



August 11, 1993

MEMORANDUM FOR: Christine Varney
Cabinet Secretary

FROM: Kevin Thurm
Chief of Staff

SUBJECT: President Clinton's August 16, 1993, Meeting
with the National Governors' Association in
Tulsa, Oklahoma -- **SUMMARY OF DHHS ISSUES**

I. PURPOSE

This memorandum is to provide background information relating to the Department of Health and Human Services (HHS) for the President's August 16, 1993, meeting with the National Governors' Association (NGA) in Tulsa, Oklahoma.

II. IMPROVING THE MEDICAID AND WELFARE WAIVER PROCESS

A. Introduction

Broad and meaningful improvements on Medicaid and welfare waivers have been achieved in response to the President's February instruction that we enter into discussion with the states. The waiver decision process has been substantially streamlined and is moving faster. As a matter of course, we now have early consultations with states regarding their proposals and provide involved and improved technical assistance.

The agreements do not go as far as we and the governors might prefer. In part this is because we do not yet have a set of principles that will guide the President's national health and welfare reform initiatives. In the coming months, as those principles emerge, we will build on this new partnership with the governors to help them shape their own reforms to dovetail with and take advantage of national reforms.

B. Background

At the NGA winter meeting last February, President Clinton directed HHS to streamline the Medicaid and Aid to Families with Dependent Children (AFDC) waiver processes.

Specifically, he asked that the Health Care Financing Administration (HCFA) institute a requirement limiting itself to only one opportunity to request additional information when reviewing program waiver applications from states. HCFA immediately implemented this request.

The President also asked HHS, in consultation with NGA, to review the entire waiver process and produce a list of additional streamlining recommendations "within 60 days." In his private meetings with governors, the President also promised waiver reform "within 90 days" of the appointment of the HCFA Administrator. The current agreements have been reached within 90 days of Bruce Vladeck's confirmation as HCFA Administrator.

Since March, HHS and NGA representatives have engaged in numerous, intensive discussions regarding waiver issues. These talks have reached substantive agreement on Section 1115 demonstration waivers, HCBC (long-term care) waivers, and FOC (managed care) waivers.

C. **Streamlining Section 1115 Demonstration Waivers**

During the week of August 9th, HHS will issue a statement of policy principles that improve the Medicaid and AFDC demonstration waiver review process and makes it faster and more efficient. Under the new guidelines:

- cost neutrality will be assessed over the life of a demonstration project, rather than on an annual basis, and HHS will be particularly sensitive to the difficulties of measuring Medicaid costs;
- HHS will consider a wide range of policy experiments, and states will be encouraged to test models consistent with Administration policy goals;
- projects that merit testing in more than one state may be replicated in multiple states;
- HHS will be more flexible in considering designs preferred by states;
- HHS will work actively with states to prompt statutory change reflecting lessons learned from successful projects; and
- HHS will continue to follow new policies established to streamline the 1115 waiver process (including early consultation with the states and regular communication that will enable HHS to give states an accurate timeline for waiver reviews and one consolidated list of questions).

In addition, HHS has approved several major reform waivers since January, including Oregon's health plan (which had languished for more than 16 months under the former Administration), Vermont's welfare reform plan, Hawaii's health insurance program, and Iowa's welfare reform proposal.

Issues/Concerns: The NGA appears satisfied with our efforts to institute a streamlined and predictable waiver review process, but it had hoped HHS would give states more flexibility to modify their Medicaid programs than our compromise allows. Given the choice, states would opt for total flexibility without any evaluative component or innovation that would surface "lessons learned" for larger policy value. The NGA would prefer that HHS automatically approve waivers that states assert have met criteria for budget neutrality and would not adversely affect access or quality. The NGA would like HHS to routinely continue or replicate projects that have already been fully evaluated when enabling statutory change has not yet occurred.

Such a broad interpretation of the Department's waiver authority is contrary to the intent of Section 1115 and would likely lead to congressional action to constrain or repeal the Department's waiver authority. In addition, we strongly believe the Administration must preserve the right to review projects on policy grounds and to assess the likely impact of a proposed project on quality, access, cost, and its potential for success.

D. Home and Community Based Service (HCBS) Waivers

As a result of the NGA discussions, HHS has agreed to:

- provide states with clear direction regarding the information required for waiver approval by improving the streamlined application format;
- make only one formal request for additional information regarding HCBS waiver proposals;
- eliminate the "cold bed" test (which currently requires states to demonstrate that they would have institutional capacity (or "beds") to serve persons covered by the waiver);
- simplify the overall cost neutrality formula; and
- eliminate the requirement that states obtain an independent assessment of their waiver performance.

Issues/Concerns: Initially, NGA had requested our support for statutory changes that would allow states to: 1) convert HCBS waivers with demonstrated effectiveness into state plan amendments (SPAs); and/or 2) adopt automatically another state's approved waiver into its state plan. Upon further discussion, the NGA and the Department agreed to defer these proposals and revisit them after states have had more time to evaluate the benefits of the newly streamlined waiver process and changes such as elimination of the cold bed rule.

E. Freedom of Choice (FOC) Waivers

After consultations with NGA, HHS has agreed to provide states with enhanced administrative flexibility which will allow states to better manage and expand Medicaid managed care programs. Specifically, states will now be allowed to use other states' waiver experience in developing their own cost effectiveness projections for primary care case management (PCCM) programs. Also, HHS has further refined its pre-determined approval criteria and has issued streamlined waiver applications for capitated health care programs, such as health maintenance organizations (HMOs).

HHS has also agreed to seek legislative changes which will:

- o allow one month of continuous eligibility for recipients in managed care plans, thereby easing states' administrative burdens;
- o extend the approval period for FOC waivers from 2 to 3 years for new waivers, and from 2 to 5 years for renewal waivers; and
- o allow states to limit client choice to a single HMO in rural areas when there is only one HMO available to serve Medicaid recipients.

Issues/Concerns: HHS and NGA have agreed to disagree on two NGA legislative proposals. The first would remove the "75/25" rule, which says that no more than 75% of the enrollees in a managed care plan may be Medicaid beneficiaries. This rule is intended to ensure quality of care by requiring a mix of income groups in an HMO serving Medicaid clients, but NGA challenges the effectiveness of the rule. HHS is now developing and testing a new quality assurance initiative for Medicaid managed care plans. We strongly believe that we must evaluate this effort before we can support NGA's legislative proposal.

The NGA is very interested in obtaining the Administration's commitment to adopt its legislative proposals to convert managed care programs which otherwise operate under FOC waiver authority as quickly as possible. The best response to this concern is to note that HHS will be very open to discussing these proposals, once alternative quality of care mechanisms are established. On a related issue, HHS and NGA continue to discuss the possibility of a legislative proposal which would permit non-capitated PCCM programs to be implemented as SPAs. HHS will also develop fiscal solvency standards and marketing practices to facilitate state efforts to expand Medicaid managed care by removing states/HMO contracting impediments.

F. Legislative and Administrative Recommendations to Improve Medicaid

The NGA also submitted to HHS more than 40 other legislative and administrative recommendations related to the Medicaid program. HHS and NGA have thoroughly discussed these issues, and will soon agree to a document describing the outcome of those discussions. Major issues of concern to the governors include qualified Medicare beneficiaries (QMB) and Early Periodic Screening and Diagnostic Testing (EPSDT) requirements.

III. PROVIDER TAXES AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

A. Background

At the President's meeting with the NGA in February 1993, he directed HHS and HCFA to reopen discussions with NGA regarding the Department's provider tax and disproportionate share hospital (DSH) payment regulations. These discussions concluded in May.

B. New Regulation

HHS issued new Medicaid provider tax and DSH reimbursement regulations the week of August 9th that, among other things:

- provide for growth in allotments for low-DSH states;
- add additional classes of health care items and services on which a state may impose permissible taxes;
- clarify that HCFA will not look behind permissible taxes that are at or below 6 percent of provider revenue for purposes of applying the 75/75 "hold-harmless" test; and
- allow more flexibility in obtaining waivers from the broad-based and uniform tax requirements.

Issues/Concerns: The new provider tax and DSH payment regulations address the vast majority of issues and concerns raised by the NGA.

C. Budget Reconciliation

The 1993 Budget Reconciliation bill contains a DSH provision which seeks to link the DSH payment amount to a particular hospital to the actual cost of providing services to uninsured patients in the hospital. The NGA views this provision as restricting the flexibility gained in the negotiations with HCFA. The Congressional Budget Office (CBO) attributed \$2 billion in federal savings to the provision.

Issues/Concerns: The Administration took no position on the provision.

IV. WELFARE REFORM

HHS is playing a major role in support of the White House interagency working group on welfare reform. The working group has consulted extensively with the NGA, as well as with the NGA-sponsored State and Local Officials' Task Force on Welfare Reform, comprised of representatives from NGA, the National Conference of State Legislatures (NCSL), the National Association of Counties (NACo), the National League of Cities (NLC), the U.S. Conference of Mayors (USCM), and the American Public Welfare Association (APWA). The NGA and other state and local organizations have been invited to testify at each of the upcoming policy forums for the Welfare Reform Working Group; asked to submit written comments; and to meet with each of the Administration's issue groups which are currently gathering information for consideration in developing the President's welfare reform proposal.

V. MIDWEST FLOOD

HHS and the Public Health Service (PHS), in conjunction with other Federal agencies, has been assisting states damaged by the flood. Secretary Shalala attended the conference held in Missouri by the President, with the governors of flood-affected states. She subsequently contacted each of the governors personally to offer Departmental assistance. State health and environmental officials met with representatives of PHS and other elected federal agencies at a Midwest Flood "Health Summit" on August 3rd and 4th in St. Louis, Missouri to develop both a near-term and long-term strategy for dealing with the public health and environmental health issues caused by the flood, such as water and food safety, communicable diseases, primary care, and mental health. PHS has 70 personnel assigned to the flood emergency, 39 of whom are on site working in coordination with state efforts.

VI. EMERGENCY ASSISTANCE

The Emergency Assistance (EA) program was authorized in 1967, under title IV-A of the Social Security Act, as an optional state complement to AFDC to provide immediate, short-term assistance and services to needy families with children. Currently 39 states operate an EA program.

States receive 50 percent Federal matching of State expenditures authorized during one 30 day period in a year, including payments for needs which arose before or which extend beyond the 30 days. Federal expenditures totaled \$347 million in FY 1992.

The statute and regulations give states wide flexibility to define "emergency" situations, eligibility criteria, and forms

of assistance. Emergencies range from natural disasters, family crisis, eviction, homelessness, utility shutoffs, loss of employment, emergency medical needs, etc. States provide assistance in the form of cash, vouchers, shelter, and counseling services.

In the mid-1980's states began to expand the use of EA to address chronic social needs. States began authorizing benefits and services for extended periods -- some times as long as 12 months -- primarily to address problems associated with homelessness. National publicity centered on state practices of sheltering welfare recipients in "welfare hotels" for months on end at costs of up to \$100 a day.

Prior Departmental attempts to restore the program to more closely reflect its purpose, i.e., to assist with short-term emergencies by enforcing the 30-day time limit and narrowly defining "emergency" have been blocked by Congress.

Issues/Concerns: Recently, there has been a steady trend by states to shift costs to the EA program which are unallowable under other existing federal programs. For example, New York recently filed a retroactive claim of \$172 million for child protective services costs which had been denied under the Foster Care program. Many other states are planning to offer family preservation and child protective services.

California is planning a major phased-in EA expansion covering juvenile justice services; shelter assistance and emergency foster care; and family preservation services. When fully implemented, the annual total federal share is estimated to run about \$400-\$500 million.

We are extremely concerned about the impact of these rapidly burgeoning costs and the potential for further program expansion on the federal deficit.