



National Disability Employment Awareness Month, 1993

By the President of the United States of America

A Proclamation

The United States has long been a champion of the civil rights of individuals, and it is only natural that we now serve in the forefront of efforts to ensure equal opportunity for persons with disabilities. Inspired by the enactment of the Americans with Disabilities Act (ADA) on July 26, 1990, other nations have begun to reexamine the challenges faced by their citizens with disabilities. The ADA, which prohibits discrimination in employment, public accommodations, government services, transportation, and communications, provides a practical model for people everywhere to ensure that individuals with disabilities will not be excluded from the social, cultural, and economic mainstream.

Together we have begun shifting disability policy in America from exclusion to inclusion; from dependence to independence; from paternalism to empowerment. And we have made a firm commitment—a national pledge of civil rights for people with disabilities—to enforce the Americans with Disabilities Act. We cannot be satisfied until all citizens with disabilities receive equal treatment under the law, whether in the workplace, in schools, in government, or in the courts. We will not be satisfied as a Nation until we have fully implemented the laws that offer equal opportunity for Americans with disabilities, including the ADA and the Rehabilitation Act of 1973.

We do not have a single person to waste. Citizens with disabilities want to lead full, independent, and productive lives. They want to work; they want to pay their fair share of taxes; they want to be self-supporting citizens. America must enable the 43 million talented Americans with disabilities to contribute by offering them the individualized training and education we offer everyone else.

Our Nation can ill afford to waste this vast and only partially tapped source of knowledge, skills, and talent. In addition to being costly—over \$300 billion is expended annually at the Federal, State, and local levels to financially support potentially independent individuals—this waste of human ability cannot be reconciled with our tradition of individual dignity, self-reliance, and empowerment. As we work to achieve thorough and harmonious implementation of the Americans with Disabilities Act, we will open the doors of opportunity for millions of people, thereby expanding, not only the ranks of the employed, but also the ranks of consumers. These individuals and their families will thus be able to pursue the real American Dream.

I congratulate the small business and industry leaders, labor leaders, and community leaders from all walks of life who are working together to implement the ADA and the Rehabilitation Act, and I commit the resources and cooperation of the Federal Government toward that effort. Our ongoing progress attests to the fundamental vitality and openness of our free enterprise system and to our abiding commitment to civil rights for all. Every American needs a chance to contribute. Our work is far from finished. America needs the continued leadership of every citizen to fulfill the promise of the Americans with Disabilities Act and related laws.

THE WHITE HOUSE
WASHINGTON

Carol -
This is the letter
in response to the POST
editorial on D.C.'s health
care waiver.

Kathi

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages ▶ 5

To <i>CAROL RASCO</i>	From <i>KATHI WAY</i>
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368

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GENERAL SERVICES ADMINISTRATION



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

NOV 10 1994

Mr. Colby King
Editor
The Washington Post
1150 15th Street, N.W.
Washington, D.C. 20071

Dear Mr. King:

Your editorial of November 9, criticizing the Health Care Financing Administration's (HCFA) response to the District's proposal to set up a managed care program for disabled children, distorts the facts. A much more accurate picture was presented in your own newspaper in a November 8 article, "Managed-Care Plan Draws Ire - D.C. Health Group's Competence Questioned."

HCFA has aggressively pursued this project and has constantly communicated with District officials, including awarding the District a grant of \$150,000 for the period August 5, 1994 through August 4, 1995, to help them develop this project. The grant award outlines 10 special terms and conditions the District is required to meet prior to seeking waivers to implement the project.

HCFA shares the District's concerns about the delivery and financing of services provided to children with special needs. But the original proposal did not adequately address those needs. The services to be provided were not specified, the method of putting together the network was not spelled out, the quality monitoring system was not described, and potential civil rights violations, including the exclusion of certain groups of children, were of major concern.

Local groups that currently provide services to these children, including United Cerebral Palsy and Easter Seals Society for Disabled Children and Adults, Inc., also expressed serious concerns about the demonstration.

Even after months of working with the applicant, the project still has significant deficiencies. We cannot, as your editorial suggests, simply "say yes or no." The Federal Government has a responsibility to these very vulnerable children to assure that any new system of care is well designed to provide for their special needs.

Sincerely,

Bruce C. Vladeck
Administrator

**District of Columbia 1115 Waiver Proposal
Managed Care System for Disabled Children
and Youth with Special Needs**

- o On March 25, 1994, the District of Columbia submitted a 1115 waiver-only proposal to conduct a Medicaid managed care demonstration for disabled children and youths with special needs. A local provider organization, Health Services for Children with Special Needs (HSCSN), was proposed to administer the managed care program on behalf of the District.
- o Although HCFA was interested in the basic concept of the demonstration, the proposal was deficient in several key areas. For example, it did not describe how the full range of services used by this vulnerable population would be provided under the demonstration, how the provider network would be established, the method of paying providers in the network, and how quality would be monitored under the demonstration.
- o There were significant issues concerning the civil rights of the disabled affected by the demonstration, including the proposal to exclude certain children with mental illness and AIDS, and the proposal to make participation in the demonstration mandatory on the part of disabled children and their families.
- o HCFA decided that the District needed assistance in developing the demonstration, and on August 5, granted \$150,000 to the District of Columbia to assist them in completing the development work for the demonstration and outlined 10 major areas of concern. HCFA also initiated contact with the Robert Wood Johnson Foundation (RWJF) to solicit their interest in providing additional grant funding to the District. RWJF has been quite willing to provide funds but the District needs to seek these funds through the Foundation's proposal process. The District/HSCSN has viewed this process as burdensome.
- o HCFA has worked closely with the District and HSCSN to make this a workable demonstration project. Attached is a chronology that identifies the activities, issues and concerns we have had during this process.
- o On October 15, the District submitted a draft response to our concerns. A preliminary review suggests considerable developmental work remains. For example, we are still concerned over the very low numbers of pediatricians available to serve 3,600 children under the demonstration.
- o On November 8, Sue Brown, the Acting Commissioner of the District's Medicaid agency verbally requested to our regional office that HCFA delay a decision regarding the waivers. She also requested that all communication go through the District to improve communication between HCFA, the District, and HSCSN.

Managed-Care Plan Draws Ire

D.C. Health Group's Competence Questioned

Post 11/8/94 A1

By Amy Goldstein
Washington Post Staff Writer

A new medical company is trying to take over care for thousands of poor, disabled children in the District, creating a dispute over how best to treat some of the city's most vulnerable patients.

If approved by federal health officials, the arrangement would be one of the nation's first experiments in whether the insurance method of managed care can provide better, cheaper treatment for children who are mentally retarded, physically disabled or chronically ill.

But the proposal by Health Services for Children with Special Needs Inc. has infuriated other groups that cater to such children. They question the company's competence and accuse District officials of misconduct for deciding to pay the company nearly \$100 million in Medicaid subsidies without competitive bids.

Health Services is a spinoff of the Hospital for Sick Children in Northeast Washington. The company has assembled a staff, a computer system and more than 150 local doctors, therapists, medical equipment

See CARE B5, Col. 1

Group Challenged on Managed-Care Plan

CARE From \$1

companies and others willing to participate in the program.

The idea of managed care has come into vogue in the federal government and some states, including Maryland and Virginia, as a way to try to control the cost of Medicaid, the government health insurance program for the poor and disabled. Managed care is intended to save money by giving patients a main doctor, emphasizing preventive care and controlling the amount and kind of treatment.

But the experience of Health Services reflects the obstacles to putting the popular idea into practice: opposition from medical groups that stand to lose patients, governmental caution and the difficulty of proving ahead of time that patients will be better off.

Before the dispute is resolved, company officials say, Health Services may go out of business. It has spent more than \$2 million getting ready to begin and expects to run out of money within two weeks.

Parents such as Karen Nesmith, of the Hillcrest neighborhood of Southeast Washington, would welcome the coordination that Health Services would provide.

Nesmith's daughter, Chanel, was born prematurely 13 months ago, weighing 1 pound 3 ounces. After spending her first eight months at George Washington University Hospital, Chanel came home in June with a machine to monitor her heart and breathing, mother to suck mucus from her underdeveloped lungs and an electric feeding pump.

But Medicaid workers told Nesmith that insurance would not pay for another machine to monitor her baby's oxygen level. "It took her going into the hospital three times in distress, turning blue on the way, for them to give her the machine," said Nesmith, 26.

"It would be beautiful . . . if you had someone to just fight those battles for the supplies and machines so you can just focus on your sick baby," she said.

But other parents, annoyed by the nuisance of checking with managed-care plans for their own care, are fearful of extending that red tape to their children and worry whether the company will authorize as much help as they think their children need.

Few places in the country have a greater stake than the District in learning how to spend less money on Medicaid. The program covers one in four city residents, and its annual cost has swollen by two-thirds since 1990 to \$668 million.

Last spring, the District switched most of its Medicaid recipients to managed-care plans, matching more than 70,000 patients with primary doctors who must authorize all their care. But the switch excluded about 3,000 children who receive Medicaid because they have disabilities such as cerebral palsy, blindness, mental retardation and serious heart and respiratory ailments.

Such children defy the very premise of managed care: helping to keep people from becoming sick enough to require expensive medical services. No matter how much their care is managed, disabled children often

need lots of medical help, therapy and training programs.

Yet there are signs that the District spends Medicaid money for disabled children inefficiently. Five percent of those children accounted for

"It jeopardizes a system that is tried and true for a system that doesn't have a clue."

—Thomas Wilds, executive director, St. Johns Community Services

more than two-thirds of the \$30 million the District spent on them last year. Meanwhile, 72 percent of that sum went for treatment in hospitals; just 6 percent went for visits to doctors' offices.

Hospitalizing a disabled child can cost \$150,000 a year, said David Corro, Health Services' chief executive officer. Giving a child a full-time nurse and lots of medical equipment at home costs about \$60,000 and is more compassionate, he said.

Medicaid does not pay to install a telephone if a family lacks one, or for home renovations to accommodate a wheelchair. Under the Health Services experiment, it would. A Health Services employee would keep track of each child's doctor visits and arrange for transportation, medicine and home equipment. Twice a year, a team would visit to assess the child's condition.

The company has told the District government that, in the first year of the three-year project, it would save

2.5 percent in Medicaid spending for its clientele.

Some parents say they would like to have a built-in group of doctors and others willing to care for their children. "A lot don't want to mess with people who have disabilities," said Toni Tyler, of the Fort Totten area of Northeast Washington. Her son, Damon, is autistic.

Damon, 21, is hyperactive and cannot speak. Since he was 2 years old, he has attended the National Children's Center, where social workers and psychologists have referred him to doctors and other medical help. Still, Tyler has had trouble keeping a dentist for her son.

Tyler said her son's last dentist said she accepted disabled patients, but she did not treat Damon herself.

"Her staff . . . didn't know how to deal with a child that was flapping around," Tyler said. Damon became agitated and broke a bathroom sink. "Shortly after that, we stopped getting those little [appointment reminder] cards," his mother said.

The Health Services plan is ardently opposed by a group of organizations that provide medical care, therapy and education to disabled youngsters.

"It jeopardizes a system that is tried and true for a system that doesn't have a clue," said Thomas Wilds, executive director of St. Johns Community Services, a non-profit agency for people with disabilities.

He and the leaders of similar organizations said Corro and his staff appear unfamiliar with available programs for disabled children, have not adequately worked out the project's finances and services, and lack plans

to evaluate its effects—criticisms that Corro rejects.

Wilds said he is particularly upset that David Coronado, the former District Medicaid chief, did not allow other groups to compete for the contract.

"It looks like, 'Forget all the historical services. Here comes health reform, and let's just sell the children to someone who can cut a political deal,'" Wilds said.

Vincent C. Gray, director of the D.C. Department of Human Services, said he is not sure competitive bids were needed because the project was experimental. But he said he was trying to satisfy the critics and had not decided whether to allow other groups to compete.

The company applied in March for permission to run the managed-care plan from federal health officials, who say they are trying to rule on Medicaid experiments within four months. In August, the officials told the District they wanted more information before deciding whether to let the project begin within a year. They gave Health Services \$150,000 in the interim.

Bruce C. Vlasek, administrator of the Health Care Financing Administration, said his staff wanted to be especially careful to make sure the project is well designed "because of the vulnerability of the kids and the novelty of this."

He said his agency also was concerned about whether the District's Medicaid agency had the staff and ability to monitor the project.

But with money running out, Corro is frustrated by the pace of government. "They just don't want to believe the program can work," he said.

MEMORANDUM FOR CAROL RASCO

FROM: KATHI WAY

DATE: 11/10/94

SUBJECT: D.C. WAIVER FOR HEALTH CARE

Eight months ago, March 25, 1994, D.C. submitted a medicaid waiver request that would allow a non-profit agency, Health Services for Children with Special Needs, to provide health care through a managed care, capitated rate plan for approximately 200 disabled children in the district. There were numerous concerns with the proposal. HCFA was concerned about potential civil rights issues because the children were disabled and because they were disproportionately minority. In addition, HCFA was concerned about the quality of care and the appropriateness of services. D.C. government representatives were unable to answer the questions posed by HCFA. On August 5, 1994 HCFA approved a planning grant of \$150,000 for D.C. to assist in refining their proposal and addressing the points in question. They continue to wait for a response.

Avis Lavelle talked with the Post editorial board prior to publication and relayed the above information. HHS believes the contractor, Health Services..., is driving the Post story. Also, candidate, Marion Barry, wrote in support of this proposal and the contractor on November 3. Bruce Vladeck is writing a response to the editorial. I have asked John to have that letter held until I get clearance from you.

A18 WEDNESDAY, NOVEMBER 9, 1994

THE WASHINGTON

The Washington Post

AN INDEPENDENT NEWSPAPER

THE PRESIDENT HAS SEEN

11.9.94

Bosnia on the Brink

BOSNIA'S Muslim-led government has surprised almost everyone—most of all its Bosnian Serb foes—by mounting its biggest offensive in three years of war. Partly through an American-sponsored accommodation with Cro-

to bear to protect these forces are foundering on the paralyzing fear—among the foreign governments that have provided the troops (no American troops are there)—of retaliation against them. Their withdrawal would remove an important sup-

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Health Care Reform, Up Close

NEXT TIME it talks about health care reform, perhaps the White House will consider the experience of a local organization, Health Services for Children with Special Needs, in trying to set up an experimental, D.C. government-approved managed care program for several thousand poor and disabled District children. Health Services has been waiting eight months for federal approval while spending an estimated \$2 million of its own money gearing up for the experiment. The

in Medicaid spending while delivering quality care and cost-effective services. When you consider that the District's Medicaid program has ballooned by two-thirds since 1990 to \$668 million, and how hard-pressed the city is generally for funds, it's understandable that the Department of Human Services would be interested in exploring a more efficient alternative. The District government, however, isn't alone.

Close to 200 District health care providers.

TH



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Charlie

approval has yet to come despite a supposed policy of quick response by the administration in such matters. Meanwhile, the organization is running out of money and could soon have to fold, the cost of D.C. Medicaid continues to soar, and the chronically ill children the experiment was—still is—intended to help remain entangled in a fractured, uncoordinated and in some respects wasteful health care system. This couldn't be what the Clinton administration had in mind.

In fact, it's not. President Clinton has made a point of saying that Medicaid waivers for state experiments should be approved by the Health Care Financing Administration (HCFA) within four months. There is a good reason for tilting toward expeditious handling of state experiments. The inability of Washington to produce health care reform has not prevented several states from seeking to achieve incrementally what Congress and the president couldn't accomplish. The Health Services experiment, which would span three years, is designed to achieve a 2.5 percent savings

including Columbia Hospital for Women, D.C. General Hospital, Howard University Hospital, the Medico-Chirurgical Society of D.C., the Edward C. Mazique Parent Child Center, along with Del. Eleanor Holmes Norton and D.C. Council member Linda Cropp, have endorsed this project. There are dissenters, to be sure. Just about every state that has attempted to introduce managed care has encountered resistance in one form or another, especially where providers found themselves confronted for the first time with pressure to compete for business by holding down costs. But change is an integral part of health care reform, so opposition from a small segment of the provider community comes as no surprise. Less understandable, however, is the pace at which the federal authorities respond to legitimate, worthwhile local and state initiatives. A provider shouldn't have to sink to the point of almost going under to get the government's prompt attention. HCFA should say yes or no. Eight months is too long a time to tread water.

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3/25/94
a little waiver D.C. wanted to do 6 months ago.
capitated rate, managed care for 200 children.
There are some civil rights issues, as well as
quality, appropriateness of services for this population.
*Disabling kids
& disproportionately minor*

8/5/94 \$ 150,000 planning grant to D.C. Govt. to
improve their proposal

Vince Gray - head of human services for D.C.
oversees Medicaid & special needs
people who run managed care program
are staking this up.

Bruce Madli

Avis LaVelle talked to editorial board and
gave them this info. they went ahead
anyway

Bruce writing a letter back to POST
explaining

November
3rd

ARIZONA - EMPLOYING AND MOVING PEOPLE OFF WELFARE AND ENCOURAGING
RESPONSIBILITY (EMPOWER)
INITIAL ISSUES

1. Although the duration of assistance (i.e., time-limited eligibility) provision applies only to adult recipients, and allows for extensions to complete training, there are no exceptions for recipients who, despite having fulfilled all of the program requirements, are still unable to find employment. Given that this would be a State-wide demonstration, there is substantial potential for a significant number of individuals to be unable to find work, particularly among groups of individuals whose specific circumstances create special barriers. For example, it would seem unreasonable to terminate, after 24 months, a Native-American recipient, without a high school diploma, who is living, with no means of transportation, in an inaccessible, rural area of a reservation.

The Department does not support demonstrations which penalize recipients who have "played by the rules." We are prepared to discuss alternatives that might address this problem.

2. Arizona proposes to implement a Family Benefit Cap (Cap), which will limit AFDC eligibility to children born to adult parents within 10 months after the parent's entry into the welfare system, and within 10 months after the parent's first redetermination following the implementation date of the waiver. In addition, this restriction would apply to adults who were temporarily ineligible for payment due to a non-compliance sanction, or were off the rolls due to voluntary withdrawal or ineligibility for less than 60 months.
 - a. The rationale for extending the Cap to include children conceived while the family did not receive AFDC for a period as long as 60 months after voluntary withdrawal or ineligibility (for reasons other than sanctions) is unclear. An extension of this duration, for any reason, is excessive. The Department does not support extending the Cap to children conceived while a family is not receiving AFDC.
 - b. Arizona's population includes a large proportion of Native Americans and other minority groups whose fertility rates may be substantially different from the population at large. The imposition of the Cap could result in disparate treatment for members of these groups. To aid in responding to questions of potential disparate treatment, we would appreciate your providing us with statistical data on the fertility rates for all ethnic, racial and religious groups represented to any

significant degree in the State's population. We will need these data both for the appropriate segments of the general population and for each group of AFDC recipients. For example, Native Americans in the State's general population vs AFDC recipients. In addition, we would like, if available, a differentiation between Native Americans living on or off a reservation.

- c. The Cap proposal "...contains an incentive for self-sufficiency by permitting an income disregard for the amount of the lost benefit." Would the State also consider, as a self-sufficiency incentive, earning back benefits eliminated under the Cap in the case of an out-of-wedlock birth if paternity is established and/or a child support order is issued?
 - d. How would a child, otherwise liable for the cap, be treated if s/he lived with a non-legally responsible relative, but not with his/her parent?
3. Regarding the pilot component (i.e., the Full Employment Demonstration Project in Pinal County), one of the basic provisions is the "cashing out" of Food Stamps to obtain the funds to subsidize minimum wage employment in lieu of Food Coupons. Recent Food Stamp appropriations language has limited approval of "cash-out" demonstrations to not than 25, and not to exceed 3 percent of the total Food Stamp recipient population. At this time State requests for approval of this provision exceed the number authorized to be granted. The issue of how to allocate the available slots has not yet been resolved.
 4. In the proposed pilot component, failure, without good cause, to comply with the pilot employment requirements will result in a 50 percent reduction of a family's AFDC grant for a minimum of one month, and the barring of the individual from further pilot participation. You provide several examples of possible grounds for sanction which include such serious actions as refusal to accept a pilot placement and willful misconduct during employment that results in termination by the employer. But, it is not clear whether all possible actions that might be deemed non-compliant, such as a few hours of unexcused absence from work, would result in the application of this significant sanction. Please provide more specific information regarding when such a sanction would be applied. Also, please describe what safeguards would be in place to ensure that children are not put at risk?
 5. The EMPOWER demonstration consists of two distinct components: One is the EMPOWER project, to be implemented State-wide, and evaluated via impact analysis by using a comparative (pre- post-test) design; two is the Full

Employment Demonstration Pilot (pilot component), to be implemented in Pinal county, and evaluated using a random assignment design.

- a. With regard to EMPOWER, the Department believes that a rigorous evaluation design of the policies being tested is a central consideration for approval of welfare reform demonstrations. We believe that a rigorous evaluation of this project will require random assignment of cases to experimental and control groups. Random assignment may be implemented State-wide, where appropriate, or in a limited number of sites used to represent the State as a whole.

Also, because the demonstration includes provisions (e.g., elimination of the 100 hour rule) that would affect eligibility determinations, the evaluation must determine the impact on applicants as well as recipients. A sufficient number of applicant cases is necessary for impact analysis because newly approved cases tend to have shorter AFDC spells, and therefore potentially differential impacts, compared to the general population of current cases. Consequently, we require random assignment of applicants for at least the first half of the demonstration, to assure that the number of approved control cases is of sufficient size to adequately represent the population of applicants in the demonstration. This also means the research sample would include both approved and denied applicant cases.

Approved demonstrations must be cost neutral to the Federal government with respect to AFDC (including child care and Emergency Assistance), Food Stamps, and Medicaid benefit and administrative costs. The cost neutrality provision will require that an ongoing measure of costs that would have been incurred in the absence of the demonstration be established. Individual random assignment would provide a mechanism for determining cost neutrality, in that the control group would be used to estimate costs in the absence of the demonstration.

- b. The demonstration also provides for pilot component participants to be excluded from the time-limit provision. This suggests that all non-exempt cases in the pilot county would initially be subject to the application of the time limit. They would remain subject to the time limit until, and if, they are assigned as an experimental case for the pilot. This would result in a major change in their treatment status during the demonstration period. This, combined with the fact control cases would remain subject to the time limit, would make it difficult, if not impossible, to attribute any measured differences between

experimental and control group cases to the pilot provisions. Would the State consider excluding all cases in the pilot site from the Statewide provisions, or, at least from the time-limit, to allow for a clearer test of this work supplementation component?

6. The Department has consistently maintained a policy of not approving waivers of Quality Control requirements. Our standard procedure is to refrain from citing errors during the payment adjustment lag (PAL) period, and then to review against the revised program requirements operative under the demonstration project.

With respect to Food Stamp error rates, regulations at 7 CFR 275.11(g) govern the treatment of demonstration project cases. Those cases which are correctly classified for participation in a demonstration project which the Food and Nutrition Service (FNS) determines to "significantly modify the rule for determining households' eligibility or allotment level" are excluded from calculation of the error rate the entire length of the demonstration. Therefore, the inclusion or exclusion of project cases from the Food Stamp error rate is not an issue which would be addressed through a waiver, but rather through a determination of whether the project terms and conditions "significantly modify" the rules for determining eligibility and allotment level. FNS cannot make this determination until the terms and conditions of the project are finalized.

APPLICATIONS RECEIVED**California**

Application Received: 3/14/94 120 Day Response Date: 7/12/94

The State seeks to progressively reduce benefits to cases as an incentive to work and impose a family cap.

The State would implement the proposed changes as amendments to the Work Pays Demonstration Project. Under its proposal, all cases would be subject to an initial 10 percent reduction in benefits (on top of the 8.5 percent reduction already imposed under the Assistance Payments Demonstration Project). After 6 months on assistance, benefits for cases with an able-bodied adult would be reduced an additional 15 percent. After 24 months on assistance, the needs of an able-bodied adult would be removed from the grant. Also, the State would not increase benefits for children conceived while a family is receiving AFDC. Because, the State has fill-the-gap budgeting, cases with earnings may be able to offset any reductions in earnings.

Sensitive issues: The first reduction of benefits would apply to all cases, regardless of the able-bodiedness of adults in the case. Unlike many other time-limited proposals, there is no mechanism to maintain a family's level of earnings through community service, participation in JOBS or a self-sufficiency plan, or guaranteed employment. The family cap and a provision restricting homeless assistance to once-in-a-lifetime, would further lower benefits. These significant reductions in assistance would likely generate enormous savings which the State may wish to bank against other demonstrations that they apply for in the future. The State also wants to eliminate the 10-day advance notice requirement for reductions in benefits.

California has also requested that their application be approved by 4/30/94.

Proposed implementation date: 7/1/94

Connecticut

Application Received: 12/30/93 120 Day Response Date: 4/30/94

The State proposes changes aimed at promoting self-sufficiency making work pay.

In a pilot site, the State would time-limit benefits by requiring work activity after two years of AFDC. In doing so, they would also eliminate most JOBS exemptions and establish a child support assurance program.

Statewide, they would enact a number of provisions that expand eligibility for benefits, increase earned income disregards, change JOBS participation requirements and provide case management during a post-employment period.

Sensitive issues: None.

Proposed implementation date: 7/1/94

Massachusetts

Application Received: 3/22/94 120 Day Response Date: 7/20/94

The State would require the bulk of AFDC cases to be placed in community service jobs.

The State would terminate cash assistance to most AFDC families by requiring recipients who could not find full-time unsubsidized employment after 60 days of AFDC receipt to perform a combination of "temporary" community service and job search. Though labeled as "temporary," it appears that cases could remain in this status indefinitely. Individuals meeting this requirement would earn a cash "subsidy" that would bring family income up to an amount equal to the applicable payment standard. JOBS education and training services would be restricted to those working at least 25 hours per week. Child care for working families would be continued for as long as they are income-eligible (but requiring sliding scale co-payment) and transitional Medicaid benefits would be increased to a total of 24 months.

Sensitive issues: The State is highly unlikely to be able to generate enough community service slots to make this kind of system work. The hours of community service would not be determined by dividing the family's grant by the minimum wage.

Proposed implementation date: 7/1/94

Michigan

Application Received: 3/8/94 120 Day Response Date: 7/6/94

The State proposes a number of changes as incentives to work and parental responsibility.

Michigan's proposal adds onto a demonstration that began implementation in October 1992. Its new provisions would include eliminating deprivation as eligibility factor; providing a monthly advance on the Earned Income Tax Credit from IV-A funds; cashing out food stamps for certain employed AFDC recipients; requiring immunization of children; and changing the sanction under the JOBS and Child Support Enforcement programs to 25% of AFDC and Food Stamp benefits. They also seek Medicaid waivers to

mandate nursing home pre-admission screening; expand eligibility for family planning services under Medicaid; and offer a Medicaid Buy-In and allow courts to require non-custodial parents without health insurance to pay the Medicaid managed care premium.

Sensitive issues: None.

Proposed implementation date: 10/1/94

Pennsylvania

Application Received: 2/18/94 120 Day Response Date: 6/18/94

The primary thrust of Pennsylvania's proposal is to provide incentives to work.

The State's program is designed to provide incentives to work. It would require participants to enter into written agreement intended to direct them into activities that will move them into unsubsidized 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. The AFDC-UP eligibility and work activity requirements would also be eliminated. 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.

Sensitive issues: None.

Proposed implementation date: 10/1/94

Wisconsin

Application Received: 2/9/94 120 Day Response Date: 6/9/94

Wisconsin seeks a broader family cap than we previously approved for them.

Wisconsin seeks to eliminate increased AFDC benefit for additional children conceived while receiving AFDC Statewide, except to cases that are part of the previously approved Parental and Family Responsibility Demonstration (PFR). PFR already includes a "family cap" type waiver that reduces the increase in

benefits for an additional child by one half and eliminates any further increase for subsequent children.

Sensitive issues: Family cap.

Proposed implementation date: 1/1/95

APPLICATIONS ANTICIPATED

Ohio

In 2 counties, in conjunction with the Empowerment Zones and Enterprise Communities program, the State would time-limit AFDC benefits and supplement recipient wages (includes Food Stamps cash-out). Job training would be provided that was geared to work force needs, including community support services needs. The nature of the time-limit on benefits has not been addressed in any detail.

In a 10 county pilot, the State would increase income disregards with fill-the-gap budgeting; extend transitional child care to 18 months; eliminate the 100-hour and work history rules for AFDC-U program; pay incentives to employees to hire AFDC recipients; extend up-front job search to three months and limit education and training activities to two years; pay paternity establishment bonuses and increase the child support pass-through.

Sensitive issues: The nature and potential consequences of the time limit Ohio proposes is unclear. We will need to determine the capacity of the State to move individuals facing the time limit into jobs and what safeguards exist in the system once a family reaches the time limit.

The State expects to submit an application to us in April.

South Carolina

This demonstration would require participants to comply with an 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. It would also relax parental the deprivation requirements for AFDC-U cases, expand earned income disregards and increase resource limits.

The State was expected to submit an application in February. One complication they are trying to work around is proposing an evaluation that would avoid having any control cases in the Charleston area which has been heavily hit by military base closures.

Sensitive issues: We are concerned about the State's capacity to move individuals facing the time limit into public or private work experience. The nature of "private" work experience is still unclear. The State has shown past reluctance to agree to rigorous evaluation.

Virginia

The legislature has passed welfare reform legislation that would severely time-limit AFDC benefits by requiring recipients who cannot find employment within 12 months to take public service jobs and eliminating all benefits after 2 years. They would also eliminate any increase in benefits for additional children conceived while receiving AFDC.

Sensitive issues: We are concerned about the complete cut-off of assistance after two years and the family cap.

We have not heard from the State concerning when to expect to submit a waiver application.

CALIFORNIA - Amendments to the California Work Pays Demonstration Project

Description

This proposal would amend the California Work Pays Demonstration Project (approved March 1, 1994) to allow the following additional procedures to be applied statewide:

- o The maximum assistance payment (MAP) would be reduced by 10 percent (this would be in addition to previously implemented reductions in benefits). The need level would not change. Since California is a fill-the-gap State, this reduction in benefits could be made up by increasing earnings.
- o After receiving AFDC benefits for 6 months the MAP rate would be reduced by an additional 15% for families with an able-bodied adult. Exceptions to this provision would be made where the parents or caretaker relative are incapacitated, caring for a disabled person, over 60 years old, non-needy non-parent caretaker, under 19 years of age and participating in Cal Learn, or attending school full time.
- o After 24-cumulative months of receiving AFDC benefits, able-bodied adults would be removed from the budget group though Medicaid eligibility would not be affected. The same exceptions apply to this provision as to the provision concerning the reduction in benefits after 6 months.
- o The 6 month and 24 month benefit reduction provisions would not apply to a family which reapplied for assistance after not receiving AFDC benefits for 24 consecutive months.
- o The MAP would not increase for children conceived while the family was receiving AFDC benefits.

Status

Application received: March 11, 1994

Proposed implementation date: July 1, 1994

CONNECTICUT - A FAIR CHANCE**Description**

The statewide provisions of the demonstration would include the following changes in the AFDC or JOBS program:

- o Eliminate the deprivation requirement for AFDC.
- o Change the filing unit requirements to allow children who have other support to be excluded from the unit.
- o Exclude the value of one motor vehicle per AFDC household.
- o Increase resource limit to \$3,000.
- o Disregard earnings of dependent children who are students.
- o Provide savings bonds or other rewards to students for excellence in grades or attendance; disregard such awards from consideration as income for both the AFDC and Food Stamp programs.
- o Send all current child support payments directly to the AFDC family and count the payments, except for \$100, as income (Note: this provision changes the "pass-through" to a disregard of the first \$100).
- o Change the earned income disregards to 33 percent of gross earnings without time limits.
- o Extend transitional child care benefits for as long as the family's income is below 75 percent of the median income in the state.
- o Extend Medicaid transitional benefits to two years and eliminate income tests and reporting.
- o Exclude assets specifically designated for future educational purposes for dependent children.
- o Coordinate AFDC and Food Stamp sanction policies regarding voluntary quitting of employment and good cause criteria.
- o Change JOBS program provisions:
 - provide case management for up to one year after loss of AFDC eligibility;
 - not give volunteers priority;
 - not base activities to be required of minor custodial parents on their age;

- require parents with children under six years of age to work more than 20 hours per week;
- calculate sanctions based on a percentage of the grant: first offense, benefit reduced by 20%; second offense, benefit reduced by 35%; third and subsequent offense, benefit reduced by 50%.
- develop JOBS components without regard to federally mandated and optional components;
- eliminate restrictions on length of time for job search;
- require at least 10 hours per week for CWEP and provide payments for such activity;
- o Count lump sum payments as assets.
- o Eliminate the 185 percent of need test.
- o Lengthen redetermination cycle for monthly reporting cases.

In selected geographic areas, the "Pathways" demonstration would include the following changes in addition to those cited above:

- o base AFDC eligibility for the entire family on participation in approved work activities after two years of assistance.
- o Establish a child support assurance program: \$3,000 per year for the first child, \$500 each for the second and third child, and nothing more for any additional children.
- o Eliminate some JOBS exemptions to create a more universal program.
- o base required hours of work activity on length of time on assistance rather than amount of grant: 15 hours per week after two years, 25 hours after three years, and 35 hours after four years.

Status

Application received December 30, 1993.

Proposed implementation date: July 1, 1994.

MASSACHUSETTS - Employment Support Program**Description**

This demonstration would replace existing AFDC program with a program of entitlement designed to encourage and help low-income families to work by:

- o Limiting cash assistance to non-exempt cases to no more than 60 days, during which the applicant head of household is expected to look for work. The family would receive a payment equivalent to three months of AFDC benefits in order to have additional income needed to fulfill job search requirement during this period.

Exemptions would apply for disabled adults or adults caring for disabled individuals, women in their third trimester of pregnancy or who have given birth within the last three months, minor parents attending secondary school full-time, and non-aided grantee relatives.

- o Requiring individuals not finding unsubsidized employment within 60 days, or reapplying for assistance at a later date, to accept temporary community service jobs of 25 hours per week and spend at least 15 hours per week in continued job search. By meeting this requirement, grantees would receive a "subsidy" in lieu of their cash assistance grant plus child care and health benefits.

Individuals working less than 40 hours per week, with total income less than the appropriate AFDC Payment Standard, would be required to participate in job search and/or temporary community service jobs. The individual would be required to work at least 25 hours per week and have a combined total of community service work and job search equaling 40 hours. Under these circumstances, the family would receive a cash subsidy equal to the difference between their unsubsidized earnings and the AFDC payment standard.

Individuals working at least 40 hours per week in unsubsidized employment paying at least minimum wage would receive a cash subsidy to bring total income up to the AFDC payment standard.

In determining the amount of any subsidy, mandatory deductions from income (such as state and federal taxes and union dues) would be disregarded, but all other income, including child support would be counted.

- o Allowing continued access to employment and training through the JOBS program to those individuals working at least 25 hours in unsubsidized jobs.

- o Continuing child care for any family finding subsidized employment for as long as the family meets income guidelines, but with each family contributing a co-payment for child care on a sliding fee scale.
- o Extending transitional Medicaid from 12 to 24 months.
- o Directly distributing all child support collected to families where the casehead is employed full-time; maintaining the current \$50 child support pass through for those employed only part-time or participating in subsidized employment.
- o Providing a food stamp cash-out for individuals who obtain unsubsidized employment.

In addition, special eligibility requirements would be placed on teen parents, including:

- o Requiring school attendance.
- o Requiring teen parents to live with a guardian or in a supportive living arrangement and, if the teen is living with an adult other than the parent, making a referral on the teen's parents for child support.

For the second year of implementation, the State is developing additional provisions which would allow two-parent families who are income-eligible to participate in the program.

Status

Application received March 22, 1994

Proposed implementation date: July 1, 1994

MICHIGAN - STRENGTHENING MICHIGAN FAMILIES (ADDENDUM)**Description**

- o Expand business expense deductions for self-employment;
- o Pay the EITC from IV-A funds;
- o Provide cash benefits rather than food stamps for households with gross earnings of \$350 or more per month;
- o Exempt one vehicle of any value for AFDC and Food Stamps;
- o Require applicants for AFDC to participate in job search without regard to the time limit; the application for assistance would be delayed until the individual participates; impose a 30-day "wait period" for all applicants who have quit a job or training without good cause;
- o Eliminate deprivation as an eligibility factor in AFDC;
- o Require that AFDC families have children under six immunized; failure to comply would result in a fiscal sanction of \$25 per month;
- o Require participation in MOST (JOBS) for an individual who has not complied with the Social Contract provisions within a year;
- o Change MOST and child support sanction to 25% of AFDC and Food Stamp benefits; after 12 months of noncompliance, close AFDC case and maintain Food Stamp case;
- o Limit overpayment recovery to cases containing the adults, not the children;
- o Offer Medicaid buy-in after Transitional Medicaid benefits end;
- o Broaden eligibility for family planning services under Medicaid;
- o Provide custody and mediation services under IV-D; and require non-custodial parents to provide health care through payment of premium for Medicaid coverage if no other coverage exists.

Status

Application received March 8, 1994.

Proposed implementation date: October 1994

PE PENNSYLVANIA - Pathways to Independence**Description**

Participants in the demonstration would enter into a written agreement called a Plan for Independence including an Agreement of Mutual Responsibility intended to move individuals to employment. In the third month of employment, recipient families would receive a "Pathways benefit" consisting of an AFDC payment plus the cash equivalent of the family's Food Stamps allotment. The demonstration would also enact the following provisions intended to facilitate the transition from welfare to employment, reward work, and bring AFDC and Food Stamps requirements into conformity.

AFDC only

- o Eliminate the following AFDC-UP eligibility and participation requirements: the 100-hour rule, connection to the labor force requirement, the 30 day unemployment prior to application condition, principal wage earner criterion, and the 16-hour work activity requirement.
- o Provide AFDC assistance to full-time students through age 20 who attend secondary school or its equivalent level of vocational or technical training.
- o Revise the treatment of stepparent income to allow a deduction of 200 percent of the State's need standard.
- o Consider lump sum payments as resources rather than as income.
- o Eliminate the Applicant Test used to determine eligibility for the \$30 and one-third disregard.
- o Exclude income tax refunds as income and as a resource when determining eligibility and benefit amount.
- o Pay the cost of child care directly to the provider up to the established local market rate ceiling, less a family fee.
- o Provide Transitional Child Care up to 12 months to families who become ineligible due to earned income and whose gross income does not exceed 235 percent of the poverty line.
- o Provide case management during the 12 months after assistance is terminated due to earned income.

PE: NSYLVANIA - Pathways to Independence (cont'd)AF C and Food Stamps

- o Eliminate the Gross income Test and determine eligibility based on the family's net income in relation to the the Gross Income Test and determine eligibility based on the family's net income in relation to the applicable net monthly income limit for Food Stamps and the state payment standard for AFDC.
- o Replace the current Food Stamps deductions with a deduction of \$200 plus 30 percent of the remainder for participants who have had earned income for two consecutive months.
- o Exclude the equity value of one vehicle up to \$7,500 when determining the family's countable resources.
- o Exclude as a resource funds up to \$10,000 deposited into retirements accounts such as IRAs, KEOUGHs, and 401K plans.
- o Exclude as a resource funds deposited into savings accounts to be established for each household member for educational purposes.
- o Increase the resource limit for applicants to \$2,000 until the third consecutive month in which the family has earnings from employment, after which they may accumulate resources up to \$5,000.

Food Stamps only

- o Add the cash equivalent of the family's Food Stamp allotment to the AFDC payment to create a single cash payment for participants who have had two consecutive months of earned income.
- o Exempt the \$50 child support pass-through as income when determining the amount of the Food Stamp benefit.
- o Allow participant households to remain as separate Food Stamp households from individuals or groups who move into the home and would ordinarily be required to be included in the household for eligibility determination purposes.

Medicaid

- o Provide Extended Medical Coverage for up to 12 months when assistance is terminated due to income from child support.

PE NSYLVANIA - Pathways to Independence (cont'd)

- o Provide Extended Medical Coverage for up to 12 months to families whose assistance is terminated due to earned income as long as their income does not exceed 235 percent of the poverty line.

Status

Application received February 23, 1994.

Planned implementation date is October 1, 1994.

WI: CONFIN - AFDC Benefit Cap (ABC) Demonstration Project**De: cription**

- o The project will be conducted Statewide except that it will exclude teen parent cases subject to the Parental and Family Responsibility demonstration (which has similar provisions).
- o No incremental payment will be added to the grant when an additional child is born to an "ongoing" case when the birth occurs more than 10 months after the effective date of project implementation or application for assistance. An "ongoing" case is any case that has been closed less than 6 continuous months within the last 16 months;

Exceptions will be made when verification is provided that the child was conceived as a result of incest or rape, or has been placed in the care of a non-legally responsible relative.

- o Apply a variety of techniques to increase awareness and availability of family planning resources among AFDC applicants and recipients.

St: tus

Application received February 9, 1994

Proposed implementation period: January 1, 1995 through December 31 1999.

WI CONSIDIN - AFDC Benefit Cap (ABC) Demonstration Project**Description**

- o The project will be conducted Statewide except that it will exclude teen parent cases subject to the Parental and Family Responsibility demonstration (which has similar provisions).
- o No incremental payment will be added to the grant when an additional child is born to an "ongoing" case when the birth occurs more than 10 months after the effective date of project implementation or application for assistance. An "ongoing" case is any case that has been closed less than 6 continuous months within the last 16 months;

Exceptions will be made when verification is provided that the child was conceived as a result of incest or rape, or has been placed in the care of a non-legally responsible relative.

- o Apply a variety of techniques to increase awareness and availability of family planning resources among AFDC applicants and recipients.

Status

Application received February 9, 1994

Proposed implementation period: January 1, 1995 through December 31, 1999.

LIST OF PARTICIPANTS

HCFA CONFERENCE CALL WITH NGA ON MEDICAID ADMINISTRATIVE AND LEGISLATIVE RECOMMENDATIONS

July 27, 1993
5:00 p.m. EST

In Washington, D.C. (Room 314-G HHH) - (410)966-1293

Bruce Vladeck, Administrator, HCFA
Karen Pollitz, Deputy Assistant Secretary for Legislation (Health), HHS
David Cooper, Senior Analyst, Asst. Secretary for Planning and Evaluation, HHS
Diana Fortuna, Special Assistant to the Administrator, HCFA
Ann Daneiski, Office of Intergovernmental Affairs, HHS
Tom Gustafson, Acting Director, Office of Legislation and Policy, HCFA

In Baltimore (Room 200 EHR) - (410)966-1293

Rozann Abato, Acting Director, Medicaid Bureau
Paul Olenick, Acting Deputy Director, MB
Bill Hickman, Director, Office of Medicaid Policy, MB
Joe Dunne, Deputy Director, Office of Medicaid Management, MB

In San Diego, CA - (410)966-1293

John Monahan, Director, Office of Intergovernmental Affairs, HHS
Richard Chambers, Director, Intergovernmental Affairs Office, MB
Joy Wilson, Health Committee Director, NCSL

In Washington, D.C. (NGA Offices) - (410)966-1293

Ray Scheppach, Executive Director, National Governors' Association
Carl Volpe, Senior Policy Analyst, Human Resources Group, NGA
Lee Partridge, Director, Health Policy Unit, APWA

State Representatives

Brenda Bacon, Health Assistant to Gov. Florio, New Jersey - (410)966-1294
Donna Checkett, Medicaid Director, Missouri - (410)966-1294
DeAnn Friedholm, Medicaid Director, Texas - (410)966-1294
Kathryn Glynn, Medicaid Director, Ohio - (410)966-1294
Eugene Laurent, Medicaid Director, South Carolina - (410)966-1294
Kevin Piper, Medicaid Director, Wisconsin - (410)966-1294

DRAFT: July 23, 1993

SUMMARY

**HCFA DISCUSSIONS WITH THE NGA
ON ADMINISTRATIVE AND LEGISLATIVE RECOMMENDATIONS
TO IMPROVE THE MEDICAID PROGRAM**

JULY 23, 1993

DRAFT: July 23, 1993

SUMMARY OF NEGOTIATIONS

The HCFA/NGA negotiations to improve the Medicaid program helped to clarify States' concerns and to assist HCFA 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 negotiations process are identified, and action steps on issues needing further evaluation are described.

The NGA recommendations on donations, taxes, and disproportionate share hospital payments were handled on a different track.

OTHER ADMINISTRATIVE AND LEGISLATIVE PROPOSALS
FOR IMPROVING THE MEDICAID PROGRAM

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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.

HCFA 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 is currently under review at OMB.)

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. To change the law to make optional the provision of necessary treatment services for children would not be consistent with our child health objectives.

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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.

HCFA Response:

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 indicated that it will work to develop a free-care policy with the goal of excluding schools from any restrictions, if permitted under present law. Both the NGA and the Medicaid Bureau concluded that legislation may be needed to permit such an exception.

The Medicaid Bureau is currently working with the Office of General Counsel to develop these policies. When the HCFA approach is formulated at the staff level, we will discuss the approach with the Public Health Service before the HCFA Administrator receives a final recommendation. We will strive to clarify the policy for States by the end of August 1993.

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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.

HCFA Response:

We share 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. In addition, as HCFA has pointed out in meetings with NGA representatives, hardly any actual disallowances are imposed for violations where harm to patients is, or even can be, documented by Federal staff reviewing State agency financial records.

Proposals for disallowances proportional to the seriousness of the violation are being considered by Congress as part of this year's budget reconciliation process. While in principle, HCFA could support such a legislative proposal, these proposals are seriously flawed. They inadvertently compromise beneficiary protections. They would have the Secretary and DAB share elements of rule-making and interpreting authority. Also, these bills would require the Federal government to pay for things for which Congress has not authorized funds.

Finally, we would also support a legislative change requiring HCFA to pay interest on reversed disallowances where we, not the State, held the funds during the appeal process. We have long believed this to be an appropriate corollary to the existing statutory requirement that States

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pay us interest on sustained disallowances that the State held during the appeal. We would also support a provision prohibiting disallowance of claims filed by a State more than three years prior to the initiation of the Federal financial review or audit except in cases of fraud and abuse. A legislative proposal including similar provisions was discussed on the Hill last year, and the NGA will explore reviving it this session.

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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.

HCFA 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 GAO study will be completed in July 1995. ORD's study will begin in August 1993 and will be completed within 6 months. OIG's study is also at the starting point and will be completed within the next 6 months. It was agreed during the April 6, 1993 meeting with the NGA that an additional study is not necessary.

Regulations are under development to close as many loopholes as possible under current law. The draft rule on transfers of assets interprets the statute as stringently as it can to catch the ever evolving devices developed by estate planners. Additionally, the administration's budget package for FY 1994 contains proposals to further tighten transfer of assets laws. In addition, proposals along these lines are being considered by Congress for inclusion in the omnibus budget package for FY 1994.

As with Medicaid Qualifying Trusts (described below at L-13), non-poor persons can exploit loopholes in the law and give away assets to artificially impoverish themselves and get Medicaid to pay the long-term care costs rather than paying for it themselves. Such transfers continue to occur

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despite the enactment of major legislation intended to stop them in 1980, 1982, and 1988, and despite HCFA's attempts to interpret the statute as stringently as possible, loopholes remain.

As with MQTs, the practice of transferring assets to qualify for Medicaid, a program that is both means-tested and the primary public payer of long-term care services, underscores the need for increased discussion about how this Country should finance long-term care services. The Administration's position on these issues is 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.

HCFA 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 interprets the statute as stringently as it can (and more stringently than already published guidelines), prohibiting many of these trust arrangements. The HCFA regulation under development would address many of the trust arrangements and related concerns addressed by State legislative activities. We will work to expedite publication of proposed and final regulations. However, statutory loopholes remain.

Additionally, the Administration's budget package for FY 1994 contains proposals to further tighten transfer of assets laws. Finally, proposals along these lines are being considered by Congress for inclusion in the Omnibus budget package for FY 1994.

Use of MQTs and other Medicaid estate planning activities appears to have increased in recent years. States and others are concerned that individuals who use these techniques are shifting a high proportion of long-term care costs that should be paid out of pocket (e.g., costs of nursing home care) to the Medicaid program.

Accordingly, the current regulatory revisions of regulations on transfer of assets and MQTs are being held pending developments in Congress that may further strengthen States' capacity to close or limit loopholes in the current statute

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that have proven open to abuse. A revised regulatory timetable will be developed once Congressional action is completed.

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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.

HCFA 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 the President's 94 budget proposes to lift the prohibition on a formulary. In this event, we assume States would be free to restrict or exclude the coverage of a specific drug or class of drugs in the same manner as before the passage of OBRA 90.

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.]

HCFA Response:

We agree with NGA's recommendation. The interim final regulation (currently in Departmental clearance) resolves the issue of the definition of new drugs. Additionally, the issue becomes moot if the Congress adopts the President's FY 1994 legislative proposal to permit States to use closed

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formularies.

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.

HCFA Response:

The President's FY 1994 budget proposes to allow States to remove the prohibition on State use of formularies.

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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.

HCFA 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.

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.

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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.

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. 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 in June and July '93 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 will share the results of these evaluations with State representatives and discuss how needed improvements may be realized.

During the June 26 meeting, with respect to recommendation L-15, States expressed concern that determinations of deficiencies are inconsistent. In addition, they were concerned about the lack of criteria that could be used to determine which penalties should be imposed as a result of certain deficiencies. Standardization of the survey process and the use of criteria concerning the imposition of penalties would promote consistency in survey,

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certification, and enforcement.

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.

HCFA and the NGA agreed that face-to-face meetings over the next few weeks would be productive in assessing the extent to which consistency may be promoted. In addition, discussions concerning the proposed survey, certification, and enforcement regulation would clarify available administrative discretion to promote consistent use of penalties as well as any difficulties in establishing a workable process to impose penalties for certain 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.

HCFA 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. HCFA agreed and noted that HCFA staff had developed alternative language that would limit this prohibition. HCFA expects to issue the policy revision by 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.

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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.

HCFA 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, and representatives in the Department of HHS. Some HHS staff would like to see certain PASARR provisions expanded to other groups (e.g., non-elderly disabled). 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. The group is scheduled to hold its first meeting August 3, 1993.

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

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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

HCFA 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 will propose eliminating the form to OMB.

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

HCFA Response:

We have substantially revised this form to eliminate much of the data being required and will require States to only report the minimal information necessary to monitor the various limits imposed by the D&T and DSH regulations. These revised forms and instructions have been distributed to the BFM-TAG members and the ROs for review and comment. The forms were discussed at the BFM-TAG meeting and the BFM-TAG agreed with the modifications noting that HCFA needed this basic information to monitor implementation of the various limits and caps in the law.

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

HCFA 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

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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 four States which needed assistance and we have scheduled trips to Georgia, Arizona, South Carolina, and Washington.

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

HCFA 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**

HCFA 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

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discussed this at the BFM-TAG meeting. We are looking into several suggestions made by the BFM-TAG and we have also scheduled four on-site State visits to assist States with systems problems they are encountering.

The NGA acknowledged HCFA's position.

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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.**

HCFA Response:

In response to NGA recommendations A-36 and A-37, HCFA 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;
- 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

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- 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 either approve the submission or, if in disagreement, 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.

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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%.

HCFA 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.

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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.

HCFA 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.

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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.

HCFA Response:

We support 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.

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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.

HCFA 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."

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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 or even HHS. The funding for substance abuse treatment must be considered in the larger context of all the other Federal agencies with responsibility for issues surrounding substance abuse policy.

HCFA recommends that the issue of changing Medicaid policy to expand funding for residential substance abuse treatment be referred to the recently formed Inter-Departmental Task Force on Substance Abuse. This offers the best approach to developing a coordinated response to the demand for increased coverage of substance abuse treatment, including further evaluation of the role Medicaid should play in any increased Federal funding of such services.

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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.

HCFA 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, we are 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.

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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.

HCFA 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, but we have a budgetary problem with it. Therefore, it is a matter of coming up with the additional Federal funds necessary to convert the program into a full

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Federal 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. These discussions are summarized below.

Legislative Recommendations - The following NGA legislative proposals are under active consideration in the 1993 budget reconciliation process. Similar proposals were included in the President's 1993 legislative package.

- Require all insurers to pay Medicaid claims directly to the Medicaid agency regardless of whether the liable third party is based in the recipient's State.
- Require 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 recovery activity.
- Clarify that Medicaid is payor of last resort.

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

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

HCFA 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 proposals; however, HCFA continues to suggest the idea.

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

HCFA Response:

HCFA will work with the leadership in the new administration to determine its position on this issue. If it supports a change in statute, a legislative proposal will be developed.

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

HCFA 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.

HCFA Response:

HCFA has considered proposing legislation, but this involves some difficult administrative issues and may not be feasible. NGA will take the lead in working directly with IRS on this issue. HCFA will keep the proposal under advisement. We note that the Senate Finance Committee has included this provision in draft language.

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 in a few weeks. Other NGA members suggested that cost avoidance waivers should focus on type of provider and client type, in addition to type of service.

HCFA Response:

Current regulations allow for waivers to be granted for cost avoidance and trauma code situations that are not cost-effective. Many States have approved waivers in operation today. HCFA was not aware of any States that have a problem with physician claims. We will discuss the matter at our next TPL Technical Advisory Group (TAG) conference call scheduled for July and seek to determine how pervasive the interest is in paying and chasing these, or other claims. If it is determined that there is a widespread problem that cannot be resolved by current

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regulations, HCFA will take action to address the problem. In the meantime, States will be reminded that waivers are available for cost-effective situations. HCFA will analyze and act quickly on any waiver request submitted.

- 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).

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.

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. The NGA also supported the concept of seeking exceptions for school-based services from TPL free care rules and for IEP/IFSP services from TPL rules.

HCFA 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), the Medicaid Bureau will review this issue further and report back to the NGA. HCFA will also determine whether IEP/IFSP services can be excepted from TPL rules.

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 during our July teleconference with TAG and

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RO staff.

- 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.

HCFA Response:

HCFA agreed to give States as much flexibility as possible and will use State plan amendments to do so, if feasible. However, this is contingent upon the flexibility afforded in the law, when enacted.

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.

HCFA 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.

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 Timelines 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.

HCFA 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

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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.

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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.

HCFA 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)

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which focused on HCFA's plans for EDI, and provided an explanation of the activities of the Workgroup 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 are working with Ms. Linda Schofield, Medicaid Director for the State of Connecticut. She represents the State Medicaid Directors' Association WEDI steering committee and on ANSI's Accredited Standards Committee (ASC X12). WEDI has published one report (July, 1992) and will publish a second one later this summer or early fall. 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 should be available for use by State agencies by 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 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.

HCFA 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.

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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.

HCFA Response:

HCFA has no plans to develop regulations on this issue.

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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.

HCFA Response:

HCFA agrees and notes that a proposal along these lines is being considered by Congress for inclusion in the omnibus budget package for FY 1994. Also, the Administration supported a similar proposal in its budget/legislative package for FY 1994. It would restore personal care as an optional service and would clarify that personal care is not required to be delivered by home health agencies.