

July 28, 1993

MEMORANDUM FOR KATHI WAY

FROM:

Richard Bavier 

SUBJECT:

Suggested language for cost-neutrality paragraphs

As requested, the paragraphs below try to respond to State concerns by distinguishing between waiver requests that are only for policies that could be adopted statewide, and others that are parts of larger packages. I think we could live without cost-neutrality in the former kind of case when it comes to welfare waivers, if it were clear that we might not approve some requests. In fact, HHS has always been able to give waivers of this kind without cost-neutrality requirements, although the Dept exercised discretion, and OMB had review of some of this kind of waiver approval under our apportionment authority.

I don't know whether HCFA would be comfortable with this position. I'm copying Vic Zafra (x4926) who works for Nancy-Ann. In addition, ACF ought to have a look at this to see if they are comfortable.

States frequently want to test, on a demonstration basis, the affects of a policy that could be adopted statewide through a plan amendment. Often, these policies are part of a larger package of welfare waivers. In light of the fact that the State could receive federal matching funds without any cost-neutrality conditions if the policy were adopted through a State plan change, it may seem unfair to include the policy in cost-neutrality calculations.

If a State requested waivers of statewideness requirements for a policy that could be implemented statewide through a State plan change, and the waivers were not part of a larger demonstration, but stood alone, the usual cost-neutrality requirements might be modified if a sound evaluation were also planned. In other words, the State would receive waivers only for policies that could be adopted statewide without waivers. In order to learn their effects on a sub-state basis. The strong evaluation component is essential in such situations, because current waiver authority is not intended to permit the Secretary to waive statewideness requirements in law in order to allow States to make permanent changes unrelated to research and pilot purposes.

In cases where a State proposed a demonstration that is statewide or sub-state, and includes both some policies that could be adopted through State plan changes and others that could not, the effects of the polices that could be

adopted statewide could not be isolated from the effects of other waivers. In such cases, the cost baseline for cost-neutrality must reflect the statewide policy that would have been in effect in the absence of the demonstration, not the policies that could have been in effect.

cc: Isabel Sawhill  
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waive

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## The Need To Rationalize HHS Decisionmaking Under § 1115

March 23, 1993

### The Problem

It is fundamental to the just exercise of governmental power that it be exercised in a lawful and uniform manner based on objective decisions that fairly balance any competing interests involved. Application of these principles to the Secretary's exercise of the authority given to her under § 1115 of the Social Security Act, 42 U.S.C. § 1315, mandates establishment of standards to rationalize the decisionmaking process and of a clearly defined review process. Current agency policies do neither. Establishing standards and defining the review process will limit the agency's ability to play fast and loose with its 1115 authority. Such limitations are what the rule of law is about.

Section 1115 (a), first adopted in 1962, allows the Secretary to waive a state's compliance with specific provisions of the Act where waiver of those provisions is "necessary" to allow a state to carry out a demonstration project "which, *in the judgment of the Secretary*, is likely to assist in promoting the objectives of" the relevant program. The statute vests broad discretion in the Secretary, but does not authorize carte blanche approval of any and every state proposal. Rather, it imposes an obligation on the Secretary to make a careful, thoughtful, and reasoned determination about the appropriateness of waiving federal requirements in light of the program's objectives. This directive is reinforced by the legislative history of the provision which explicitly indicates that Congress expected the Secretary to "selectively approv[e]" projects. Sen. Rep. No. 1589, 87th Cong., 2d Sess. (1962), 1962 U.S. Code Cong. and Admin. News 1943, at 1962. The Secretary must weigh heavily the importance of federal entitlements for program beneficiaries in determining whether, if at all, requested waivers that reduce entitlements are likely to promote the program's objectives.

The problems caused by the failure to establish such guidelines were graphically illustrated by the agency's approval during 1992 of a number of AFDC projects designed to regulate recipients' behavior in areas such as childbirth, school attendance, immunization, and interstate migration with little or no consideration of the fact that they posed a substantial risk of damage to poor children and their caretakers. HHS's only "standard" seemed to be "anything goes as long as it does not cost the federal government money".

In addition to ignoring its duty to evaluate the merits of the projects in light of their potential for harm, HHS turned a blind eye to numerous other defects in the proposals. For example: the explanations of the proposed project activities were often unclear and/or incomplete; proposals were submitted and approved despite their inconsistency with governing state law and before adequate evaluations were assured.

### Rationale For Standards And A Defined Review Process

1. A statement of standards is needed to provide notice to states, poor families, and the general public of how the Secretary's discretion under § 1115 will be exercised, information that all three are entitled to.
2. The significance of § 1115 authority and its effect on program beneficiaries require articulated standards to provide some uniformity in the decision making process and thereby minimize the potential for arbitrary and capricious exercises of discretion.
3. A defined process and standards would promote a more rational, thorough consideration of the issues raised by § 1115 applications by giving guidance to the agency staff responsible for analyzing the proposal and preparing recommendations for the Secretary.

### Recommended Policies

#### The § 1115 review process

1. There should be *public notice of applications and the opportunity to comment* thereon. It is as inappropriate to use a closed process to consider § 1115 proposals that could directly and seriously impact on people's lives as it would be to legislate in secret.

HHS should require states to give public notice in the state, make the project material available for review, solicit comments and consider them in formulating their application, and advise HHS as to the tenor of such comments (or in the alternative solicit such comments after submitting application to HHS and submit such comments to HHS).

HHS should publish notice in the Federal Register of receipt of an § 1115 application or any major and significant changes in a previously submitted application with a general summary of the project and information on the availability of documents for review, and should solicit public comment.

2. There should be a *clearly defined application, review, and approval process*. To avoid undue burden, the process could distinguish between procedures applicable to projects that are limited to demonstration of procedural and/or substantive requirements that are fully authorized by federal law, and those that seek approval of steps not permitted under federal law.

At a minimum, this process should include:

- clear *delineation of the departmental offices involved* in review of the application and of the authority of each office;
- establishment of *time frames for agency action* that assure time for reasoned consideration and an adequate opportunity for public participation in the process, and publication of such time frames;
- definition of procedures to establish an *agency record for the decision making process* that assures that all relevant documents and information are fully and readily available to the decisionmaker(s);

- clear *delineation of the information that must be included* in a project application in order to receive consideration by HHS, including a requirement that the application demonstrate compliance with all of the requirements that must be met for approval;
- commitment to an *open review process* in which all interagency contacts and communications are part of the public record;
- *depoliticization of the review process* -- placement of full and final responsibility for project review and approval within HHS as required by law, with provision for coordination with other federal agencies where programs within their jurisdiction are implicated by project applications, and abandonment of politically motivated reviews and intervention by White House "advisory" groups;
- a requirement that the decisionmaker(s) 1) *make and record findings* as to how the application meets the substantive criteria set out in the statute and regulations; and 2) *discuss public comments*, including the agency's responses to such comments;
- *publication of notices of decisions* that include the reasons given for disapproval or the terms of any approval;
- provision for *monitoring project results* through a system of required timely evaluative reports and receipt of public comments about the project operations, and for taking action to modify or revoke the project approval where indicated by the results of such monitoring;
- provision for taking action to modify or revoke project approval where the project is *not operated in compliance with the terms* of the approval.

### Criteria for assessing 1115 applications

1. All project applications that are other than demonstrations of permissible activities should be reviewed in accordance with the department's rules governing *protection of human subjects in research and experimentation*, 45 C.F.R. Part 46, to assure that there is an independent assessment by a qualified professional body of whether the project would subject human subjects to a possibility of more than minimal risk and whether it should nonetheless be permitted to proceed because the potential benefits of the project outweigh such risk and adequate procedures have been put in place to safeguard the rights and welfare of the participants to the maximum extent possible.
2. All project proposals should be reviewed for an assessment of whether they pose a danger to the physical, emotional or mental well-being of a participant within the meaning of § 211 of *the Appropriations Act* and therefore require the written informed consent of participants. The agency should define what is meant by "danger".
3. HHS must recognize that § 1115 is not an authorization for states to do whatever they think best. Approval of a project must be conditioned on *the Secretary's "judgment" that the proposed approach is "likely to assist in promoting the objectives of" the particular federal statutory title involved* and there should be clear delineation of the questions and factors that will be explored to reach that judgment. Although projects are initiated by units of state governments, HHS has primary responsibility for assessment of whether a proposed project is

ethical, sensible, practicable, warranted in light of past experience and otherwise consistent with the purposes of the AFDC program.

A cardinal principle should be a return to the original purposes of § 1115 and its only reasonable reading, that projects which would *involuntarily subject participants to limitations on or withholding of benefits to which they would be entitled absent the project can not promote the objectives of a public assistance program.* (This principle would not foreclose experimentation with financial incentives and sanctions since projects could provide benefits not otherwise available and withhold those benefits if certain conditions were not met.) Consideration must also be given to whether there is any *likelihood of implementation on a nationwide basis.*

4. HHS should not approve projects *involving a policy area that HHS itself has identified for policy development until it has formulated its overall position on the issue and specified the research questions it wants addressed.* The development of an overall policy and a research approach can take into account the views of others outside the agency, such as states and program beneficiaries. Project approval before HHS has articulated its own views would be premature because HHS will not be able to assess whether the project will test a policy that HHS would consider for nationwide implementation or whether its results would be useful elsewhere. In addition, a state has no urgent need for HHS action that would warrant approval before HHS has had the chance to develop its own policy.

5. The requirement that projects should be "*cost-neutral*" should be abandoned because it produces a bias against projects that treat the poor fairly. By precluding a state from proposing anything that would increase costs by improving assistance or services unless it is willing to cut assistance or services in some other way, the requirement insures that states will focus on proposals to cut programs. It also insures that a state can not test the use of financial incentives and sanctions without also taking away existing benefits.

6. Project proposals should not be entertained unless and until --

- the state certifies that the proposed activities are *permissible under state law;* and
- the application contains a *complete and specific statement* of the project activities and of which features require waiver because of their inconsistency with federal requirements, and a specific identification of the statutory provisions and/or regulations which would need to be waived.

To consider projects while state law barriers exist is a waste of resources since the necessary changes in state law may never be forthcoming. In addition, any acceptance by HHS could improperly influence consideration at the state level of the issue of whether the project should be authorized. Specific definition of the project is needed because there is no way to truly judge the impact of the proposal on participants without full delineation of its features or to provide a standard for measuring whether a project is operating in accordance with the terms on which it was approved.

7. HHS should review all proposals for their *conformity with applicable federal law, including the Constitution.* Just as it is appropriate for a state to ascertain that a proposal is consistent

with state law, so too HHS should satisfy itself that there are no federal law impediments to the proposal.

8. Consideration of proposals for activities not permitted under federal law should be conditioned on submission of a *clearly articulated hypothesis* to be tested along with an analysis of relevant data supporting and refuting such hypothesis. Nothing less can suffice to establish that there is something more at stake than a desire to be freed of federal requirements or to provide a basis for a judgment as to whether operation of the project is likely to assist in promoting the objectives of the program.

9. Projects should not be approved unless and until there is an *adequate evaluation scheme* fully in place and the adequacy of the plan should be assessed by an independent panel of qualified experts. Allowing projects to begin before the evaluation scheme is finalized can seriously impede evaluation by requiring evaluators to base data collection on a preexisting scheme of operation rather than providing for consideration of such needs in the project design. Independent assessment assures an adequate pool of experts whatever staffing limitations exist within the agency and also provides an appropriate further immunization from political pressures.

10. If projects that *reduce existing benefits or otherwise impose more stringent conditions than currently authorized* are not completely banned, they should be subject to special scrutiny --

- the projects should be required to be less than statewide and be limited in scope to the number of participants required to fairly test the hypothesis,
- multiple experiments with the same activity should not be permitted absent a showing that the subsequent project will yield necessary information that can not be obtained from the already approved project,
- the duration of the project should be no more than what is absolutely required to fairly test the hypothesis, and
- the state must be required to demonstrate that the issue cannot be studied in a less onerous way.

AMB/MRM



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

JUL 26 1993

TO: The Secretary  
Through: DS \_\_\_\_\_  
COS \_\_\_\_\_  
ES \_\_\_\_\_

FROM: Administrator  
Health Care Financing Administration

SUBJECT: Results of the Health Care Financing Administration/National Governors' Association (HCFA/NGA) Negotiations on Home and Community-Based Services and Freedom of Choice Waivers--  
DECISION

**BACKGROUND**

In his February 1993 address to NGA, President Clinton promised to further streamline the application process for Medicaid waivers. This paper focuses on legislative, regulatory and administrative approaches to implement this directive for home and community-based services (HCBS) and freedom of choice (FOC) waivers.

HCBS and FOC waiver programs have enabled States to develop cost-effective service arrangements to meet the needs of specific populations. As a result, States have increasingly sought maximum flexibility in designing and administering their waiver programs. Because HCFA is charged with ensuring that States maintain high quality programs, provide cost-effective services, and ensure access while meeting statutory requirements, States' desire for flexibility at times has conflicted with Federal perspectives on program requirements. Yet, there are also many common areas of interest between the States and HCFA. The discussions with the NGA have focused on ways in which the waiver process can be improved to meet these common goals. (OMB and OIA were involved in the discussions.)

**SUMMARY**

Discussions with the NGA have led to agreements on administrative, regulatory, and legislative changes to improve Medicaid program waivers. These changes will enhance State flexibility and ease the burden on States, while maintaining program goals of access, quality, and cost containment. ✓

By adopting the approach proposed by HCFA and supported by the NGA, the Secretary will be able to report to the President that the following improvements will be made to the Medicaid HCBS and FOC waiver programs:

**Page 2 - The Secretary****HCBS WAIVERS:**

1. The waiver formula will be simplified and the data required to show cost-neutrality of HCBS waiver programs will be decreased from 14 to 4 data elements. The test of State institutional bed capacity will be eliminated via the regulatory process.
2. Administrative changes will be made to:
  - improve communications and technical assistance to States to expedite waivers;
  - limit HCFA to only one formal request for additional information on waiver applications;
  - make the requirement for an independent assessment of State waiver performance optional;
  - disseminate a revised version of the initial and renewal waiver application formats to simplify the waiver application process for all HCBS waiver programs;
  - develop prototype waiver formats for HCBS programs serving persons with traumatic brain injuries, AIDS, and medically fragile children which will improve the waiver application process for these target populations; and
  - simplify the reporting requirements for State HCBS waiver programs.
3. NGA recommendations regarding legislative changes to convert the HCBS waiver process to State plan amendments (SPAs) were deferred until States have had experience with the streamlined waivers and the new waiver formula. If the experience demonstrates the continued need for such legislation, HCFA will support it (with the exception of an NGA proposal for conversion of waivers to State plan amendments from one State to another). The NGA believes that because of progress made during NGA/HCFA negotiations, legislative changes should not be pursued at this time.

**Page 3 - The Secretary****FOC WAIVERS**

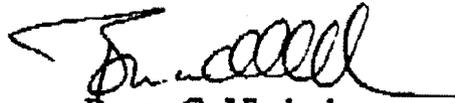
Significant changes in the FOC waiver process are also envisioned or have already taken place. These are expected to result in the enhancement of State flexibility and an expansion of Medicaid managed care programs.

1. The following administrative changes have taken place as a result of the NGA discussions:
  - States will be allowed to use other States' waiver experience on cost effectiveness projections in developing initial primary care case management programs. ✓
  - Pre-determined approval criteria and streamlined applications have been further developed and refined, including the development of a streamlined waiver application for capitated programs. ✓
2. HCFA supports the following legislative proposals to FOC waivers:
  - A legislative change which will allow 1 month continuous eligibility to recipients in a managed care plan, thereby easing the administrative burden on States and managed care plans caused by late income reports from clients. ✓
  - A legislative change which will extend the period of approval for FOC waivers from 2 to 3 years for new waivers and from 2 to 5 years for renewal waivers. This will ease the administrative burden on States. ✓
  - HCFA will support legislation to allow States to limit client choice to a single HMO in rural areas if there is only one HMO available to serve Medicaid recipients. Rural areas, and any conditions, will be defined through the legislative and regulatory process. ✓
  - Additionally, HCFA will support legislation to eliminate the 75/25 enrollment composition requirement and convert FOC waivers to SPAs; however, HCFA will not support implementation of such legislation until the managed care quality assurance guidelines (currently being evaluated in three States) have been determined to be a valid means of assessing the quality of care delivered to Medicaid recipients. In the interim, HCFA is willing to support legislation that would allow waivers to be converted to time-limited SPAs that would be periodically re-assessed based on certain criteria and standards related to quality and access. ✓

**Page 4 - The Secretary**

These initiatives, combined with the quality assurance activities undertaken by HCFA and other efforts to develop standards on fiscal solvency and marketing practices, will facilitate State efforts to expand Medicaid managed care by removing impediments to States contracting with HMOs. Finally, the OMB involvement in the review of FOC waivers is being reviewed in a separate initiative. An attempt will be made to limit their involvement by establishing certain thresholds.

HCFA's proposals for improving the FOC and HCBS waiver process are presented in Tab A. The NGA administrative and legislative recommendations on Medicaid program waivers are listed in Tab B and can be used for more detail related to specific NGA recommendations. Tab C outlines the current HCBS waiver formula and Tab D presents data on HCBS waiver costs.



Bruce C. Vladeck

**4 Attachments:**

Tab A - Proposals for Improving the FOC and HCBS Waiver Processes

Tab B - NGA's Administrative and Legislative Recommendations to Improve  
Medicaid Program Waivers

Tab C - The Current Waiver Formula

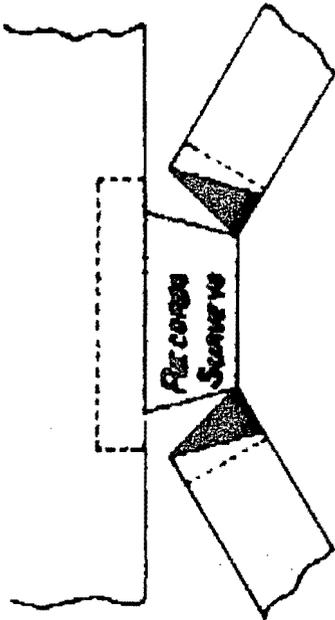
Tab D - Background Information on HCBS Waiver Costs

**HOW TO USE  
THESE SEPARATORS**

Use one page for each separation.

Select appropriate tab, add further identification if desired, and cover it with scotch tape.

Cut off and discard all tabs except the one covered by tape.



**TABBED SEPARATOR SHEET**

Form SSA-697 (5-80)

**TAB A**

**PROPOSALS FOR IMPROVING THE FREEDOM OF CHOICE AND HOME AND  
COMMUNITY-BASED SERVICES WAIVER PROCESSES**

## **PROPOSALS FOR IMPROVING THE FREEDOM OF CHOICE (FOC) AND HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROCESSES**

This paper summarizes the Health Care Financing Administration/National Governors' Association (HCFA/NGA) discussions on improving the FOC and HCBS waiver processes.

The issues discussed are outlined below:

- I. Recommendations to Expedite the Approval Process for both FOC and HCBS Waivers by Decreasing Formal Requests for Additional Information (NGA recommendations: A-1 and A-3)**
- II. Recommendations on HCBS Waivers**
  - A. Proposals to Simplify the Waiver Formula and to Eliminate the "Cold Bed" Test  
(NGA recommendations: A-11, A-12, and A-14)**
  - B. Proposals Which Further Streamline the HCBS Waiver Administrative Process  
(NGA recommendations: A-12, A-13, A-15)**
  - C. Proposals to Develop "Prototype Waivers"**
  - D. Proposals to Convert HCBS waivers to State Plan Amendments (SPAs)  
(NGA recommendations: A-39, L-1, L-2, and L-8)**
- III. Recommendations on FOC Waivers**
  - A. Proposals to Improve Standardized Application Format  
(NGA recommendations: A-8, A-9, and L-7)**
  - B. Proposals to Remove Impediments to States Contracting with Health Maintenance Organizations (HMO)  
(NGA recommendations: A-10, L-3, L-5, and L-6)**
  - C. Proposals to Change Waivers to SPAs  
(NGA recommendations: L-1, L-2, and L-4)**

**I. RECOMMENDATIONS TO EXPEDITE THE APPROVAL PROCESS FOR BOTH FOC AND HCBS WAIVERS BY DECREASING FORMAL REQUESTS FOR ADDITIONAL INFORMATION**

The NGA proposes in recommendations A-1 and A-3 that HCFA should be given only one opportunity to request additional information on both FOC and HCBS waivers during the approval process. Recommendation A-3 encourages HCFA's presumptive approval of waivers.

**HCFA's Proposal:**

HCFA is committed to working with States to develop ways to ensure expeditious approval of both HCBS and FOC waivers. HCFA further explained that it is an extremely rare occurrence for HCFA to deny a HCBS or FOC waiver. For example, in 1992 HCFA processed 55 freedom of choice waiver actions and disapproved only one. Since the formation of the Medicaid Bureau in April 1990, we have approved 16 new freedom of choice waiver programs, for a current total of 44 such programs.

Similarly, HCFA continues to approve home and community-based services waivers at an increasing rate. Since the home and community-based services waiver program came into effect (October 1, 1981) until the formation of the Medicaid Bureau (April 1990), 274 waivers were approved--an average of 33 waivers per year. Since the formation of the Medicaid Bureau, 116 additional home and community-based services waivers have been approved--an average of 42.2 per year. This represents an increase of approximately 29% per year in the number of waivers approved. The number of waivers disapproved has also decreased significantly since the formation of the Medicaid Bureau. During this period, only one waiver was disapproved. The increase in these waivers (and corresponding decrease in disapprovals) has resulted largely from increased efforts by HCFA central office and regional office staff to work with States to develop approvable waivers and waiver renewals.

HCFA will continue to work with States to improve these processes. The following steps to further streamline the process are proposed or have been completed as a result of the NGA discussions.

- HCFA will continue to make only one formal request for additional information on waivers, as required by current law.
- HCFA will further refine the streamlined waiver format for initial HCBS waiver submissions and submit to States the streamlined format for renewal of HCBS waivers.
- For FOC waivers, the initial and renewal application formats have been revised and submitted to NGA State representatives and the State Managed Care Technical Advisory Group for

review. In addition, a new streamlined waiver application for capitated programs is being developed.

- HCFA will improve communications with States to minimize the need for, and the length of, formal requests for additional information. HCFA is committed to:
  - making increased use of early informal consultation to resolve issues on waivers under review;
  - accepting information on waivers in facsimile form; and
  - continuing to review draft submissions of waiver requests in an effort to assist States prior to formal submission of waiver proposals.
- HCFA will continue to improve its technical assistance by:
  - developing technical assistance guides on areas of specific interest in waivers; e.g., approaches to quality, client assessment instruments, etc.;
  - providing technical assistance during waiver development so that issues can be resolved prior to submission of the request;
  - awarding an outside contract to develop a clearinghouse of information on approved waivers;
  - providing training to regional and central office staff to ensure a consistent approach to waiver issues.

NGA Reaction:

The NGA was supportive of HCFA's proposals and implementation approach.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

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

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

NGA administrative recommendations A-11 and A-14 address the simplification of the waiver formula and the elimination of the "cold bed" test.

#### Background:

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

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

#### HCFA's Proposal:

The revisions proposed for the formula are a direct reflection of the States' request and an indication that the Secretary supports elimination of the "cold-bed" test. This test of bed capacity has been the key tool HCFA employed to limit the numbers of people served under HCBW programs. Over time, the test has become less effective and, after 12 years, more difficult to assess and substantiate. Therefore, it is not in the State or Federal interest to employ the bed capacity test if the data is so imprecise.

Thus, we have worked with State officials to remove unnecessary elements from the current formula and reduce it to the minimum necessary to administer the program effectively and satisfy statutory requirements.

HCFA believes the current waiver formula could be reduced from 14 elements to 4 and still satisfy the key statutory requirement that cost-neutrality be assured. The new formula would consist of a comparison of average per capita costs with and without the program waiver. This can be represented using the currently defined formula elements:  $D$  plus  $D'$  <  $G$  plus  $G'$ .

In plain language, we assure that the average annual per capita cost of waiver

and other Medicaid costs for the waiver group are less than the costs the same group would incur without the waiver (both institutional and other Medicaid costs).

In order to project total waiver costs and provide some protection to the States from demand to serve more persons than they can manage, it was agreed that the State would also report the number of waiver participants proposed for service each year, but this data element would exist outside the waiver cost-neutrality formula. It is the equivalent of the current "C" value in regulations.

These four waiver formula elements (plus a fifth quantitative element outside the formula) are consistent with the definitions of existing data elements, no new State data collection would be required. Basic data to support cost-neutrality would be obtained through this approach.

The elimination of utilization factors is the principal difference between the old formula and the new. The budgetary impact of this change is difficult to predict. It has become increasingly evident that (absent the inclination to make arbitrary decisions to limit waiver utilization) the budgetary control achieved through the old formula and bed capacity test has diminished with time. Put simply, a test that relies on what would have happened without a program when the program has been in effect for 12 years is methodologically crippled. Thus, in radically simplifying the formula we may be eliminating a measure of control that had become more administrative illusion than reality.

It seems any significant growth over that which would have occurred without this change will result from advocacy group pressure on States to the degree they realize that waiver utilization limits have become State driven, not a Federal limitation.

The willingness of States to expand their waiver programs will be limited by the availability of State funding, which is in turn related to issues of provider taxes and intergovernmental transfers, among other State budgetary issues.

The consensus of State and HCFA staff to defer consideration of alternative approaches, such as conversion to a State plan with caps, is based on concern that achieving a meaningful and workable cap on which there would be State consensus would be unlikely.

#### Discussion:

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

- Decrease the amount of data collected and reported by States, and improve the review process at HCFA.

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

NGA Reaction:

The NGA was extremely supportive of this proposal because they find the current waiver formula to be complex and burdensome.

Other Reactions:

Nursing home associations may view this as a expansion of community-based care. In the past, OMB has expressed concern regarding the cost of the HCBS waiver program. They may view elimination of the "cold bed" test as further expansion.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

**B. Proposals Which Further Streamline the HCBS Waiver Administrative Process.**

NGA recommendations a-12, A-13, and A-15 proposed to expedite the administrative processes for HCBS waivers, to clarify types of services available under waivers, and to expedite the HCBS waiver re-application process.

**HCFA's Proposals:**

1. **Administrative Streamlining** - HCFA will further expedite the processing of 1915(c) home and community-based waivers by:
  - finalizing revised regulations on 1915(c) waivers, including provisions to delete the "cold bed" test and ease the complexity of the waiver formula;
  - disseminating the streamlined waiver renewal format to States;
  - further refining the streamlined waiver format currently used by many States;
  - developing a streamlined data collection form for reporting annual costs of approved waivers; and
  - continuing to provide technical assistance to States developing new waivers, waiver renewals, or waiver amendments.
2. **Clarify State Flexibility on Services Covered Through the HCBS Waiver Program** - Discussions with the NGA revealed that there is considerable confusion on the degree of State flexibility to cover services under HCBS waivers. HCFA will issue an "All States Letter" to further clarify that States already have considerable flexibility to add service definitions in their HCBS waivers.

Additionally, consensus was reached that current levels of State flexibility were sufficient and that HCFA should continue to work to ensure that services proposed by States are consistent with Medicaid HCBS program objectives.

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

To ensure that States have the flexibility to contract for an independent assessment and obtain Federal Financial Participation (FFP), the regulation will be revised to eliminate the independent assessment

requirement, but reaffirm (in the preamble to the regulation) the availability of FFP for such assessments when voluntarily undertaken by the State.

NGA Reaction:

The NGA was supportive of the HCFA proposals.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

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

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

HCFA's Proposal:

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

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

NGA Reaction:

The NGA was supportive of the HCFA proposals. Consensus was reached on the target populations selected and the overall approach to be taken to develop the prototype waiver formats.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

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

NGA recommendations A-39, L-1, L-2, and L-8 proposed that HCBS waivers be converted to the SPA process. During HCFA's discussions with the NGA and with the Non-institutional Long-term Care Technical Advisory Group, it was agreed that changes requiring legislative action should be deferred. This decision was made because of the progress made during the NGA/HCFA negotiations which resulted in an agreement to proceed with many positive administrative and regulatory changes to the HCBS waiver process.

However, HCFA also agreed that once States have had experience with the streamlined waivers and new waiver formula, if the State experience demonstrates the continued need for legislation to convert HCBS waivers to SPAs, HCFA would support it. However, because of the variation in State Medicaid Programs, HCFA did not support one NGA proposal which would provide that once one State demonstrated through the waiver process that the program was effective and efficient, other States would have the opportunity to make that program part of their State plan.

### III. NGA RECOMMENDATIONS ON FREEDOM OF CHOICE (FOC) WAIVERS

During HCFA/NGA discussions, NGA representatives acknowledged the considerable work that HCFA has done in the last 18 months to improve the FOC waiver process.

HCFA and NGA agreed, either fully or in part, to implement the NGA recommendations on FOC waivers, as follows.

#### A. Improve Standardized Application Format and Process

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

##### HCFA's Proposal:

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

- **Develop Pre-Determined Approval Criteria** - NGA's recommendation A-9 proposed that HCFA continue and expand its efforts to develop pre-approved waiver packages.

##### HCFA's Proposal:

HCFA had already implemented this recommendation and issued two streamlined waiver applications: one for initial primary care case management programs (on November 25, 1991), and the other for renewal of primary care case management programs (on June 19, 1992). Recently, HCFA issued a streamlined waiver application for capitation programs and updated the previous applications. HCFA will continue to actively assist States in making applications and obtaining approval of such applications.

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

HCFA's Proposal:

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

NGA Reaction:

The NGA was supportive of the HCFA proposals.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

**B. Remove Impediments to State Contracting with Health Maintenance Organizations (HMO)**

- **Limit Client Choice to One HMO in Rural Areas** - In recommendations A-10 and L-5, the NGA proposed that States be allowed to limit client choice to one HMO in rural areas.

HCFA's Proposal:

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

- **Continuous Eligibility** - In legislative recommendation L-3, the NGA proposed that States be allowed to offer 1 month of continuous eligibility for clients enrolled in managed care plans.

HCFA's Proposal:

HCFA supports a legislative change which would allow 1 month of continuous eligibility for recipients in managed care plans to ease the administrative burdens on States and health plans caused by late income reports from clients.

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

HCFA's Proposal:

HCFA believes that the 75/25 enrollment composition rule is not the best proxy for quality of care furnished in an HMO. HCFA has completed a quality assurance reform initiative to identify appropriate ways to measure quality of care. All States have recently received a copy of these guidelines, and an evaluation in three States is underway. If usage of the guidelines can be determined as a valid proxy for quality of care in HMOs, HCFA will support a legislative change to eliminate the 75/25 requirement.

NGA Reaction:

The NGA continues to push its original legislative proposals in this area.

**SECRETARY'S DECISION:**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_

**C. Change Waivers to State Plan Amendments (SPA)**

- **Convert Waivers to SPAs** - In recommendations L-1, L-2, and L-4, NGA proposed that within certain limits, waivers be converted to SPAs.

**HCFA's Proposal:**

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

HCFA will support legislation to convert FOC waivers to SPAs; however, HCFA will not support implementation of such legislation until the managed care quality assurance guidelines (currently being evaluated in three States) have been determined to be a valid means of assessing the quality of care delivered to Medicaid recipients. In the interim, HCFA is willing to support legislation that would allow waivers to be converted to time-limited SPAs that would be periodically re-assessed based on certain criteria and standards related to quality and access.

**NGA Reaction:**

The NGA continues to support its original proposal.

**SECRETARY'S DECISION:**

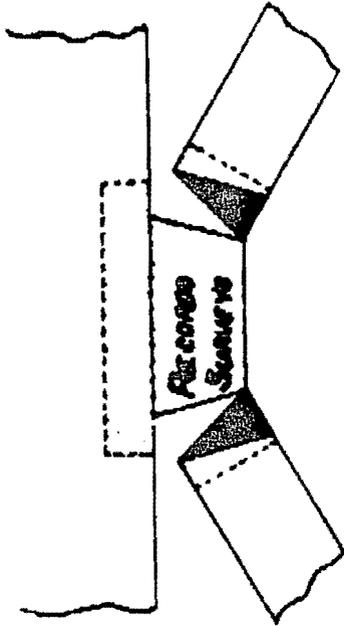
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**TAB B**

**THE NATIONAL GOVERNORS' ASSOCIATION ADMINISTRATIVE AND  
LEGISLATIVE RECOMMENDATIONS TO IMPROVE MEDICAID PROGRAM WAIVERS**

**NATIONAL GOVERNORS' ASSOCIATION (NGA)  
SUMMARY OF STATE RECOMMENDATIONS  
FOR MEDICAID ADMINISTRATIVE CHANGES**

**MEDICAID WAIVERS**

**General**

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

**1915(b) Freedom of Choice (FOC) and Managed Care Waivers**

- A-8. **Other State Experience.** Consider 1915(b) waiver requests to be cost-effective if they include reasonably understood managed care principles, modeled after managed care plans which have received prior approval from HCFA, or have demonstrated cost containment in actual practice nationally.
- A-9. **Pre-Determined Approval Criteria.** HCFA should continue and expand its efforts to develop pre-approved waiver packages with standard elements for target populations. HCFA should actively assist states in making application and obtaining approval of such applications.
- A-10. **FOC in Managed Care.** Specify in regulations that, under certain limited circumstances, a 1915(b) program can limit client choice to one health maintenance organization in an area rather than current requirements of two. Permissible circumstances might be in rural areas for example. (Although listed by NGA as an administrative change, this would require legislation.)

### 1915(c) Home and Community-Based Waivers

- A-11. Cold-Bed Rule. HCFA should develop a policy that moves away from the "cold-bed" analysis to control costs and move toward cost control projections and managed care analysis in order to determine cost-effectiveness.
- A-12. General. Issue regulations or expedite waivers that encourage the use of less costly home and community-based waivers rather than institutional care for older and disabled people.
- A-13. Service Package. HCFA should expand the types of non-institutional services that might be allowable under a 1915(c) waiver.
- A-14. Waiver Formula. Simplify the waiver formula and the measures used in the formula. Many of the measures are extremely difficult to project in a manner that is acceptable to HCFA.
- A-15. Re-application. Waivers should be approved for the full duration allowed under the statute without the need for re-application. The annual HCFA 372 reports, federal reviews, and the requirements of formal amendments for change offer sufficient ongoing control and oversight by HCFA for waivers. Verifiable waiver values for the formula could be recalculated on a periodic schedule.

### State Plan Amendments (SPAs)

- A-39. Waivers. States should have the ability to turn waivers into permanent SPAs once they have been proven effective. (Although listed by NGA as an administrative change, this would require legislation.)

**NATIONAL GOVERNORS' ASSOCIATION**  
**SUMMARY OF STATE RECOMMENDATIONS**  
**FOR MEDICAID LEGISLATIVE CHANGES**

**MEDICAID WAIVERS**

**General**

- L-1. **Waiver to State Plan I.** Once a State has demonstrated through the waiver process that the program is effective and efficient, the waived program should become a part of the State's plan.
- L-2. **Waiver to State Plan II.** Once a State has demonstrated through the waiver process that the program is effective and efficient, other States should have the opportunity to make that program a part of their State plan as an optional service without having to submit a waiver.

**1915(b) Freedom of Choice Waivers**

- L-3. **Continuous Eligibility.** Allow 1 month continuous eligibility to participants in managed care plans to ease the administrative burdens on States and health plans caused by late income reports from clients.
- L-4. **Elimination of Waiver.** Within limits, like some of those identified in the Moynihan managed care legislation, States must be given the authority to establish managed care programs under the State plan amendment (SPA) process.
- L-5. **Rural Areas.** Permit States to use single source contracting or a single managed care entity in rural areas.
- L-6. **75/25 Rule.** All health maintenance organizations should be able to participate in managed care regardless of whether they elect to accept commercial enrollment in addition to Medicaid enrollment.
- L-7. **Waiver Duration.** 1915(b) waivers should be approved for an initial 3-year period with 5-year renewals.

**1915(c) Home and Community Based Waivers**

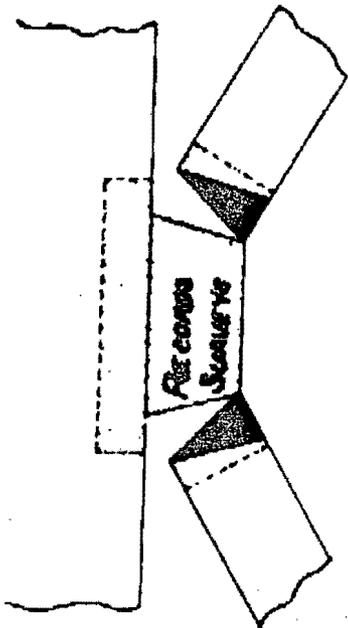
L-8. **Elimination of Waiver.** Within limits, States must be given the authority to establish home and community based care programs under the SPA process.

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**TABBED SEPARATOR SHEET**

Form SSA-897 (5-80)

C

**TAB C**

**THE CURRENT WAIVER FORMULA**

## § 441.303

## 42 CFR Ch. IV (10-1-92 Edition)

(a) A description of the safeguards necessary to protect the health and welfare of recipients. This information must include a copy of the standards established by the State for facilities that are covered by section 1816(e) of the Act.

(b) A description of the records and information that will be maintained to support financial accountability.

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including—(1) A description of who will make these evaluations and how they will be made; (2) A copy of the evaluation instrument to be used; (3) The agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and (4) The agency's procedure to ensure reevaluations of need at regular intervals.

(d) A description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services.

(e) An explanation of how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in § 435.217 of this chapter).

(f) An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the per capita expenditures for services. This information must include but is not limited to the estimated utilization rates and costs for services included in the plan, the number of actual and projected beds in Medicaid certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(A \times B) + (A' \times B') + (C \times D) + (C' \times D') + (H \times I)}{F + H} \leq \frac{(F \times G) + (H \times I) + (F' \times G')}{F + H}$$

where:

- A = the estimated annual number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.
- B = the estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.
- C = the estimated annual number of beneficiaries who would receive home and community-based services under the waiver.
- D = the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.
- F = the estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.
- G = the estimated annual Medicaid expenditure per eligible Medicaid user of such institutional care in the absence of the waiver.

H = the estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I = the estimated annual Medicaid expenditure per eligible Medicaid user of the noninstitutional services referred to in H.

The symbol " $\leq$ " is intended to mean that the result of the left side of the equation must be less than or equal to the result of the right side of the equation.

A' = the estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.

B' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.

## Health Care Financing Administration, HHS

§ 441.304

C = the estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.

D = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in C.

F = the estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.

G = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F.

(2) For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

(3) Data on the estimated annual number of beneficiaries and expenditures for those who would otherwise receive an SNF, ICF, or ICF/MR level of care is required for all three types of institutions only if the waiver request provides that each of these groups will be offered home and community-based services. For example, if the request does not include persons who would otherwise receive an ICF/MR level of care, the State is not required to furnish data on that group.

(4) The data must show the estimated annual number of beneficiaries who will be deinstitutionalized from certified SNFs, ICFs and ICF/MRs because they would receive home and community-based services under the waiver, and the estimated annual number of beneficiaries whose admission to such institutions would be diverted or deflected because of the waiver services. For the latter group, the State's evaluation process required by § 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be limited to persons who would otherwise receive the level of care provided in an SNF, ICF, or ICF/MR.

(g) Except as HCFA may otherwise specify for particular waivers, the agency must provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment must be

submitted to HCFA at least 90 days prior to the third anniversary of the approved waiver period and cover at least the first 24 months of the waiver.

[46 FR 48532, Oct. 1, 1981, as amended at 50 FR 10027, Mar. 13, 1985; 50 FR 25080, June 17, 1985]

## § 441.304 Duration of a waiver.

(a) The effective date for a waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by HCFA prospectively on or after the date of approval and after consultation with the State agency. The waiver continues for a three-year period from the effective date. If the agency requests it, the waiver may be extended for additional three-year periods, if HCFA's review of the prior three-year period shows that the assurances required by § 441.302 of this subpart were met.

(b) HCFA will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver.

(1) Generally, if a State's extension request proposes a change in services provided, eligible population, service area, or statutory sections waived, HCFA will consider it a new waiver request.

(2) If a State submits an extension request that would add a new group to the existing group of beneficiaries covered under the waiver, HCFA will consider it to be two requests: one as an extension request for the existing group, and the other as a new waiver request for the new group.

(c) HCFA may grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. HCFA will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when HCFA disapproves a State's request for extension.

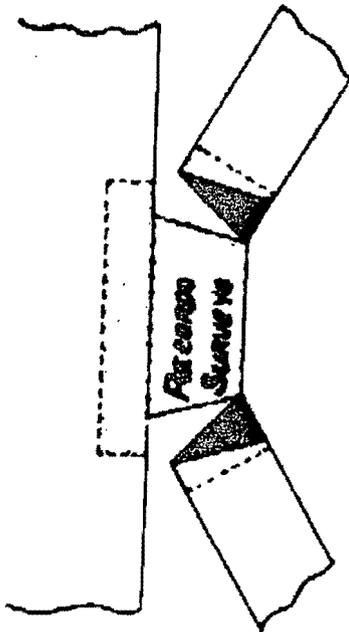
(d) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart, the agency will be given a notice of

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**TAB D**

**BACKGROUND INFORMATION ON HCBS WAIVER COSTS**

## TAB D

## BACKGROUND INFORMATION ON HCBS WAIVER COSTS

Estimate of Effect of Removing Cold-Bed Requirement  
for Home and Community Based Waivers

In estimating this effect, HCFA/OACT looked at the growth rate of spending on HCBS waivers both in the past and projected to the future under the FY94 current services budget baseline. Then OACT attempted to break down this growth rate into a growth in prices and a growth in population served.

The question then becomes: how much more will the population grow if HCFA does away with the cold-bed rule? The case has been made that many states have become adept at writing waiver proposals, so that the cold-bed requirement has not limited these states in serving as many people as they want, and their served population won't grow much. On the other hand, there are other states who have not attained that level of sophistication. Also, in this area there is considerable pressure from advocacy groups to expand these programs. States that have been limited by this requirement have sometimes been forced to create programs funded by state-only money, or to refuse participation to some otherwise eligible people because of lack of funds. In both cases, a relaxation of the cold-bed requirement will let some of these eligibles participate in the partially federally-funded Medicaid program.

Thus it seems reasonable to expect an incremental population growth rate due to this modification of the regulations. Currently, the population served is projected to grow at a rate of approximately 10%, and we believe a plausible estimate for the incremental growth rate resulting from elimination of the cold bed test might be an additional 3% to 5%. In developing this range we considered that some of the additional individuals served may have been receiving comparable Medicaid services outside of a waiver. Adding this incremental population growth to current cost projections produces additional projected Federal Medicaid expenditures of about \$500-800 million over a five year period.

Office of the Actuary  
July 22, 1993

\* - Questions may be directed to Isi Strauss on 67924.



HCFA/OEO #9302231331

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

FEB 23 1993

TO: William Toby, Jr.  
 Acting Administrator  
 Health Care Financing Administration

Kenneth Thorpe  
 Office of Planning and Evaluation

SUBJECT: Implementation of the President's Directives

As you know, the President recently directed this Department to undertake several Medicaid initiatives. The purpose of this memorandum is to outline the President's directives and specify a course of action for their timely implementation.

1. Revise the Medicaid regulations governing provider taxes and disproportionate share promptly following the new negotiations with the National Governors Association that were ordered by the President. I am pleased that the process of negotiating with the NGA has already begun. So that I can give direction to the negotiations, a briefing should be scheduled on the issues before the next meeting with the NGA. Please work together to develop an options paper addressing the pros and cons of various alternatives as well as their potential budget impact. This paper should be provided to me through the Executive Secretariat.

In the interim, actions which HCFA must take in this area of the Medicaid program must be consistent with current regulations.

2. Conduct a thorough review of the Medicaid waiver process, and act promptly to streamline the waiver process. HCFA should prepare a paper providing a broad range of options for streamlining the Medicaid waiver process. These options should address legislative and regulatory issues as well as possible administrative streamlining. The review should include consultation with the National Governors Association and should incorporate an analysis of each of the NGA recommendations related to Medicaid waivers. Please provide the options paper to the Executive Secretariat by March 15 so that we can meet the President's request to develop a list of streamlining recommendations by April 1.

The options paper should also provide alternative approaches to implementing the President's directive that HCFA develop standardized initiatives for program waivers that can be approved automatically so that states can take advantage of other states' successes with far greater ease.

HCFA should take immediate action to revise the process for review of Medicaid program waivers ("freedom-of-choice" and home and community-based services waivers) so that HCFA will request additional information or clarification only once. Any further

- 2 -

requests for information must be related to, or be derived from the information submitted in response to the first request. In the options paper on waivers, HCFA should evaluate the applicability of this rule to all other waivers.

3. Evaluate the remaining NGA recommendations. By April 1, HCFA should complete its evaluation of the remaining NGA recommendations (i.e., excluding waivers and the donations and taxes/disproportionate share rule discussed above) and forward recommendations to the Executive Secretariat for review.

I am confident that these actions will go far in forging a stronger partnership between the federal government and the states to meet the health care needs of our citizens.



Donna E. Shalala

HCFA/OEO #9302231331

MB: ACTION

CC: Toby; Hays

AAC; AAM; AAO; PHC; OLP; OGC; MB

Means; Trout; Giebelhaus;

Schmidt; McCabe

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WAIVERS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



PHONE: (202)690-8794 FAX: (202)690-6518

Date: 5/21/93

From: DAVID ELLWOOD

To: CAROL RASCO

Division: OASPE

Division: WHITE HOUSE

City & State:

City & State:

Office Number: 690 6443

Office Number:

Fax Number:

Fax Number: 456 2878

Number of Pages + cover 3

REMARKS:

## MEMORANDUM

To: Carol Rasco

From: David J. Elwood

Re: AFDC and Medicaid Waivers

Date: May 21, 1993

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I wanted to provide you with a brief update on Waivers prior to your meeting with the NGA. We had a meeting with ACF and HCFA people in an attempt to hammer out a consistent waiver policy for all of HHS. We had before us the ACF draft which you have and some preliminary drafts of HCFA. Although AFDC and Medicaid waivers often go to different agencies, and although there is little indication that states are unhappy with the AFDC/ACF waiver process, many in the department expressed concern that any changes/clarification in the AFDC waiver process would immediately be interpreted as indicating the direction that Medicaid will go as well, and might be misinterpreted. As you know HCFA folks have been meeting with NGA representatives in an effort to significantly improve the Medicaid 1115 Demonstration waiver process. We do not want to create any concern or confusion regarding these negotiations.

If we go forward with a letter to the Governors, we have tentatively decided to send only one letter to each Governor which discusses both types of waivers. It may come from the Secretary or the President depending on your preferences. Initially there were significant areas of agreement, but some areas of disagreement between ACF and HCFA remain. But we did reach a loose consensus. I am confident that we can reach a joint position within the Department next week. Given the President's and your strong interest in this issue, I think it would be prudent to discuss this issue with you sometime soon to be certain you are comfortable with the direction we are moving.

In the meantime, the question arises as to what you should say to the Governors. The talking points below point to the broad consensus that is emerging here. My own preference is that you not get too specific. We have not fully cleared these either internally nor with you and the President. But this gives some indication of how far you could go if you are comfortable with the ideas.

- o The Administration has been engaged in very productive negotiations with the NGA. We expect to have a waiver policy complete in the next few weeks. While there are still details to be worked out, and you would like to avoid getting into specifics, you can say a few things.
- o First, we are establishing a very different relationship between the states and federal government, one of greater trust, more information sharing, and better

service.

- o We are absolutely committed to making the Medicaid 1115 waiver process faster, more straightforward, and more friendly. We believe we can dramatically improve things.
- o States need to understand that the legislation and the legislative history make very clear that 1115 waiver authority is for demonstrations, not simply a mechanism for increasing state flexibility. (Demonstrations are typically designed to test specific new ideas for a specified period of time.) The Congress is very concerned that waivers be granted for genuine demonstrations of new ideas, not as a device to avoid rules and projections legislated by the Congress. If Congress perceives that 1115 waivers are being abused, we could easily lose this waiver authority.
- o The President has indicated that demonstrations need to be carefully evaluated. That is, after all, the goal of demonstrations. Still we will not have rigid rules requiring a particular type of evaluation strategy in all cases. We will seek evaluation strategies that are appropriate to the demonstration.
- o Cost neutrality remains an objective and expectation, but it will likely be applied over the life of the demonstration.
- o States should be aware that health and welfare reform are likely to establish new statutory and fiscal relationships between the states and the federal government. Some states may wish to wait until the central elements of these plans emerge before moving forward with major new demonstrations. The administration is strongly supportive of state initiatives and will, of course, continue to evaluate and grant waivers under the current authority.

I hope this is of use. I'll talk to you soon. I can be reached at home this weekend at

P6/(b)(6)

file-  
WAIVERS

Thank you for the material you sent prior to my visit to New Jersey. I am sorry we were unable to reach one another by phone successfully....working for the vote this week has complicated the ability to spend time at my desk.

There were over 27 states represented at the meeting in New Jersey. Almost ALL the questions directed to me were related to waivers. I would certainly find that particular group of states in attendance not to fit into the categorization in your memo to the effect that "...there is little indication that states are unhappy with the AFDC/ACF waiver process." I would agree that we all have a great deal of discussion to undertake before I am ready to recommend a letter from the President and/or Secretary.

My sense from NGA is that they feel significant progress has been made in the discussions with HCFA outside the 1115 Demonstration waiver process but there is strong feeling that more realistic negotiations need to occur on the 1115 waivers. This will be a must if we are to genuinely establish the "very different relationship between the states and federal government..." you reference and which I am certain we all want.

While the President has certainly been on record as strongly stating that demonstrations need strong evaluation, he has done so in the context of saying such demonstrations should be encouraged, evaluated and terminated if unsuccessful, replicated if successful. He has indicated to me, however, in repeated terms that he questions the previous and continuing emphasis on "control groups." He and I were encouraged by your language "Still we will not have rigid rules requiring a particular type of evaluation strategy in all cases."

In the spirit of encouraging states as laboratories, we do not want to be in the position of appearing to caution states against demonstrations as we proceed on the development of both health care reform and welfare reform.

I will be out until Friday, June 4. I have designated Kathi Way of the Domestic Policy staff to be a liaison from this staff to HHS on these waiver discussions and have asked her to contact you just after the holiday next week.

Kathi will also be able to share with you through the welfare reform working group discussions the issues/ideas raised by the states on that matter.

Thank you...have a great Memorial Day weekend!

*Waiver's  
file  
new file*

DATE: *June 16, 1993*

TO: ~~Kathi Way, Domestic Policy Council~~  
~~John Monahan, DHHS~~  
Richard Tarplin, DHHS, ASL  
Canta Pian, DHHS, ASPE  
Sam Shellenberger, DHHS, ASMB  
Richard Bavier, OMB

FROM: Paul Bordes  
Office of Policy and Evaluation  
Administration for Children and Families  
401-9224

RE: Weekly Tracking Update - Welfare Reform: Section 1115 Waiver Activity

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - June 16, 1993

STATE	INITIATIVE	KEY DATES	COMMENTS
<b>APPROVED</b>			
Vermont	Require participation in subsidized employment after 30 mo for AFDC and 15 mo for AFDC-UP cases, broaden AFDC-UP eligibility, change earnings disregards, change JOBS exemptions, disburse child support to AFDC family, require most minors to live in supervised setting, extend eligibility in child-only cases.	Appl. Rec'd 10/27/92  Appl. Approved 4/12/93	
<b>RECEIVED</b>			
Arkansas	Eliminate increased AFDC benefits for additional children; provide special counseling to 13-17 yr olds and require participation in educational activity.	Appl. Rec'd 1/14/93	Discussion of potential modifications currently underway with State.
Georgia	Provide family planning and parenting services; eliminate increased AFDC benefit for additional children; require able-bodied adults to accept full-time employment if they are not caring for children under 14.	Appl. Rec'd 5/18/93	Application has been distributed to Federal reviewers. Analysis of potential issues has been prepared by ACF for Federal review.

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - June 16, 1993

Illinois	Provide incentives for school attendance; require participation in a Community Service Corps (CSC) for those with children under 3; provide wage subsidy for up to 6 mo. after completing CSC; pay lesser of previous state or Illinois benefit for 12 mo. for new residents.	Appl. Rec'd 10/7/92	Relocation grant pending with ACF; other waivers were tabled by the State for reconsideration; awaiting state action.
Iowa	Multi-faceted proposal including: changes in income disregards, increased resource limits, limiting JOBS exemptions, extending child care transitional benefit to 24 mo., paying lesser of previous state or Iowa benefit for 12 mo. for new residents, requiring most parents to develop self-sufficiency plan which includes individually based time limit on public assistance.	Appl. Rec'd 4/29/93	Met with State representatives on 6/16/93; State will submit an evaluation design proposal.
Massachusetts	Require JOBS participants to pay co-payment for child care.	Appl. Rec'd 1/14/93	Application distributed to Federal reviewers.
Oklahoma	Require school attendance of AFDC recipients aged 13-18.	Appl. Rec'd 12/28/92	Draft Terms and Conditions prepared by ACF for Federal review.
South Carolina	Provides for work experience at for-profit sites, disregard of training allowances, changes to earnings disregards.	Appl. Rec'd 12/9/92	Have discussed and clarified application with state; ACF has prepared description and analysis of proposal for Federal review.

JUN-16-1993 16:11 FROM HHS/ACF/POLICY&EVALUATION TO WH/K. WAY P.03/05

Wyoming	Require able-bodied AFDC applicants and recipients to work or perform community service, require school attendance for those 16 and over, change sanction penalties for non-compliance with work requirements, increase resource limit for employed families, limit or eliminate AFDC benefits in certain cases where recipient is in post-secondary ed. program, provide JOBS to non-custodial parents court-ordered to participate, provide lesser of benefit for Wyoming or prior state of residence for 12 mo. for new residents.	Appl. Rec'd 5/20/93	New application incorporates provisions from prior applications. Gov. has contacted Secretary regarding expedited processing; letter to state identifying issues has been drafted for Federal review.
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**PRE-APPLICATION CONTACT**

Nevada

Contacts received from state; application expected.

South Dakota

Outline of waiver provisions sent by the state 5/20; being reviewed.

JUN-16-1993 16:12 FROM HHS/ACF/POLICY&EVALUATION TO WH/K. WAY P.04/05

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<b>Wisconsin</b>	Provides a maximum of 4 years eligibility with cash benefits for up to 2 years and 12 mo. transitional medical and child care benefits; no cash benefits available for a period of 36 months after last month in which a demonstration benefit was paid; cash-out food stamps and make part of the benefit; education and training services provided; CWEP placements or public job required for those who remain unemployed; changes JOBS exemptions; no additional benefit for children born to AFDC families; child support payments will be directed to the family and counted as income; fixed period of benefit calculation.	Draft Appl. Rec'd 6/3/93	ACF has prepared an analysis of issues and questions for the State.
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**ANTICIPATED**

Massachusetts

Letter received from congressional delegation supporting waiver; however, we have not received a request from the state.

West Virginia

RO III to send letter from state regarding income disregard waivers in conjunction with HUD initiative.

JUN-16-1993 16:12 FROM HHS/ACF/POLICY&EVALUATION TO WH/K. WAY P.05/05

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 6, 1993

STATE	INITIATIVE	KEY DATES	COMMENTS
<b>APPROVED</b>			
Vermont	Require participation in subsidized employment after 30 mo for AFDC and 15 mo for AFDC-UP cases, broaden AFDC-UP eligibility, change earnings disregards, change JOBS exemptions, disburse child support to AFDC family, require most minors to live in supervised setting, extend eligibility in child-only cases.	Appl. Rec'd 10/27/92  Appl. Approved 4/12/93	
<b>DENIED</b>			
Illinois	Would have paid lesser of previous State of Illinois benefit for 12 months for new residents.	Appl. Rec'd. 10/7/92 Appl. Den'd. 8/3/93	
<b>RECEIVED</b>			
Arkansas	Eliminate increased AFDC benefits for additional children; provide special counseling to 13-17 yr olds and require participation in educational activity.	Appl. Rec'd 1/14/93	Discussion of potential modifications currently underway with State

AUG-06-1993 13:12 FROM HHS/ACF/POLICY&EVALUATION TO LHK, WAY P.02/11

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 6, 1993

Colorado	<p>Establish a 2-year time limitation sanction for non-cooperative employable AFDC adults; consolidate AFDC, Food Stamp, and Child Care benefits into a single comprehensive benefits package; disregard a portion of all earned income, replacing all current income disregards; require all AFDC households with children under the age of 24 months to have current immunization, failure to comply will result in a financial sanction; provide incentives to participants who graduate from high school or obtain a GED; exempt the asset value of one care; and increase the resource limit to \$5,000 for those families with an able-bodied adult who is employed or has been employed within the last 6 months.</p>	<p>Appl. Rec'd 6/30/93</p>	<p>Analysis paper sent to Federal reviewers.</p>
Georgia	<p>Provide family planning and parenting services; eliminate increased AFDC benefit for additional children; require able-bodied adults to accept full-time employment if they are not caring for children under 14.</p>	<p>Appl. Rec'd 5/18/93</p>	<p>Application has been distributed to Federal reviewers. Decision memorandum sent to Secretary on family cap on benefits. Issue discussed by Senior Department Staff in briefing with Deputy Secretary on 8/4.</p>
Illinois	<p>Provide incentives for school attendance; require participation in a Community Service Corps (CSC) for those with children under 3; provide wage subsidy for up to 6 mo. after completing CSC.</p>	<p>Appl. Rec'd 10/7/92</p>	<p>These waivers were tabled by the State for their reconsideration; awaiting state action.</p>

Iowa	Multi-faceted proposal including: changes in income disregards, increased resource limits, limiting JOBS exemptions, extending child care transitional benefit to 24 mo. paying lesser of previous state or Iowa benefit for 12 mo. for new residents, requiring most parents to develop self-sufficiency plan which includes individually based time limit on public assistance.	Appl. Rec'd 4/29/93	Met with State representatives on 6/16/93. Draft terms and conditions sent to Federal Reviewers 8/5.
Massachusetts	Require JOBS participants to pay co-payment for child care.	Appl. Rec'd 1/14/93	Application distributed to Federal reviewers.
Oklahoma	Require school attendance of AFDC recipients aged 13-18.	Appl. Rec'd 12/28/92	Draft Terms and Conditions sent to State 7/16 for their review.
South Carolina	Provides for work experience at for-profit sites, disregard of training allowances, changes to earnings disregards.	Appl. Rec'd 12/9/92	Sent State 7/20 analysis paper regarding issues needing further discussion or clarification.
Virginia	1) Up to 600 participants would voluntarily exchange AFDC/Food Stamp benefits for jobs expected to pay \$15-18,000/yr. Training stipends equal to AFDC and FS benefits would be paid initially. 2) Provide additional 24 mo. child care and Medicaid transition benefits. 3) Establish a child support insurance program for those leaving AFDC due to earnings. 4) Disregard step-parent income when AFDC recipient marries; increase resource limit to \$5,000 for education and housing purposes; extend AFDC eligibility to full-time students until age 21.	Appl. Rec'd 7/13/93	Application distributed to Federal reviewers. Analysis paper being prepared.

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 6, 1993

Wisconsin	<p>Provides a maximum of 4 years eligibility with cash benefits for up to 2 years and 12 mo. transitional medical and child care benefits; no cash benefits available for a period of 36 months after last month in which a demonstration benefit was paid; cash-out food stamps and make part of the benefit; education and training services provided; CWEP placements or public job required for those who remain unemployed; changes JOBS exemptions; no additional benefit for children born to AFDC families; child support payments will be directed to the family and counted as income; fixed period of benefit calculation.</p>	<p>Appl. Rec'd 7/14/93</p>	<p>Conference call with State 6/28 discussed issues and questions. Decision memo sent to Deputy Secretary regarding time-limited welfare demonstration and issue was discussed by Senior Department Staff in briefing with Deputy Secretary on 8/4.</p>
Wyoming	<p>Require able-bodied AFDC applicants and recipients to work or perform community service, require school attendance for those 16 and over, change sanction penalties for non-compliance with work requirements, increase resource limit for employed families, limit or eliminate AFDC benefits in certain cases where recipient is in post-secondary ed. program, provide JOBS to non-custodial parents court-ordered to participate, provide lesser of benefit for Wyoming or prior state of residence for 12 mo. for new residents.</p>	<p>Appl. Rec'd 5/20/93</p>	<p>State desired approval by July 1. Draft terms and condition sent to State 7/8. Subsequent negotiations proceeding.</p>

AUG-06-1993 13:13 FROM HHS/ACF/POLICY&EVALUATION TO LHK, WY P.05/11

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**PRE-APPLICATION CONTACT**

Alaska

Would repeal 100-hour rule for AFDC-up; expand working incentives; increase resource and vehicle asset limit; eliminate "new job" requirement for work supplementation and extend transitional medicaid benefits.

ASPE official met with State Staff 6/22.

AUG-06-1993 13:14 FROM HHS/ACF/POLICY&EVALUATION TO LHK, WY P.06/11

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California

Implement Cal. Learn, a Learnfare program that provides both bonuses and sanctions. Increase the resource limit to \$2,000 and the automobile exemption to \$4,500 and allow savings of up to \$5,000 in restricted accounts. Create an Alternative Assistance Program that allows AFDC applicants and recipients with earned income to choose Medicaid and Child Care Assistance in lieu of a cash grant. Allow for alternative to the current systems of monthly reporting of income and family circumstances, AFDC annual redetermination, and Food Stamp recertifications. Test one or more modifications to the AFDC and Food Stamp requirements for verification of eligibility information. Modify AFDC and Food Stamp program requirements to streamline eligibility determinations by making eligibility requirements compatible between the two programs. Provide supplemental child care payments to working AFDC recipients who have child care costs in excess of the child care income disregard amount. Implement multiple reforms to the GAIN (JOBS) program. Conduct a demonstration, in up to 3 counties, of alternatives to the current monthly reporting system, AFDC redetermination, and Food Stamp recertification for recipients of Alternative Assistance.

State officials met with ACF Staff on 7/19 on plans to apply for additional waivers.

Connecticut

Statewide, would remove deprivation requirement in AFDC to allow children to receive assistance even if living with both parents, increase resource and vehicle asset limits and increase child support pass-through to \$100. In selected pilot sites, would decrease AFDC cash benefits and cash-out Food Stamps, impose a time limit on eligibility, create a child support assurance system, increase earned income disregards, establish even higher asset limits, and extend medical, child care and case management supports after a case is made ineligible due to earnings.

State officials met with ACF staff on 7/21 to discuss applying for waivers.

Florida

With some exceptions, AFDC benefits will not be received for more than 24 months in any 60-month period by applicants and current recipients. Would also replace the current \$90 and \$30 and one-third disregards with a single, non-time-limited disregard of \$200 plus one-half remainder; eliminate the 100-hour rule, the required quarters of work, and (on a case-by-case basis) the 6-month time limit requirements in the AFDC-UP program. Increase transitional Medicaid and child care benefits; disregard the income of a stepparent whose needs are not included in the assistance unit for the first 6-months of receipt of public assistance, raise the asset limit to \$5,000 plus a vehicle of reasonable worth used primarily for self-sufficiency purposes. Require school conferences, regular school attendance, and immunizations; and lower age of child for JOBS exemption to 6-months.

Draft application received and being analyzed by ACF. Formal application expected soon.

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 6, 1993

Minnesota	Would increase vehicle issue limits and earned income disregards for students.	Plans to apply for waivers.
Mississippi		Proposal being developed by State. State representatives met with ACF staff 7/28.
Nevada		Contacts received from state; application expected.
Pennsylvania	The Penn. Governor's task force has recommended a number of new provisions designed to help AFDC families move toward work and independence. These provisions would establish mutual responsibility, eliminate disincentives to work, strengthen families and support children, promote economic independence with a number of disregards and intensive case management, and simplify the process.	Program presented by Penn. in a meeting on 7/13 with ACF Staff. Application expected.
South Dakota	Would require a "Social Contract" setting goals for economic self-sufficiency, require participation in community/volunteer service to "earn" AFDC grant after specific time limits, increase earned income disregards, sanction cases for voluntarily quitting employment and extend eligibility for full-time high school students through age 19.	ACF provided feedback to State based on outline of waiver provisions sent 5/20. State expects to submit application soon.

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**ANTICIPATED**

Kansas

Would eliminate 100-hour and work history rules for AFDC-UP cases, make case eligibility dependent on experience to a self-sufficiency plan, increase earned income disregards, extend medicaid transition benefits, exempt assets of one vehicle, extend CWEP and OJT activities to include private businesses, provide case incentives for staying in school, establish coordinated teen pregnancy prevention effort and other initiatives targeting youth at-risk of long-term welfare dependency, guarantee payment of child support, seek voluntary acknowledgement of paternity, allow fathers of unborn child to receive assistance if they acknowledge paternity, establish electronic benefit transfer (EBT).

Proposal being developed by State.

Massachusetts

Letter received from congressional delegation supporting earned income disregard waiver; however, we have not received a request from the state. ACF responded to State's letter of intent that approval would be subject to cost neutrality.

New Hampshire

Would increase earned income disregard to \$200 and 1/2 without time duration limits.

State legislation passed. Proposal being developed by State.

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North Dakota	Would provide incentives to encourage participation in education and training activities.	Proposal being developed by State.
Washington	Legislation involves methods of calculating benefits and elimination of the 100-hour rule for AFDC-UP cases.	ACF Regional Office staff indicate that State legislation which would require waivers is being considered. 6/24 ACF had telephone call with state staff to discuss application procedures.

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STATE WAIVER REQUESTS

September 8, 1993

I. President's message regarding state flexibility.

II. Process outside HHS/USDA to achieve sign-off.  
Current process  
Changes to consider

III. Agency concerns

IV. Pending requests from states.  
Health care  
Welfare Reform

o agreement to concurrent review from intake  
U.S. D.A / HHS / OMB / DPC

- SANCTIONS
- POLITICAL SUCCESS
- 
- substance
- politics
- process
- ENTITLEMENT TARGETS & their impact on waiver requests

- substance - determined case by case.  
agree to legitimate evaluation.  
consistency with health & welfare reform, FMS  
can behavior be changed and the sanction lifted.  
can we make a "good faith defense"

Politics → agree agency receiving waiver distributes  
Process → to other agencies - HHS, HCFR, FNS, OMB, DPC.  
questions to states circulated throughout  
agencies. person who distributes is person  
who gets response.



*main file*

**FACSIMILE TRANSMISSION COVER SHEET**  
**Administration for Children and Families**

**370 L'Enfant Promenade, S.W.**  
**Washington, D.C. 20447**

Fax (202) 205- 3598

Date 8/21

To: See below  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

From: Karl Koerper  
Phone: 401-4535  
Cover + 10 pages

**Message:**

- Kathi Way
- Richard Bavier
- Canta Piau
- Sam Skellenberger
- John Monahan
- Rich Farplin

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 31, 1993

STATE	INITIATIVE	KEY DATES	COMMENTS
<b>APPROVED</b>			
Iowa	Multi-faceted proposal including: changes in income disregards, increased resource limits, limiting JOBS exemptions, extending child care transitional benefit to 24 months, requiring most parents to develop self-sufficiency plan which includes individually based time limit on public assistance; those refusing to develop a plan can be terminated from AFDC and cannot re-apply for 6 months.	Appl. Rec'd 4/29/93  Appl. Approved 8/13/93	
Vermont	Require participation in subsidized employment after 30 mo for AFDC and 15 mo for AFDC-UP cases, broaden AFDC-UP eligibility, change earnings disregards, change JOBS exemptions, disburse child support to AFDC family, require most minors to live in supervised setting, extend eligibility in child-only cases.	Appl. Rec'd 10/27/92  Appl. Approved 4/12/93	
<b>DENIED</b>			
Illinois	Would have paid lesser of previous State of Illinois benefit for 12 months for new residents.	Appl. Rec'd. 10/7/92 Appl. Den'd. 8/3/93	

## RECEIVED

Arkansas	Eliminate increased AFDC benefits for additional children; provide special counseling to 13-17 yr olds and require participation in educational activity.	Appl. Rec'd 1/14/93	Issues analysis paper sent to State and Federal reviewers 8/23.
Colorado	Establish a 2-year time limitation sanction for non-cooperative employable AFDC adults; consolidate AFDC, Food Stamp, and Child Care benefits into a single comprehensive benefits package; disregard a portion of all earned income, replacing all current income disregards; require all AFDC households with children under the age of 24 months to have current immunization, failure to comply will result in a financial sanction; provide incentives to participants who graduate from high school or obtain a GED; exempt the asset value of one care; and increase the resource limit to \$5,000 for those families with an able-bodied adult who is employed or has been employed within the last 6 months.	Appl. Rec'd 6/30/93	Analysis paper sent to State 8/9. Conference call scheduled for 8/17. Draft Terms and Conditions sent to Federal reviewers 8/18.
Georgia	Provide family planning and parenting services; eliminate increased AFDC benefit for additional children; require able-bodied adults to accept full-time employment if they are not caring for children under 14.	Appl. Rec'd 5/18/93	Analysis paper sent to State 8/11. Terms and Conditions sent to Federal reviewers 8/23.

ACF - WELFARE REFORM: SECTION 1115 WAIVER ACTIVITY - August 31, 1993

Illinois	Provide incentives for school attendance; require participation in a Community Service Corps (CSC) for those with children under 3; provide wage subsidy for up to 6 mo. after completing CSC.	Appl. Rec'd 10/7/92	These waivers were tabled by the State for their reconsideration; awaiting state action.
Illinois	Change earnings disregards and increase goals income test.	Appl. Rec'd 8/2/93	Appl. distributed to Federal Reviewers.
Massachusetts	Require JOBS participants to pay co-payment for child care.	Appl. Rec'd 1/14/93	Analysis paper sent to State 8/13.
North Dakota	Would make women in their first and second trimester of pregnancy eligible for AFDC.		Appl. to be mailed to Federal Reviewers 8/31.
Oklahoma	Require school attendance of AFDC recipients aged 13-18.	Appl. Rec'd 12/28/92	Draft Terms and Conditions sent to State 7/16 for their review. No response to date.
South Carolina	Provides for work experience at for-profit sites, disregard of training allowances, changes to earnings disregards.	Appl. Rec'd 12/9/92	Sent State 7/20 analysis paper regarding issues needing further discussion or clarification. Telephone call with state staff indicate that this is not currently a priority.

South Dakota	<p>Time limit cash benefits for 24 mo. for those assigned to employment-readiness track and for 60 mo. for those in training track followed by required employment or volunteer service; total family ineligibility for 3 mo. for voluntarily quitting employment; provide one month transitional allowance after case closes due to earnings; disregard earned income and other assets of full-time students.</p>	<p>Appl. Rec'd 8/6/93</p>	<p>Application distributed to Federal reviewers. Analysis paper sent to Federal reviewers.</p>
Virginia	<p>1) Up to 600 participants would voluntarily exchange AFDC/Food Stamp benefits for jobs expected to pay \$15-18,000/yr. Training stipends equal to AFDC and FS benefits would be paid initially. 2) Provide additional 24 mo. child care and Medicaid transition benefits. 3) Establish a child support insurance program for those leaving AFDC due to earnings. 4) Disregard step-parent income when AFDC recipient marries; increase resource limit to \$5,000 for education and housing purposes; extend AFDC eligibility to full-time students until age 21.</p>	<p>Appl. Rec'd 7/13/93</p>	<p>Analysis paper sent to State 8/12. Conference call with State 8/20. ACF drafting Terms and Conditions.</p>

Wisconsin	Provides a maximum of 4 years eligibility with cash benefits for up to 2 years and 12 mo. transitional medical and child care benefits; no cash benefits available for a period of 36 months after last month in which a demonstration benefit was paid; cash-out food stamps and make part of the benefit; education and training services provided; CWEP placements or public job required for those who remain unemployed; changes JOBS exemptions; no additional benefit for children born to AFDC families; child support payments will be directed to the family and counted as income; fixed period of benefit calculation.	Appl. Rec'd 7/14/93	Draft Terms and Conditions (excluding Implementation section) sent to State 8/20. Conf. call 8/26 with State.
Wyoming	Require able-bodied AFDC applicants and recipients to work or perform community service, require school attendance for those 16 and over, change sanction penalties for non-compliance with work requirements, increase resource limit for employed families, limit or eliminate AFDC benefits in certain cases where recipient is in post-secondary ed. program, provide JOBS to non-custodial parents court-ordered to participate, provide lesser of benefit for Wyoming or prior state of residence for 12 mo. for new residents.	Appl. Rec'd 5/20/93	In clearance in the Department.

PRE-APPLICATION  
CONTACT

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Alaska	<p>Would repeal 100-hour rule for AFDC-up; expand working incentives; increase resource and vehicle asset limit; eliminate "new job" requirement for work supplementation and extend transitional medicaid benefits.</p>	<p>ASPE official met with State Staff 6/22.</p>
California	<p>Implement Cal. Learn, a Learnfare program that provides both bonuses and sanctions. Increase the resource limit to \$2,000 and the automobile exemption to \$4,500 and allow savings of up to \$5,000 in restricted accounts. Create an Alternative Assistance Program that allows AFDC applicants and recipients with earned income to choose Medicaid and Child Care Assistance in lieu of a cash grant. Allow for alternative to the current systems of monthly reporting of income and family circumstances, AFDC annual redetermination, and Food Stamp recertifications. Test one or more modifications to the AFDC and Food Stamp requirements for verification of eligibility information. Modify AFDC and Food Stamp program requirements to streamline eligibility determinations by making eligibility requirements compatible between the two programs. Provide supplemental child care payments to working AFDC recipients who have child care costs in excess of the child care income disregard amount. Implement multiple reforms to the GAIN (JOBS) program. Conduct a demonstration, in up to 3 counties, of alternatives to the current monthly reporting system, AFDC redetermination, and Food Stamp recertification for recipients of Alternative Assistance.</p>	<p>State officials met with ACF Staff on 7/19 on plans to apply for additional waivers.</p>

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Connecticut

Statewide, would remove deprivation requirement in AFDC to allow children to receive assistance even if living with both parents, increase resource and vehicle asset limits and increase child support pass through to \$100. In selected pilot sites, would decrease AFDC cash benefits and cash-out Food Stamps, impose a time limit on eligibility, create a child support assurance system, increase earned income disregards, establish even higher asset limits, and extend medical, child care and case management supports after a case is made ineligible due to earnings.

State officials met with ACF staff on 7/21 to discuss applying for waivers.

Florida

With some exceptions, AFDC benefits will not be received for more than 24 months in any 60-month period by applicants and current recipients. Would also replace the current \$90 and \$30 and one-third disregards with a single, non-time-limited disregard of \$200 plus one-half remainder; eliminate the 100-hour rule, the required quarters of work, and (on a case-by-case basis) the 6-month time limit requirements in the AFDC-UP program. Increase transitional Medicaid and child care benefits; disregard the income of a stepparent whose needs are not included in the assistance unit for the first 6-months of receipt of public assistance, raise the asset limit to \$5,000 plus a vehicle of reasonable worth used primarily for self-sufficiency purposes. Require school conferences, regular school attendance, and immunizations; and lower age of child for JOBS exemption to 6-months.

Draft application received and analyzed by ACF. Oral comments to State on 8/4. Formal application expected soon.

Minnesota	Would increase vehicle issue limits and earned income disregards for students.	Plans to apply for waivers.
Mississippi		Proposal being developed by State. State representatives met with ACF staff 7/28.
Nevada		Contacts received from state; application expected.
New Hampshire	AFDC applicants and recipients would have the first \$200 plus 1/2 the remaining earned income disregarded.	State called 8/11 to seek guidance and assistance. State submitted draft application 8/13 for comment. Comments sent to State 8/27.
Pennsylvania	The Penn. Governor's task force has recommended a number of new provisions designed to help AFDC families move toward work and independence. These provisions would establish mutual responsibility, eliminate disincentives to work, strengthen families and support children, promote economic independence with a number of disregards and intensive case management, and simplify the process.	Program presented by Penn. in a meeting on 7/13 with ACF Staff. Application expected.

**ANTICIPATED**

AUG-31-1993 13:20 FROM HHS/ACF/POLICY&EVALUATION TO WH/K. WRY P.09/11

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Kansas

Would eliminate 100-hour and work history rules for AFDC-UP cases, make case eligibility dependent on experience to a self-sufficiency plan, increase earned income disregards, extend medicaid transition benefits, exempt assets of one vehicle, extend CWEP and OJT activities to include private businesses, provide case incentives for staying in school, establish coordinated teen pregnancy prevention effort and other initiatives targeting youth at-risk of long-term welfare dependency, guarantee payment of child support, seek voluntary acknowledgement of paternity, allow fathers of unborn child to receive assistance if they acknowledge paternity, establish electronic benefit transfer (EBT).

Proposal being developed by State.

Massachusetts

Letter received from congressional delegation supporting earned income disregard waiver; however, we have not received a request from the state. ACF responded to State's letter of intent that approval would be subject to cost neutrality.

Texas

Would apply earned income against the need standard rather than the payment standard.

ACF Regional Office staff indicate the State staff are considering submission of a waiver application.

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Washington

Legislation involves methods of calculating benefits and elimination of the 100-hour rule for AFDC-UP cases.

ACF Regional Office staff indicate that State legislation which would require waivers is being considered. 6/24 ACF had telephone call with state staff to discuss application procedures.

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