 waiver process to:
 - move their AFDC, and more recently their disabled populations, into managed care;
 - obtain federal matching funds for costs that are not otherwise matchable under Title XIX (i.e. private health insurance premiums for the working poor);
 - use the managed care savings and other waiver-related revenues to cover traditionally non-Medicaid populations;
 - waive statutory enrollment requirements (e.g., the "75/25" rule that requires the enrollment of at least 25 percent privately insured patients in a managed care entity);
- After approval of the waivers, states later often seek federal approval for amendments to the waiver. Most often, the amendments are designed to reduce the costs of the waiver program by reducing the number of new eligibles or by reducing the costs per new eligible by a reduction in services or by imposing higher premiums.
- HCFA has funded an evaluation of five of the waivers (Tennessee, Hawaii, Rhode Island, Oklahoma, and Vermont). The evaluation should answer questions regarding how these demonstrations work, how they affect individuals, what they cost, and whether they are able to provide care that is as good as or better than that provided under the current Medicaid program. The final evaluation report is expected in September of 1998.

Non-statewide §1115 Waivers

- In addition to the statewide waivers which move large portions of a state's Medicaid population into managed care, states have also used the §1115 waiver authority to affect changes in smaller portions of their programs. Like the statewide §1115 waivers, these waivers also must be budget neutral.
 - *Family Planning Demonstrations* -- Several states have received waivers to extend coverage of family planning services to women who would lose their Medicaid eligibility post-partum. More recently, states are applying for waivers to extend family planning benefits to all women who would become Medicaid eligible if they became pregnant. These waivers also must be budget neutral. States must prove that the averted expenditures on new Medicaid births would outweigh the expenditures on expanded family planning services.

- *Integration of Medicaid and Medicare Financing* -- States are beginning to experiment with combining Medicare financing of acute care services with Medicaid financing of wrap-around acute care services and long-term care services. In these waivers, a managed care organization would receive one capitated payment for all Medicaid and Medicare services. Minnesota has already received a waiver to do this, although it is not yet implemented. Several other states have recently applied for similar waivers. The most recent Republican Medicaid proposal on May 22, 1996 would authorize HCFA to approve 10 such demonstrations.

- *Special Populations* -- Maryland received a waiver to provide enhanced case management to Medicaid recipients whose expenditures were or were anticipated to be in the top 10% of all recipients. The District of Columbia received a waiver to enroll disabled children into a specialty managed care plan designed to address their needs.

Budget Neutrality Process

- In 1993, the Administration recognized the desire and the need of states to have greater flexibility in reforming their Medicaid systems. At the same time, the Administration has also stated that the waivers must be budget neutral to the federal government. Although budget neutrality is not required by law, an agreement was reached on this issue with the National Governors Association (NGA) that was published in the Federal Register on September 27, 1994.

- The agreement with the NGA, includes the following guidelines:
 - HCFA now establishes a well-defined review schedule for each waiver with a target decision date that is approximately four months from HCFA's receipt of the proposal;
 - HCFA may make only one consolidated request for additional information about a proposal;
 - HCFA will not limit the lifespan of the waivers to 4-5 years;
 - OMB, HCFA and HHS review the waiver proposal concurrently to expedite the process;
 - demonstration waivers can now be used to test similar policies in more than one state and are no longer required to be unique;

- HCFA will provide states with technical assistance through a contract with the National Academy for State Health Policy;
- HCFA will assess cost neutrality over the lifetime of the project;
- and, when an experiment is successful, the Administration will seek legislation to allow for permanent change and the Administration will consider extensions to existing waivers that are successful until legislative authority is granted.

Budget Neutrality Negotiations

- OMB plays a major role in the negotiations between the states and the federal government to assure budget neutrality.
- Though the Administration has pledged to remain open to new methodologies for calculating budget neutrality, a budget-neutral waiver expenditure limit is generally set by projecting a state's "without-waiver baseline" current-law expenditures as follows:

- **Per-capita method.** Budget neutrality can be defined solely in terms of per-capita costs as follows:

$$\text{Baseline Expenditures} = \text{Projected Per-Capita Spending} \times \text{Actual Enrollment}$$

All but two states thus far have chosen this methodology because it does not hold them at risk for unexpected increases in enrollment.

- **Aggregate method.** Budget neutrality may also be defined in the aggregate, relying on projections of both per-capita costs and enrollment, as follows:

$$\text{Baseline expenditures} = \text{Projected Per-Capita Spending} \times \text{Projected Enrollment}$$

Only Tennessee and Florida have chosen an aggregate cap.

- The budget neutrality calculation generally includes only the services and recipients eligible for waiver services. Typically states do not include beneficiaries dually eligible for Medicaid and Medicare, residents of institutions, and medically needy eligibles under the waiver. States also do not usually include long-term care services.

- The budget neutrality discussions with the states generally focus on the development of an appropriate estimate of federal spending in a *base year* without the waiver, as well as appropriate *trend factors* over the five year life of the waiver. The federal without-waiver baseline is the limit of what the federal government will spend on the people and services under the waiver.
- In the budget neutrality negotiations, the state's incentive is to increase the without-waiver baseline as much as possible, especially if they are expanding eligibility or services. As a result, most of the budget neutrality discussions with states have revolved around the following issues:
 - "*Current Services*" Baseline v. "*Current Law*" Baseline -- Several states have wanted to project their without-waiver costs by including expenditures necessary to maintain their current program, i.e. a current services baseline, although federal or state law had changed, which would make that current services baseline impossible to support. For example, the OBRA 93 hospital-specific limits may reduce some states ability to continue to fund DSH at its historic levels.
 - *Hypothetical Eligibles* -- §1902(r)(2) of the Social Security Act allows states to expand eligibility for children under 10, pregnant women, the medically needy and qualified Medicare beneficiaries (QMBs) by liberalizing statutory income standards. For example, several states have incorporated into their without-waiver baseline eligibility expansions authorized under §1902(r)(2), but which are not yet implemented. The Administration policy has been to allow the baseline to be increased to reflect these hypothetical eligibles, if the state intends to include them in their waiver.
 - *Hypothetical Services* - Some states have requested including services in the without-waiver baseline that they have not yet provided under Medicaid, but intend to under the waiver. Administration policy has been to only include in the base year expenditures services which are currently being offered.
 - *DSH Payment Projections* -- Due in large part to the full implementation of the OBRA 93 hospital-specific payment caps in FY 96, it is difficult to estimate base year spending and to forecast growth in these expenditures in states which have been affected by the implementation of this law.
 - *Mixed §1115/§1915(b) Approach* -- States have begun to use the §1115 waiver authority to move their current Medicaid eligibles into managed care without an expansion in services or coverage. Section 1115 is supposed to be used only for "an experimental, pilot or demonstration project," although several states are using the waiver mostly to move recipients into managed care. States prefer a §1115 waiver to a §1915(b) waiver because they can lock enrollees into a managed care organization for a specified time period, can use managed care organizations that enroll less than 25%

private payors, and can obtain federal match for services not otherwise matchable. Allowing states to use the §1115 waiver process, however, could undermine the §1915(b) process. On the other hand, a §1115 waiver does subject a state to a more strict "budget neutral" standard, whereas a §1915(b) waiver is only held to a "cost effectiveness" standard.

- *Certified Public Expenditures (CPE)* -- CPE are costs incurred by states or local public agencies in the provision of Medicaid services. Under a §1115 waiver, the definition of Medicaid services and Medicaid eligibles can be expanded almost without limit. Thus, States have requested extending the base of federally-matchable expenditures to include local expenditures for non-Medicaid services, such as public health services, by using CPE.
- *Provider Taxes* -- The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 were enacted to curb the tremendous growth in the DSH program, in part, by restricting the ability of states to use certain types of provider taxes. Several states with §1115 waiver applications have been alerted that the expenditures supported by these taxes may be disallowed if the tax is determined to be impermissible. It is not yet clear how these potentially disallowable expenditures will be accounted for in the without-waiver baseline.
- *Current Managed Care Savings* -- Several states are requesting §1115 waivers which will cover Medicaid recipients already enrolled in a §1915(b) waiver. The Administration's policy has been that the savings that have accrued from currently implemented §1915(b) managed care waivers should be reflected in the base year expenditures. States have argued that this unfairly penalizes "good" states which have been pursuing managed care all along.

Criticisms of Administration's Waiver Policy

- In two reports, the GAO has criticized the Administration for approving waivers GAO considers not to be budget neutral to the federal government. GAO studied 4 of the §1115 waivers and found that only Tennessee was budget neutral, while Oregon, Hawaii and Florida were not budget neutral. GAO conclusion's are based on its judgment that budget neutrality calculations should rely on the use of the average of the 50 states' baseline rates of growth (i.e. the national Medicaid growth rates), instead of the more flexible approach based on individual state experience that has been taken by the Administration. The Administration responded by describing the flaws in GAO's methodology and pointing out that the Administration had crafted without-waiver baselines which promote fairness and State flexibility by taking into consideration the complexity and variation of a State's program, while also evaluating the robustness and appropriateness of the historical data in comparison to national trend rates.

COMPREHENSIVE HEALTH CARE REFORM DEMONSTRATIONS (05/17/96)			
STATE	KEY DATES	PROJECT OFFICER	TEAM LEADER/ BUDGET NEUTRALITY ANALYST
APPROVED - IMPLEMENTED (9)			
Arizona	Implemented: 1982 Amendments Under Review	Joan Peterson (410) 786-0621	Mike Fiore Ed Hutton
Delaware	Submitted: 1/29/94 Awarded: 3/17/95 Implemented: 1/1/96	Alisa Adamo (410) 786-6618	Paul Boben
Hawaii	Submitted: 4/19/93 Awarded: 7/16/93 Implemented: 8/1/94 Amendment Under Review	Anne Wade (410) 786-4175	Mike Fiore Ed Hutton
Minnesota	Submitted: 7/27/94 Awarded: 4/27/95 Implemented: 7/1/95	Bruce Johnson (410) 786-0615	Paul Boben
Oklahoma	Submitted: 1/6/95 Approved: 10/12/95 Implemented: 3/1/96	Patricia Seliger (410) 786-2672	Mike Fiore Paul Boben
Oregon	Submitted: 8/15/91 Awarded: 3/19/93 Implemented: 2/1/94 Amendment Under Review	Bruce Johnson (410) 786-0615	Sid Trieger Paul Boben
Rhode Island	Submitted: 7/20/93 Awarded: 11/1/93 Implemented: 8/1/94 Amendment Submitted	Debbie Van Hoven (410) 786-6625	Sid Trieger Paul Boben
Tennessee	Submitted: 6/16/93 Awarded: 11/18/93 Implemented: 1/1/94 Amendments Under Review	Rose Hutton (410) 786-6630	Sid Trieger Ed Hutton
Vermont	Submitted: 2/24/95 Awarded: 7/28/95 Implemented: 1/1/96	Sherie Fried (410) 785-6619	Mike Fiore Ed Hutton
APPROVED - PENDING IMPLEMENTATION (4)			
Florida	Submitted: 2/9/94 Awarded: 9/15/94 No Legislation	Alisa Adamo (410) 786-6618	Sid Trieger Paul Boben
Kentucky	Submitted: 5/26/93 Awarded: 12/9/93 Revised: 6/22/95 Amendment Approved: 10/6/95 Proposed Implementation: 1/1/97	Maria Boulmetis (410) 786-0552	Mike Fiore Ed Hutton
Massachusetts	Submitted: 4/15/94 Awarded: 4/24/95 Proposed Implementation: 9/1/96 Waiting for Legislation	Ed Hutton (410) 786-6616	— Ed Hutton
Ohio	Submitted: 3/2/94 Awarded: 1/1/95 Proposed Implementation: 7/1/96	David Walsh (410) 786-6628	Debbie Van Hoven Paul Boben

COMPREHENSIVE HEALTH CARE REFORM DEMONSTRATIONS (05/17/96)			
STATE	KEY DATES	PROJECT OFFICER	TEAM LEADER/ BUDGET NEUTRALITY ANALYST
FRAMEWORK APPROVED (1)			
South Carolina	Submitted: 3/1/94 Framework Approved: 11/18/94 Suspended: 4/95	Sherrie Fried (410) 786-6619	Paul Boben
DISAPPROVED (1)			
Montana Behavioral Health	Submitted: 6/15/95 Disapproved: 9/13/95	Nancy Goetschius (410) 786-0707	Mike Fiore Paul Boben
PROPOSAL UNDER REVIEW (11)			
Alabama	Submitted: 7/10/95	Maria Boulimacis (410) 786-6552	Mike Fiore Paul Boben
Georgia Behavioral Health	Submitted: 9/1/95	Nancy Goetschius (410) 786-0707	Debbie VanHoven Ed Hutton
Illinois	Submitted: 9/14/94	Olga Clemons (410) 786-9644	Lu Zawistowich David Walsh
Kansas	Submitted: 3/23/95	David Walsh (410) 786-6628	Mike Fiore Ed Hutton
Louisiana	Submitted: 12/31/94 Financial Proposal Disapproved: 6/8/95	Alisa Adamo (410) 786-6618	Lu Zawistowich Paul Boben
Maryland	Submitted: 5/3/96	Gina Clemons (410) 786-9644	Bruce Johnson Ed Hutton
Missouri	Submitted: 6/30/94 Revised: 5/24/95	Nancy Goetschius (410) 786-0707	Sid Trieger Paul Boben
New Hampshire	Submitted: 6/14/94 Revised Concept Papers Submitted: 6/13/95 9/20/95 1/96	Mike Fiore (410) 786-0623	Lu Zawistowich Ed Hutton
New York	Submitted: 3/20/95	Debbie Van Hoven (410) 786-6625	Lu Zawistowich Paul Boben
Texas	Submitted: 9/6/95	Alisa Adamo (410) 786-6618	Paul Boben
Utah	Submitted: 7/7/95	David Walsh (410) 786-6628	Ed Hutton
PRE-APPLICATION (2)			
New Jersey	Expected: 5/96	Bruce Johnson (410) 786-5615	Debbie Van Hoven
Washington	Concept Paper Submitted: 4/17/96 Proposal Expected: 5/96	---	---



Medical Waivers

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

FACSIMILE COVER SHEET

TO: CHRIS

FAX Number:

FROM: Jeanne

Pages:

Comments: (1) WISCONSIN - I realized that I'm not really sure what you're looking for. I DID NOT INCLUDE NO FED. ENTITLEMENT OR BENEFITS STUFF. I DID INCLUDE THE MED-WELFARE LINK, AND I'M NOT SURE IF IT'S APPROPRIATE. LET ME KNOW.

(2) 1115 Waivers - I AM REALLY WORRIED ABOUT THIS. WE WON THE EXCLUSION OF THESE STATES LAST YEAR BECAUSE THE SKY WAS FALLING. IF YOU APPROVE NY, WI AND OTHER STATES THIS SUMMER, HOW CAN YOU TURN AROUND IN JANUARY + TAKE THE MONEY AWAY?

(3) COALITION: HAS BRIDGES KEPT YOU UP TO DATE ON THEIR \$70 billion in MED USING CHAFFE-FORAYX LANGUAGE? IF BROWNIE GO DOWN, THEY WILL HAVE 1 FED. SAVINGS THAN REPUBLICANS.

DRAFT

WISCONSIN'S WELFARE PLAN: HIDDEN REPEAL OF MEDICAID GUARANTEE

Wisconsin's "welfare reform" proposal actually contains hidden provisions that end the Medicaid guarantee for many poor families.

NEEDLESS REPEAL OF MEDICAID GUARANTEE: The Wisconsin plan ends the nationwide guarantee of Medicaid — independent of welfare — for poor children and pregnant women.

- Over 45,000 children and pregnant women will lose guaranteed Medicaid coverage under Wisconsin's welfare plan — even though they do not get Medicaid because of welfare.
- While most of these Medicaid recipients will be eligible for a scaled-back health program, the State itself predicts that less than half will join because of required premiums. This means that over 27,000 poor children and pregnant women could lose health insurance coverage in Wisconsin in 1997.

MORE EXTREME THAN EVEN THE CONGRESSIONAL REPUBLICANS' PLAN:

The Wisconsin plan has greater restrictions on access to health coverage for poor children between 13 and 18 than for younger children.

- Both the House and the Senate Republicans put back into their Medicaid block grant bills a phased-in guarantee of coverage of children 13 to 18 years old, bowing to pressure from Democrats and groups concerned about children's health.

INCREASED UNINSURED AND UNCOMPENSATED CARE: The repeal of the Medicaid guarantee for poor children and pregnant women is coupled with denied eligibility for some people who currently receive welfare.

- Over 100,000 people in Wisconsin could become uninsured under the Wisconsin plan, according to the non-partisan Wisconsin Legislative Fiscal Bureau.
- The Wisconsin Hospital Association worries about increases in emergency room use and uncompensated care from the Wisconsin plan: "If even a fraction of this group goes uninsured, the costs down the road to hospitals and the privately insured may be high".

NOT NEEDED FOR WELFARE REFORM: Medicaid and welfare reform are not linked because of Medicaid's reliance on welfare but because of partisan politics.

- **Only a fraction of Medicaid spending relates to welfare recipients.** While there is a strong relationship between Medicaid and welfare, less than 20 percent of total Medicaid spending is dedicated to welfare (AFDC) recipients.
- **Governors agree that politics, not policy, drive the Medicaid - welfare link.** The Democratic Governors stated: "although we agree that welfare and Medicaid are inextricably linked in practice, we cannot agree to a legislative strategy that insists that they be united." (5/29/96). Even the Republican Governors acknowledge that they insist on the link because, if Medicaid reform is not included in the "plan now, public pressure to address this issue will fade and an historic opportunity will be lost." (6/25/96).

Issue: **Potential conflict between Medicaid 1115 waiver and reform policies.** 1115 states have negotiated budgets. In 1995 and 1996 Medicaid reform, these budgets were over-ridden by the per capita cap and DSH limits. However, the more waivers that are approved, the more difficult it will be to pre-empt them, especially if the per capita cap is introduced only months after waiver approval.

Effect: The President's \$54 billion in savings between 1997 and 2002 would be reduced to about \$30 billion if waiver states are excluded from the policies. Medicaid savings consistent with the 1995 and 1996 targets cannot be achieved if waiver states are excluded from the per capita and DSH limits.

Background: The following states have received 1115 waivers, or are likely to receive them:

State	Federal Benefits (\$ m)	Federal DSH (\$ m)	Total (\$ m, 1994)
Arizona	1,052 (1.4%)	70 (0.7%)	1,122 (1.3%)
Delaware	136 (0.2%)	3 (0.0%)	139 (0.2%)
Florida	2,690 (3.7%)	156 (1.5%)	2,846 (3.4%)
Hawaii	214 (0.3%)	15 (0.1%)	229 (0.3%)
Illinois *	2,424 (3.3%)	150 (1.4%)	2,574 (3.1%)
Kentucky	1,253 (1.7%)	48 (0.5%)	1,301 (1.6%)
Louisiana *	2,108 (2.9%)	975 (9.3%)	3,083 (3.7%)
Massachusetts	1,911 (2.6%)	271 (2.6%)	2,181 (2.6%)
Minnesota	1,325 (1.8%)	24 (0.2%)	1,349 (1.6%)
New York *	9,483 (13.0%)	1,253 (12.0%)	10,736 (12.9%)
Ohio	3,054 (4.2%)	303 (2.9%)	3,357 (4.0%)
Oklahoma	724 (1.0%)	17 (0.2%)	741 (0.9%)
Oregon	675 (0.9%)	13 (0.1%)	688 (0.8%)
Rhode Island	371 (0.5%)	51 (0.5%)	422 (0.5%)
Tennessee	1,722 (2.4%)	72 (0.7%)	1,794 (2.2%)
Vermont	160 (0.2%)	11 (0.1%)	171 (0.2%)
Wisconsin *	1,383 (1.7%)	7 (0.1%)	1,391 (1.5%)
TOTAL	30,544 (42.0%)	3,437 (32.9%)	33,981 (40.8%)

* May or may not be approved / treated as an 1115 state. Numbers may not sum to totals due to rounding.

Methodology: To estimate the effect on per capita cap and DSH savings from excluding these state, the following assumptions were made. About 40% of Federal benefits spending and 40% of person-year recipients were removed from the baseline. The 40% of spending comes from the table above. To maintain the 1995 per capita spending by group used in the CBO per capita cap model, 40% of recipients were excluded as well. Note that this is simplistic; since the distribution of spending and beneficiaries in these states is not likely to equal the national average, their exclusion would change the per capita spending. However, this analysis is meant to give an approximation, not a precise estimate. This approach lowers the per capita cap savings from about \$34 billion to \$21 billion between 1997 - 2002.

For DSH, it was assumed 30% of the Federal DSH baseline is excluded, and that the limits set in legislation are revised so that the savings are the same proportion relative to the revised baseline as they were without the 1115 state exclusion. This has the effect of reducing DSH savings from about \$39 billion to about \$28 billion between 1997 - 2002. The pool payments were not changed.

he may be "willing to limit eligibility" for medical savings accounts (MSAs) under the Kassebaum/Kennedy health insurance reform bill to businesses with 75 workers or less, instead of 100 workers as proposed earlier by congressional Republicans. Lott also said that staff and legislators "not among the leadership" were meeting yesterday to try to work out an MSA compromise that is "acceptable to Republicans and the White House." However, if no deal is reached on MSAs soon, Lott said he may "make another attempt" to appoint Senate conferees to the House-Senate negotiations on the bill. However, he said, "I might change the numbers or the mix around."

MIXING IT UP: Lott told CONGRESS DAILY that GOP leaders will "look at a mix that's acceptable" to Democrats. In referring to the ratio of Republican to Democratic conferees, Lott said, "We might go with 7-4, we might go with 5-3, we might go with 6-4." The current proposal, which has been rejected by Democrats, reportedly includes seven Republicans and four Democrats. A Senate Democratic source said that Democrats "will not approve the appointment of conferees who are predetermined to stack the outcome of the conference" in favor of MSAs (6/25).

MSA COST: The Republican MSA proposal could cost the average American family "more than 20 percent of its annual income if the family needed costly medical care," according to a study released today by Consumers Union. According to Consumers Union, families could face out-of-pocket expenses as high as \$7,500, or 23% of the average American family income of \$33,000.

ADD IT UP: According to Consumers Union, most current health insurance plans limit out-of-pocket expenses, with the median health insurance deductible for an individual at \$250 and \$500 for a family in 1995. However, Consumers Union estimated that a family living in the Washington, DC area expected a child would face an additional \$5,500 in expenses for an uncomplicated birth before their insurance kicked in under an MSA plan with a \$2,000 employee contribution and a \$7,500 deductible. In addition, the same family could be responsible for 30% of the cost of their care even after the deductible was met, which would add an additional \$2,250 to their expenses.

PUTTING IT IN CONTEXT: Consumers Union Director of Health Policy Analysis Gail Shearer said, "Today, four out of five consumers who get their health care from their employers are protected against never-ending health care costs. Under the proposal now being debated in Congress, those who choose MSAs would lack similar guarantees. Whether your health need is for childbirth, diabetes, paralysis or heart bypass surgery, MSA plans would mean financial agony for the average family" (release, 6/26).

Hea Hline 6/26

MORE ON LINK

*2 **MEDICAID/WELFARE:** REPUBLICANS WILL NOT SEPARATE REFORMS
 Republican leaders have decided to "stick to their original decision" and link proposals for Medicaid and welfare reform together in one piece of legislation, WASHINGTON POST reports (Yang, 6/26). House Speaker Newt Gingrich (GA) said yesterday that Republicans would include the reforms in one package, noting that a letter from the Republican Governors Association (RGA) was "the primary reason for proceeding in this manner" (Faulkner and Gray's HEALTH LEGISLATION, 6/26 issue). In the letter, the governors state, "There is no question that these two issues are inextricably linked and cannot be separated. ... Medicaid and

cash welfare are mutually dependent, and failure to reform both will mean the failure to reform either."

CAN'T HAVE ONE WITHOUT THE OTHER: The letter states that "many families become dependent on welfare mainly because they need the health care coverage provided by Medicaid. At the same time, a barrier to leaving the welfare rolls is the prospect of losing Medicaid coverage." In addition, the governors write that if Medicaid reform is not included in the "plan now, public pressure to address this issue will fade, and an historic opportunity will be lost" (RGA release, 6/25).

POSSIBLE CHANCE OF DIVORCE: However, HEALTH LEGISLATION reports that "speculation continues as to whether the package could be separated later." House Majority Leader Richard Arney (TX) left the door open, saying, "I'm willing and still open to finding out the best way to get this job done." However, Senate Budget Committee Chair Pete Domenici (NM) "questioned" whether the divided bills "would still be treated as a reconciliation bill, and, therefore, enjoy expedited procedure rules in the Senate." House Budget Committee Chair John Kasich (OH) "speculated" that should the reforms be split, the welfare bill would be treated as reconciliation legislation, while the future of the Medicaid component would be "unclear." The Senate Finance Committee is scheduled to begin marking up the Medicaid/welfare bill today (6/26 issue).

HEALTH ALLOWANCE: The House Appropriations Committee passed a \$65.6 billion spending bill which would fund health, welfare, labor and education programs for FY '97 by a 27 to 17 vote yesterday. The panel adopted an amendment by Reps. Jay Dickey and (R-AR) and Roger Wicker (R-MS) on a 25-20 vote that would continue the ban on federal funding for human embryo research. Dickey said that human embryo research is "lethally experimenting with a life" (POST, 6/26). WASHINGTON TIMES notes that the committee "blocked an effort" by Rep. Nita Lowey (D-NY) to "weaken" the ban "to allow some research on embryos created as a byproduct of in vitro fertilization."

RURAL AND IMMIGRATION SPECIFICS: Under the bill, \$2.6 million would be cut from the Centers for Disease Control and Prevention's (CDC) budget and shifted into a rural health care program designed to recruit physicians and nurses to "underserved" areas. TIMES notes that the National Rifle Association backs the cut, which is "equal to the amount the CDC spent last year studying gunshot wounds." Dickey said that the CDC's research "took the approach that gun ownership 'is a kind of disease.'" The committee rejected a provision, introduced by Rep. Esteban Torres (D-CA), which would have softened the language of spending restrictions for health and social services for the children of illegal immigrants (Sands, 6/26).

FAMILY PLANNING: The committee also rejected legislation which would have required individuals with incomes over 150% of the federal poverty level to pay the full amount for any family planning services they obtain. Noting that government funded family planning programs helped to prevent 500,000 abortions last year, Rep. John Porter (R-IL) called the provision a "direct attack" on the programs. Instead, the panel adopted an amendment which would require persons with incomes between 100% and 250% of the poverty level to pay for the services on a sliding scale basis.

Doing More With Less Money

Kenneth E. Thorpe, director of the Institute for Health Services Research at Tulane University Medical Center, suggested that states and cities must develop ways to care for growing numbers of the uninsured without expecting any more Medicaid money.

"Medicaid growth is over — that's just the reality," he said. Despite the stalling of congressional proposals for block grants, he continued, "no matter who is elected in November, my sense is not only that this debate will be revisited but that block grants will pass."

Backing acceleration of managed care enrollment, Thorpe suggested that while TennCare provided lessons "about how to do this wrong," experiments in Oregon and Arizona were worth studying for their effectiveness in reducing the number of the uninsured.

States and cities must learn "to act in the same role as any big purchaser," Thorpe said. "They cannot allow the managed care organizations to set the rules. Public authorities must make sure the rules are set up right and enforced." The result must be a system that does not just cut costs, but also is "designed around satisfaction and quality," he said. □

Accreditation

JCAHO DEVELOPS STANDARDS FOR LONG-TERM CARE PHARMACIES

CHICAGO—The Joint Commission on Accreditation of Healthcare Organizations announced June 19 the launching of a new accreditation program for long-term care pharmacies, with the initial surveys being scheduled for this summer.

The new standards have been designed for pharmacies that provide dispensing and consultation services to long-term care organizations such as nursing homes. The standards focus on pharmacy services provided directly to the resident (such as assessment of the medications used, planning of drug treatment, and drug therapy monitoring) and on those services provided to the organization (such as medication distribution, delivery of services, and staff education).

Approximately 5,000 organizations in the country currently meet the eligibility criteria for long-term care pharmacy accreditation. Individual practitioners or consultant pharmacists will not be accredited, except as part of an organization that is, or contracts with, a licensed pharmacy.

Hospital pharmacies and pharmacies owned and operated on-site by long-term care facilities only will be eligible under this program if they provide pharmaceutical services to patients in long-term care facilities that are not part of the same applicant organization.

For more information, contact Darryl Rich, service integrator, Home Care and Long Term Care Services, JCAHO, at (708) 916-5752. □

Public Health

MORE THAN 100 PUBLIC, PRIVATE GROUPS TO WORK TOGETHER FOR COMMUNITY HEALTH

More than 100 groups pledged June 21 to work together to develop long-term solutions for communi-

ty health improvement and to create an Action Agenda, according to the American Hospital Association.

The groups included national associations such as the AHA, the Association of American Medical Colleges, and the American Public Health Association, and public agencies led by the federal Centers for Disease Control and Prevention. They signed the declaration at a meeting called "Leadership Action Forum II: Building Bridges Between Public and Private Sectors for Community Health Improvement" held in Arlington, Va.

The Action Agenda declaration, according to the AHA press release, was aimed at helping communities deal better with their priority health issues, and promoting a broader definition of health including social, spiritual, physical, and mental dimensions of wellness. The document stated the groups will promote "community ownership of the health improvement process" and "literacy, education, and economic development as strategies to improve health."

Dick Davidson, AHA president, said at the meeting that the private and public sectors must align their priorities with each other and communities they serve to create a healthier environment.

Other groups signing the declaration included the American Lung Association, National Association of Public Hospitals and Health Systems, National Civic League, the National Association of Local Boards of Health, the Joint Commission on Accreditation of Healthcare Organizations, and the Midwest Business Group on Health. □

Provider Licensure

PHYSICIAN CREDENTIALS DATA BANK MAY BE 'UP AND RUNNING' JAN. 1997

The Federation of State Medical Boards intends to have a physician credentials data bank "up and running" by January 1997, Leroy B. Buckler, a federation director, said June 20.

The "Federation Credentials Verification Service" would serve as a "repository of verified credentials," Buckler told a District of Columbia Bar Health Law Section program on legal aspects of telemedicine.

"We hope all states will submit data, which will then be verified by federation personnel," he said, noting that the American Medical Association tried to advance a similar project but relied too heavily on physicians verifying their own credentials.

Any entity that must credential physicians could use the data bank, saving large amounts of time and money involved with primary verification of physicians' credentials, he said.

The proposed data bank also could ease the way for state adoption of the federation's "Model Act to Regulate the Practice of Telemedicine or Medicine by Other Means Across State Lines," he said.

The model act, approved last October, would allow a physician holding a valid unrestricted license in one state to expediently receive a medical license limited to the practice of medicine across state lines in other states.

Presently, physicians who practice medicine across state lines without being located physically in the