

TAB E - HHS/NCA
WAIVER NEGOTIATIONS
SUMMARIES

SUMMARY OF 1115 WAIVER NEGOTIATIONS

NEGOTIATIONS WITH NGA ON
MEDICAID SECTION 1115 DEMONSTRATION WAIVERS

NGA RECOMMENDATIONS: Essentially, NGA wants -

- faster waiver approvals, preferably within a set timeframe;
- less rigorous approval standards, with "assumed approval" if access to quality care and budget neutrality (over the life of the project) are apparent; and
- ability to continue and/or to replicate successful projects that would otherwise have to await Federal legislative change.

AGREEMENTS

- The waiver review process has been streamlined -- it is both faster and friendlier.

It's faster because we are eliminating the old "one step at a time" bureaucratic processes. Now, everyone in the review process is involved, collaboratively and intensively, from the day the proposal is received. This means we can now give the State one consolidated list of questions and comments, early in the process--no last minute afterthoughts or surprises. And, we set a target date for decision on each proposal. We tell the State what it is, and we meet it.

It's friendlier because the States are at the table. We are working with them, candidly and constructively, to settle any concerns before decisions are made, and to agree on Terms and Conditions before an approval decision is announced. And, we've opened our doors to help States shape approvable demonstration proposals, before the formal waiver request comes in. We invite preliminary discussion and concept papers, and we welcome opportunities to be of assistance.

- Our approval standards are more flexible.

We encourage projects that will help us all learn about innovative ways to increase cost-effective access to quality care. We will encourage States to test models consistent with our policy goals, but we're open to alternative approaches. Cost neutrality will be assessed over the life of the project, and we'll be particularly sensitive to the difficulties of measuring Medicaid costs.

- We will foster continuation or replication of promising innovations.

Projects that merit testing in more than one State can be replicated, and we will solicit multi-State demonstrations in areas of priority concern. We will renew waivers for promising projects long enough to be sure they have been fully evaluated. And, we will work more actively with States to prompt quicker statutory change reflecting lessons learned from successful projects.

POTENTIAL NGA CONCERNS/ISSUES

NGA would like us to use our demonstration waiver authority to give States "carte blanche" flexibility to modify their Medicaid programs; i.e., not just for innovative, evaluable projects that can surface "lessons learned" of larger policy value. Related NGA interests would include: going further toward "automatic approval" of waivers based on State assurances for quality, access and cost neutrality; and using our waiver authority to routinely continue or replicate projects that have already been fully evaluated, when enabling statutory change has not yet occurred.

Response: This is contrary to the intent of section 1115, and would invite congressional action to constrain or repeal our waiver authority. Also, we must preserve our interests in the policy value of approved projects, and our stewardship responsibilities for assessing the likely impact of a proposed project on quality, access, cost, and its potential for success.

1115 WAIVER PRINCIPLES

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

Approval Criteria

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

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

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

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

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

Duration

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

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

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

Evaluation

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

Cost Neutrality

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

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

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

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

Timeliness and Administrative Complexity

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

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

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

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

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

SUMMARY OF HCBS WAIVER NEGOTIATIONS

**NEGOTIATIONS WITH NGA ON MEDICAID
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS**

AGREEMENTS

In the HCFA/NGA negotiations on HCBS program waivers, the following agreements were made:

- HCFA agreed to make only one formal request for additional information on both Freedom of Choice (FOC) and HCBS program waivers.
 - This fulfills the President's promise in his February address to the NGA.
- The test in the waiver formula related to how nursing facility beds are counted (cold bed test) will be eliminated and the overall waiver cost neutrality formula will be simplified.
 - States have found these data requirements to be very cumbersome. Eliminating these requirements will help to expedite the overall waiver approval process.
- The HCBS waiver administrative processes will be further streamlined.
 - This will help to expedite the waiver approval process and provide States with clear directions on the information required for waiver approval.
- HCFA will eliminate the requirement for an independent assessment of a State's waiver performance as a requirement for waiver approval.
 - Eliminating this requirement will reduce costs for States. States wishing to do independent assessments, however, will be allowed to do so and Federal financial participation (FFP) will be available.

POTENTIAL NGA CONCERNS/ISSUES

States also requested that the following statutory changes be made to improve the HCBS waiver process:

- HCBS waivers be converted to State plan amendments after having demonstrated that the waiver is effective;

- An option for a State to adopt another State's effective waiver as part of its own State plan without submitting a waiver application; and
- An option to provide home and community based care as a regular plan amendment.

NGA and the Department negotiators agreed that these types of statutory changes should be deferred at this time. The Department has agreed that these issues may be revisited after States have experience with waivers not subject to the cold-bed test.

The agreement is based on a common understanding of the following facts:

- Any decision to make statutory changes that permit States to convert HCBS waivers to plan amendments must be considered in the light of the potential fiscal consequences to States.
 - While Medicaid is an entitlement program, services offered under the HCBS waiver program are available only to those individuals served by the waiver, and States have the authority to determine how many people will receive the services irrespective of the need.
 - Any service or constellation of services offered under a state plan must be available to any individual who meets the criteria for that service, and States cannot limit enrollment.
- There is a significant un-met need for HCBS in most, if not all States. While it is true that legislation may be crafted that will allow States to offer HCBS to specific beneficiary groups, both the NGA and the Department agree that if HCBS is offered as a State plan option, States may have significant fiscal exposure.

SUMMARY OF NEGOTIATIONS ON MANAGED CARE & FOC WAIVERS

**NEGOTIATIONS WITH NGA ON MEDICAID
MANAGED CARE AND FREEDOM OF CHOICE WAIVERS**

NGA RECOMMENDATIONS:

- Streamline the freedom of choice waiver process, by:
 - Deeming waiver requests to be cost effective if modeled after currently approved waiver programs,
 - Developing pre-determined waiver approval criteria, and
 - Supporting a legislative proposal to extend waiver approval periods from the current two years, to an initial three year period with five year renewals;

- Remove impediments to States contracting with HMOs by supporting legislation to:
 - Limit beneficiary choice to one provider in certain circumstances,
 - Allow one month continuous eligibility for managed care enrollees to ease administrative burden on States caused by late income reports, and
 - Eliminate the rule which says that an HMO cannot have more than 75 percent Medicaid or Medicare enrollment; and

- Change freedom of choice waivers to State Plan Amendments by permitting a State to:
 - Change its waiver program to state plan authority once the State has demonstrated the program's effectiveness and efficiency through the waiver process,
 - Incorporate other States' successful programs into its State plan without a waiver request, and
 - Establish certain managed care programs under the State plan amendment process without waivers, within some limits.

AGREEMENTS

- The freedom of choice waiver application and approval process have been simplified and made more efficient.

HCFA has accepted the recommendations to allow States to use the experience of other States' programs to document cost effectiveness and expanded its efforts to develop pre-approved waiver packages through the issuance of streamlined waiver applications to be used by States.

HCFA recently issued a streamlined application form for prepaid, capitation programs. Based on State input, HCFA also substantially revised two previously released streamlined application forms for initial and renewal primary care case management waiver programs. In addition, we are actively assisting States in developing their waiver applications.

● HCFA supports legislation to (1) extend the approval period for freedom of choice waivers, and (2) limit beneficiary choice to a single managed care contractor in certain circumstances, e.g., in rural areas, and (3) allow one month continuous eligibility for managed care enrollees.

HCFA supports legislation to extend the approval periods for freedom of choice waivers.

Although HCFA has permitted States to operate waiver programs in which only one HMO participates, the HMO requirements in section 1903(m) of the Act (which may not be waived), mandate that enrollees in these plans be permitted to disenroll from the HMO. HCFA would support a legislative change, based on the NGA recommendation, permitting States to mandate enrollment into a single HMO in rural areas, if there is only one HMO available to serve Medicaid beneficiaries.

HCFA agrees with NGA that allowing one month of continuous eligibility for managed care enrollees will ease administrative burdens on States and health plans caused by late income reports from clients, and supports legislation to permit this.

● HCFA agrees that the requirement that no more than 75 percent of an HMO's enrollees be Medicare or Medicaid beneficiaries is not the best proxy for quality of care, and would support legislation to eliminate this requirement if HCFA's recently issued Quality Assurance Reform Initiative (QARI) produces satisfactory results.

All States have received copies of the QARI guidelines, which identify appropriate ways to measure quality of care, and three States are participating in a demonstration to evaluate the application of these guidelines in their managed care plans.

POTENTIAL NGA CONCERNS/ISSUES

NGA has asked that the freedom of choice waiver process be eliminated for most types of managed care waiver programs (both fee-for-service and risk-based contracting).

Response: HCFA does not support a legislative change to permit States to operate all managed care freedom of choice waivers under non-time limited State Plan authority.

We will not support a broader incorporation of waivers into State plan amendments until the QARI guidelines have been determined to be a valid means of assessing the quality of care delivered to Medicaid beneficiaries.