

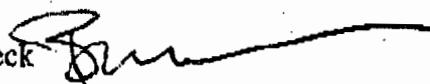


DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

NOV 16 1993

NOTE TO: CAROL RASCO**FROM:** Bruce Vladeck **SUBJECT:** Status of TennCare Negotiations

Our negotiations with David Manning on the TennCare demonstration proposal have been very productive over the past two weeks. We have substantially reached agreement with Tennessee on the outstanding issues, with one exception. The remaining issue is how we will treat individual health insurance premiums for federal matching purposes. We are prepared to recognize those premiums as part of the State's match, but with a reasonable limit. Without a limit, the State has an incentive to focus its enrollment efforts on high-income eligibles and to avoid enrolling the poorest eligibles. The attachment provides further information on this issue.

I believe that final approval could be granted within the next few days pending resolution of the premium issue. I will keep you informed of our progress.

Attachment

cc:

Kevin Thurm

Entitlements Conference

Federal Matching of Individual Health Insurance Premiums

Background

Under TennCare all adults and children with incomes above 100 percent of the federal poverty level, other than mandatory Medicaid eligibles, would be required to share in the costs of their health care. Cost sharing consists of premiums, deductibles, and copayments. Individual premiums would be based on the capitation rates paid to health care plans under TennCare. Premiums would be graduated so that payments will increase as income rises.

The State would collect individual premiums from beneficiaries required to pay premiums. Those monies would be used by the State as part of the capitation payments it makes to managed care organizations (MCOs). If the State fails to collect the required payment from some enrollees, it has indicated that it will continue to pay the full capitation payment to the MCO.

Issue

Under current Medicaid rules, premium revenue would not qualify for federal matching. However, under this demonstration, HCFA has proposed to count premium revenues as State matching funds, subject to a restriction on the percentage enrollment of higher-income persons whose premium payments exceed the State's share of MCO capitation payments. If enrollment of these higher-income individuals exceeds 25 percent of non-mandatory TennCare enrollment, federal financial participation (FFP) would be reduced. The reduction would insure that payments made to the State from beneficiary premiums and federal share would not exceed the capitation payment made by the State to the MCO for enrollees beyond the 25 percent limit.

Discussion

Limiting FFP for insurance premiums (as described above) is necessary for the following reasons:

- o **Protection of the Poorest TennCare Eligibles** - The State has a strong incentive to enroll higher-income eligibles when FFP is allowed for the full amount of premiums collected. For these individuals, the State receives a premium payment greater than its share of MCO capitation costs, as well as the full federal share of those costs. In contrast, the poorest eligibles will pay little or no premium, requiring the State to pay most or all of its share of the capitation costs from its other sources of revenue. The financial incentive to enroll higher-income individuals is inappropriate for TennCare, which should be seeking to provide insurance protection for those with the least ability to afford health care.

- o **Prudent Exercise of Federal Fiduciary Responsibility - Recognizing premiums as State matching funds allows the State to make a profit on higher-income individuals paying premiums greater than the State share of capitation costs. The HCFA proposal to reduce FFP would take effect only after an enrollment threshold has been reached recognizes that some of this "profit" will be utilized to offset the costs of new enrollees with incomes below the federal poverty level, who will not be liable for premiums. Without an effective limit, the State could finance a substantial program expansion using new federal dollars but no new State dollars.**

MEMORANDUM OF CALL

Previous editions usable

TO: *Carol*

YOU WERE CALLED BY YOU WERE VISITED BY

Gov. McWhorter
Governor of Tennessee

OF (Organization)

PLEASE PHONE FTS AUTOVON

WILL CALL AGAIN IS WAITING TO SEE YOU

RETURNED YOUR CALL WISHES AN APPOINTMENT

MESSAGE
Re: Thank you for arranging a meeting with the President, and the department is responding just like you said they would.

RECEIVED BY *Geoff* DATE *11-10-93* TIME *6:10*

Health

93

Op'd
Oregon Mar
Penn. Dec.
Hawaii Aug.
Kentucky Dec.
R.I. Nov.

94

Rec'd
Georgia 2/94
Ohio 3/94
S. Carolina 4/94
Mass. 4/94
N.H. 6/94
Mo. 6/30

WR

8 in 93 / 8 in 94

Ill. 1/93

Iowa 8/93

Verm. 4/93

Vi. 1/93

Wisc. 1/93

WY 9/93

AR 1/93

Cal. 3/94

Cal. 1/94

Florida 1/94

Nebr. 1/93

Hawaii 6/94

N.D. 4/94

Okla. 1/94

S.D. 3/94

Wis. 6/94

Health

5 in 93

1 in Nov. but op. in Aug.
2 of these were
done last Dec.,
open in 94

W.R. 8 in 93 full yr.

8 in 94 in 1st 6 mos.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D. C. 20201*File: Penn.
Medicaid
Waiver*

AUG 27 1993

MEMORANDUM TO THE PRESIDENT

SUBJECT: Pennsylvania's Request to Expand the HealthPASS
Medicaid Waiver Program in Pennsylvania

Knowing of your interest in state waiver requests, I am writing to let you know where the Department is heading on the request by the State of Pennsylvania to expand the State's Medicaid freedom of choice waiver program known as HealthPASS. Pennsylvania has requested that its waiver authority be modified to expand the geographic area now served by HealthPASS to include the remainder of Philadelphia County and five surrounding counties including Delaware, Bucks, Chester, Montgomery, and Berks County.

Since we are required by statute to take action on the State's request within 90 days (i.e., by August 30), we must inform the State of our decision on Monday. A description of the background is attached.

Discussion

Although HealthPASS has proven to be cost effective and while we are committed to promoting State flexibility and expanding Medicaid managed care, we plan to reject the State's request to expand this program geographically for the following reasons:

- o Medicaid beneficiaries will not have a choice. If we grant the waiver, Pennsylvania would be permitted to force Medicaid recipients into a single plan in each service area for a five year period. Our experience with Medicaid HMO's leads us to believe that this arrangement is likely to present serious problems with underservice over time. The monopolistic provision of service to Medicaid recipients is inconsistent both with the principles of health reform and with current law, which requires that there be at least two service providers even under Medicaid waivers. Pennsylvania points out that it could contract with more than one bidder, but the waiver grants them the authority to stay with a single contractor. Further, the length of the waiver could leave us without recourse for a long time even if we had good evidence that lack of choice had led to a deterioration in the quality of care.
- o Congressman Henry Waxman will vigorously oppose the expansion of HealthPASS within the existing exemptions, and would perceive the expansion as an abuse of the statutory authority under which HealthPASS operates. In 1986 legislation, Mr. Waxman effectively prohibited future

Page 2 -- The President

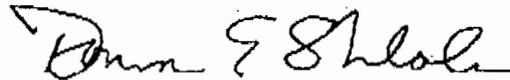
managed care programs like HealthPASS (single provider source) while grandfathering those in existence. Mr. Waxman is also very concerned about Medicaid beneficiaries having a choice of more than one plan.

- o HHS's General Counsel analyzed the law and the Congressional intent and concluded that the exemptions were not intended to apply to a substantially expanded program such as Pennsylvania proposes. Although a legal opinion could be constructed to expand the current exemptions from Medicaid HMO law, General Counsel also cautions that approving the waiver would set a precedent that would limit our discretion on future proposals.

Finally, the State of Pennsylvania can achieve the same goal of managed care in this area using an alternative method. We have explained to the State how they could apply for a freedom of choice waiver that complies with current law regarding HMO enrollment composition and disenrollment. This approach is identical to waiver programs that are currently operational in Wisconsin, Ohio, New York, and Washington, and one recently approved in California.

Under this type of waiver program, Medicaid beneficiaries have a choice between plans, as well as the ability to disenroll and re-enroll in at least one other plan. While these plans would be subject to the statutory provision requiring that no more than 75 percent of a plan's membership be Medicare or Medicaid beneficiaries, a 3-year waiver from this requirement is available to new HMOs to give them time to reach this level. And, to date, Congress has been willing, on a case by case basis, to legislatively extend this 3-year waiver where it is deemed to be warranted.

HCFA has informed the State that it would expedite a waiver request to implement this type of waiver program. During the past week, the state has indicated that our recommended approach may create conflicts with state law, but we are prepared to work with them to overcome such problems.



Donna E. Shalala

Attachment

ATTACHMENT

Background

Since March 1986, Pennsylvania has mandated enrollment of nearly all Medicaid beneficiaries in south and west Philadelphia in this prepaid, managed care program. The program currently covers approximately 75,000 Medicaid enrollees. The State wants to expand this program to cover the remainder of Philadelphia and five surrounding counties, enrolling a total of 517,000 beneficiaries.

HealthPASS operates under an unusual Congressionally-granted "grandfathered" exemption from two significant Medicaid HMO rules that would otherwise apply. The exemption permits the State to contract with only one plan per area (current law requires at least two), and it also permits the State to use "Medicaid-only" HMOs indefinitely (current law allows no more than 75 percent of an HMO's enrollees to be Medicare or Medicaid). If the expansion request is approved, these exemptions would enable the State to enroll all eligibles in the expanded area into a single source for their health care.

The key issue in making the decision is whether to accept the State's argument that this "grandfathered" exemption should apply to the new geographic areas and Medicaid population the State proposes to add. We have serious concerns about extending the program's exemptions to such a large-scale expansion, and believe that it may run counter to congressional intent and the principles underlying Health Care Reform.

Recent Events

A conference call was held with Ms. Karen Snider, Secretary of Pennsylvania's Department of Public Welfare on August 24. In addition, HHS Counsel met with Pennsylvania's legal counsel on August 26 to allow the state an opportunity to fully explain the legal rationale for its request.

MEMORANDUM FOR BRUCE LINDSEY

FROM: Carol H. Rasco

SUBJ: Waivers

DATE: July 18, 1994

I am sending you the following:

1. A letter to Carnahan which is the form used by Sec. Shalala to send all governors with an outstanding waiver request prior to each NGA meeting. The paragraph that is personalized about the individual state's waiver(s) has formed the basis for item (2) below. *(Put back w/ other letters)*

2. A compilation of the outstanding waiver requests by state. Notes regarding this chart are as follows:

a. When it is stated a list of questions/concerns have been sent to a state by HHS, this is the standard procedure after an initial review by the agency for things like budget neutrality, legal issues, etc. The state and HHS then use this list as a negotiating tool.

b. Once issues have been resolved through negotiation, HHS sends to the state agency a list of terms and conditions which serves as a "contract" for implementing the waiver.

c. Reference is made to the Food Stamp problem: an amendment was added to the HHS appropriation bill by the subcommittee chair which prohibits food stamp cashout after July 1. The Administration was on record opposing this prohibition. It does mean in those states that have included a cash out in pending waivers that a renegotiation will occur as states will be depending on that cash out to make the budget of the waiver. HHS is working to reach a later date and/or deletion of this amendment in conference. The only reason we state (see Michigan) on the chart is that it is the first state listed with the problem and we included more narrative there.

d. Reference is made to the 9th Circuit court decision. You and I discussed this matter, Bruce. It will not only affect currently approved California waivers but their pending ones as well; this decision will affect how HHS looks at the Oregon waiver as well as possibly other states. Again, this decision has primarily to do with public notice issues which the Administration has been negotiating with NGA and others. The decision is based on actions by the Bush HHS, but as I mentioned to you, this administration should be very careful not to use that as a talking point at this time. Hopefully the President will AVOID saying ANYTHING at this time about this problem.

Finally, several of these waivers have been in the Department for some time. We must remember that some of these are very difficult to negotiate and that many of the people in the Department that must do the actual work on these are and have been deeply involved in health care reform and/or welfare reform development.

Please keep in mind that Kathi Way of my staff is in Boston at the Sheraton in room 2560. Kathi wears a SkyPager, 1-800-503-5018, no pin necessary. She works with the states, HHS and NGA on these waiver issues for the White House. Additionally, John Monahan who serves as the intergovernmental person at HHS is in Boston; I am not certain of his hotel but Kathi should be able to find him. I believe Monahan's Skypager is the traditional 1-800-SkyPage, pin 2074366. Both Kathi and John have complete notebooks with them on these issues.

I am faxing a copy of all this to Kathi tonight so that she will know precisely what I have sent you. She will see that Marcia Hale and her staff are aware of our communications on this matter.

I am on the White House beeper, probably won't be at my house until well after 10 p.m. tonight. Thanks.



July 14, 1994

TO: Carol Rasco
Mark Gearan
Marcia Hale ✓
John Hart
Keith Mason
Kathi Way

FROM: John Monahan *lupf/jm*
Director, Office of Intergovernmental Affairs

SUBJECT: Informational Materials on HHS Issues for National
Governors' Association Annual Meeting

In preparation for this weekend's National Governors' Association meeting, enclosed you will find several documents relating to current Department of Health and Human Services initiatives of interest to governors and states. As a result of the national prominence of the health care reform and welfare reform debates, and as a consequence of the President's demonstrated commitment to state flexibility and experimentation, states are submitting their own health care and welfare proposals to HHS in unprecedented numbers. In addition, governors have been active participants in HHS consultations on major Administration initiatives such as welfare reform and immunization.

The components of this briefing book supply information both on key state issues currently pending at the Department and on the accomplishments of HHS over the past eighteen months in promoting a strong state-federal partnership. These materials include:

- o a letter from Secretary Shalala to all governors, sent last week, which details the major initiatives of the Department and highlights the integral role of governors in these efforts;
- o individual letters from the Secretary to all governors who have major health care and welfare waivers pending at the Department, informing them of the status of their proposals and emphasizing her commitment to an expedited waiver review process;

- o talking points discussing the way in which the waiver approval process has been streamlined and made more efficient;
- o short summaries of the major state health care reform and welfare reform waivers approved by HHS since the beginning of 1993;
- o the revised HHS waiver policy developed last year in consultations with the NGA, and NGA policy resolutions adopting this policy and commending the Administration on its commitment to state flexibility;
- o letters of support from the NGA and individual governors commending the President on his Work and Responsibility Act of 1994; and
- o a letter of strong support from the NGA co-chairs regarding the recent lawsuit filed by the National Association of Community Health Centers.

Please feel free to contact me if you have any questions. I can be reached at 690-6060.

Accomplishments - Letters
to All Governors



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

JUL 7 1994

Dear Governor:

From time to time, I have written you about the major initiatives in which the Department of Health and Human Services (HHS) is involved. Under President Clinton's dynamic leadership, we have worked very hard over the past eighteen months to strengthen the federal-state partnership that is crucial to the successful operation of so many of our Department's programs.

To this end, our Department has worked closely with individual states and the National Governors' Association (NGA) in the development of legislation, regulations, policies, and initiatives that will improve the health and well-being of our nation's citizens.

I am committed to continuing and building upon this improved relationship with our state partners. In this spirit, I am enclosing a short report summarizing activities in our Department of interest to states. If you have any questions, please do not hesitate to contact me or have your staff contact John Monahan, our Director of Intergovernmental Affairs, at (202) 690-6060.

Please accept my best wishes for a productive meeting in Boston later this month.

Sincerely,

Donna E. Shalala

Enclosure

REPORT TO THE NATION'S GOVERNORS

from

DONNA E. SHALALA
SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

July 1994

Health Care Reform

Health care reform remains the top priority of the Clinton Administration. The President strongly believes that every American should have guaranteed private health insurance. To that end, last fall President Clinton proposed the Health Security Act (HSA) to reform our nation's health care system. Developed in close consultation with states and the National Governors' Association, the Health Security Act provides states substantial flexibility to design health care strategies that meet the needs of their citizens.

The Health Security Act reflects the Administration's commitment to working with Governors to achieve comprehensive health care reform. We have assembled, and sent to each state, a state-specific analysis of the Act. As the Congress deliberates health care reform in the next few weeks, we look forward to a continuing dialogue with the nation's Governors to meet our shared goal of reform.

Welfare Reform

In June 1994, President Clinton outlined his plan to "end welfare as we know it" by announcing the introduction of his Work and Responsibility Act of 1994. This legislative proposal culminated months of discussions with our state and local government partners, business and labor leaders, advocacy organizations, and welfare recipients themselves. These unprecedented consultations assisted us greatly in crafting a proposal that strives to provide states with maximum flexibility and needed resources to change fundamentally our nation's welfare system.

President Clinton's welfare reform proposal is based on two simple principles: work and responsibility. Under our plan, states will be given the tools to make welfare truly a transitional system that leads recipients to work and self-sufficiency. Understanding that states will need time to restructure their welfare systems, our proposal focuses first on those most at risk -- young mothers born after 1971 -- as we phase in the new time-limited welfare system. In the new system, a person may receive no more than two years of benefits before he or she is expected to work. Included in our package are child support reform measures to prevent adolescent pregnancy, child

care enhancements, and measures to simplify and improve assistance programs.

The Work and Responsibility Act builds upon current state innovations by giving states the option to implement many program changes which now require waivers (e.g., income disregards and asset exclusions, elimination of the "100-hour" rule which limits the amount of time two parent families on Aid to Families with Dependent Children program can work per month). The President's legislative proposal also recognizes the fiscal burdens faced by states and provides significantly enhanced match rates for both the JOBS program and child care services.

Childhood Immunization

On April 21, 1994, President Clinton launched a comprehensive outreach campaign for the Childhood Immunization Initiative (CII), a critical program in which federal, state and local governments are working together to ensure that all children, particularly infants, are protected against vaccine-preventable diseases. Under the CII, the federal government, working through the states and local governments, will provide free vaccines to needy children. In addition, we are providing increased funding to states and cities to improve the service delivery infrastructure, build an enhanced disease surveillance and monitoring system, and conduct an aggressive national outreach program. The strong support of the nation's Governors will be crucial in fulfilling this commitment to our nation's children. The Department invites your active leadership in coordinating your states efforts.

Welfare Reform Waivers

The Department's continuing commitment to state flexibility is evident in the approval of several major welfare reform demonstrations. Since the beginning of this Administration, HHS has approved 16 welfare demonstration projects in 15 states: Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, North Dakota, Oklahoma, South Dakota, Vermont, Virginia, Wisconsin, and Wyoming. We expect the approval of more waiver proposals in the near future. The Department's Administration for Children and Families (ACF) has used a streamlined review process to evaluate and act on waiver requests in a timely and efficient manner, even with a dramatic increase in the number and complexity of waiver submissions in the last year.

Health Care Reform Waivers

The Health Care Financing Administration (HCFA) has also approved demonstration waivers to allow five states (Oregon, Rhode Island,

Tennessee, Kentucky, Hawaii) to conduct statewide health care reform experiments. Others are under review. HCFA's streamlined waiver review process and close consultations with the states have permitted us to significantly improve the speed and quality of the decision-making process. On average, these statewide waivers have been processed in a time frame over 50 percent faster than similar waivers have been processed in the past. HCFA will continue to seek improvements to the waiver review process.

Medicaid Program Waivers

HCFA also has instituted procedures to simplify and expedite action on the two types of Medicaid "program waivers" -- Home and Community Based Services (HCBS) and Freedom of Choice (FOC) waivers. These waivers provide the states increased flexibility to manage their Medicaid plan, both to improve services and to reduce federal and state costs.

- o HCBS waivers permit states to expand non-institutional long-term care services to Medicaid recipients. Since January 1993, HCFA has granted or renewed 80 HCBS waivers. Over 70 percent of these HCBS waivers were approved within 90 days of receipt. In the last year, HCFA has issued streamlined application formats for initial and renewal HCBS waiver applications. To further expedite the approval process, HCFA is now working with state representatives to develop three prototype formats for home and community based services waivers based on "best practices" already underway in some states. These prototype formats will be designed for waivers that serve individuals with AIDS, people with traumatic brain injuries, and medically fragile children.
- o FOC waivers enhance states' ability to implement managed care programs. HCFA has improved the FOC waiver review process in several ways and has made special efforts to assist states that have not had substantial experience with managed care. More than half of the FOC waiver requests were approved within 90 days of receipt last year, and overall Medicaid managed care enrollment increased by 33 percent in 1993.

Family Preservation and Support

In January 1994, HHS sent each state detailed information about implementation of the new Family Preservation and Support program. Established in the President's 1993 budget reconciliation bill, this five-year, \$1 billion initiative helps

states provide needed services to families at risk or in crisis. Our Department's Regional Offices are now working with states to complete the award of FY 1994 grants, which support the development of five-year Family Preservation and Support State Plans.

In the coming year, our Department will continue working closely with state child welfare agencies as they develop and begin to implement their five-year plans. We will also assist states in identifying and effectively using other federal resources, including newly-enhanced reimbursement for child welfare information systems and a new program of self-assessment and improvement grants for State courts.

Head Start

Our Department has taken major steps toward implementing the broad goals outlined in Creating A 21st Century Head Start, the report issued by the Advisory Committee on Head Start Quality and Expansion in January 1994. The Advisory Committee, which included representation by the NGA, issued a bold plan to expand Head Start and to improve program quality. Many of the Committee's recommendations were included in the Administration's Head Start reauthorization proposal, which enjoyed broad bipartisan support in both Houses of Congress, and was signed into law by President Clinton on May 18.

A key feature of the Head Start reauthorization bill is a call for closer linkage between Head Start and appropriate agencies at state and local levels. It strengthens our program of "collaboration grants" to encourage greater coordination of Head Start services with state efforts in health, welfare, child care, education, family literacy, services to children with disabilities and national service activities. It also encourages closer partnerships between Head Start and schools and requires Head Start agencies to implement collaborative activities to help children and parents with the transition to elementary school.

Empowerment Zones/Enterprise Communities

The Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA) have received over 500 applications from communities around the country seeking Empowerment Zones and Enterprise Community (EZ/EC) designations. In order for a community to receive a designation, its application must have been nominated by the local and state government. Congress provided an additional \$1 billion to HHS in special Title XX Social Service Block Grant funds for the EZ/EC awardees.

By fall, HUD and USDA will have announced the first round of awards, and HHS will begin to allocate, through state governments, the special Title XX funds to selected applicants. We will also assist the selected communities in making our full range of federal programs work as effectively as possible in their jurisdictions -- including rapid review and action on waiver requests.

For further information on any of these initiatives, please contact:

U.S. Department of Health and Human Services
Office of Intergovernmental Affairs
200 Independence Avenue, S.W., Room 600E
Washington, D.C. 20201
(202) 690-6060

Waiver Talking Points

STATE HEALTH CARE AND WELFARE DEMONSTRATION WAIVERS

THE CLINTON ADMINISTRATION RECORD

- Shortly after taking office, President Clinton promised the nation's governors that his Administration would work closely with the states to streamline and improve the health care and welfare waiver process.
- Eighteen months later, the Department of Health and Human Services has made this promise a reality:
 - The Administration has approved comprehensive **health care reform** initiatives for five states: Hawaii, Kentucky, Oregon, Rhode Island, Tennessee.
 - The Administration has approved 16 **welfare reform** demonstrations for 15 states since the beginning of 1993: Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, North Dakota, Oklahoma, South Dakota, Vermont, Virginia, Wisconsin, and Wyoming.

A STREAMLINED WAIVER PROCESS

- HHS has moved aggressively to speed the consideration of state waiver proposals through a more efficient waiver process developed in close consultation with the National Governors' Association. The Administration now:
 - conducts a concurrent, rather than sequential, review of waiver applications by different Executive Branch components;
 - assesses cost neutrality over the life of the proposed demonstration program instead of year by year;
 - allows waivers to test the same or related policies in more than one state;
 - considers joint Medicare-Medicaid waivers, as well as joint AFDC-Medicaid waivers; and
 - allows demonstrations of sufficient duration to give the new policy approaches a fair test.
- In October 1993, President Clinton signed an Executive Order on Intergovernmental Partnership, which requires all federal agencies, including HHS, to process state waiver and grant applications within a time frame not to exceed 120 days.

- As a result of this streamlining, Medicaid and AFDC waivers have been processed in a time frame much faster than similar applications have been handled in the past. Specifically,
 - major Medicaid waivers have been decided over 50 percent faster;
 - nearly three-fourths of all Medicaid Home and Community Based Services (HCBS) waiver applications have been approved within 90 days of receipt; and
 - Medicaid Freedom-of-Choice (FOC) managed care waivers were approved in significantly greater numbers, resulting in increased Medicaid managed care enrollment increase of over 30 percent in 1993.

- At the same time it was speeding up the waiver review process, the Department of Health and Human Services considered and approved Medicaid and AFDC waivers unprecedented in complexity and scope.

Waiver Status Letters



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

JUL 14 1994

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

Dear Governor Carnahan:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop innovative health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our more streamlined review procedures, the number of state waiver requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's request for a section 1115 Medicaid waiver. As you know, we received the waiver application for Missouri's Waiver Demonstration Project on June 30, 1994. We are in the very early stages of our review and are looking forward to working closely with state staff to identify and clarify issues for discussion.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,

Donna E. Shalala

Personalized
Paragraph reflected
on short.



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

JUL 14 1994

The Honorable William F. Weld
Governor of Massachusetts
Boston, Massachusetts 02133

Dear Governor Weld:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to ^①update you on the status of your state's waiver requests for the Employment Support Program and the Child Care Co-Payment Project. The Administration for Children and Families (ACF) expects to send the Massachusetts Department of Public Welfare a list of issues and questions which have arisen out of the federal review of the Employment Support Program application in the next couple of weeks. If their response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff. We have recently identified a potential legal difficulty related to the Child Care Co-Payment Project. We expect to complete our analysis and contact your staff on the matter by the end of the month. 3/1/94 (rec'd) ②
rec'd
1/14/93

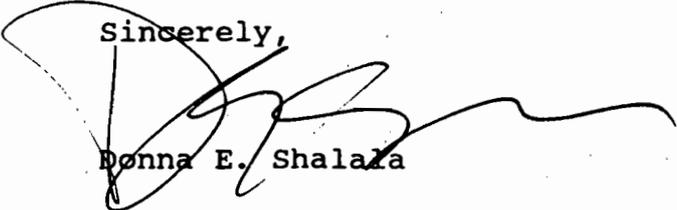
③ I also would like to let you know the status of your state's request for a section 1115 Medicaid waiver. The Health Care Financing Administration (HCFA) received Massachusetts' waiver application for the MassHealth program on April 15, 1994. On May 10, 1994, the state provided an informative briefing for the Department on the proposal. On June 24th, HCFA asked the state

Page 2 --- The Honorable William F. Weld

~~to provide additional information about their proposal, and we
look forward to receiving and reviewing their response.~~

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060, Ann Rosewater, ACF, at (202) 401-5180, or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,



Donna E. Shalala



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

JUL 14 1994

The Honorable Pete Wilson
Governor of California
Sacramento, California 95814

Dear Governor Wilson:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver requests for the AFDC and Food Stamp Compatibility Demonstration Project and amendments to the California Work Pays Demonstration Project. The Administration for Children and Families (ACF) received California's application for the AFDC and Food Stamp Compatibility Demonstration Project on May 23, 1994. It expects to send the California Department of Social Services (DSS) a list of issues and questions which result from a federal review of the application by the end of August. If the DSS response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff. In regard to the requested amendments to the California Work Pays Demonstration Project, received on March 14, 1994, ACF recently sent the DSS a list of issues and questions which arose out of the federal review of that application. We look forward to receiving your response.

Page 2 - The Honorable Pete Wilson

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', written over the typed name below.

Donna E. Shalala



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

JUL 14 1994

The Honorable Lowell P. Weicker, Jr.
Governor of Connecticut
Hartford, Connecticut 06106

Dear Lowell:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

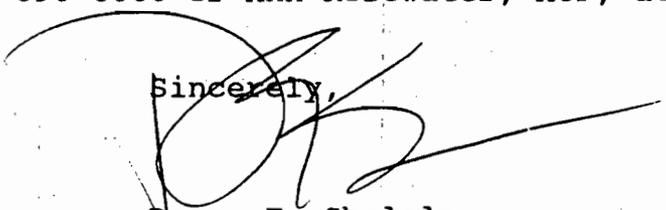
As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

*Received
12/30/93*

I would like to take this opportunity to update you on the status of your state's waiver request for "A Fair Chance" welfare reform demonstration project. The Administration for Children and Families has been working with the Connecticut Department of Social Services to resolve a number of issues and questions which arose out of a federal review of the waiver application. Having resolved the key issues of concern, we are in the process of developing draft terms and conditions which we expect to send to the Connecticut Department of Social Services in the next couple of weeks.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,


Donna E. Shalala



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

JUL 14 1994

The Honorable Zell Miller
Governor of Georgia
Atlanta, Georgia 30334

Dear Zell:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

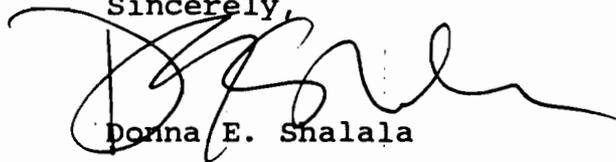
I would like to take this opportunity to update you ^{welfare waiver} on the status of your state's waiver requests for Project Fulton and the Work for Welfare Project. The Administration for Children and Families ^{Rec'd 10/21/93} has been working with the Georgia Department of Human Resources (DHS) to resolve a number of issues and questions which arose out of a federal review of the waiver application for Project Fulton. Having resolved the key issues of concern, we are in the process of developing draft terms and conditions which we expect to send to DHS in the next couple of weeks.

ACF also ^{by end of August} expects to send the Georgia Department of Human Resources a list of issues and questions which result from a federal review of the Work for Welfare Project application, which was received on June 30, 1994, by the end of August. If their response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff.

Page 2 - The Honorable Zell Miller

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', written over a printed name.

Donna E. Shalala



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

JUL 14 1994

The Honorable Evan Bayh
Governor of Indiana
Indianapolis, Indiana 46204

Dear Evan:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative to change their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request for the Manpower, Placement and Comprehensive Training Program. The Administration for Children and Families (ACF) received this proposal on June 21, 1994, and expects to send the Indiana Family and Social Services Administration a list of issues and questions which result from a federal review of the application by the end of August. If their response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

Donna E. Shalala



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

JUL 14 1994

The Honorable William D. Schaefer
Governor of Maryland
Annapolis, Maryland 21404

Dear Governor Schaefer:

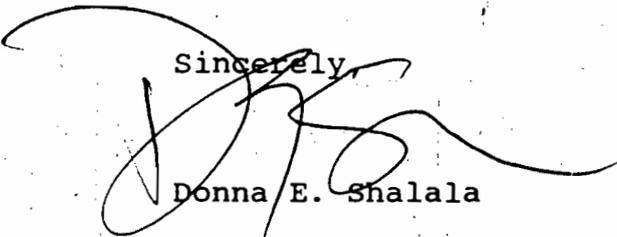
Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request for the Maryland Welfare Reform Project, received by the Department on March 1, 1994. The Administration for Children and Families recently sent a letter on July 1, 1994 to the Maryland Department of Human Resources addressing certain legal and funding concerns applicable to this project. After we have received the necessary information we requested pertaining to these concerns, we will proceed as expeditiously as possible to make a final decision on your request.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,



Donna E. Shalala



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

JUL 14 1994

The Honorable John Engler
Governor of Michigan
Lansing, Michigan 48909

Dear Governor Engler:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

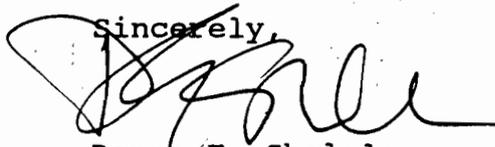
As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request to expand the Strengthen Michigan Families Demonstration, received on March 8, 1994. The Administration for Children and Families and the Health Care Financing Administration have been working with the Michigan Department of Social Services (DSS) to resolve issues and concerns based on a federal review of the waiver application. A significant issue has arisen in Congress regarding the federal funding of Food Stamp cash-outs in state demonstrations. Until Congress resolves this question, we will continue to work with your DSS to address all other non-Food Stamp cash-out issues in an expeditious manner.

Page 2 -- The Honorable John Engler

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna E. Shalala". The signature is fluid and cursive, with a large initial "D" and "S".

Donna E. Shalala



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

JUL 14 1994

The Honorable Carroll A. Campbell Jr.
Governor of South Carolina
Columbia, South Carolina 29211

Dear Carroll:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request entitled "Self-Sufficiency and Parental Responsibility Program", received by the Department on June 13, 1994. The Administration for Children and Families (ACF) expects to send the South Carolina Department of Social Services a list of issues and questions which result from a federal review of the application by mid-August. If their response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff.

I also would like to let you know the status of your state's request for a section 1115 Medicaid waiver. The Department received the waiver application for South Carolina's Palmetto Health Initiative on March 1, 1994. The Health Care Financing Administration (HCFA) is now reviewing the material submitted by the state on May 13, 1994 in response to our request for additional information. As you know, our staffs are working together to set up a meeting within the next two weeks to discuss outstanding issues following a

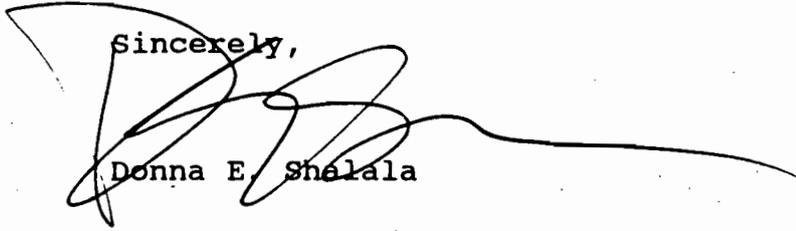
meeting held in last 10 days.

HHS & So Carolina

Page 2 -- The Honorable Carroll A. Campbell, Jr.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060, Ann Rosewater, ACF, at (202) 401-5180, or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,



Donna E. Shalala



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

JUL 14 1994

The Honorable Kirk Fordice
Governor of Mississippi
Jackson, Mississippi 39205

Dear Governor Fordice:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

Rec'd 12/10/93
I would like to take this opportunity ^{Welfare waiver!} to update you on the status of your state's waiver request for the New Direction Demonstration Program. The Administration for Children and Families has been working with the Mississippi Department of Human Resources (DHR) to resolve issues and concerns based on a federal review of the waiver application. A significant issue has arisen in Congress regarding the federal funding of Food Stamp cash-outs in state demonstrations. Until Congress resolves this question, we will continue to work with you to address other non-Food Stamp cash-out issues.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

Donna E. Shalala



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

JUL 14 1994

The Honorable Marc Racicot
Governor of Montana
Helena, Montana 59620

Dear Governor Racicot:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

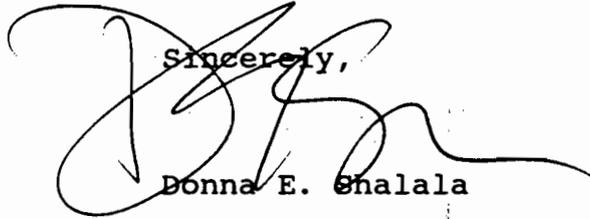
As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request for the Achieving Independence for Montanans Project, received on April 19, 1994. The Administration for Children and Families (ACF) expects to send the Montana Department of Social and Rehabilitation Service a list of issues and questions which have been identified based on the federal review of the application by the end of next week. A significant issue has arisen in Congress regarding the federal funding of Food Stamp cash-outs in state demonstrations. Until Congress resolves this question, we will continue to work with your Department of Social and Rehabilitative Services to address other non-Food Stamp cash-out issues in an expeditious manner.

Page 2 - The Honorable Marc Racicot

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Shalala', with a long horizontal flourish extending to the right.

Donna E. Shalala



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

JUL 14 1994

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

Dear Governor Merrill:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative to change their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

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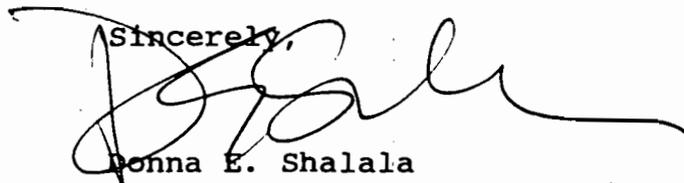
① I would like to take this opportunity to update you on the status of your state's waiver request Earned Income Disregard Project, received September 20, 1993. In October 1993, the Administration for Children and Families sent the New Hampshire Department of Health and Human Services draft terms and conditions. When we receive your response, we should be able to reach a final decision promptly. HHS

② I also would like to let you know the status of your state's request for a section 1115 Medicaid waiver. The Health Care Financing Administration (HCFA) received New Hampshire's waiver application for the Granite State Partnership for Access and Affordability in Health Care program ^{received} on June 14, 1994. HCFA is currently in the very early stages of our review of your detailed proposal and expects to contact your state agency in the next few weeks to discuss issues relating to the waiver request. We look forward to working cooperatively with your staff over the next few months to address issues that require clarification and resolution.

Page 2 -- The Honorable Stephen Merrill

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060, Ann Rosewater, ACF, at (202) 401-5180, or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna E. Shalala", with a long horizontal flourish extending to the right.

Donna E. Shalala



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

JUL 14 1994

The Honorable Mario M. Cuomo
Governor of New York
Albany, New York 12224

Dear Mario:

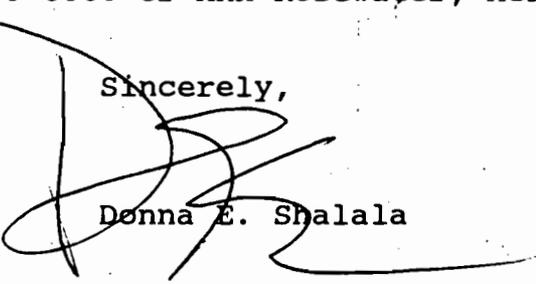
Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request for the Jobs First Demonstration. The Administration for Children and Families (ACF) received this application on June 7, 1994, and expects to send the New York Department of Social Services a list of issues and questions which result from a federal review of the application by mid-August. If their response provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,


Donna E. Shalala



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

JUL 14 1994

The Honorable George Voinovich
Governor of Ohio
Columbus, Ohio 43215

Dear George:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver requests for the "A State of Opportunity" Project, received on May 28, 1994, and the "Automobile Assets Disregard Project", received on October 13, 1993. The Administration for Children and Families (ACF) expects to send the Ohio Department of Human Services (DHS) a list of issues and questions which have been identified based on the federal review of the "A State of Opportunity" Project application by the end of the month. A significant issue has arisen in Congress regarding the federal funding of Food Stamp cash-outs in state demonstrations. Until Congress resolves this question, we will continue to work with your DHS to address other non-Food Stamp cash-out issues in an expeditious manner.

(2) In January, ACF sent DHS a list of issues and questions which arose out of the federal review of the "Automobile Assets Disregard Project" application. If, when we receive their response, it provides sufficient clarification and resolves significant issues, ACF would promptly submit draft terms and conditions to your staff. However, we understand Ohio may choose to withdraw this waiver request as it has since been included in the more recent request for waivers under the "A State of Opportunity" Project.

welfare reform

Rec'd 10/13/93

then 3

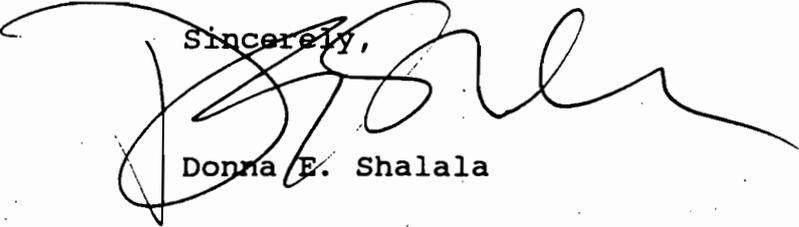
(see next page)

Page 2 -- The Honorable George Voinovich

③ I also would like to let you know the status of your state's request for a section 1115 Medicaid waiver. The Department received Ohio's waiver application for the OhioCare program on March 2, 1994. The Health Care Financing Administration (HCFA) and other HHS officials are looking forward to meeting with your staff on July 21st to discuss the proposal in more depth.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060, Ann Rosewater, ACF, at (202) 401-5180, or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,



Donna E. Shalala



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

JUL 14 1994

The Honorable Robert P. Casey
Governor of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Casey:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

I would like to take this opportunity to update you on the status of your state's waiver request for the Pathways to Independence Demonstration. The Administration for Children and Families received this proposal on February 18, 1994, and since that time has been working closely with the Pennsylvania Department of Public Welfare (DPW) to answer questions and concerns based on a federal review of the waiver application. A significant issue has arisen in Congress regarding the federal funding of Food Stamp cash-outs in state demonstrations. Until Congress resolves this question, we will continue to work with your DPW to address other non-Food Stamp cash-out issues in an expeditious manner.

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060 or Ann Rosewater, ACF, at (202) 401-5180.

Sincerely,

Donna E. Shalala



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

JUL 14 1994

The Honorable Mike Lowry
Governor of Washington
Olympia, Washington 98504

Dear Governor Lowry:

Since the beginning of his Administration, President Clinton has been committed to a close partnership with the nation's Governors and to allowing states the flexibility to develop and test innovative change to their health and welfare programs. The Department of Health and Human Services has worked very hard to foster this intergovernmental relationship and has worked closely with the National Governors' Association in developing a more efficient and timely process for evaluating state proposals for health care and welfare reform experiments. Many states, including yours, have submitted waiver requests that are being evaluated under our new waiver review procedures.

As we have implemented our streamlined review procedures, the number of state demonstration requests have increased significantly. We are committed, however, to continue responding to these requests as quickly as possible, while maintaining the integrity and thoroughness of the review process.

① I would like to take this opportunity to update you on the status of your state's waiver request for the Success Through Employment Project, received on November 16, 1993. In January 1994, the Administration for Children and Families (ACF) sent the Washington Department of Social and Health Services a list of issues and questions which arose out of the federal review of the application. When we receive your response, ACF should be able to promptly submit draft terms and conditions to your staff, if it provides sufficient clarification and resolves significant issues.

② I also would like to let you know the status of your request to renew your State's Alternative Disposition Plan (ADP) waiver (#0203.91) which provides home and community-based services to developmentally disabled individuals in nursing facilities. The Seattle Regional Office received your revised renewal request on June 28, 1994. The Health Care Financing Administration (HCFA) currently is reviewing the request and believes that any outstanding issues can be resolved within the current 90-day period.

Page 2 -- The Honorable Mike Lowry

If you have any questions about our process or about the status of your waiver proposal, please do not hesitate to contact me or have your staff call John Monahan, Director of Intergovernmental Affairs, at (202) 690-6060, Ann Rosewater, ACF, at (202) 401-5180, or Richard Chambers, HCFA, at (202) 690-8501.

Sincerely,



Donna E. Shalala

| STATE | INITIATIVE | KEY DATES |
|-----------------|--|--|
| APPROVED | | |
| Arkansas | Eliminate increased AFDC benefits for additional children; provide special counseling to 13-17 year olds and require participation in educational activity. | Received 1/14/93 Approved 4/5/94 |
| California | Implement Cal Learn, a Learnfare program that provides both bonuses and sanctions. Increase the resource limit to \$2,000 and the automobile exemption to \$4,500 and allow savings of up to \$5,000 in restricted accounts. Create an Alternative Assistance Program that allows AFDC applicants and recipients with earned income to choose Medicaid and Child Care Assistance in lieu of a cash grant. Implement multiple reforms to the GAIN (JOBS) program. | Received 9/29/93 Approved 3/1/94 |
| Colorado | Establish a 2-year time limitation sanction for non-cooperative employable AFDC adults; consolidate AFDC, Food Stamp, and Child Care benefits into a single comprehensive benefits package; disregard a portion of all earned income, replacing all current income disregards; require all AFDC households with children under the age of 24 months to have current immunization, failure to comply will result in a financial sanction; provide incentives to participants who graduate from high school or obtain a GED; exempt the asset value of one care; and increase the resource limit to \$5,000 for those families with an able-bodied adult who is employed or has been employed within the last 6 months. | Received 6/30/93 Approved 1/13/94 |
| Florida | With some exceptions, limits AFDC benefits to 24 months in any 60-month period followed by participation in transitional employment. Replaces current \$90 and \$30 and one-third disregards with single, non-time-limited disregard of \$200 plus one-half remainder; disregards income of a stepparent whose needs are not included in the assistance unit for the first 6-months of receipt of public assistance; excludes interest income in determining benefits, lowers age of child for JOBS exemption to 6-months, raises asset limit to \$5,000 plus a vehicle of reasonable worth used primarily for self-sufficiency purposes; and extends transitional Medicaid and child care benefits. Eliminates 100-hour and required quarters of work rules, and (on a case-by-case basis) the 6-month time limit requirements in the AFDC-UP program. Requires school conferences, regular school attendance, and immunizations. | Received 9/21/93 Approved 1/27/94 |

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| Georgia | Provide family planning and parenting services; eliminate increased AFDC benefit for additional children conceived while receiving AFDC; require able-bodied adults to accept full-time employment if they are not caring for children under 14. | Received 5/18/93 Approved 11/1/93 |
| Hawaii | Place individuals on waiting list for placement in employment and training components under JOBS in On-the-Job Training (OJT) positions. | Received 11/3/93 Approved 6/24/94 |
| Illinois | Change earnings disregards and increase gross income test. | Received 8/2/93 Approved 11/23/93 |
| Iowa | Multi-faceted proposal including: changes in income disregards, increased resource limits, limiting JOBS exemptions, extending child care transitional benefit to 24 months, requiring most parents to develop self-sufficiency plan which includes individually based time frame for achieving self-sufficiency. Those unable to achieve self-sufficiency, but demonstrating effort and satisfactory performance, will have their time frames extended; those failing to do so, or choosing not to develop a plan, can be terminated from AFDC and cannot re-apply for 6 months. | Received 4/29/93 Approved 8/13/93 |
| North Dakota | Would make women in their first and second trimester of pregnancy eligible for AFDC. | Received 8/19/93 Approved 4/11/94 |
| Oklahoma | Require school attendance of AFDC recipients aged 13-18. | Received 12/28/92 Approved 1/25/94 |
| South Dakota | Time limits AFDC cash benefits for 24 months for those assigned to employment-readiness track and for 60 months for those in training track followed by required employment or volunteer service; makes full family ineligible for 3 months for voluntarily quitting employment; provides one month transitional allowance after case closes due to earnings; disregards earned income and other assets of full-time students. | Received 8/6/93 Approved 3/14/94 |

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| Vermont | Require participation in subsidized employment after 30 mo for AFDC and 15 mo for AFDC-UP cases, broaden AFDC-UP eligibility, change earnings disregards, change JOBS exemptions, disburse child support to AFDC family, require most minors to live in supervised setting, extend eligibility in child-only cases. | Received 10/27/92 Approved 4/12/93 |
| Virginia | Includes 4 project components: 1) Recipients on AFDC for at least 2 years who meet other criteria can volunteer to be considered for jobs expected to pay \$15-18,000/yr. Training stipends equal to AFDC will be paid initially. 2) Provide additional 24 mo. child care and Medicaid transition benefits. 3) Establish a child support insurance program for those leaving AFDC due to earnings. 4) Change method of counting step-parent income when AFDC recipient marries; increase resource limit to \$5,000 for education and housing purposes; extend AFDC eligibility to full-time students until age 21. | Received 7/13/93 Approved 11/23/93 |
| Wisconsin | AFDC and cashed-out food stamps benefits are combined into one Work Not Welfare (WNW) payment with benefits limited to 24 monthly payments and 12 months of transition benefits within a 48 month period; after 24 months of payments no additional cash payments are available for 36 months unless an exemption is granted. The WNW benefit must be "earned" by participation in education, training or work-related activities and in most cases benefits do not change between eligibility determinations as income changes. The AFDC portion of the WNW payment for children conceived after first receiving a WNW payment is not increased unless a child was conceived after not receiving a WNW payment for six months; child support collections are paid directly to the family; the 100 hour rule is eliminated for AFDC-UP cases; and earned income disregard of \$30 and 1/3 is replaced by continuous disregard of \$30 and 1/6. | Received 7/14/93 Approved 11/1/93 |
| Wisconsin | Eliminate increased AFDC benefit for additional children conceived while receiving AFDC. | Received 2/9/94 Approved 6/24/94 |
| Wyoming | Require able-bodied AFDC applicants and recipients to work or perform community service, require school attendance for those 16 and over, change sanction penalties for non-compliance with work requirements, increase resource limit for employed families, limit or eliminate AFDC benefits in certain cases where recipient is in post-secondary ed. program, and provide JOBS to non-custodial parents court-ordered to participate. Denied additional waiver request to provide lesser of benefit for Wyoming or prior state of residence for 12 months for new residents. | Received 5/20/93 Approved 9/1/93 |

DENIED

| STATE | INITIATIVE | KEY DATES |
|---------------------------------------|---|---|
| Illinois | Would have paid lesser of previous State of Illinois benefit for 12 months for new residents. | Received 10/7/92 Denied 8/3/93 |
| WITHDRAWN OR REVIEW TERMINATED | | |
| Illinois | Provide incentives for school attendance; require participation in a Community Service Corps (CSC) for those with children under 3; provide wage subsidy for up to 6 months after completing CSC. | Received 10/7/92 |
| South Carolina | Provides for work experience at for-profit sites, disregard of training allowances, changes to earnings disregards. State developing alternative proposal. | Received 12/9/92 Withdrawn 11/4/93 |
| Texas | Would extend AFDC benefits to two-parent families without regard to labor force attachment or number of hours worked. | Received 9/29/93 Terminated 4/18/94 |
| Texas | In three pilot counties, replaces current earned income disregards for AFDC families headed by teen parent(S) with fill-the-gap earned income disregard. | Received 12/28/93 Terminated 4/18/94 |

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| STATE | INITIATIVE | KEY DATES |
|-----------------|---|------------------|
| RECEIVED | | |
| California | Would amend Work Pays Demonstration Project by adding provisions to: reduce benefit levels by 10% (but retaining the need level); reduce benefits an additional 15% after 6 months on assistance for cases with and able-bodied adult; time-limit assistance to able-bodied adults to 24 months, and not increase benefits for children conceived while receiving AFDC. | Received 3/14/94 |

| STATE | INITIATIVE | KEY DATES |
|-------------|--|----------------------|
| California | Would make AFDC and Food Stamp policy more compatible by making AFDC households categorically eligible for Food Stamps; allowing recipients to deduct 40 percent of self-employment income in reporting monthly income; disregarding \$100 per quarter in non-recurring gifts and irregular/infrequent income; disregarding undergraduate student assistance and work study income if payments are based on need; reinstating food stamp benefits discontinued for failure to file a monthly report when good cause is found for the failure; and simplifying vehicle valuation methodology. | Received 5/23/94 |
| California | Would eliminate annual AFDC redetermination and Food Stamp recertification requirements for monthly reporting households in 19 counties. | Received 7/1/94 |
| California | Would require face-to-face AFDC redetermination and Food Stamp recertification interviews only every 24 months and would simplify review form for monthly reporting cases. | Received 7/8/94 |
| Connecticut | Statewide, eliminate deprivation requirement; change filing unit requirements; increase motor vehicle and asset limits; eliminate 185 percent of need test; disregard student earnings; increase earned income disregards; redirect support payments to the AFDC family; extend transitional child care benefits; extend transitional Medicaid; change voluntary quit policy to comply with Food Stamp policy; various JOBS program changes, including: 1-year post AFDC case management; require 20 hrs participation of parents with children under 6; change sanction; change limit on job search; require at least 10 hrs/wk for CWEP and provide payments for such activity; and develop state-defined JOBS components. In pilot sites, require work activity after two years of AFDC; eliminate most JOBS exemptions; establish a child support assurance program. | Received 12/30/93 |
| Georgia | Work for Welfare Project. In 10 pilot counties would require every recipient and non-supporting parent to work 20 hours per month in a state, local government, federal agency or nonprofit organization; extends job search; and increases sanctions for JOBS noncompliance. On a statewide basis, would increase the automobile exemption to \$4,500 and disregard earned income of children who are full-time students. | Received 6/30/94 |
| Georgia | Project Fulton. Would assist recipients in securing unsubsidized employment by disregarding income earned by recipients for 12 months, disregarding resources accrued as a result of participation for 18 months, and providing intensive counseling and support services. Participants' AFDC and Food Stamp benefits would be frozen at the existing level when entering the project, gradually reduced following entry into employment, and not increased for changes in day care or housing costs. | Received 10/21/93 |

Welfare

| STATE | INITIATIVE | KEY DATES |
|---------------|---|-----------------------------------|
| Indiana | <p>Would limit AFDC benefits to 24 months; provide preferential treatment in other Federal assistance programs during the time limit; freeze AFDC benefits at initial payment level for the 24 months and Food Stamp benefits for 6 months after initial employment; not increase AFDC benefits for birth of additional children; make development of personal responsibility agreement and cooperation with self-sufficiency plan a condition of eligibility; deny eligibility to: applicants who quit employment without cause within the prior 6 months, individuals convicted of welfare fraud, parents who obtain physical custody of children for sole purpose of obtaining AFDC eligibility and those who do not "have their grants diverted" (accept subsidized employment?); extend grant diversion to up to 24 months and allow its use for child care and training and development projects; eliminate 100-hours of work rule for AFDC-UP; require children to attend school and be immunized; increase resource limit to \$1500; extend transitional child care to 18 months; provide only one-time JOBS exemption for care of child under 3 years of age; eliminate JOBS participation rate and target group expenditure requirements; impose minimum JOBS/E&T sanction of two month AFDC/Food Stamp ineligibility; eliminate JOBS exemption for VISTA volunteers, recipients living in rural/hard to access areas, and those employed 30 or more hours per week; extend post-employment support services, including case management; require minors to live with responsible adult; require that Food Stamp program fair hearing requests be in writing; enact other changes making AFDC and Food Stamp eligibility and JOBS/E&T compliance rules compatible and allowing eligibility and program services to be administered differently in accordance to community needs.</p> | <p>Received 6/21/94 4</p> |
| Maryland | <p>Statewide, eliminate increased AFDC benefit for additional children conceived while receiving AFDC and require minor parents to reside with a guardian. In pilot site, require able-bodied recipients to do community service work after 18 months of AFDC receipt; impose full-family sanction on cases where JOBS non-exempt parent fails to comply with JOBS for 9 months; eliminate 100-hour rule and work history requirements for AFDC-UP cases; increase both auto and resource limits to \$5000; disregard income of dependent children; provide one-time payment in lieu of ongoing assistance; require teens parent to continue education and attend family health and parenting classes; and extend JOBS services to unemployed non-custodial parents.</p> | <p>Received 3/1/94</p> |
| Massachusetts | <p>Require JOBS participants to pay co-payment for child care.</p> | <p>Received 1/14/93</p> |

| STATE | INITIATIVE | KEY DATES |
|---------------|---|--------------------------|
| Massachusetts | Would end cash assistance to most AFDC families, requiring recipients who could not find full-time unsubsidized employment after 60 days of AFDC receipt to do community service and job search to earn a cash "subsidy" that would make family income equal to the applicable payment standard; provide direct distribution of child support collections to, and cash-out food stamps for, those who obtain jobs; continue child care for working families as long as they are income-eligible (but requiring sliding scale co-payment); restrict JOBS education and training services to those working at least 25 hours per week; extend transitional Medicaid for a total of 24 months; and require teen parents to live with guardian or in a supportive living arrangement and attend school. | Received 3/22/94 4 |
| Michigan | Provide monthly advance Earned Income Tax Credit from IV-A funds; cash out food stamps to certain employed AFDC recipients; eliminate deprivation as eligibility factor; remove certain AFDC and Food Stamp Program restrictions on self-employment business income and assets; offer a Medicaid Buy-In and allow courts to require non-custodial parents without health insurance to pay the Medicaid managed care premium; exclude one vehicle of any value; require immunization of AFDC children; mandate nursing home pre-admission screening; expand eligibility for family planning services under Medicaid; and change sanction under the JOBS and Child Support Enforcement programs to 25% of AFDC and Food Stamp benefits. | Received 3/8/94 |
| Mississippi | Two work programs would be implemented in different locales, one of which would expand earned income disregards, and the other would emphasize work supplementation. In addition learnfare, mandatory immunizations, and other provisions would be implemented statewide. | Received 12/10/ 93 |
| Montana | Would establish: (1) Job Supplement Program consisting of a set of AFDC-related benefits to assist individuals at risk of becoming dependent upon welfare; (2) AFDC Pathways Program in which all applicants must enter into a Family Investment Contract and adults' benefits would be limited to a maximum of 24 months for single parents and 18 months for AFDC-UP families; and (3) Community Services Program requiring 20 hours per week for individuals who reach the AFDC time limit but have not achieved self-sufficiency. The office culture would also be altered in conjunction with a program offering a variety of components and services; and simplify/unify AFDC and Food Stamp intake/eligibility process by: 1) eliminating AFDC deprivation requirement and monthly reporting and Food Stamp retrospective budgeting; 2) unifying program requirements; 3) simplifying current income disregard policies. Specific provisions provide for cashing out food stamps, expanding eligibility for two-parent cases, increasing earned income and child care disregards and resource limits, and extending transitional child care. | Received 4/19/94 |
| New Hampshire | AFDC applicants and recipients would have the \$200 plus 1/2 the remaining earned income disregarded. | Received 9/20/93 |

letter
no

| STATE | INITIATIVE | KEY DATES |
|------------|---|----------------------|
| New Mexico | Would increase vehicle asset limit to \$4500; disregard earned income of students; develop an AFDC Intentional Program Violation procedure identical to Food Stamps; and allow one individual to sign declaration of citizenship for entire case. | |
| New York | Would provide payments for one-time work-related expenses or child care in lieu of AFDC benefits; modify allowable work experience, job training and other employment activities in addition to job search for AFDC and food stamp applicants and recipients; consolidate and streamline food stamp and AFDC eligibility requirements, including expansion of AFDC-UP eligibility; provide incentives for children to attend school; make unemployed non-custodial parents of children on AFDC eligible for JOBS programs; and encourage start-up of microenterprises. | Received 6/7/94 |
| Ohio | Three demonstration components proposed would test provisions which: divert AFDC and Food Stamp benefits to a wage pool to supplement wages of at least \$8/hour; eliminate 100-hour rule for UP cases; provide fill-the-gap budgeting for 12 months from month of employment; increase child support pass-through to \$75; provide a one-time bonus of \$150 for paternity establishment; provide an additional 6 months of transitional child care; increase automobile asset limit to \$4500 equity value; require regular school attendance by 6 to 19 year olds; continue current LEAP demo waivers (i.e., eliminate many JOBS exemptions and provide incentive payments and sanctions); and disregard JTPA earnings without time limit. | Received 5/28/94 |
| Ohio | Would increase automobile asset limit to \$6000. | Received 10/13/93 |
| Oklahoma | Five pilot demonstrations would test provisions which: 1) eliminate 100-hour rule for UP cases; 2) increase auto asset level to \$5000; 3) time-limit AFDC receipt to cases with non-exempt JOBS participants to 36 cumulative months in a 60 month period followed by mandatory workfare program; 4) provide intensive case management; and 5) apply fill-the-gap budgeting. | Received 2/24/94 |
| Oregon | Provide individuals with short-term subsidized public or private OJT at State minimum wage with continued Medicaid eligibility and supplemental payments to offset any loss of AFDC benefits, provide participants with workplace mentoring and other support services, create an employer-funded "individual education accounts," and distribute child support collections directly to custodial family. Modify eligibility computation and income disregard, and increase resource limitation to \$10,000. | Received 10/28/93 |
| Oregon | Would increase automobile asset limit to \$9000. | Received 11/12/93 |

letter
no

no letter

| STATE | INITIATIVE | KEY DATES |
|-------------------|--|----------------------|
| Pennsylvania | Participants would enter into written agreement intended to move them to employment. In the third month of employment, recipient families would receive a benefit consisting of an AFDC payment plus the cash equivalent of the family's Food Stamps allotment; AFDC earned income disregards and Food Stamps deductions would be replaced with a deduction of \$200 plus 30 percent; resource limits would rise in from \$2,000 to \$5,000; and recipients could exclude the equity value of one vehicle up to \$7,500 as well as tax refunds and deposits into educational and retirement accounts. AFDC-UP eligibility and work activity requirements would be eliminated, and full-time students through age 20 could receive AFDC. Child care providers would receive direct payment to cover the cost of care up to the established local market rate ceiling, less a fee. Transitional Child Care and Medicaid would be provided to families with earned income up to 235 percent of poverty and case management services for such families may continue for 12 months after assistance. Transitional Medicaid for cases closed due to receipt of child support would be extended to 12 months. | Received 2/18/94 |
| South Carolina | In pilot sites, would increase earned income disregards; disregard earned income of children, interest, dividends, and payments by the Employment Security Commission or DOD, and allow stepparents same earnings disregard as recipients; relax parental deprivation requirements for AFDC-U cases; disregard the cash value of one vehicle and life insurance and increase resource limit to \$3000; and require participants to comply with individualized, time-limited, self-sufficiency plan as a condition of welfare receipt, placing recipients in public or private work experience if an unsubsidized job is not found. | Received 6/13/94 |
| Washington | Eliminate 100-hour rule and work history requirements for AFDC-UP cases and subtract client earnings from 55 percent of the State need standard rather than the payment standard. | Received 11/16/93 |

STATUS OF STATE HEALTH REFORM INITIATIVES
July 13, 1994

| STATE | INITIAL CONTACT/ CONCEPT DISCUSSIONS | PROPOSAL RECEIVED/ TECHNICAL REVIEW | CLEARANCE/ DECISION | AWARD ANNOUNCEMENT/ ACCEPTANCE OF T&Cs | OPERATIONAL DEVELOPMENT | OPERATIONAL START | NEW ACTIVITY |
|-------|---|--|------------------------|---|----------------------------|----------------------|-----------------|
| OR | | | | 03/19/93 / 04/16/93 | | 02/94 | |
| TN | | | | 11/18/93 / 12/16/93 | | 01/94 | X |
| HI | | | | 07/15/93 / 08/02/93 | X | (08/94) | X |
| KY | | | | 12/09/93 / 02/03/94 | X | (07/94) | X |
| RI | | | | 11/01/93 / 11/02/93 | X | (07/94) | X |
| FL | | X | | | | (10/94) | X |
| OH | | X | | | | (07/95) | X |
| SC | | X | | | | (07/95) | |
| MA | | X | | | | | X |
| NH | | X | | | | (01/95) | |
| MO | | X | | | | | X |
| DE | X | | | | | | X |
| WA | X | | | | | | |
| MN | X | | | | | | X |
| IL | X | | | | | | |
| UT | X | | | | | | |
| OK | X | | | | | | X |
| VT | X | | | | | | |
| AZ | X | | | | | | X |
| CA | X | | | | | | |
| CO | X | | | | | | |
| WY | X | | | | | | |
| NV | X | | | | | | |

**Date in parentheses represent expected dates.

KEY FOR CHART HEADINGS

- **APPROVED:** Demonstration has been approved by the HCFA
- **DISAPPROVED:** Demonstration has been disapproved by HCFA
- **RECEIVED:** A formal 1115 application has been received from a State.
- **ANTICIPATED:** HCFA has had either formal or informal communication indicating that a State is planning to submit an 1115 waiver application.
- **OTHER STATE ACTIVITY:** General information concerning the health care reform activities of a State.

NOTE: Information that is underlined indicates new activity.

SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------|---|--|---|
| APPROVED | | | |
| OREGON | <p>Expand access to uninsured; cost containment through managed care; benefit package defined by priority list.</p> <p>Oregon has submitted two proposals for amendment of the "Oregon Reform Demonstration", "A Waiver Amendment Request to Add Persons Age 65 or Older, Persons with Disabilities, and Children in Foster Care" and "A Waiver Amendment Request to Add Mental Health and Chemical Dependency Services."</p> | <p>Waivers approved 03/19/93.</p> <p>The special terms and conditions were accepted on 04/16/93.</p> <p>Operations began 2/1/94.</p> <p>Review panel for additional waiver held March 7.</p> | <p>Questions concerning the proposals were sent to the State for comments, and their responses have been received. The State's responses have been forwarded to HCFA and DHHS components for review.</p> <p>The State has indicated that they may be sued under the American with Disabilities Act (ADA) because they have not enrolled people with disabilities in the demonstration. These people will be covered if Oregon's amended waiver request is approved.</p> |
| TENNESSEE | <p>Expand access to uninsured through expansion of Medicaid. TENNCARE would establish a system of managed care similar to the current plan for State employees. There are no income or asset limits, but Tennessee wants to cap the program at 1.5 million enrollees.</p> | <p>Proposal received 06/17/93.</p> <p>Waivers approved 11/18/93.</p> <p>The special terms and conditions were accepted on 12/16/93.</p> <p>Operations began 1/1/94.</p> | <p>The RO is planning to visit Tennessee in mid-July as part of the ongoing monitoring of the State's compliance with the terms of the award.</p> <p><u>On July 6, HCFA met with the American Medical Association's council to discuss their concerns about TennCare.</u></p> <p><u>HCFA is considering significant deferral of FFP for failure to reconcile payments from the "pool" to providers with the actual costs of providers.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------|---|--|---|
| APPROVED | | | |
| HAWAII | Hawaii's HealthQuest will provide seamless coverage of those on public programs, as well as the current 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>Proposal received 04/20/93.</p> <p>Waivers approved 07/15/93.</p> <p>The special terms and conditions were accepted on 08/02/93</p> | <p><u>During the week of June 27 through July 1, HCFA conducted an on-site operational readiness review of Quest. Hawaii must address a number of issues before the August 1 start date, but HCFA does not expect these to keep the State from beginning operations.</u></p> |
| KENTUCKY | The Kentucky Health Care Reform Plan calls for universal access through: Medicaid eligibility to 100 percent FPL, elimination of certain categorical requirements, through managed care, primary care case management. | <p>Proposal received 03/30/93.</p> <p>Waivers were approved 11/8/93, announcement was made 12/9 at the request of Kentucky.</p> | <p><u>The Kentucky Legislature reported out a bill on June 17 concerning the implementation of Medicaid managed care programs to the Governor. Language in the bill prohibits operation of any waiver programs expanding Medicaid services or eligibility which was not implemented by January 1, 1994. The bill also prohibits any amendments to existing waivers without approval from the General Assembly. The Governor has executed some line item vetoes, but the language prohibiting Medicaid expansion has remained intact. Therefore, at this time the State cannot implement the K-MACC waiver program.</u></p> <p><u>The State met with the Secretary on July 11 to discuss whether the Department would permit the State to "bank" the savings from managed care under 1915(b) during this year and then use the money in subsequent years to expand eligibility under an 1115 waiver.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------|--|--|--|
| APPROVED | | | |
| RHODE ISLAND | Rhode Island was given Medicaid waivers allowing for 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. | <p>Proposal Rec'd 7/2/93.</p> <p>Waivers approved 11/1/93.</p> <p>The special terms and conditions were accepted on 11/2/93.</p> | <p><u>The State has been informed that implementation is contingent upon the following. (1) Access to FQHC services on a FFS basis is available prior to October 1, when its FQHC HMO plan is expected to receive its license. (2) The Boston RO's evaluates Rhode Island's MMIS system to be adequate for the demonstration.</u></p> <p><u>Rlte Care marketing and outreach will begin July 25 and new participants would receive services through health plans as of August 1.</u></p> |

SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|--|---|--|---|
| RECEIVED | | | |
| <p>FLORIDA</p> <p><i>no letter added</i></p> | <p>Florida's Agency for Health Care Administration (AHCA) has requested section 1115 waivers 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 (AHPs) and sold by Community Health Purchasing Alliances (CHPAs).</p> | <p>Meeting with Shalala 03/05/93.</p> <p>Meeting with Clinton and Governor Chiles 04/28/93.</p> <p>Meeting with HHS and HCFA staff 1/19.</p> <p>Waiver proposal received 2/10/94.</p> <p>Review panel was held 3/8.</p> <p>Meetings held with State on 5/24, 6/19, and 6/23.</p> | <p><u>Governor Childs met with President Clinton on June 30 to discuss the State's proposal.</u></p> <p><u>HCFA has shared draft special terms and conditions with the State and received their comments. HCFA is negotiating the remaining outstanding issues, including budget neutrality and the role of agents.</u></p> |
| <p>OHIO</p> | <p>Ohio has submitted an 1115 waiver application which would allow them to implement OhioCare. Under OhioCare, Medicaid eligibility would be expanded to include the uninsured population with incomes up to 100% of FPL. Ohio expects to enroll approximately 500,000 additional recipients. The State will enroll all new eligibles and current Medicaid recipients into managed care programs throughout the State.</p> | <p>Proposal received 3/2/94.</p> <p>Review panel was held on 6/27.</p> | <p><u>A meeting with the State has been scheduled for July 21 to discuss outstanding issues.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------|---|--|--|
| RECEIVED | | | |
| SOUTH CAROLINA | <p>South Carolina has submitted an 1115 waiver application which would allow them to implement the South Carolina Palmetto Health Initiative. The program will extend Medicaid eligibility to include residents with incomes up to 100 % FPL. South Carolina expects to cover approximately 280,000 additional recipients. All Medicaid recipients will be enrolled in managed care programs.</p> | <p>Proposal received 3/1/94.</p> <p>Review panel was held 6/13/94.</p> | |
| MASSACHUSETTS | <p>Massachusetts has submitted an 1115 waiver application, entitled MassHealth. The demonstration has nine component strategies which are intended to cover the 524,000 uninsured in Massachusetts. 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 FPL.</p> | <p>Proposal received 4/15/94.</p> <p>Meeting held with the State on 5/10/94.</p> | <p><u>Comments/questions compiled from DHHS and HCFA components have been sent to the State. Their responses are due July 15.</u></p> <p><u>A meeting is scheduled with Boston City Hospital to discuss their concerns about the proposal.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------|---|-----------------------------------|---|
| RECEIVED | | | |
| NEW HAMPSHIRE | New Hampshire submitted a proposal entitled, "The Granite State Partnership for Access and Affordability in Health Care". The State proposes the expansion of Medicaid eligibility to adults with incomes below the AFDC cash standard, along with the introduction of a public insurance product for low-income workers. Also, the State proposes to implement a number of pilot initiatives to help to ultimately redesign the State's health care delivery system. | Proposal submitted on 6/14/94. | The proposal has been submitted to HCFA and DHHS components for concurrent review. |
| MISSOURI | 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. | <u>Proposal received June 30.</u> | <u>Missouri hand delivered their proposal to the Secretary on June 30. It has been distributed to HCFA and DHHS components for concurrent review.</u> |

SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|--------------------|---|--|---|
| ANTICIPATED | | | |
| DELAWARE | Delaware has indicated that they are developing an 1115 waiver proposal which will increase Medicaid eligibility and put all recipients in a state-wide managed care program. This program would be part of a state health care reform initiative, which is presently being developed by the State. | | <p>HCFA met with Delaware Medicaid on 5/24 to discuss the requirements for encounter data.</p> <p><u>Delaware indicates that they will be submitting their proposal towards the end of July.</u></p> |
| WASHINGTON | State seeks to guarantee health insurance for all State residents by 1997 through: employers, expansion of State-subsidized Basic Health Plan, and expansion of Medicaid. Prohibits exclusion for medical conditions. | Passed State Legislature 04/25/93. | <p>The plan provides for basic coverage for the uninsured, authorizes up to 10 health insurance cooperatives, requires employers to contribute to health insurance premiums. Also provides for the Health Services Commission to explore the mechanics of implementing the goals of the plan, outline cost controls and market reforms, define minimum benefit package, and set maximum premiums. It appears that the State will require 1115 waivers.</p> <p>Washington's Medicaid Director has indicated that the State will be seeking 1115 waivers in the future.</p> |
| MINNESOTA | Reform plan calls for expansion of health benefits to uninsured by 1997. The Minnesota Health Care Commission submitted its plan in January, and it was passed into law in May. The plan relies on managed competition style purchasing alliances, global spending limits, and an all-payer system for non-alliance services. | <p>Conference calls with HCFA 03/22/93 and 05/06/93.</p> <p>Meeting with the State and HCFA was held on May 27 to discuss the concept paper the State has submitted.</p> | <p><u>The State has indicated that they will be submitting their proposal on July 25.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|--------------------|---|-----------|---|
| ANTICIPATED | | | |
| ILLINOIS | Illinois has indicated that they will be submitting an 1115 waiver proposal to expand Medicaid managed care in the State. | | Illinois met with HCFA on May 6 to discuss their potential 1115 waiver proposal. They hope to submit the proposal in July, with an April 95 start date. |
| UTAH | Utah has indicated that they will be submitting an 1115 waiver proposal which will increase Medicaid coverage to 100% of the FPL. | | The RO indicated that Utah will be submitting a proposal in September. |
| OKLAHOMA | <u>Oklahoma has indicated that they will be submitting a formal 1115 waiver proposal focusing on managed care for Medicaid recipient.</u> | | <u>Oklahoma's consultants indicate that the State will be submitting their proposal in September.</u> |

SECTION 1115 WAIVER ACTIVITY
STATEWIDE HEALTH REFORM

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------------------|---|---|---|
| OTHER STATE ACTIVITY | | | |
| VERMONT | Comprehensive reform legislation was passed in 1992 creating the Vermont Health Care Authority (VHCA), which was charged with submitting to the State Legislature by November 1993 two universal access designs; one based on a single-payer concept and the other based on a regulated multiple payer model. | <p>Meeting with Clinton and Governor Dean 04/28.</p> <p>Meeting with HCFA RO and Vermont 06/21/93.</p> <p>Meeting with HCFA and Vermont was held on 09/22/93.</p> | The Governor and Legislature have been unable to reach an agreement on an approach to comprehensive health reform. Also, they were unable to reach an agreement on Medicaid reform. The State will be meeting with their consultants to decide on what direction to take. Any plan will be have to be approved by the Legislature since there is no appropriation for a new program. |
| ARIZONA | Arizona has indicated that they will be submitting a waiver proposal to expand Medicaid eligibility to individuals and families with incomes up to 100% of the FPL. The current managed care program will be expanded to cover new eligibles | | <p>HCFA has received a request for a 3-year continuation of the AHCCCS demonstration waiver. The application has been forwarded to HCFA and DHHS components for review.</p> <p>Arizona has submitted an addendum to their proposal which would enroll American Indians on reservations into managed care programs.</p> <p><u>A decision memo for the continuation of AHCCCS is in clearance. The new waiver requests from the State will be treated separate from the continuation.</u></p> |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------------------|--|--|--|
| OTHER STATE ACTIVITY | | | |
| CALIFORNIA | California is proposing an expansion of their Medi-Cal managed care program. In designated regions of the State, the Department of Health Services will contract with two managed care plans to enroll the Medicaid recipients. One plan will be locally-developed (ex. county government), referred to as the local initiative, and one plan will be a private sector HMO. | Draft proposal was received from the RO on 12/15/93. | The RO advised HCFA/ORD that California will seek 1915(b) waivers (1/94). |
| COLORADO | On September 16, Colorado released the ColoradoCare Preliminary Feasibility Study. ColoradoCare is designed to guarantee uninterrupted health insurance for all Coloradans. It would create a "health alliance" that will form a statewide purchasing pool. Everyone would be able to choose a private health care plan from this pool, including indemnity plans, PPOs, HMOs, and other plan configurations. ColoradoCare would assume much of what is currently provided through Medicaid. | | Colorado held 32 hearings on State reform, in the fall. The results of these hearings have been compiled. The issue most often mentioned by participants was the need for preventive medicine. Due to public opposition to ColoradoCare, the Governor will wait to see progress at the national level before taking any action. |
| WYOMING | The Wyoming Legislature is proposing a task force of private sector representatives and the Legislature to recommend a health insurance proposal. House Speaker Doug Chamberlain is calling for a plan that pools State, University of Wyoming, Community College, public school and local government employees, and XIX recipients into a single group health insurance system. | | HCFA's RO reports that Wyoming's Health Reform Commission has begun to shape the overall direction of the State's health plan. At this point, the Commission is in the very early stages. |

| STATE | INITIATIVE | KEY DATES | COMMENTS |
|-----------------------------|---|---|---|
| OTHER STATE ACTIVITY | | | |
| NEVADA | Nevada is considering a statewide managed care initiative for the Nevada Medicaid program. Nevada has submitted a concept paper outlining two options for the overall management structure of a state-wide Medicaid managed care program. The first model is based on the CHAMPUS program, where Nevada would contract with a single risk-bearing entity to arrange Medicaid health care services. The second model is based on Rhode Island RiteCare, where the State would contract with a management firm to assist in the oversight of the HMOs participating in the managed care initiative. | Meeting with representatives from Nevada and HCFA, 4/29/94. | <p>On April 29, HCFA met with representatives from Nevada to discuss the pros and cons of submitting 1115 versus 1915(b) waivers. Nevada will be informing HCFA about what avenue they will be pursuing.</p> <p>Nevada has informed HCFA that they will be seeking 1915(b) waivers. (5/11/94)</p> |



AUG 11 1993

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

Dear Mr. Scheppach:

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

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

Sincerely,



John Monahan

Director, Intergovernmental Affairs

Enclosure

**DISCUSSION DRAFT
POLICY PRINCIPLES FOR SECTION 1115 WAIVERS**

Approval Criteria

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

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

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

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

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

Duration

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

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

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

Evaluation

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

Cost Neutrality

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

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

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

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

Timeliness and Administrative Complexity

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

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

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

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

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

Rename the policy: **Health Care Reform: A Call to Action**

Add; **Section 1: Federal Barriers to State Health Reform**

Add to the end of the policy

Section 2: A Call To Action

The nation's Governors call upon President Clinton and the Congress to pass health care legislation this year that includes, at a minimum, the following:

Insurance Reform. We support minimum federal standards that result in portability of coverage; guaranteed renewability of policies; limitations on both medical underwriting and preexisting conditions exclusions; and modified community rating that limits the variation in rates that different individuals and groups are charged.

State-Organized Purchasing Cooperatives. Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating these cooperatives.

Core Benefits and Access. In order to ensure portability of coverage, Governors believe that there must be a core benefits package that is comparable to those that are now provided by the most efficient and cost effective health maintenance organizations. The cornerstone of this package must be primary and preventive care. All employers must make the core benefits package available to those employees who wish to purchase it. While Governors do not agree on whether employers should be required to pay for any portion of the premium, Governors agree that coverage should be available.

Tax Deductibility of Health Care Premiums. Health insurance premiums should be tax deductible to the value of the core benefits package regardless of who pays the premium. Governors do not support limiting health benefits; however, policies that afford benefits above the limit should be subject to taxation. The Governors do support tax changes that would correct the inequities now suffered by self-employed individuals. These individuals would be eligible to purchase fully deductible health insurance within the federal limit.

Low Income Subsidies. Low income families and individuals will require subsidies in order for them to afford health care. Governors support a streamlined eligibility process for these subsidies, and believe that the subsidies must be sufficient to make this goal a reality. Governors also look forward to a system of subsidies that provide low income families and individuals with a core benefits package which Governors believe will be a more effective method for providing care than the current Medicaid program. This program could be financed partially through revenues resulting from limits on tax deductibility.

Changes to the Current Medicaid System. Governors strongly believe that some critical changes to the Medicaid program must be made now to improve the cost efficiency of the program. Specifically,

- States should have the ability to move their Medicaid populations into managed care settings through a plan amendment rather than through a waiver.

EC-7. FEDERAL BARRIERS TO STATE HEALTH CARE REFORM

7.1

PREAMBLE

THE NATION'S GOVERNORS ARE COMMITTED TO COMPREHENSIVE HEALTH REFORM THAT CALLS FOR A FEDERAL FRAMEWORK WITH SIGNIFICANT STATE FLEXIBILITY, AND THEY WILL WORK WITH CONGRESS AND THE ADMINISTRATION TO DEVELOP SUCH A SYSTEM. AT THE SAME TIME, HOWEVER, THE GROWING DEMAND FOR AFFORDABLE QUALITY HEALTH CARE, COUPLED WITH THE IMMEDIATE BUDGETARY PRESSURES CAUSED BY THE MEDICAID PROGRAM, REQUIRES IMMEDIATE ACTION. VIRTUALLY EVERY GOVERNOR HAS SOME HEALTH REFORM INITIATIVE IN PROGRESS. THESE INCLUDE COMPREHENSIVE STATE-BASED REFORM INITIATIVES, PROGRAMS THAT ASSIST SMALL BUSINESSES IN SECURING AFFORDABLE HEALTH INSURANCE, PROGRAMS THAT EXPAND HEALTH CARE COVERAGE TO A GREATER NUMBER OF UNINSURED POOR, AND PROGRAMS THAT IMPLEMENT MANAGED CARE NETWORKS FOR MEDICAID BENEFICIARIES. NONE OF THESE STATE INITIATIVES ARE INCOMPATIBLE WITH NATIONAL REFORM; INSTEAD, THEY CONTINUE TO BUILD A STRONG POLICY FOUNDATION FOR REFORM AT THE FEDERAL LEVEL.

AS STATES HAVE MOVED AHEAD, HOWEVER, THEIR SUCCESS HAS BEEN LIMITED BY BARRIERS RESULTING FROM CURRENT FEDERAL STATUTES. THE NATION'S GOVERNORS CALL UPON THE ADMINISTRATION AND CONGRESS TO IMMEDIATELY REMOVE THOSE FEDERAL BARRIERS.

7.2

MEDICAID

BY FAR, MEDICAID REPRESENTS THE LARGEST HEALTH CARE EXPENDITURE FOR STATES. ON AVERAGE, ONLY SPENDING FOR ELEMENTARY AND SECONDARY EDUCATION CONSTITUTES A LARGER PORTION OF STATE BUDGETS. GOVERNORS BELIEVE THAT IRRESPECTIVE OF ANY NATIONAL HEALTH REFORM STRATEGY, MEDICAID COSTS MUST BE BROUGHT UNDER CONTROL. SHOULD CONGRESS MOVE TO LIMIT OR CAP THE FEDERAL CONTRIBUTION TO MEDICAID, A MOVE THE GOVERNORS ADAMANTLY OPPOSE, THE GOVERNORS BELIEVE THESE CHANGES AND OTHER RELIEF WILL BECOME EVEN MORE URGENT. THE GOVERNORS RECOMMEND THE FOLLOWING CHANGES THAT WILL CONTRIBUTE TO CONTROLLING THOSE COSTS.

HOWEVER, WAS DESIGNED FOR RESEARCH PURPOSES AND HAS SOME IMPORTANT LIMITATIONS. STATES MUST DEMONSTRATE, THROUGH THE APPLICATION PROCESS, THAT THEY ARE TESTING AN INNOVATION. THE LAW REQUIRES AN EVALUATION THAT, IN SOME CASES, REQUIRES CONTROL GROUPS. PROJECTS APPROVED UNDER THE 1115A PROCESS ARE APPROVED FOR A LIMITED TIME PERIOD, USUALLY THREE TO FIVE YEARS AT THE DISCRETION OF THE ADMINISTRATION, AND REQUIRE SPECIAL STATUTORY CHANGES TO GO BEYOND THE DEMONSTRATION PERIOD. FINALLY, THESE PROJECTS MUST BE COST NEUTRAL OVER THE LIFE OF THE PROJECT.

SECTION 1115A IS ESSENTIAL TO ENSURE THE TESTING OF ALTERNATIVE HEALTH AND SOCIAL POLICIES. HOWEVER, THE CURRENT STATUTE FALLS SHORT BY REQUIRING STATUTORY CHANGES IF A STATE WANTS TO CONTINUE ITS SUCCESSFUL EFFORT. IN SHORT, ONCE A STATE HAS PROVEN THAT ITS RESEARCH PROJECT WORKS, IT CANNOT CONTINUE WITHOUT CONGRESSIONAL ACTION. GOVERNORS SUPPORT CHANGES TO THE SOCIAL SECURITY ACT SO THAT A STATE MAY APPLY THROUGH THE EXECUTIVE BRANCH OF GOVERNMENT FOR RENEWABLE WAIVERS OF THEIR INNOVATIONS. THIS WAIVER PROCESS SHOULD BE CONSISTENT WITH THE STREAMLINED APPROACHES USED BY THE CLINTON ADMINISTRATION AND STATES SHOULD HAVE TO REAPPLY FOR THESE WAIVERS NO LESS THAN EVERY FIVE YEARS.

7.2.3

BOREN AMENDMENT. THE BOREN AMENDMENT TO THE MEDICAID PROVISIONS OF THE SOCIAL SECURITY ACT WAS PASSED IN THE EARLY 1980S TO GIVE STATES GREATER FLEXIBILITY IN ESTABLISHING REIMBURSEMENT RATES FOR HOSPITALS AND NURSING HOMES AND TO ENCOURAGE HEALTH CARE COST CONTAINMENT. INSTEAD, IT HAS LED TO HAVOC IN THE ADMINISTRATION OF MEDICAID PROGRAMS. COURT DECISIONS HAVE INTERPRETED THE BOREN AMENDMENT TO EMBODY A RESTRICTIVE AND UNREALISTIC SET OF REQUIREMENTS IN SETTING REIMBURSEMENT RATES, AND HAVE IN EFFECT GIVEN JUDGES THE POWER TO ESTABLISH REIMBURSEMENT RATES LEVELS AND CRITERIA. BECAUSE OF THESE DECISIONS, STATES REMAIN FRUSTRATED IN THEIR ABILITY TO BRING SOME DISCIPLINE TO THEIR BUDGETS AND HAVE BEEN THWARTED IN THEIR ATTEMPTS TO ACHIEVE THE ORIGINAL PURPOSE OF THE AMENDMENT.

- THE REIMBURSEMENT RATE IS EQUAL TO A BENCHMARK RATE PLUS INFLATION NO LESS THAN THE RATE OF INFLATION FOR THE OVERALL ECONOMY ACCORDING TO A GENERAL INDEX (NATIONAL OR STATE), SUCH AS THE CONSUMER PRICE INDEX (CPI) OR THE GROSS DOMESTIC PRODUCT (GDP-IPD). THE BENCHMARK RATE WOULD BE THE APPROVED RATE AS OF THE DATE OF ENACTMENT OF THE STATUTE OR THE CURRENT RATE APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION. *This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.*

THE GOVERNORS ALSO BELIEVE THAT THE PROCEDURAL REQUIREMENTS IN THE CURRENT BOREN AMENDMENT MUST BE STREAMLINED. FINALLY, THE GOVERNORS SUPPORT STRATEGIES THAT WOULD REDUCE OR ELIMINATE THE COSTS OF PROLONGED AND COSTLY LITIGATION.

7.3

EMPLOYEE RETIREMENT INCOME SECURITY ACT

ALTHOUGH THE GOVERNORS ARE EXTREMELY SENSITIVE TO THE CONCERNS OF LARGE MULTISTATE EMPLOYERS, THE FACT REMAINS THAT ONE OF THE GREATEST BARRIERS TO STATE REFORM INITIATIVES IS THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA). ERISA PREEMPTS ALL SELF-INSURED HEALTH PLANS FROM STATE REGULATIONS AND SUBJECTS THOSE PLANS ONLY TO FEDERAL AUTHORITY. AS A RESULT OF JUDICIAL INTERPRETATIONS OF ERISA, STATES ARE PROHIBITED FROM:

- ESTABLISHING MINIMUM GUARANTEED BENEFITS PACKAGES FOR ALL EMPLOYERS;
- DEVELOPING STANDARD DATA COLLECTION SYSTEMS APPLICABLE TO ALL STATE HEALTH PLANS;
- DEVELOPING UNIFORM ADMINISTRATIVE PROCESSES, INCLUDING STANDARDIZED CLAIM FORMS;
- ESTABLISHING ALL PAYER RATE-SETTING SYSTEMS;
- ESTABLISHING A STATEWIDE EMPLOYER MANDATE;
- IMPOSING PREMIUM TAXES ON SELF-INSURED PLANS; AND
- IMPOSING PROVIDER TAXES WHERE THE TAX IS INTERPRETED AS A FORM OF DISCRIMINATION ON SELF-INSURED PLANS.

Proposed NGA Policy
Resolutions (HHS)

EC-9. MANAGED CARE AND HEALTH CARE REFORM

9.1 PREAMBLE

AS THE NATION MOVES TO COMPREHENSIVELY REFORM ITS HEALTH CARE SYSTEM, STATES ARE AGAIN AT THE FOREFRONT OF CHANGE. A NUMBER OF STATES HAVE AGGRESSIVELY MOVED TO REDUCE HEALTH CARE INFLATION, EXPAND ACCESS FOR THE WORKING POOR, AND BRING GREATER ACCOUNTABILITY TO THE SYSTEM. MANAGED CARE HAS PLAYED AN INTEGRAL ROLE IN THE EFFORTS OF MANY STATES TO REFORM THEIR HEALTH CARE SYSTEMS AND IS AN IMPORTANT PART OF NATIONAL HEALTH CARE REFORM.

9.2 ANTI-MANAGED CARE LEGISLATION

ANTI-MANAGED CARE LEGISLATION HAS APPEARED RECENTLY IN A NUMBER OF STATE LEGISLATURES. SO-CALLED "ANY WILLING PROVIDER" LEGISLATION IS USUALLY FRAMED AS A PATIENT CHOICE ISSUE. SUCH LEGISLATION MAY UNDERMINE STATE HEALTH CARE REFORM EFFORTS AND COULD ROLL BACK OUR SIGNIFICANT STATE-BY-STATE PROGRESS IN THIS AREA.

GENERALLY, THE LEGISLATION REQUIRES THAT ANY HEALTH CARE PROVIDER WHO AGREES TO MEET THE TERMS AND CONDITIONS OF A HEALTH PLAN BE ALLOWED TO PARTICIPATE IN THAT PLAN. THIS TYPE OF LEGISLATION IS PROBLEMATIC BECAUSE IT HAS THE POTENTIAL TO UNDERMINE THE EFFORTS OF MANAGED CARE ORGANIZATIONS TO CONTROL COSTS AND LIMIT THE SIZE OF NETWORKS IN ORDER TO ACHIEVE MAXIMUM EFFICIENCY. THE RESULT MAY BE DECREASED PATIENT VOLUME TO MANAGED CARE ORGANIZATIONS, CRIPPLING THEIR ABILITY TO CONTROL UTILIZATION OF HEALTH CARE SERVICES. THIS TYPE OF LEGISLATION CAN HAVE DEVASTATING EFFECTS ON CURRENT MANAGED CARE DELIVERY SYSTEMS BY:

- DESTROYING THE GATEKEEPER CONCEPT ESSENTIAL TO MANAGED CARE, SEVERELY CURTAILING MANAGED CARE ORGANIZATIONS' ABILITY TO CONTROL HEALTH CARE COSTS AND THE QUALITY OF THEIR PROVIDER NETWORKS;
- SIGNIFICANTLY INCREASING MANAGED CARE ORGANIZATIONS' ADMINISTRATIVE AND CLAIMS COSTS;
- PREVENTING MANAGED CARE ORGANIZATIONS FROM ACHIEVING SIGNIFICANT PROVIDER DISCOUNTS IN EXCHANGE FOR PATIENT VOLUME;

- UNDERCUTTING THE ADMINISTRATIVE EFFICIENCIES OF MANAGED CARE;
- ACTUALLY REDUCING CONSUMER CHOICE BY LIMITING THE PATIENT'S CHOICE TO INDEMNITY PLANS; AND
- IMPEDING EFFORTS TO IMPROVE HEALTH CARE QUALITY THROUGH CONTRACTING STANDARDS AND INFORMATION EXCHANGES THAT CAN LEAD TO BETTER OUTCOMES AND HIGHER QUALITY CARE FOR PATIENTS.

9.3 CONCLUSION

"ANY WILLING PROVIDER" LAWS ARISE FROM GOOD MOTIVES—THE DESIRE TO PRESERVE EXISTING PATIENT-PROVIDER RELATIONS AND TO SAFEGUARD PATIENTS' CHOICE OF PROVIDER FROM ARBITRARY DECISIONS BY HEALTH PLANS TO EXCLUDE OR DROP PROVIDERS FROM THEIR NETWORKS. THESE ARE LEGITIMATE GOALS THAT NEED TO BE ADDRESSED THROUGH VEHICLES THAT DO NOT THREATEN THE COST, QUALITY, AND ACCESS ADVANTAGES THAT WELL-DESIGNED MANAGED CARE DELIVERY SYSTEMS CAN PROVIDE.

THE GOVERNORS DO NOT SUPPORT, AT EITHER THE STATE OR FEDERAL LEVEL, OVERLY RESTRICTIVE "ANY WILLING PROVIDER" LAWS. WE REMAIN COMMITTED TO RETAINING THE STATE FLEXIBILITY THAT MANAGED CARE DELIVERY SYSTEMS PROVIDE TO US AS WE MOVE TO REFORM OUR HEALTH CARE SYSTEM.

Time limited (effective July 1994-July 1996).

STATE EXPERIMENTATION UNDER NATIONAL HEALTH CARE AND WELFARE REFORM (Resolution*)

THROUGHOUT OUR DISCUSSIONS ON HEALTH CARE AND WELFARE REFORM, THE GOVERNORS HAVE EMPHASIZED THE IMPORTANCE OF FLEXIBILITY AND CONTINUED INNOVATION. THERE IS NO ONE-SIZE-FITS-ALL SOLUTION TO THESE ISSUES, AND STATES MUST HAVE THE FLEXIBILITY TO DEVELOP PROGRAMS AND SERVICES THAT WILL ADDRESS THE UNIQUE CHARACTERISTICS OF THE POPULATIONS AND ECONOMIC CONDITIONS WITHIN OUR INDIVIDUAL STATES.

MANY OF THE IDEAS INCORPORATED INTO THE VARIOUS HEALTH CARE AND WELFARE REFORM PROPOSALS BUILD ON LESSONS LEARNED IN STATE REFORM INITIATIVES. THE GOVERNORS BELIEVE THAT SUCH STATE EXPERIMENTATION WILL CONTINUE TO BE CRITICAL TO NATIONAL PROGRESS ON THESE ISSUES. STATES HAVE INVESTED CONSIDERABLE TIME AND EFFORT IN THE DEVELOPMENT OF EXPERIMENTS TO TEST A VARIETY OF REFORM INITIATIVES, INCLUDING MANY APPROVED BY THE ADMINISTRATION. THE GOVERNORS HAVE LONG-STANDING POLICY IN SUPPORT OF NATIONAL FRAMEWORKS FOR HEALTH CARE AND WELFARE REFORM. IN THIS CONTEXT, THE GOVERNORS FEEL STRONGLY ABOUT THE FOLLOWING PRINCIPLES.

- STATES MUST BE ABLE TO COMPLETE THEIR CURRENTLY APPROVED WAIVERS.
- STATES MUST BE PERMITTED TO APPLY FOR AND RECEIVE ADDITIONAL WAIVERS PRIOR TO AND DURING ANY TRANSITION PERIOD THAT HEALTH CARE OR WELFARE REFORM MAY INCLUDE. THESE WAIVERS WILL ENABLE STATES TO CONTINUE DEVELOPING EFFECTIVE MODELS FOR DELIVERING HEALTH AND WELFARE SERVICES.
- THERE MUST BE A WAIVER PROCESS INCLUDED IN THE FINAL STRUCTURE OF THE REFORMED HEALTH AND WELFARE SYSTEMS SO THAT STATES CAN PURSUE RESEARCH PROJECTS AND EXPERIMENTATION THAT IS CONSISTENT WITH THE GOALS OF THOSE REFORMED SYSTEMS.

* Based upon Policies HR-5, "A Conceptual Framework for National Welfare Reform" and EC-7, "Health Care Reform: A Call to Action."

Time limited (effective July 1994-July 1995).

HR-16. COMPREHENSIVE PROGRAM FOR ATTACKING VIOLENT CRIME

16.1 PREAMBLE

VIOLENT CRIME IS A GRAVE THREAT TO THE SAFETY OF ALL AMERICANS. EVERY AMERICAN HAS A RIGHT NOT TO BE VICTIMIZED BY CRIME AND TO LIVE WITHOUT FEAR OF VIOLENT CRIME. EACH LEVEL OF GOVERNMENT IS RESPONSIBLE FOR ATTACKING VIOLENT CRIME. PUBLIC SAFETY MUST BE A TOP PRIORITY FOR FEDERAL, STATE, AND LOCAL GOVERNMENTS.

ALTHOUGH EACH LEVEL OF GOVERNMENT PLAYS A ROLE IN PUBLIC SAFETY, STATE AND LOCAL GOVERNMENTS ARE ON THE FRONT LINES IN THIS COUNTRY'S STRUGGLE TO CONTROL VIOLENT CRIME. THEREFORE, STATE AND LOCAL GOVERNMENTS SHOULD DEVELOP A COMPREHENSIVE PROGRAM TO ADDRESS VIOLENT CRIME IN GENERAL, AND SPECIFIC AREAS OF VIOLENT CRIME IN PARTICULAR, INCLUDING SEXUAL VIOLENCE, DOMESTIC VIOLENCE, CHILD ABUSE, HATE CRIMES, AND YOUTH VIOLENCE.

WELL-PLANNED, COMPREHENSIVE CRIMINAL AND JUVENILE JUSTICE PROGRAMS SHOULD BE:

- ORGANIZED AT THE STATE LEVEL AND DEVELOPED IN COOPERATION WITH LOCAL UNITS OF GOVERNMENT;
- COORDINATED WITH THE FEDERAL GOVERNMENT; AND
- SUPPORTED BY THE GOVERNOR AND THE LEGISLATURE.

16.2 COORDINATING THE CRIMINAL AND JUVENILE JUSTICE SYSTEM

IF STATE AND LOCAL CRIMINAL AND JUVENILE JUSTICE SYSTEMS ARE TO OPERATE EFFECTIVELY AND EFFICIENTLY, IT IS ESSENTIAL THAT THE ACTIVITIES OF AGENCIES OF THOSE SYSTEMS BE COORDINATED TO ENSURE CONSISTENT POLICIES. MANY STATE AND LOCAL OFFICIALS AND AGENCIES IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEM PERFORM THEIR RESPECTIVE DUTIES WITHOUT FULL REGARD FOR THE EFFECTS OF THEIR ACTIONS ON THEIR COLLEAGUES OR FELLOW AGENCIES WITHIN THE SYSTEM. COORDINATION AMONG THE AGENCIES WITHIN THE SYSTEM—THE COURTS, POLICE, CORRECTIONS OFFICIALS, DRUG AND CRIME PREVENTION GROUPS, AND OTHERS—ON POLICIES AND ACTIVITIES THAT ARE BASED ON A CLEAR SET OF GOALS WOULD HELP PRESERVE SCARCE RESOURCES THROUGH IMPROVED MANAGEMENT AND EFFICIENCY. THEREFORE,

THE NATION'S GOVERNORS BELIEVE THAT STATES SHOULD TAKE THE LEADERSHIP ROLE IN ESTABLISHING AND MAINTAINING APPROPRIATE STATE AND LOCAL CRIMINAL AND JUVENILE JUSTICE COORDINATION POLICIES, STRUCTURES, AND MECHANISMS.

16.3 PLANNING FOR THE CRIMINAL AND JUVENILE JUSTICE SYSTEM

CRIMINAL AND JUVENILE JUSTICE PLANNING IS THE APPLICATION OF FORETHOUGHT TO THE HIGHLY DISPERSED FIELD OF CRIMINAL JUSTICE ADMINISTRATION WITHIN A STATE. THE EFFECT OF SOUND PLANNING FOR THE ENTIRE SYSTEM REDUCES UNCERTAINTY IN BOTH PURPOSE AND DIRECTION WITHIN STATE AND LOCAL ENTITIES. AS A RESULT, DECISIONS MADE BY A NUMBER OF AUTONOMOUS OFFICIALS WITHIN THE SYSTEM CAN BE MORE ACCURATE AND TIMELY.

CRIMINAL AND JUVENILE JUSTICE PLANNING EMPLOYS DATA ANALYSIS AND CONCEPTS TO COMPARE POSSIBLE GOALS, PRIORITIES, AND STANDARDS WITH THE AVAILABLE RESOURCES TO IDENTIFY FUTURE CRIMINAL JUSTICE NEEDS. PLANNING SEEKS TO ANTICIPATE FUTURE TRENDS, WHAT RESOURCES WILL OR SHOULD BE AVAILABLE TO ADDRESS THEM, WHAT OPTIONS ARE AVAILABLE FOR GOVERNMENT POLICY AND ACTION, AND WHAT RESULTS ARE LIKELY.

PLANNING ALSO MAKES IT POSSIBLE TO ASSESS POTENTIAL FISCAL AND ECONOMIC EFFECTS OF PROPOSED CRIMINAL JUSTICE PROGRAMS AND POLICIES. FOR EXAMPLE, IN CONSIDERING CHANGES IN SENTENCING LAW, THE STATES MAY WISH TO ASSESS THE POTENTIAL IMPACT ON OTHER COMPONENTS OF THE CRIMINAL JUSTICE SYSTEM, ESPECIALLY CORRECTIONS. FURTHER, THE STATES ALSO SHOULD CONSIDER THE POTENTIAL QUANTIFIABLE ECONOMIC AND SOCIAL IMPACT OF PROPOSED CRIMINAL JUSTICE PROGRAMS AND POLICIES. IN THIS WAY, ADDITIONAL RESOURCE NEEDS CAN BE ANTICIPATED FOR OTHER UNITS IN THE SYSTEM, AND THE EFFECT OF THE NEW POLICIES CAN BE ASSESSED AGAINST THE TOTAL RESOURCE NEEDS FOR THE ENTIRE CRIMINAL JUSTICE SYSTEM.

16.4 THE FEDERAL ROLE: RESEARCH, STATISTICS, EVALUATION, AND RESOURCES

ALL LEVELS OF GOVERNMENT SHOULD CONDUCT RESEARCH ON THE CRIMINAL JUSTICE SYSTEM. HOWEVER, THE FEDERAL GOVERNMENT HAS A SPECIAL RESPONSIBILITY TO DEVELOP AND TEST ALTERNATIVE METHODS OF

CRIMINAL JUSTICE POLICY. THE FEDERAL GOVERNMENT HAS THE RESOURCES TO UNDERTAKE BOTH BASIC AND APPLIED RESEARCH. THEREFORE, THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PROVIDE ADEQUATE SUPPORT FOR RESEARCH ON CRIMINAL JUSTICE ISSUES IDENTIFIED BY STATE AND LOCAL CRIMINAL JUSTICE PLANNERS AND PRACTITIONERS THROUGHOUT THE COUNTRY. FURTHER, THE FEDERAL GOVERNMENT SHOULD BE A SOURCE FOR STUDY, EVALUATION, AND DISSEMINATION OF STATE RESEARCH ACTIVITIES ON ALTERNATIVE APPROACHES TO FIGHTING CRIME.

THE HIGHEST PRIORITY SHOULD BE GIVEN TO RESEARCH AND EVALUATION EFFORTS THAT ARE MOST LIKELY TO BE IMMEDIATELY USEFUL TO STATE AND LOCAL CRIMINAL JUSTICE AGENCIES IN CONTROLLING AND REDUCING VIOLENT CRIME. TO THE EXTENT PRACTICABLE, STATE AND LOCAL CRIMINAL JUSTICE PRACTITIONERS SHOULD BE DIRECTLY INVOLVED IN PLANNING AND EXECUTING ANY FEDERALLY INITIATED RESEARCH EFFORT.

OBJECTIVE, RELIABLE, AND ACCURATE STATISTICS ON CRIME, ITS VICTIMS, ITS PERPETRATORS, AND THE ACTIVITIES OF THE CRIMINAL JUSTICE SYSTEM ARE CRITICAL FOR EFFECTIVE CRIMINAL AND JUVENILE JUSTICE PLANNING. THE BUREAU OF JUSTICE STATISTICS (BJS) COLLECTS COMPREHENSIVE CRIMINAL JUSTICE STATISTICS ON A NATIONAL BASIS TO PROVIDE CONTINUOUS INDICATORS REGARDING CRIME.

THE NATION'S GOVERNORS BELIEVE BJS SHOULD DEVELOP DATA THAT WILL BE RELEVANT, USEFUL, TIMELY, AND UNDERSTANDABLE TO STATE AND LOCAL CRIMINAL JUSTICE PLANNERS IN THEIR EFFORTS TO CONTROL AND REDUCE THE PRESENCE OF VIOLENT CRIME. BJS ALSO SHOULD PROVIDE ADEQUATE SUPPORT FOR THE DEVELOPMENT OF STATE CRIMINAL JUSTICE INFORMATION SYSTEMS THAT GENERATE THE DATA UTILIZED BY BJS AND THE STATE STATISTICAL ANALYSIS CENTERS THAT CONTRIBUTE ASSISTANCE AND ADVICE TO STATE AND LOCAL CRIMINAL JUSTICE OFFICIALS. BJS ALSO SHOULD WORK TO ENSURE THAT INFORMATION IS DISSEMINATED AS RAPIDLY AS POSSIBLE TO THE STATES.

FINALLY, IN TERMS OF FEDERAL RESEARCH, STATISTICAL AND EVALUATION CAPABILITIES, THE AREA OF RECIDIVIST CRIMINAL BEHAVIOR NEEDS SIGNIFICANT IMPROVEMENT IN TERMS OF THE STATES' ABILITY TO DEVELOP AND TRACK THE EFFECTIVENESS OF NEW SENTENCING POLICIES. CURRENTLY,

MOST STATE AND FEDERAL REPORTING AND TRACKING SYSTEMS DO NOT CONTAIN BUILT-IN PARAMETERS TO ALLOW FOR THE EVALUATION OF RECIDIVIST PATTERNS OR TRENDS. THIS TYPE OF INFORMATION IS EXTREMELY IMPORTANT FOR POLICY DEVELOPMENT AND EVALUATION OF THE CRIMINAL JUSTICE SYSTEM.

THEREFORE, THE NATION'S GOVERNORS BELIEVE BJS SHOULD PLACE A HIGH PRIORITY ON CREATING THESE CAPABILITIES. BJS ALSO SHOULD IMMEDIATELY BEGIN TO RESTRUCTURE THE APPROPRIATE REPORTING SYSTEMS TO ALLOW FOR THE INSERTION OF CRIMINAL RECIDIVIST INFORMATION. IN ADDITION, THE FEDERAL GOVERNMENT SHOULD PROVIDE THE NECESSARY AID AND SUPPORT TO THE STATES TO ENABLE THEM TO IMPROVE THEIR REPORTING AND TRACKING SYSTEMS, BUT ALSO TO PROVIDE THE RESULTING ENHANCED INFORMATION FOR FEDERAL EVALUATION.

BECAUSE OF ITS EXTENSIVE RESOURCES AND NATIONAL SCOPE, THE FEDERAL GOVERNMENT IS BEST POSITIONED TO PROVIDE THE RESOURCE ASSISTANCE NECESSARY FOR THE STATES TO IMPLEMENT EFFECTIVE POLICIES LOCALLY. ALTHOUGH CONGRESS HAS AUTHORIZED VARIOUS CRIMINAL JUSTICE PROGRAMS, IT IS INCUMBENT UPON THE FEDERAL GOVERNMENT TO PROVIDE THE NECESSARY FUNDS FOR THESE PROGRAMS. WITHOUT THIS FEDERAL FISCAL SUPPORT, THE AUTHORIZED PROGRAMS ARE OF LITTLE OR NO VALUE AND SERVE TO MISLEAD THE PUBLIC INTO BELIEVING THAT THESE PROGRAMS WILL HAVE AN IMPACT WHEN, IN FACT, THAT WOULD NOT BE THE CASE.

A COROLLARY ISSUE WITH REGARD TO FEDERAL FUNDING OF CRIMINAL JUSTICE PROGRAMS RELATES TO THE SOURCE OF FUNDS. IN SEEKING FUNDING FOR NEW FEDERAL PROGRAMS OR INITIATIVES, CAREFUL ATTENTION SHOULD BE PAID TO ENSURE THAT FUNDS ARE NOT DIVERTED FROM EXISTING STATE AND LOCAL PROGRAMS THAT HAVE PROVEN TO BE EFFECTIVE.

16.5 MANAGING CAREER CRIMINALS

RESEARCH AND DATA ANALYSIS INDICATE CLEARLY THAT A SMALL NUMBER OF OFFENDERS ARE RESPONSIBLE FOR A DISPROPORTIONATE NUMBER OF CRIMES. THE ECONOMIC AND SOCIAL IMPACT OF THESE CRIMES IS REAL AND AT TIMES IRREVERSIBLE.

THE APPREHENSION, ADJUDICATION, AND SENTENCING OF OFFENDERS WHO HAVE BEEN DETERMINED TO BE REPEAT OFFENDERS SHOULD BE A PRIORITY OF THE CRIMINAL JUSTICE SYSTEM. FEDERAL, STATE, AND LOCAL CRIMINAL JUSTICE OFFICIALS SHOULD FOCUS ON IDENTIFYING, APPREHENDING, PROSECUTING, AND INCARCERATING CAREER CRIMINALS.

IN SEVERAL STATES, PROGRAMS DESIGNED TO INCAPACITATE CAREER CRIMINALS, MANDATORY MINIMUM SENTENCING, AND GOOD-TIME CREDIT REDUCTION HAVE PROVEN TO BE EFFECTIVE. SUPPORT FOR THE INCARCERATION OF CAREER CRIMINALS DOES NOT MEAN ABANDONMENT OF THE GOALS OF REHABILITATION, DETERRENCE, AND PREVENTION.

16.6 MANDATORY SENTENCES FOR CAREER CRIMINALS

APPROXIMATELY 5 MILLION PEOPLE WILL BE VICTIMS OF A VIOLENT CRIME EACH YEAR, AND FOR EVERY CRIMINAL IN PRISON, THERE ARE FIVE FREE ON PAROLE OR PROBATION. SIXTY PERCENT OF PRISONERS RELEASED EARLY ARE REARRESTED WITHIN THREE YEARS AND CHARGED WITH AN AVERAGE OF FIVE NEW CRIMES.

IN THE LONG RUN, IT IS CRUCIAL TO PREVENT YOUNG PEOPLE FROM BECOMING CRIMINALS BY INTERVENING IN THEIR LIVES AT EARLY STAGES TO HELP THEM DEVELOP THEIR TALENTS AND MOTIVATION, GOOD VALUES, AND DISCIPLINE.

THE NATION'S GOVERNORS BELIEVE VIOLENT CRIME IS MOST EFFECTIVELY ADDRESSED BY INCREASING THE LIKELIHOOD AND LENGTH OF INCARCERATION FOR REPEAT, HABITUAL, VIOLENT OFFENDERS. FEDERAL LAW SHOULD REQUIRE THAT ANY INDIVIDUAL CONVICTED OF A FEDERAL FELONY WHO HAS TWO PRIOR CONVICTIONS FOR SERIOUS VIOLENT OFFENSES SHOULD BE SENTENCED TO LIFE IMPRISONMENT WITHOUT PAROLE OR PROBATION. SUPPORT FOR THE INCAPACITATION OF VIOLENT CRIMINALS DOES NOT MEAN ABANDONMENT OF THE GOALS OF REHABILITATION, DETERRENCE, AND PREVENTION.

16.7 CRIME IN RURAL COMMUNITIES

IN SOME RURAL COMMUNITIES, CRIME HAS REACHED EPIDEMIC PROPORTIONS. FOR EXAMPLE, REPORTS FROM THE BUREAU OF JUSTICE STATISTICS SAY THAT GANG AND ILLEGAL DRUG ACTIVITIES ARE INCREASING IN

RURAL AREAS. RESPONSE TO CRIME IN THESE SETTINGS MUST REFLECT THE UNIQUE CONCERNS AND NEEDS OF RURAL AMERICANS. CRIME ABATEMENT AND CONTROL PROGRAMS OFTEN ARE BASED ON THE ASSUMPTION THAT A RURAL COMMUNITY'S CRIMINAL JUSTICE SYSTEM CAN AND SHOULD USE PROGRAMS APPLICABLE TO URBAN AREAS. FEDERAL, STATE, AND LOCAL DECISIONMAKERS SHOULD REALIZE THAT THE UNIQUE QUALITIES OF RURAL COMMUNITIES CREATE A RANGE OF NEEDS, PROBLEMS, AND SOLUTIONS THAT URBAN-ORIENTED PROGRAMS ARE NOT FORMULATED TO ADDRESS.

IN DEVELOPING POLICIES TO CONTROL AND REDUCE RURAL CRIME, THE FEDERAL GOVERNMENT SHOULD CONSIDER THE FOLLOWING PRINCIPLES.

- LAW ENFORCEMENT OFFICIALS AT ALL LEVELS OF GOVERNMENT MUST BE SENSITIVE TO THE NEEDS AND TRADITIONS OF RURAL AREAS. LAW ENFORCEMENT AND CRIME PREVENTION TECHNIQUES AND MODELS SHOULD BE DEVELOPED TO INCORPORATE THE UNIQUE ECONOMIC AND SOCIAL CONDITIONS OF RURAL LOCAL GOVERNMENTS.
- MORE ANTICRIME MEASURES SHOULD BE DEVELOPED FOR RURAL AREA RESIDENTS, AND IN PARTICULAR, SPECIAL PROGRAMS SHOULD BE DEVELOPED TO ADDRESS RURAL JUVENILE CRIME.
- RURAL RESIDENTS SHOULD BE ENCOURAGED TO PARTICIPATE IN CRIME PREVENTION PROGRAMS GEARED TO THEIR NEEDS.

16.8 TREATMENT OF CRIME VICTIMS AND WITNESSES

EVERY AMERICAN HAS A RIGHT NOT TO BE VICTIMIZED BY CRIME AND THE FEAR OF CRIME. FEDERAL AND STATE LAWS PROVIDE EXTENSIVE PROTECTIONS AND RIGHTS TO ACCUSED AND CONVICTED OFFENDERS IN OUR NATION'S CRIMINAL JUSTICE SYSTEM. CRIME VICTIMS AND WITNESSES AND THEIR FAMILIES SHOULD ALSO BE GUARANTEED BASIC RIGHTS IN OUR CRIMINAL JUSTICE SYSTEM. ANY COMPREHENSIVE PROGRAM THAT ADDRESSES VIOLENT CRIME MUST RECOGNIZE THE NEEDS OF CRIME VICTIMS AND WITNESSES AND THEIR FAMILIES. THE NATION'S GOVERNORS SUPPORT PROGRAMS THAT PROVIDE CRISIS INTERVENTION AND ADVOCACY SERVICES TO VICTIMS TO HELP THEM RECOVER FROM THE EFFECTS OF CRIME.

SEVERAL STATES HAVE DEVELOPED PROGRAMS TO REDUCE THE FINANCIAL BURDEN OF CRIME ON VICTIMS AND ENCOURAGE REPORTING OF CRIME AND

COOPERATION OF WITNESSES WITH POLICE. THESE PROGRAMS HAVE FUNCTIONED EFFECTIVELY AND ECONOMICALLY FOR A NUMBER OF YEARS.

GOVERNMENTS AT ALL LEVELS LIKEWISE SHOULD STRIVE TO PROVIDE BASIC GUARANTEES FOR CRIME VICTIMS AND WITNESSES AND THEIR FAMILIES, INCLUDING:

- A CRIMINAL JUSTICE SYSTEM THAT TREATS WITNESSES, CRIME VICTIMS, AND THEIR FAMILIES WITH DIGNITY AND COMPASSION;
- INFORMATION ON READILY ACCESSIBLE PROGRAMS OFFERING FINANCIAL ASSISTANCE AND SOCIAL SERVICES;
- INFORMATION ABOUT THEIR LEGAL RIGHTS, SUCH AS THE RIGHT TO FILE CIVIL SUIT FOR DAMAGES OR TO SEEK RESTITUTION THROUGH APPROPRIATE CHANNELS;
- INFORMATION ON PROCEDURES TO HELP ENSURE THAT WITNESSES AND VICTIMS ARE NOTIFIED OF THE DEATH, RELEASE, OR ESCAPE OF AN INMATE, AND TO ALLOW A VICTIM TO BRING AN ADVISOR TO THE PAROLE HEARING OF A PRISONER SERVING A LIFE SENTENCE;
- INFORMATION ON PROCEDURES THAT ALLOW FOR VICTIMS OF YOUTHFUL OFFENDERS TO DESIGNATE A REPRESENTATIVE TO APPEAR AND SPEAK ON THEIR BEHALF AT PAROLE BOARD HEARINGS;
- INFORMATION ON PROCEDURES THAT ALLOW FOR BOTH PARENTS TO ATTEND AND SPEAK AT SENTENCING PROCEEDINGS IF THE CRIME VICTIM IS A MINOR; AND
- ALLOWANCE OF VICTIMS' IMPACT STATEMENTS AS EVIDENCE BY FAMILY MEMBERS DURING THE PENALTY PHASE OF VIOLENT CRIME CASES.

WITNESS AND CRIME VICTIM ASSISTANCE PROGRAMS DEVELOPED BY THE FEDERAL GOVERNMENT MUST RECOGNIZE AND SUPPLEMENT EXISTING STATE PROGRAMS AND ALLOW STATES THE FLEXIBILITY TO MANAGE ANY PROPOSED FEDERAL PROGRAM CONSISTENT WITH EXISTING STATE ORGANIZATIONAL STRUCTURES.

16.9 VIOLENCE AGAINST WOMEN

16.9.1 PREAMBLE. THE INCIDENCE OF VIOLENCE AND THREATS OF VIOLENCE AGAINST WOMEN IN THIS COUNTRY IS STAGGERING. THOUSANDS OF WOMEN SEEK EMERGENCY SERVICES EACH MONTH BECAUSE OF A VIOLENT ACT COMMITTED AGAINST THEM. TENS OF THOUSANDS OF WOMEN ARE BEATEN IN THEIR HOMES EACH WEEK. EVERY HOUR, SCORES OF WOMEN ARE THE VICTIMS OF RAPE AND SEXUAL ASSAULT. AND A GROWING NUMBER OF WOMEN FIND THEMSELVES THE TARGETS AND VICTIMS OF STALKING OR HARASSMENT BY AN INDIVIDUAL IN A MANNER THAT PLACES THE VICTIM IN IMMINENT FEAR OF DEATH OR SERIOUS BODILY INJURY.

16.9.2 COMPREHENSIVE STRATEGY. THE NATION'S GOVERNORS ARE ALARMED AT THE ESCALATION OF VIOLENCE AGAINST WOMEN AND BELIEVE THAT THE STATES SHOULD CONSIDER, AS A PART OF THEIR OVERALL CRIME CONTROL STRATEGIES, PENALTIES, PROGRAMS, AND REFORMS IN THE JUDICIAL SYSTEM UNIQUELY TARGETED TO CONTROL AND REDUCE VIOLENCE TARGETED AGAINST WOMEN, INCLUDING BUT NOT LIMITED TO, THE FOLLOWING:

- MANDATORY PENALTIES AGAINST SEXUAL PREDATORS, WHICH MAY INCLUDE LIFE IMPRISONMENT WITHOUT PAROLE FOR RAPISTS AND CHILD MOLESTERS;
- MANDATORY PENALTIES FOR STALKING OFFENSES;
- REFORMS IN CRIMINAL PROCEDURES THAT PROTECT THE RIGHTS OF VICTIMS OF RAPE, SEXUAL ABUSE AND ASSAULT, AND DOMESTIC VIOLENCE;
- REFORMS IN THE RULES OF EVIDENCE THAT ENSURE FAIRNESS TO VICTIMS OF RAPE, SEXUAL ABUSE AND ASSAULT, AND DOMESTIC VIOLENCE;
- ENCOURAGEMENT OF ARREST OR TEMPORARY SEPARATION POLICIES FOR SPOUSE ABUSERS;
- ADMISSION OF EXPERT TESTIMONY ON BATTERED WIFE SYNDROME IN CRIMINAL ACTIONS;
- TRAINING FOR JUDICIAL OFFICIALS, PROSECUTORS, CORRECTIONAL OFFICIALS, AND OTHER AFFECTED STATE EMPLOYEES ON ISSUES RELATED TO BATTERED WIFE SYNDROME AND DOMESTIC VIOLENCE;

- RESOURCES TO SHIELD AND PROTECT VICTIMS OR POTENTIAL VICTIMS OF SEXUAL OR DOMESTIC VIOLENCE, INCLUDING DOMESTIC VIOLENCE HOTLINES AND SHELTERS;
- RESOURCES FOR COUNSELING AND SUPPORT SERVICES FOR VICTIMS OF RAPE, SEXUAL ABUSE AND ASSAULT, AND DOMESTIC VIOLENCE;
- EDUCATION AND PREVENTION PROGRAMS TO REDUCE SEXUAL ABUSE AND ASSAULT;
- EDUCATION AND PREVENTION PROGRAMS TO REDUCE RAPE AND SEXUAL ASSAULT ON COLLEGE CAMPUSES;
- PROGRAMS THAT CREATE A SAFE ENVIRONMENT FOR WOMEN, SUCH AS THE CONSTRUCTION, DESIGN, OR REDESIGN OF PARKS, RECREATION AREAS, CAMPUSES, TRANSPORTATION SYSTEMS, AND OTHER PUBLIC FACILITIES; AND
- PROGRAMS THAT INCREASE AWARENESS, REPORTING, AND PREVENTION OF STALKING.

16.10 HATE CRIMES

RACIALLY AND RELIGIOUSLY MOTIVATED ATTACKS ON INDIVIDUALS OR ETHNIC GROUPS ARE INTOLERABLE IN OUR SOCIETY. THE FEAR GENERATED BY SUCH WANTON ATTACKS VICTIMIZES ENTIRE COMMUNITIES. PRESERVING OUR CONSTITUTIONAL RIGHTS OF FREE SPEECH, RELIGION, AND EXPRESSION REQUIRES THAT ALL LEVELS OF GOVERNMENT MUST WORK TOGETHER TO COMBAT THESE ATTACKS.

THE VARIOUS LEVELS OF GOVERNMENT SHOULD WORK IN CONCERT TO PROVIDE THE MOST EXTENSIVE DATA POSSIBLE ON HATE CRIMES AND RELATED INCIDENTS. GOVERNMENTS SHOULD SEEK TO RAISE PUBLIC AWARENESS OF SPECIFIC INSTANCES OF HATE CRIMES, UNDERSTANDING THAT ANY SINGLE OCCURRENCE CAN SEND POWERFUL SHOCK WAVES THROUGH THE RELIGIOUS AND MINORITY COMMUNITY AT WHICH THE CRIME WAS DIRECTED. FURTHER, TRADITIONAL FORMS OF AWARENESS—RANGING FROM PUBLIC EDUCATION TO PUBLIC INFORMATION NETWORKS—SHOULD REINFORCE THE STRONG AND SIMPLE MESSAGE THAT HATE CRIMES HAVE NO PLACE IN OUR SOCIETY AND WILL BE MET BY SWIFT AND CERTAIN PUNISHMENT TO THE PERPETRATOR.

A NUMBER OF STATES HAVE ENACTED LAWS THAT IMPOSE ADDITIONAL PENALTIES WHEN ANY VIOLENT CRIMINAL ACT OR ATTEMPTED ACT IS TARGETED TOWARD SPECIFIC INDIVIDUALS BASED ON THE VICTIM'S RACE, GENDER, RELIGION, NATIONALITY, DISABILITY, OR SEXUAL ORIENTATION. TO ASSIST THOSE STATES AND OTHERS SEEKING TO COMBAT HATE CRIMES, THE NATION'S GOVERNORS URGE THE FEDERAL GOVERNMENT TO PROVIDE FOR SENTENCING ENHANCEMENTS FOR VIOLENT CRIMES AGAINST, OR ATTEMPTED AGAINST, ANY INDIVIDUAL BASED ON THE VICTIM'S RACE, GENDER, RELIGION, NATIONALITY, DISABILITY, OR SEXUAL ORIENTATION.

16.11 YOUTH VIOLENCE AND DELINQUENCY PREVENTION

16.11.1 PREAMBLE. YOUNG PEOPLE REPRESENT OUR NATION'S FUTURE AND THEREFORE ITS MOST VALUABLE HUMAN RESOURCE. IN MANY RESPECTS, THEY HAVE BECOME OUR MOST VULNERABLE CLASS OF CITIZENS. DELINQUENCY, PARTICULARLY DRUG- AND GUN-RELATED VIOLENCE, IS ESCALATING AT A DISTURBING RATE. YOUNG PEOPLE ARE KILLING EACH OTHER. CHILDREN ARE TERRORIZING THEIR SCHOOLS, PARKS, AND NEIGHBORHOODS. YOUNG PEOPLE ARE EITHER THE FOOT SOLDIERS OR RINGLEADERS IN CRIMINAL ENTERPRISES INVOLVED IN DRUG TRAFFICKING. THIS INCREASE IN EXPOSURE OF OUR YOUTH TO VIOLENT CRIME WILL HAVE A SERIOUS IMPACT ON THEIR ABILITY TO DEVELOP AND BECOME USEFUL AND PRODUCTIVE ADULTS.

THE NATION'S GOVERNORS BELIEVE THAT COMBATING YOUTH DELINQUENCY AND VIOLENCE REQUIRES THE DEVELOPMENT AND IMPLEMENTATION OF PROGRAMS AND POLICIES THAT PREVENT DELINQUENCY, ELIMINATE THE PRESENCE OF VIOLENCE WHEREVER CHILDREN CONGREGATE, AND ENSURE STRONG PUNISHMENT FOR THOSE RESPONSIBLE FOR EXPOSING YOUNG PEOPLE TO DELINQUENCY, DRUGS, AND VIOLENCE.

16.11.2 PREVENTION. THE FIRST LINE OF DEFENSE AGAINST YOUTH VIOLENCE IS THE ESTABLISHMENT OF COMPREHENSIVE SERVICES AND PROGRAMS FOR AT-RISK CHILDREN AND THEIR FAMILIES. SUCCESS IN SCHOOL AND IN LIFE REQUIRES THAT CHILDREN BE PREPARED WHEN THEIR REGULAR SCHOOLING BEGINS. THESE SERVICES AND PROGRAMS SHOULD BE DESIGNED TO REACH OUT AND RESPOND TO CHILDREN AND YOUTH FROM INFANCY TO ADULTHOOD. EARLY PREVENTION THROUGH PROGRAMS THAT BUILD SELF-ESTEEM AND OFFER AN ALTERNATIVE TO VIOLENT AND CRIMINAL ACTIVITY IS CRITICAL TO THE

SUCCESSFUL REDUCTION OF CRIME, VIOLENCE, AND GANG ACTIVITIES IN OUR NEIGHBORHOODS. EFFECTIVE MEASURES MAY INCLUDE, BUT ARE NOT LIMITED TO:

- PROGRAMS THAT GIVE EDUCATION, EMPLOYMENT, AND TRAINING OPPORTUNITIES TO YOUTH IN HIGH-CRIME AREAS;
- PROGRAMS FOR KEEPING SCHOOLS OPEN AFTER-HOURS;
- PROGRAMS TO ENSURE A SAFE SCHOOL ENVIRONMENT;
- ACCESS TO SUBSTANCE-ABUSE PREVENTION AND TREATMENT;
- PROGRAMS THAT EXPAND COMMUNITY RECREATIONAL AND SPORTS OPPORTUNITIES; AND
- PROGRAMS THAT INVOLVE COUNSELING AND MENTORING.

16.11.3 ENVIRONMENT. CHILDREN AND YOUTH SHOULD NOT HAVE TO FEAR VIOLENCE IN THEIR PARKS AND SCHOOLS. THE NATION'S GOVERNORS BELIEVE THAT THE STATES SHOULD CONSIDER TOUGH AND INNOVATIVE MEASURES TO ENSURE THAT PLACES WHERE CHILDREN CONGREGATE ARE FREE FROM VIOLENT ACTIVITY, INCLUDING:

- ADDITIONAL PENALTIES FOR THOSE WHO ILLEGALLY SELL OR TRANSFER FIREARMS, OR ENGAGE IN DRUG TRAFFICKING AT OR NEAR A SCHOOL SITE, PARK, OR OTHER AREA WHERE CHILDREN AND YOUTH CONGREGATE; AND
- PROGRAMS AND RESOURCES DESIGNED TO REDUCE AND PREVENT DRUG TRAFFICKING OR VIOLENT CRIMINAL ACTIVITY AT OR NEAR A SCHOOL SITE, PARK, OR OTHER AREA WHERE CHILDREN AND YOUTH CONGREGATE.

16.11.4 PUNISHMENT AND REHABILITATION. THE NATION'S GOVERNORS ARE CONCERNED WITH THE RAPID RISE IN HANDGUN-RELATED VIOLENCE, PARTICULARLY IN SCHOOLS AND OTHER AREAS WHERE CHILDREN CONGREGATE. SWIFT AND CERTAIN PUNISHMENT IS A STRONG DETERRENT TO CRIMINAL ACTIVITY. THEREFORE, THE GOVERNORS BELIEVE THAT PROMISING STRATEGIES DESIGNED TO COMBAT JUVENILE DELINQUENCY AND GUN-RELATED VIOLENCE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING MEASURES:

- MANDATORY PRISON TIME FOR ANY ADULT WHO ILLEGALLY TRANSFERS OWNERSHIP OR SELLS A FIREARM TO A MINOR;
- STRICT PENALTIES FOR CHILDREN BELOW THE AGE OF EIGHTEEN WHO ILLEGALLY POSSESS A FIREARM;
- IMMEDIATE SEIZURE OF GUNS ILLEGALLY POSSESSED BY MINORS;
- FORMULATION OF STANDARDS AND PROCEDURES FOR THE OPENING OF JUVENILE RECORDS TO THE COURT AND TO THE PUBLIC WHEN A JUVENILE IS ACCUSED OF SUCCESSIVE OR MULTIPLE VIOLENT CRIME OFFENSES;
- ESTABLISHMENT OF THE RULE THAT THOSE FOURTEEN YEARS OF AGE OR OLDER WHO COMMIT SERIOUS VIOLENT OFFENSES OR HAVE COMMITTED PRIOR VIOLENT FELONIES BE TRIED AS ADULTS; AND
- ESTABLISHMENT OF BOOT CAMPS OR SIMILAR REHABILITATIVE MEASURES FOR NONVIOLENT OFFENDERS.

16.12 CHILD ABUSE

THE GOVERNORS ARE CONCERNED ABOUT THE INCREASE IN CHILD ABUSE IN THE NATION. CHILD ABUSE REPRESENTS THE INTERACTION OF NUMEROUS SOCIAL FACTORS IN THE LIFE OF THE ABUSER. ALTHOUGH ALL ARE IMPORTANT, SEVERAL ARE ESPECIALLY SIGNIFICANT: BEING ABUSED AS A CHILD, POVERTY, FAMILY AND COMMUNITY DYSFUNCTION, MENTAL HEALTH PROBLEMS, SUBSTANCE ABUSE, AND THE CHALLENGE PLACED ON FAMILIES WHO HAVE SPECIAL NEEDS CHILDREN.

PROGRAMS MUST RECOGNIZE THESE FACTORS, ESPECIALLY THE FACT THAT MANY JUVENILE OFFENDERS WERE ABUSED AS CHILDREN; WE NEED TO RECOGNIZE THAT THE CYCLE OF VIOLENCE CAN BEST BE BROKEN BY HELPING THESE YOUNG WOMEN AND MEN BECOME BETTER PARENTS.

RESEARCH RECOGNIZES A CLEAR LINK BETWEEN CHILD ABUSE AND CRIME. THEREFORE, A COMPREHENSIVE PROGRAM TO COMBAT AND PREVENT CHILD ABUSE WILL BOTH IMPROVE THE WELL-BEING OF OUR NATION'S YOUNG PEOPLE AND WORK AS A CRIME PREVENTION TOOL. THE GOVERNORS SUPPORT A COMPREHENSIVE PROGRAM INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING COMPONENTS. IT SHOULD:

- PROVIDE ADEQUATE INFORMATION AND TECHNICAL ASSISTANCE TO IMPROVE COORDINATION OR ELIMINATE ROADBLOCKS THAT WORK AGAINST INTERAGENCY COOPERATION;
- ELIMINATE FEDERAL BARRIERS THAT STAND IN THE WAY OF THE STATES PROVIDING COORDINATED COMMUNITY SERVICES RELATED TO THE PROTECTION OF CHILDREN;
- ENCOURAGE RESEARCH AND PRIVATE EFFORTS THAT IDENTIFY MODELS FOR THE STATES THAT CAN PREVENT SERIOUS AND FATAL CHILD ABUSE, AND THAT RESPOND TO CHILD ABUSE THROUGH SOCIAL SERVICES, PUBLIC HEALTH, AND THE CRIMINAL JUSTICE SYSTEM;
- ESTABLISH PARENTING CLASSES AND SUPPORT SERVICES FOR YOUTHFUL OFFENDERS TO BREAK THE CYCLE OF VIOLENCE AND ABUSE THAT IS HANDED DOWN FROM GENERATION TO GENERATION;
- ESTABLISH STRONG PENALTIES, UP TO LIFE IMPRISONMENT WITHOUT PAROLE, FOR CHILD ABUSERS AND SEX OFFENDERS; AND
- OFFER GENERAL FAMILY SUPPORT SERVICES THROUGH INTERVENTION THAT COULD STRENGTHEN THE FAMILY TO HELP PREVENT CRISIS, AND THEREBY REDUCE THE NEED FOR INTENSIVE SERVICES.

16.13 CONCLUSION

DEVELOPING A COMPREHENSIVE CRIMINAL AND JUVENILE JUSTICE PROGRAM IS A DIFFICULT CHALLENGE. IF THE STATES ARE TO EFFECTIVELY ADDRESS THE PROBLEMS FACING TODAY'S STATE AND LOCAL CRIMINAL JUSTICE SYSTEMS, SUCH AS PRISON CROWDING, COURT CASE OVERLOAD, AND VIOLENT CRIME, A COMPREHENSIVE PROGRAM IS NEEDED. IF THE FEDERAL GOVERNMENT OPTS TO DEVELOP PROGRAMS TO ASSIST THE STATES IN HANDLING THE NUMEROUS PROBLEMS ASSOCIATED WITH AND CAUSED BY VIOLENT CRIME, IT SHOULD DO SO AS A PARTNER WITH STATE CRIMINAL JUSTICE SYSTEMS AND IN A MANNER CONSISTENT WITH NGA'S PRINCIPLES FOR STATE-FEDERAL RELATIONS. THE NATION'S GOVERNORS OPPOSE ANY DIRECT ASSISTANCE TO LOCAL UNITS OF GOVERNMENT OR AGENCIES WITHOUT APPROVAL OF A STATE COORDINATING AGENT AND/OR AGENCY DESIGNATED BY THE GOVERNOR. ANY AID, WHETHER FINANCIAL OR IN KIND, MUST BE COORDINATED WITH THE STATE TO ENSURE STATE AND LOCAL COOPERATION,

AND THE COORDINATION AND IMPLEMENTATION OF CRIMINAL AND JUVENILE JUSTICE PLANNING AND GOALS.

Time limited (July 1994-July 1996).

16.1 Preface

Violent crime is a grave threat to the safety of all Americans. Government at all levels must deal with it. But a significant burden for meeting the threat of violent crime falls on the states and local governments. It is at these levels of government that a comprehensive program should be developed to handle the problem.

A comprehensive criminal and juvenile justice program should: be statewide and be coordinated with local units of government; be well planned; recognize a role for the federal government; have the support of the Governor; have the support of the legislature; and have top quality professional management.

16.2 Coordinating the Criminal and Juvenile Justice System

If the criminal and juvenile justice system is to operate effectively and efficiently, it is essential for the principal actors in the system at all levels of government to coordinate their activities and ensure consistent policies. Many officials and agencies in the criminal and juvenile justice system perform their duties without full regard to the consequences of their actions for other officials in the system. Coordinating the activities of the courts, police, corrections officials, and others could lead to the formulation of policy based on a clear understanding of the goals of each of the separate components and would help preserve scarce resources through improved management and efficiency. Therefore, the state should take the leadership role in support of the establishment and maintenance of appropriate criminal and juvenile justice coordinative policies, structures, and mechanisms at the state and local levels of government.

16.3 Planning for the Criminal and Juvenile Justice System

Criminal and juvenile justice planning is the application of forethought to the highly dispersed field of criminal justice within a state. Its effect is the reduction of uncertainty about the future, so that decisions made, often by a number of autonomous officials, can be more accurate and timely. It is using data analysis and concepts to discover and compare possible goals, priorities, and standards so as to best identify future criminal justice needs. It seeks to visualize what situations are apt to exist in the near or more distant future, what resources will or could be available to deal with them, what options are available for governmental policy and action, and what results are likely.

Planning also must be focused and able to assess impact and expenditures for proposed criminal justice programs. For example, if the state proposes changes in sentencing law, it also should assess the impact on other components of the criminal justice system, especially corrections. In this way, resource needs can be anticipated for other units in the system, and the effect of the new changes can be assessed against the total resource needs for the entire criminal justice system.

16.4 The Federal Role: Research, Statistics, and Evaluation

Although all levels of government do and should conduct research on the criminal justice system, the federal government has a special responsibility to develop and test alternative methods of improving it. The federal government has the resources and perspective to undertake both basic and applied research. The federal government should continue to adequately support research on criminal justice problems identified by state and local governmental practitioners throughout the country. The highest priority should be given to research and evaluation efforts that are most likely to be immediately useful to state and local criminal justice agencies. To the extent practicable, state and local criminal justice practitioners should be involved in the research effort and then should perceive its results.

There is need for objective, reliable, and accurate statistics on crime, its victims, its perpetrators, and the activities of the criminal justice system. The Bureau of Justice Statistics collects comprehensive criminal justice statistics on a national basis to provide continuous indicators regarding crime. In the future, the bureau should give primary attention to data that will be useful to state and local criminal justice officials who have the major responsibility to deal with crime. It must provide adequate support for the development of state criminal justice information systems that generate the data utilized by the bureau and the State Statistical Analysis Centers that contribute assistance and advice to state and local criminal justice officials. In developing its data, the bureau should give special attention to the systemic nature of the operations being recorded. It should develop statistics that can record points at which criminal justice agencies interact. To ensure that the bureau maintains a state and local criminal justice orientation, it should rely upon the advice and direction of state and local criminal justice officials.

The bureau should concentrate on disseminating information as rapidly as possible to the states. The information also should be developed in a form that practitioners will find useful in helping them fight violent crime.

16.5 Active Support of the Governor

If a comprehensive criminal and juvenile justice program is to work, it must have the active support of the Governor. The Governor should address the issue of crime and the functioning of criminal justice programs not only in terms of providing the state services, such as prisons or a highway patrol, important as these are, but also in terms of strengthening the state/local partnership in crime control.

16.6 Active Support of the Legislature

Strong legislative relations in matters dealing with criminal justice need to be maintained on an ongoing basis. Misguided or isolated legislative initiatives that lack full information on their implications should not be allowed to influence policy directions.

The legislature is the one body in the state where all the ties of the criminal and juvenile justice system, including the constitutionally independent judicial branch of government, come together in the resource allocation process. It generally sets the boundaries within which criminal justice system actors must operate.

16.7 Top Quality Professional Managers

The Governor must ensure that the most competent individuals are appointed to key criminal and juvenile justice positions. It is especially important for the Governor to select individuals with whom he or she can work directly and in whom he or she can have confidence to handle the mission of systemwide analysis, problem solving, and advice on policy direction.

16.8 Managing Career Criminals

Research and data analysis indicate clearly that a small number of offenders are responsible for a disproportionate number of crimes. Until recently, many of these "career criminals" were treated like other offenders by the criminal justice system.

The apprehension, adjudication, and long-term sentencing of offenders who have been determined to have repetitive or crime-prone records should be a priority of the criminal justice system. Federal, state, and local criminal justice officials should focus on identifying, apprehending, and prosecuting career criminals.

Programs designed to incapacitate career criminals have proven through evaluation to be effective in many states. Support for the incapacitation of career criminals does not mean abandonment of the goals of rehabilitation or deterrence. The task force report of the National Academy of Sciences noted that many rehabilitative programs have been evaluated by inadequate research designs and the potential of these programs has not truly been tested.

Criminal justice officials and scholars should continue to develop responsible programs for managing all offenders. Research must be conducted on how to reach and deal with career criminals once they are incapacitated.

16.8.1 **Mandatory Sentences for Career Criminals.** Crime is the issue of concern to the majority of citizens in the United States. Approximately 5 million people will be the victim of a violent crime each year, and for every criminal in prison, there are five free on parole or probation. Sixty percent of prisoners released early are re-arrested within three years and charged with an average of five new crimes each.

In the long run, it is crucial to prevent young people from becoming criminals by intervening in their lives at early stages to help them develop their talents and motivation, good values, and discipline.

But at the present, the Governors believe violent crime is most effectively addressed by increasing the likelihood and length of incarceration for repeat, habitual violent offenders. Seventy-eight percent of the citizens of the state of Washington supported the 1993 "three strikes, you're out" initiative.

The Governors further believe that any individual convicted of a federal felony who has two prior convictions for violent offenses should be sentenced to life imprisonment without parole or probation. Therefore, the Governors recommend that Congress pass a crime bill that includes a provision that would place third-time violent offenders in federal prison for life without possibility of probation or parole.

16.9 **Crime in Rural Communities**

Crime is a major problem in rural communities. In some rural communities, crime has reached epidemic proportions. The response must reflect the unique concerns and needs of rural Americans.

Crime abatement and control programs are often based on the assumption that the rural community and its criminal justice system can and should use programs applicable to urban areas. Federal, state, and local decisionmakers should realize that issues of population density, regional and local customs, and varying community mores create a range of needs, problems, and solutions that urban-oriented programs do not address.

In developing policy to cope with rural crime, the administration should consider the following principles.

- Law enforcement officials must be sensitized to the needs and traditions of rural areas. Techniques and models should be developed to incorporate the unique economic and social conditions of rural local governments.
- More anticrime measures should be developed for rural area residents.
- Rural residents should be encouraged to participate in crime prevention programs geared to their needs.
- Special programs should be developed to address rural juvenile crime.

16.10 **Treatment of Crime Victims and Witnesses**

It is the duty of government to promote the public safety of its citizens. Federal and state governments must develop programs that enhance citizens' protection from criminal activities and provide efficient and fair programs for those who have been victimized by criminal activity.

Several states have developed programs that help reduce the financial burdens on victims and encourage reporting of crime and cooperation of witnesses with police. These programs have functioned effectively and economically for a number of years. Other states are encouraged to develop victim/witness programs.

Standards of fair treatment for crime victims and witnesses must be recognized and promoted by government at all levels. These standards must be based on principles that crime victims and witnesses should be:

- treated with dignity and compassion by the criminal justice system;
- protected from intimidation and harm;
- informed about programs of financial assistance and social services that may be available to them; and
- informed about their legal rights, such as the right to file civil suit for damage or to seek restitution through appropriate channels.

Programs developed by the federal government to assist victims and witnesses must recognize existing state programs and allow states flexibility to manage any proposed federal program consistent with existing state organizational structures.

16.11 Conclusion

~~Developing a comprehensive criminal and juvenile justice program is a difficult challenge. If states are to effectively address the problems facing the criminal justice system, such as prison overcrowding, court case overload, and violent crime, a comprehensive program is needed.~~

~~If the federal government develops a program to assist states in handling the problem of violent crime, it should do so in a manner that is consistent with NGA's principles for state-federal relations. There must be no direct assistance to local units of government or agencies without approval of a state coordinating agent and/or agency designated by the Governor. Any aid, whether financial or in kind, must be coordinated with the state so that federal, state, and local resources will be well coordinated.~~

~~Time limited (effective February 1994-February 1996).~~

~~Adopted August 1982; revised August 1992 and February 1994 (formerly Policy B-1).~~

B-9. NATIONAL INSTITUTE AGAINST PREJUDICE AND VIOLENCE

There is documented and compelling evidence attesting to a continued increase in overt acts of violence and intimidation aimed at specific racial, ethnic, and religious groups in every region of the country. These activities, such as cross burnings, swastika displays, and vandalistic desecrations of religious sanctuaries, are directly contradictory to the basic principles of our American democracy. The nation's Governors deplore these acts of intimidation.

Therefore, the National Governors' Association supports the private, nonprofit National Institute Against Prejudice and Violence to:

- Serve as a clearinghouse to collect, analyze, and disseminate accurate and comparable information on manifestations of racially, ethnically, and religiously motivated violence and extremism;
- Serve as a reference and referral service for individuals and agencies interested in better understanding what information is available on various aspects of the issues of violence and extremism;
- Promote, conduct, assist, and publicize empirical research on the causes, prevention, and control of racially, ethnically, and religiously motivated violence and extremism;
- Function as a training and referral service and provide assistance both to victims of intimidation and violence and to public and private agencies;
- Provide technical and educational assistance to jurisdictions experiencing abnormal levels of violence and extremism that are racially, ethnically, or religiously motivated;
- Provide assistance in the review, analysis, and drafting of legislation to address general and specific problems of violence and extremism.

Adopted February 1984; revised August 1991.

HR-19. COMBATING AND CONTROLLING SUBSTANCE ABUSE AND ILLEGAL DRUG TRAFFICKING

19.1 PREAMBLE

THE NATION'S GOVERNORS ARE APPALLED AT THE SOCIAL ILLS CAUSED BY INDIVIDUALS WHO ABUSE SUBSTANCES SUCH AS ALCOHOL AND LEGAL DRUGS BY DIVERSION, AS WELL AS ILLICIT DRUGS. THERE ARE MORE DEATHS, ILLNESSES, AND DISABILITIES FROM SUBSTANCE ABUSE THAN FROM ANY OTHER PREVENTABLE HEALTH CONDITION. SUBSTANCE ABUSE, ESPECIALLY ALCOHOL ABUSE, IS AMONG THE LEADING CAUSES OF SOCIAL VIOLENCE SUCH AS SPOUSAL AND CHILD ABUSE.

ABUSE OF ILLICIT SUBSTANCES, ESPECIALLY TRAFFICKING IN ILLEGAL DRUGS, INFECTS EVERY ELEMENT OF OUR SOCIETY. IT IS THE ROOT CAUSE OF MUCH VIOLENT STREET AND GANG-RELATED CRIME. DRUG TRAFFICKERS REPRESENT A GREAT THREAT TO THE SAFETY OF CHILDREN AND YOUTH IN PARKS AND SCHOOLS. THEY NOT ONLY HAVE POTENTIALLY DESTRUCTIVE EFFECTS ON INDIVIDUALS AND COMMUNITIES, BUT ALSO POSE UNIQUE AND DIFFICULT PROBLEMS FOR PUBLIC OFFICIALS AND LAW ENFORCEMENT OFFICERS. EVEN WORSE, DRUG TRAFFICKING IS A MULTINATIONAL, HUNDRED BILLION DOLLAR, TAX-FREE ENTERPRISE FOR DRUG DEALERS, PEDDLERS, AND OTHER CRIMINAL ELEMENTS.

TO REDUCE THE PRESENCE OF ILLEGAL DRUGS, DRUG-RELATED ORGANIZED CRIME, AND THE ADVERSE EFFECTS OF DRUG ABUSE IN SOCIETY REQUIRES A COMPREHENSIVE STRATEGY INVOLVING FEDERAL, STATE, AND LOCAL GOVERNMENTS. THIS APPROACH SHOULD INCLUDE INTERNATIONAL COOPERATION, DIPLOMATIC INITIATIVES, DRUG LAW ENFORCEMENT, EDUCATION, PREVENTION, DETOXIFICATION, CLIENT-BASED HUMAN SERVICES, TREATMENT, AND RESEARCH.

19.2 THE STATE ROLE

ALTHOUGH THE PRIMARY RESPONSIBILITY FOR DEALING WITH DRUG TRAFFICKING, ESPECIALLY INTERDICTION AT THE BORDERS, IS A FEDERAL ONE, GOVERNORS PLAY A KEY ROLE IN SUBSTANCE ABUSE REDUCTION. THE NATION'S GOVERNORS ARE IN A UNIQUE POSITION TO LAUNCH AN ASSAULT ON THE DEMAND FOR DRUGS, AS WELL AS ON DRUG TRAFFICKING. THE GOVERNORS

NOT ONLY CAN MARSHAL THE RESOURCES OF STATE GOVERNMENT ACROSS DEPARTMENTAL LINES, BUT ALSO CAN EXERCISE THE POWER AND PRESTIGE OF THEIR OFFICES TO MOBILIZE A STATEWIDE COALITION, CUTTING ACROSS BOTH THE PUBLIC AND PRIVATE SECTORS. SUCH LEADERSHIP CAN BE ENORMOUSLY EFFECTIVE IN ENABLING LOCAL ELECTED OFFICIALS, AS WELL AS WHOLE COMMUNITIES, TO ASSUME THE DRUG PREVENTION CHALLENGE.

THE GOVERNORS ARE SENDING A STRONG MESSAGE THAT SUBSTANCE ABUSE AND TRAFFICKING IN ILLEGAL DRUGS CAN AND MUST BE ABOLISHED. THE GOVERNORS ARE A GUIDING FORCE AS REPRESENTATIVES OF STATE AGENCIES, LOCAL COMMUNITIES, BUSINESSES, INDUSTRY, RELIGIOUS AND CIVIC INSTITUTIONS, THE MEDIA, AND LAW ENFORCEMENT COME TOGETHER TO DEVELOP A STRATEGY FOR DEALING WITH SUBSTANCE ABUSE AND ILLEGAL DRUG TRAFFICKING.

THE GOVERNORS ARE PLAYING A CENTRAL ROLE IN MOBILIZING COMMUNITY AND STATE GOVERNMENT COOPERATION IN A COMPREHENSIVE EFFORT TO CONTROL SUBSTANCE ABUSE AND ILLEGAL TRAFFICKING, AS WELL AS THE DIVERSION OF LEGALLY PRESCRIBED DRUGS FOR ILLICIT PURPOSES. THIS IS BEING ACCOMPLISHED BY:

- DIRECTING STATE AGENCIES TO WORK TOGETHER AND COOPERATE IN AREAS OF EDUCATION, PREVENTION, TREATMENT AND REHABILITATION, AND LAW ENFORCEMENT IN ADDRESSING THE PROBLEM;
- ENCOURAGING LOCAL OFFICIALS, COMMUNITY LEADERS, AND CITIZENS TO GET INVOLVED STATEWIDE TO CARRY OUT AN EFFECTIVE STRATEGY; AND
- WORKING WITH LOCAL GOVERNMENTS AND THE BUSINESS COMMUNITY TO ADDRESS THE IMPORTANCE OF PROGRAMS THAT PROMOTE DRUG-FREE SCHOOLS AND WORKPLACES.

THE GOVERNORS BELIEVE THE STATES SHOULD CONSIDER DEVELOPING AN EFFECTIVE STATEWIDE ALLIANCE AGAINST DRUGS THAT WOULD INCLUDE, BUT WOULD NOT BE LIMITED TO, THE FOLLOWING COMPONENTS.

- THE FORMULATION, IMPLEMENTATION, AND COORDINATION OF A COMPREHENSIVE PLAN FOR A STATEWIDE CAMPAIGN AGAINST DRUGS AND ALCOHOL ABUSE, CONSISTING OF PROGRAMS AND INITIATIVES

RELATING TO EDUCATION, PREVENTION, TREATMENT, AND LAW ENFORCEMENT.

- A NETWORK OF PREVENTION CENTERS, TO PROVIDE EXPERT SUBSTANCE ABUSE SERVICES TO LOCAL COMMUNITIES, AND OF TREATMENT FACILITIES, TO PROVIDE OPPORTUNITIES FOR RECOVERY, BASED ON PERIODIC STATEWIDE NEEDS ASSESSMENTS.
- AN OUTREACH PROGRAM TO MAKE MAJOR MEDIA OUTLETS, BUSINESSES, FINANCIAL INSTITUTIONS, AND CELEBRITIES FULL-FLEDGED PARTNERS IN THE STATEWIDE CAMPAIGN.

TO BE SUCCESSFUL, A STATEWIDE SUBSTANCE ABUSE PREVENTION CAMPAIGN MUST BE PLANNED AS AN ONGOING AND LONG-TERM COMMITMENT; TO BE SUSTAINED, IT MUST BE COMMUNITY-BASED. GOVERNORS ARE IN A UNIQUE POSITION TO PLAY AN INSTRUMENTAL ROLE IN MOBILIZING DISPARATE LOCAL GROUPS AND COALITIONS TO PARTICIPATE IN CONJUNCTION WITH, RATHER THAN COUNTER TO, STATEWIDE INITIATIVES, PROGRAMS, AND ALLIANCES.

19.3 THE FEDERAL ROLE

THE FEDERAL GOVERNMENT SHOULD ACCELERATE RESOURCE ASSISTANCE TO AID IN THE IMPLEMENTATION OF STATEWIDE DEMAND REDUCTION CAMPAIGNS. THE PROFITS FROM ILLICIT DRUG TRAFFICKING CAN BE EFFECTIVELY USED TO HELP STATE EFFORTS TO DRY UP THE DEMAND FOR THESE DRUGS.

THE NATION'S GOVERNORS URGE THE PRESIDENT AND CONGRESS TO FULLY FUND DRUG ABUSE EDUCATION, TREATMENT, PREVENTION, AND LAW ENFORCEMENT EFFORTS AT THE STATE AND LOCAL LEVELS OF GOVERNMENT. IT IS THROUGH RESOURCE ASSISTANCE THAT THE FEDERAL GOVERNMENT INTENDS TO FOLLOW THROUGH ON ITS COMMITMENT TO ASSIST STATE AND LOCAL GOVERNMENTS IN RIDDING THE NATION OF THE SCOURGE OF DRUGS.

19.3.1 INTENSIFIED ERADICATION AND INTERDICTION—MILITARY AND NATIONAL GUARD ASSISTANCE TO STATE AND LOCAL GOVERNMENTS. THE FEDERAL GOVERNMENT HAS EXCLUSIVE RESPONSIBILITY FOR COORDINATING INTERDICTION OF DRUG SHIPMENTS FROM FOREIGN COUNTRIES AND ASSISTING THOSE COUNTRIES IN

THE ERADICATION OF DRUGS AT THE SOURCE. THIS SHOULD BE A TOP PRIORITY OF THE FEDERAL GOVERNMENT.

FEDERAL FUNDING FOR USE OF THE NATIONAL GUARD IN DRUG AND BORDER ENFORCEMENT DESERVES CONTINUED SUPPORT. THE GOVERNORS URGE THE PRESIDENT AND CONGRESS TO ENSURE THAT THE PROCESS FOR APPROVING STATE PLANS FOR NATIONAL GUARD DRUG INTERDICTION EFFORTS IS STREAMLINED TO ENSURE THAT AVAILABLE FUNDS ARE DISTRIBUTED TO STATES AS EXPEDITIOUSLY AS POSSIBLE FOLLOWING SUBMISSION OF A PLAN TO THE NATIONAL GUARD BUREAU.

THE MILITARY SHOULD WORK WITH FEDERAL, STATE, AND LOCAL OFFICIALS IN MULTIGOVERNMENTAL EFFORTS TO CONTROL DRUG SMUGGLING INTO THE COUNTRY AND DRUG-RELATED ORGANIZED CRIME. THE GOVERNORS URGE THE PRESIDENT AND CONGRESS TO UTILIZE THE ROLE OF U.S. MILITARY FORCES IN AIR AND SEA INTERDICTION EFFORTS. THIS ROLE SHOULD COVER ALL REGIONS OF THE COUNTRY AND CAN BE FOSTERED THROUGH MORE FREQUENT JOINT MILITARY AND LAW ENFORCEMENT MISSIONS AND COMPACTS PROMOTING INTERGOVERNMENTAL COOPERATION.

19.3.2 THE FEDERAL ROLE IN REDUCING INTERNATIONAL DRUG TRAFFICKING. ALTHOUGH THE NATION'S GOVERNORS CONTINUE TO COMBAT THE SUPPLY AND DEMAND FOR DRUGS THROUGH PUBLIC AWARENESS CAMPAIGNS AND INCREASED FUNDING FOR ANTIDRUG PROGRAMS IN EDUCATION, PREVENTION, TREATMENT, AND LAW ENFORCEMENT, INTERNATIONAL DRUG TRAFFICKING CONTINUES TO FLOURISH AND EXPAND ITS GLOBAL IMPACT. DRUG INTERDICTION MUST BE ADDRESSED IN AN INTERNATIONAL CONTEXT AND MUST BE CONSIDERED A CRUCIAL ELEMENT OF FOREIGN POLICY. THEREFORE, THE STATE DEPARTMENT, THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT, AND THE DRUG ENFORCEMENT ADMINISTRATION'S FOREIGN ANTIDRUG OPERATION MUST BE GIVEN SUFFICIENT RESOURCES TO BE EFFECTIVE.

THE GOVERNORS SUPPORT INCREASED FEDERAL ACTION AGAINST THE EFFORTS OF THE INTERNATIONAL DRUG CARTELS TO EXPAND THEIR MARKETS AND THEIR DRUG OPERATIONS INTO OTHER COUNTRIES. SUCCESS REQUIRES THE FULL COOPERATION OF OTHER GOVERNMENTS, PARTICULARLY THOSE THAT ARE HOME TO INTERNATIONAL DRUG TRAFFICKERS AND CARTELS. THEREFORE, THE NATION'S GOVERNORS URGE THE ADMINISTRATION AND

CONGRESS TO SIGNIFICANTLY TIGHTEN PROCEDURES FOR CERTIFYING FOREIGN COUNTRIES FOR ELIGIBILITY TO RECEIVE U.S. AID BASED ON THEIR COOPERATION WITH U.S. SURVEILLANCE, INTERDICTION, AND ERADICATION EFFORTS. IN CASES WHERE THE AMOUNT OF U.S. AID TO SOME UNCOOPERATIVE COUNTRIES IS INCONSEQUENTIAL, THE FEDERAL GOVERNMENT SHOULD DEVELOP OTHER SANCTIONS AGAINST THOSE COUNTRIES WHOSE GOVERNMENTS PARTICIPATE IN, BENEFIT FROM, OR FAIL TO COMBAT INTERNATIONAL DRUG TRAFFICKING.

19.4 DRUG LEGALIZATION

A NUMBER OF STATES HAVE DEVOTED LIMITED RESOURCES TOWARD REDUCING THE DEMAND FOR DRUGS AND INCREASING THE AVAILABILITY OF TREATMENT. TREATMENT, PREVENTION, AND EDUCATION ARE WORKING, AND THE FEDERAL GOVERNMENT SHOULD ASSIST THE STATES IN THEIR EFFORTS TO PROVIDE THE SERVICES AND PROGRAMS NEEDED TO REDUCE DRUG DEMAND.

THE NATION'S GOVERNORS ARE STRONGLY OPPOSED TO THE LEGALIZATION OF ILLICIT DRUGS. THE LAWS OF OUR COUNTRY ARE A STATEMENT OF A CULTURE'S ETHOS. IN THIS CASE, LAWS ARE FIRM REMINDERS OF THE DEVASTATING IMPACT ILLICIT DRUGS HAVE ON YOUNG PEOPLE, FAMILIES, AND ENTIRE COMMUNITIES. MORE IMPORTANT, LEGALIZATION WOULD SERVE TO REVERSE THE GAINS MADE BY A NUMBER OF STATES TO REDUCE ILLICIT DRUG USE THROUGH EDUCATION, TREATMENT, AND PREVENTION. FOR THESE REASONS, THE NATION'S GOVERNORS BELIEVE ILLICIT DRUG LEGALIZATION IS NOT A VIABLE ALTERNATIVE, EITHER AS A PHILOSOPHY OR AS A PRACTICAL REALITY.

Time limited (effective July 1994-July 1996).

**HR-26. PRINCIPLES FOR REFORM OF SERVICES FOR CHILDREN,
YOUTH, AND FAMILIES**

26.1 PREAMBLE

CHILDREN ARE AMERICA'S MOST VALUABLE RESOURCE. THEY ARE IMPORTANT TO SOCIETY BECAUSE OF THEIR POTENTIAL FOR THE FUTURE. CHILDREN DESERVE TO BE LOVED AND CARED FOR, TO FEEL SECURE IN THE PRESENT, AND TO BE ABLE TO REACH FOR THE FUTURE. THEY DESERVE GOOD HEALTH CARE, ADEQUATE NUTRITION, SAFE AND AFFORDABLE HOUSING, A SAFE ENVIRONMENT, AND A QUALITY EDUCATION. CHILDREN NEED SENSITIVITY FOR AND AWARENESS OF THEIR CULTURE, BELIEF IN THEIR SELF-WORTH, AND A STRONG AND POSITIVE SENSE OF THEIR RESPONSIBILITY TO THEMSELVES AND TO SOCIETY.

FAMILIES ARE THE FUNDAMENTAL BUILDING BLOCKS OF A STRONG SOCIETY. PARENTS SHOULD BE CHILDREN'S FIRST AND PRIMARY NURTURERS. THEY PROVIDE THEIR CHILDREN WITH THE PHYSICAL AND EMOTIONAL NECESSITIES. PARENTS ARE ALSO THEIR CHILDREN'S FIRST TEACHERS. THEY PROVIDE MORAL GUIDANCE, INTELLECTUAL STIMULATION, AND CONTINUING ENCOURAGEMENT FOR LEARNING. AT TIMES, ALL FAMILIES MAY NEED SUPPORT TO CARRY OUT THESE FUNCTIONS. THIS SUPPORT MAY COME FROM EXTENDED FAMILIES, FRIENDS, RELIGIOUS AND CULTURAL INSTITUTIONS, SCHOOLS, BUSINESSES, COMMUNITY INSTITUTIONS, OR GOVERNMENT.

COMMUNITIES ARE ENVIRONMENTS IN WHICH CHILDREN THRIVE AND FAMILIES ARE SUPPORTED IN THEIR EFFORTS TO NURTURE THEIR CHILDREN. STATE AND LOCAL GOVERNMENTS SUPPORT COMMUNITIES AS THEY SEEK TO EMPOWER FAMILIES. THE FEDERAL GOVERNMENT SUPPORTS STATES, LOCAL GOVERNMENTS, AND COMMUNITIES IN THEIR EFFORTS TO ENHANCE THE WELL-BEING OF CHILDREN, YOUTH, AND FAMILIES.

THE WELFARE OF CHILDREN AND YOUTH IS ONE OF THE FOREMOST NEEDS OF SOCIETY AND MUST BE PROTECTED NOT ONLY BY FAMILIES AND COMMUNITIES BUT ALSO BY GOVERNMENTS, WHEN APPROPRIATE. IT IS CRITICAL THAT PROGRAM APPROACHES BE COMPREHENSIVE, CHILD-CENTERED, FAMILY-FOCUSED, AND COMMUNITY-BASED. THE NATION'S GOVERNORS BELIEVE THAT PROGRAM PRIORITIES AND FINANCING FOR PROGRAMS FOR

CHILDREN AND FAMILIES SHOULD BE FOCUSED ON PREVENTION OF PROBLEMS, EARLY INTERVENTION, AND FAMILY PRESERVATION AND SUPPORT ACTIVITIES.

26.2 PRINCIPLES FOR REFORM

THE NATION'S GOVERNORS SUPPORT THE FOLLOWING PRINCIPLES FOR REFORM OF SERVICES FOR CHILDREN, YOUTH, AND FAMILIES.

- SUPPORT FOR CHILDREN AND YOUTH—WHETHER FROM FAMILY, FRIENDS, RELIGIOUS AND CULTURAL INSTITUTIONS, SCHOOLS, BUSINESSES, COMMUNITY INSTITUTIONS, OR GOVERNMENT — SHOULD PROMOTE PHYSICAL AND EMOTIONAL SECURITY AND HEALTH, HELP CHILDREN REACH THEIR FULL POTENTIAL, AND HELP CHILDREN DEVELOP AND SUSTAIN CARING RELATIONSHIPS WITH OTHERS AND PARTICIPATE IN LEARNING AND SOCIAL ACTIVITIES WITHIN THEIR SCHOOLS AND COMMUNITIES.
- COMMUNITIES SHOULD PLAY A KEY ROLE IN CREATING ENVIRONMENTS WHERE CHILDREN AND YOUTH CAN GROW AND DEVELOP BY BUILDING ON THE STRENGTHS OF EVERY FAMILY AND SUPPORTING THEM IN MEETING THEIR RESPONSIBILITIES.
- THE PRIVATE SECTOR—BUSINESSES AND PRIVATE AND NONPROFIT ORGANIZATIONS—SHOULD ALSO PLAY AN IMPORTANT ROLE IN SUPPORTING CHILDREN, YOUTH, AND FAMILIES THROUGH SUCH INITIATIVES AS FAMILY LEAVE, FLEXIBLE WORKING SCHEDULES, CHILD CARE SERVICES, RECREATION AND AFTER-SCHOOL PROGRAMS, SCHOOL-TO-WORK PROGRAMS, MENTORING PROGRAMS, AND HEALTH AND MENTAL HEALTH SERVICES.
- GOVERNMENT'S PRIMARY RESPONSIBILITY TO CHILDREN, YOUTH, AND FAMILIES—AT THE LOCAL, STATE, AND FEDERAL LEVELS—SHOULD BE TO FOSTER AND SUSTAIN FAMILY STABILITY AND UNITY WHEN APPROPRIATE. GOVERNMENT'S EFFORTS SHOULD FOCUS ON EMPOWERING FAMILIES AND COMMUNITIES IN THEIR WORK WITH CHILDREN AND YOUTH. EACH LEVEL OF GOVERNMENT SHOULD STRIVE TO ELIMINATE PERVERSE INCENTIVES THAT PLACE THE NEEDS OF CHILDREN AND THEIR FAMILIES IN CATEGORICAL BOXES AND DISCOURAGE FAMILY UNITY OR FINANCIAL STABILITY.

- THE ROLE OF FEDERAL, STATE, AND LOCAL GOVERNMENTS SHOULD BE TO PROMOTE AND SUPPORT THE BASIC HEALTH AND SAFETY OF ALL CHILDREN AND YOUTH, ENSURE ACCOUNTABILITY FOR PUBLIC FUNDS, AND, IN COLLABORATION WITH THE PRIVATE SECTOR, SUPPORT THE DEVELOPMENT OF PROGRAMS AND SERVICES THAT MEET THE NEEDS OF FAMILIES IN COMMUNITIES.
- GOVERNMENT SUPPORT SYSTEMS FOR CHILDREN, YOUTH, AND FAMILIES SHOULD BE BUILT ON NEW PARTNERSHIPS AMONG FEDERAL, STATE, AND LOCAL POLICYMAKERS. EACH NEW PARTNERSHIP SHOULD BE CHARACTERIZED BY SHARED VISIONS, GOALS, AND OBJECTIVES. THE RELATIONSHIP BETWEEN FEDERAL, STATE, AND LOCAL GOVERNMENTS SHOULD BE BASED ON A COMMON SET OF SPECIFIC, POSITIVE RESULTS FOR WHICH ALL PARTIES ARE HELD ACCOUNTABLE. ACCOUNTABILITY SHOULD BE MEASURED AND SHARED AT THE COMMUNITY, LOCAL, STATE, AND FEDERAL LEVELS.
- FUNDING PRIORITIES SHOULD SUPPORT PROGRAMS AND SERVICES FOR CHILDREN AND YOUTH THAT HAVE DEMONSTRATED RESULTS, ARE COST-EFFECTIVE, ARE EASILY ACCESSIBLE, AND ENCOURAGE AND EXPEDITE PREVENTION AND EARLY INTERVENTION TO AVOID CRISES AND THE NEED FOR MORE COSTLY ASSISTANCE LATER IN THE PROCESS. FEDERAL, STATE, AND LOCAL FUNDING STRATEGIES SHOULD BE DESIGNED TO PROMOTE ACHIEVEMENT OF THESE POSITIVE RESULTS. AT THE SAME TIME, GOVERNMENT MUST RECOGNIZE THE NEED TO SUPPORT CHILDREN, YOUTH, AND FAMILIES IN CRISIS.
- FEDERAL, STATE, AND LOCAL GOVERNMENT STRATEGIES SHOULD RECOGNIZE THE IMPORTANCE OF INDIVIDUAL AND COMMUNITY RESPONSIBILITY. THEY SHOULD PROMOTE THE DEVELOPMENT OF CONSOLIDATED SERVICES THROUGH INTEGRATED NONCATEGORICAL FUNDING STREAMS AND PROGRAMS THAT MEET THE MULTIPLE AND INTERRELATED NEEDS OF CHILDREN, YOUTH, AND THEIR FAMILIES. THESE STRATEGIES SHOULD ENCOURAGE FLEXIBLE APPROACHES THAT ACHIEVE POSITIVE RESULTS AND RECOGNIZE THE DIVERSITY OF STATES AND LOCALITIES THROUGH POLICIES, BUDGET PROCESSES, AND STRATEGIC PLANNING.

- THE TRANSITION FROM THE CURRENT SYSTEM TO A MORE COMPREHENSIVE, INTEGRATED SYSTEM MUST ENSURE EFFICIENCY AND ENHANCED SYSTEM CAPACITY. FEDERAL, STATE, AND LOCAL GOVERNMENTS, IN COOPERATION WITH ALL PUBLIC AND PRIVATE SUPPORT SYSTEMS, SHOULD ASSIST IN MEETING THIS GOAL THROUGH STRATEGIES THAT INCLUDE TECHNICAL ASSISTANCE, PROFESSIONAL DEVELOPMENT, AND THE ESTABLISHMENT OF EVALUATION SYSTEMS TO TRACK PROGRESS TOWARD GOALS AND IDENTIFY AREAS OF CONCERN.

26.3 FEDERAL AND STATE RESPONSIBILITIES AND ROLES

FEDERAL AND STATE PROGRAMS HAVE TRADITIONALLY BEEN BASED ON THE FOLLOWING PRINCIPLES:

- A SHARED FEDERAL/STATE ROLE IN MAKING AVAILABLE TO CHILDREN, YOUTH, AND FAMILIES A FULL RANGE OF HEALTH, WELFARE, AND OTHER SERVICES THAT ARE DESIGNED TO PREVENT FUTURE PROBLEMS, AS WELL AS TO SOLVE CURRENT CRISES;
- A SHARED FEDERAL/STATE ROLE IN PROTECTING THE CIVIL RIGHTS OF CHILDREN AND YOUTH WHO ARE ESPECIALLY DISADVANTAGED, BY WORKING TO ELIMINATE THE EFFECTS OF BIAS; AND
- A STATE ROLE IN REGULATING THE SAFETY OF CHILDREN IN THE CARE OF OTHERS.

THE NATION'S GOVERNORS ARE STRONGLY COMMITTED TO:

- ENSURING COORDINATION OF SERVICES AND PROGRAMS;
- SECURING, AT A STATE'S OPTION, PROGRAMMATIC AND REGULATORY RESPONSIBILITY FOR FEDERAL PROGRAMS THAT PROVIDE SERVICES TO CHILDREN, YOUTH, AND FAMILIES;
- DEVELOPING AND ENACTING FEDERAL POLICY THAT PROVIDES FOR STATE FLEXIBILITY IN THE USE OF FEDERAL FUNDS TO DEVELOP PROGRAMS THAT ARE MOST APPROPRIATE AND ARE SPECIFICALLY TARGETED TO THE NEEDS OF CHILDREN, YOUTH, AND FAMILIES IN THAT STATE;
- PROMOTING FEDERAL SUPPORT AND ENCOURAGEMENT FOR STATE EFFORTS TO IMPROVE, COORDINATE, AND INTEGRATE

MULTIGOVERNMENTAL PROGRAMS AND SERVICES, INCLUDING GRANTS AND MECHANISMS DESIGNED TO COORDINATE THE DIVERSE PROGRAMS NOW SERVING CHILDREN, YOUTH, AND FAMILIES; AND

- ENCOURAGING PUBLIC-PRIVATE PARTNERSHIPS TO SHARE RESPONSIBILITY AND OPPORTUNITY FOR SERVICES FOR CHILDREN AND FAMILIES.

Time limited (July 1994-July 1996).

C-12. CHILDREN

12.1 Federal and State Responsibilities

Children make up the future human capital of a nation. To attempt to economize on the needs of children is not only to ignore the value of each of 62 million lives, it is to shortchange America's economic vitality for decades to come. Investment in children is a measure not only of a nation's ultimate decency, but also of how clearly it sees its own self-interest.

Every child in our society should have equal access to adequate health care and opportunity for normal growth in order to develop his or her full potential in conditions of freedom and dignity.

The responsibility for meeting these needs has been and will continue to be secured primarily through the family. When families require support, community and governmental agencies must be available to assist our society's most vulnerable members.

While significant disagreement remains about the relative roles of government, the family, and other institutions in caring for children, federal and state programs over more than half a century have been premised on the following:

- A federal role in reducing the disparities among states in providing basic health, welfare, and other services to children;
- A shared federal/state role in making available a full range of services to families with children not just in times of crisis, but to prevent illness and maltreatment;
- A shared federal/state role in guaranteeing the civil rights of children who are especially disadvantaged, by working to eliminate the effects of bias due to race, language, sex, or disability;
- A shared federal/state role in targeting the benefits of educational opportunities on children whose poverty or handicapping condition impedes educational progress;
- A state role in regulating the safety of children in the care of others.

12.2 Principles

State governments bear a direct responsibility for the health and welfare of children in the ways they budget, tax, regulate, evaluate, and organize services. In addition, within the discretion provided by many federal programs, states can decide whether millions of children will receive health coverage, social services, and other benefits intended to make their families more self-sufficient. NGA supports the following principles in guiding the continued development and improvement of state services to children:

- 12.2.1 General.** All policy and legislative recommendations should be considered both from the child's point of view and their potential impact on families. Government intervention should place first priority on enhancing parental capability.
- 12.2.2 Access.** Parents and others seeking governmental assistance on behalf of their children should have timely access to services, the opportunity to choose among available services and voice in their design, development, and delivery.
- 12.2.3 Economic Security.** More than 12 million American children live in poverty. Providing a minimum income level sufficient to provide some basic level of food, shelter, transportation, clothing, and health care through employment or income security or child support programs, is an essential step to ensuring family stability and healthy child development. States should continue to support the development of a national income security policy in accordance with the principles of eligibility based solely on need, adequate benefit levels, equitable treatment across state lines, incentives for self support, and full federal financial responsibility for a basic set of benefits.
- 12.2.4 Health.** The health status of American children has improved dramatically over the last two decades. Particularly significant has been the Medicaid program, almost half of whose recipients are children, and maternal and child health programs. Nonetheless, sharp differences in mental and physical health persist depending on family income, ethnic background, and geographic location. Eight million children living below the federal poverty level are not covered by Medicaid; 6 million children have no regular source of medical care.

States should support the development of a federal and state health policy that provides equal access to mental and physical health services for children regardless of income or residence; that

provides incentives for pregnant women and children to use cost-effective preventive and primary health care; and that does not penalize low-income pregnant women because they live in two-parent families or are pregnant with their first child.

12.2.4.1 **Gestational Diabetes.** A significant problem in prenatal health is gestational diabetes. There is a need to expand the public health response to this disease, which exists in every state, is prevalent among American Indians/Alaska Natives and Hispanic and black Americans, and is associated with poor pregnancy outcomes.

The Governors call on Congress and the President to help states identify populations at high risk for this disease; coordinate and disseminate research among high-risk populations; and promote an integrated approach among appropriate federal, state, and local agencies to facilitate these recommendations.

12.2.5 **Education.** The federal government has played a key role in helping states provide special educational services for economically disadvantaged and handicapped children. Without the Education Consolidation and Improvement Act and the Education for All Handicapped Children Act, states could not have begun to give adequate attention to children with special learning problems. States should endorse increased federal support for educating poor and disabled children and a strong federal commitment to civil rights enforcement and equal educational opportunity for children and youth. Beyond these issues, educational policy should be left to the states and localities, as reflected in the NGA policy statement on education (C-2).

12.2.6 **Child Welfare and Family Support.** States should place the highest value on enabling families to maintain the safety and well-being of their children at home by providing a variety of services—counseling, homemaker, child care, and alcoholism treatment, among others. In considering the removal of a child, states should base all decisions on the best interest of the child. NGA supports the permanency principles embodied in the Adoption Assistance and Child Welfare Act of 1980. States should give priority to developing alternatives to long-term foster care including services to prevent unnecessary placement, to reunite children with their families, and to encourage adoptive placement when returning home is not possible.

12.2.7 **Child Care.** States should seek a balance of public and private support for families who require child care for developmental, protective, special needs, or work-related reasons. While states have the responsibility to set standards and monitor program quality, the federal government should expand tax credits and provide increased monetary support for child care for low-income families. States should explore innovative mechanisms for private sector assistance.

12.2.8 **Housing.** The federal and state governments should assist in developing an adequate supply of housing for families with children that is affordable, safe, and sanitary. They should promote practices that discourage discrimination in housing and encourage the availability of housing for families with children.

12.2.9 **Youth.** Among the most worrisome group of children in American society are adolescents who have run away, who have been forced out of their homes by their parents, who have experienced unwanted pregnancies, or who have been abusers of alcohol and drugs. This population requires concerted attention by families, church, schools, and government at all times. NGA supports federal initiatives such as runaway youth, youth training and employment, and juvenile justice programs. Government at all levels should give priority to developing preventive, emergency, and remedial services designed for this age group.

12.2.10 **Working Parents.** Federal and state governments recognize and are sensitive to the problem that working parents face in balancing family and work responsibilities. Federal and state government should encourage personnel policies and fringe benefits that support families with children. Specifically, federal and state government should serve as model employer, encouraging the private sector to introduce flexible work scheduling and leave policies, opportunities for part-time work without the loss of fringe benefits, improved maternity, health and employee assistance benefits, and a reduction in the punitive effects and discriminatory nature of break-in-service personnel policies.

12.3 **Child Development Programs**

12.3.1 **Preface.** States and localities have borne the primary responsibility for preparing children and youth to become productive members of the workforce. In recent years, states have strengthened their commitment to educating children and preparing youth for the world of work by investing additional resources to improve their education programs. These educational reforms have improved the quality

of education, assisting states in attracting new industry in need of trained workers and providing a better quality of life for the next generation. Unfortunately, the investment in human capital being made in the area of education is being undermined by a growing number of problems that children are facing.

There are a number of factors, learning deficiencies, lack of school readiness, physical and emotional handicapping conditions, that cause children to enter school with skills far behind other children in the same age groups. Poverty is another key factor. In the United States, the wealthiest nation on earth, one in four children under five years of age is now living in poverty. All these children face a greater risk of becoming school dropouts, unemployed, welfare dependent, and delinquent, and have increased needs for special and remedial education programs. There is a national responsibility to our children for a sustained and systematic commitment to an investment in human capital through early prevention measures so that disadvantaged children and their families will have the opportunity to become productive members of the nation's workforce.

12.3.2 Federal Role. Projected future demographic change indicates a growing number of poverty-level children in the next decade. Demand for governmental assistance will continue. The federal government has an interest in and responsibility for the development of preventive measures and provision of assistance to this most vulnerable at-risk population. The social and economic costs of delaying assistance in preschool child development programs are potentially high.

A key component of the federal support for preschool child development has been provided through the Head Start program — serving three- to five-year-old disadvantaged children and their families with needed assistance in the areas of health, education, nutrition, parent involvement, and social services.

In preschool child development areas, the federal government has a responsibility for the following activities and functions:

- Set goals for the preschool child development programs;
- Develop, building upon the basis of available research findings, a set of national performance standards for program outcome for federally-funded child development programs;
- Assure equity and access to child development programs without regard to race, national origin, sex, or handicapping condition;
- Provide assistance to special populations who are "at risk" in standard educational and health and social service programs.

12.3.3 State Role. State government is the only unit of government that can marshal the critical and available resources in the human service areas at the state and local levels to make certain that various state-initiated and federal preschool child development efforts are well-coordinated and cost-effective. States can strengthen preschool child development programs through maximum utilization of the wide range of resources at their command, including health, social services, mental health, education, and nutrition programs.

In order to assure maximum utilization of all available resources, states should have the primary responsibility and authority to ensure that federally-funded child development programs are administered effectively in their states. Functions best carried out at the state level include:

- State-level planning of child development activities that should consist of an assessment of the population in need of services, including the appropriate ages to be served and the competencies of the staff providing such services, and a resource allocation based on these assessments;
- Monitoring and evaluation of child development programs to assure effective administration of these programs;
- Coordination of child development programs with other state human service programs.

In recognition of both the different ways state governments are organized and the need for maximum coordination of resources, these responsibilities are most appropriately coordinated within the office of the Governor.

It is recognized that service delivery of this program works most efficiently at the local level. Further, decisions about the appropriate mix of services to respond to children's needs are best made, with parent involvement, at the local community level. Society cannot afford the likely costs of postponing action in this important area.

Adopted August 1983, revised February 1986 and July 1990.

HR-27. PREVENTION OF TEEN PREGNANCY

27.1 PREAMBLE

THE NUMBER OF TEENAGERS AND ADOLESCENTS IN THE UNITED STATES WHO BECOME PARENTS HAS REACHED TROUBLING PROPORTIONS. EACH YEAR MORE THAN 1 MILLION TEENAGERS BECOME PREGNANT. EACH YEAR MORE THAN 500,000 YOUNG WOMEN BETWEEN THE AGES OF TEN AND NINETEEN GIVE BIRTH. THIS COUNTRY SPENDS \$25 BILLION EACH YEAR TO SUPPORT FAMILIES BEGUN BY TEENAGERS.

THERE IS ALSO A HUMAN COST TO YOUNG MOTHERS AND THEIR CHILDREN OF THIS EPIDEMIC. TEEN MOTHERS ARE MORE LIKELY TO BEAR CHILDREN WITH LOW BIRTH WEIGHTS. TEEN MOTHERS ARE LESS LIKELY TO FINISH SCHOOL, AND ARE LIKELY TO HAVE A LOWER-PAYING JOB THAN THEIR COUNTERPARTS WHO HAVE NOT BECOME PARENTS. CHILDREN OF TEEN PARENTS ARE AT GREATER RISK OF DOING POORLY IN SCHOOL. MANY FATHERS OF CHILDREN BORN TO ADOLESCENT GIRLS ARE MEN IN THEIR TWENTIES WHO ASSUME NO ONGOING RESPONSIBILITY FOR THEIR CHILDREN.

27.2 RISK FACTORS

CERTAIN RISK FACTORS MAKE IT MORE LIKELY FOR A YOUNG WOMEN TO BECOME PREGNANT AND GIVE BIRTH. SOLUTIONS MUST ADDRESS THESE RISK FACTORS.

- LOW INCOME. TEEN MOTHERS TEND TO COME FROM LOW-INCOME FAMILIES.
- HISTORY OF ABUSE. MANY TEEN MOTHERS HAVE A HISTORY OF BEING PHYSICALLY AND/OR SEXUALLY ABUSED.
- LOW SELF-WORTH. ADOLESCENTS WHO HAVE FEWER OPTIONS FOR THEIR FUTURE AND SUFFER FROM LOW SELF-ESTEEM ENGAGE IN MORE HIGH-RISK BEHAVIORS THAN THEIR COUNTERPARTS AND ARE MORE LIKELY TO BECOME TEEN PARENTS.

27.3 PREVENTION AS PART OF THE SOLUTION

BECAUSE TEEN PREGNANCY IS A COMPLEX ISSUE, SOLUTIONS MUST BE COMPREHENSIVE. PROGRAMS TO REDUCE TEEN PREGNANCY MUST DO MORE THAN EXPEND FUNDS ON ALREADY-PARENTING TEENS. WE MUST INVEST FUNDS

IN PRIMARY PREVENTION ACTIVITIES. PREVENTION EFFORTS MUST START BEFORE YOUNG PEOPLE BECOME SEXUALLY ACTIVE AND PROGRAMS SHOULD REACH BOTH YOUNG MEN AND YOUNG WOMEN.

PREVENTIVE PROGRAMS MAY BUILD ON ALREADY-ESTABLISHED EFFECTIVE STRATEGIES SUCH AS USING PEER EDUCATORS OR ADULT AND PEER MENTORS, AND REACHING HIGH-RISK ADOLESCENTS WITH A BROAD RANGE OF ACTIVITIES THAT DECREASE THEIR FREE TIME AND INCREASE THEIR LIFE OPTIONS, INCLUDING EDUCATION, COMMUNITY SERVICE, JOB TRAINING, FAMILY PLANNING, AND PARENTING EDUCATION, AS WELL AS ASSISTING WITH THE DEVELOPMENT OF A GREATER SENSE OF PERSONAL RESPONSIBILITY AND INCREASED SELF-ESTEEM.

THE GOVERNORS REQUEST THAT FEDERAL POLICIES AND LEGISLATION REGARDING HEALTH, WELFARE, EDUCATION, SUBSTANCE ABUSE, AND VIOLENCE EMPHASIZE THE CRITICAL ISSUE OF TEEN PREGNANCY PREVENTION.

Time limited (effective July 1994-July 1996).



January 27, 1994

Mr. Raymond Scheppach
Executive Director
National Conference of State Legislatures
444 North Capitol Street, N.W.
Suite 250
Washington, D.C. 20001

Dear Mr. Scheppach:

Enclosed are copies of the responses to the governors' administrative and legislative recommendations to improve the Medicaid program. One attachment addresses Medicaid program waivers, and the other responds to all other administrative and legislative recommendations.

We have developed these responses after convening a series of discussions between Department staff and representatives of the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL). We are very pleased that we have been able to respond positively to the majority of the concerns raised. We also believe that the benefits proceeding from the new channels of communication developed in this process will continue to accrue, as we work together to further the interests of Medicaid beneficiaries.

We have made considerable progress in our collaborative efforts to improve the administration of the Medicaid program. Further, we believe the President's Health Security Act provides the best vehicle for addressing the legislative concerns relating to the Medicaid program which were highlighted in the NGA's recommendations. Slowing the growth of State and Federal health care costs is a central goal of the Clinton Administration. We believe that this goal can best be accomplished through enactment of the key elements of the President's Health Security Act. However, where indicated in the attachments, the Department will support State-initiated proposals for Medicaid legislative changes in Congress.

Let me thank you again for NGA's contribution to the open and cooperative atmosphere which characterized the discussions

Page 2 - Mr. Raymond Scheppach

surrounding these documents. I am confident that this working relationship will carry over to successful implementation of health care reform.

I have sent a similar letter to William Pound, Executive Director of the NCSL.

Sincerely,



John Monahan
Director for Intergovernmental
Affairs.

Enclosures

DISCUSSIONS BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
AND THE NATIONAL GOVERNORS' ASSOCIATION (NGA)
ON ADMINISTRATIVE AND LEGISLATIVE RECOMMENDATIONS
TO IMPROVE MEDICAID PROGRAM WAIVERS

JANUARY 27, 1994

SUMMARY OF DISCUSSIONS

The HHS/NGA discussions to improve the Medicaid program helped to clarify States' concerns and to assist HHS in developing policies to meet States' needs. This paper summarizes the results of these discussions by topic area. Also, those issues which were resolved during the discussions process are identified, and action steps on issues needing further evaluation are described.

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1. RECOMMENDATIONS TO EXPEDITE THE APPROVAL PROCESS FOR BOTH HOME AND COMMUNITY BASED SERVICES (HCBS) AND FREEDOM OF CHOICE (FOC) WAIVERS BY DECREASING FORMAL REQUESTS FOR ADDITIONAL INFORMATION

NGA Proposals:

- A-1 Approval Process - The Health Care Financing Administration (HCFA) should be given one opportunity to identify all deficiencies and request clarifications in a waiver. HCFA currently has a process by which the entire waiver request is reviewed at each submission and items which may not have been identified as deficiencies in earlier submittals may be so identified later in the process.
- A-3 Presumption of Approval - Currently, HCFA has a bias toward denial of waivers. They should be instructed to approve waivers unless strong evidence exists that the waiver will be excessively expensive, limit the access of beneficiaries, or adversely affect the quality of care.

HHS Response:

HHS is committed to working with States to develop ways to ensure expeditious approval of both HCBS and FOC waivers. The following steps to further streamline the process are proposed:

- HCFA will continue to make only one formal request for additional information on waivers, as required by current law.
- HCFA will improve communications with States to minimize the need for, and the length of, formal requests of additional information. HCFA is committed to:
 - making increased use of early informal consultation to resolve issues on waivers under review;
 - accepting information on waivers in facsimile form; and
 - continuing to review draft submissions of waiver requests in an effort to assist States prior to formal submission of waiver proposals.

- HCFA will continue to improve its technical assistance by:
 - developing technical assistance guides on areas of specific interest in waivers; e.g., approaches to quality, client assessment instruments, etc.;
 - providing technical assistance during waiver development so that issues can be resolved prior to submission of the request;
 - awarding an outside contract to develop a clearinghouse of information on approved waivers;
 - providing training to regional office (RO) and central office (CO) staff to ensure a consistent approach to waiver issues.

- Since the formation of the MB, the HCBS waiver application and review process has been simplified and speeded up considerably. Between October 1981 and April 1990, 274 HCBS waivers were approved, an average of 32 per year. Between April 1990 and the end of FFY 1992, the average rose to 44; and in the past fiscal year alone, 53 waiver approvals were processed, 71% of them within 90 days of receipt. In the past 6 months, HCFA has stepped up efforts to build on the progress already made by:
 - In August 1993, published a guide to community-based care options under Medicaid, explaining the full range of services that may be provided in various settings under HCBS waiver programs.
 - In September 1993, issued to all State Medicaid Directors a streamlined HCBS waiver renewal format to supplement the streamlined format already in use for initial waiver applications.
 - In September 1993, conducted a 2-day waiver training session attended by regional office staff.
 - In October 1993, issued instructions to all regional offices removing the requirement for independent assessments of HCBS waiver programs, but preserving Federal financial participation (FFP) for States that voluntarily undertake such assessments.

-- At the October 1993 SMDA conference, HCFA staff conducted workshop sessions on HCBS waivers.

- As in the case of HCBS waivers, the FOC waiver process has experienced steady improvement since the establishment of the Medicaid Bureau. A sign of the growing efficiency of the FOC waiver process can be seen in the fact that the MB's small coordinated care staff were able to handle 71 such waiver requests in 1993, approving 51% of them within 90 days of receipt. These actions helped to boost total Medicaid managed care enrollment by 33% over the previous year. Additionally, the MB has either completed or agreed to undertake the following action steps to improve the FOC approval process:

-- In July 1993, issued all States a streamlined waiver application format for HMO programs operating on a prepaid risk capitation basis, together with revised PCCM application and renewal formats.

-- In July 1993, released to States a final version of the Phase 1 QARI end product, a published document entitled "A Health Care Quality Improvement System for Medicaid Managed Care - A Guide for States."

-- In September 1993, disseminated copies of a guide developed by the American Public Welfare Association (APWA) entitled "Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies."

-- In September 1993, disseminated copies of a second APWA publication entitled "Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement."

-- At the October 1993 SMDA Conference, HCFA staff conducted workshop sessions on FOC waivers.

2. RECOMMENDATIONS ON HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

A. Simplification of the Waiver Formula and the "Cold Bed" Test

NGA Proposal:

A-11 Cold-Bed Rule - HCFA should develop a policy that moves away from the "cold-bed" analysis to control costs and move toward cost control projections and managed care analysis in order to determine cost effectiveness.

A-14 Waiver Formula - Simplify the waiver formula and the measures used in the formula. Many of the measures are extremely difficult to project in a manner that is acceptable to HCFA.

HHS Response:

Since 1985, Federal regulations have implemented the statutory requirement that the HCBS waiver program be cost-neutral through the use of a formula with 14 data elements. The formula has been used to demonstrate that serving persons in HCBS waiver programs is no more costly than providing care in institutions.

Associated with the waiver formula in examining cost-neutrality is the so-called "cold bed" or bed-capacity test. This requires that States prove that they would have the institutional capacity to place all persons served by the waiver in an institution. This requirement allowed States to claim cost savings by diverting the individuals from such care. It has served as the principal impediment to the growth of the HCBS program.

HHS believes the current waiver formula could be reduced from 14 elements to 4. Moreover, because the remaining four waiver formula elements (plus a fifth quantitative element outside the formula) are consistent with the definitions of existing data elements, no new State data collection would be required. Basic data to support cost-neutrality would be obtained through this approach.

HHS also proposes to eliminate the "cold-bed" test, substituting instead the acceptance of reasonable State assurances that the average per capita cost of Medicaid services under the waiver does not

exceed the average per capita cost of Medicaid services without the waiver.

These changes to the waiver formula will be implemented through the HCBS proposed regulation under development. This approach would:

- Decrease the amount of data collected and reported by States, and improve the review process at HCFA.
- Require no additional data collection or systems changes on the part of the States.
- Remove the necessity of States having to get involved in plans for constructing more nursing facility beds, merely for the purpose of demonstrating that a HCBS waiver is cost effective.
- Allow resources to be redirected to more effective technical assistance to States and related programmatic goals.
- Allow HCFA to project waiver costs, but offers some budget protection to States by limiting their exposure for serving waiver clients beyond their annual budget projections.
- Possibly result in a modest cost increase in the Medicaid program. (We believe that, generally, States will not develop waivers unless they are cost-effective. But, there could be exceptional cases where some shifting from State to Federal funding occurs.)

B. Proposals Which Further Streamline the HCBS Waiver Administrative Process

NGA Proposal:

- A-12 **General** - Issue regulations or expedite waivers that encourage the use of less costly home and community-based waivers rather than institutional care for older and disabled people.
- A-13 **Service Package** - HCFA should expand the types of non-institutional services that might be allowable under a 1915(c) waiver.
- A-15 **Re-application** - Waivers should be approved for the full duration allowed under the statute without the

need for re-application. The annual HCFA 372 reports, federal reviews, and the requirements of formal amendments for change offer sufficient ongoing control and oversight by HCFA for waivers. Verifiable waiver values for the formula could be recalculated on a periodic schedule.

HHS Response:

NGA recommendations A-12, A-13, and A-15 proposed to expedite the administrative processes for HCBS waivers, to clarify types of services available under waivers, and to expedite the HCBS waiver re-application process. In response to these proposals, HHS will implement the following steps:

1. **Administrative Streamlining** - HCFA will further expedite the processing of 1915(c) home and community-based waivers by:
 - finalizing revised regulations on 1915(c) waivers, including provisions to delete the "cold bed" test and ease the complexity of the waiver formula;
 - disseminating the streamlined waiver renewal format to States in September 1993;
 - further refining the streamlined waiver format currently used by many States;
 - developing a streamlined data collection form for reporting annual costs of approved waivers; and
 - continuing to provide technical assistance to States developing new waivers, waiver renewals, or waiver amendments.

2. **Clarify State Flexibility on Services Covered Through the HCBS Waiver Program** - Discussions with the NGA revealed that there is considerable confusion on the degree of State flexibility to cover services under HCBS waivers. HCFA will issue an "All States Letter" to further clarify that States already have considerable flexibility to add service definitions in their HCBS waivers.

Additionally, consensus was reached that current levels of State flexibility were sufficient and that HCFA should continue to work to assure that

services proposed by States are consistent with Medicaid HCBS program objectives.

3. **Make Requirement for Independent Assessment Optional** - Although not a formal NGA recommendation, based on our discussions with the NGA, HHS now proposes to eliminate the requirement for an independent assessment of State waiver performance. To implement this proposal, the regulations currently in process will be revised.

To assure that States have the flexibility to contract for an independent assessment and obtain FFP, the regulation will be revised to eliminate the independent assessment requirement, but reaffirm (in the preamble to the regulation) the availability of FFP for such assessments when voluntarily undertaken by the State.

C. Proposals to Develop "Prototype" Waiver Formats for Selected HCBS Waivers

During the discussions with the NGA, several State representatives expressed an opinion that the development of a standardized or prototype waiver format, to be available but not mandated for selected types of waivers, would help facilitate the waiver application process.

HHS Response:

HCFA will convene work groups with States to develop prototype initial and waiver application formats for the following target groups:

- Traumatic Brain Injury (Lead State consultant: New Jersey)
- AIDS (Lead State consultants: Colorado, California)
- Medically Fragile Children (Lead State consultant: Nebraska)

D. Proposals to Convert HCBS Waivers to State Plan Amendments (SPAs)

NGA Proposal:

- A-39 Waivers - States should have the ability to turn waivers into permanent plan amendments once they have been proven effective. (Although listed by NGA as an administrative change, this would require legislation.)
- L-1 Waiver to State Plan I - Once a state has demonstrated through the waiver process that the program is effective and efficient, the waived program should become a part of the state's plan.
- L-2 Waiver to State Plan II - Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional service without having to submit a waiver.
- L-8 Elimination of Waiver - Within limits, states must be given the authority to establish home and community based care programs under the state plan amendment process.

HHS Response:

NGA recommendations A-39, L-1, L-2, and L-8 proposed that HCBS waivers be converted to an SPA process. During HHS' discussions with the NGA and with the Non-institutional Long-term Care TAG, it was agreed that these changes requiring legislative action should be deferred. This decision was made, not only because of the likelihood of changes to the Medicaid program during health care reform, but also because of the progress made during the NGA-HHS discussions. These resulted in an agreement to proceed with many positive administrative and regulatory changes to the HCBS waiver process.

3. NGA RECOMMENDATIONS ON FREEDOM OF CHOICE (FOC) WAIVERS

A. Improve Standardized Application Format and Process

NGA Proposal:

A-8 Other State Experience - Consider 1915(b) waiver requests to be cost-effective if they include reasonably understood managed care principles, modeled after managed care plans which have received prior approval from HCFA, or have demonstrated cost containment in actual practice nationally.

HHS Response:

In NGA's recommendation A-8, it was proposed that HCFA allow States to use other States' experience with managed care plans that have been approved by HCFA in determining cost effectiveness.

HHS has accepted this recommendation, and finds that it corresponds to current Federal practice. On pages 16 through 18 of the streamlined waiver application for initial primary care case management programs, issued November 25, 1991, HCFA informed States that it was acceptable to demonstrate the cost effectiveness of new programs by using the experience of another State's program. HCFA requests that States specify the similarities of their programs to the other State's program. Of course, for renewal of these programs, States would continue to document cost effectiveness using the experience and data from their own programs.

NGA Proposal:

A-9 Pre-determined Approval Criteria - HCFA should continue and expand its efforts to develop pre-approved waiver packages with standard elements for target populations. HCFA should actively assist states in making application and obtaining approval of such applications.

HHS Response:

NGA's recommendation A-9 proposed that HCFA continue and expand its efforts to develop pre-approved waiver packages.

HCFA has already implemented this recommendation and has previously issued two streamlined waiver

applications: one for initial primary care case management programs (on November 25, 1991), and the other for renewal of primary care case management programs (on June 19, 1992). On July 26, 1993, HCFA issued a streamlined waiver application for capitated programs, and revised the initial and renewal applications, as well.

NGA Proposal:

L-7 Waiver Duration 1915(b) waivers should be approved for an initial three year period with five year renewals.

HHS Response:

In legislative recommendation L-7, the NGA proposed that waiver approval be extended to 3 years for initial programs and 5 years for renewals.

HHS agrees that legislation should be enacted to extend the period of approval for freedom of choice waivers from 2 years to 3 years for initial programs and 5 years for renewals. HCFA has previously made efforts to effectuate this change, but has been unsuccessful. Those efforts will continue with NGA assistance.

B. Remove Impediments to State Contracting with HMOs

NGA Proposal:

A-10 Freedom of Choice in Managed Care - Specify in regulations that, under certain limited circumstances, a 1915(b) program can limit client choice to one HMO in an area rather than current requirements of two. Permissible circumstances might be in rural areas for example. (Although listed by NGA as an administrative change, this would require legislation.)

L-5 Rural Areas - Permit states to use single source contracting or a single managed care entity in rural areas.

HHS Response:

In recommendations A-10 and L-5, the NGA proposed that States be allowed to limit client choice to

one HMO in rural areas. HCFA currently allows States to use the freedom of choice waiver authority to restrict Medicaid recipients to one HMO in a geographic area. For example, HCFA approved such a restriction in one county in a Wisconsin waiver program. However, because the freedom of choice waiver authority does not permit States to waive the HMO requirements, recipients retain the right to disenroll and States are required to have an alternative provider network available into which recipients can disenroll. HHS would support a legislative change, based on the NGA recommendations, to mandate enrollment into a single HMO in rural areas if there is only one HMO available to serve Medicaid recipients. Rural areas, and any conditions would be defined through the legislative and regulatory process.

NGA Proposal:

L-3 Continuous Eligibility - Allow one month continuous eligibility to participants in managed care plans to ease the administrative burdens on states and health plans caused by late income reports from clients.

HHS Response:

In legislative recommendation L-3, the NGA proposed that States be allowed to offer one month of continuous eligibility for clients enrolled in managed care plans. HHS supports a legislative change which would allow one month of continuous eligibility for recipients in managed care plans to ease the administrative burdens on States and health plans caused by late income reports from clients.

NGA Proposal:

L-6 75/25 Rule All health maintenance organizations should be able to participate in managed care regardless of whether they elect to accept commercial enrollment in addition to Medicaid enrollment.

HHS Response:

In legislative recommendation L-6, NGA proposed to eliminate the 75/25 enrollment composition rule which requires that at least 25 percent of the enrollees be commercial-based.

HCFA believes that the 75/25 enrollment composition rule is not the best proxy for quality of care furnished in an HMO. HCFA has completed a quality assurance reform initiative to identify appropriate ways to measure quality of care. All States have recently received a copy of these guidelines, and an evaluation in three States is underway. Thereafter, HCFA will support state proposals which rely on adequate quality assurances as a rationale for relaxing or eliminating the 75/25 rule.

C. Change Waivers to State Plan Amendments

NGA Proposal:

- L-1 Waiver to State Plan I - Once a state has demonstrated through the waiver process that the program is effective and efficient, the waived program should become a part of the state's plan.
- L-2 Waiver to State Plan II - Once a state has demonstrated through the waiver process that the program is effective and efficient, other states should have the opportunity to make that program a part of their state plan as an optional service without having to submit a waiver.
- L-4 Elimination of Waiver - Within limits, like some of those identified in the Moynihan managed care legislation, states must be given the authority to establish managed care programs under the state plan amendment process.

HHS Response:

In recommendations L-1, L-2, and L-4, NGA proposed that within certain limits, waivers be converted to State plan amendments.

The traditional focus of Medicaid oversight has been on service utilization monitoring. HCFA believes that the focus of managed care plans should be access to quality care furnished in a cost-efficient manner.

HCFA has completed a quality assurance reform initiative to identify appropriate ways to measure quality of care. All States have recently received a copy of these guidelines, and an evaluation in three States is underway. Thereafter, HCFA will support legislation to convert capitated FOC waivers to SPAs and will support state proposals which rely on adequate quality of care mechanisms.

HHS supports a legislative change which would permit States to operate non-capitated primary care case management (PCCM) programs through State Plan Amendments (SPAs) rather than as freedom of choice waivers. Under such a proposal, a PCCM program that has been operating under a FoC waiver and has undergone at least one waiver renewal process would not be subject to further HCFA review prior to converting to an SPA. Newly developed PCCM programs or FoC waivers in their initial waiver period would be subject to a HCFA focused review of access and quality factors in order to operate as an SPA. A PCCM program could be less than statewide, or apply only to a specific population within the State.

DISCUSSIONS BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
AND THE NATIONAL GOVERNORS' ASSOCIATION (NGA)
ON OTHER ADMINISTRATIVE AND LEGISLATIVE
RECOMMENDATIONS TO IMPROVE THE MEDICAID PROGRAM

JANUARY 27, 1994

SUMMARY OF DISCUSSIONS

The HHS/NGA discussions to improve the Medicaid program helped to clarify States' concerns and to assist HHS in developing policies to meet States' needs. This paper summarizes the results of these discussions by topic area. Also, those issues which were resolved during the discussions process are identified, and action steps on issues needing further evaluation are described.

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1. EPSDT

NGA Proposals:

A-24 EPSDT - Service Flexibility - Give States flexibility and reduce their fiscal exposure by making optional some of the more expansive regulatory interpretations of EPSDT that require States to provide services not covered by their Medicaid State plans.

L-12 EPSDT - Scope of Services - Allow States to specify the extent to which States can limit the scope of Medicaid reimbursed services covered as a result of EPSDT screens.

HHS Response:

Recommendations A-24 and L-12 reflect States' concerns regarding the degree of State flexibility in the EPSDT program. The discussion focused on the level of State flexibility allowed in the current NPRM and in interim policy until regulations are published. (The NPRM was published in the Federal Register on October 1, 1993. The comment period closes on November 30, 1993.)

Discussions with the NGA concluded that some of the States' concerns may have been based on lack of information on the degree of flexibility States currently have in implementing their EPSDT programs. To deal with NGA recommendation A-24, the Medicaid Bureau issued an All-States letter on May 24, 1993. This letter emphasized the flexibility States have in applying medical necessity criteria, including the use of cost comparisons of alternative forms of treatment, to determine the scope of services provided under the EPSDT program.

Even with this policy clarification, States expressed the desire to limit the scope of Medicaid services even further, perhaps limiting EPSDT services to only those covered in their State plan. This would require legislative changes as outlined in recommendation L-12. HCFA cannot support this legislative proposal.

We understand that States feel that an obligation to pay for all medically necessary treatment services for children can place them in a budgetary dilemma whereby they may have to forego coverage of some optional Medicaid services or populations. Nevertheless, we believe that in matters concerning EPSDT, as well as other statutorily required services, the Federal government has a role in assuring that those required services are covered.

NGA Proposals:

A-25 EPSDT - Screening Rates - In order to meet the goal of having 80 percent of EPSDT beneficiaries screened, HCFA must remove the barriers which limit the use of schools as a place for screening.

A-26 EPSDT - Free Care Policy - Current HCFA policy prohibits reimbursement for services when those services are otherwise provided free to the public. This policy will limit the ability of States to establish Medicaid reimbursable EPSDT screening programs in schools since the schools give free care.

HHS Response:

This issue will be dealt with in the context of health care reform. The President's Health Security Act includes authorization for increased funding to establish school-based health clinics and to fund services.

In the discussion of school-based services (NGA recommendations A-25 and A-26), the Medicaid Bureau further reinforced its support of school-based programs and described its work on removing barriers, to the extent that the law permits, in the development of school-based programs. The Medicaid Bureau will continue to discuss with NGA the development of a free-care policy with the goal of excluding schools from any restrictions, if permitted under present law. A work group was formed in January 1994 with HCFA staff and three State Medicaid Directors to examine these issues.

2. AUDITS AND DISALLOWANCES

NGA Proposals:

A-21 Audits and Disallowances - Refocus Audit Efforts - HCFA should refocus its audit efforts on areas of substantial costs and potential abuse. The current emphasis is on technical audit exceptions that become extremely time consuming and costly for States. HCFA should be prohibited from its practice of penalizing States for violations that have no direct harm to patients.

L-9 Technical Disallowances - Enact Federal legislation to prohibit Federal disallowances for minor technical noncompliance issues or infractions that do not involve any serious allegations of harm to patients.

HHS Response:

HHS shares the States' concern that the size of a disallowance often seems out of proportion to the significance of the State violation. This occurs because HCFA is charged with ensuring State compliance, and has no choice but to disallow all Federal funding related to a violation. The Departmental Appeals Board (DAB) likewise must sustain or reverse the disallowance in its entirety, on appeal.

We do not agree, however, that penalties should be limited only to violations that directly harm patients. The Federal government could not responsibly oversee the Medicaid program if it lacked the threat of disallowances for such violations as unauthorized or inappropriate payments.

Proposals for basing the magnitude of disallowances on the seriousness of the violation were considered by Congress this year. HHS supports this concept and provided extensive technical assistance to Hill staff to develop acceptable language. This proposal was included in section 1668, introduced by Senator Moynihan on November 17, 1993.

3. TRANSFER OF ASSETS AND MEDICAID QUALIFYING TRUSTS (MQTs)

NGA Proposal:

A-30 Transfer of Assets - The Secretary should undertake a national study of the potential of the TEFRA lien and transfer of assets issue in general. This would allow for the development of federal policy that States could implement to identify an obvious attempt to transfer assets in order to gain eligibility for long-term care benefits under Medicaid.

L-18 Transfer of Assets - Tighten the transfer of assets statutes so that individuals would be penalized for transferring income, resources, and even the right to receive income and resources. Individuals who make disqualifying transfers should be ineligible for all Medicaid covered services and would remain ineligible until they incur the liability or pay for services themselves, in an amount equal to the amount they transferred away. Penalty periods should be imposed consecutively, not concurrently, for multiple transfers.

HHS Response:

Three separate studies of this issue are currently in the planning stages. One study will be conducted by the General Accounting Office (GAO), one by the Office of the Inspector General (OIG), and one by HCFA's Office of Research and Demonstrations (ORD). HCFA continues to support these efforts and will share information with the NGA, as soon as data are available. It is anticipated that the full GAO study will be completed in July 1995. Results of a GAO field study conducted in Massachusetts were issued in 1993, with further field work to be undertaken. ORD's study will begin in February 1994 and should be completed within 6 months. OIG's study is also at the starting point and will be completed by September 1994. It was agreed during the April 6, 1993 meeting with the NGA that an additional study is not necessary.

Additionally, OBRA 93 contains requirements to further tighten transfer of assets laws. States have the option to make individuals who make disqualifying transfers ineligible for a greater number of services, but not all services. The law also requires consecutive penalty periods for multiple transfers, and provides for longer penalty periods. Implementing instructions and regulations are under development.

NGA Proposal:

L-13 Medicaid Qualifying Trusts - Federal requirements on Medicaid qualifying trusts are too liberal. As a result, individuals who have sufficient resources to pay for some or all of their long-term care are able to shield income and resources from the eligibility process.

HHS Response:

In response to the concern that Medicaid would be less able to serve the truly poor if public funds were diverted to the artificially poor, Congress enacted a provision in 1986 to restrict eligibility for persons with MQTs. States have received HCFA guidance while the MQT regulation is under development. The current draft regulation interprets the statute as stringently as it can (and more stringently than already published guidelines), prohibiting many of these trust arrangements.

OBRA 93 contains provisions which considerably tighten trust loopholes. The Medicaid qualifying trust provision is replaced by provisions which deal, in a much more specific manner, with a broader range of trust arrangements. Implementing instructions and regulations are under development.

4. **PRESCRIPTION DRUGS**

NGA Proposal:

A-33 Prescription Drug Program - Prior Authorization -
Assure that States may still use prior authorization as a cost containment mechanism for prescription drugs. This can be accomplished by giving States the authority to expand the list of drugs subject to restriction under section 1927(d)(2) of OBRA 90. States should also be allowed to make prior authorization decisions based on the cost of the drug.

HHS Response:

Neither OBRA 90, nor instructional material we have issued subsequent to the law, preclude the use of the cost of the drug from being considered in deciding whether the drug should be on a list to be prior authorized. When a State is making a decision to grant an authorization for a drug, it is permissible for the State to consider whether a substitute drug could meet the medical necessity test, yet be furnished more cheaply. We believe that a proper prior authorization system can also serve as a cost containment mechanism for the States' Medicaid prescription drug programs.

We note that OBRA 93 lifted the prohibition on a formulary. States are free to restrict or exclude the coverage of a specific drug or class of drugs in the manner described in OBRA 93.

NGA Proposal:

A-34 Prescription Drug Program - New Drugs - Assure that the definition of "new drugs" in the Medicaid program is assigned only to drugs that are new chemical or molecular entities.

L-23 New Drugs - States should not be required to cover new drugs in their prescription drug programs beyond those normally covered under 1396(r-8)(d)(2). [This reference is confusing; section 1927(d)(2) is the list of permissible restrictions, and States are allowed to exclude new drugs if they fall within one of the listed categories.]

HHS Response:

The issue is moot based on the OBRA 93 provision to permit States to use closed formularies within the terms of OBRA 93. New drugs are also no longer exempt from the States' prior authorization system, based on another OBRA 93 change.

NGA Proposal:

L-22 Prescription Drugs - Formularies - Repeal the OBRA '90 statutory provisions that prohibit States from using formularies in the management of their Medicaid programs.

HHS Response:

OBRA 93 removed the prohibition on State use of formularies as described in that law.

5. NURSING FACILITIES / NURSE AIDE TRAINING / PASARR

NGA Proposal:

- A-29 Enforcement Regulations for Nursing Facilities - The proposed enforcement regulations to implement the statute are unrealistic. They put the States at risk of loss of funds for circumstances beyond their control and promote an adversarial relationship between surveyors and providers that will be a barrier to the improvement of care.
- A-32 Survey and Certification - Long Term Care (LTC) Process -The survey and certification process has become overly long and cumbersome for State agencies. As a result, deficiencies are not being identified adequately.
- L-15 OBRA 87 Enforcement - The enforcement statute of OBRA 87 defines deficiencies too broadly. Each deficiency, no matter how minor, requires a remedy. The determination of deficiencies requires some form of scope and severity index to assure that limited State resources are directed to the enforcement of the most egregious deficiencies.

HHS Response:

In response to items A-29, A-32, and L-15, HCFA and the NGA agreed to revitalize the Institutional Long-term Care Technical Advisory Group (TAG) to consider a variety of survey, certification, and enforcement issues and other issues in both nursing homes and ICFs/MR. A more detailed summary of NGA and HCFA discussions on some of these issues is presented below.

The TAG will consider what relief may be provided via regulation or other guidance and what statutory changes may be needed. Membership of the TAG will be comprised of HCFA representatives, five State Medicaid representatives, and five survey and certification representatives. The TAG will draw on expertise from other agencies as needed. Should legislative solutions be proposed by the TAG, policy guidance would be needed to ascertain whether HCFA would advance these proposals. (HCFA is working to finalize the TAG group membership and meeting schedule.)

In discussions with HCFA, States explained their concern about the absence of final survey, certification, and enforcement regulations. States indicated that the absence of such regulations created difficulties in establishing consistent survey, certification, and enforcement practices and subjected States to disallowances. Also, States believe that such disallowances absent regulation are unreasonable and unfair. Additionally, States are concerned that

absent final regulations, they are vulnerable to lawsuits regarding implementation of the interim nursing home survey process. HCFA is now finalizing the regulation on the survey, certification and enforcement regulation of SNFs and Nfs. HCFA expects that the final rule will be published early next year.

In response to recommendation A-29, negotiations with NGA have clarified States' concern that statutory requirements place States at financial risk for Federal dollars received should Medicaid nursing facilities fail to correct deficiencies during a period of correction. States believe it is unreasonable to hold States responsible for circumstances they assert are beyond their control. HCFA has discussed these issues with States and is fully aware of the States' concerns. State issues will be taken into consideration when finalizing the regulation.

With respect to a variety of survey, certification, and enforcement issues, HCFA's Health Standards and Quality Bureau (HSQB) indicated that it will soon issue policy guidance to States and HCFA regional offices that consolidates a series of Questions and Answers developed in the past by HSQB. A draft State Operations Manual transmittal, which consolidated these questions and answers, was presented to the Association of Health Facility Survey Agencies (AHFSA) board for review and comment on July 29 at HCFA's annual survey and certification leadership conference. Because the publication of the final survey, certification and enforcement rule is imminent, only final instructions will be issued when the final rule is published. In addition, both States and HCFA agreed that the issuance of final survey, certification, and enforcement regulations should be a top priority and to not engage in any activities that could slow the promulgation of this regulation.

HCFA and the NGA agreed to convene a work group to further discuss provisions in the proposed survey, certification, and enforcement regulation to identify where administrative flexibility exists and when requirements are established due to statutory provisions. The first meeting of this work group was convened on June 26, 1993. In this meeting, States expressed concern about the statutory provision that requires a reduction in Federal payment of administrative costs should a State's survey performance be found to be substandard.

With respect to recommendation A-32, States also indicated that the required survey documentation is excessive and proposed an alternative option. Under

the States' survey approach, "good facilities" would be subject to an abbreviated survey and monitoring process.

During this work group meeting (and earlier NGA/HCFA negotiations), HCFA reported on various internal and external evaluations of the survey process that are presently underway. These evaluations are expected to be helpful in assessing areas in need of improvement in the survey process. HCFA shared the results of these evaluations with State representatives and discussed how needed improvements may be realized at the HCFA annual survey and certification leadership conference on July 27, 1993. In addition, a Federal/State work group was formed to develop and oversee pilot testing of survey improvements. To date, three meetings have been held.

During the June 26 meeting, with respect to recommendation L-15, States expressed concern that determinations of deficiencies are inconsistent. To deal with potential inconsistencies with deficiency determinations, HCFA is developing review protocols to improve consistency and is assessing its mechanisms for training surveyors. A work group of State, customer, and Federal representatives are conducting the training assessment which is scheduled for completion in December 1994.

In addition, States were concerned about the lack of criteria that could be used to determine which penalties should be imposed as a result certain deficiencies. Standardization of the survey process and the use of criteria concerning the imposition of penalties would promote consistency in survey, certification, and enforcement. HCFA is fully aware of the States' concerns and will take them into consideration when finalizing the regulation.

States suggested using some standard measure of scope and severity to determine deficiencies and penalties. In addition, States suggested the use of a total quality management program in the survey process. In response, HCFA reported on the progress of surveyor training designed to promote consistency in the survey process and determination of deficiencies.

NGA Proposal:

L-14 Nurse Aide Training - The current nurse aide training statute disqualifies a facility from giving training for 2 years if the facility has any deficiency. This is too tight a restriction and creates a real burden in rural areas. The limitation on training should be imposed only if the deficiency relates to quality of care.

HHS Response:

States expressed concern that current prohibitions on the approval of nurse aide training programs were too restrictive and created a shortage of trained nurse aides in rural areas. States expressed concern that the FY 94 Energy and Commerce provision on nurse aide training fails in its attempts to limit the prohibition on the approval of nurse aide training programs. HHS agreed and noted that HCFA staff had developed alternative language that would limit this prohibition. HCFA issued the policy revision in July 1993.

HCFA and the NGA agree that the revitalized Institutional Long-Term Care TAG could examine the prohibitions on approval of nurse aide training programs. Issues to be considered include how such prohibitions could be limited, and to what extent rural nursing homes could be provided relief from these requirements. Consideration would be given as to how to effect changes via guidance, regulation, and/or legislative proposals.

The revitalized Institutional TAG is expected to initially meet in Summer '93 and subsequently thereafter to discuss these and other issues.

NGA Proposal:

L-16 PASARR - The PASARR statute should be rewritten to give States the flexibility, at the discretion of the Secretary, to establish more cost efficient preadmission screening and resident review procedures.

HHS Response:

States expressed concern about the utility and cost effectiveness of the preadmission screening and annual resident review (PASARR) requirements applied to mentally ill or mentally retarded individuals residing in or applying to nursing facilities.

HCFA and the NGA agreed that further discussion is needed between HCFA, NGA, APWA, and representatives in the Department of HHS. It was agreed that a group consisting of these interested parties will meet to evaluate the utility, cost-effectiveness, and expanded application of PASARR requirements. Further, this group will determine what desired changes could be achieved under current law and those that would require statutory modification. HCFA and the NGA agreed to defer resolution of this issue until this group completes its review.

Should legislative changes be recommended, policy guidance would be needed as to whether the Department should pursue such changes.

6. MEDICAID PROGRAM REPORTING REQUIREMENTS

NGA Proposal:

A-18 Medicaid Program Reporting Requirements - HCFA must reduce its reporting requirements for States beyond those of the HCFA Form 37. Specifically,

18a. Eliminate reporting related to specific reimbursement rates--

HHS Response:

This form was mandated by OMB as an outgrowth of the Budget Estimating Initiative (BEI) to track changes in reimbursement rates for some common procedures. States have had problems capturing the information and we have not specifically used the information. We would agree to eliminate the form and discussed this with the BFM-TAG at the meeting in Baltimore on June 28 and June 29. The BFM-TAG members also agreed that the form was very labor intensive and did not provide comparable data across States. They also agreed that the form should be eliminated. We have proposed eliminating the form to OMB.

18b. Eliminate the "survey" reporting requirements related to DSH adjustments to hospital rates (HCFA Form 37.13)

HHS Response:

Currently, HCFA is using a significantly revised HCFA 37.13 which was developed in consultation with the States, and has received OMB approval for 6 months. HCFA will continue discussion on the content of the form with OMB and the States during the next 6 months.

18c. Eliminate all on-line submission of narrative data

HHS Response:

We cannot agree to this proposal. Given the volume of information we receive, the tight timeframes for the budget and grant award process, and the limited staff resources, we are unable to accept manual submission of data and information. We sampled several States (including those which submit the most detailed budget submissions) and most of these States take only about 1.5 to 2.5 hours to submit the entire budget package on-line. We believe that this amount of effort, only once every quarter, is not an undue burden on the States. We would be willing to work with individual States on specific problems that are identified.

The NGA acknowledges HCFA's position and agreed to help identify States that many require assistance. During

the BFM-TAG meeting, we initially identified three States which needed assistance and we have scheduled trips to Georgia, South Carolina, and Washington. Georgia, South Carolina and Washington on-site technical assistance trips have been completed.

- 18d. Accept narrative data in a format consistent with a State's budgeting process

HHS Response:

We cannot agree to this proposal. One of the main problems that was identified during the BEI is that we did not have any consistency in our budgeting information. Thus, working with the State TAG representatives and the national organizations, we were able to develop a budget reporting process and format that is consistent with the best Medicaid budgeting practices in the States. We believe that to accept narrative information and data on a State specific basis, inconsistent with the national format, would be a significant step backwards in this process of improving the overall Medicaid budget estimates.

The NGA acknowledged HCFA's position.

- 18e. Eliminate on-line HCFA-37 submission until such time as HCFA is able to install computer systems with reliable and responsive software

HHS Response:

We cannot agree to this proposal. Given the vast amount of information we are processing, and the intense scrutiny and use of this information by all types of users, we cannot possibly move back to a manual paper submission of information--even for some States. We could not meet any of our deadlines or information requests if we had to process everything manually. While we acknowledge that, at any given point in time, there may be problems with an individual State using the system (given the size of the system and the size of the data base involved), we have provided on-site training to all the States and the ROs. We have gone on-site to States with specific problems and worked with them individually, and will continue to do this whenever specific problems are identified. Also, during the 2 weeks prior to, and the 2 weeks after, the deadline for any submission, central office staff, the ROs, contractor staff, and the HCFA Data Center staff are on-call to immediately address any problem that arises. Overall, we believe the system is responsive and reliable, given the magnitude of the system itself. We, of course, are always open to specific suggestions for improvements and we discussed this at the BFM-TAG meeting. We are looking

into several suggestions made by the BFM-TAG and we completed four on-site State visits during 1993 to assist States with systems problems they were encountering. At the next BFM-TAG meeting in February 1994, the results of those State visits will be discussed and a determination will be made if further improvements are needed.

The NGA acknowledged HCFA's position.

7. STATE PLAN AMENDMENTS (SPAs)

NGA Proposals:

- A-17 Regional Differences - Establish procedures that would result in more regional uniformity in the approval of plan amendments and waivers. Currently, differences among regional offices result in substantive differences among State programs.
- A-36 State Plan Amendment Approvals - Expedite final approval for all State plan modification requests no more than 90 days from the date of request, including time required for request for clarification or required analysis.
- A-37 State Plan Amendment Approval Process - HCFA should be given one opportunity to identify all deficiencies in a SPA and then should be allowed only to consider the deficiencies once the State responds. HCFA currently has a process by which the entire plan amendment is reviewed at each submission, and items which may not have been identified as deficiencies in earlier submittals may be so identified later in the process.
- A-38 State Plan Amendments - Other States Experience - Presumptively approve any SPA modeled after any SPA having already received approval by HCFA and actively assist States in identifying and preparing such amendments.

HHS Response:

In response to NGA recommendations A-36 and A-37, HHS explained that current law provides for two 90-day time periods for HCFA to review SPAs. Given resource constraints it is not possible for HCFA to process all SPAs within one 90-day period. However, HCFA central and HCFA regional offices will work as closely as possible with States to resolve problematic issues in amendments, either prior to submission or during the first 90-day timeframe.

To improve the overall SPA process, HCFA will improve communications with States to minimize the need for, and the length of, formal requests of additional information. HCFA is committed to:

- making increased use of early informal consultation to review new State proposals and to resolve issues on SPAs under review;
- accepting information on SPAs in facsimile form and on a pilot basis, PROFS, (March 1, 1994 is the anticipated start-up date for the use of PROFS),;

- continuing to work with States to develop draft submissions of SPAs in an effort to assist States prior to formal submission of SPA proposals; and
- conducting conference calls with HCFA regional offices and States to resolve issues prior to formal submission of SPAs.

Additionally, HCFA will continue to improve its technical assistance to States by:

- providing technical assistance during SPA development so that issues can be resolved prior to submission of the request;
- providing training to regional and central office staff to ensure a consistent approach to SPAs. These training sessions will be conducted during the regularly scheduled bi-weekly conference calls with regional offices and in special training sessions on issues where States have specific concerns or program needs.

In response to recommendation A-17 to improve consistency in SPAs approval nationwide, States agreed to inform their associated HCFA regional offices when an SPA is modelled after another State's approved plan. When one HCFA regional office learns that another regional office has approved a plan amendment containing the same substance as the one under consideration, the regional office will raise the issue to the central office for resolution. This will help to improve consistency in the approval process across all regions.

With regard to presumptive approval of SPAs modelled after another State's program, (NGA recommendation A-38), it was agreed that States working jointly with the regions would help to expedite the approval of these types of State programs. Using this approach, it is HCFA's intent to improve interregional consistency on State plan approvals. In addition, HCFA is planning a conference with State and Regional office personnel to discuss possible inconsistencies with institutional plan amendments that may exist and to develop steps to resolve any regional variations.

8. ELIGIBILITY ISSUES

NGA Proposals:

- L-10 Eligibility Categories - Simplify eligibility by collapsing existing categories and optional groups where appropriate. The great number of eligibility categories is administratively complex and leads to worker errors in which individuals are inappropriately found ineligible and services are denied.
- L-11 Pregnant Women and Children - Modify the Medicaid statute so that a State that chooses the option to provide benefits in excess of 133% of poverty for pregnant women and infants may, for its own policy reasons, reduce the percentage to some other level, but not less than the mandated 133%.

HHS Response:

These proposals should be deferred within the broader context of health care reform and other program simplification efforts. Although advanced originally as an administrative simplification, collapsing groups into a single group requires a decision regarding eligibility criteria for the new group. If those criteria are below the highest among all the previous levels of the collapsed groups, then some people will lose eligibility. Alternatively, if the new criteria are set at the highest among the previous levels, then Medicaid eligible caseloads and spending would increase. The NGA and HCFA both agreed that this laudatory goal of achieving administrative simplicity could only be achieved at additional cost.

States may set eligibility income levels for pregnant women and infants within the statutory range of 133% to 185% of poverty. However, those States that had chosen a level higher than 133% as of December 19, 1989, cannot lower it. This proposal would allow those States to reduce income levels to 133% of poverty. Additionally, States were interested in making marginal changes in eligibility in order to limit the coverage of certain population groups.

At a time when we are developing a health reform proposal to expand coverage to the uninsured, we cannot support a proposal which may result in creating a larger pool of uninsured individuals.

9. OBSTETRIC AND PEDIATRIC (OB/PED) STATE PLAN AMENDMENTS

NGA Proposal:

A-31 State Plan Amendments; Obstetric and Pediatric Services Access; and, the Omnibus Budget Reconciliation Act of 1989 Regulations - The standards identified for annual assurance that a State's rates for obstetric and pediatric services are adequate to provide access to care are difficult and costly to meet. HCFA requires data that States do not have uniformly available. Alternative criteria should be developed for States to use in demonstrating access.

L-25 Repeal the annual reporting requirements for OB and Pediatric care.

HHS Response:

HCFA has been searching for alternative methods for States to use in documenting access to OB/PED care. Given that the measurement of recipient access to OB/PED care is extremely complex, and given that the statutory requirements focus solely on payment rates, it is difficult to devise other adequate methods of documenting access without imposing an additional burden on the States. HCFA welcomes suggestions and is willing to work with the States on the development of alternative standards.

HCFA has initiated a contract with the NGA to develop alternative methods for States to document access to OB/PED services. Such methods must be feasible for States to implement on a yearly basis, as required by current statute. They must also provide for consistency across the States and accurately measure access to care while remaining within the parameters of the current statute, which links access to OB/PED services to payment rates. Under this contract, NGA may also consider statutory changes that would allow access to be measured in different ways. HCFA and NGA agreed that we should await the result of this study before taking further action on A-31 and L-25.

The NGA has agreed to complete this study as soon as possible. A meeting will be scheduled with HCFA and the NGA to discuss a revised schedule for the final report and other outstanding issues.

10. BOREN ISSUES

NGA Proposals:

A-23 Boren Amendment - HCFA has failed to issue through regulations the definition and criteria for adequate reimbursement rates under Boren. Without such guidance, States remain vulnerable to lawsuits based on wide-ranging interpretations of the statutory principle by the courts. By default, the Federal courts are developing criteria through case law, and no clear rules appear to be emerging. HCFA should define through regulation the terms of the Boren amendment, so as to restore State flexibility in setting rates for hospitals and nursing homes without setting a minimum reimbursement level.

L-20 Boren - Repeal the Boren Amendment, remove the word "cost" from the statute, or restrict the ability of the Federal courts to consider issues concerning Medicaid payment rates.

HHS Response:

HHS supports continued discussions between State and Federal representatives to identify problems with the Boren Amendment and any legislative or other solutions that would provide States with flexibility while ensuring recipient access to needed services. In response to the NGA recommendation, a work group was convened representing States, APWA, NGA, and HCFA to examine policy alternatives. This work group will make policy recommendations to HCFA. Based on these discussions, HCFA has decided to propose new Boren regulations which will spell out the process under which amendments are reviewed and to give States more guidance in the "findings" they are required to make.

On February 23-25, 1994, HCFA's Denver Regional Office will sponsor a technical assistance conference for State Medicaid agencies to provide guidance on the preparation and submission of institutional reimbursement State Plan Amendments.

11. SUBSTANCE ABUSE TREATMENT

NGA Proposal:

A-27 Inpatient Services for Treatment of Alcohol or Drug Dependency - The Secretary should issue regulations which clarify that services provided in any setting solely for the treatment of alcohol or drug dependency shall not be considered IMD services simply on the basis that they are related to drug or alcohol treatment.

HHS Response:

Recently HCFA has made two policy changes which will be helpful to States in this area. These policies will provide relief from the IMD exclusion for small substance abuse treatment facilities designed to treat pregnant women and accommodate their children. When substance abuse treatment facilities are established to treat pregnant women, they often include beds for children of the women in treatment so that these children can remain with their mothers. The following policies were developed to facilitate substance abuse treatment for pregnant women, while keeping families intact and assuring children necessary medical treatment.

- In determining whether a facility has 16 or fewer beds (and thus is not an IMD), HCFA developed a policy where it is not necessary to count the beds occupied by children if these beds are not designed to be, and are not being used as, treatment beds. We advised the regions on June 28, 1993 of this policy change, which allows facilities designed to treat up to 16 women, and house any number of accompanying children, to avoid the IMD payment exclusion as long as the beds occupied by children are not used as treatment beds.
- Also, children residing in an IMD with their mother while she is undergoing treatment will not be considered to be patients in the IMD if they are not receiving any treatment. For this reason, any covered services provided to these children during their mother's stay can be reimbursed by Medicaid. This policy was sent to the regions on February 17, 1993.

HCFA has relied on the published International Classification of Diseases, which categorizes alcohol and drug dependency as mental disorders. HCFA has also looked to the nature of the services provided to persons being treated for alcohol and drug dependency to ascertain if the treatment was oriented toward mental health interventions. This has caused many residential substance abuse treatment programs to be subject to the statutory Medicaid funding restrictions which apply to "institutions for mental diseases."

The pressure on States to use increased Medicaid funding for residential substance abuse treatment is completely understandable given the increase in demand for such services and limits on other sources of Federal funding. However, this is an issue which cannot be addressed independently by HCFA. HCFA has formally recommended that the issue of changing Medicaid policy to expand funding for residential substance abuse treatment be considered by the Departmental Task Force on Substance Abuse.

12. PHYSICIAN QUALIFICATIONS

NGA Proposal:

L-21 Provider Qualifications - OBRA '90 established minimum qualifications for physicians who serve pregnant women and children. These provisions are more stringent than other requirements for physician participation in the program. Either the provisions should be repealed or exemptions should be permitted for States who are making good faith efforts to upgrade the skills and qualifications of physicians participating in the program. Implementing these provisions may have the unintended effect of reducing access to clients.

HHS Response:

We agree with NGA's concerns about retaining adequate access. For this reason, we have used the Secretarial certification provisions of this legislation to provide for a "grace period," during which any licensed physician is considered certified and can provide covered services to pregnant women and children. The grace period extends until December 31, 1994.

In the preamble of the proposed regulation, HCFA is specifically soliciting comments on the feasibility of providing blanket Secretarial certification of selected categories of physicians. The preamble also requests comments on other categories of physicians that might be recommended for blanket certification. For example, States have expressed an interest in the certification of certain providers not included specifically in the statute. These providers may include: internists, doctors of osteopathy, physicians (regardless of specialty or board certification status performing a service not usually related to childhood illness or pregnancy), physicians board-eligible in obstetrics or family practice, physician residents and recent medical graduates, etc. We are asking commenters to provide a rationale for including such groups as qualified providers.

The preamble of the regulation also asks commenters to advise us of situations where this regulation might adversely affect access to care. In addition, we have asked for specific reasons or barriers that prevent certain groups of physicians from meeting any of the criteria specified in the law.

The NPRM was published on August 6, 1993 and the comment period closed on October 5, 1993. HCFA will take all comments into consideration in developing the final regulations. (It is anticipated that NGA concerns will be dealt with through the regulatory process.)

13. QUALIFIED MEDICARE BENEFICIARIES (QMBs)

NGA Proposal:

L-24 Repeal the QMB program - This program rightly belongs to Medicare and should have a full Federal solution.

HHS Response:

The fundamental issue here is whether QMBs are more like Medicaid recipients, defined by their poverty and therefore a joint Federal-State responsibility, or more like Medicare beneficiaries, entitled to a uniform and fully Federally funded and administered set of benefits. NGA argues that QMBs fall into the Medicare, not Medicaid, orbit.

Since 1989, States have been required by law to pay Medicare cost-sharing (premiums, deductibles, coinsurance) for all persons entitled to Medicare and with very low incomes and resources. From 1965 to 1989, States elected to pay Medicare cost-sharing for virtually all persons entitled to both Medicare and "regular" Medicaid. They did so because Medicare Part B premiums, which are heavily subsidized by Federal general revenues, made it a better "buy" for the States than if they paid directly for the same benefits. The change legislated in 1989 mandated what had previously been a State option. More significantly to States, it expanded coverage and payment of Medicare Part A premiums and the numbers of people for whom State payments for Medicare cost-sharing (but not "regular" Medicaid) are required. It is not clear whether the NGA proposal encompasses all persons for whom they pay Medicare cost-sharing or just those who are poor enough to qualify for Medicare cost-sharing only, but not poor enough to also qualify for "regular" Medicaid.

Making the QMB program into a full Federal program would shift its costs from the States to the Federal government, with no expansion of the benefit. Costs would consist of the current State share plus an additional amount to establish a single, national payment level for deductibles and coinsurance (presumably at the full Medicare amount). Federal administrative costs and personnel requirements would also increase if all eligibility and other functions were shifted to the Federal government. An alternative State position is for the Federal government to provide 100% FFP for the Medicaid cost sharing and administrative costs for QMBs.

We support, in principle, the concept of federalizing the QMB program. Given the current budgetary climate at the Federal level, we do not see this as a very likely possibility. We will consider this within the framework of financing issues under health reform.

14. THIRD PARTY LIABILITY (TPL)

NGA Proposals:

L-26 Third Party Liability - The NGA made a series of legislative recommendations related to TPL. Discussions with the NGA focused on NGA's legislative recommendations and other related issues. NGA's recommendations and HCFA's responses to the recommendations are summarized below.

Legislative Recommendations - The following NGA legislative proposals were included in OBRA 1993:

- Require all insurers to pay Medicaid claims directly to the Medicaid agency whether or not the liable third party is based in the recipient's State.
- Standardize the definition of dependents for all liable third parties to include children covered by a court order for medical support regardless of residency or other means tests.
- Include assets transferred through joint tenancy survivorship, life estate retention, or living trusts as assets that can be subject to estate recovery either through TEFRA liens or normal probate recovery activity.

The following NGA legislative proposals were not included in OBRA 1993:

- Clarify that Medicaid is payor of last resort.

HHS Response:

OBRA imposes specific requirements on insurers through passage of State laws. Even though OBRA does not explicitly state that Medicaid is payor of last resort, we believe that the requirements placed on insurers will achieve similar results. We do not plan to take any further action at this time, but will monitor the effects of OBRA and propose legislative changes in the future if warranted.

- Establish financial penalties against liable third parties who refuse to cooperate with any State Medicaid agency pursuing claims.

HHS Response:

HCFA has, in the past, proposed that States be permitted to file suits in Federal court against third parties and to seek double the amount originally owed. So far this concept has not been incorporated into any Congressional proposal. With all of the additional requirements placed

on insurers by OBRA, the need for penalties become even more important. HCFA will continue to support the idea.

- Allow States to pay Medicaid rates for those services provided to recipients for whom the State has purchased cost-effective group health plan insurance policies.

HHS Response:

HCFA is considering recommending a legislative change to allow States to pay at the Medicaid rate.

- Clarify that States could pay health insurance premiums for individuals with cost-effective policies other than employer group health plans.

HHS Response:

HCFA clarified that section 1905 of the Social Security Act already allows for the payment of health insurance premiums for individuals with cost-effective policies other than employer group health plans. This provision will be clarified in the State Medicaid Manual.

- Allow Medicaid to run IRS refund intercepts to collect overpayments due from providers, absent parents, recipients, etc.

HHS Response:

Legislation to collect from absent parents was proposed in 1993 but not enacted. NGA will take the lead in working directly with IRS. HCFA will keep the proposal under advisement.

Other TPL Issues

- Pay and Chase - A State wants to "pay and chase" physician claims. The State believes this will help avoid access problems and is more efficient from a systems point of view. The State will submit a cost avoidance waiver to HCFA. Other NGA members suggested that cost avoidance waivers should focus on type of provider and client type in addition to type of service.

HHS Response:

The State submitted a waiver request to "pay and chase" physician claims. The regional office approved the State's waiver on August 13.

- HCFA should work with sister agencies to resolve conflicts with other agencies - NGA pointed out some of the conflicts relating to the Department of Education's interpretation of "Individuals with Disabilities Education Act" (IDEA), formerly known as Education of the Handicapped Act and with regulations governing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Department of Education

- The Department of Education interprets IDEA as prohibiting schools from billing the third party for Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) services if it results in a cost to the parent (such as deductibles and coinsurance or even in reducing lifetime benefits). Medicaid rules require State agencies to pursue third party resources and HCFA to deny Federal financial participation (FFP) for services when TPL is not pursued.

Further, Medicaid considers care for which no individual or third party is charged to be "free care" and ineligible for FFP. While there is an exception for services provided under an IEP or an IFSP, other school-based services are often subject to this exclusion when schools bill only Medicaid recipients for services. The NGA supports the concept of seeking exceptions for school based services from TPL free care rules and IEP/IFSP services from TPL rules.

HHS Response:

HCFA is exploring its statutory authority to develop a free care policy that would alleviate the problem when services are provided by a school-based clinic. In regard to services that are only arranged for (rather than provided) by the school (e.g., speech therapy), HCFA is reviewing this issue and will report back to the NGA. HCFA will also look into a means to exempt IEP/IFSP services from TPL rules.

Department of Defense

- NGA wants HCFA to encourage CHAMPUS to change its policy regarding noncoverage of claims when non-availability of services statements (NAS) are not secured by Medicaid recipients.

HHS Response:

HCFA supports NGA's efforts to clarify CHAMPUS rules and is agreeable to raising the issue at a higher level with the Department of Defense. HCFA will ask regional offices to help identify other States that may be having a problem in this area.

- Estate Recovery Programs - NGA requested that, if estate recovery programs are mandated by statute, States be given flexibility to delineate the specifics of their program through the State plan amendment process.

HHS Response:

Estate recovery programs are mandated by OBRA 93. HCFA will give States as much flexibility as possible within the constraints of the new law.

Basically, OBRA 93 mandates States to develop estate recovery programs. However, it allows States a great deal of flexibility because they can either use the new Federal definition of estate or they can use the definition that exists in the States' probate law. States also can elect, by State plan amendment, which services they will include in their estate recovery programs beyond the minimum requirements of the statute to recover for nursing facility, home and community based, and related hospital and prescription drug services. Flexibility is provided by the provision to waive recovery for undue hardship.

15. BENEFICIARY COPAYMENTS

NGA Proposal:

A-2 Copays and Deductibles - Allow States to impose copays and other cost sharing for services to individuals between the ages of 18 and 21. This might be done either through waivers or some other means.

L-19 Beneficiary Copayments - Amend the statute [section 1916] to permit States broader latitude to impose copayments for additional services and additional eligible populations.

HHS Response:

Recommendations A-2 and L-19 envision more State flexibility regarding cost-sharing as States expand their programs to new populations with higher income (and assets). Therefore, HCFA recommends that these proposals be considered as part of the larger debate on health care reform and the States' role in it.

These recommendations envision more State flexibility to impose cost-sharing as they expand their programs to cover persons with higher incomes (and assets) than the traditional Medicaid program allows. State purposes in wishing to impose such cost-sharing are typically twofold: to restrain cost increases associated with such program expansions; and to make conditions in Medicaid for higher income persons more closely resemble conditions typically imposed by the private health plans to which, it is hoped, these persons will eventually migrate.

Under current law, States are permitted to impose deductibles, copayments, or similar charges on Medicaid recipients, but their flexibility to do so is severely limited by statutes, e.g., amounts must be nominal, no cost-sharing for certain persons and certain services. These limitations cannot be waived unless the revised cost-sharing rules meet several tests prescribed by the statute.

HCFA endorses recommendation L-19, for section 1115 waivers, which deal with broader issues than copays. However, by mutual agreement, HCFA and the NGA deferred any legislative changes on these issues for the health care reform process.

16. TECHNICAL ASSISTANCE / COMMUNICATIONS / REGULATIONS

NGA Proposal:

- A-19 Medicaid Program - Technical Assistance - HCFA central office and regional offices should be a source of technical assistance to States in the administration of their programs. Currently, the "we/they" adversarial mentality within HCFA offices reduces the interest of States to seek assistance. Again, while the executive management of Medicaid Bureau in recent years has attempted to address this problem, more work is needed, especially in the regional offices, to give States the assistance they need.
- A-20 Timely Information - Certain statutes require that HCFA make information available to States and then impose statutory mandates based on that information. On occasion, HCFA has failed to distribute the information in a timely manner and has caused needless problems for States.
- A-35 Timeliness of Regulations - HCFA must be more timely in the publication of regulations pursuant to statutory changes. Until HCFA promulgates the regulations, States are subject to ambiguity of the statute. For example, there are some statutes passed in 1987 for which HCFA has yet to publish regulations.

HHS Response:

One of the fundamental purposes of HCFA's day-to-day contact with States is to provide technical assistance in the implementation and administration of Federal Medicaid requirements. These contacts are conducted at the State level, primarily by the HCFA regional offices. The emphasis of these activities is on providing timely direction to States for implementing new and difficult Medicaid statutory and regulatory provisions.

Our ongoing communication with States provides HCFA a mechanism to identify, document, and effectively present priority needs for policy or operational changes which will foster improvements in Federal program direction.

We understand NGA's concern and HCFA endorses regional office technical assistance efforts, to the extent that resources are available in the regions. As noted by the NGA, the Medicaid Bureau has made strides in this area, and both central and regional offices will continue to work to foster better communication with States.

As regards timely regulations, the NGA accepts that much of the regulations process, particularly the clearance process, is outside HCFA's control. The NGA plans to address this issue at higher levels within HHS.

HCFA is committed to making every effort to develop and publish regulations as rapidly as possible, resources permitting. HCFA will also disseminate information in other ways (manual issuances, All States letters, etc.), as appropriate and will work with HHS to improve the regulations process.

17. CLAIMS FORMS

NGA Proposal:

A-16 Medicaid Program Administration - Claim Forms - Support the continuation of efforts toward common claims forms that can be used beyond the Medicaid program. HCFA also should continue to and expand its support for electronic claims management and automated eligibility.

HHS Response:

The Medicaid Bureau has been working closely with the State agencies to develop a common paper claim form for use by physicians and other non-institutional providers in all States in an effort to reduce administrative expenses and the "hassle factor" for providers.

To date, we have received over 260 recommendations from 40 States on how to improve the December 1990 HCFA-1500. Working with the State Medicaid Directors Association through the offices of Virginia's Medicaid Director, Bruce Kozlowski, we have reached consensus at the staff level within the Medicaid Bureau on what elements will be contained in the new version, and mapped those changes to the electronic claim form (ANSI-837, see below) to ensure both formats are compatible with the proposed changes. We are currently working through the consensus process with staff outside of HCFA.

In addition, in October 1992, HCFA published an Advance Notice of Proposed Rule Making (ANPRM) in the Federal Register. The ANPRM outlines our intent to work with State Medicaid agencies and others to develop a universal claims form. The form will be used primarily by all physicians and many other non-institutional providers participating in State Medicaid programs.

On October 21, 1992, we released a State Medicaid Director's letter announcing our plans for electronic data interchange (EDI) activities and alerted State directors to the Secretary of Health and Human Services' initiative to promote the routine use of efficient EDI among health insurance payers.

We plan to provide State directors with information concerning EDI developments through a series of directors' letters each with a distinct EDI heading. The first letter, Release No. 1, explained the Secretary's initiative and the efforts expended to date to achieve the initiative's goal. The newsletter also alerted directors that we will be conducting a survey of EDI activities in

each State agency. Since then, we have published two additional newsletters (and are about to publish a third) which focused on HCFA's plans for EDI, and provided an explanation of the activities of the Work Group on Electronic Data Interchange (WEDI) and the American National Standards Institute's (ANSI) Health Insurance Subcommittee. To date the response has been quite favorable with the State agencies, providing constructive suggestions for additional topics and further elaborations for future issues.

In addition, we have worked with State Medicaid representatives from Connecticut and California on the WEDI steering committee and on ANSI's Accredited Standards Committee (ASC X12). WEDI has published one report (July, 1992) and will publish a second report prior to the end of CY93. These reports articulate the overall strategy, goals, objectives, etc., of the public and private sectors in health care moving toward an all-electronic environment to transmit not only claims but medical records, lab tests, third part information and other useful data.

We also informed the State directors that HCFA published a proposed rule announcing a new requirement for (mostly large) hospitals to bill Medicare and receive payments and related remittance advises electronically. Under this proposal, all hospitals that have not been granted an exemption will have to submit all inpatient and outpatient bills using a HCFA-approved standard electronic media claims (EMC) format. We have been participating in the Medicare work groups in an effort to have information that States require for Medicaid crossover claims included in the Medicare EMC format. This rule can be found on page 4705 of the January 15, 1993 Federal Register, Vol. 58, No. 10.

Medicare and Medicaid staff have been mapping the paper hospital claim form (UB-92) and physician claim form (HCFA-1500) to the electronic version of these forms (the ANSI-837). The ANSI-837 has been made available for use by State agencies as of October 1, 1993. An electronic remittance advice, the ANSI-835, has already been developed and is available for use by the States.

State directors have been alerted that the results of all the above efforts will probably evolve into requirements for States to follow in the exchange of electronic claims data between providers of health services and all other health insurance organizations. The claims data, for example, must be in a standard format that can be recognized, read, and processed by any of the exchanging organizations.

18. BORDER EMERGENCY TRANSFERS

NGA Proposal:

A-22 Emergency Transfers from Foreign Hospitals - HCFA should rescind its interpretation that hospitals in border regions must accept emergency transfers from foreign hospitals of foreign nationals.

HHS Response:

HCFA has rescinded its interpretation that hospitals in border regions must accept emergency transfers of foreign nationals from foreign hospitals. After an extensive review of the requirements of section 1867 of the Social Security Act (the Act), Examination and Treatment for Emergency Medical Conditions and Women in Labor, HCFA determined that section 1867(g) of the Act, the nondiscrimination provision, does not apply to transfers originating outside the United States. Congress, in passing section 1867 of the Act, did not extend its applicability to individuals or hospitals located outside the United States (e.g., Mexico). Accordingly, hospitals in the United States are not required by section 1867(g) to accept the transfer of individuals from hospitals located outside the United States. This does not change the requirement that any individual, whether a United States citizen or not, who comes to a Medicare participating hospital that offers emergency services must be appropriately screened and treated or appropriately transferred.

19. INTERGOVERNMENTAL FUNDS TRANSFERS

NGA Proposal:

A-28 Intergovernmental Funds Transfers - Prohibition of Regulations - Forbid DHHS from taking actions that prohibit States from financing Medicaid expenditures through intergovernmental funds transfers. Also reaffirm that States are only subject to the limitation that at least 40 percent of the State share must come from State funds.

HHS Response:

HCFA has no plans to develop regulations at this time. However, if that changes, we assure the States that pursuant to the President's Executive Order we will consult with States at all stages of regulations development.

20. PERSONAL CARE

NGA Proposal:

L-17 Personal Care - OBRA '90 should be modified to clarify that personal care is not a mandatory service and that it can be delivered or provided by other providers beside home health agencies.

HHS Response:

HCFA agrees and notes that a proposal along these lines was enacted by OBRA 93, Section 13601. It restores personal care as an optional service in the Medicaid statute and clarifies that personal care is not required to be delivered by home health agencies. Action is now underway to develop regulations to support the statutory change. The effective date of this provision is October 1, 1994.

Welfare Reform Support Letters

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June 14, 1994

Statement on President Clinton's Welfare Reform Proposal

The National Governors' Association supports the principles embodied by President Clinton's welfare reform proposal, which builds on lessons learned in state welfare initiatives. We believe that such state experimentation will continue to be critical to national progress in welfare reform. We also believe that comprehensive reform must be accompanied by a commitment to allow states to complete already approved demonstration projects.

The President's proposal builds on the 1988 Family Support Act and incorporates many of the reform principles endorsed by the Governors:

- Welfare as a transition to self-sufficiency
- Assistance for those not yet ready for employment or training
- Time-limited cash assistance, including education and training to help prepare for work
- Improved child care and Earned Income Tax Credits for low-income working families
- Enhanced interstate child support enforcement
- Expanded programs to encourage family stability and limit teen pregnancy
- Increased state flexibility in program design
- Improved coordination between Aid to Families With Dependent Children (AFDC) and Food Stamps
- Enhanced federal financing, including lower state matching rates

We believe welfare reform is an essential component in restoring responsibility and stability to the American family. The President's proposal is a positive contribution to the welfare reform debate and we particularly welcome its focus on incentives for work and time limits for cash assistance for those able to work.

The Administration consulted extensively with states and localities in developing the welfare reform proposal, and we commend the President and his Working Group on Welfare Reform for their commitment to an open consultation process. Like the Governors' policy, the President's proposal recognizes the importance of work as an alternative to welfare and includes numerous elements designed to enhance state ability to prepare and place recipients in work.

Throughout our discussions, the states have emphasized the importance of flexibility and continued innovation. There is no one-size-fits-all solution to welfare, and states must have the flexibility to develop programs and services that will address the unique characteristics of our welfare populations and economic conditions within our individual states. We applaud the President's efforts, within the framework of his plan, to afford states specific options to try different approaches without having to apply for waivers. These state options include making

work pay by expanding earned income disregards and providing advance payments of the Earned Income Tax Credit.

States have invested considerable time and effort in the development of experiments to test a variety of reform initiatives, including many approved by the administration. We must emphasize, however, the importance of allowing states to complete the welfare demonstrations currently underway through waivers and to look favorably on new waiver applications.

Welfare is a complex program. The fundamental changes sought by the President and the Governors will require the enactment of a law that clearly recognizes the balance between the federal role in defining basic policy objectives and the state and local role in crafting the procedures and processes needed to obtain those objectives. The NGA will work closely with the administration and the Congress to ensure that the balance is achieved. Final federal legislation must not become overly prescriptive or detailed.

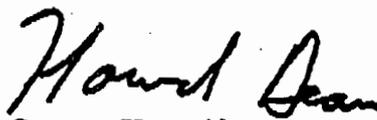
It should be noted that NGA has not yet seen legislative language and that individual Governors may have additional comments on specific issues as that language becomes available for review.

Our policy does not address specifically the issue of financing. States are concerned, however, that current program costs, such as the cost of assistance to immigrants without other resources, not be shifted to the states in order to pay for the federal share of welfare reform. We will be doing additional analysis of the financing mechanisms as details become available in order to determine the financial impact on states. We are also concerned about any sanctions that would penalize states for failing to adopt mandated intrastate child support procedures or reduce the federal match for basic assistance, such as for failing to meet employment program performance standards. We believe there is a shared federal-state responsibility for providing basic benefits, and we are concerned about a precedent of this kind.

In summary we support the principles in the President's proposal. The Governors note that there are other proposals currently before the Congress that also incorporate a number of these principles and urge Congress to take advantage of this apparent momentum to enact welfare reform as quickly as possible that reflects the Governors' principles and addresses our concerns. We look forward to working with the Administration and Congress to this end.



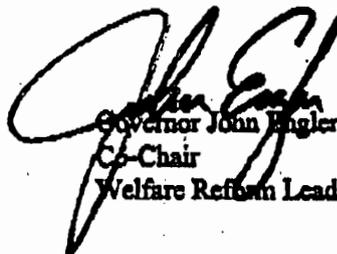
Governor Carroll Campbell
Chair



Governor Howard Dean
Vice Chair



Governor Tom Carper
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June 14, 1994

Roy Romer
Governor

The Honorable William Clinton
The White House
1600 Pennsylvania Ave.
Washington, D.C. 21510

Dear Mr. President:

I want to add my strong support to your efforts to restructure our nation's welfare system. It is important that we change from the current system of writing checks to one focused on helping employable adults move rapidly into productive work and improving the long-term self-sufficiency of families.

Most families in Colorado leave the Aid to Families with Dependent Children (AFDC) program within one year. However, many of these families face barriers such as lack of health insurance, inadequate child care or low paying jobs that force them to return to AFDC. Welfare reform must recognize and address these underlying factors to provide real opportunities for self-sufficiency.

As you know, earlier this year, Colorado was granted a waiver by your administration to begin one of the nation's most stringent and innovative welfare reform programs. Under this pilot program, AFDC recipients who refuse to enter job training or to take a job will be permanently removed from welfare rolls after two years. In addition, participants will be given a cash amount to purchase food, rather than food stamps. I appreciate having the opportunity to move forward with these programs, which we hope will help Coloradans get off welfare and stay off it. We look forward to continuing to work with your administration to develop effective strategies for implementing welfare reform in Colorado and the nation.

I would also like to take this opportunity to share with you some of my concerns about welfare reform. First, I am concerned that welfare reform may present significant economic challenges to the states. I agree that long-term self-sufficiency efforts will require an investment of resources. However, Colorado, as many other states, is not in the position to implement new federal mandates without sufficient federal funding. States must be given enough flexibility to implement reform within the resources that are available.

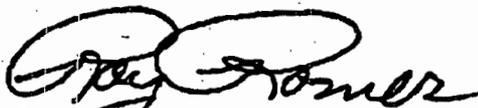
Page Two

Second, I am concerned that proposed reforms not assume that any type of job is better than no job. "Make-work" or jobs that will disappear when subsidies run out will not solve our real problems. In addition, if welfare recipients are perceived as taking jobs from others who are marginally employed, the reform effort may be seen as further impoverishing another group of citizens. Colorado is prepared to work with the administration to develop effective job development strategies.

Finally, I agree that personal responsibility for support of children is extremely important. A strong emphasis on child support enforcement will have a positive effect on children and family self-sufficiency. I am encouraged to see that some costs for these changes will be addressed with enhanced federal funding.

In conclusion, I am strongly committed to welfare reform and support your efforts to "end welfare as we know it." Thank you for the opportunity to participate in this important initiative and for your consideration of my concerns.

Sincerely,



Roy Romer
Governor

RR:wkg



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FOR IMMEDIATE RELEASE
Tuesday, June 14, 1994

FOR FURTHER INFORMATION
CONTACT: Sheri L. Woodruff
(302) 739-4101 Dover

[Redacted] Home Payer

GOVERNOR CARPER ISSUES STATEMENT PRAISING CLINTON ADMINISTRATION'S WELFARE REFORM PACKAGE

(Dover, Del.) -- Governor Thomas R. Carper today announced his strong support for the broad principles embodied in President Clinton's welfare reform package, expected to be unveiled later today in Kansas City, Missouri.

According to Carper, "I strongly support the principles incorporated in President Clinton's welfare reform package and am pleased to see that it closely mirrors policies we seek to implement here in Delaware. The people of Delaware and this country will be well-served by the Administration's proposed plan, in light of its emphasis on: encouraging individual responsibility by requiring clients to enter into mutually agreed-upon contracts that outline goals and expectations; expanding client participation in Job Opportunities and Basic Skills programs such as Delaware's nationally-acclaimed "First Step" initiative; and emphasizing 'work over welfare.' Just as important, the Clinton Administration plan provides additional funding and incentives to support the transition from welfare to work, including increased child care and added tools for states to improve child support collection."

-- more --

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OFFICE OF THE GOVERNOR

FAX NO. 13027392775

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Carper continued, "President Clinton should be commended for his leadership and creativity in developing a reform plan that provides Americans with the opportunity to improve their lives and achieve self-sufficiency. Because the Administration consulted closely with governors and their program directors in developing this proposed package, the recognition that there is no 'one-size-fits-all' solution to this challenge will serve states well by allowing them to craft programs based upon the specific needs of their residents. This flexibility, illustrated by the President's inclusion of several state options within his plan, allows states more latitude than has previously been the case to solve their own problems and to address their particular challenges head-on."

Governor Carper is the Democratic co-chair of the National Governors' Association (NGA) Welfare Reform Leadership Team. The 12-member working group explores welfare reform policy and programming from around the country and is working to build bipartisan consensus around a national plan on behalf of the NGA.

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GOVPRESS 685

**STATEMENT OF GOVERNOR ZELL MILLER OF GEORGIA
ON PRESIDENT'S WELFARE REFORM PROPOSAL**

In 1992, candidate Bill Clinton promised to "end welfare as we know it." With the proposal announced today, President Clinton has moved to radeem this pladge, and has made welfare reform a top legislative priority for Congress.

As the Governor of a state which has led the nation in welfare reform, I welcome the President's proposal. It offers welfare recipients a clear path into productive work in the private sector, and it requires all Americans to play by the same rules and take personal responsibility for their lives.

I am especially pleased that the President has incorporated into his proposal so many of the reforms pioneered here in Georgia, including strong child support enforcement measures, a requirement that minor mothers on welfare remain at home, and the ability to limit payments for additional children without the complicated and burdensome process of securing a waiver from federal agencies.

The President's proposal should receive immediate attention in Congress.



EXECUTIVE CHAMBERS
HONOLULU

JOHN WAIHEE
GOVERNOR

June 14, 1994

The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

I am writing to express my support for your proposal on welfare reform. The mood of the nation regarding the receipt of welfare benefits has shifted, thus necessitating new strategies to assist families to become self-sufficient. Your concept of a two-year limit is a bold proposal which will challenge both the families who receive Aid to Families with Dependent Children (AFDC) assistance as well as the states to strive even harder to assist families to become independent of public assistance. I applaud your courage to change a system that has gone unchanged for so many years. I also thank you for seeking the input and support of the Governors in drafting this sweeping reform. Your current proposal, to focus on teen parents and to help AFDC families to get changes that will not require them to return to the welfare rolls shows your broad-based concern for the factors that lead to dependence on government.

In the months ahead, as your proposal works its way through Congress, you can count on my support for your welfare reform plan. It is only by working together at the federal and state levels that we can have cohesive policies that will benefit the families of this nation.

Thank you for your thoughtfulness and hard work that has led to this reform proposal. America's families will be better off because of your vision which has been followed by timely action.

With kindest regards,

Sincerely,

A handwritten signature in black ink that reads "John Waihee".

JOHN WAIHEE



OFFICE OF THE GOVERNOR

STATE CAPITOL
BOISE 83720-1000CECIL D. ANDRUS
GOVERNOR

(208) 334-2100

June 9, 1994

The Honorable William F. Clinton
President
The White House
Washington, D. C. 20510

Dear Mr. President:

Like you, I have observed the operation of the welfare system over many years and have concluded that, in most cases, it does not lift citizens up into a new, self-supporting way of life but only makes them slightly more comfortable in their poverty.

In reviewing your plan for welfare reform, it seems to me it is right on target in requiring recipients to regard it as only a temporary measure while they acquire the training and experience to become independent. Somewhere along the line, a program that was designed to help people face a temporary income shortfall has turned into the "dole," and your proposal makes the right course correction to turn it, instead, into a program designed to empower people and enable them to stand on their own.

I support your proposal and have instructed the Idaho Department of Health and Welfare to assist however it can to adapt the program to Idaho's needs and to cooperate fully in helping make it a reality.

With best wishes for success,

Sincerely,

A handwritten signature in cursive script that reads "Cecil D. Andrus".

Cecil D. Andrus
Governor

CDA:cw



**OFFICE OF THE GOVERNOR
INDIANAPOLIS, INDIANA 46204-2707**

**EVAN BAYH
GOVERNOR**

For immediate release Wednesday, June 15, 1994

GOVERNOR BAYH ENDORSES CLINTON WELFARE REFORM

Indiana Governor Evan Bayh today praised President Clinton's welfare reform proposal as "the biggest step any President has taken toward meaningful welfare reform."

"President Clinton is keeping his promise to 'end welfare as we know it,' by recognizing the need to make work more attractive than welfare, establishing a two-year limit and a family cap," the governor said.

He noted that his own welfare reform plan for Indiana shares these same goals as the President's program.

"It is very important that meaningful welfare reform make work preferable to welfare, emphasize personal responsibility for self-sufficiency, and make clear that public assistance is temporary, not a way of life," the governor said.

"At the same time, as the President emphasizes, there must be strong incentives to take advantage of job and training opportunities and encouragement for families to stay together," he said. "The President's program has all of these, and I hope Congress acts quickly and positively."

For more information: Fred J. Nation 317-232-4578



COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

BRERETON C. JONES
GOVERNOR

THE CAPITOL
700 CAPITAL AVENUE
FRANKFORT 40601
(502) 564-2611

June 13, 1994

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

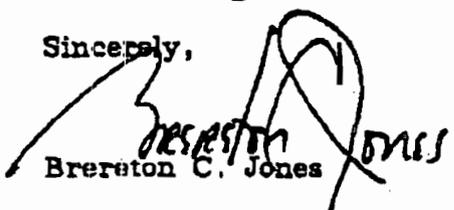
Dear Mr. President:

I want to thank you and congratulate you on your commitment to undertake welfare reform. As you know, we have discussed the need for meaningful welfare reform since the early days of your administration. I also want to thank you for giving other Kentucky officials the opportunity to participate in discussions with your office on this important subject. We feel that the partnership we are developing will allow both of us to accomplish our goals in this important area. Also, I am most impressed by your willingness to allow the states to exercise flexibility in coordinating their own initiatives in partnership with the federal government.

Please accept this letter as my endorsement of your efforts and my commitment to continue to work with you on these and other matters for which we share a common concern.

With best regards, I am

Sincerely,


Brereton C. Jones

/srb



State of Louisiana
Department of Social Services
OFFICE OF FAMILY SUPPORT
755 RIVERSIDE NORTH
P. O. BOX 94065 - PHONE - 504/342-3950
BATON ROUGE, LOUISIANA 70804-4065

EDWIN W. EDWARDS
GOVERNOR

GLORIA BRYANT-BANKS
MSW, ACSW, BCSW
SECRETARY

June 13, 1994

Welfare Reform Working Group
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20510

RE: Talking Points: Overall Plan,
State Issues: Financing, Flexibility,
and Waivers, Waivers

ATTN: Keith Mason

Dear Mr. Mason:

I agree in principle with the approach you are taking to these issues.

Sincerely,

Howard L. Prejean
Assistant Secretary

HLP/cdp

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

JOHN ENGLER
GOVERNOR

FOR IMMEDIATE RELEASE
June 15, 1994

CONTACT: Chuck Pellar
(517) 373-7394

Governor Engler Comments on Clinton Welfare Plan

Michigan Governor John Engler today commented on President Clinton's welfare reform proposal.

"We support the principles embodied in this proposal because it builds on the lessons learned through the welfare initiatives of the individual states. Many of the concepts are similar to what we have been doing in Michigan for almost two years under To Strengthen Michigan Families: welfare should be a temporary transition to self-sufficiency; emphasis should be placed on the need for education and training leading to employment; more emphasis is needed in the area of child-support enforcement; and programs to encourage family stability should be expanded.

"Our reforms in Michigan are based on the value of work, strong families, and personal responsibility. Instead of increasing grants, we're increasing opportunities to earn money and become independent. Instead of paying people not to work, we're getting them to go to work."

"In Michigan, we are defining success by the number of people who are positively engaged in constructive activities and by how many get off the welfare rolls and onto payrolls. Success must be measured one worker, one parent, one family at a time - as they find jobs, grow stronger, and reach independence."

"Flexibility allowing states to design their own programs is essential. This issue has been included in the discussions between the Clinton Administration and

(MORE)

Governor Engler Comments on Clinton Welfare Plan
Page 2

the National Governors' Association, i.e., that the states must be allowed to complete already approved demonstration projects, and the states must be allowed to develop programs and services which address the unique characteristics of the population and economic conditions in each state. In this vein I support President Clinton's commitment to approve waivers for the states.

"Many of the issues addressed by President Clinton's proposal are ongoing initiatives in Michigan. We have made several policy changes which 'Make Work Pay' and recipients have responded. The number of welfare recipients working in Michigan has increased from 15.7 percent (33,500) of the caseload in September 1992 to 24.3 percent (52,100) in May 1994. The national average is about 8 percent.

"In contrast to the national statistics, the AFDC caseload in Michigan decreased by almost 7,000 families in the past year (232,795 in April 1993 to 226,138 in April 1994).

"Michigan's commitment to the Social Contract is also paying dividends. DSS figures show that over 72 percent of those expected to participate are actively involved in employment, education, training, or community services.

"I have had the privilege of working closely with the administration in the development of this plan in my role as the Co-chair of the National Governors' Association Welfare Reform Leadership Team. I look forward to working with the Administration and Congress to enact welfare reform which reflects the NGA's principles and addressed our concerns."



OFFICE OF THE GOVERNOR
STATE CAPITOL
SANTA FE, NEW MEXICO 87503

BRUCE KING
GOVERNOR

(505) 827-3000

June 27, 1994

The Honorable Bill Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear President Clinton:

As Governor of New Mexico, I support your plans to reform welfare as outlined in the proposal released on June 14, 1994. New Mexico's efforts have stressed education and training as preparation for employment which is consistent with the issues in your plan. Our desire is to assure the dignity of our citizens while providing them with opportunities to become self sufficient.

You have taken courageous steps by bringing this vital issue to the forefront and involving states and Governors into the discussions. I thank you for the opportunity to be a part of this historic action and appreciate not only being heard by you, but seeing you act on the concerns of Governors. Your plan offers us the flexibility for initiating positive changes to the provision of needed services to our citizens through the ideas incorporated in your welfare reform proposals. All welfare reform efforts must continue to strengthen individual and family efforts toward education, job skill enhancements and self sufficiency, including supportive services.

New Mexico is ready and waiting to begin working with you and your administration to implement the welfare reform initiatives.

Sincerely,

BRUCE KING
Governor of New Mexico

MH



STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

MARIO M. CUOMO
GOVERNOR

June 14, 1994

Mr. President:

I commend you for making welfare reform one of your Administration's top priorities and for tackling this complex and critical issue. Many of the themes and principles embodied in your proposal are consistent with New York's own welfare reform initiatives, and I support your efforts to promote the value of work, responsibility and self-sufficiency. I share your aim to make public assistance transitional, with its primary focus on jobs.

The program that you have outlined is certainly a laudable proposal for achieving our shared goals. Although there are certain fiscal and program issues of concern to New York, we plan to work with members of your Administration and the Congress to resolve them.

I look forward to working with you to address these matters and to meet the goal of reforming the welfare system.

Respectfully,

Mario M. Cuomo

The President
The White House
Washington, D.C. 20500



OFFICE OF GOVERNOR DAVID WALTERS
STATE OF OKLAHOMA
212 State Capitol • Oklahoma City, OK 73105

NEWS RELEASE

FOR IMMEDIATE RELEASE
Tuesday, June 14, 1994

CONTACT: Steve Hill
Press Secretary
(405) 523-4251

GOVERNOR WALTERS SUPPORTS CLINTON'S WELFARE REFORM PACKAGE

Washington, D.C. — Governor David Walters announced his support for President Clinton's welfare reform package that the President unveiled today in Kansas City, MO.

"I support the President's efforts to reform welfare. The State of Oklahoma has sought regulatory reform in the past to avoid unnecessary and duplicative federal intervention as we try new approaches to solving problems. If the President's plan is enacted, Oklahoma will be able to move forward with these changes," Governor Walters said.

In particular, the Governor said he "supports the President's principle of time-limited benefits, coupled with more education and training. Also, the principle allowing increased flexibility for the states in program design leaves behind a one-size-fits-all mentality that has inhibited state innovations. This will enable us to solve our own problems, different from those of most other states. Oklahoma currently has five welfare reform pilot test proposals around the state that we would like to see implemented."

"Just as important, the Clinton plan includes additional funding and incentives to support the transition from welfare to work. The funding also includes increased child care and the capabilities for our State to improve child support collection efforts," Walters said.

In conclusion, the Governor said, "welfare reform is an essential step to stabilizing the American family and to stabilizing government spending. President Clinton should be commended for his efforts."

BARBARA ROBERTS
GOVERNOR



OFFICE OF THE GOVERNOR
STATE CAPITOL
SALEM, OREGON 97310-0370
TELEPHONE: (503) 378-3111
TDD (503) 378-4838

June 13, 1994

President William Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20005

Dear Mr. President:

I want to congratulate you and your administration for the leadership, courage and vision you have shown on welfare reform. National welfare reform will help give many Americans the tools the need to be self-sufficient, productive members of our society.

Oregon is already enacting many elements of welfare reform. Oregon welfare recipients participate in the JOBS program at twice the national rate. Each month, more than 900 families get off welfare and get jobs because they were given the job skills, child care and job placement they needed to succeed. Overall welfare caseloads have dropped 2.6% in the last year alone, compared to a national increase of 1.34%. Our JOBS Plus pilot project, still awaiting final federal waivers, will give some Oregonians on-the-job mentoring, child care and health care in lieu of traditional welfare.

Once again, Oregon's innovation is in prevention. Most welfare clients are teen mothers. I have made reducing the rate of teen pregnancy a top priority for the remainder of my term so that we can reach our state benchmark of cutting the rate in half by the year 2000. Oregon has also dramatically expanded health care coverage for low-income Oregonians, removing the need for welfare simply to have basic health care services.

Oregon is proud to serve as a model for welfare reform, as we have served for health care reform. We appreciate the support you and your administration have shown in allowing flexibility for states' individual health care innovations, and I look forward to working with you in the same productive way on welfare reform.

Thank you for your courage on this important public policy.

Sincerely,

Barbara Roberts
Governor

**State of Rhode Island
and Providence Plantations**

Bruce Sundin, Governor



**State House,
Providence**

June 13, 1994

**President William Clinton
The White House
Washington, DC 20500**

Dear President Clinton:

I applaud and support your leadership in the area of welfare reform.

I am personally appreciative of the consultation your Administration has provided to the nation's governors in the formulation of your welfare reform plan. In particular, I am in full agreement with the basic tenet of your comprehensive plan that reinforces the values of work, family, opportunity and responsibility.

Both welfare recipients and tax payers have become the victims of an inefficient system. Short sighted approaches to improve the welfare system in the past three decades have discouraged intact families and have promoted welfare dependency.

At the state level, increased numbers of children born to welfare families are living in poverty. While creative programs promoting economic independence are abundant, a cohesive and encompassing national policy is needed to solve a societal problem of this magnitude.

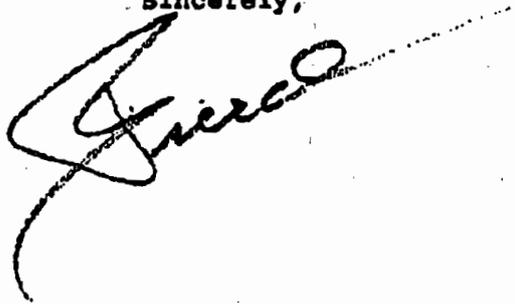
I have introduced a welfare reform bill that mirrors your plan's philosophy. My proposal emphasizes that work is valued by making work pay. It stresses that both parents are responsible to support their children and that parents should not have children until they are ready and able to raise them. I am heartened that the plan you have formulated is consistent with our goal of assisting people gain self-sufficiency.

The President
June 13, 1994
Page 2

I fully support your welfare reform plan and strongly urge the Congress to enact it this year. It is about time that our welfare system is designed to benefit the welfare of all citizens of this country.

Best personal wishes.

Sincerely,

A handwritten signature in black ink, appearing to read "Bill Clinton", written in a cursive style. The signature is positioned below the word "Sincerely," and extends across the width of the page.

BS:la
0021P.11



State of Tennessee

NED McWHERTER
GOVERNOR

June 13, 1994

The Honorable Bill Clinton
President of the United States
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Mr. President:

I strongly support your call for Welfare Reform. If there is anything program recipients and taxpayers alike can agree on it's that the present system is greatly in need of reform.

Your plan to build on the successful Family Support Act of 1988 is noteworthy because it permits us to expand our JOBSWORK program, which has been the stimulus for nearly 14,000 Tennessee AFDC families going to work in the past five years.

In addition to the continued emphasis on employment and training, as well as the necessary support for that effort, your plan also renews the call for stronger parental commitment through the regular payment of child support. In doing so, you have placed important emphasis on two elements central to our families gaining self-sufficiency: Work and Child Support.

I applaud your effort, and I am committed to work with you on this vital undertaking.

Sincerely,

Ned McWherter

NRW:pgh



STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

P.O. Box 40002 • Olympia, Washington 98504-0002 • (206) 753-6780

June 13, 1994

President William J. Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20503

Dear President Clinton:

I am writing to comment on your administration's proposal for welfare reform. I understand the complex challenge you face in attempting to initiate real change to the current welfare system. I am pleased that you have opened the dialogue and discussion to representatives from states. This state has already responded in detail to Deputy Assistant Keith Mason on this proposal.

As you may be aware, Washington State has been grappling with welfare reform for several years. Legislation was passed in 1993, and again this year that stresses welfare as a temporary measure. Many of the reforms that have been developed at the state level, however, apply to federally funded programs and require changes at the federal level before they can be implemented.

Of the many provisions detailed in your Welfare Reform Issue Paper, the simplification and conformity of application processing for the Food Stamp and AFDC programs is of paramount importance. The efficiencies resulting from this will help to shift resources to achieve the goals of the entire proposal.

I am pleased that welfare reform is focusing on the JOBS program. I believe we can make a difference in peoples lives by offering a mix of services that provides appropriate education, skills training, child care and work experience to help AFDC recipients become self-sufficient.

This state vigorously supports removing the "100-hour rule" limitation. We are currently in the process of seeking a Title IV-A State Plan amendment and associated federal approvals to comply with new state legislation. We need your support on this issue.

President William J. Clinton
June 13, 1994
Page Two

There are some areas of the proposal with which we have concerns, one of which is the two year eligibility time limit. Without a safety net, this will increase homelessness and child welfare caseloads. Washington has adopted legislation that reduces assistance in a graduated manner after four years.

While we support parents having responsibility for minor mothers, the possibility of abusive situations leads us to recommend the alternative of establishing protective payees. We also oppose making states fully responsible for benefits paid when paternity has not been established after one year. And while we strongly endorse the intent to enhance and simplify the federal match rate for states, we believe this will not produce the desired effect. Many states will have difficulty finding additional state funds to draw-down the federal dollars.

Finally, adequate funding must be available to provide the support needed for those moving towards self-sufficiency. Without considerable financial commitment by the federal government, true and lasting reform will not occur.

I look forward to working in partnership with you and the other states to resolve concerns and uncertainties about welfare reform. A continuing dialogue with states is crucial if positive, long-term changes are to take place.

Sincerely,


MIKE LOWRY
Governor



STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
CHARLESTON 26305

June 14, 1994

GASTON CAPERTON
GOVERNOR

The Honorable Bill Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

As you prepare to announce your welfare reform package, I want to thank you for giving governors and their representatives the opportunity to work closely with your Administration in developing this proposed legislation. The Administration is to be commended for involving the states in direct consultation on such an important issue.

I also commend you for your leadership in undertaking such a difficult task. Our welfare system must be changed to provide a helping hand to our nation's most needy citizens, without creating dependence on welfare as an alternative to self-sustaining opportunities. I am especially encouraged by the importance you are placing on the principles of work and responsibility, and I encourage you to continue to allow the states the necessary flexibility to provide those services in the most appropriate way for their citizens.

You certainly have my support and encouragement as you undertake this difficult task. I look forward to working with your Administration in the months ahead to help make the necessary improvements in providing support for the children and families of West Virginia and our country.

Sincerely,

Gaston Caperton
Gaston Caperton
Governor

GC:SB

July 11, 1994

**The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201**

Dear Secretary Shalala:

On behalf of the nation's Governors, we are writing you to express our strong support for you and the Administration in the lawsuit filed by the National Association of Community Health Centers (NACHC) regarding Section 1115(a) waivers.

We strongly disagree with the assertion of NACHC that the Department has gone beyond the statute in its procedures and review of state waiver applications. From the outset, Department staff affirmed the statutorily determined requirements of 1115(a) waivers, and especially as they pertain to its research requirements. Moreover, the position of the Department was re-affirmed in the written statement of policy principles released in August of 1993.

We also know that the claims of ignoring beneficiary protections in approving these waivers are equally without merit. One only has to look at the degree to which the Department scrutinizes waiver applications to know that the safety and rights of beneficiaries remain protected. Their claims are clearly inappropriate given the personal commitment of the President and yourself to those who need public assistance.

States are at a unique point in the evolution of publicly funded health care systems. Governors have seen Medicaid wreak havoc with state budgets in the last decade. In addition, more and more low income people are finding themselves without health coverage. As we await Congressional action on reforming the nation's health care systems, states must continue to test innovative strategies for delivering health care that are cost effective. If successful, this lawsuit will stop those efforts.

Cost effective health care does not have to mean poorer quality and less access. Community and migrant health centers have played an important role in providing health care to the poor. States have no interest in eliminating this "safety net" for the poor. Public providers have been invaluable in the fragmented and fractured American health

The Honorable Donna E. Shalala

July 11, 1994

Page 2.

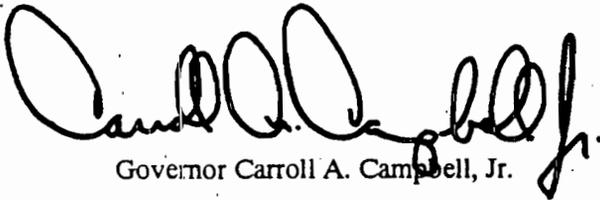
care system. However, while we believe in the importance of public providers, we also believe that they should not remain protected if there is a private sector provider that can assure equal or higher quality at a lower price while maintaining critical services for low income and vulnerable populations. This protectionism, we believe, is the heart of the NACHC complaint -- a provider trying to retain special treatment in the market in the face of competition.

We cannot stress more firmly how important it is for the Department to defend against this challenge and not negotiate any kind of out of court settlement on this issue. If the Department capitulates in any way, fewer people will get health care, and the ability of states to test innovations will be stifled. Moreover, we believe that you will see other providers making protectionist claims in the name of the poor.

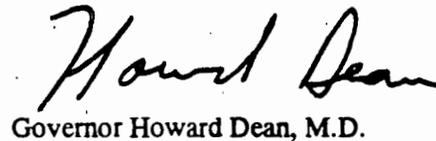
You have all the tools necessary to assure that waiver proposals meet the highest quality and access standards. You have used them in reviewing state waivers in the past, and we believe that you will continue to use them. To change your behavior in any way in the face of this lawsuit will be an admission of guilt to a crime that you have not committed.

The Administration must stand firm, and we are available to help you in any way we can.

Sincerely,



Governor Carroll A. Campbell, Jr.



Governor Howard Dean, M.D.

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