

PENDING MEDICAID WAIVERS

STATE	DESCRIPTION	ISSUES	120 DAYS
Florida	Governor Chiles submitted amendments to a waiver granted in 1994. The state legislature has so far refused to implement his plan, and these changes are intended to make implementation possible on a smaller scale. Original plan would have used managed competition to allow 1.1 million uninsured access to a limited Medicaid benefits package.	None, except timing. State officials have asked that the new waiver be approved within a few weeks, and HHS will try to accommodate them.	1/96
Georgia	Proposal to manage behavioral health services.	None identified yet.	1/96
Kentucky	State has asked for revisions to a waiver granted in 1993, after legislature rebuffed original plan to expand Medicaid eligibility. New plan would impose managed care using 8 regional partnerships.	Issue of lack of choice of health plans has held up approval. Yesterday HHS made offer to state and is waiting to hear back from them.	10/95
Missouri	Would impose managed care and expand coverage.	Problems with the state's use of provider taxes and disproportionate share funds.	7/95
Alabama	Would impose managed care and expand Medicaid eligibility for children and young adolescents to 133% of poverty level.	Problems with lack of choice of plans and competitive bidding.	11/95
California	Would impose managed care and offer beneficiaries a choice of a public or private HMO. However, public institutions are very concerned that the capitation rate will be so low that they will not be able to compete with the private sector, and that the state has allowed the private sector an advantage in enrolling Medicaid clients.	This is a "1915b" waiver. By statute, 1915b waivers are deemed approved after 180 days unless HHS denies them. (Most waivers are 1115 demonstration waivers, which HHS tries to act on in 120 days under executive order.) HHS has much less ability to control the approval process for 1915b waivers.	end of 12/95

State	Description	Issues	120 Days
Illinois	Would impose managed care. Public providers such as community health centers are very concerned about the waiver, but Cook County Hospital made a deal with the state for special financial protection.	Illinois owes providers \$1.5 billion in back payments. HHS has asked that this issue be addressed as part of the waiver. The state has not responded, and is no longer lobbying intensely for approval.	1/95
Kansas	Would test non-competitive managed care model in rural and small urban counties; and expand eligibility for children.	State would not competitively bid managed care contracts. State has agreed to offer a choice of plans.	7/95
New Hampshire	Would expand eligibility and establish pilots to help redesign health care delivery system.	None.	10/95
New York	New York has submitted 2 similar waivers: an 1115 demonstration waiver and a 1915b "freedom of choice" waiver. Both would rapidly enroll most clients in managed care, and have raised tremendous concerns for public institutions, unions, and advocates.	The state delayed its original implementation timetable, but it remains a very aggressive attempt to change the health care delivery system in a short time. HHS has less discretion on the 1915b waiver.	1115: 7/95 1915b: end of 10/95
Oklahoma	Would develop managed care in rural areas.	Budget neutrality issue.	5/95
Texas	Would impose managed care.	None identified yet.	1/96
Utah	Would impose managed care, expand eligibility, and create a state-subsidized health insurance plan for small employers.	Eligibility streamlining may cause some to lose benefits; charging premiums to those at 75% of poverty level too strict.	11/95
Los Angeles County	Details of waiver must still be worked out, including county agreement on the specifics of streamlining and state cooperation.	SEIU very disappointed that HHS did not require the county to negotiate with unions during transition.	NA

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THE WHITE HOUSE
WASHINGTON

22 September 1995

MEMORANDUM FOR THE VICE PRESIDENT
LEON PANETTA
CAROL RASCO

FROM: HAROLD ICKES *HI*
SUBJECT: LABOR PROTECTION IN THE MEDICAID WAIVER PROCESS

Attached is a self-explanatory memorandum to the President from me. It describes three options laid out by the Department of Health and Human Services for addressing the concerns of unions in the Medicaid waiver process. Also attached is a memorandum to me from Jennifer O'Connor summarizing the HHS memorandum and explaining the preferences of Secretaries Reich and Shalala on this issue. Also attached is a memorandum from Carol Rasco addressing these issues.

Finally, attached is a chart from HHS which describes all approved and pending Medicaid waiver requests, along with expected dates for pending decisions.

The President has requested a meeting regarding these issues. I believe it will take place next week.

THE PRESIDENT HAS SEEN

9/12/95

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THE WHITE HOUSE
WASHINGTON

September 11, 1995

MEMORANDUM FOR THE PRESIDENT

CC: LEON PANETTA
CAROL RASCO

FROM: Harold Ickes

SUBJECT: Medicaid waivers and worker protection

*We need to discuss
2 & 3 & consultation
let's meet w/ w/ on this*

On 11 August 1995, you met with Gerald McEntee, International President of American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME") on a number of issues including one that he is very concerned about -- the adverse affect on employees of medicaid waivers being granted by the Administration. The short of his brief was that medicaid waivers should not be approved by the Administration absent their containing adequate protection for current employees.

Both Mr. McEntee and John Sweeney, International President of Service Employees International Union, AFL-CIO ("SEIU"), have met several times jointly with Secretary Shalala, Secretary Reich, and others, as well as myself, to discuss this issue. The membership of both unions, which are staunch supporters of this Administration, have a large number of healthcare workers. At my request, HHS and Labor have discussed a number of alternative solutions to this situation and have prepared a draft memorandum with 4 alternatives, the first of one is do nothing more than is being done now. Attached is a self-explanatory 16 August 1995 memorandum to me from Jennifer O'Connor regarding "medicaid waivers and worker protections" and a 7 page draft memorandum discussing the problem and describing 4 options. Also attached is a 1 page memorandum to me dated 7 September 1995 from Carol Rasco detailing her thoughts on the situation.

This has long been a festering problem with both of the unions and as things stand is not likely to go away.

Let's discuss at your convenience.

August 16, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: JENNIFER O'CONNOR *MO*

SUBJECT: MEDICAID WAIVERS AND WORKER PROTECTIONS

Attached is a memorandum from the Department of Health and Human Services, produced with input from the Department of Labor, which addresses options for changing the current Medicaid waiver approval process so that worker protection issues are taken into account. It describes four options for addressing the effects of Medicaid waivers on health care employees: 1) do nothing; 2) strongly encourage states during the waiver process to implement budget neutral transitional assistance; 3) require states to show that employees are included in the waiver planning process and to show how the reforms will affect the hospital workforce, and/or to show how they will address those effects; 4) develop a transition assistance program by either requiring states to assist employees or by furnishing federal funds to assist employees.

The memorandum discusses the pros and cons of each option. Secretary Shalala prefers option 2 and the pros and cons to that section explain her preference.

Secretary Reich prefers option 3, which he thinks should be even stronger than currently worded in the attached memorandum. He recommends requiring states to: 1) show employees were included in the waiver planning process, 2) show how reforms will affect employees and 3) show how they will address those effects. He comments that option 4 costs money, which AFSCME has not asked for; and option 2 will not satisfy AFSCME and will be perceived to be a decision to do nothing. He also thinks the argument that option 3 represents a breaking of the President's 1993 commitment to the National Governor's Association (NGA) is flawed because the 1993 NGA was an entirely different group of governors, most of whom were Democrats; the Secretary comments that the political landscape is so changed that we can legitimately change our policy.

Introduction

Ongoing efforts by private sector payers to control health care costs have led to large-scale dislocations in the employment of health care workers. These painful effects in the labor market may be exacerbated by current and potential federal government actions, including Medicaid waivers granted to states implementing aggressive managed care programs and probable congressional budget cuts to the Medicare and Medicaid programs. In combination, these private and public sector actions may dislocate hundreds of thousands of health care workers by the end of the decade, especially in hospitals.

Traditionally, when the federal government's actions have been expected to cause dislocations even of relatively small groups of workers, labor protection provisions have been implemented to assist dislocated workers. In at least 27 different federal statutes, various types of assistance intended to alleviate adverse employment effects caused by direct federal action or by other causes have been enacted. Industries in which workers have received such protections have included railroads, airlines, public transit, mining, communications, and mental health. Recently, the President proposed similar steps for 26,000-36,000 workers affected by the terms of the Forest Summit. In fact, notable by its absence is the broad health care sector which has one of every twelve jobs in the United States.

Indeed, the Health Security Act (HSA) proposed significant labor protections to redress the effects on workers that would have resulted had the HSA been enacted. Yet, with the failure of Congress to enact the HSA, the federal government has not provided meaningful protections for health care workers who will lose their jobs in the coming months and years.

Issues

During negotiations with states seeking Medicaid demonstration waivers, are there any steps the Department of Health and Human Services should take to address these trends? Should statutory authority be sought for health workforce protections?

Background

Reducing cost growth is generally one of the major goals of states pursuing Medicaid demonstration waivers¹. A principle technique is to require managed care enrollment (e.g., HMOs) by current Medicaid beneficiaries and others brought into the program through expanded Medicaid eligibility (typically low-income and indigent persons). Private HMOs that contract with the state to enroll and manage care for these beneficiaries lower their costs by reducing their use of high-cost health services, and by substituting

1. States use two types of waivers to enroll Medicaid beneficiaries in mandatory managed care programs. Under Section 1115 of the Social Security Act, the Department has broad authority to permit States to implement demonstration projects to test variations to Medicaid policies, including enrolling people into managed care as long as the change is "consistent with the purposes of the Social Security Act." Second, under Section 1915(b), States may require Medicaid recipients to enroll in mandatory managed care programs if the programs meet statutorily established criteria for quality, access and cost-containment. To date, although most public attention has been focussed on 1115 waivers, most of the expansion of Medicaid managed care has been achieved through 1915(b) waivers. The Administration has supported automatic approval of 1915(b) waivers.

preventive and primary care services. And they steer these public enrollees to contracting providers the HMOs believe will help achieve these reductions. This pattern mirrors what private employers hire HMOs to accomplish. Hospital inpatient and outpatient costs account for about 35-40% of Medicaid costs, making them an obvious target for HMO cost-cutting.

Hospitals compete for HMO contracts substantially on the basis of costs. To position themselves to compete, hospitals are seeking increased productivity and efficiency by, among other steps, cutting labor costs (estimated at 60% of hospital costs): they do this by removing and consolidating staffing layers; reducing numbers of semi-skilled and unskilled workers and substituting a smaller number of skilled persons who can be cross-trained for several jobs; automating; and switching to more part-time and as-needed staffing arrangements. The restructuring of the health care delivery system may result in the elimination, nationally, of 500,000 hospital jobs (many in urban areas) by the end of the decade; some congressional proposals for cutting Medicaid and Medicare could accelerate this dislocation. An estimated 80 percent of the most vulnerable jobs are held by women, and 20 percent are held by African-Americans.

Public hospitals, and nonprofit hospitals which serve similar roles in their communities, are in an especially poor position to secure managed care contracts. In general, private HMOs do not find these publicly-oriented hospitals to be highly desirable business partners because:

- their physical plants are often outdated, deteriorating, and located in areas that are undesirable to and at some distance from the HMO's private sector enrollees;
- the community continues to expect the hospitals to perform other public missions (e.g., care for violent trauma, the homeless, the mentally ill/substance abusers, illegal aliens, and people remaining uninsured) for which they are generally underpaid (hence, requiring cross subsidies);
- their historic mission as advocates for the poor may make them undependable agents for reducing costs by reducing utilization of inpatient, diagnostic and specialty clinic services;
- their resources are often insufficient to finance changes necessary to enhance efficiency, overcome physical deterioration, and update technological capacity; and
- any plan to change these institutions is likely to involve local government and the public, and, therefore, is apt to be contentious and take a long time for approval.

Representatives of the American Federation of State, County and Municipal Employees (AFSME) and the Service Employees' International Union (SEIU) are raising deep concerns to top officials in DOL, HHS and the White House about the effect of Medicaid demonstrations upon their members. In particular, they are concerned that rapid enrollment of Medicaid recipients (and other indigent persons) in mandatory managed care programs, and the redirection of public funds away from hospitals and into capitation payments to HMOs, will undermine the financial viability of certain "safety net" inner city providers (particularly public, although including many non-profit hospitals) which rely heavily upon Medicaid reimbursement and other public funding.

Since the beginning of the Administration, in response to governors' longstanding criticisms of the slow pace and inflexibility of HHS's waiver review process, HHS has implemented a streamlined review process and has committed itself to according the states broad design flexibility, policies reinforced publicly on numerous occasions by the President. (In 1994, guidelines reflecting these policies -- and expanded state public notice requirements -- were published in the Federal Register.) Governors of both parties are likely to react negatively to any Administration change in policy which would reduce state flexibility and, in their view, further micro-manage state affairs, by requiring that special consideration be given in demonstrations to these "essential community providers" or, more directly, to the employees of those institutions.

Discussion

Public and public service-oriented non-profit hospitals lie at the intersection of two important concerns: (1) the jobs of their employees and (2) the access of low-income people to needed health services. Historically, these institutions have provided inpatient and clinic services in areas which other institutions and individual providers have chosen to avoid, have often provided services which other facilities have considered insufficiently profitable, and have provided costly services to people who could not pay. Indeed, other facilities often transfer patients to these public and nonprofit hospitals.

Furthermore, these institutions will continue to play an important role even as the health system is reshaped by states' managed care demonstration programs:

- o Substantial numbers of poor persons are likely to remain ineligible for even expanded state Medicaid programs; some clients will cycle in and out of eligibility; some needed services will not be covered by the managed care plans; and some HMOs' providers will not be within acceptable access. The result will be a continuing indigent health care burden. But with reduced loads of paying patients and probable caps on or absolute reductions in disproportionate share (DSH) payments, the resources available to public hospitals will be even more limited than in the current climate.
- o The number of care-managing physicians and primary care providers may prove inadequate to successfully implement state managed care programs. During the time period in which primary care capacity is developed, public hospitals and their outpatient clinics offer important "safety valve" access.
- o The success of states' managed care efforts is not assured. If, for example, public revenues do not grow enough to sustain a capitation rate sufficiently high to attract private HMO and provider participation, and the program is pared back in eligibility or covered benefits, a public sector fail-safe mechanism will be important.

These considerations suggest that the federal government may have a continuing strong interest in how, in the context of their Medicaid demonstrations, states propose to take account of the special needs and contributions of institutions that have been serving large numbers of public beneficiaries.

Preserving these institutions may also assist in the protection and transition of many of their workers who would be at particular risk of harm from changes in the health care market. In the long run, however, while workforce reductions can be ameliorated or delayed, jobs will certainly be lost in hospitals, and possibly even more broadly across the health care sector.

In considering alternatives for addressing the effects of Medicaid waivers on "safety net" providers and/or their employees, the federal government confronts a broad spectrum of options. At one end, HHS could continue permitting States broad flexibility which allow them to choose whether to stand aside from shake-outs in the hospital sector caused by the Medicaid demonstration, and take no special steps with respect to these hospital providers or their workers. At the other end, HHS could require states to address directly the workforce effects of their waivers by developing and funding retraining programs for displaced workers, and/or statutory authority could be sought for any of a range of measures related to income maintenance, job training, or employer-based protections. Between these poles lie a range of Federal, State and employer measures to address the transitional needs of public service institutions and their health care workers.

Option 1: Leave unchanged the current breadth of state Medicaid demonstration flexibility and current HHS waiver review practice of leaving health service system redesign (and treatment of public-oriented hospitals) to state initiative within the broad requirement of "adequate" access.

- Pros:
- o Consistent with commitment to maximum state flexibility.
 - o Keeps the federal government out of state provider payment negotiations, and relationships between state and local governments.
 - o Puts maximum pressure on the public hospitals to enter a frank reappraisal of their needs to reform, and enter an open dialogue with the state on this matter.
- Cons:
- o Can result in precipitous and wrenching fiscal adjustments to public hospitals as their funds and their traditional clients are abruptly rechanneled to managed care providers.
 - o Provides no relief to at-risk public hospital workers.
 - o May mean the federal government will be drawn into participating publicly to bail out safety net public hospitals after the waiver has begun (e.g., recent dispute over Tennessee's payments to the public hospital in Memphis).

Option 2: Call each waiver-requesting state's attention to the special circumstances of public hospitals and public beneficiary-serving non-profit hospitals, and strongly encourage states to implement some form of budget neutral transitional assistance for safety net providers.

In pre-submission consultations with states, a stage at which states are customarily seeking reactions and alternatives, HHS could signal to states its interest in safety net providers during waiver negotiations, with the goal of securing protections. Examples could include extra state payments (e.g., from special funding pools) for safety net hospitals during a transitional period; assistance to safety net providers in becoming HMO contract providers; where states assign beneficiaries who fail to select a managed care plan, inclusion of safety net providers among assignment entities; and enhanced payments for safety net providers that serve members of managed care plans.

- Pros:**
- o Eases transition pressure on beneficiary access in under-served areas.
 - o May indirectly assist the workers of these institutions.
 - o Provides an opportunity for public hospitals to arrange an orderly transformation of missions and performance.
 - o Emphasizes that federal interest is in delivery system integrity, beneficiary access and orderly change.
 - o Consistent with HCFA's recent waiver-related negotiations with states (e.g., Massachusetts, Illinois, Tennessee) over public hospitals.
 - o Consistent with Administration's position in Health Security Act.
- Cons:**
- o May be seen and characterized as a breach of HHS's commitment to greater state flexibility in Medicaid demonstrations.
 - o Eases pressures on public hospitals to move vigorously in reforming their missions and performance; delays can result in continued inefficiencies and unnecessary costs.
 - o Could meet with Congressional resistance.
 - o Will not provide explicit response to concerns of at-risk workers.

Option 3: As part of the waiver negotiation process, HHS could require that states show that hospital employees were included in demonstration planning discussions, describe how the reforms can be expected to affect the hospital workforce, and/or discuss how states intend to take account of those affects.

Examples of steps that States might take could include inclusion of employees on waiver planning and advisory councils; analysis in the proposal of expected workforce impact data; explicit inclusion of health system worker complaints and questions in "hotline" analyses; and inclusion of workers on post-implementation quality review and feedback-and-correction work groups.

- Pros:
- o Responds specifically to at-risk workers' interests.
 - o Could require no additional federal costs by defining any related costs as falling within waiver budget neutrality requirements.
 - o Would be consistent with the Secretary's March letter to the Governor of New York reflecting concerns about public providers and their workforces.
 - o Would provide workers and their representatives with a seat at the table from which to seek substantive waiver protections.
 - o Would not be an unfunded mandate.

- Cons:
- o Will be seen by states as:
 - a serious breach of HHS's commitment to greater state flexibility in waiver reform design;
 - raising issues outside the scope of the Medicaid program.
 - requiring their intervention in labor-management relationships between local governments and workers.
 - o Will be interpreted as federal micro-management.
 - o Could open the door to other entities (e.g., medical schools, specialized hospitals, specialist physicians) lobbying for protections.
 - o Would likely meet Congressional resistance.

Option 4: Develop a program of assistance for these dislocated hospital workers.

4A: Explicitly require that states provide for assistance. For example, states might impose requirements on the hospitals including advance notice of layoff, preferential call-back, and retention of seniority and fringe benefits. Alternatively, states might be required to directly finance worker assistance programs.

- Pros:
- o Responds directly to workers' needs under broad-scale reforms.
 - o Could keep retraining costs outside of the waiver budget neutrality limits (thus not diminishing funds available for beneficiary services).

- Cons:
- o Same as Option 3; plus, without federal financing, will be characterized as an unfunded federal mandate.

4B: Directly furnish federal assistance to dislocated hospital workers. Steps which might be taken by the Federal Government could include obtaining statutory authority for special unemployment insurance compensation, worker training and retraining assistance, job search and income guarantees.

- Pros:**
- o Responds directly to unions' proposals.
 - o Can be undertaken in combination with other options.
 - o With federal financing, avoids "unfunded mandates" objections.
- Cons:**
- o Same as Option 3, plus would necessitate either finding offsetting budgetary savings or justifying added costs.
 - o Could be difficult to restrict to workers from hospitals serving large numbers of public beneficiaries.

THE WHITE HOUSE

WASHINGTON

September 7, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: CAROL H. RASCO *CHR*
DIANA FORTUNA

Subject: Medicaid Waivers and Worker Protections

I. Jennifer's Memo to Harold

As to paragraph three where Sec. Reich's argument is stated about a changed NGA: that won't hold water with the governors. NGA works in a way such that the governors who were the lead negotiators on this agreement in 1993 are still in NGA, are now the leadership from both political parties. I can't stress enough how important this factor is.

II. HHS/LABOR Memo

In general: Option two is the option that most clearly respects the agreements negotiated with the governors at the direction of the President. Option three opens the door to all kinds of groups that will want to be included in the mandate to be shown as included in the waiver development process which will lead to excessive (as perceived by the states) regulation of the waiver process which in itself is supposed to be a relief from regulation.

In the introduction and background sections, the memo does not always present both sides of the argument. On page 2 of the memo, the list of reasons why hospitals serving poor people are not attractive to HMOs does not mention the fact that these hospitals do have some advantages that often make them essential partners for HMOs coming in to seek Medicaid business. This is because they are often the only hospitals in these neighborhoods and the populations are accustomed to getting health care there.

Last paragraph on page 2, 5th line: It is not clear what the phrase "and other indigent persons" means. The uninsured are not being enrolled in managed care.

First bullet on page 3: replace "are likely to" with "will"; Medicaid will not cover all the medically indigent.

On page 4, add to the "pros" under Option 1: HCFA can and already does to some extent address the concerns of essential community provider hospitals in its waiver review process, through its emphasis on assuring access and quality.

Also, the cons should point out that the Governors would object to the argument that they would not consider these issues on their own (although the unions would respond that many Republican Governors really don't care about their workers).

**MEDICAID SECTION 1115 DEMONSTRATION ACTIVITY
STATEWIDE HEALTH REFORM PROJECTS**

In All States
September 1, 1995

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
ALABAMA (Under Review)	Alabama submitted an 1115 demonstration waiver proposal entitled, "Bay (Better Access for You) Health Plan," on July 10, 1995. The five year demonstration project will enroll current Medicaid beneficiaries into managed care, expand eligibility for children ages 6-18 from 100 to 133% of FPL, expand eligibility for young adolescents from 16 to 133% of FPL, and offer enhanced family planning benefits up to 24 months to low income women. The State will initially implement the demonstration in Mobile County with possible expansion to other counties.	On 8/3, the State, Department and HCFA met to discuss the State's waiver request. Among the issues discussed were recipient choice, competitive bidding, relationship of Prime Health, and budget neutrality. A major issues letter is expected to be sent to the State shortly.	Proposal received 7/10/95. State Presentation 8/3/95. <i>Anticipated Decision: January 1996</i>
ALASKA	None		
ARIZONA (Approved/ Implemented)	Arizona has a long standing statewide Medicaid managed care program, "The Arizona Health Care Cost Containment System." The Arizona program serves 410,000 beneficiaries in acute care and 20,000 beneficiaries in long term care. The initial program was implemented in 1982.	In late June, a major issues letter regarding Arizona's proposal to expand eligibility to 100% of FPL was sent to the State. On June 27, Mabel Chen (the Arizona Medicaid Director) received two signed award letters: one approving Arizona's 13th Year Continuation Application, a new LTC waiver, and an increase in the limit on home and community-based services, and the other approving their request for waivers to simplify eligibility and to provide extended family planning services. On June 28, HCFA ORD staff meet with Mabel Chen to discuss a number of proposals. On July 10-12, a site visit was conducted to investigate eligibility, plan enrollment, and plan reimbursement concerns raised by a former agency employee. A careful examination of records and procedures by Regional Office staff revealed no problems.	13th Year Continuation Application approved 6/27/95.
ARKANSAS	None		
CALIFORNIA	The State is pursuing an 1115 demonstration to increase access to health care services through the use of managed care plans.	On August 9, LA County submitted a revised draft proposal. The proposal is under review by the Department. <u>Tentatively, a meeting is scheduled for the week of September 5.</u>	

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STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
COLORADO	None		
CONNECTICUT	None		
DELAWARE (Approved/Pending Implementation)	Delaware has submitted an 1115 waiver proposal which will increase access to health care services through managed care plans by expanding Medicaid coverage to the State's uninsured adult population up to 100 percent of the FPL. This statewide proposal will include a comprehensive benefit package emphasizing primary and preventive care.	Delaware has begun implementation of the program, and has, to this point, met deadlines for all deliverables. The program is expected to be implemented in January, 1996. On August 14, a representative from HCFA attended a conference for managed care organizations in the State. HCFA is currently working on the readiness assessment procedures.	Proposal received 7/29/94. Waiver approved 5/16/95.
DISTRICT OF COLUMBIA (Receivd)	The District of Columbia has submitted an 1115 waiver application that proposes to implement a specialized managed care program, targeted to the needs of its Medicaid-eligible disabled children. There would be mandatory enrollment of the eligibles into a newly-formed health plan-Health Services for Children with Special Needs, Inc. (HSCSN). Full financial risk would be transferred to HSCSN, in the form of monthly capitation payments.	Discussions continue with the District on special terms and conditions and budget neutrality. On August 4, the District submitted a revised demonstration protocol.	Proposal received 3/25/94. Review panel was held 5/17/94.
FLORIDA (Approved/Pending Implementation)	Florida's Agency for Health Care Administration has been granted Medicaid waivers under section 1115 to permit Federal financial participation for the Florida Health Security Program (FHS). FHS will utilize a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250% of the FPL. Health plans will be offered by Accountable Health Partnerships and sold by Community Health Purchasing Alliances.	The Legislature has yet to pass the enabling legislation for the demonstration. The State is currently exploring what program changes can be made without legislative authority. The Governor is considering calling a special session of the legislature to consider health care reform issues, including the 1115 waiver. It is expected that this will not occur before September.	Waiver proposal received 2/10/94. Waiver approved 9/15/94.
GEORGIA (Under Review)	Behavioral health proposal submitted in September 1996		Anticipated Decision: January 1996

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STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
HAWAII (Approved/ Implemented)	Hawaii's HealthQuest provides seamless coverage for those on public programs, as well as the currently uninsured. Through Medicaid expansions (300% FPL, elimination of categorical and asset tests) and a managed care delivery system, the State expects to expand access and control costs.	<p>Enrollment as of June 1, 1995 was 150,000. (Originally, enrollment was projected to be 110,000.)</p> <p>On June 30, 1995, we approved the first continuation of the QUEST program.</p> <p>The State is developing a proposal to include the aged, blind, and disabled population under QUEST, and incorporate long term care. We expect to receive the proposal in late 1995.</p> <p><u>A letter was sent to the State approving changes in incentives and disincentives regarding the State's request to impose penalties for QUEST beneficiaries who fail to make copayments or keep appointments, or who misuse the emergency room.</u></p>	<p>Proposal received 04/20/93.</p> <p>Waiver approved 07/15/93.</p> <p>The special terms and conditions were accepted on 08/02/93.</p> <p>First continuation approved on 6/30/95.</p>
IDAHO	None		
ILLINOIS (Under Review)	Illinois section 1115 demonstration program, "MediPlan Plus," seeks to increase access and quality of health care for Medicaid eligible beneficiaries while controlling costs, by expanding the use of managed care. Illinois seeks to develop a managed care delivery system using a series of networks, either local or statewide, to tailor its Medicaid delivery system to the needs of local urban neighborhoods or large rural areas. Current Medicaid beneficiaries will be offered a choice of service delivery options, including traditional HMOs, managed care community networks, provider gatekeepers, and Federally Qualified Health Centers and Rural Health Centers.	We are currently negotiating budget neutrality and terms and conditions with the State. Issues on budget neutrality, back payments, and default assignment need to be resolved.	<p>Proposal received 9/15/94.</p> <p><i>Anticipated Decision: Pending resolution of difficult issues.</i></p>
INDIANA	None		
IOWA	None		
KANSAS (Under Review)	Community Care of Kansas, has goals of fostering the development of managed care in rural and small urban communities, preserving and enhancing choice, and improving health outcomes by assuring a continuum of care. The demonstration, to be implemented in one predominantly urban/suburban county, and three predominantly rural counties, plans to test the success of a non-competitive managed care model in rural areas. The demonstration would enroll current eligible in the AFDC and AFDC-related categories, and would expand eligibility to children ages five and under who lose eligibility under these categories and whose family income does not exceed 200 percent of the FPL.	On May 15, HCFA sent the State a letter which raised strong concerns about the proposed use of a sole source managed care contract to serve all beneficiaries in the demonstration. In June, HCFA, the state, and CCK (the prepaid health plan that would be the sole source contract under the demonstration) had two conference calls to discuss the major issues: competitive bidding for managed care contracts and beneficiary choice. On August 3, HCFA sent a letter to the State that summarized the position it took on these issues during the conference call. On August 4, technical questions were sent to the State.	<p>Proposal received 3/23/95.</p> <p><i>Anticipated Decision: January 1996</i></p>

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
<p>KENTUCKY (Revised Proposal Under Review)</p>	<p>The State is proposing to establish "The Partnership," a single entity administering their managed care program. "The Partnership" will be an umbrella organization that will contract with other partnerships in the eight managed care regions. Eligibles will include all AFDCs including the categorically and medically needy, SSI, State Supplemental to Aged, Blind, and Disabled, SOBRA women and children, and individuals who have lost SSI primarily due to Cost of Living Adjustments. There will be no eligibility expansion.</p>	<p>Kentucky's original 1115 waiver was put on hold indefinitely. Kentucky needed legislation in order to implement its demonstration. In June 1994, Kentucky's legislature passed a budget bill that included language prohibiting operation of any waiver programs expanding Medicaid eligibility or services that were not implemented by January 1, 1994.</p> <p>HCFA will be releasing a major issues letter to the State shortly.</p>	<p>Revised proposal received 6/22/95 Anticipated Decision on revised proposal: January 1996</p>
<p>LOUISIANA (Pending)</p>	<p>"Louisiana Health Access", a statewide section 1115 demonstration proposal, has goals of emphasizing primary and preventive care, increasing access to quality care, and controlling the State's spiraling costs through managed care. The original proposal included a request for a block grant of Federal Medicaid funds. On April 11, the State submitted a revised proposal focusing on a public managed care organization for Medicaid and the uninsured populations.</p>	<p>On June 9, HCFA rejected the State's financial proposal. The financing proposal submitted depended upon "profits" obtained from the public managed care plan (MCP) whereby the State would pay the public MCP a capitation rate that exceeds actual costs. This profit margin would then be transferred back to the State and used as State share to obtain additional Federal funds - thus, indirectly increasing the Federal matching percentage for the State. The State may develop an alternative proposal or submit a 1915(b) proposal that would enroll the Medicaid population into existing, private HMOs. The State is also considering a voluntary managed care system where no waivers would be necessary.</p>	<p>Proposal submitted 1/3/95 Disapproved: 6/9/95 State will resubmit in late 1995.</p>
<p>MAINE</p>	<p>None</p>		
<p>MARYLAND (Expected)</p>	<p>HCFA representatives are working closely with the State in the development of an 1115 waiver demonstration program that would incorporate managed care.</p>		

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STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
MASSACHUSETTS	Massachusetts has submitted an 1115 waiver application, entitled "MassHealth". The demonstration has nine component strategies which are intended to cover a portion of the 524,000 uninsured in Massachusetts, as well as provide assistance to the low-income insured. The proposed strategies address needs specific to the mixture of social economic groups that are uninsured in Massachusetts, which include the employed, the short-term unemployed, and the long-term employed. The proposal includes direct strategies that provide public health care and indirect strategies that seek to promote market forces and responsible decision making by providing financial incentives in the form of tax credits to employers, tax deferred medical saving accounts for insured individuals, and subsidies in the form of insurance vouchers for employees with incomes up to 200% of the EPL.	The enabling legislation, which is part of a more comprehensive health care reform legislation package, has been referred to the legislature's Joint Committee on Health Care for review. <u>A site visit to the State is planned for the week of September 5. Meetings will be held with the State staff, the contractor which manages mental health and substance abuse services, and the Federally Qualified Health Centers and Community Mental Health Centers.</u>	Proposal received 4/15/94. Waiver approved 04/24/95. The State accepted the special terms and conditions on 5/16/95.
MICHIGAN	None		
MINNESOTA (Approved/ Implemented)	Minnesota submitted a waiver proposal with three major components: (1) integration of low-income and uninsured programs, (2) expansion of the managed care delivery system; and (3) linkage of Medicare to overall State health care reform efforts. The proposal would be implemented in two phases. Phase 1 would involve the first two components. In Phase 2, Minnesota would develop a framework for implementing broader reforms in subsequent years.	Instead of approving Phase 1 of Minnesota's proposal, HCFA approved an amendment to Minnesota's current Section 1115 waiver on April 27, 1995. The amendment permits the State to expand eligibility to children and to expand managed care waivers to all counties, and extended the waiver for the period July 1, 1996 through June 30, 1998. <u>A meeting with the State is planned for the week of September 18.</u>	Proposal received 7/28/94. PMAP+ was approved on 4/27/95.
MISSISSIPPI	None		
MISSOURI (Under Review)	Missouri's Department of Social Services has submitted an 1115 waiver proposal that will provide managed care medical services to the State's Medicaid population and to the uninsured.	HCFA and the State are negotiating budget neutrality issues.	Proposal received 6/30/94. Anticipated Decision: Dec 95
MONTANA (Under Review) (Disapproved)	The State submitted a section 1115 demonstration waiver proposal entitled, "Montana Mental Health Access Plan" on June 15, 1995. The State seeks 1115 demonstration waivers to enable them to place all State funded mental health delivery systems for Medicaid and non-Medicaid under a single capitated full risk managed care provider.	The issue paper and the letter to the Governor concerning the States waiver request are undergoing final clearance.	Proposal was received 6/15/95. Disapproved 9/13/95.
NEBRASKA	None		
NEVADA	None		

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
NEW HAMPSHIRE (Under Review)	New Hampshire submitted a proposal entitled, "The Granite State Partnership for Access and Affordability in Health Care". The State proposed to expand Medicaid eligibility to adults with incomes below the AFDC cash standard, and introduce a public insurance product for low-income workers. Also, the State proposed to implement a number of pilot initiatives to help to ultimately redesign the State's health care delivery system.	The State decided not to implement its original proposal. On June 20, the State submitted a revised concept paper. On June 26, a meeting was held between State Officials and the Administrator to discuss various options for health reform, including the possibility of incorporating Medicare and Medicaid waivers. On July 25, ORD and RO staff met with the State. The State appears interested in a broad health care reform demonstration.	Proposal was submitted on 6/14/94. <i>Anticipated Decision: State revising proposal</i>
NEW JERSEY (Expected)	The State has submitted a concept paper for a section 1115 demonstration waiver. The State plan to incorporate its "Health Access New Jersey" program for the uninsured and the recently approved section 1915(b) managed care waiver for the Medicaid population in a comprehensive proposal to streamline eligibility, expand coverage, and manage behavioral health and long term care services.	Concept paper received on July 5. The Medicaid Director met with HCFA staff on July 10 to discuss the State's concept paper.	Concept paper received on 7/5/95.
NEW YORK (Under Review)	"New York Partnership Plan," a state-wide section 1115 demonstration proposal will enroll its Medicaid population (excluding the elderly and institutionalized disabled) and its Home Relief population (those that are financially needy but not Medicaid eligible) into managed care programs. The plan also establishes new health plans to meet the needs of special populations.	The State's response to questions on their waiver application was disseminated throughout the Department for review. A site visit to the State is planned for the week of September 2.	Proposal was received on 3/20/95. <i>Anticipated Decision: Dec 95-Jan 96</i>
NEW MEXICO	None		
NORTH CAROLINA	None		
NORTH DAKOTA	None		
OHIO (Approved/Pending Implementation)	OhioCare will expand eligibility for Medicaid to the uninsured population with incomes up to 100 percent of the FPL. An estimated 500,000 new eligibles will receive coverage. The State will enroll all new and current Medicaid beneficiaries into managed care programs throughout the State. Ohio will also test the use of managed care for the provision of certain special health related services, to be provided on a risk basis by several State agencies.	The Ohio Legislature has passed legislation giving the Ohio Department of Human Services the ability to implement managed care throughout the State. A draft implementation work plan was received from the State. The State is intending to proceed with implementing statewide managed care for basic services. The authorizing legislation for eligibility expansion and managed care for special health related services was not passed by the Legislature, so these programs pieces can not be implemented.	Proposal received 3/2/94. Project approved 1/17/95. Accepted the terms of the award on 2/22/95.
OKLAHOMA (Under Review)	Oklahoma has submitted an 1115 waiver proposal to implement "SoonerCare". The focus of the program is on development of managed care in rural areas, through three partially capitated delivery models. The State is encouraging the use of safety net providers through various mechanisms.	On August 22, a conference call was held with HCFA and the State to discuss the terms and conditions of their proposal. A follow-up call is scheduled.	Proposal received 1/6/95. <i>Anticipated Decision: October 1995</i>

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STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
OREGON (Approved/ Implemented)	The Oregon Health Plan, designed to expand access to health care to the uninsured and contain costs through managed care, establishes a basic set of benefits available to all Oregonians at or below 100 percent of the FPL. The basic package reflects a prioritized ranking of service-treatment pairs developed by the Oregon Health Services Commission.	As a result of budget cuts by the State Legislature, Oregon has submitted a request to modify its current waiver in areas of premiums, copays, and eligibility requirements for new eligibles. HCFA has also received a request from the State to cutback on the number of services covered on the State's prioritized list that is under consideration. The State's request have been distributed for review among DHHS and OMB components.	Waivers approved 03/19/93. The special terms and conditions were accepted on 04/16/93. Operations began 2/1/94. Phase 2 waivers were approved 9/28/94.
PENNSYLVANIA	None		
RHODE ISLAND (Approved/ Implemented)	Under RiteCare, Rhode Island was given Medicaid waivers allowing the extension of Medicaid eligibility to pregnant women and children up to 250% FPL and enrollment of all recipients in a capitated managed care delivery system.	Operations began 8/1/94. As of July 6, enrollment was 60,563. HCFA is discussing a proposed emergency room policy with the State, and expect to finalize the policy shortly. A conference call was held with the Department, and Birch&Davis to discuss budget neutrality issues. The State is expected to submit their proposal shortly.	Proposal was received on 7/2/93. Waivers approved 11/1/93. The special terms and conditions were accepted on 11/2/93. Operations began 8/1/94.
SOUTH CAROLINA (Postponed)	South Carolina submitted an 1115 waiver application entitled the South Carolina Palmetto Health Initiative. The program would extend Medicaid eligibility to include residents with incomes up to 100% of the FPL. South Carolina expects to cover approximately 240,000 additional recipients. Most Medicaid recipients will be enrolled in managed care programs. South Carolina would also implement a 500-member long term care pilot project to demonstrate the effectiveness of a targeted managed care system that emphasizes home- and community-based services for the nursing facility population.	On November 18, 1994, HCFA approved the framework of the project and agreed to work with the State to meet a set of milestones over the coming year. When South Carolina successfully completes these milestones, HCFA will act on their request for waivers. At this time, the State has decided to indefinitely postpone proceeding with the developmental phase of the project. The State will proceed with voluntary enrollment into HMO's for Medicaid recipients and some pilot projects for partially capitated providers.	Proposal received 3/1/94. Review panel was held 6/13/94. Approval letter for initial award was sent 11/18/94.
SOUTH DAKOTA	None		

STATE	PROJECT DESCRIPTION	STATUS	TIME FRAME
TENNESSEE (Approved/ Implemented)	<p>"TennCare," a statewide 1115 waiver demonstration program that provides health care benefits to Medicaid beneficiaries, uninsured State residents, and those whose medical conditions make them uninsurable. Enrollment is capped at 1.4 million. All enrollees are served in capitated managed care plans that are either HMOs or PPOs.</p>	<p>HCFEA has reached agreement with the State on plans for additional funding to provide relief to 2 large public hospitals, the Regional Medical Center in Memphis, and Nashville General/Hubbard Hospital in Nashville.</p> <p>HCFEA and the State held a conference call to explain what is expected of the State so that they can comply with the public notice requirements with respect to the State's proposal to include the mentally retarded/developmentally disabled (MAR/DD) population in their plan.</p> <p>HCFEA received a letter from the State indicating that they wish to withdraw their proposal for a modification to the TennCare demonstration to include the mentally retarded/developmentally disabled (MAR/DD) population. The State plans to deinstitutionalize this group through other options.</p>	<p>Proposal was received on 6/17/93.</p> <p>Waivers approved 11/18/93.</p> <p>The special terms and conditions were accepted on 12/16/93.</p> <p>Operations began on 1/1/94.</p>
TEXAS (Under Review)	<p>The State has indicated that they will be submitting a section 1115 waiver proposal focusing on Medicaid managed care.</p>	<p>A proposal from the State is expected shortly. HCFEA has been providing consultative services to the State on an informal basis as they work on their proposal.</p>	<p>Submitted: Sept 95 Anticipated Decision Jan-March 96</p>
UTAH (Under Review)	<p>Utah has submitted a proposal for a section 1115 waiver demonstration which will expand access to health care for residents under 100% of the FPL; enroll urban Medicaid clients in managed care; encourage small employers to participate in a health insurance plan (subsidized by the State); and simplify the eligibility process and streamline the administrative process.</p>	<p>The proposal was received 7/3/95 and is currently being reviewed by Department and HHS staff members. HCFEA will be releasing a major issues letter to the State shortly.</p>	<p>Proposal was received 7/3/95. Anticipated Decision January 1996</p>
VERMONT (Approved/Pending Implementation)	<p>Through the state-wide section 1115 program, "Vermont Health Security Plan," the State plans to expand eligibility to uninsured Vermonters with incomes under 150 percent of the FPL, implement a managed care system, and extend a prescription drug benefit to the State's lower income Medicare beneficiaries.</p>	<p>On August 23, a bidders conference dealing with technical issues in the Managed Care Request for Proposal was held. Written general questions are to be submitted to the State by August 25. A bidders conference dealing with financial issues will follow.</p>	<p>Proposal was submitted on 2/22/95. Award 7/95.</p>
VIRGINIA	<p>None</p>		

FRIDAY Medicaid mtg.

THE PRESIDENT HAS SEEN

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THE WHITE HOUSE
WASHINGTON

September 11, 1995

MEMORANDUM FOR THE PRESIDENT

CC: LEON PANETTA
CAROL RASCO

FROM: Harold Ickes ^{HI}

SUBJECT: Medicaid waivers and worker protection

*Let's meet w/ We need to discuss
2 + 3 + construction
on this*

On 11 August 1995, you met with Gerald McEntee, International President of American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME") on a number of issues including one that he is very concerned about -- the adverse affect on employees of medicaid waivers being granted by the Administration. The short of his brief was that medicaid waivers should not be approved by the Administration absent their containing adequate protection for current employees.

Both Mr. McEntee and John Sweeney, International President of Service Employees International Union, AFL-CIO ("SEIU"), have met several times jointly with Secretary Shalala, Secretary Reich, and others, as well as myself, to discuss this issue. The membership of both unions, which are staunch supporters of this Administration, have a large number of healthcare workers. At my request, HHS and Labor have discussed a number of alternative solutions to this situation and have prepared a draft memorandum with 4 alternatives, the first of one is do nothing more than is being done now. Attached is a self-explanatory 16 August 1995 memorandum to me from Jennifer O'Connor regarding "medicaid waivers and worker protections" and a 7 page draft memorandum discussing the problem and describing 4 options. Also attached is a 1 page memorandum to me dated 7 September 1995 from Carol Rasco detailing her thoughts on the situation.

This has long been a festering problem with both of the unions and as things stand is not likely to go away.

Let's discuss at your convenience.