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THE GOVERNORS, POLITICAL AFFILIATIONS, AND TERMS OF OFFICE, 1999

<i>State or jurisdiction</i>	<i>Governor</i>	<i>Regular term, in years</i>	<i>Present term began</i>	<i>Number of previous terms</i>	<i>Maximum consecutive terms</i>
Alabama	Don Siegelman (D)	4	1-99	—	2
Alaska	Tony Knowles (D)	4	12-98	1	2
American Samoa	Tauese P.F. Sunia (D)	4	1-97	—	2
Arizona	Jane Dee Hull (R)	4	1-99	1 (a)	2
Arkansas	Mike Huckabee (R)	4	1-99	1 (b)	2 (b)
California	Gray Davis (D)	4	1-99	—	2
Colorado	Bill Owens (R)	4	1-99	—	2
Connecticut	John G. Rowland (R)	4	1-99	1	—
Delaware	Thomas R. Carper (D)	4	1-97	1	2 (c)
Florida	Jeb Bush (R)	4	1-99	—	2
Georgia	Roy Barnes (D)	4	1-99	—	2
Guam	Carl T.C. Gutierrez (D)	4	1-99	1	2
Hawaii	Benjamin J. Cayetano (D)	4	12-98	1	2
Idaho	Dirk Kempthorne (R)	4	1-99	—	2
Illinois	George H. Ryan (R)	4	1-99	—	—
Indiana	Frank O'Bannon (D)	4	1-97	—	2
Iowa	Tom Vilsack (D)	4	1-99	—	—
Kansas	Bill Graves (R)	4	1-99	1	2
Kentucky	Paul E. Patton (D)	4	12-95	—	2
Louisiana	Mike Foster (R)	4	1-96	—	2
Maine	Angus S. King Jr. (I)	4	1-99	1	2
Maryland	Parris N. Glendening (D)	4	1-99	1	2
Massachusetts	Argeo Paul Cellucci (R)	4	1-99	1 (d)	—
Michigan	John Engler (R)	4	1-99	2	2 (e)
Minnesota	Jesse Ventura (Reform)	4	1-99	—	—
Mississippi	Kirk Fordice (R)	4	1-96	1	2
Missouri	Mel Carnahan (D)	4	1-97	1	2 (c)
Montana	Marc Racicot (R)	4	1-97	1	2 (f)
Nebraska	Mike Johanns (R)	4	1-99	—	2 (g)
Nevada	Kenny C. Guinn (R)	4	1-99	—	2
New Hampshire	Jeanne Shaheen (D)	2	1-99	1	—
New Jersey	Christine T. Whitman (R)	4	1-98	1	2
New Mexico	Gary E. Johnson (R)	4	1-99	1	2
New York	George E. Pataki (R)	4	1-99	1	—
North Carolina	James B. Hunt Jr. (D)	4	1-97	3 (h)	2
North Dakota	Edward T. Schafer (R)	4	1-97	1	—
Northern Mariana Is.	Pedro P. Tenorio (R)	4	1-98	2 (i)	2
Ohio	Bob Taft (R)	4	1-99	—	2
Oklahoma	Frank Keating (R)	4	1-99	1	2
Oregon	John A. Kitzhaber (D)	4	1-99	1	2
Pennsylvania	Tom Ridge (R)	4	1-99	1	2
Puerto Rico	Pedro Rosselló (D) (j)	4	1-97	1	—
Rhode Island	Lincoln Almond (R)	4	1-99	1	2
South Carolina	Jim Hodges (D)	4	1-99	—	2
South Dakota	William J. Janklow (R)	4	1-99	3 (k)	2
Tennessee	Don Sundquist (R)	4	1-99	1	2
Texas	George W. Bush (R)	4	1-99	1	—
Utah	Michael O. Leavitt (R)	4	1-97	1	1 (l)
Vermont	Howard Dean, M.D. (D)	2	1-99	3 (m)	—
Virginia	James S. Gilmore III (R)	4	1-98	—	2 (n)
Virgin Islands	Charles W. Turnbull (D)	4	1-99	—	2
Washington	Gary Locke (D)	4	1-97	—	2 (o)
West Virginia	Cecil H. Underwood (R)	4	1-97	1 (p)	2
Wisconsin	Tommy G. Thompson (R)	4	1-99	3	—
Wyoming	Jim Geringer (R)	4	1-99	1	2

(See notes on back page.)

NOTES

Party affiliations: Democrat (D), Republican (R), Independent (I), Reform (Reform)

- a Governor Hull, as secretary of state, became Governor in September 1997 after Governor Fife Symington resigned. She was elected in November 1998 to a full four-year term. She is not eligible to serve another term.
- b Governor Huckabee, as lieutenant governor, became Governor in July 1996 after Governor Jim Guy Tucker resigned. He was elected to a full four-year term in November 1998. He is eligible to serve one more term.
- c Absolute two-term limitation, but terms need not be consecutive.
- d Governor Cellucci, as lieutenant governor, became Governor in July 1997 after Governor William F. Weld resigned. He was elected to a full four-year term in November 1998.
- e The term of office is limited to two four-year terms; however, the law became effective after Governor Engler was first elected in 1990, so he is grandfathered.
- f Absolute limit of eight years of service out of every sixteen years.
- g After two consecutive terms as Governor, the candidate must wait four years before becoming eligible to run again.
- h Governor Hunt served previous terms from 1977 to 1981, from 1981 to 1985, and from 1993 to 1997.
- i Governor Tenorio served previous terms from 1981 to 1985 and from 1985 to 1989.
- j Governor Rosselló also is a member of the New Progressive Party in Puerto Rico.
- k Governor Janklow served previous terms from 1979 to 1983 and from 1983 to 1987.
- l The term of office is limited to three consecutive four-year terms beginning with the Governor elected in 1996; however, because this provision was passed during Governor Leavitt's administration, he has been grandfathered from the provision and is eligible to serve one additional term after the completion of his current term.
- m Governor Dean, as lieutenant governor, became Governor in August 1991 after the death of Governor Richard A. Snelling. He was elected to full two-year terms in November 1992, November 1994, November 1996, and November 1998.
- n Governor cannot serve immediate successive terms.
- o Absolute limit of eight years of service out of every fourteen years.
- p Governor Underwood served a previous term from 1957 to 1961.

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For biographies and up-to-date information on the Governors, visit the National Governors' Association web site at <www.nga.org>.

C#P Update

List of Children's Health Insurance Program Plans (2/18/98)
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<u>State</u>	<u>Date Received</u>	<u>Status/Clock Expires</u>	<u>Days Remaining</u> (as of 2/18/99)	<u>Type</u>
MO	9/29/97	Approved -- 4/28/98 Amendment approved -- 9/11/98 Amendment approved -- 1/11/99 (1115 modification)	--	Medicaid
CO	10/14/97	Approved -- 2/18/98	--	S-CHIP
AL	11/3/97	Approved -- 1/30/98 Amendment approved -- 8/18/98	--	Medicaid
PA	11/3/97	Approved -- 5/28/98 Amendment approved -- 10/29/98	--	S-CHIP
NY	11/5/97	Approved -- 4/1/98 (Amendment disapproved)	--	S-CHIP
CA	11/19/97	Approved -- 3/24/98 Amendment approved -- 6/29/98 Amendment -- 1/8/99	-- 50	Combo
FL	12/3/97	Approved -- 3/6/98 Amendment approved 9/8/98 Amendment -- 12/2/98	-- 32*	Combo S-CHIP
SC	12/8/97	Approved -- 2/18/98	--	Medicaid
OH	12/23/97	Approved -- 3/23/98	--	Medicaid
MI	12/29/97	Approved -- 4/7/98 Amendment approved -- 6/29/98	--	S-CHIP
TN	1/2/98	clock stopped	66*	Medicaid
RI	1/5/98 11/11/98	Approved -- 5/8/98 Amendment approved -- 2/8/99	--	Medicaid

IL	1/5/98	Approved -- 4/1/98 Amendment -- 11/10/98	-- 52*	Medicaid
MA	1/15/98	Approved -- 5/29/98	--	Combo
CT	1/21/98	Approved -- 4/27/98	--	Combo
OK	1/23/98	Approved -- 5/27/98 Amendment -- 12/31/98	-- 42	Medicaid
NJ	2/6/98	Approved -- 4/27/98	--	Combo
ID	2/13/98	Approved -- 6/15/98 Amendment approved -- 12/4/98	--	Medicaid
OR	3/2/98	Approved -- 6/12/98	--	S-CHIP
WI	3/12/98	Approved -- 5/29/98	--	Medicaid
NV	3/11/98	Approved -- 8/13/98	--	S-CHIP
VT	11/9/98	Approved -- 12/15/98	--	Combo
PR	3/30/98	Approved -- 6/26/98	--	Medicaid
TX	4/1/98	Approved -- 6/15/98	--	Medicaid
UT	4/2/98	Approved -- 7/10/98	--	S-CHIP
MT	4/13/98	Approved -- 9/11/98	--	S-CHIP
IN	4/17/98	Approved -- 6/26/98	--	Medicaid
MN	4/28/98	Approved -- 7/17/98	--	Medicaid
MD	4/30/98	Approved -- 7/29/98	--	Medicaid
DC	5/11/98	Approved -- 9/17/98	--	Medicaid
AR	5/12/98	Approved -- 8/6/98 Amendment -- 12/4/98	-- 71*	Medicaid

NC	5/13/98	Approved -- 7/14/98 Amendment approved -- 1/20/99	--	S-CHIP
NE	5/13/98	Approved -- 8/7/98 Amendment approved -- 9/11/98	--	Medicaid
ME	5/19/98	Approved -- 8/7/98	--	Combo
NM	5/19/98	Approved -- 1/11/99 1115 waiver approved -- 1/11/99	--	Medicaid
NH	5/29/98	Approved -- 9/15/98 Amendment -- 12/29/98	-- 39	Combo
GA	5/29/98	Approved -- 9/3/98	--	S-CHIP
IA	6/1/98	Approved -- 9/1/98	--	Medicaid
SD	6/5/98	Approved -- 8/25/98	--	Medicaid
KY	6/12/98	Approved -- 11/25/98	--	Combo
VA	6/15/98	Approved -- 10/22/98	--	S-CHIP
WV	6/18/98	Approved -- 9/15/98 Amendment -- 12/21/98	-- 32	Medicaid
AZ	6/26/98	Approved -- 9/18/98	--	S-CHIP
DE	6/30/98	Approved -- 9/1/98	--	S-CHIP
KS	7/14/98	Approved -- 9/1/98	--	S-CHIP
VI	7/19/98	Approved -- 9/17/98	--	S-CHIP
ND	7/24/98	Approved -- 10/9/98	--	Medicaid
MS	7/29/98	Phase I -- Approved Phase II -- Approved -- 2/10/99	-- --	Medicaid S-CHIP
LA	7/31/98	Approved -- 10/20/98	--	Medicaid
AK	8/31/98	Approved -- 12/11/98	--	Medicaid
HI	10/22/98	Approved -- 1/19/99	--	Medicaid

GU 12/30/98

3/30/99

41

Medicaid

* Denotes the review clock has stopped and the number of days remaining are based on when that action occurred.

Totals:	50 plans approved	2 plans, 9 amendments under review
	28 Medicaid expansions	15 Separate State CHIP programs
	9 Combination plans	

STATUS OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM
TITLE XXI
February 15, 1999
INTERNAL DOCUMENT

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
AL	X	11/3/97			1/30/98			2/1/98 Phase I 9/1/98 Phase II	
Amendment	X	Amendment 5/21/98			Amendment 8/18/98				
AK	X	8/31/98	10/26/98 - I 11/6/98	11/20/98	12/11/98			(3/1/99)	
AS	Draft proposal 9/28/98	1/14/99				59	4/14/99		X
AZ	Draft proposal 4/24/98	6/24/98	8/12/98 - I 8/26/98 - I	8/19/98 8/27/98	9/18/98			11/1/98	
AR	Letter submitted 2/19/98	5/12/98	6/26/98 - I	7/16/98	8/6/98			10/1/98	
Amendment	X	Amendment 12/4/98	Amendment 12/23/98			71*	clock stopped		
CA	X	11/19/97	1/9/98 3/3/98 3/16/98	2/9/98 3/5/98 3/19/98	3/24/98			3/1/98 XIX 7/1/98 XXI	
Amendment	X	Amendment 4/14/98			Amendment 6/29/98				
Amendment	X	Amendment 1/8/99	Amendment 2/8/99			59*	clock stopped		X
CO	X	10/14/97	11/26/97	1/9/98	2/18/98			4/22/98 fee for service 6/1/98 managed care	
Amendment	X	Amendment 2/1/99				77	5/2/99		X
CT	X	1/21/98	3/18/98	3/30/98	4/27/98			6/1/98 enrollment 7/1/98 services	
DE	X	6/30/98	8/7/98 - I	8/26/98 8/28/98	9/1/98			1/1/99	

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
DC	X	5/11/98	7/2/98	8/12/98	9/17/98			10/1/98	
FL	X	12/3/97	1/14/98 2/27/98	1/26/98 3/3/98	3/6/98			4/1/98 Phase I 7/1/98 Phase II	
Amendment	X	Amendment 7/17/98	Amendment 8/20/98 - I	Amendment 8/21/98 8/24/98	Amendment 9/8/98				
Amendment	X	Amendment 12/2/98	Amendment 1/29/99			32*	clock stopped		
GA	X	5/29/98	7/20/98 - I 8/13/98 8/25/98	8/19/98 8/28/98	9/3/98			11/1/98	
GU	X	12/30/98				44	3/30/99		X
HI	X	10/22/98	12/9/98 - I	12/28/98	1/19/99				
ID	X	2/13/98	5/8/98	6/10/98	6/15/98			10/1/97	
Amendment	X	Amendment 10/13/98			Amendment 12/4/98				
IL	X	1/5/98	2/13/98 - I	3/2/98	4/1/98			1/5/98	
Amendment	X	Amendment 11/10/98	Amendment 12/18/98			52*	clock stopped		
IN	X	4/17/98	6/8/98 - I	6/15/98	6/26/98			10/1/97	
IA	X	6/1/98	7/21/98 - I 8/21/98	8/13/98 8/26/98	9/1/98			7/1/98	
KS	X	7/14/98	8/13/98 - I	8/26/98	9/1/98			1/1/99	
KY	Draft proposal 4/30/98	6/12/98	7/24/98 9/22/98	9/2/98 11/2/98	11/25/98			7/1/98 M-CHIP 7/1/99 S-CHIP	
LA	X	7/31/98	9/28/98 - I	10/1/98	10/20/98			11/1/98	
ME	X	5/19/98	6/24/98-I	7/2/98	8/7/98			7/1/98 M-CHIP 8/1/98 S-CHIP	

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
MD	X	4/30/98	6/12/98 - I	6/18/98	7/29/98			7/1/98	
MA	X	1/15/98	2/26/98 4/23/98 5/1/98	3/23/98 4/27/98 5/18/98	5/29/98			10/1/97 M-CHIP 7/1/98 S-CHIP	
MI	X	12/29/97	2/23/98	3/6/98	4/7/98			5/1/98 S-CHIP 7/1/98 M-CHIP	
Amendment	X	Amendment 4/16/98			Amendment 6/29/98				
MN	Concept paper submitted 1/30/98	4/28/98			7/17/98			10/1/98	
MS - Phase I	X	Phase I 7/29/98	9/23/98 - I 10/14/98 - I	10/7/98 10/15/98	10/26/98			7/1/98	
MS - Phase II	X	Phase II 8/4/98	9/28/98 11/25/98 1/5/99 1/8/99	11/9/98 12/21/98 1/7/99	2/10/99			(1/1/99)	X
MO	X	9/29/97	11/12/97 3/6/98	2/17/98 4/15/98	4/28/98			9/1/98	
Amendment	X	Amendment 6/26/98	Amendment 8/19/98	Amendment 8/20/98	Amendment 9/11/98				
MT	X	4/13/98	6/2/98 7/29/98	7/9/98 8/18/98(part) 8/25/98	9/11/98			1/1/99	
NE	X	5/13/98			8/7/98			5/1/98	
Amendment	X	Amendment 7/31/98			Amendment 10/13/98				
NV	X	3/11/98	4/28/98 6/2/98 6/19/98	5/12/98 6/17/98 7/28/98	8/13/98			10/1/98	
NH	X	5/29/98	7/17/98 8/11/98	7/31/98 9/14/98	9/15/98			5/1/98 Phase I 1/1/99 Phase II	
Amendment									

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
	X	Amendment 12/28/98	2/8/99 - I			42	3/28/99		X
NJ	X	2/6/98			4/27/98			2/1/98 expansion 3/1/98 CHIP	
NJ Amendment	X	Amendment 2/9/99				85	5/10/99		X
NM	X	5/19/98	7/7/98 8/7/98 12/17/98	7/28/98 11/23/98 1/5/99	1/11/99				
NY	X	11/5/97	12/9/97 1/6/98 3/3/98 3/20/98	12/24/97 1/30/98 3/16/98 3/26/98	4/1/98			4/15/98	
Amendment	X	Amendment 3/27/98			Amendment denied 4/1/98				
Request for reconsidera- tion	X	Request for re- consideration 5/26/98							
NC	X	5/13/98	6/16/98 - I	6/17/98	7/14/98			10/1/98	
Amendment	X	Amendment 10/21/98			Amendment 1/15/99				
ND	X	7/24/98	9/4/98 - I	9/18/98	10/9/98			9/1/98	
OH	X	12/23/97	2/20/98 - I	3/2/98	3/23/98			1/1/98	
OK	X	1/23/98	3/18/98	4/21/98	5/27/98			12/1/97	
Amendment	X	Amendment 12/31/98	Amendment 1/28/99 - I			45	3/31/99		
OR	Concept paper submitted 1/15/98	3/2/98	4/15/98	5/7/98	6/12/98			7/1/98	
PA	X	11/3/97	12/17/97 3/4/98	2/9/98 5/6/98	5/28/98			5/28/98	
Amendment									

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
	X	Amendment 8/14/98	Amendment 9/10/98 - I	Amendment 9/29/98	Amendment 10/29/98				
PR	X	3/30/98	5/12/98 - I 6/3/98 - I	5/18/98 6/11/98	6/26/98			1/1/98	
RI	X	1/5/98	3/13/98	4/16/98	5/8/98			5/1/98	
Amendment	X	Amendment 11/10/98			2/5/99				X
SC	X	12/8/97	1/15/98 - I	1/29/98	2/18/98			8/1/97	
SD	X	6/5/98	7/29/98 - I	8/5/98	8/25/98			7/1/98	
TN	X	1/2/98	1/26/98			66*	clock stopped	8/1/97	
TX	X	4/1/98	5/14/98 - I	5/21/98	6/15/98			7/1/98	
UT	X	4/2/98	5/21/98	6/1/98	7/10/98			8/3/98	
Amendment	X	Amendment 1/28/99				73	4/28/99		
VT	Draft proposal submitted 10/13/98	3/16/98 Withdrawn 8/5/98	4/2/98	7/10/98					
New Proposal	X	11/6/98			12/15/98			10/19/98	
VI	X	7/1/98	8/13/98 - I	8/27/98	9/17/98			4/1/98	
VA	X	6/15/98	8/5/98 - I 8/27/98 - I 9/9/98 10/5/98	8/13/98 9/3/98 10/2/98 10/19/98	10/22/98			10/22/98	
WVA	X	6/18/98	8/3/98 - I	9/1/98	9/15/98			7/1/98	
Amendment	X	Amendment 12/21/98				42	3/21/99		
WI	Concept paper submitted 9/30/97	3/12/98	4/17/98 - I	5/8/98	5/29/98			(4/1/99)	
Amendment									

STATE	INITIAL CONTACT/ CONCEPT DISCUSSIONS	PROPOSAL REC'D	COMMENTS SENT TO STATE	RESPONSE REC'D FROM STATE	AWARD ANNOUNCEMENT	DAYS REMAINING ON CLOCK	90-DAY CLOCK EXPIRES	IMPLEMENTATION DATE	NEW ACTIVITY
	X	Amendment 12/30/98	Amendment 1/13/99 - I	Amendment 1/15/99	Amendment 1/22/99				

NOTE: - dates in parentheses are anticipated dates.
- underlined activity on the following pages indicates new activity.
- * indicates the clock stopped.
- I indicates informal comments, which does not stop the clock.
- Bold/shaded signifies less than 20 days remaining on clock

STATE CHILDREN'S HEALTH INSURANCE PROGRAM
TITLE XXI PROJECTS
February 15, 1999

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
ALABAMA (Approved) (Amendment Approved)	Alabama's Title XXI State Plan will provide expanded benefits under the State's Title XIX Plan. The State is proposing expanding Medicaid eligibility to children under age 19, who were born on or before September 30, 1983, with family income levels at or below 100 percent of the FPL. Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply.	On 1/30/98, the State's proposal was approved. On 5/21/98, the State submitted an amendment to its plan. Comments due 6/10/98. Review panel met on 6/17/98. Questions for clarification were sent to the State on 6/18/98. An informal conference call was held with the State on 6/22/98. On 8/7/98, the clearance panel met, but no final recommendation was made. On 8/14/98, a final clearance panel was held, recommending approval. On 8/18/98, the State's amendment was approved.	Proposal received 11/3/97. Proposal approved 1/30/98. Implemented (Phase I) 2/1/98. Implemented (Phase II) 9/1/98. Amendment submitted 5/21/98. Amendment approved 8/18/98.
ALASKA (Approved)	Alaska's Title XXI State Plan will provide expanded benefits under the State's Title XIX plan. The State proposes to expand Medicaid eligibility for children up to age 19 with family incomes levels at or below 200 percent of the FPL.	On 8/31/98, the State's proposal was received. Comments were due 9/20/98. On 10/14/98, a team conference call was held. An informal letter will be sent to the State addressing our concerns. Informal questions were sent to the State the week of 10/26/98. On 11/6/98, a stop-the-clock letter was sent to the State. On 11/20/98, the State's response was received. On 12/11/98, the State's proposal was approved.	Proposal received 8/31/98. Clock stopped 11/6/98. Response received 11/20/98. Proposal approved 12/11/98. Proposed Implementation 3/1/99.
AMERICAN SAMOA (Under Review)	American Samoa is proposing an expansion of their Medicaid program. <u>American Samoa plans to expand Medicaid to children receiving services through a Territory-funded program.</u>	On 9/29/98, American Samoa submitted a draft proposal. On 10/13/98, a team conference call was held to discuss their draft proposal. On 1/14/99, American Samoa submitted its proposal.	Draft proposal submitted 9/29/98. Proposal submitted 1/14/99.
ARIZONA (Approved)	Arizona' Title XXI State Plan will provide benchmark coverage for children up to age 19	On 6/24/98, the State's proposal was received. Comments from the internal review team were due on 7/20/98.	Draft proposal submitted 4/24/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
ARKANSAS (Approved) (Amendment Under Review)	under a state CHIP health plan. The State expects to gradually increase the income eligibility thresholds, beginning with 150% FPL; increasing to 175% FPL in July 1999; and increasing to 200% FPL in July 2000. The benefit package will be the state employees health plan with dental and vision added. Arkansas's Phase I Title XXI State Plan provides expanded eligibility under the State's Title XIX Plan. The State expanded Medicaid eligibility to children who were born after 9/30/82 and prior to 10/1/83, with family income levels at or below 100 percent of the FPL. Eligible children receive the full Medicaid benefit package. All Medicaid program policies apply. In Phase II, the State would like to convert its existing section 1115 demonstration, ARKids First, to a separate State health insurance program, although ARKids First does not comply with Title XXI requirements in several areas. Arkansas has requested a waiver to retain the cost sharing requirements of ARKids First. The benefit package would be an enhanced state employee plan. Children under 19 would be covered through 200% of the FPL.	An internal call was held on 8/12/98. Informal questions were faxed to the State following the call. A call with the State was held on 8/14/98 to go over questions, and they submitted their response 8/19/98 and then some amendments on 9/21/98. A team call was held on 8/26/98 and two follow-up questions were identified. These were faxed to the State on 8/26/98. A response from the State was received on 8/27/98. On 9/1/98, a call took place during which the team discussed the State's response and recommended approval of the Plan. On 9/2/98, the Clearance Panel met and formally recommended approval. On 9/18/98, the State's proposal was approved. On 2/19/98, a letter was received from the State requesting that the ARKids First section 1115 demonstration be converted to a Children's Health Insurance Program. Since no other details were specified, a letter was sent to the State on 3/12/98 asking them to provide the information required by law. A conference call with the State was held on 3/26/98. On 5/12/98, the State's proposal was received. This is the first phase of their CHIP initiative, and is a Medicaid expansion for children born after 9/30/82 and prior to 10/1/83. On 6/26/98, an internal call was held and informal questions were faxed to the State. On 6/30/98, a call was held with the State. On 7/16/98, the State's response to our questions was received. On 7/20/98, a call took place during which the review team discussed the State's response and recommended approval of the Plan. On 7/23/98, the Clearance Panel met and formally recommended approval. On 8/6/98, the State's proposal was approved. On 12/4/98, the State submitted its Phase II plan. Comments were due 12/15/98. An internal call was held on 12/16/98. On 12/23/98, a stop-the-clock letter was sent to the State. The two major concerns addressed in the letter pertain to screen and enroll and cost sharing requirements. A call with the State to go over questions took place on 1/22/99. The State is planning to respond in a few weeks. On 1/9/98, a stop-the-clock letter was sent to the State. On 2/9/98, a formal response was received from the State. On 2/17/98, the review team met to discuss the responses.	Proposal received 6/24/98. Proposal approved 9/18/98. Implemented 11/1/98. Letter submitted 2/19/98. Proposal received 5/12/98. Proposal approved 8/6/98. Implemented 10/1/98. Amendment received 12/4/98. Clock stopped 12/23/98. Proposal received 11/19/97. Clock stopped 1/9/98. Response received 2/9/98.
CALIFORNIA (Approved) (Amendment Approved)	California's Title XXI State Plan will expand insurance coverage to children within the State. The State will combine a Medicaid expansion with an insurance purchasing pool, and also seek Title XXI match for a State program known as the Access to Infants and		

STATE (Amendment Under Review)	PROJECT DESCRIPTION	STATUS	KEY DATES
	Mothers (AIM) program. The State would cover children from age 1 to 19 with family incomes up to 200 percent of the FPL through the insurance program, and infants up to age 1 from 200 percent to 250 percent of the FPL through the AIM program.	On 2/25/98, a meeting was held with the State. On 3/3/98, a stop-the-clock letter was sent to the State. On 3/5/98, a formal response was received from the State. On 3/16/98, a stop-the-clock letter was sent to the State. On 3/19/98, the State's response was received. On 3/24/98, the State's proposal was approved. On 4/14/98, the State submitted an amendment to its plan. A review team meeting was held on 4/20/98. Informal clarification requested of the State. Clarification received and on 5/7/98 the review panel met. On 6/16/98, an approval panel met. On 6/29/98, the State's amendment was approved. On 1/8/99, the State submitted an amendment to its plan. A review team meeting was held on 1/28/99. <u>On 2/8/99, a stop-the-clock letter was sent to the State.</u>	Clock stopped 3/3/98. Response received 3/5/98. Clock stopped 3/16/98. Response received 3/19/98. Proposal approved 3/24/98. Implemented (XIX) 3/1/98. Implemented (XXI) 7/1/98. Amendment submitted 4/14/98. Amendment approved 6/29/98. Amendment submitted 1/8/99. <u>Clock stopped 2/8/99.</u>
COLORADO (Approved) (Amendment Under Review)	Colorado's Title XXI State Plan, "Child Health Plan Plus (CHP+)" is designed to provide coverage to children ages 0 through 17 with family income at or below 185 percent of the FPL.	On 2/18/98, the State's proposal was approved. On 2/1/99, the State submitted an amendment to its plan. <u>On 2/5/99, the amendment was distributed for review. Comments are due 2/19/99.</u>	Proposal received 10/14/97. Clock stopped 11/26/97. Response received 1/9/98. Proposal approved 2/18/98. Implemented (fee for service) 4/22/98. Implemented (managed care) 6/1/98. <u>Amendment submitted 2/1/99.</u>
CONNECTICUT (Approved)	Connecticut's Title XXI State Plan will expand coverage for children and create a new program based on the state employee benchmark coverage. Under Part A of the HUSKY Program, Medicaid eligibility will be	On 1/22/98, the proposal was distributed for review. Comments were received on 2/17/98. On 2/19/98, an internal conference call was held to discuss comment issues.	Proposal received 1/21/98. Clock stopped 3/18/98. Response received 3/30/98.

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	expanded to include children up through age 18 with household incomes below 185 percent of the FPL. Part B of the HUSKY Program creates a new program for children through age 18 with household incomes up to 235 percent of the FPL. The State will make a buy-in option available to children with household incomes above 300 percent of the FPL with no federal or state subsidy. The State will also offer two supplemental benefit packages to children with special needs who are eligible for support under Part B.	On 3/18/98, a stop-the-clock letter was sent to the State. Issues involve: 1) Crowd out strategy; 2) Medicaid screening process for determining if CHIP applicant is Medicaid eligible; and 3) need three year budget with total spending and administrative costs within 10 percent limit. On 3/23/98, a conference call was held with the State. On 3/30/98, the State's response was received. On 4/7/98, an internal team conference call was held. On 4/8/98, a conference call was held with the State. On 4/17/98, the CHIP panel was held. On 4/27/98, the State's proposal was approved.	Proposal approved 4/27/98. Implemented (enrollment) 6/1/98. Implemented (services) 7/1/98.
DELAWARE (Approved)	Delaware's Title XXI plan titled Delaware's Healthy Children's Program (DHCP) will create a new program that will provide coverage to children under the age of 19 with incomes at or below 200% of poverty. The Benefit package is comparable to the one that is being used for their Medicaid Demonstration. The delivery system will also be the same. Approximately 10,000 new children will be covered as a result of Title XXI.	On 6/30/98, the State's proposal was received. Comments were due 7/24/98. On 8/7/98, informal questions were sent to the State. On 8/24/98, a meeting was held with the State. On 8/26/98, the State's response was received. On 8/27/98, a team meeting was held. On 8/28/98, additional information was received from the State. A clearance panel was held and approval was recommended also on 8/28/98. On 9/1/98, the State's proposal was approved.	Proposal received 6/30/98. Proposal approved 9/1/98. Implemented 1/1/99.
DISTRICT OF COLUMBIA (Approved)	Washington D.C. submitted a Title XXI State Plan to expand Medicaid coverage to children under age 19 and with family income at or below 200 percent of the FPL.	On 5/11/98, the District's proposal was received. Comments were due on 6/1/98. A team meeting was held on 6/22/98. On 7/2/98, a stop-the- clock letter was sent to the State. On 7/13/98, a conference call was held with the District. On 8/12/98, the District's response was received. On 8/24/98, a team meeting was held. On 9/9/98, additional information was received from the District. A clearance panel was held on 9/11/98 and approval was recommended.	Proposal received 5/11/98. Clock stopped 7/2/98. Response received 8/12/98. Proposal approved 9/17/98. Implemented 10/1/98.

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		On 9/17/98, the District's proposal was approved.	
FLORIDA (Approved) (Amendment Approved) (Amendment Under Review)	Florida's Title XXI State Plan will extend Medicaid coverage for children ages 15 to 19 in families with incomes up to 100 percent of the FPL and it will extend the State's current school enrollment based Florida Healthy Kids program to additional counties. Florida's amendment reflects recently enacted State legislation which authorizes implementation of Florida KidCare for children in families with incomes up to 200% of the FPL, except for Medicaid. Florida KidCare consists of 4 components: 1) MediKids, ages 0 to 5; 2) Florida Health Kids, ages 5 to 19; 3) the Children's Medical Services Network for children with special health care needs, ages 0 to 19; and 4) Medicaid for children up to age 19. <u>Florida's amendment seeks to implement an employer-sponsored component to their plan.</u>	On 1/26/98, the State's response was received. On 2/13/98, a call was held with the State to discuss their response. The State is anxious to receive a decision before 3/1/98. On 2/16/98, the State met with the entire Congressional delegation to provide update. On 2/19/98, the State submitted additional information that we had requested on an earlier call. On 2/27/98, a stop-the-clock letter was sent to the State. On 3/3/98, the State's response was received. On 3/6/98, the State's proposal was approved. On 7/17/98, the State submitted an amendment to their approved title XXI program. Comments were due 8/14/98. On 8/18/98, a team meeting to review comments was held. On 8/20/98, informal questions were sent to the State and a meeting was held to discuss the questions and our concerns. On 8/21/98, a response was received from the State. On 8/24/98, an additional response was received from the State. On 8/26/98, a review team meeting was held. On 9/1/98, the clearance panel met and recommended approval. On 9/8/98, the State's amendment was approved. On 12/2/98, the State submitted an amendment to its plan. <u>On 1/29/99, a stop-the-clock letter was sent to the State.</u>	Proposal received 12/3/97. Clock stopped 1/14/98. Response received 1/26/98. Clock stopped 2/27/98. Response received 3/3/98. Proposal approved 3/6/98. Implemented (Phase I) 4/1/98. Implemented (Phase II) 7/1/98. Amendment received 7/17/98. Amendment approved 9/8/98. Amendment received 12/2/98. <u>Clock stopped 1/29/99.</u>
GEORGIA (Approved)	Georgia has opted to construct a separate state child health program for uninsured children from birth through 18 years of age in families with income below 200 percent of the FPL who are not eligible for medical assistance under Medicaid.	On 5/29/98, the State's plan was received. Comments were due 6/23/98. On 7/16/98, a team teleconference was held. On 7/20/98, a list of questions and clarifications was sent to the State. On 8/13/98, a stop-the-clock letter was sent to the State.	Proposal received 5/29/98. Clock stopped 8/13/98. Response received 8/19/98. Clock stopped 8/25/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		On 8/19/98, the State submitted its response. On 8/21/98, a review panel was held. Budget questions were raised. Questions were faxed to State on 8/21/98. On 8/25/98, a stop-the-clock letter was sent to the State. On 8/28/98, the State's faxed its response. On 9/3/98, the State's proposal was approved.	Response received 8/28/98. Proposal approved 9/3/98. Implemented 11/1/98.
GUAM (Under Review)	The Guam plan is a Medicaid expansion for children from birth through age 18 in families with incomes up to 133 percent of the FPL.	On 12/30/98, Guam submitted a proposal. Comments were due 1/22/99. <u>On 2/4/99, a team conference call was held.</u>	Proposal received 12/30/98.
HAWAII (Approved)	On 10/22/98, the State submitted a Title XXI proposal to implement a Medicaid expansion for uninsured children age one to six in families with income between 133 and 185 percent of the Federal Poverty Level (FPL). This group is currently covered up to 133 percent of the FPL. The State plans to submit amendments in the future to incrementally increase coverage until all children under age 19 with incomes up to 200 percent of the FPL are covered.	On 10/22/98, the State's proposal was received. Comments were due 11/16/98. A team meeting was held on 11/24/98. On 12/9/98, a set of questions and clarifications was sent to the State. On 12/11/98, a conference call was held with the State. On 12/28/98, the State's response was received. A team conference call was held on 1/7/99. On 1/19/99, the State's plan was approved.	Proposal received 10/22/98. Plan approved 1/19/99.
IDAHO (Approved) (Amendment Approved)	Idaho's Title XXI plan will expand Medicaid coverage for children up to age 19 with incomes at or below 150 percent of the FPL.	On 2/13/98, the State's proposal was received. Comments were due on 3/10/98. A call was held with the State for 4/6/98 to discuss the questions. The State has indicated that their responses will be forthcoming by 4/17/98. On 4/17/98, the State's responses were received but were incomplete. A complete version was received on 4/23/98 and distributed to the Department. Comments were due on 4/28/98. On 5/8/98, a stop-the-clock letter was sent to the State. The State canceled a 5/14/98 call to discuss the stop-the-clock letter and their compliance with 1902(a)(17). The State indicated that they will call when they are ready to discuss their response. On 5/28/98, a call was held with the State to discuss their income eligibility criteria. The State is expected to send additional	Proposal received 2/13/98. Clock stopped 5/8/98. Response received 6/10/98. Proposal approved 6/15/98. Retroactive implementation 10/1/97. Amendment submitted 10/13/98. Amendment approved 12/4/98.

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		information. On 6/10/98, the State's response was received. On 6/15/98, the State's proposal was approved. On 10/13/98, the State submitted an amendment to its plan to change eligibility from 160% of the FPL to 150% of the FPL. Comments were due 10/28/98. A call is scheduled for 11/9/98 with the team to discuss approval of the State's amendment. On 12/4/98, the State's amendment was approved.	
ILLINOIS (Approved) (Amendment Under Review)	On 1/5/98, Illinois submitted a Title XXI plan to provide expanded benefits under the State's Medicaid Title XIX Plan. The Title XIX Plan amendments required to implement the Title XXI program will be submitted under separate cover. The State proposes to expand Medicaid eligibility to children between the ages of 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The State anticipates that the program will serve an additional 40,400 children. Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply.	On 1/5/98, the State's proposal was received. On 2/13/98, informal questions for discussion were sent to the State. On 2/26/98, a meeting was held to discuss informal questions. On 3/2/98, the State submitted a written response to key questions, that is currently under review within the agency. On 4/1/98, the State's proposal was approved. On 6/19/98, the State presented a concept paper for Phase II to HCFA. On 11/10/98, the State submitted an amendment to its plan. Comments were due on 11/30/98. A team conference call is scheduled for 12/9/98 to review questions. On 12/18/98, a stop-the-clock letter was sent to the State. On 12/23/98, the State submitted a letter requesting clarification to question #4 regarding Medicaid "look alike."	Proposal received 1/5/98. Proposal approved 4/1/98. Retroactive implementation 10/1/97. Amendment submitted 11/10/98. Clock stopped 12/18/98.
INDIANA (Approved)	Indiana's Title XXI program will expand Medicaid eligibility to include SOBRA children between the ages of 14 and 18 up to 100 percent of the FPL and expand Medicaid to all children between the ages of 0-18 up to 150 percent of the FPL. Enrollment will be conducted as part of the overall process for Medicaid enrollment. The State anticipates	On 4/17/98, the State's proposal was received. Comments were due on 5/11/98. On 5/14/98, an internal call was held with the RO and HRSA. A team call is scheduled for 5/27/98. On 5/27/98, a team call was held. On 6/8/98, informal questions for written clarification were sent to the State. On 6/15/98, the State	Proposal received 4/17/98. Proposal approved 6/26/98. Implemented 7/1/98.

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	that the program will serve an additional 65,515 children under the SOBRA expansion and 36,236 children under the 150 percent of the FPL expansion.	submitted their response. On 6/16/98, a call was held with the State. On 6/19/98, a clearance panel was held. On 6/26/98, the State's proposal was approved.	
IOWA (Approved)	Iowa opted to expand Medicaid to 133 percent of the FPL for children up to age 19. This expansion provides coverage for children ages 6 through 14 between 100 percent and 133 percent of the FPL and for children ages 15 through 18 between 37 percent and 133 percent of the FPL.	On 6/1/98, the State's proposal was received. Comments were due 6/26/98. On 7/17/98, a team teleconference was held to discuss comments and clarifications. On 7/21/98, a list of questions and clarifications was sent to the State. The State's response was due on 8/10/98. On 8/13/98, the State's response was received. On 8/19/98, a review panel was held. On 8/20/98, a clearance panel was held. On 8/21/98, a stop-the-clock letter was sent to the State. On 8/26/98, the State's response was received. On 8/27/98, a team teleconference was held; all issues are considered resolved. On 8/28/98, a clearance panel was held and approval was recommended. On 9/1/98, the State's proposal was approved.	Proposal received 6/1/98. Clock stopped 8/21/98. Response received 8/26/98. Proposal approved 9/1/98. Retroactive implementation 7/1/98.
KANSAS (Approved)	Kansas opted for a separate child health plan covering children to age 19 in families up to 200% of the FPL. The coverage offered is the state employee package (benchmark).	On 7/14/98, the State's proposal was received. Comments were due 8/6/98. On 8/12/98, a team meeting was held. On 8/13/98, informal questions were sent to the State. On 8/20/98, a conference call was held with representatives from Kansas City legislature. On 8/26/98, a response was received from the State. On 8/27/98, a team meeting was held. On 8/28/98, additional information was received from the State. On 8/28/98, a clearance panel was held and approval was recommended. On 9/1/98, the State's proposal was approved.	Proposal received 7/14/98. Proposal approved 9/1/98. Implemented 1/1/99.
KENTUCKY (Approved)	Kentucky submitted a proposal to use a combined Medicaid expansion/State Child Health Insurance Program (CHIP) approach. The Medicaid expansion would cover children ages 14 to 19 from the current eligibility level	On 4/30/98, the State submitted a draft proposal. On 5/28/98, a conference call was held with Kentucky's Health Secretary.	Draft proposal received 4/30/98. Proposal received 6/12/98. Clock stopped 7/24/98.

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	of 33 percent of the FPL to 100 percent of the FPL. The state would develop a separate CHIP to cover children up to age 19 between 100 percent - 200 percent of the FPL who are not otherwise eligible for Medicaid. The State CHIP would use a benchmark equivalent benefit package.	On 6/12/98, the State's proposal was received. Comments were due 7/7/98. On 7/24/98, a stop-the-clock letter was sent to the State. On 9/2/98, the State's response was received. The State has decided not to pursue the employer-buy in at this time. On 9/10/98, a team meeting was held to discuss the State's response. On 9/22/98, a second stop-the-clock letter was sent to the State. On 10/16/98, a conference call was held with the State to discuss informal questions. On 10/26/98, a meeting was held with the State to discuss cost-sharing provisions. On 11/3/98, the State's response was received. On 11/5/98, a team meeting was held to discuss the State's response to the stop-the-clock letter. A conference call was held with the State on 11/9/98 to clarify the responses to the questions. On 11/10/98 and 11/19/98, the State submitted additional clarification to the questions. On 11/25/98, the State's proposal was approved.	Response received 9/2/98. Clock stopped 9/22/98. Response received 11/3/98. Proposal approved 11/25/98. Implemented (M-CHIP) 7/1/98. Proposed Implementation (S-CHIP) 7/1/99.
LOUISIANA (Approved)	Louisiana submitted a proposal to expand Medicaid eligibility to children between ages 6 and 19 with income up to 133 percent of the FPL. The children would receive the same benefit package as that offered to the Medicaid population.	On 7/31/98, the State submitted its proposal. Comments were due 8/24/98. Questions to the State are being prepared. Sending of comments has been delayed because of Medicaid compliance issues. On 9/21/98, a call was held with the State to discuss questions relative to the State's plan. On 10/1/98, the State's response was received. A conference call is scheduled for 10/6/98. A clearance panel was held on 10/7/98. On 10/20/98, the State's proposal was approved.	Proposal received 7/31/98. Proposal approved 10/20/98. Implemented 11/1/98.
MAINE (Approved)	Maine's plan is a combination plan to expand Medicaid for children age 1 to 18 in families with income up to 150 percent of the FPL and to implement a new Cub Care program to provide coverage to children age 1 to 18 in families with income up to 185 percent of the	On 5/19/98, the State's proposal was received. Comments were due on 6/12/98. On 6/22/98 a review team meeting was held; informal comments were send to the state on 6/24/98; and a conference call was held with the state on 6/26/98.	Proposal received 5/19/98. Proposal approved 8/7/98. Implemented (M-CHIP) 7/1/98. Implemented (S-CHIP) 8/1/98.

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	FPL.	On 7/2/98, the State sent a response to our questions. On 7/10/98, a conference call was held with the State. On 7/20/98, the State submitted their final response and a conference call was held with the State on 7/23/98. On 7/29/98, the clearance panel was held. On 8/7/98, the State's proposal was approved.	
MARYLAND (Approved)	Maryland submitted a Title XXI State Plan to expand Medicaid coverage to children under age 19 and with family income at or below 200 percent of the FPL. The State is proposing to deliver services through the section 1115 demonstration project, HealthChoice, which is a mandatory managed care program.	On 4/30/98, the State's proposal was received. Comments were due on 5/24/98. On 6/4/98, a team meeting was held to discuss comments. On 6/12/98, informal comments were sent to the State. On 6/17/98, a conference call was held with the State to discuss response. On 6/18/98, the State submitted a response. A team meeting was held on 6/26/98 to discuss responses. On 7/1/98, a call was held with the State for informal clarifications. On 7/2/98, a panel meeting was held. On 7/17/98, a roll-out meeting was held. On 7/29/98, the State's proposal was approved.	Proposal received 4/30/98. Proposal approved 7/29/98. Retroactive implementation 7/1/98.
MASSACHUSETTS (Approved)	Massachusetts would enroll eligible children through age 18 who are in families with income at or below 200 percent of the FPL. The State would use State Plan amendments under Title XIX for their children's health insurance program for children in families with income at or below 150 percent of the FPL. Other eligible children, who will be between 150 percent and 200 percent of the FPL, would be enrolled in either a separate children's health insurance program or if they have access to employer base coverage, would be eligible for premium assistance payments to assist the families in the purchase of group health insurance.	On 1/5/98, the State's proposal was received. On 2/26/98, a stop-the-clock letter was sent to the State. On 3/5/98, a conference call was held with the State to discuss the stop-the-clock letter. On 3/23/98, the State's response was received. An internal staff meeting was held on 4/6/98. A staff to staff discussion with the State was held on 4/7/98. Issues remain with the employer-buy-in. On 4/23/98, a second stop-the-clock letter was sent to the State. On 4/27/98, the State's response was received. On 4/30/98, a conference call was held with the State to discuss clarification of their response.	Proposal received 1/15/98. Clock stopped 2/26/98. Response received 3/23/98. Clock stopped 4/23/98. Response received 4/27/98. Clock stopped 5/1/98. Response received 5/18/98. Proposal approved 5/29/98. Implemented (M-CHIP) 10/1/97. Implemented (S-CHIP) 7/1/98.

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		On 5/1/98, a stop-the-clock letter was sent to the State. HCFA is working with the State to resolve differences while the clock is stopped. On 5/5/98, 5/11/98 and 5/15/98 conference calls were held to discuss responses which the State had submitted in draft. On 5/18/98, the State submitted its response. On 5/21/98, a review panel meeting was held. On 5/29/98, the State's proposal was approved.	
MICHIGAN (Approved) (Amendment Approved)	MiChild will provide comprehensive health care coverage to all children under age 19 who reside in families whose incomes are at or below 200 percent of the FPL and who are uninsured. Michigan estimates that there are approximately 133,000 that will be eligible for the MiChild program.	On 2/9/98, a meeting was held with State to review issues. On 2/23/98, a stop-the-clock letter was sent to the State. On 3/6/98, the State's response was received. An internal call was held on 3/17/98 to discuss the State's response. On 3/19/98, a call was held with the State informally to ask for additional information. On 3/20/98, the informal information was received. On 3/25/98, an internal call was held to discuss the informal response. On 3/27/98, a call was held with the State to discuss issues. We also received their response at this time. On 4/2/98, the clearance panel met. On 4/7/98, the State's proposal was approved. On 4/16/98, the State submitted an amendment to its plan. Comments were due on 5/18/98. On 5/27/98, additional information was requested from the State. On 6/29/98, the State's amendment was approved.	Proposal received 12/29/97. Clock stopped 2/23/98. Response received 3/6/98. Proposal approved 4/7/98. Implemented (S-CHIP) 5/1/98. Implemented (M-CHIP) 7/1/98. Amendment submitted 4/16/98. Amendment approved 6/29/98.
MINNESOTA (Approved)	On 1/30/98, Minnesota submitted a concept paper containing several options for their Title XXI program. The State's preferred option is to use their current section 1115 expansion to 275 percent of the FPL as their Title XXI program. Minnesota's other options include: keeping the current income standard at 275	On 1/30/98, the State submitted a concept paper. On 2/24/98, the Administrator met with the Governor to discuss the paper. On 3/13/98, the State was informed that they could submit a plan containing both the 275 - 280 percent of the FPL increase and coverage	Concept paper submitted 1/30/98. Proposal received 4/28/98. Proposal approved 7/17/98. Implemented 10/1/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
	percent but decreasing premiums (thereby increasing coverage of children); increasing the income level of the Minnesota program from 275 percent of the FPL to 280 percent of the FPL; covering children under 275 percent of the FPL who are ineligible for Medicaid based on the State requirement that children be uninsured for 18 months after the loss of employer-based coverage; and seeking a waiver of the 10 percent limit on expenditures for outreach and special health initiatives.	of children up to 275 percent who are ineligible for the 18-month period after loss of employer-based coverage. On 4/28/98, the State submitted its proposal to extend coverage from 275 -280 percent of the FPL. The proposal was distributed for review and comments were due on 5/18/98. On 6/1/98, an internal call was held to discuss the comments on the proposal. On 6/10/98, a call was held with the State informally to ask for additional information and clarification. On 6/24/98, an internal call was held to discuss the State's response to our informal request for information. On 7/7/98, the CHIP panel was held. On 7/17/98, the State's proposal was approved. On 5/22/98, the State submitted an 1115 waiver of the Title XXI provisions. On 7/17/98, the State's 1115 proposal was denied.	
MISSISSIPPI (PHASE I) (Approved)	Mississippi has submitted a Medicaid expansion and a CHIP proposal. The expansion will cover children born after 9/30/79, from 6 to 19 years of age, with family incomes at or below 100% of the FPL.	On 7/29/98, the State's Phase I proposal was received. Comments are currently being edited and compiled. A team teleconference was held on 9/16/98 to discuss comments. On 9/23/98, informal questions were sent to the State. On 9/24/98, a call was held with the State to ask for additional information and clarification. On 10/7/98, the State responded to our questions. On 10/14/98, an informal letter was sent to the State requesting additional information. On 10/15/98, the State responded. On 10/16/98, an internal call was held to discuss comments. On 10/21/98, a panel meeting was held. On 10/26/98, the State's Phase I plan was approved.	Proposal received 7/29/98. (Phase I) Phase I plan approved 10/26/98. Retroactive implementation 7/1/98.
MISSISSIPPI (PHASE II) (Approved)	The CHIP plan targets all children under 19 between 100% and 133% of the FPL not eligible for Medicaid who have no other creditable health coverage and who do not participate in Phase I.	On 8/4/98, the State's Phase II proposal was received. On 9/24/98, a call was held with the State to ask for additional information and clarification and a stop-the-clock letter is being prepared. On 9/28/98, a stop-the-clock letter was sent to the State.	Proposal received 8/4/98. (Phase II) Clock stopped 9/28/98. Response received 11/9/98. Clock stopped 11/25/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		On 11/9/98, the State's response was received. A team call was held on 11/23/98 to review responses. On 11/25/98, a stop-the-clock letter was sent to the State. A conference call was held on 12/8/98 with State to work thru ESI issues. On 12/21/98, the State's response was received. On 1/5/99, a stop-the-clock was sent to the State. On 1/7/99, the State's response was received. On 1/8/99, a stop-the-clock letter was sent to the State. On 1/20/99, the State submitted a DRAFT response addressing three of the four issues. On 1/27/99, a conference call was held with the State to discuss their DRAFT response. On 1/28/99, the State submitted a revised DRAFT response addressing three of four issues. On 2/3/99, a conference call was held with the State to discuss their crowd-out strategy. On 2/4/99, the State submitted additional information to support their crowd-out strategy and a call was held with the State. On 2/10/99, the State's Phase II plan was approved.	Response received 12/21/98. Clock stopped 1/5/99. Response received 1/7/99. Clock stopped 1/8/99. <u>Phase II plan approved 2/10/99.</u> Proposed retroactive implementation 1/1/99.
MISSOURI (Approved) (Amendment Approved)	Missouri's Title XXI plan would cover children up to age 19 with gross income up to 300 percent of the FPL. When the Title XXI allocation runs out, which the State anticipates will take three years, the children would be enrolled in a section 1115 waiver program and the cost of their coverage would be matched at the regular Title XIX rate. The State proposes to use the section 1115 waiver authority to waive certain Title XIX provisions, which would permit the State to use a benefit package that is different from the standard Medicaid benefit package.	On 2/11/98, a call was held with the State to discuss their draft responses. The State plans to revise its proposal. On 2/17/98, the State submitted a revised final plan. On 2/24/98, the Administrator met with the Governor to discuss the State's proposal. On 3/6/98, a stop-the-clock letter was sent to the State. On 3/10/98, a meeting was held with the State. On 3/11/98, a draft response was received from the State. It was distributed for review and comments were due on 3/17/98.	Proposal received 9/29/97. Clock stopped 11/12/97. Revised plan received 2/17/98. Clock stopped 3/6/98. Response received 4/15/98. Plan approved 4/28/98. Implemented 9/1/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		On 4/15/98, the State's response was received. On 4/20/98, the CHIP panel was held. On 4/28/98, the State's plan was approved. On 6/26/98, the State submitted an amendment to its plan. A team meeting to discuss amendment was held on 7/17/98. On 8/19/98, a stop-the-clock letter was sent to the State. On 8/20/98, the State's response was received. We have drafted a letter to the State approving the change to their crowd-out policy, and a separate letter regarding their Section 1115 waiver request for their cost-sharing proposal. On 9/11/98, the State's amendment on crowd-out policy was approved. We still have issues on the Section 1115 waiver request.	Amendment submitted 6/26/98. Clock stopped 8/19/98. Response received 8/20/98. Amendment approved 9/11/98.
MONTANA (Approved)	Montana submitted a Title XXI State Plan to expand coverage to children through a benchmark-equivalent benefit package. The State will seek contracts with indemnity insurance plans and health maintenance organizations. The State proposes to provide coverage for children under the age of 19 and with family income at or below 150 percent of the FPL.	On 4/13/98, the State submitted its proposal. The proposal was distributed for review and comments are due 5/4/98. On 5/7/98, a conference call was held with the State and Senator Baucus's office. On 5/19/98, a team meeting was held to discuss comments. On 6/2/98, a stop-the-clock letter was sent to the State. On 6/17/98, a conference call was held with the State. On 6/25/98, a conference call was held with the State. On 7/9/98, the State's response was received. On 7/14/98, a team meeting was held to discuss their response to the stop-the-clock letter. On 7/21/98, a conference call was held with the State. On 7/29/98, a stop-the-clock letter was sent to the State. On 8/13/98, a draft response on screen and enroll issues was received. On 8/18/98, a partial response was received from the State. On 8/24/98, a team meeting was held. On 8/25/98, the remainder of the State's response was received. On	Proposal received 4/13/98. Clock stopped 6/2/98. Response received 7/9/98. Clock stopped 7/29/98. Response received 8/25/98. Proposal approved 9/11/98. Implemented 1/1/99.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		8/27/98, additional information was received from the State. On 8/28/98, a team meeting was held. Decision must be made on acceptability of source of funding, and the necessary documentation. On 9/9/98, the clearance panel met and recommended approval. On 9/11/98, the State's proposal was approved.	
NEBRASKA (Approved) (Amendment Approved)	Nebraska submitted a Title XXI plan to expand Medicaid for children ages 15 through 18 to 100 percent of the FPL. The State submitted an amendment to expand Medicaid eligibility for all targeted low-income children up to 185 percent of the FPL.	On 5/13/98, the State's proposal was received. Comments were due on 6/8/98. Comments have been received and are being compiled. A team meeting is being scheduled to discuss the issues. On 8/7/98, the State's proposal was approved. On 7/31/98, the State submitted an amendment to it's plan. Comments were received 8/25/98. A conference call was held on 9/14/98. On 9/24/98, a clearance panel met and recommended approval. On 10/13/98, the State's amendment was approved.	Proposal received 5/13/98. Proposal approved 8/7/98. Retroactive implementation 5/1/98. Amendment submitted 7/31/98. Amendment approved 10/13/98.
NEVADA (Approved)	Nevada submitted a Title XXI CHIP Plan to provide coverage to children ages 0 to 18 with family income at or below 200 percent of the FPL. Nevada will offer benchmark coverage through managed care organizations.	On 3/11/98, the State's plan was received. On 3/16/98, the plan was distributed for review. On 4/16/98, a team meeting was held to discuss the consolidated comments. On 4/28/98, a stop-the-clock letter was sent to the State. Governor wrote to Secretary on 5/8/98 challenging legal basis of determination on non-eligibility for Medicaid. On 5/12/98, the State's response was received. On 5/21/98, a team meeting was held to discuss the State's response. On 6/2/98, a second stop-the-clock letter was sent to the State. On 6/17/98, the State's response was received. On 6/19/98, a third stop-the-clock letter was sent to the State. On 7/28/98, the State's response was received. On 7/30/98, the review team met and had no problems with the State's response. On 8/7/98, the clearance panel met and recommended approval.	Plan received 3/11/98. Clock stopped 4/28/98. Response received 5/12/98. Clock stopped 6/2/98. Response received 6/17/98. Clock stopped 6/19/98. Response received 7/28/98. Plan approved 8/13/98. Implemented 10/1/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		On 8/13/98, the State's plan was approved.	
NEW HAMPSHIRE (Approved) (Amendment Under Review)	New Hampshire's plan is a combination plan to extend Medicaid coverage for children ages zero to one in families with incomes up to 300 percent of the FPL and to purchase health care coverage for children ages one to 19 in families with incomes up to 300 percent of the FPL through the New Hampshire Healthy Kids Corporation. The amendment makes modification to the benefit package.	On 5/29/98, the State's plan was received. Comments were due 6/25/98. On 7/15/98, a call is scheduled to clarify legal issues before a stop-the-clock letter is sent. On 7/17/98, a stop-the-clock letter was sent to the State. On 7/31/98, the State's response was received. On 8/5/98, a team meeting was held to discuss the State's response. On 8/11/98, a second stop-the-clock letter was sent to the State. On 8/13/98, the State's response was received. A team meeting was held on 8/14/98. On 8/19/98, a review team meeting was held. Actuarial issues were clarified on 8/21/98. On 8/25/98, a letter was received from the State clarifying actuarial issues. Draft award letter is under review. On 9/9/98, the clearance panel met and recommended approval. On 9/10/98, the State informed HCFA that their 8/13/98 response was to be considered a draft response. On 9/14/98, the State's response was received. On 9/15/98, the State's proposal was approved. On 12/28/98, the State submitted an amendment to its plan. Comments were due 1/18/99. On 2/3/99, a team meeting was held. <u>On 2/8/99, informal questions were sent to the State.</u>	Plan received 5/29/98. Clock stopped 7/16/98. Response received 7/31/98. Clock stopped 8/11/98. Response received 9/14/98. Proposal approved 9/15/98. Retroactive implementation (Phase I) 5/1/98. Implemented (Phase II) 1/1/99. Amendment received 12/28/98.
NEW JERSEY (Approved) (Amendment Under Review)	New Jersey has submitted two State Plan amendments, 98-2-MA and 98-4-MA. Plan Amendment 98-2 MA concerns expanded Title XIX coverage for children under age 19 who meet certain requirements pursuant to section 4901 of the Balanced Budget Amendment of 1997.	On 2/6/98, the State's proposal was received. The proposal has been distributed for review and comments are due 2/26/98. An internal conference call was held on 3/24/98 to discuss comments prior to drafting a stop-the-clock letter to the State. At that time the team decided that all issues could be handled via a conference call with the State, and the State's subsequent submission of written answers to any questions raised.	Proposal received 2/6/98. Proposal approved 4/27/98. Implemented (expansion) 2/1/98. Implemented (CHIP) 3/1/98. <u>Amendment submitted 2/9/99.</u>

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
	State Plan 98-4-MA is a Title XIX State Plan which concerns targeted low-income children whose family income exceeds 133 percent of the FPL pursuant to Title XXI.	On 3/30/98, a conference call was held with the State. All questions were discussed and resolved, and the State sent written responses to the questions on 4/1/98. These responses were distributed for review, with comments due on 4/3/98. On 4/16/98, the CHIP Final Clearance Panel convened via conference call. On 4/27/98, the State's proposal was approved. <u>On 2/9/99, the State submitted an amendment to its plan. The amendment was distributed for review; a conference call will be scheduled to discuss the amendment.</u>	
NEW MEXICO (Approved)	The New Mexico plan is a Medicaid expansion for children from birth through 18 in families with income up to 235% of the FPL.	On 5/19/98, the State's proposal was received. Comments were due on 6/12/98. On 6/25/98, a review team meeting was held to discuss comments. On 7/7/98, a stop-the-clock letter was sent to the State. On 7/28/98, the State's response was received. A team meeting is scheduled this week. On 8/7/98, a stop-the-clock letter was sent to the State. On 9/14/98, the State submitted an 1115 Medicaid waiver request of cost sharing. Comments were due 9/30/98. On 10/15/98, a team meeting was held regarding the State's Section 1115. A letter was sent to the State on 10/30/98 regarding our concerns. On 11/13/98, the State submitted a revised Section 1115 proposal. On 11/23/98, the State's response was received. On 12/17/98, the State's clock was stopped. On 1/5/99, the State's response was received. On 1/11/99, the State's proposal was approved.	Proposal received 5/19/98. Clock stopped 7/7/98. Response received 7/28/98. Clock stopped 8/7/98. Response received 11/23/98. Clock stopped 12/17/98. Response received 1/5/99. Proposal approved 1/11/99.
NEW YORK (Approved) (Request for	New York's Title XXI State Plan, "Child Health Plus (CHPlus) program will expand children's access to health coverage by expanding enrollment in its existing Statewide	On 1/30/98, the State submitted its response to questions outlined in the second stop-the-clock letter. On 2/10/98, Department staff participated in an internal conference call	Proposal received 11/5/97. Clock stopped 12/9/97.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
reconsideration of amendment)	program, which is based on a partnership between government and private insurers through the subsidization of private health insurance coverage. The CHPlus program currently provides coverage for children under the age of 19 with family income at or below 222 percent of the FPL.	to discuss the State's response to questions outlined in the most recent stop-the clock letter, which was forwarded to the State on 1/6/98. A number of issues were discussed, and will be raised in a call with the State that is scheduled for 2/24/98. On 3/3/98, a stop-the-clock letter was sent to the State. On 3/16/98, the State submitted its response. On 3/20/98, a stop-the-clock letter was sent to the State. On 3/26/98, the State submitted its response. On 3/27/98, the State submitted an amendment to its plan, requesting retroactive access to its allotment, effective 10/1/97. On 4/1/98, the State's proposal was approved. On 4/1/98, the State's amendment requesting retroactivity was denied. On 5/26/98, the State submitted a request for reconsideration of the amendment that was denied. On 7/3/98, the Administrator informed the State of an administrative hearing to be held on 7/29/98 to reconsider disapproval decision.	Response received 12/24/97. Clock stopped 1/6/98. Response received 1/30/98. Clock stopped 3/3/98. Response received 3/16/98. Clock stopped 3/20/98. Response received 3/26/98. Proposal approved 4/1/98. Implemented 4/15/98. Amendment submitted 3/27/98. Amendment denied 4/1/98. Request for reconsideration submitted 5/26/98.
NORTH CAROLINA (Approved) (Amendment Approved)	North Carolina's Title XXI plan will be based on a supplemented version of the plan offered to state employees. Eligibility will reach 200 percent of the FPL for children ages 0 through 18.	On 5/13/98, the State's proposal was received. Comments were due on 6/2/98. A review panel was held on 6/10/98. On 6/16/98, Informal questions for clarification were sent to the State and an informal conference call was held with the State. On 6/17/98, the State submitted its response. On 6/18/98, a review panel was held. On 7/14/98, the State's proposal was approved. On 10/21/98, the State submitted an amendment to it's plan. A review team meeting was held on 11/23/98. A letter has been drafted treating amendment as administrative clarification - issue to be considered by the Steering Committee. On 12/16/98, a draft approval letter was forwarded for review. On 12/23/98, the final clearance panel was held.	Proposal received 5/13/98. Proposal approved 7/14/98. Implemented 10/1/98. Amendment received 10/21/98. Amendment approved 1/15/99.

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		On 1/15/99, the State's amendment was approved.	
NORTH DAKOTA (Approved)	North Dakota's Title XXI program will expand Medicaid eligibility for 18 year old children in families with incomes up to 100 percent of the FPL.	On 7/24/98, the State's proposal was received. Comments were received 8/26/98. A team meeting was held 9/3/98 and on 9/4/98 questions were sent to the State. On 9/10/98, a team meeting was held with the State. On 9/18/98, the State's response was received. On 9/24/98, an internal conference call was held. On 10/1/98, a clearance panel was held. On 10/9/98, the State's proposal was approved.	Proposal received 7/24/98. Proposal approved 10/9/98. Retroactive implementation 9/1/98.
OHIO (Approved)	Ohio will enroll non-Medicaid eligible children up to age 19 in families with income at or below 150 percent of the FPL. The State will use State Plan amendments under Title XIX for their children's health insurance program.	On 2/12/98, a conference call was held with the State to discuss eligibility issues related to the State plan amendments the State submitted. On 2/20/98, informal comments were sent to the State. On 2/25/98, a call was held with the State to discuss questions. On 3/2/98, the State submitted their response to our informal questions. On 3/23/98, the State's proposal was approved.	Proposal received 12/23/97. Proposal approved 3/23/98. Retroactive implementation 1/1/98.
OKLAHOMA (Approved) (Amendment Under Review)	Oklahoma will expand health insurance coverage to uninsured children born on or after 10/1/83 with family incomes at or below 185 percent of the FPL through an expansion of the State's Title XIX Medicaid program.	On 1/23/98, the State submitted its proposal. The proposal has been distributed for review and comments. Comments were due on 2/19/98. Comments are currently being reviewed and compiled. A conference call was held the week of 2/23/98 to discuss the comments. On 3/18/98, a stop-the-clock letter was sent to the State. On 4/21/98, a response dated 4/17/98 was received from the State. The response was distributed to the review team. A conference call to discuss the response was held on 4/27/98. On 4/28/98, the State was provided a list of remaining concerns and issues discussed in the conference call. The State is in the process of drafting a response to these concerns. On 5/6/98, a conference call was held with the State. The State agreed to respond in writing to the one remaining issue - "crowd-out." That response was received 5/14/98, and distributed to the team for review with comments due on 5/15/98.	Proposal received 1/23/98. Clock stopped 3/18/98. Response received 4/21/98. Proposal approved 5/27/98. Retroactive implementation 12/1/97. Amendment submitted 12/31/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		If there are no further issues, the clearance panel will meet the week of 5/18/98 for the final plan approval. On 5/27/98, the State's proposal was approved. On 12/31/98, the State submitted an amendment to its plan. A conference call is scheduled for 1/26/99 to discuss the proposal. On 1/28/99, an informal letter was sent to the State to request additional budget information.	
OREGON (Approved)	Oregon's concept paper describes a plan to cover uninsured children birth through 5 years of age with incomes between 133 - 170 percent of the FPL and children age 6 through 18 with incomes between 100 - 170 percent of the FPL. The benefit package will be identical to the Medicaid OHP Basic package.	On 1/15/98, the State submitted a concept paper. On 2/6/98, a call was held with the State to discuss their concept paper. On 2/18/98, a draft plan was submitted by the State. On 3/2/98, the State submitted its plan. On 4/6/98, a team meeting was held to discuss the comments and next steps. On 4/15/98, a stop-the-clock letter was sent to the State. On 4/22/98, a call was held with the State regarding HCFA's requirement that the State submit an actuarial analysis. The State will submit a benchmark comparison of OHP to the State Employee's health plan. On 5/7/98, a response dated 4/29/98 was received from the State. On 5/19/98, the team decided to consult with principals on the approach to designating the health plan as Secretary-approved coverage. The Department, OMB and HCFA staff agreed to this approach. A panel meeting was held on 5/28/98. On 6/12/98, the State's plan was approved. On 8/31/98, a conference call was held with the State to discuss their concept for an employer buy-in component to their plan. The State will take our comments and submit a concept paper in the near future.	Concept paper submitted 1/15/98. Plan submitted 3/2/98. Clock stopped 4/15/98. Response received 5/7/98. Plan approved 6/12/98. Implemented 7/1/98.
PENNSYLVANIA (Approved)	Pennsylvania submitted a Title XXI State plan to expand coverage to children within the	On 12/17/97, a stop-the-clock letter was sent to the State.	Proposal received 11/3/97.

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(Amendment Approved)	existing State's Children's Health Insurance Program (Pa CHIP). The plan will provide free coverage to children 1 through 16 years of age with family incomes at or below 185 percent of the FPL. The Pa CHIP also provides a subsidized program for children zero through five years of age whose family income falls between 185 and 235 percent of the FPL.	On 2/9/98, a response dated 2/4/98 was received from the State. On 2/12/98, the review team met to discuss the State's responses. On 2/19/98, a conference call was held with the State. On 3/4/98, a stop-the-clock letter was sent to the State. On 3/16/98, a letter was sent to the State at their request clarifying the statutory citations that are not in compliance. On 5/6/98, the State's response was received. On 5/7/98, the review panel met. On 5/28/98, the State's proposal was approved. On 8/14/98, the State submitted an amendment to its proposal. On 9/9/98, a review panel meeting was held. On 9/10/98, a technical review panel was held. The State has been asked for informal clarifications. We are waiting for their reply. On 9/29/98, the State's reply was received. A technical review panel was held on 10/1/98. On 10/7/98, a clearance panel was held on the State's amendment. On 10/29/98, the State's amendment was approved.	Clock stopped 12/17/97. Response received 2/9/98. Clock stopped 3/4/98. Response received 5/6/98. Proposal approved 5/28/98. Implemented 5/28/98. Amendment received 8/14/98. Amendment approved 10/29/98.
PUERTO RICO (Approved)	On 3/30/98, Puerto Rico submitted a Title XXI Plan for providing expanded Medicaid benefits. Puerto Rico is proposing to cover Title XXI eligible children through Puerto Rico's Health Reform Initiative. Puerto Rico's Health Reform Initiative, which delivers care through a managed care system currently provides coverage for children through age 18 with family income at or below 200 percent of the commonwealth poverty level.	On 3/30/98, Puerto Rico submitted its plan. Comments are due on 4/20/98. On 5/1/98, a team meeting was held to discuss comments. On 5/12/98, a call was held with the Commonwealth to present questions. On 5/18/98, a response was received from the State. On 5/28/98, a team meeting was held to discuss response. On 6/3/98, additional informal comments were sent to Puerto Rico. On 6/5/98, a call was held with Puerto Rico to discuss comments. On 6/11/98, a response was received from Puerto Rico. On 6/16/98, a	Plan received 3/30/98. Plan approved 6/26/98. Retroactive implementation 1/1/98.

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		team meeting was held to discuss their response. On 6/19/98, a clearance panel was held. On 6/26/98, Puerto Rico's plan was approved.	
RHODE ISLAND (Approved) (Amendment Under Review)	On 1/5/98, the Rhode Island Department of Human Services submitted a Title XIX State Plan Amendment and Title XXI State Plan for providing expanded Medicaid benefits. The State is proposing to receive enhanced matching funds for certain children currently eligible as part of the State's section 1115 waiver program, entitled "RIteCare." The State proposes expanding Medicaid eligibility to uninsured children aged eight to eighteen up to 250 percent of the FPL. The RIteCare program was amended, effective 5/1/97, to include this population. The coverage purchased will be the Medicaid benefit package, as operationalized under the State's approved Section 1115 waiver for RIte Care. On 11/10/98, the State submitted an amendment to expand benefits under Rhode Island's Title XXI Program for uninsured children up to age 19 to 300 percent of the FPL. The expansion will be accomplished in two ways: (1) using Section 2110 of Subtitle J of the BBA of 1997 to cover uninsured children up to age 8 up to 300 percent of the FPL; (2) using income disregards to cover children aged 8 to 19 up to 300 percent of the FPL.	A conference call was held on 2/6/98 with RO and HRSA representatives to discuss questions on the State's plan that were received from Departmental components. An internal call with the Department team was held on 2/11/98. The review team decided to send questions to the State. A stop-the-clock letter has been drafted. On 3/9/98, an internal call was held to discuss questions that will be asked as part of the stop-the-clock letter that will be sent to the State. On 3/13/98, a stop-the-clock letter was sent to the State. On 4/16/98, the State submitted its response. On 4/30/98, a discussion was held with the State concerning final issues. On 5/8/98, the State's proposal was approved. On 11/10/98, the State submitted an amendment to its plan. Comments were due 12/1/98. On 1/19/99, a team call was held to discuss comments. On 1/22/99, a call was held with the State. A clearance package is being prepared. On 1/29/99, revised budget information was received from the State. On 2/5/99, the State's amendment was approved.	Proposal received 1/5/98. Clock stopped 3/13/98. Response received 4/16/98. Proposal approved 5/8/98. Retroactive implementation 5/1/98. Amendment submitted 11/10/98. <u>Amendment approved 2/5/99.</u>
SOUTH CAROLINA (Approved)	South Carolina submitted a Title XIX State Plan Amendment and a Title XXI State Plan for providing expanded benefits under the South Carolina Medicaid Agency's Title XIX Plan. The State proposes using Title XXI to provide Medicaid coverage to children who are under age 19 with family incomes at or below 150 percent of the FPL.	On 1/15/98, a conference call was held with the State to discuss informal clarifications. We are waiting for the State's response. On 1/29/98, we received the States's response to the informal clarifications. On 2/18/98, the State's proposal was approved.	Proposal received 12/8/97. Proposal approved 2/18/98. Retroactive implementation 8/1/97.
SOUTH DAKOTA	South Dakota submitted a Title XXI proposal	On 6/5/98, the State submitted its proposal. Comments were due	Proposal received 6/5/98.

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(Approved)	to expand its Medicaid program. The program would cover children ages 6 thru 18 with incomes from 100 percent to 133 percent of the FPL.	6/30/98. On 7/15/98, a call was scheduled to clarify issues and it was determined we would not stop-the-clock but only ask for informal clarifications. On 7/29/98, a discussion was held with the State concerning final issues. On 8/5/98, the State submitted its response. On 8/10/98, a clearance panel was held. On 8/25/98, the State's proposal was approved.	Proposal approved 8/25/98. Implemented 7/1/98.
TENNESSEE (Under Review)	Tennessee will extend coverage to uninsured children under age 19, including children who have access to health insurance but who cannot afford it because their family incomes do not exceed 200 percent of the FPL.	On 1/26/98, a stop the clock letter was sent to the State. On 2/11/98, a call was held with the State to discuss cost-sharing issues. On 3/24/98, the project officer held a call with the State to provide assistance on revising the State's proposal. On 6/3/98, the State submitted a draft revised plan. However, the clock was not re-started. We are continuing to work with the State to help them overcome compliance problems in the areas of cost sharing, crowd out, premium match, and assurances regarding Social Security Act provisions.	Proposal received 1/2/98. Clock stopped 1/26/98.
TEXAS (Approved)	The First Phase of The Texas Title XXI Plan will expand Medicaid coverage of teens age, 15-18 up to 100 percent of the FPL. Phase 2 will be submitted to DHHS sometime in 1999 and will be designed to give additional low income children access to Health Insurance.	On 4/1/98, the State's proposal was received. Comments are due 4/23/98. On 5/5/98, a review team meeting determined that informal questions and comments will be sent to the State. On 5/14/98, review team informally discussed questions and comments with the State. On 5/21/98, the State submitted their response to our informal questions. Responses were sent to the review team and comments were due 5/28/98. On 6/4/98, a panel meeting was held. On 6/15/98, the State's proposal was approved.	Proposal received 4/1/98. Proposal approved 6/15/98. Implemented 7/1/98.
UTAH (Approved) (Amendment Under Review)	Utah submitted a Title XXI State Plan which proposes expanding coverage to children through a benchmark-equivalent benefit package. The State is proposing to provide	On 4/2/98, the State's proposal was received. Comments are due 4/23/98. On 5/7/98, a team meeting was held to discuss comments.	Proposal received 4/2/98. Clock stopped 5/21/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
Review)	this coverage by using a combination of contracts with managed care organizations in the urban areas and a fee-for-service system in rural areas. The State proposes to provide coverage for children under the age of 19 and with family income at or below 200 percent of the FPL.	On 5/21/98, a stop-the-clock letter was sent to the State. On 6/1/98, the State's submitted its response. A team meeting was held on 6/10/98 to discuss their response. On 6/25/98, additional comments were faxed to the State and a conference call was held to discuss comments. On 7/1/98, the State submitted its response. On 7/7/98, a panel meeting was held. On 7/10/98, the State's proposal was approved. <u>On 1/28/99, an amendment to the State's plan was received. Comments are due 2/19/99.</u>	Response received 6/1/98. Proposal approved 7/10/98. Implemented 8/3/98. <u>Amendment received 1/28/99.</u>
VERMONT (Approved)	On 3/16/98, Vermont submitted its Title XXI State Plan, which would extend coverage through a Medicaid expansion to uninsured and underinsured children in families with incomes at or below 300 percent of the FPL. It would also extend coverage to uninsured adults with children living at home when family income is between 150 and 185 percent of the FPL. The State wishes to build on its 1115 demonstration, the Vermont Health Access Plan.	On 3/16/98, the State's plan was received. On 4/2/98, a stop the clock letter was sent to the State. Issues involved: (1) requested waiver of definition of targeted low-income children; (2) coverage of adults with Medicaid eligible children; (3) crowd-out; (4) copayments for preventive services; (5) reporting and evaluation. On 4/6/98, the State spoke with the project officer and proposed to revise their plan by covering underinsured children through 1902 (r)(2) under Title XIX. Cost-sharing for this population is an issue. On 4/27/98, the review team met to discuss issues not addressed in the stop-the-clock letter. Issues involve: (1) co-payments for Medical and dental services; (2) assurance of the 5 percent limits on cost-sharing; and (3) budget revision. On 5/7/98, the Project Officer and the State discussed the State's response to two issues raised in the 4/2/98 stop-the-clock letter: reporting and assessment requirements and crowd-out. They also discussed informal issues raised by the review team during the 4/27/98 meeting. On 5/26/98, the Project Officer and the State discussed cost sharing and the delivery system for dental services. On 7/10/98, the State submitted its response to the 4/2/98 stop-the-clock letter. A team meeting was held on 7/16/98 to discuss the response. On 8/5/98, the Governor wrote to President Clinton withdrawing their	Plan received 3/16/98. Clock stopped 4/2/98. Response received 7/10/98. Proposal withdrawn 8/5/98. Draft proposal received 10/13/98. Proposal received 11/6/98. Proposal approved 12/15/98. Retroactive Implementation 10/19/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		application. On 10/13/98, the State submitted a draft proposal. On 10/16/98, a call was held with the State to discuss comments on the draft. On 11/6/98, the State submitted a formal proposal. On 11/19/98, a team meeting was held to discuss the application. On 12/2/98, the clearance panel met and recommended approval of the State's plan. On 12/15/98, the State's plan was approved.	
VIRGIN ISLANDS (Approved)	The Virgin Islands submitted a Title XXI plan to expand Medicaid to children in a Territory-funded program. Because the Territory's Medicaid program has a federally mandated ceiling on federal funding, services that are provided beyond the available federal funds are financed with only Territory funds. The Territory is not increasing its Medicaid poverty level.	On 7/1/98, a proposal was received from the Virgin Islands. On 8/4/98, a team meeting was held to discuss comments. On 8/11/98, a second team meeting was held to discuss comments. On 8/13/98, comments were sent to the Territory. On 8/25/98, a conference call was held with the Territory. On 8/27/98, we received the Territory's response. On 9/4/98, a final review team meeting was held. A clearance panel is scheduled for 9/11/98. On 9/17/98, the Territory's proposal was approved.	Proposal received 7/1/98. Proposal approved 9/17/98. Retroactive implementation 4/1/98.
VIRGINIA (Approved)	On 6/15/98, Virginia submitted a proposal for a Title XXI program to be known as the Virginia Children's Medical Society Insurance Plan (VCMSIP). The plan has two components: Component One provides coverage for children under 19 in families with incomes up to 150% of the FPL; Component Two will cover the same population up to 185% of the FPL. A single combined mail-in application will be used for both programs, which will address specific questions about other health insurance coverage or available coverage. The goal of the proposed CHIP program is the enrollment of 63,200 in VCMSIP by 6/30/01.	On 6/15/98, the State submitted its proposal. Comments were due on 7/11/98. On 7/22/98, a teleconference was held. Further team and RO conference calls have been held, and on 8/5/98 a conference call with the State was held to discuss questions and clarifications. On 8/13/98, the State's response was received and distributed to the review team. On 8/27/98, a team teleconference was held. Issues remain, and further questions were sent to the State. On 9/3/98, the State's response was received; a conference call will be held on 9/4/98 to discuss the response. An issue has been raised on the benefit package.	Proposal received 6/15/98. Clock stopped 9/9/98. Response received 10/2/98. Clock stopped 10/5/98. Response received 10/19/98. Proposal approved 10/22/98. Implemented 10/22/98.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
WEST VIRGINIA (Approved) (Amendment Under Review)	West Virginia will use the Medicaid expansion option to cover children age 1 through 5 up to 150% of the FPL.	Further questions have arisen on CHIP funding and abortion coverage policy. On 9/9/98, a stop-the-clock letter was sent to the State. On 9/15/98, an additional request for information was sent to the State. On 10/2/98, we received a response to the stop-the-clock letter. On 10/5/98, a second stop-the-clock letter was sent to the State. We continue to have discussions with the State on the benefit package. The State is assessing whether to ask for a waiver of the uniformity test. On 10/19/98, the State's response was received. On 10/22/98, the State's proposal was approved. On 6/18/98, the State's proposal was received. Comments are due 7/24/98. On 8/3/98, informal questions were sent to the State. On 8/20/98, a call was held with the State to discuss questions. A response was received on 9/1/98. A final review team meeting was held on 9/4/98, but an issue was raised concerning crowd-out for a 1902(r)(2) eligibility expansion. On 9/11/98, the State submitted clarification. A second review meeting was held on 9/11/98, and the plan was conditionally approved, subject to clarification of the BC Caring Program. On 9/15/98, the State's proposal was approved. On 12/21/98, the State submitted an amendment to its plan. Comments were due 1/22/99.	Proposal received 6/18/98. Proposal approved 9/15/98. Retroactive implementation 7/1/98. Amendment received 12/21/98.
WISCONSIN (Approved) (Amendment Approved)	On 3/12/98, the State submitted a proposal for the BadgerCare program. The program is designed to extend health care coverage to all low-income working families with children who have not had access to employer-provided insurance by providing access to health care for all uninsured families with income below 185 percent of the FPL.	On 1/23/98, the State submitted its section 1115 proposal which describes Title XXI. On 3/12/98, the State submitted its Title XXI proposal. Comments are due 4/6/98. On 4/17/98, informal questions were sent to the State. On 5/8/98, the State's response was received. A panel meeting was held the week of 5/18/98.	Concept paper submitted 9/30/97. Proposal received 3/12/98. Proposal approved 5/29/98. Amendment received 12/30/98. Amendment approved 1/22/99.

STATE	PROJECT DESCRIPTION	STATUS	KEY DATES
		On 5/29/98, the State's proposal was approved. HCFA continues to have discussions with the State on its Section 1115 waiver request. The State will pursue legislative approval for its Section 1115 waiver request. On 8/19/98, the State was informed that a cap in Title XXI eligibles would not be approved. State released a press release criticizing decision. On 12/30/98, the State submitted an amendment to its plan. On 1/13/98, an informal letter was sent to the State. On 1/15/99, the State's response was received. On 1/22/99, the State's amendment was approved.	

CHIP Approval Map

CHIP State Plans

February 16, 1999

Approved

-  Separate State Child Health Plan
-  Medicaid Expansion
-  Combination

Pending

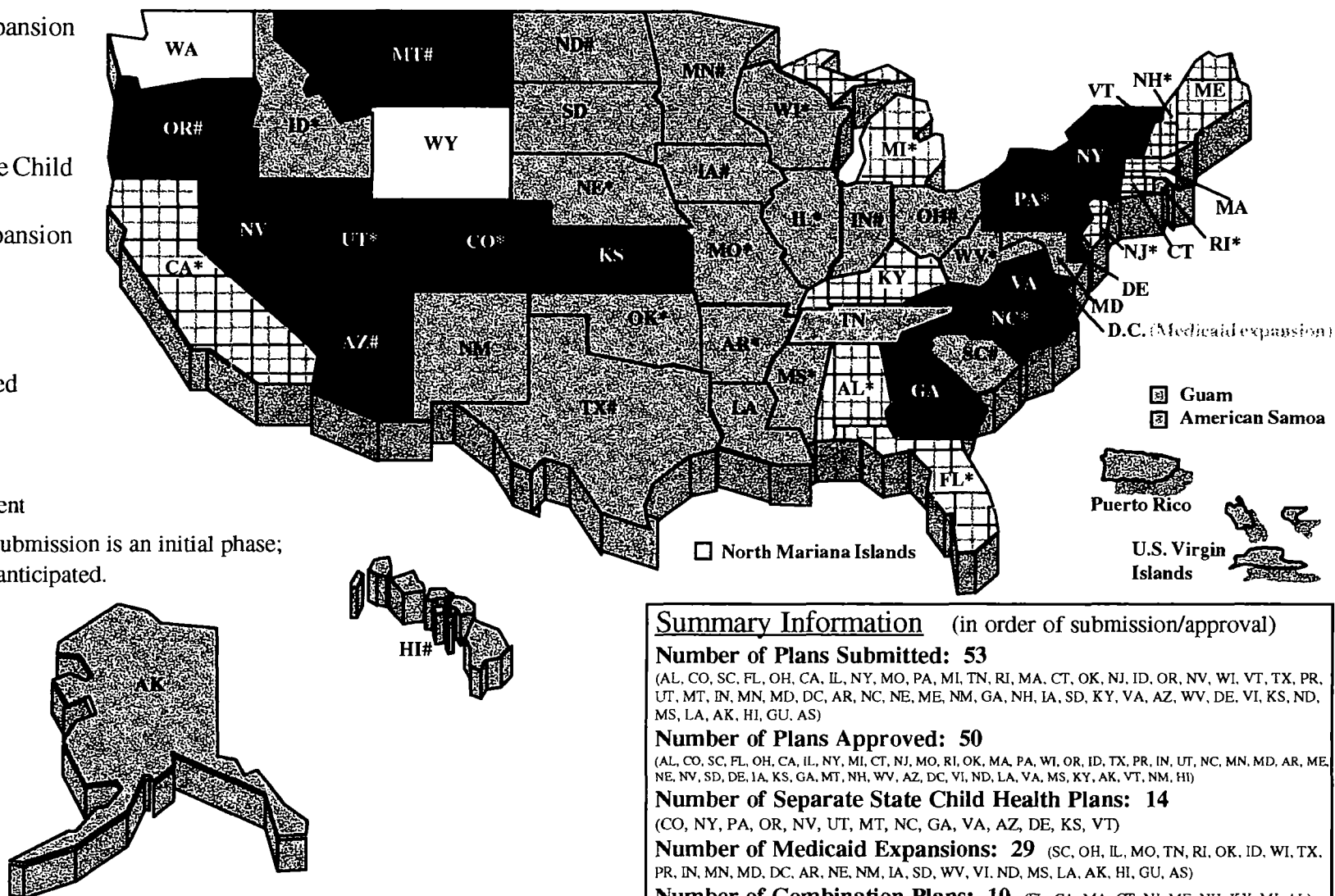
-  Separate State Child Health Plan
-  Medicaid Expansion
-  Combination

No Submission

-  Not Submitted

* State Plan Amendment

State has indicated submission is an initial phase; plan amendment is anticipated.



Summary Information (in order of submission/approval)

Number of Plans Submitted: 53

(AL, CO, SC, FL, OH, CA, IL, NY, MO, PA, MI, TN, RI, MA, CT, OK, NJ, ID, OR, NV, WI, VT, TX, PR, UT, MT, IN, MN, MD, DC, AR, NC, NE, ME, NM, GA, NH, IA, SD, KY, VA, AZ, WV, DE, VI, KS, ND, MS, LA, AK, HI, GU, AS)

Number of Plans Approved: 50

(AL, CO, SC, FL, OH, CA, IL, NY, MI, CT, NJ, MO, RI, OK, MA, PA, WI, OR, ID, TX, PR, IN, UT, NC, MN, MD, AR, ME, NE, NV, SD, DE, IA, KS, GA, MT, NH, WV, AZ, DC, VI, ND, LA, VA, MS, KY, AK, VT, NM, HI)

Number of Separate State Child Health Plans: 14

(CO, NY, PA, OR, NV, UT, MT, NC, GA, VA, AZ, DE, KS, VT)

Number of Medicaid Expansions: 29 (SC, OH, IL, MO, TN, RI, OK, ID, WI, TX, PR, IN, MN, MD, DC, AR, NE, NM, IA, SD, WV, VI, ND, MS, LA, AK, HI, GU, AS)

Number of Combination Plans: 10 (FL, CA, MA, CT, NJ, ME, NH, KY, MI, AL)

Number of Amendments Approved: 12

(CA, MI, AL, FL, MO, NE, PA, ID, NC, WI, RI, MS)

Number of Amendments Under Review: 10

(IL, FL-2nd amendment, AR, WV, NH, OK, CA-2nd amendment, UT, CO, MS)

Medicaid Waiver Status

MEDICAID DEMONSTRATIONS AND WAIVERS APPROVED DURING THE CLINTON ADMINISTRATION

(January 21, 1993-February 18, 1999)

STATE	1115 HEALTH CARE REFORM DEMONSTRATIONS	1915(b) FREEDOM OF CHOICE WAIVERS*	1915(c) HOME AND COMMUNITY-BASED WAIVERS *
	Permit states to: -restructure eligibility and coverage under Medicaid; -acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating state health programs.	Permit states to: -waive beneficiaries' rights to free choice of providers in order to, for example, implement a primary care case management system or a speciality physician services arrangement; -require Medicaid beneficiaries to receive services from specified providers, generally on a negotiated rate contract basis.	Permit states to: -provide a broad array of home and community-based services (excluding room and board) not otherwise covered under the Medicaid program as an alternative to institutional care.
Alabama	✓	✓ (7)	✓(15)
Alaska			✓(21)
Arizona			
Arkansas	✓	✓(6)	✓(18)
California	✓	✓(34)	✓(13)
Colorado		✓(6)	✓(26)
Connecticut		✓(1)	✓(12)
Delaware	✓		✓(9)
D.C.		✓(3)	✓(5)
Florida	✓	✓(11)	✓(29)
Georgia		✓(7)	✓(10)
Hawaii	✓		✓(8)
Idaho		✓(2)	✓(10)
Illinois	✓		✓(21)

Indiana		✓(3)	✓(39)
Iowa		✓(14)	✓(38)
Kansas		✓(5)	✓(18)
Kentucky	✓	✓(8)	✓(11)
Louisiana		✓(8)	✓(15)
Maine		✓(4)	✓(17)
Maryland	✓	✓(3)	✓(8)
Massachusetts	✓	✓(1)	✓(8)
Michigan		✓(6)	✓(14)
Minnesota	✓	✓(2)	✓(28)
Mississippi		✓(4)	✓(7)
Missouri	✓	✓(8)	✓(18)
Montana		✓(6)	✓(7)
Nebraska		✓(5)	✓(18)
Nevada		✓(1)	✓(10)
New Hampshire			✓(11)
New Jersey	✓	✓(4)	✓(17)
New Mexico		✓(4)	✓(8)
New York	✓	✓(12)	✓(20)
North Carolina		✓(5)	✓(18)
North Dakota		✓(7)	✓(9)

Ohio	✓	✓(3)	✓(13)
Oklahoma	✓	✓(1)	✓(20)
Oregon	✓	✓(2)	✓(7)
Pennsylvania		✓(13)	✓(25)
Rhode Island	✓		✓(12)
South Carolina	**	✓(3)	✓(16)
South Dakota		✓(5)	✓(10)
Tennessee	✓		✓(21)
Texas		✓(16)	✓(40)
Utah		✓(7)	✓(12)
Vermont	✓		✓(12)
Virginia		✓(9)	✓(9)
Washington		✓(18)	✓(20)
West Virginia		✓(6)	✓(5)
Wisconsin		✓(4)	✓(22)
Wyoming		✓(3)	✓(11)
TOTALS	20	277	792

*The numbers indicated include new waivers, renewals, and modifications. **Only framework for SC's plan was approved.

Problem Waiver Talking
Points



Maryland

- The Department remains committed to working in partnership with your staff to realize our common goal: improving the coordination of care for low-income vulnerable populations.
 - Currently, we are in receipt of your proposed amendment to your Section 1115 demonstration. This proposal would add certain substance abuse treatment services to the benefit package for demonstration individuals who are recipients of Temporary Cash Assistance (TCA).
 - Very soon, the Department will send some questions and clarifications regarding the amendment, and we will look forward to receiving your responses.
 - I would also like to extend my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on July 29 of last year. We look forward to continuing to work with your staff as Maryland implements this important new program.
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Wisconsin

- I would like to extend my sincere congratulations on the approval of Wisconsin's BadgerCare program, which will expand health care coverage to low-income children and their parents.
 - Using section 1115 demonstration authority for Medicaid and Title XXI Children's Health Insurance Program (CHIP) funding, we were able to realize your goal of insuring low-income families under BadgerCare.
 - Yours has been a state that is eager to test innovative approaches to providing services to lower-income individuals. The Department looks forward to an ongoing partnership with Wisconsin as it implements the expanded BadgerCare program.
 - We are currently reviewing your amendment regarding coverage of foster care children, and expect to be able to give you an answer shortly.
 - Throughout negotiations on the BadgerCare proposal, your staff agreed with the Department to deal separately with the issue of coverage for foster parents of children in BadgerCare. The Department has continued to discuss this Medicaid reimbursement issue with your staff, and we appreciate your willingness to address this issue outside of the process of approving your Medicaid demonstration and Title XXI plan.
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Hawaii

- The Department remains committed to working in partnership with your staff to realize our common goal: improving access to health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.
- We are in receipt of your proposed amendment to QUEST, your Section 1115 demonstration. This proposal would enroll the aged, blind, and disabled populations in QUEST, building upon the achievements of your existing demonstration.
- The Department continues to work with Hawaii to assure that the review process for this amendment is expeditious.
- I would also like to extend my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on January 19, 1999. We look forward to continuing to work with your staff as Hawaii implements this important new program.

Minnesota

- The Department remains committed to working in partnership with your staff to realize our common goal: improving access to health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.
- The amendment to the Prepaid Medical Assistance Plan Plus (PMAP+), which would implement Phase II of MinnesotaCare is under review in the Department. We will continue to work with your staff to address issues related to this amendment and hope to be able to notify you of a decision in the near future.
- In addition, this month we also received the latest amendment to PMAP+, a proposal to implement a county-based prepaid medical assistance program.
- We have assured your staff that we will do our utmost to ensure an expeditious review of this amendment, while simultaneously working toward resolution on the Phase II amendment.

Vermont

- The Department remains committed to working in partnership with your staff to realize our common goals: improving access to and coordination of health care coverage for low-income individuals not traditionally eligible for Medicaid coverage.
- We have been working with your staff on the behavioral health services component of your Medicaid program. Your state proposed five amendments to your current section 1115 Medicaid demonstration the Vermont Health Access Plan (VHAP), which would improve access to and coordination of care in a variety of ways.
- Amendments to VHAP include a coordinated care program for long-term behavioral health services; expanded eligibility in the number of parents and caretaker relatives of Medicaid-eligible children; an extended and enhanced benefits package; and reductions in cost-sharing for beneficiaries.
- We anticipate announcing a decision on four of these amendments very soon, and understand that you would like to have them approved by March 1. Furthermore, we will continue to work with State staff to ensure a very expeditious approval of the outstanding amendment pertaining to long-term behavioral health services.
- I would also like to reiterate my congratulations on the approval of your State's Title XXI Children's Health Insurance Program on December 15, 1998. We look forward to continuing to work with your staff as Vermont implements this important new program.

Rhode Island

- I would like to take this opportunity to update you on the status of the Rhode Island CHOICES section 1115 demonstration, which will allow the developmentally disabled to have more choice and control over the acute and long-term care services that they receive.
- A planning grant from the Department assisted with the development of this proposal, a final version of which was received by HCFA on May 15, 1997.
- Currently, the Department and the Office of Management and Budget are reviewing the demonstration proposal, and will be in regular contact with your staff to resolve outstanding issues.
- We look forward to continuing the progress we have made on the CHOICES demonstration, which promises disabled beneficiaries the opportunity to make informed decisions about the care that they require.
- I would also like to take this opportunity to congratulate you on the recent approval of the amendment to your Title XXI plan.
- As you know, the amendment will allow Rhode Island to expand health care coverage to additional uninsured children. We look forward to continuing to work with your staff as Rhode Island implements this important new program.

Secretary's Report
to the Governors

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

FEB 18 1999

Dear Governor:

Over the past year, our Department has worked closely with states to make important progress in improving the health and welfare of all Americans. We have made major investments to ensure the health of our nation's children through the Children's Health Insurance Program (CHIP), taken steps to reduce the major disparities in health that exist between whites and racial and ethnic minorities, and worked hard to help thousands of families leave welfare for meaningful employment opportunities.

As we begin 1999 with a new Congress and 14 new state governors, I would like to take this opportunity to highlight a few important issues on which we look forward to collaborating with you over the coming months. My Department and I are committed to working with you and your state's health and human services agencies to address these issues with the goal of better serving our nation's most vulnerable citizens.

Welfare Reform

First, I would like to commend you for your state's role in the successful implementation of welfare reform and your commitment to helping families make the transition from welfare to work. States and territories have now had more than two full years to implement the historic Personal Responsibility and Work Opportunity Reconciliation Act, which the President signed into law in August of 1996, and the initial results show important progress. States were successful in meeting the first overall work participation rates required under the law. An estimated 1.5 million people who were on welfare in 1997 were working in 1998.

As we continue our successful partnership on welfare reform, I urge you to continue to invest the resources available to you through the Temporary Assistance for Needy Families (TANF) block grant. The investment choices you make right now, in this period of sustained economic growth and declining caseloads, will determine in large part the long-term success of welfare reform. This is a crucial time to make investments in those hard-to-serve families remaining on the caseload that may face barriers to work such as substance abuse, domestic violence, or disabilities, and thus require more intensive service interventions.

Moving people from welfare to work is an important first step. I urge you to take the next step by investing TANF resources to support those who have recently moved from welfare to work. These investments will help people succeed at work – by providing the

tools, supports and resources, such as child care, transportation assistance, and health insurance, these new workers need to retain employment and move toward self-sufficiency.

Medicaid/Children's Health Insurance Program (CHIP) Enrollment

A key component of welfare reform is ensuring that low-income families with children enroll or maintain enrollment in the Medicaid and CHIP programs. I will write you soon with more detailed information regarding this issue and will focus on the legal requirements and program options for providing Medicaid and CHIP to families seeking TANF, families leaving TANF, and low-income working families who may not have come into contact with TANF.

States and territories can be proud of the great strides our nation is making to ensure that our children have access to health care. I am pleased to report that since the Children's Health Insurance Program (CHIP) took effect on October 1, 1997, fifty-three states and territories have submitted CHIP plans for approval, and 50 have been approved. According to the states' estimates, more than 2.5 million children will be covered when these CHIP plans are fully implemented.

Although we will work diligently with states and territories to approve additional CHIP plans and plan amendments, we must now focus on the next important step in program implementation, enrolling eligible children. An additional aspect of insuring more children will be enrolling children in Medicaid who are currently eligible but not enrolled. Our Department stands ready to assist states and territories in establishing effective enrollment processes. For example, we will be launching with the National Governors' Association a national toll-free CHIP information line.

Additionally, the President's FY 2000 budget proposes to support states' outreach efforts by increasing their flexibility in using available CHIP and Medicaid outreach funding. We hope that these proposals will contribute to the efforts already underway in your state aimed at increasing participation in both the Medicaid and CHIP programs.

Assuring Year 2000 Readiness

I recently wrote you about our preparations to achieve Year 2000 compliance for our Department's information systems. This has been a top priority for us for quite some time. I am happy to report that we finished 1998 with 85 percent of our HHS mission-critical systems Year 2000 (Y2K) compliant at the end of December, three months prior to the government-wide March 31, 1999 deadline. We are well on our way to meeting the deadline for the remainder of our critical systems, including the particularly complex Y2K issues for the Medicare systems. Furthermore, we are committed to making all other HHS systems fully compliant well before the end of the fiscal year.

Page 3

I am sure that you share my concern that state systems achieve Y2K compliance as soon as possible, particularly state health and human services information systems. I urge you to continue in and expedite your Year 2000 preparedness efforts. As I indicated in my earlier letter, these systems are critical for many federally- and state-funded programs that serve children and families. My Department will continue to work with all states to ensure that these important information systems continue to operate effectively well into 2000 and beyond.

During my tenure as Secretary of Health and Human Services, I have appreciated the considerable expertise, innovation, and commitment that many states have brought to health and human services programs. President Clinton and I remain fully committed to the federal-state partnership, and I look forward to working with you and other governors to meet these and other challenges in the year ahead. If you have any questions, please do not hesitate to contact me or have your staff contact Andrew D. Hyman, our Acting Director of Intergovernmental Affairs, at (202) 690-6060.

Best wishes for a very successful National Governors' Association Winter Meeting.

Sincerely,

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

Donna E. Shalala

NGA Policy Resolutions

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.2.3 -- Medicare & Medicaid

SUMMARY: The NGA recommendation consists of two parts. The first relates to Medicare reform. The NGA urges the Federal government not to reform Medicare in a way that negatively affects States. For example, increasing Medicare premiums or other cost-sharing would increase amounts that States pay on behalf of dually eligible low-income seniors and disabled Medicare beneficiaries.

The second part of the recommendation relates to demonstrations under which methods for integrating acute and long-term care services for the elderly can be tested. Under current law, administration and financing of services can be roughly divided as follows: Medicare for acute care services, Medicaid for Medicare cost-sharing, and long-term care services. In addition, Medicaid covers prescription drugs for many dually eligible persons.

HHS POSITION: HHS is aware of the many complexities and sometimes conflicting priorities that the Medicare Commission must juggle as it deliberates approaches to Medicare reform. We believe it is likely that State Medicaid programs will continue to play a role in serving low-income Medicare beneficiaries after Medicare reform, both in terms of being the principal provider and source of funding for long-term care services, and of subsidizing Medicare cost-sharing. But we cannot predict the extent or nature of the States' role until the broad outlines of Medicare reform are more clearly drawn.

On the issue of integration of care for dual eligibles, HHS is aware of a high level of State interest and work on this issue. We agree with the problem as identified by NGA that individuals needing the full range of services may have to navigate between these two systems of care, resulting in care that is fragmented and uncoordinated and that ultimately produces less than optimal results. Those most affected are the oldest and sickest --those least able to manage their own care. States are interested in managed care models that integrate service delivery and financing streams under the two programs. HHS, in close and extensive collaboration with States, is also spending considerable effort in developing better information so that we may better understand who these individuals are and how we serve them. With States, we are exploring new approaches to improvement to be tested in a demonstration setting. In its deliberations with States on these demonstrations, HHS has insisted that beneficiaries' rights under Medicare not be infringed in any way.

SUGGESTED RESPONSE: Medicare reform is one of the most difficult public policy issues that the country now faces. We do not yet know the Medicare Commission's final recommendations, but we recognize that the Medicare reform cannot be accomplished by shifting the burden to States. On the issue of integration of care for dual eligibles, HHS shares States' commitment to improvement, and has demonstrated this commitment by working very closely with States to clarify areas where we agree and to resolve areas of disagreement to our mutual understanding or satisfaction.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.2.4 -- Disproportionate Share Hospital (DSH) Program.

SUMMARY: NGA states that disproportionate share hospital (DSH) funds should continue to be distributed through the States and should not be further reduced.

HHS POSITION: HHS agrees that Medicaid DSH funds are an integral part of the support network to provide access to health care for the uninsured.

SUGGESTED RESPONSE: The President's budget does not contain any provisions which would result in a reduction in DSH payments to States or restrict State discretion in distributing those funds.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.2.5 -- Budget Neutrality

SUMMARY: NGA would like to call attention to the fact that expenditures in one program often realize savings in others. NGA would like States to have the flexibility to consider budget neutrality across Federal programs, and not just for individual programs.

HHS Position: HHS supports States in their efforts to coordinate funding from many Federal sources. We recognize that the differing requirements of the multiple funding streams present many challenges. We have historically supported States' efforts to use waiver authority to explore new ways to deliver services to more of their vulnerable citizens. We have always worked with States, within the authority granted us by Congress, to grant flexibility that has allowed States to streamline service delivery systems and serve more people. We believe we have assisted States in implementing waiver programs that are financed using the most flexible interpretation of budget neutrality envisioned by Congress.

Suggested Response: HHS believes that Medicaid waivers continue to be a useful vehicle for States to achieve their goals of serving the health care needs of the maximum number of vulnerable citizens in the most effective way possible. In addition, we will continue to work with States to establish new models for serving persons who are dually eligible for Medicare and Medicaid, as is the case with dual eligible demonstrations such as the PACE program. We are, however, prohibited by statute from looking at funding across different programs beyond certain linkages such as the Medicaid and Medicare programs. We look forward to our continued work with States to devise new and innovative ways of using waiver authority, within our statutory limitations, to benefit their most vulnerable citizens.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.1 -- Allow States Greater Flexibility to Establish Managed Care Networks

SUMMARY: NGA feels that the proposed Medicaid managed care regulations implementing the BBA actually restrict state flexibility and place greater regulatory burdens on State Medicaid programs. Therefore, NGA feels that States should have the opportunity to establish networks in Medicaid through the plan amendment process.

HHS POSITION: HHS recognizes the desire of States to be prudent purchasers of high quality health care through managed care networks. The Balanced Budget Act created additional flexibility, along with certain standards and limitations, to mandatorily enroll Medicaid beneficiaries in managed care. On September 29, HHS published a Notice of Proposed Rulemaking implementing the flexibility, quality standards, and consumer protections outlined by Congress for Medicaid managed care programs. This NPRM represents the Department's effort to reconcile the intentions of Congress with the needs of States, managed care organizations, beneficiaries, and other stakeholders in implementing the BBA.

SUGGESTED RESPONSE: HHS supports States in their efforts to expand mandatory managed care programs consistent with the BBA. We are currently in the process of reviewing comments from Governors, Medicaid agencies, managed care organizations, and other stakeholders on the NPRM, and will give full consideration to these comments as we develop the final rule implementing the BBA.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.2 -- Managed Care Quality Standards

SUMMARY: The NGA states that, while the Governors' are committed to providing quality care in Medicaid managed care, HCFA has developed regulations that are prescriptive in nature and impede State and managed care plan flexibility.

HHS POSITION: HHS supports high quality health care for Medicaid managed care enrollees. HCFA intends on continuing to work in partnership with the states to continuously improve quality of care for Medicaid beneficiaries. HCFA was guided in the development of the NPRM by three principles: the preservation of State flexibility wherever possible and appropriate, consistency with the Medicare program, and incorporation of the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

SUGGESTED RESPONSE: Health care quality improvement is a rapidly changing field. In the NPRM, HCFA has made a good faith effort to bring Medicaid managed care quality standards and activities in line with those found in both the commercial and Medicare markets. HCFA recognizes that the NPRM represents a significant expansion in the scope of quality assurance activities, from collection of quality assurance data to performance improvement projects. To assist states in these endeavors we have developed QISMC, a voluntary tool for states to use to implement the quality assurance provisions of the Balanced Budget Act. While QISMC is mandatory for Medicare managed care plans, states have the option of utilizing QISMC to satisfy most of the quality provisions of the NPRM.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.3 -- Waivers

SUMMARY: NGA maintains that States should not have to produce and defend waivers that are "similar to" previously-approved ones in other States. NGA argues that developing and securing approval for similar waivers is a waste of both Federal and State resources. Therefore, a State should be able to import any previously-approved waiver in place without securing additional Federal approvals.

HHS POSITION: Throughout the Clinton Administration, HHS has championed State flexibility by granting unprecedented numbers of waivers of Federal requirements, including the approval of eighteen statewide health reform demonstrations. Allowing the wholesale importation of whole or parts of waivers into other waivers would neglect to take the particulars of a State's circumstances (e.g., physicians per capita, percentage of uninsured, reimbursement rates) into account. Furthermore, waivers for the statewide health reform demonstrations are approved under Section 1115 of the Social Security Act: the precept is to test innovations that may lead to more effective State medical assistance programs. As this is the case, furthering the research aims of the Department may warrant testing an innovation only in certain States' cases, while not concurrently testing it elsewhere.

SUGGESTED RESPONSE: In keeping with its unprecedented commitment to state flexibility under the Clinton Administration, HHS will continue to work in partnership Governors to approve waivers and demonstrations that are tailored to a particular State's circumstances. In the case of demonstrations, another consideration is whether the granting of particular waivers furthers the Department's aim of testing improved ways to deliver health care to the beneficiaries of State medical assistance programs.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.5 -- Allow States to Manage Costs in the EPSDT Program By Providing Services Within their State Medicaid Plan and Selecting Less Costly Alternatives for Diagnosis and Treatment without Risking Quality.

SUMMARY: States have no ability to limit the range or cost of services required in the EPSDT program. The open-ended requirement is driving up Medicaid costs at uncontrollable rates. HHS should work with States to develop and finalize rules that allow States to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

HHS POSITION: EPSDT is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21. It provides children with an entitlement to a Medicaid benefit package more comprehensive than that furnished to adults. The goal of the program is to ensure health care for children to prevent the development of health problems and to provide early detection and treatment of conditions in children before they become serious. HCFA policy allows States to pay for treatment in the most cost-effective setting, as long as it meets the child's needs.

The BBA mandated that HHS conduct a study of EPSDT in consultation with Governors, Medicaid Directors, American Academy of Actuaries and representatives of provider and beneficiary organizations. The study must examine the actuarial value of the treatment portion of EPSDT.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.6 -- Ensure that States Will Not Be Expected to Implement Any Changes in the Medicaid Program Until HCFA Has Published Final Regulations to Guide Program Administration.

SUMMARY: NGA feels that States should not be held liable for operating under state law or state interpretation of Federal statutes until the Federal regulations are adopted.

HHS POSITION: The BBA gave States increased flexibility in Medicaid eligibility and enrollment and eliminated certain requirements viewed by State agencies as impediments to the growth of managed care programs. The BBA also established new beneficiary protections in areas such as quality assurance, grievance rights, and coverage of emergency services. HHS has fiduciary responsibility to ensure that new requirements outlined by Congress are met. We also, however, have a responsibility to States and other stakeholders to translate the BBA into regulations that represent the most efficient and effective means of ensuring that Congress's intentions are carried out. Toward that end, on September 29, we published a Notice of Proposed Rulemaking (NPRM) implementing the Medicaid managed care provisions of the BBA. Recognizing that development of a final rule is a lengthy process, and that States should not be held liable for meeting requirements of the BBA without official guidance, we have also issued a series of 19 State Medicaid Director letters indicating steps States should take to comply with the requirements of the BBA based on direct statutory authority. Historically, HHS has used these letters as a vehicle to clarify statutory intent after new laws have been enacted and before regulations have been finalized.

SUGGESTED RESPONSE: HHS is sensitive to the desire of States to be guided by final regulations that are complete, consistent, clear, and reflect the input of Governors and other stakeholders. We will give comments from Governors full consideration as we revise the Medicaid managed care NPRM into a final rule. In addition, HHS will continue our cooperative work with Governors and Medicaid agencies in implementing those requirements of the BBA that have already been communicated in the form of State Medicaid Director letters.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.7 -- Promote Cost Control and Efficiency

SUMMARY: NGA wants states to be encouraged to continue innovations in provider payment methods.

HHS POSITION: HHS is sensitive to the desires of States to have more latitude in determining payments arrangements. Congress has spoken very clearly through the Medicaid statute on its desire for Federally Qualified Health Centers and similar providers to be paid on the basis of their costs. However, in the Balanced Budget Act, Congress set forth a requirement to phase-out cost-based reimbursement for FQHCs.

SUGGESTED RESPONSE: HHS is committed to carrying out the intent of the Congress to phase-out cost-based reimbursement for FQHCs through the gradual process outlined in the BBA. We will work with States and FQHCs throughout this process to ensure that high-quality care to Medicaid beneficiaries is not interrupted or impaired.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.8 -- Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries Who are Not Otherwise Medicaid-Eligible

SUMMARY: The Governors indicate that Medicaid is responsible for meeting Medicare cost-sharing obligations for many low-income beneficiaries, and for providing a full range of benefits to others. The section indicates that NGA does not support further responsibility of State Medicaid programs for Medicare beneficiaries, since Medicare is a Federal program and the Federal government should bear all of its costs. At the very least, NGA asks that Congress consider the implications of the cost-shift should the Federal government not bear all of the costs for low-income Medicare beneficiaries.

HHS POSITION: Out of concern for the health status of low-income Medicare beneficiaries, Congress has on several occasions expanded the role of the Medicaid program in meeting the Medicare cost-sharing requirements on behalf of such beneficiaries. The statutory provisions pertaining to groups of low-income Medicare beneficiaries are one aspect of the Medicaid program's evolving role in providing medical assistance to vulnerable populations beyond only cash-assistance linked groups. The costs to the Medicaid program are shared by the State and Federal government in all cases. For Qualified Medicare Beneficiaries, Specified Low-Income Beneficiaries, and Qualified Disabled and Working Individuals, Federal Financial Participation (FFP) is equal to the Federal Assistance Matching Percentage (FMAP), the percentage at a State's medical assistance costs are reimbursed for regular Medicaid services. For the new Qualifying Individuals, FFP is again equal to FMAP, but capped on an annual basis -- meaning that there are no additional costs to either the State or the Federal governments once the cap is reached. *While HHS understands the rationale for the NGA recommendation, we are committed to maintaining at least the current level of assistance to low-income Medicare beneficiaries. We note that the NGA recommendation would merely shift the costs of paying for these benefits from the States to the Federal government. States would benefit, but the benefits to low-income Medicare beneficiaries would be dubious. Moreover, the NGA has also not identified a commensurate budget reduction to match this proposed increase in Federal spending.*

SUGGESTED RESPONSE: As are the Governors, HHS is committed to ensuring that low-income beneficiaries receive the medical care that they require. Over the years, Congress has increased the scope of the Medicaid program to include cost-sharing assistance to low-income Medicare beneficiaries. As with other Medicaid beneficiaries, Congress envisioned a shared State and Federal responsibility to pay for the costs of their care: in the cases of all of these groups, State Medicaid programs receive a Federal Assistance Matching Percentage (FMAP) for the Medicare cost-sharing they pay on behalf of low-income Medicare beneficiaries. With the low-income groups Congress has recently added, both Federal and State financial exposure is limited by an annually capped allocation. This underscores that Congress was considering the financial implications -- to both State and Federal governments -- of establishing a new low-income Medicare group eligible for some Medicaid coverage of their cost-sharing. *HHS is willing to continue to work with states on the broad range of issues pertaining to how we deliver and pay for the health care of low-income seniors and persons with disabilities.*

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.9 -- Make Audit and Disallowance Policies More Equitable.

SUMMARY: The NGA states that the Medicaid statute should be revised to prohibit federal practices that impose heavy penalties when the State violation does not result in direct harm to beneficiaries. States should be held harmless against possible penalties or disallowances for reasonable Interpretations of law based on Departmental guidance prior to the issuance of regulations.

HHS POSITION: HHS does not agree that penalties should be limited only to violations that directly harm patients. Part of the Federal Government's responsibility for overseeing the Medicaid program is to employ disallowances for violations such as unauthorized or inappropriate payments. At the same time, we share the States' concern that the size of a disallowance may be in proportion to the significance of the State violation. Proposals for basing the magnitude of a disallowance on the seriousness of the violation were considered by Congress -with considerable technical assistance provided by HHS - but no statute was enacted. It should be noted that HCFA in recent years has worked hard to strengthen its partnership with the States, providing extensive policy guidance on new Federal requirements through all-State letters as well as manual issuance and regulations, and issuing very few disallowances (fewer than 10 nationally in each of fiscal years 1997 and 1998).

SUGGESTED RESPONSE: HHS does not support prohibiting Federal disallowances except where a State violation results in direct harm to beneficiaries. However, we share the States' concern that the size of a disallowance be in proportion to the significance of the State violation. This would require a statutory change.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.10 -- Allow Greater Flexibility in Medicaid Home & Community-based Programs.

SUMMARY: The Governor's request the ability to administer Home and Community-Based Care programs through plan amendments rather than through waivers. However, the States would like to retain the ability to limit the number of beneficiaries served under the Home and Community-Based Care Program. Additionally, the States would like the incentives to place beneficiaries in institutional care, which currently exist in the Medicaid program, to be eliminated.

HHS POSITION: There continues to be strong support for the provision of home and community-based services from the Department of Health and Human Services. HCFA has tried to operate with a maximum of flexibility in approving waivers for home and community-based services. Currently, each state is operating at least one home and community-based services program.

Without restructuring the Home and Community-Based Services Program, the Administration is supporting the elimination of barriers to home and community based care by equalizing the eligibility standards for HCBS and institutional care which was included in the long-term care portion of the Administration's budget.

The effect of implementing a Home and Community Based Services Program through a plan amendment without comparability and statewideness would be the same as implementing a block-grant program which the Administration opposes. HHS supports the Medicaid program as an entitlement program by nature which requires the comparability and statewideness mandates.

SUGGESTED RESPONSE: The President's budget contains a provision to eliminate the institutional bias in Medicaid by implementing an equal eligibility standard for all institutional and home and community-based services programs (300% SSI).

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.11 -- Children Eligible for Medicaid

SUMMARY: Federal outreach efforts to Medicaid-eligible children who are not enrolled should be developed in conjunction with the States. Outreach efforts must be designed in a way that discourages employers from discontinuing private sector insurance coverage for children. The Governors would oppose tying receipt of Medicaid funds to achieving increased enrollment targets.

HHS POSITION: We agree that Federal outreach efforts should be developed in conjunction with the States. To date, our outreach efforts have included advising States of Medicaid options such as presumptive eligibility and continuous eligibility. We also have advised States of opportunities for receiving Federal match for outreach including outstationing eligibility workers and simplifying Medicaid applications. We have highlighted these opportunities in a series of letters to State Health Officials. We do not support tying receipt of Medicaid funds to achieving increased enrollment targets in the program.

SUGGESTED RESPONSE: HHS is committed to enrolling the Medicaid-eligible children who are not enrolled in Medicaid. We believe that States understand what strategies will be most effective with their populations and have provided them flexibility to determine the options and strategies that best meet their needs. Toward this end, we sent two informational letters to State Health Officials encouraging them to engage in outreach activities. In January of 1998, we sent a letter describing examples of and options for successful outreach and enrollment and Federal funding available for these activities. We issued a second letter September of 1998 highlighting the flexibility States have to simplify the application and enrollment processes. In addition, we have been working with States to develop outreach strategies.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.12 -- Flexibility for Optional Eligibility Groups

SUMMARY: The States request the flexibility to customize a package of optional benefits to meet the particular needs of optional eligibility groups, acknowledging that this would require a waiver of comparability and statewideness. The States wish to use services like respite care to keep beneficiaries in their homes for longer periods of time. This will help individual beneficiaries and their families while saving State and Federal dollars.

HHS POSITION: HHS recognizes that States would like to continue to improve the services that they offer to their citizens and believe that greater flexibility would help them achieve this. HHS also opposes any form of block grants to States and cannot support a de facto block grant through the Medicaid program that would permit some to receive services that others with equal eligibility criteria would not.

SUGGESTED RESPONSE: The Administration cannot support a program that would change the entitlement nature of Medicaid by providing services to only a portion of those who would qualify under equal eligibility criteria. HHS has worked with the States, through the waiver programs to allow flexibility while demonstrating improvements in service delivery and cost-efficiency.

U.S. Department of Health and Human Services

RESPONSE TO: HR-16: Medicaid, section 16.3.13 -- The Americans With Disabilities Act

SUMMARY: The NGA states that recent court decisions have interpreted the Americans with Disabilities Act (ADA) in such a way that home and community based services will become open-ended entitlements for people with disabilities. The Governors' are seeking reconsideration of the case law and Constructive clarification" of the parameters of states' requirements under ADA.

HHS POSITION: The ADA requires states to provide services to Medicaid beneficiaries with disabilities in the most integrated setting appropriate to their needs so long as such placements do not alter the fundamental nature of State Medicaid programs. HHS encourages states to continue to strive to meet the objectives of the ADA by maintaining and enhancing home and community based services under their Medicaid waivers within the parameters of the State's Medicaid budget. HHS does not have the authority to initiate a reconsideration of current ADA case law.

SUGGESTED RESPONSE: HHS supports State flexibility in designing a range of institutional and home and community based services to serve Medicaid beneficiaries with disabilities. HHS is committed to working closely with states to ensure the civil rights protections found in the ADA while affording states the flexibility to provide services to each Medicaid beneficiary who is disabled in the setting most appropriate to their needs.

HR-16. ~~EC-8~~. MEDICAID

16.1 Preamble

The Medicaid program is a state/federal program that serves as the primary source of acute health care coverage and long-term care for the poor. Because it is a national program PROVIDING ACCESS TO HEALTH CARE FOR MORE THAN 40 MILLION ~~serving more than 37 million~~ beneficiaries, the Governors believe that quality services must be provided as efficiently and effectively as possible.

In 1998 ~~1996~~ approximately \$184 ~~\$164~~ billion was spent in the Medicaid program. Of that amount, about \$80 ~~\$71~~ billion was state funds. Medicaid is now one of the largest components of state budgets, comprising 20 percent of state spending. Medicaid spending has grown in both absolute and relative terms, and as a result of this growth, Medicaid is now the second-largest expenditure in state budgets. As a result, states are experiencing great difficulty in finding the money to fund Medicaid. Even more important, perhaps, is that increased Medicaid spending makes it difficult, if not impossible, to increase funding for other priorities. ~~such as education~~. Finding ways to control Medicaid spending is a major priority for the Governors.

Medicaid financing and administration are shared jointly by the federal government and the states. This federal-state partnership of financial responsibility must be maintained without further cost shifts from the federal government to the states and without expansions of federal programmatic mandates that increase state costs or limit state flexibility. In recent years, federal policymakers have narrowed the administrative flexibility of states and made legislative and regulatory changes that mandate greatly increased state expenditures. As a result, states increasingly view their relationship with the federal government not as a partnership, but as a relationship in which states have been forced to accept federal mandates that have great impact on state budgets and health policy initiatives.

CONGRESS HELPED TO ALLEVIATE SOME OF THIS PRESSURE WITH ITS PASSAGE OF THE BALANCED BUDGET ACT OF 1997 (BBA). THE REPEAL OF THE BOREN AMENDMENT, THE PHASE-OUT OF THE REQUIREMENT FOR COST-BASED REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS, AND THE ABILITY FOR STATES TO OPERATE MANDATORY MANAGED CARE PROGRAMS WITHOUT A WAIVER WERE ALL MUCH-APPRECIATED PROGRAMMATIC IMPROVEMENTS. CLEARLY, CONGRESSIONAL INTENT WAS TO PROVIDE STATES WITH MORE FLEXIBILITY TO DEVELOP AND OPERATE MEDICAID MANAGED CARE PROGRAMS, AND SPECIFICALLY TO GIVE STATES THE ABILITY TO DO SO THROUGH THE STATE PLAN AMENDMENT OPTION WITHOUT REQUIRING A WAIVER. THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) HAS SIGNIFICANTLY RESTRICTED STATE FLEXIBILITY TO DEVELOP AND ADMINISTER MEDICAID MANAGED CARE INITIATIVES BY INCREASING ITS FEDERAL OVERSIGHT ROLE IN PROMULGATING REGULATIONS THAT GO FAR BEYOND CONGRESSIONAL INTENT.

THERE ARE ENOUGH ~~States must have relief from the~~ real and pressing problems presented by the Medicaid program WITHOUT CREATING NEW REGULATORY BURDENS. ~~if they are to move forward with long-term solutions. Despite the failure of fundamental Medicaid reform efforts in previous Congresses,~~ The Governors continue to believe that urgent changes are needed to promote effectiveness and efficiency. Therefore, the Governors call on Congress and the administration to work to immediately address the problems with this program. Included among those solutions must be an overall reduction in the federal statutory and regulatory micro-management that has typified the program in the last decade.

16.2 Federal Financing

16.2.1 **THE FEDERAL COMMITMENT TO THE MEDICAID PROGRAM.** ~~Impose No Unilateral Caps for Federal Spending on Medicaid Entitlements.~~ THE GOVERNORS ARE EXTREMELY CONCERNED ABOUT VARIOUS RECENT PROPOSALS THAT WOULD ACTUALLY REDUCE THE FEDERAL COMMITMENT TO THE MEDICAID PROGRAM. PROPOSALS TO REDUCE THE FEDERAL MATCHING PERCENTAGE FOR ADMINISTRATIVE COSTS OF THE PROGRAM, OR TO, IN ANY WAY, WEAKEN THE FOUNDATION OF THE FEDERAL-STATE PARTNERSHIP THAT GUIDES THE OPERATION OF THE MEDICAID PROGRAM, ARE UNACCEPTABLE. MEDICAID HAS CONTRIBUTED SIGNIFICANT SAVINGS TO THE HISTORIC BALANCED BUDGET AGREEMENT, AND THERE IS SIMPLY NO WAY FOR ADDITIONAL FUNDS TO BE CUT WITHOUT SERIOUSLY JEOPARDIZING PATIENT PROTECTIONS AND SUCH IMPORTANT FUNCTIONS AS "YEAR 2000" (Y2K) CONTINGENCY PLANNING, MEDICAID FRAUD CONTROL UNITS, AND THIRD-PARTY LIABILITY RECOVERIES. THE GOVERNORS ARE COMMITTED TO CONDUCTING OUTREACH TO POTENTIALLY ELIGIBLE CHILDREN AND THE ELDERLY; CUTS IN NEEDED ADMINISTRATIVE FUNDING WOULD INTERFERE WITH THEIR ABILITY TO DO SO. ~~As the President and congressional leaders develop their policy agendas for the 105th Congress, it appears that the Medicaid reform debate will be very different than it was in the 104th Congress. The debate likely will focus more on improvements to the existing Medicaid program than on a fundamental reconsideration of basic program design. Given this premise, Governors are eager to work with Congress and the administration to make needed improvements and promote efficiencies in the Medicaid program as listed in this policy.~~

FURTHER, THE GOVERNORS FIRMLY HOLD THAT ~~At the same time,~~ Medicaid SHOULD NOT ~~will~~ be included in efforts to balance the budget, NOR BE USED AS A FUNDING SOURCE FOR OTHER PURPOSES. Governors already have contributed to significant budgetary savings by controlling Medicaid growth rates. In the late 1980s and early 1990s, Medicaid spending grew at an annual average of more than 20 percent. FROM 1995 TO 1997, ~~In 1995 and 1996,~~ Medicaid growth has been held to an average of less than 4 percent. The Congressional Budget Office recently revised its Medicaid spending

projections to reflect an average annual growth rate between now and 2008 ~~2002~~ of 7.4 ~~7.7~~ percent ;
producing Medicaid savings of almost \$86 billion.

These reductions in growth rates were made possible by taking advantage of the limited flexibility currently afforded by the Medicaid program to contain costs. However, economic pressures and other factors beyond state control will continue to be driving forces propelling Medicaid spending growth. ~~Therefore,~~ States HAVE MAXIMIZED THE EFFICIENCIES POSSIBLE IN THEIR CURRENT MANAGED CARE PROGRAMS AND will not be able to absorb any Medicaid cuts within existing program parameters. Additional flexibility will be needed to move beyond the results already achieved.

~~The Governors would welcome the opportunity to work with Congress and the administration to develop equitable and effective cost containment strategies, because the Governors strongly believe that the federal budget must not be balanced by shifting costs to states. In addition, Governors would oppose cost-cutting strategies that unfairly burden states.~~

Any unilateral federal cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. The Governors adamantly oppose a cap on federal Medicaid spending in any form. If Congress and the administration are serious about reducing the costs of the program, they must reexamine the authorizing legislation that has brought the program to the condition it is in today and restructure the program to make it consistent with congressional spending strategies.

- 16.2.2 **Medicaid Mandates.** The Unfunded Mandates Reform Act of 1995 is designed to protect states from the cost shifts that occur when the federal government requires states to enact expensive new policies but fails to provide the funding necessary for implementation. The Governors unequivocally oppose unfunded federal mandates and CALL ON CONGRESS TO CLARIFY THE ORIGINAL INTENT OF THE ACT WITH REGARD TO MEDICAID MANDATES. ~~applaud the protection afforded by the new law.~~ State Medicaid programs have historically been vulnerable to unfunded mandates and should particularly benefit from mandate relief. GOVERNORS CALL ON CONGRESS TO ENACT STATUTORY LANGUAGE TO CLARIFY THAT A CUT OR CAP ON THE MEDICAID PROGRAM, WITHOUT GIVING STATES NEW OR EXPANDED FLEXIBILITY, IS AN UNFUNDED MANDATE.

- 16.2.3 **Medicaid and Medicare.** As Congress and the administration debate possible Medicare reforms, the impact of those changes on Medicaid programs must be carefully considered. The Governors cannot support Medicare reform strategies, such as increased cost-sharing obligations for the dually eligible, that result in cost shifts to the states. The long-term financial needs of Medicaid and Medicare must be considered jointly to successfully prepare each program for the increased demands that will accompany the aging of the baby boomer generation. Although the aged, blind, and disabled represent roughly a quarter of the Medicaid caseload, they currently consume roughly three quarters of program spending. The Governors STRONGLY ~~also~~ support ALLOWING DEMONSTRATIONS FOR THE INTEGRATION OF ACUTE AND LONG-TERM CARE SERVICES FOR THE ELDERLY, ~~experimentation with mandatory managed care pilot projects for the dually eligible,~~ as discussed in NGA's Long-Term Care Policy, HR-17 ~~EC-7~~. STATES SHOULD BE ALLOWED TO BUILD ON THE

INNOVATIONS THEY HAVE DEVELOPED IN HOME- AND COMMUNITY-BASED CARE PROGRAMS. THESE PROGRAMS HAVE BEEN PROVEN TO PROVIDE COST-EFFECTIVE SERVICES THAT ARE PREFERABLE FOR BOTH BENEFICIARIES AND THEIR FAMILIES. WITH SOME ABILITY TO INTEGRATE MEDICAID AND MEDICARE FUNDING STREAMS, BENEFIT PACKAGES, AND DELIVERY SYSTEMS, STATES COULD VASTLY IMPROVE ON THE CURRENT FRAGMENTED SYSTEMS OF CARE.

16.2.4 Disproportionate Share Hospital (DSH) Program. Medicaid's DSH funds are an important part of statewide systems of health care access for the uninsured. The Governors strongly believe that DSH funds must continue to be distributed through states, AND WITHOUT FURTHER CUTS, to ensure that the program effectively complements other federal and state sources of health care funding.

16.2.5 BUDGET NEUTRALITY. FOR SOME INDIVIDUALS, GOVERNMENT ASSISTANCE COMES IN MANY FORMS: MEDICAID, MEDICARE, SUPPLEMENTAL SECURITY INCOME, AND FOOD STAMPS, AS WELL AS BENEFITS FROM THE RYAN WHITE CARE ACT, THE MATERNAL AND CHILD HEALTH BLOCK GRANT, AND THE SOCIAL SERVICES BLOCK GRANT, TO NAME A FEW. JUST AS IT CAN BE OVERWHELMING FOR INDIVIDUALS TO MANAGE ALL THE BENEFITS FOR WHICH THEY ARE ELIGIBLE, IT CAN ALSO BE VERY DIFFICULT FOR STATES TO COORDINATE MULTIPLE BENEFITS. THE GOVERNORS CALL ON CONGRESS AND THE ADMINISTRATION TO RECOGNIZE THAT EXPENDITURES IN ONE PROGRAM OFTEN REALIZE SAVINGS IN OTHERS. THE MEDICAID PRESCRIPTION DRUG BENEFIT IS RESPONSIBLE FOR PREVENTING HOSPITALIZATIONS FOR THE ELDERLY, THEREBY SAVING THE MEDICARE PROGRAM FROM ADDITIONAL COSTS. STATE-FUNDED RESPITE CARE CAN PREVENT NURSING HOME PLACEMENTS, THEREBY SAVING MONEY FOR THE MEDICAID PROGRAM. FUNDING FOR PROTEASE INHIBITORS FOR PEOPLE WHO ARE HIV POSITIVE WILL PREVENT THE ONSET OF AIDS AND PROVIDE SAVINGS TO A NUMBER OF OTHER HEALTH AND SOCIAL WELFARE PROGRAMS. CURRENTLY, STATES ARE UNABLE TO FACTOR IN SUCH COST SAVINGS WHEN APPLYING FOR MEDICAID WAIVERS. THE FLEXIBILITY TO CONSIDER BUDGET NEUTRALITY ACROSS FEDERAL PROGRAMS WOULD ENABLE THE MEDICAID PROGRAM TO HELP PEOPLE WITH DISABILITIES RETURN TO THE WORKFORCE, INTEGRATE AND COORDINATE CARE FOR SENIORS, AND PREVENT THE ONSET OF AIDS IN PEOPLE INFECTED WITH HIV.

16.3 Programmatic Recommendations

16.3.1 Allow States Greater Flexibility to Establish Managed Care Networks. There is a national trend in health care service delivery toward organized systems of care. These systems or networks have been shown to provide cost-efficient, quality care while ensuring that the patient has a reliable SOURCE place

from which to seek primary care and to which specialty care can be directed. Systems of coordinated care have particular benefits for Medicaid beneficiaries. These systems ensure a medical home for beneficiaries, encourage primary and preventive care, and discourage the use of emergency rooms and specialists for routine medical care.

ALTHOUGH THE BBA CONTAINED MANY MEASURES DESIGNED TO GIVE STATES MORE FLEXIBILITY, THE SUBSEQUENT PROPOSED REGULATIONS, IF ENACTED, WOULD NOT ONLY FAIL TO PROVIDE THAT FLEXIBILITY, BUT WOULD IN FACT PLACE A GREATER REGULATORY BURDEN ON STATE MEDICAID PROGRAMS. THE PROPOSED RULES WOULD CREATE SO MANY BARRIERS FOR STATES TO IMPLEMENT MANDATORY MANAGED CARE THROUGH THE STATE PLAN AMENDMENT OPTION THAT IT WOULD NOT BECOME A VALID OPTION AT ALL. FURTHER, THE DECISION TO APPLY AN ENTIRELY NEW SET OF PRESCRIPTIVE REGULATIONS TO CURRENTLY EXISTING 1915(B) AND 1115 WAIVERS COULD VERY WELL RESULT IN THE END OF MEDICAID MANAGED CARE. THE EXTENSION OF THIS REGULATORY BURDEN TO EVEN THE RELATIVELY SIMPLE "GATEKEEPER" PREMISE OF PRIMARY CARE CASE MANAGEMENT PROGRAMS MAY PREVENT PHYSICIANS AND GROUP PRACTICES FROM BECOMING MEDICAID PROVIDERS AND THEREBY JEOPARDIZE CONTINUITY OF AND ACCESS TO CARE FOR MANY FAMILIES.

~~Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. Although the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed. To ensure continuity and quality of care and to reduce administrative costs, states should have the option to require Medicaid beneficiaries to stay in an HMO for a period of up to twelve months. States also should be allowed to guarantee enrollment for certain Medicaid beneficiaries in HMOs for a period of up to twelve months.~~

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. The Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care.

Congress should clarify that under federal law, the states' obligation to provide services is satisfied if the state enters into a contract with a provider or HMO that covers the necessary benefits. Beyond that, any dispute by a client regarding covered services should be resolved as a contractual matter between the client and the provider or HMO under state law. Many states have alternative dispute resolution processes that should be exhausted before recourse to the state court system. There should be no private right of action for providers or health plans regarding payment rates.

16.3.2

~~16.3.11~~ **Managed Care and Quality Standards.** Governors are committed to ensuring that every Medicaid recipient receives high-quality health care. ~~and~~ Managed care has been an effective strategy for meeting

that goal BY PROVIDING ~~Medicaid managed care has delivered~~ high-quality, cost-effective health care services to millions of recipients.

Given the expertise states have developed with Medicaid managed care, the Governors HAD HOPED ~~would like to work closely with Congress and the administration as quality issues WERE are debated.~~ UNFORTUNATELY, HCFA DEVELOPED PROPOSED RULES ON MEDICAID MANAGED CARE WITHOUT ANY MEANINGFUL STATE INPUT. THE PRESCRIPTIVE APPROACH WILL CREATE SYSTEMIC DIFFICULTIES IN IMPLEMENTING ANY FORM OF MANAGED CARE, PARTICULARLY IN THE AREA OF QUALITY STANDARDS. A SINGLE REFERENCE IN THE BBA ABOUT GRIEVANCE STANDARDS BECAME MANY PAGES OF PRESCRIPTIVE REGULATIONS AND MANDATES FOR THE STATES. THE GOVERNORS RECOMMEND THAT STATES BE ALLOWED TO ESTABLISH MEANINGFUL GOALS AND BE GIVEN THE TOOLS TO HOLD PLANS ACCOUNTABLE FOR MEETING THOSE GOALS, RATHER THAN CONSTRAINING ALL PARTIES BY PRESCRIBING IN MINUTE DETAIL THE STEP-BY-STEP APPROACH THAT MUST BE FOLLOWED. MANY STATES HAVE SPECIFIC GRIEVANCE AND APPEAL PROCEDURES SPELLED OUT IN THEIR PLAN CONTRACTS, AND/OR HAVE STATE LAWS IN THIS AREA. NONE OF THEM WOULD CONFORM IN ALL RESPECTS TO THESE PROPOSED REGULATIONS. ~~Although there can be no disagreement that individuals enrolled in managed care networks should have their health care needs met with quality services, the Governors are concerned that efforts to ensure quality, if not undertaken carefully, could result in rigid guidelines that dictate state contractual relationships or fail to keep up with technological innovations.~~

Any time Congress mandates coverage of a particular benefit or sets requirements around the terms of that benefit, careful consideration must FIRST be given to the fiscal impact of the change on Medicaid. Even requirements limited to the private sector can have a strong Medicaid impact through contractual relationships with HMOs. Governors OPPOSE ~~will view~~ any changes in the health care market THAT WILL RESULT IN ~~a context framed by opposition to unfunded mandates TO THE STATES.~~

16.3.3 **Waivers.** Currently, each state must produce and defend waiver requests even if other states have already received approval to implement similar waivers. Obtaining redundant federal approval is an inefficient use of resources at both the state and federal level. States should be allowed to import any waiver in place in another state without securing additional federal approval.

~~16.3.4 **Repeal of the Boren Amendment.** The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. The courts have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment. The nation's Governors believe that any coherent approach to improving our nation's health care system must address the inflexible provider reimbursement standard of the Boren Amendment. The Governors call for repeal of the Boren Amendment in its entirety.~~

- 16.3.4 **Boren-Like Provisions.** THE REPEAL OF THE BOREN AMENDMENT IN THE BBA WAS ONE OF THE MOST IMPORTANT PROGRAMMATIC IMPROVEMENTS TO THE MEDICAID PROGRAM IN MANY YEARS. STATES ARE NOW ABLE TO NEGOTIATE REIMBURSEMENT RATES FOR NURSING HOMES AND OTHER FACILITIES THAT MORE ACCURATELY REFLECT MARKET PRESSURES.

The same ambiguity that has caused problems for states in the Boren Amendment exists in other parts of the Medicaid statute as well. For example, Section 1902(A)(30) allows states to set reimbursement rates to safeguard against unnecessary utilization of care and to ensure that payments are "consistent with efficiency, economy, and quality of care." To clarify this undefined terminology, courts have begun to establish parameters for reimbursement rates. Given the PAST ~~growing~~ problem of court interpretations of "Boren-like" provisions in statute, Section 1903 (M)(2)(A)(III) also appears vulnerable to litigation. This section ambiguously requires state contracts with HMOs to be made on an "actuarially sound basis." The Governors recommend that all such reimbursement provisions be REPEALED IN ORDER ~~clarified~~ to preclude any litigation over provider or health plan payment rates. In all instances, provisions should include the opportunity to allow the market to establish rates, as through the competitive bidding process or direct negotiation.

- 16.3.5 **Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program By Providing Services Within Their State Medicaid Plan and Selecting Less Costly Alternatives for Diagnosis and Treatment Without Risking Quality.** Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. The U.S. Department of Health and Human Services should work with the states to develop and finalize rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

- 16.3.6 **Ensure that States Will Not Be Expected to Implement Any Medicaid Program Changes Until the Health Care Financing Administration Has Published Final Regulations to Guide Program Administration.** In too many cases, HCFA has failed ~~completely~~ to publish regulations associated with statutory changes in the Medicaid program or has done so after many years of delay. Too often, states have had to implement statutory changes and in some cases, have been held financially accountable for unclear laws, even though HCFA failed to provide clarification through implementing regulations. Lack of timely action by HCFA in issuing regulations has resulted in particular difficulties in the area of spousal impoverishment protection. STATES SHOULD NOT BE HELD LIABLE FOR OPERATING UNDER STATE LAW OR STATE INTERPRETATION OF FEDERAL STATUTES UNTIL THE FEDERAL REGULATIONS ARE ADOPTED. THIS POLICY WOULD REPLACE ARBITRARY HCFA INTERPRETATIONS THAT HAVE NO BASIS IN LAW. NOR SHOULD STATES BE BOUND BY INFORMAL POLICY DIRECTIVES THAT ARE ISSUED IN VIOLATION OF THE FORMAL RULEMAKING PROCESS.

- 16.3.7 **Promote Cost Control and Efficiency.** States should be encouraged to continue innovations in provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain Medicaid providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement strategies should be repealed.
- 16.3.8 **Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries Who Are Not Otherwise Medicaid-Eligible.** ~~Since the passage of the Medicare catastrophic legislation in 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary Program, THE SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM, AND THE NEW GROUPS OF BENEFICIARIES CREATED BY THE BBA, THE QUALIFYING INDIVIDUALS). The Medicare program is a federal program and the federal government should bear all of its costs.~~ Currently, Medicaid is responsible for meeting the Medicare cost-sharing obligations of MANY low-income beneficiaries AND FOR PROVIDING A FULL RANGE OF BENEFITS TO OTHERS. THE GOVERNORS WANT TO ENSURE THAT ELDERLY BENEFICIARIES RECEIVE THE BEST POSSIBLE CARE, BUT THE MEDICARE PROGRAM IS A FEDERAL PROGRAM AND THE FEDERAL GOVERNMENT SHOULD BEAR ALL OF ITS COSTS. SHOULD MEDICARE NOT ASSUME FULL FINANCIAL RESPONSIBILITY, CONGRESS SHOULD CONSIDER THE IMPLICATIONS OF THIS COST SHIFT WHEN IT MAKES CHANGES TO THE ELIGIBILITY PROVISIONS OF THE MEDICARE PROGRAM. ~~Should Medicare not assume full financial responsibility, Congress should at a minimum clarify that copayments may be reimbursed at Medicaid, rather than Medicare, rates. Paying at Medicaid rates preserves equity and access among all Medicaid clients.~~
- ~~16.3.9 **Reconsider the Nursing Home Reform Mandates in the Omnibus Reconciliation Act of 1987.** Congress mandated extensive new quality assurance measures for the Medicaid nursing home program. The statutory language permits limited state flexibility and puts Congress in the position of micro-managing the program. In addition, Congress should repeal the preadmission screening requirements. Since enactment, states have found preadmission screening to be extremely cost inefficient and have developed other strategies to ensure the appropriate placement of individuals with disabilities.~~
- 16.3.9 **Make Audit and Disallowance Policies More Equitable.** Under current law, federal audit and disallowance requirements do not discriminate between violations of "obscure policies" and those that have direct harm to beneficiaries. The statute should be revised to prohibit federal practices that impose heavy penalties when the violation constitutes no beneficiary harm. States should be held harmless against possible penalties or disallowances for reasonable interpretations of law based on departmental guidance prior to the issuance of regulations.
- 16.3.10 **Allow Greater Flexibility in Medicaid Home- and Community-Based Care (HCBC) Programs.** Home- and community-based care is an important alternative to institutional care for the elderly and people with chronic and disabling conditions. Currently, every state in the country has at least one HCBC program PROVIDING A BROAD RANGE OF MEDICAL AND SOCIAL SERVICES TO BENEFICIARIES. Existing Medicaid STATUTE REQUIRES ~~statutes require~~ states to establish and administer these programs through waivers. The statutes must be revised to give states the authority to administer HCBC programs through a plan amendment process. However, states must be able to retain

the authority to CONTROL ~~limit~~ the number of beneficiaries receiving Medicaid home- and community-based care. Finally, Congress and the states must work together to restructure the Medicaid program to eliminate the incentive to place beneficiaries in institutional care when community care would be more appropriate and COST-EFFECTIVE. ~~possibly more cost-efficient.~~

- 16.3.11 Children Eligible for Medicaid.** Recently there has been a great deal of attention focused on the population of children eligible for Medicaid but not currently enrolled in the program. Governors agree that health care is essential to the well-being of children. Accordingly, children entitled to Medicaid benefits should receive those benefits. ~~In thirty-nine states, Medicaid eligibility for children has been expanded beyond federally mandated minimum requirements.~~

Exact estimates of the number of children who are Medicaid-eligible but not enrolled are difficult to develop. Eligible children may not be enrolled in Medicaid for a number of reasons. For example, a child may have health insurance coverage through a noncustodial parent. Many states already have implemented a range of innovative outreach strategies targeted to those who need benefits but may not be aware of their Medicaid eligibility. THESE STRATEGIES INCLUDE ~~,including~~ enrollment centers located out in communities, "one-stop shops," and simplified presumptive eligibility processes.

Should the federal government consider additional strategies to reach out to families of children eligible for Medicaid but not receiving benefits, those strategies must be developed in conjunction with the states. Uncoordinated outreach efforts would be administratively cumbersome and would fail to achieve the desired results. FOR EXAMPLE, WHILE THE SPECIAL SUPPLEMENTAL NUTRITIONAL PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) SERVES A LARGE NUMBER OF CHILDREN WHO ARE IN NEED OF HEALTH CARE COVERAGE, THE U.S. DEPARTMENT OF AGRICULTURE HAS DETERMINED THAT WIC ADMINISTRATIVE FUNDS CAN ONLY BE USED TO PROVIDE INFORMATION ABOUT THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AND ENROLL CHILDREN UNDER VERY LIMITED CIRCUMSTANCES. CHANGING THIS POLICY WOULD HELP STATES MAXIMIZE THEIR OUTREACH AND ENROLLMENT EFFORTS.

Outreach efforts also must be designed in a way that discourages employers from discontinuing private sector insurance coverage for children. The Governors believe strongly that no Medicaid outreach strategy should create an opportunity for shifting private sector insurance costs to the public sector.

Because the group of children currently eligible for Medicaid but not enrolled has proved difficult to accurately quantify and has been resistant to previous outreach efforts, the Governors would oppose tying receipt of Medicaid funds to achieving increased enrollment targets. THE FULL RESULTS OF THESE OUTREACH EFFORTS MAY TAKE SOME TIME TO DEVELOP, AS STATES EXPERIMENT WITH METHODS THAT WILL BE MOST EFFECTIVE FOR REACHING THE FAMILIES IN THOSE STATES.

- 16.3.12 Flexibility for Optional Eligibility Groups.** States interested in expanding or restructuring Medicaid eligibility for optional beneficiary categories should have the flexibility to customize a package of

optional benefits to meet the particular needs of the optional group. This flexibility would require the waiver of benefit comparability and statewideness standards related to the amount, duration, and scope of benefits. STATES HAVE SHOWN THAT THE PROVISION OF A FEW WELL-PLACED SERVICES, SUCH AS RESPITE CARE, MINOR HOME MODIFICATIONS, OR LIMITED AMOUNTS OF PERSONAL CARE CAN SIGNIFICANTLY DELAY THE ONSET OF DEBILITATING CONDITIONS AND KEEP BENEFICIARIES IN THEIR HOMES FOR LONGER PERIODS OF TIME. NOT ONLY IS THIS SOUND PUBLIC POLICY, BUT THE POTENTIAL SAVINGS FOR THE INDIVIDUAL, THE FAMILY, AND THE STATE AND FEDERAL GOVERNMENTS IS SIGNIFICANT. ~~Savings realized through restructuring the benefits provided to existing optional eligibility groups should be used to meet health care needs.~~

- 16.3.13 THE AMERICANS WITH DISABILITIES ACT.** THE AMERICANS WITH DISABILITIES ACT OF 1990 (ADA) IS A CIVIL RIGHTS LAW PROHIBITING DISCRIMINATION AGAINST THE DISABLED. RECENT COURT DECISIONS HAVE INTERPRETED ADA IN A WAY THAT MEANS THAT STATES MUST PROVIDE COMMUNITY PLACEMENTS FOR VIRTUALLY ALL OF THE MENTALLY AND PHYSICALLY DISABLED PERSONS ELIGIBLE TO RECEIVE STATE SERVICES. GOVERNORS BELIEVE THESE DECISIONS HAVE EXTENDED ADA'S REACH BEYOND ANYTHING CONGRESS INTENDED. WITHOUT RECONSIDERATION OF THIS CASELAW AND CONSTRUCTIVE CLARIFICATION OF THE REASONABLE AND PERMISSIBLE LIMITS ON STATES' ADA OBLIGATIONS, THE PROLIFERATION OF COSTLY LITIGATION AGAINST STATES WILL CONTINUE AND THE INTEGRITY OF THE STATE MEDICAID PROGRAMS WILL BE JEOPARDIZED.

Time limited (effective WINTER MEETING 1999–WINTER MEETING 2001 ~~Winter Meeting 1997–Winter Meeting 1999~~).
Adopted Winter Meeting 1995; revised Winter Meeting 1997.

U. S. Department of Health and Human Services

RESPONSE TO: NGA Resolution on Improving The Coordination of Acute, Primary and Long-Term Care and Case Management Models and Integrated Care Plans

SUMMARY: NGA states that the lack of coordination between the Medicare and the Medicaid programs causes fragmentation of health care delivery, and poor clinical outcomes. NGA suggests that there are two strategies to end this fragmentation; case management and full integration of funding and care delivery. States are eager to assess the potential of these strategies, but are hampered by administrative and statutory obstacles as well as a federal waiver process that often requires years to navigate.

NGA suggests that stronger partnerships between states and HCFA will augment development of integrated care models and be more cost effective.

HHS POSITION: HHS remains very interested in working with states to develop programs for the integration of acute and long term care. HHS has a strong track record of developing and implementing initiatives such as Program for All-inclusive Care for the Elderly (PACE), The Social Health Maintenance Organization (SHMO), Evercare, and Channeling. All of these programs provide integrated health care delivery systems for populations of Medicare beneficiaries and/or dual eligibles.

The Balanced Budget Act outlined broad parameters for the expansion of Medicare managed care, and HHS believes that state integrated care demonstrations should stay within this framework. HHS also remains committed to beneficiary choice in the Medicare program. Medicare beneficiaries should retain the choice as to whether or not to join a managed care organization. HHS will continue to develop ways for dual eligibles to receive better integration or coordination of care, and state Medicaid programs should continue to play a major role.

SUGGESTED RESPONSE: HHS is aware of the need for greater innovation in the development of integrated care programs and is interested in working with NGA on developing new models.

U. S. Department of Health and Human Services

RESPONSE TO:

NGA Resolution on Private Long Term Care Insurance

SUMMARY:

While recognizing that long term care insurance is not a complete solution to the country's long term care problems, NGA views it as helpful. NGA has a number of concerns with this type of insurance and suggests that passage of the Health Insurance Portability and Accountability act of 1996 (HIPAA) has the potential to mitigate these concerns.

NGA suggests that the federal government work closely with states to ensure that the quality standards enacted in HIPPA be effectively implemented.

NGA further suggests that the federal government expand state authority to implement partnerships for long term care, that are now operating in four states.

HHS POSITION:

HHS shares NGAs interest in long term care insurance and strongly supports the implementation of the quality standards enacted as a part of HIPAA.

HHS supports programs designed to promote prudent planning for long term care, and is currently pursuing long term care insurance as an option for federal employees.

HHS should explore the issue of expanding state authority to implement partnerships for long term care so that states may begin to craft long term care financing systems that accommodate both poor and middle income residents.

SUGGESTED RESPONSE:

HHS will continue to support state efforts to implement the quality standards enacted in HIPPA. These safeguards are critical to a more expansive market for long term care insurance. Further, HHS looks forward to discussing the expansion of state authority to implement partnerships for long term care.

U. S. Department of Health and Human Services

RESPONSE TO: NGA Resolution on Eliminating Institutional Bias

SUMMARY: NGA states that while beneficiaries would rather remain independent, federal Medicare and Medicaid policy provides incentives for the unnecessary use of hospitals and nursing homes. NGA suggests that current federal policy related to long term care is very complicated and results in care management based on reimbursement instead of need.

NGA calls on the federal government to redesign federal policies to encourage and expand the availability of a continuum of services that facilitate continued family involvement and independence. NGA suggests that such a continuum should be the rule and not the exception requiring a waiver.

HHS POSITION: HHS shares NGA's perspective that disabled persons would prefer to live independently. While aspects of Medicaid and Medicare continue to contain an institutional bias, HHS believes that there is significant flexibility within Medicaid's current structure through the personal care option and the home and community care waiver program to allow recipients access to a comprehensive range of home and community based services. Several states have taken advantage of this flexibility to develop comprehensive community based systems for a wide range of disability groups.

SUGGESTED RESPONSE: HHS is eager to work with the NGA to continue to improve and reduce its institutional bias so that Medicaid eligible populations with disabilities can have access to a broad range of long term care services and settings.

HR-17 ~~EC-7~~. LONG-TERM CARE

17.1 PREAMBLE

INCREASES IN LIFE EXPECTANCY, IMPROVEMENTS IN MEDICAL TECHNOLOGY, AND THE AGING OF THE BABY BOOM GENERATION ARE CONTRIBUTING TO UNPRECEDENTED GROWTH IN THE POPULATION OLDER THAN SIXTY-FIVE. THE GROWING POPULATION OF SENIORS WILL FUEL AN INCREASING DEMAND FOR PRIMARY, ACUTE, AND LONG-TERM HEALTH CARE SERVICES THROUGH THE MIDDLE OF THE NEXT CENTURY. AT THE SAME TIME DEMOGRAPHIC AND CULTURAL CHANGES ARE DECREASING THE AVAILABILITY OF INFORMAL CARE. THESE FACTORS WILL PLACE A SIGNIFICANT STRAIN ON OUR NATION'S CURRENT LONG-TERM CARE SYSTEM, ON SENIORS AND THEIR FAMILIES, AND ON CURRENT SOURCES OF PUBLIC AND PRIVATE FUNDING FOR THESE SERVICES.

THE MEDICARE PROGRAM WAS ORIGINALLY INTENDED TO PROVIDE HEALTH INSURANCE COVERAGE FOR THE MEDICAL NEEDS OF THE OLDER AMERICANS. HOWEVER, THERE HAVE ALWAYS BEEN SIGNIFICANT GAPS IN COVERAGE. THE MOST IMPORTANT GAPS ARE FOR PREVENTIVE CARE, PRESCRIPTION DRUGS, AND LONG-TERM CARE. ADDITIONALLY, THERE ARE SIGNIFICANT BENEFICIARY COST SHARING RESPONSIBILITIES. AS A RESULT, MEDICARE COVERS ON AVERAGE ONLY ABOUT HALF OF BENEFICIARIES' HEALTH CARE COSTS.

THE GAPS IN MEDICARE COVERAGE ARE WIDENING. ADVANCES IN MEDICAL CARE THAT HAVE EXPANDED THE AVAILABILITY AND USE OF OUTPATIENT TREATMENT AND HOME HEALTH CARE HAVE INCREASED BENEFICIARIES' OUT-OF-POCKET COSTS FOR PART B PREMIUMS, COPAYMENTS, AND PRESCRIPTION DRUGS. MEDICAL ADVANCES HAVE INCREASED LIFE EXPECTANCY SO THAT AN INCREASING NUMBER OF CHRONICALLY ILL SENIORS NEED LONG-TERM CARE AND SUPPORT WITH BASIC ACTIVITIES OF DAILY LIVING, SUCH AS EATING, BATHING, AND DRESSING.

THESE FACTORS CONTRIBUTE TO AND ARE COMPOUNDED BY CHALLENGES FACING THE LONG-TERM FINANCIAL VIABILITY OF MEDICARE. ALTHOUGH THE BALANCED BUDGET ACT OF 1997 (BBA) ENSURES THE SHORT-TERM SOLVENCY OF THE MEDICARE PART A TRUST FUND, THE TRUST FUND IS PROJECTED TO GO BANKRUPT IN 2008 WITHOUT FURTHER REFORM. ADDITIONALLY, PROVISIONS OF THE BBA DESIGNED TO ADDRESS FRAUD AND ABUSE ARE EXACERBATING THE FINANCIAL CRUNCH FOR SOME SENIORS. FOR EXAMPLE, CHANGES IN MEDICARE'S HOME HEALTH PAYMENT METHODOLOGY HAVE LED TO SERVICE REDUCTIONS THAT ARE FORCING MANY BENEFICIARIES TO SEEK PRIVATE, STATE, AND MEDICAID-FUNDED ALTERNATIVES TO

SUPPLEMENT OR REPLACE THEIR MEDICARE HOME HEALTH SERVICES. ALTHOUGH SOME CAN AFFORD TO ABSORB INCREASES IN THEIR OUT-OF-POCKET COSTS, THE MAJORITY CANNOT: 40 PERCENT OF MEDICARE SENIORS HAVE ANNUAL INCOMES OF LESS THAN \$15,000 AND 70 PERCENT HAVE ANNUAL INCOMES OF LESS THAN \$25,000.

AS MEMBERS OF THE 106TH CONGRESS CONSIDER STRATEGIES FOR ADDRESSING MEDICARE'S FINANCIAL PROBLEMS, THE GOVERNORS URGE CONGRESS TO WORK WITH STATES. THE PROBLEMS THAT FACE MEDICARE CANNOT BE ADDRESSED WITHOUT INPUT FROM THE STATES, BECAUSE THE MEDICARE AND MEDICAID PROGRAMS ARE FUNDAMENTALLY INTERRELATED DEMOGRAPHICALLY, PROGRAMMATICALLY, AND FINANCIALLY. THE MOST OBVIOUS CATEGORICAL CONNECTION BETWEEN THE MEDICAID AND MEDICARE PROGRAMS IS THE POPULATION ELIGIBLE FOR BOTH MEDICARE AND MEDICAID COVERAGE. IN 1997, 30 PERCENT OF MEDICARE SPENDING, OR \$62 BILLION, WAS FOR DUAL-ELIGIBLES. MEDICAID SPENDING FOR THESE 6 MILLION DUAL-ELIGIBLES TOTALED \$58 BILLION. ALTHOUGH THE ELDERLY AND INDIVIDUALS WITH DISABILITIES COMPRISE ONLY ABOUT ONE-THIRD OF THE MEDICAID CASELOAD, THEY ACCOUNT FOR APPROXIMATELY TWO THIRDS OF ITS EXPENDITURES.

STATES ALSO PLAY A KEY ROLE IN FUNDING SERVICES PROVIDED TO LOW-INCOME INDIVIDUALS WHO ARE NOT ELIGIBLE FOR MEDICAID. THESE SERVICES OFTEN INCLUDE PRESCRIPTION DRUGS; HOME HEALTH; HOMEMAKER SERVICES; PERSONAL CARE; ADULT DAY HEALTH, BOARD, AND CARE; ASSISTED LIVING; AND NONMEDICAL TRANSPORTATION. TO PAY FOR SERVICES, STATES OFTEN USE A COMBINATION OF FUNDS FROM THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM, THE SOCIAL SERVICES BLOCK GRANT, THE OLDER AMERICANS ACT, THE COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT, AND THE DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT, AS WELL AS U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD) RESOURCES AND STATE GENERAL REVENUES. CONSEQUENTLY, MEDICARE SAVINGS APPROACHES THAT RAISE THE COST-SHARING REQUIREMENTS FOR BENEFICIARIES WILL PLACE AN ADDITIONAL BURDEN ON STATES FOR DUAL-ELIGIBLES AND OTHER LOW-INCOME SENIORS AND WILL LEAD TO INCREASING EFFORTS BY STATES TO SHIFT COSTS BACK TO MEDICARE. SIMILARLY, APPROACHES THAT FOCUS ON MANAGING MEDICARE ONLY, SUCH AS THE MEDICARE+CHOICE PROGRAM, ALSO INVITE COST SHIFTING. CHANGES MADE TO THE MEDICARE PROGRAM, WHETHER TO STRENGTHEN THE SOLVENCY OR FOR OTHER PURPOSES, SHOULD ALWAYS BE MADE WITH THE POTENTIAL IMPACT TO MEDICAID IN MIND.

THE GOVERNORS BELIEVE THAT GREATER FLEXIBILITY FOR STATES AND A NEW FEDERAL-STATE PARTNERSHIP ARE KEYS TO DEVELOPING INNOVATIVE AND

IMPROVED SYSTEMS OF HEALTH CARE FOR OLDER AMERICANS. TO ACCOMMODATE SUCH A STRATEGY, CONGRESS, THE ADMINISTRATION, AND THE STATES SHOULD WORK TOGETHER TO:

- DEVELOP STRONG, SUSTAINABLE FEDERAL, STATE, AND LOCAL PARTNERSHIPS THAT ENCOURAGE A CONSUMER-FOCUSED SYSTEM OF CARE;
- ENSURE THAT ADEQUATE CONSUMER PROTECTIONS ARE ESTABLISHED FOR BENEFICIARIES;
- ELIMINATE THE INSTITUTIONAL BIAS OF CURRENT LONG-TERM CARE PROGRAMS AND EXPAND THE AVAILABILITY OF COST-EFFECTIVE HOME- AND COMMUNITY-BASED LONG-TERM CARE SERVICES;
- DEVELOP MECHANISMS AND INCENTIVES FOR PRIMARY, ACUTE, AND LONG-TERM CARE PROVIDERS TO WORK TOGETHER TO COORDINATE CARE, PREVENT DECLINE IN DISABILITY, AND IDENTIFY OPPORTUNITIES FOR PREVENTION OF UNNECESSARY HOSPITALIZATIONS AND LONG-TERM NURSING FACILITY ADMISSIONS;
- ELIMINATE BARRIERS TO THE DEVELOPMENT OF STATE-PROPOSED INTEGRATED CARE PLANS THAT OFFER THE FULL RANGE OF ACUTE AND LONG-TERM CARE BENEFITS;
- BROADEN THE SOURCES OF FINANCING FOR COMPREHENSIVE HEALTH COVERAGE BY STIMULATING THE DEVELOPMENT OF VIABLE PRIVATE LONG-TERM CARE INSURANCE PRODUCTS, BY IMPROVING CONSUMER UNDERSTANDING OF SUCH PRODUCTS, AND BY INTEGRATING FEDERAL, STATE, AND, WHERE POSSIBLE, PERSONAL RESOURCES TO SUPPORT CONTINUITY OF CARE;
- REINFORCE THE ALREADY STRONG DEDICATION TO THE CONCEPT OF QUALITY IN THE PROVISION OF LONG-TERM CARE SERVICES AND THE IMPORTANCE OF TRAINING FOR CAREGIVERS; AND
- CREATE A STATE OPTION TO ENABLE INDIVIDUALS WITH DISABILITIES TO RE-ENTER THE WORKFORCE, AND UP TO REASONABLE INCOME AND ASSET LEVELS, RETAIN THE HEALTH CARE BENEFITS THAT THEY ALREADY RECEIVE.

17.2 ELIMINATING THE INSTITUTIONAL BIAS

BENEFICIARIES GENERALLY PREFER TO LIVE IN THEIR OWN HOMES AND REMAIN AS INDEPENDENT AS POSSIBLE, YET CURRENT FEDERAL ELIGIBILITY, COVERAGE, AND PAYMENT POLICIES ARE BIASED TOWARD INSTITUTIONAL CARE. ALSO, EXISTING

DISTINCTIONS BETWEEN MEDICARE AND MEDICAID POLICIES RELATED TO COVERAGE OF AND ELIGIBILITY FOR NURSING FACILITIES AND HOME- AND COMMUNITY-BASED CARE ARE PARTICULARLY COMPLICATED. OFTEN THE REIMBURSEMENT-DRIVEN POLICIES CREATE A SYSTEM WHERE MEDICARE HAS A FISCAL INCENTIVE TO INSTITUTIONALIZE BENEFICIARIES KNOWING THAT MEDICAID WILL PAY FOR THE BILL. THE LACK OF RESPONSIBLE COORDINATION AND THE COST-SHIFTING IS UNACCEPTABLE FOR BENEFICIARIES AND THE STATES.

ALTHOUGH INSTITUTIONAL CARE MUST BE AVAILABLE AND AFFORDABLE TO THOSE WHO NEED IT, FEDERAL POLICIES MUST BE REDESIGNED TO ELIMINATE THE INSTITUTIONAL BIAS OF THE MEDICARE AND MEDICAID PROGRAMS. FEDERAL POLICIES SHOULD ENCOURAGE THE AVAILABILITY OF A CONTINUUM OF SERVICES, INCLUDING ADDITIONAL HOME- AND COMMUNITY-BASED LONG-TERM CARE OPTIONS, WITH THE GOAL OF PREVENTING OR DELAYING ADMISSION INTO AN INSTITUTION FOR AS LONG AS POSSIBLE. THE INDEPENDENCE OF THE INDIVIDUAL MUST BE MAINTAINED AND ENHANCED TO THE MAXIMUM EXTENT POSSIBLE; FAMILY EFFORTS TO ASSIST THE INDIVIDUAL MUST ALSO BE SUPPORTED. PLACEMENT IN A NURSING HOME SHOULD BE THE EXCEPTION AND REQUIRE SIGNIFICANT JUSTIFICATION, RATHER THAN HOME- AND COMMUNITY-BASED PLACEMENT BEING THE EXCEPTION AND REQUIRING A WAIVER.

17.3 IMPROVING THE COORDINATION OF ACUTE, PRIMARY, AND LONG-TERM CARE

THE LACK OF COORDINATION BETWEEN THE MEDICARE AND MEDICAID PROGRAMS CONTRIBUTES TO FRAGMENTATION OF ACUTE AND LONG-TERM CARE. IT IS CURRENTLY IMPOSSIBLE FOR MEDICAID TO PARTICIPATE IN THE ACUTE CARE DECISIONS MADE WHEN MEDICARE IS THE PRIMARY PAYER. MEDICARE'S CURRENT MANAGED CARE PROGRAM IS INCAPABLE OF ADDRESSING THESE ISSUES, BECAUSE PARTICIPATING MANAGED CARE ORGANIZATIONS ARE NEITHER RESPONSIBLE FOR PROVIDING LONG-TERM CARE SERVICES, NOR ACCOUNTABLE FOR THE COST OF SUCH SERVICES.

AS A RESULT OF THE LACK OF CLINICAL CARE COORDINATION, PRIMARY CARE PHYSICIANS OR SPECIALISTS ARE FREQUENTLY UNAWARE WHEN THEIR PATIENTS ARE ADMITTED TO NURSING FACILITIES, AND HOME CARE CASE MANAGERS ARE OFTEN NOT INFORMED WHEN THEIR CLIENTS ARE HOSPITALIZED. THIS FRAGMENTATION OF CARE AND A LACK OF ACCOUNTABILITY FOR OUTCOMES CONTRIBUTE TO HIGHER RATES OF PREVENTABLE HOSPITALIZATIONS AND TO NURSING FACILITY ADMISSIONS. ULTIMATELY, POOR CLINICAL OUTCOMES AND SERVICE DECISIONS THAT ARE

REIMBURSEMENT-DRIVEN LEAD TO HIGHER EXPENDITURES FOR BOTH MEDICARE AND MEDICAID.

THERE MUST BE MORE EFFECTIVE COORDINATION OF ACUTE AND LONG-TERM CARE SERVICES TO BETTER SERVE BENEFICIARIES AND TO ELIMINATE UNNECESSARY DECLINE IN DISABILITY. TWO GENERAL STRATEGIES EXIST FOR COORDINATING CARE MORE EFFECTIVELY. THE FIRST RELIES MOSTLY ON CASE MANAGEMENT OF INDIVIDUALS WITH ACUTE AND LONG-TERM CARE NEEDS. THE SECOND, MORE COMPREHENSIVE APPROACH, IS TO FULLY INTEGRATE CARE.

17.3.1 CASE MANAGEMENT MODELS AND INTEGRATED CARE PLANS. STATES AND THE FEDERAL GOVERNMENT HAVE BEGUN TO ASSESS THE EFFICACY OF CASE MANAGEMENT AND INTEGRATED CARE PROGRAMS FOR SENIORS. HOWEVER, A NUMBER OF SIGNIFICANT OBSTACLES, BOTH STATUTORY AND ADMINISTRATIVE, HAVE ARISEN TO CONDUCTING EFFECTIVE COORDINATED CARE DEMONSTRATIONS. AMONG THE MAJOR ADMINISTRATIVE OBSTACLES IS A FEDERAL WAIVER REVIEW PROCESS THAT CAN TAKE SEVERAL YEARS. AS A RESULT, ONLY ONE STATE IS CURRENTLY OPERATING AN INTEGRATED CARE PROGRAM THAT IS AVAILABLE TO THE FULL RANGE OF UNIMPAIRED, MODERATELY IMPAIRED, AND SEVERELY IMPAIRED DUAL-ELIGIBLE SENIORS.

THE GOVERNORS CALL ON CONGRESS AND THE ADMINISTRATION TO ADDRESS FEDERAL BARRIERS TO THE TIMELY DEVELOPMENT OF CASE MANAGEMENT AND INTEGRATED CARE PROGRAMS SO THAT INTERESTED STATES CAN MAKE SUCH PROGRAMS BROADLY AVAILABLE TO LOW-INCOME BENEFICIARIES. THE AUTHORITY TO TEST NEW APPROACHES COULD BE CLARIFIED EITHER THROUGH EXPLICIT LEGISLATIVE AUTHORIZATION OR THROUGH THE CREATION OF SUBSTANTIAL MEDICARE WAIVER AUTHORITY SIMILAR TO THE WAIVER OPTIONS THAT EXIST IN MEDICAID. A SIMPLE CHANGE THAT WOULD ENABLE THE DEVELOPMENT OF SUCH INTEGRATED PROGRAMS WOULD BE THE EXPLICIT RECOGNITION THAT BUDGET NEUTRALITY SHOULD BE MEASURED ACROSS ALL FEDERAL BENEFIT PROGRAMS, NOT JUST THE MEDICAID PROGRAM. INTEGRATION AND COORDINATION CAN PROVIDE SAVINGS FROM MEDICARE, SSI, SOCIAL SECURITY DISABILITY INSURANCE, AND OTHER PROGRAMS; STATES SHOULD BE ALLOWED TO FACTOR IN THOSE SAVINGS.

IN ADDITION, STRONGER PARTNERSHIPS BETWEEN THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND STATES ARE NEEDED TO STRENGTHEN THE COORDINATION OF MEDICARE AND MEDICAID. COOPERATION BETWEEN STATES AND HCFA IN THE DEVELOPMENT OF DEMONSTRATION PROGRAMS THAT INTEGRATE

BENEFIT PACKAGES AND FUNDING STREAMS WOULD PRODUCE BETTER HEALTH OUTCOMES AS WELL AS BE COST-EFFECTIVE.

The U.S. population is aging; people are living longer and improvements in medical technology have extended life for many with severe disabilities. These demographic trends and technological advances, when considered together, suggest that the need for long-term care will continue to grow for the next half century. As this demand grows, so will the demand for well-designed private savings and long-term care insurance instruments, carefully integrated with responsive, publicly funded programs. Typically, the frail elderly and people with disabilities require basic support for normal everyday activities. This long-term care may be provided through a variety of home and community-based care services or institutions (i.e., nursing homes, residential facilities for people with mental illness, and residential facilities for people with mental retardation). It also is important to appreciate that there is a significant amount of family and other private caregiving on behalf of many chronically ill and functionally impaired individuals that should be acknowledged and supported, rather than necessarily replaced, as both public and private policy options for long-term care are developed.

Among publicly funded long-term care programs, there are four primary populations served—the frail elderly, individuals with physical disabilities, individuals with chronic mental illnesses, and individuals with developmental disabilities. Because of a long tradition of developing public programs around certain population categories, the funding streams and delivery systems for these populations are distinct and tend to reflect the unique needs of individuals in each subpopulation.

Virtually all publicly financed long-term care programs are administered at the state or local level, with the largest share funded by the Medicaid program. To pay for services, states often use a combination of funds from Medicaid, the Supplemental Security Income (SSI) program, the Social Services Block Grant, the Older Americans Act, the Community Mental Health Services Block Grant, and the Developmental Disabilities Assistance and Bill of Rights Act, as well as state general revenues. Because people who need long-term care also may need specialized housing assistance, states also use Housing and Urban Development (HUD) resources, as well as SSI, to pay for care in facilities (such as board and care) that does not meet institutional Medicaid definitions.

Although a variety of public programs provide long-term care, most, including Medicaid, are available only to those with limited income and assets. Unfortunately, with a high demand for these services and severe limits on state and federal funding, many Americans do not qualify for care. As such, the burden and the cost of long-term care primarily fall on individuals and their families. Most Americans become aware of the prohibitive costs of prolonged institutional or community-based long-term care only when confronted by family illness. Few alternatives exist to help pay for institutional care; even fewer alternatives exist to pay for home and community-based care. In most cases, the high costs of care ultimately force people to spend their life savings and then turn to Medicaid for financial assistance.

Current federal policies are fragmented and emphasize institutional care. Although institutional care must be available to and affordable for those who need it, federal policies must be redesigned to encourage the availability of a continuum of services, including home and community-based care, with the goal of preventing or delaying admission into an institution for as long as possible. The independence of the individual must be maintained and enhanced to the maximum extent possible; family efforts to assist the individual also must be supported. Moreover, federal policy must encourage Americans to plan for their long-term care needs. In addition to public programs, the federal government should coordinate with states to stimulate viable, private sector long-term care insurance products and other means to assist individuals and families in securing private sources of protection against at least part of the potential costs of long-term care.

7.2 — A Comprehensive Long-Term Care System

One of the most important priorities of the 105th Congress will be ensuring the continued financial viability of Medicare. Medicare faces significant challenges related to the short-term financial status of the hospital trust fund, as well as longer-term demands tied to the aging of the baby boom generation. From the perspective of the Governors, the needs of Medicaid and Medicare must be considered together, because the two programs are fundamentally interrelated demographically, programmatically, and financially.

Regardless of whether Congress and the White House decide to address Medicare reform directly or through a commission, Medicaid long-term care should be part of the discussion. By examining the needs of the two programs jointly, reform offers the potential of creating a more coordinated and cost-effective system of care. To undertake Medicare reform without consideration of the impact of changes on Medicaid exposes Medicaid to the risk of cost-shifting and misses an opportunity to fundamentally improve an inefficient status quo.

7.2.1 — Nursing Home Care and Home and Community-Based Care. Existing distinctions between Medicare and Medicaid policies related to coverage of and eligibility for nursing home care and home and community-based care are particularly complicated. Simplification would be an important component of a more rational long-term care system, promoting coordination of care across service settings. The most comprehensive approach to simplification would be an integrated model, which would offer a choice of services in a range of settings and would provide a unified plan of care. To accommodate such a strategy, Congress, the administration, and the states should work together to:

- encourage a consumer-focused system of long-term health care;
- eliminate the institutional bias of current long-term care programs;
- increase the supply of long-term care options, including a range of community-based and in-home services;
- integrate delivery systems for institutional, residential, and community and in-home services;
- ensure that adequate consumer protections are established for beneficiaries;
- emphasize cost-effective treatment in the least restrictive setting;
- integrate federal, state and, where possible, personal resources, including private-sector long-term care insurance policies, to provide continuity of care;
- integrate health and social service funding streams; and
- stimulate the development of a viable private long-term care insurance product market and encourage industry development of strategies to attract younger buyers of long-term care insurance.

7.2.2 — Managed Care and Long-Term Care. The most obvious categorical connection between the Medicaid and Medicare programs is the dually eligible population. The dually eligible qualify for both programs and receive a full package of benefits from each. Because the two programs are so closely linked, changes made in one directly impact the other. For example, reductions in Medicare reimbursement rates for hospitals could lead to earlier hospital releases, resulting in increased nursing home enrollment. For the dually eligible, that leads to a transition from Medicare coverage of hospital benefits to Medicaid coverage for nursing home care.

Successful management of the programmatic connections between Medicaid and Medicare would result in the creation of a more seamless system of benefits for recipients, make home and community-based care a more viable alternative to institutional placements, and reduce cost-shifting. One management strategy many Governors would like the flexibility to pursue is mandatory managed care for the dually eligible.

Three general strategies exist for the application of managed care practices to long-term care. The first is the integrated care model, which attempts to combine both primary and preventive care, as well as home and community-based and institutional care, into a single integrated system. The second is the primary/acute care model, which focuses solely on primary and preventive care but excludes long-term care services. This model, though technically not long-term care, is extremely important because health care networks do not have much experience in providing primary and preventive care to the frail elderly and people with developmental or physical disabilities—individuals with unique and demanding health care needs. The third strategy is the long-term care model, which focuses on the integration of home and community-based care and institutional care but excludes primary and preventive care. Common to all three models is the goal of providing quality and cost-efficient care in the most appropriate setting.

States and the federal government have begun demonstrations to assess the efficacy of each of these three general approaches. However, a number of significant obstacles, both statutory and administrative, have arisen to conducting effective managed care experiments. The Governors call on Congress and the administration to permit interested states to experiment with mandatory managed care pilot projects for the dually eligible. This authority to experiment could be clarified either through an explicit legislative

~~sanction of mandatory managed care programs for the dually eligible or through the creation of substantial Medicare waiver authority similar to the waiver options that currently exist in Medicaid.~~

~~Medicaid fills the gaps in Medicare coverage for low-income senior citizens and certain people with disabilities. When a Medicare health maintenance organization (HMO) option is not available or does not offer prescription drug coverage, Medicaid assumes the cost of providing this important benefit. As Congress and the administration make decisions regarding Medicare HMO rates, special consideration should be given to the disparities that exist between the rates paid to HMOs in rural and urban areas and the impact of those disparities on the range of options and services available to beneficiaries. Adjustments to HMO payment methodologies should be considered that encourage the expansion of Medicare managed care in states where low payments have restricted options and services and have led to low participation.~~

~~The Governors are committed to working with Congress, the administration, and health care providers and beneficiaries to ensure that networks of care are practical and viable for people with developmental and physical disabilities, as well as for people with chronic mental illnesses. All interested parties must build on the lessons learned from existing pilot projects to design integrated service delivery models to meet the special needs of these populations.~~

17.4 Private Long-Term Care Insurance

In recent years, there has been growth in the availability of private long-term care insurance. Although the growth of this market has been slow and has had mixed success, for those who have access to and can afford such coverage, it may represent a reasonable alternative to public financing. Of particular interest are new efforts in some states to create a private-public partnership for long-term care insurance that allows individuals to purchase state-certified private policies and then have a portion of their assets protected once the private benefits are paid out and public financing becomes necessary. Currently, four states are operating these programs, but further expansion has been restricted. These existing public-private partnerships must be permitted to continue, and federal barriers must be eliminated. GOVERNORS ARE DEDICATED TO THE CONTINUED PROVISION OF CONSUMER PROTECTIONS IN THESE PROGRAMS AND ARE READY TO WORK WITH CONGRESS AND THE ADMINISTRATION TO ENSURE THAT ESTABLISHED STATE LAWS ARE NOT PREEMPTED OR INFRINGED. In addition, authority to implement such programs must be expanded to all states.

Although public-private initiatives must be supported, the Governors have been concerned about the quality of many of the private long-term care policies that are available. However, the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) extends important quality protections to the long-term care insurance market. The Governors call on the federal government to work closely with states when implementing these quality standards to ensure that beneficiaries receive the benefits they have purchased when they need them. (SEE HR-37, PRIVATE-SECTOR HEALTH CARE REFORM)

Despite the real improvements set forth in HIPAA, the Governors continue to have several concerns regarding long-term care insurance. Often, the policies have limited coverage for home care AND OTHER SERVICES THAT ARE PROVIDED TO IMPROVE THE HEALTH AND FUNCTIONAL STATUS OF BENEFICIARIES. In addition, they often have high lapse rates, require medical

underwriting, and are unavailable to people with existing disabilities. Also, some insurers have not been forthcoming in paying out benefits. Long-term care insurance policies are often so expensive to purchase that they are unaffordable for a large segment of the general population. However, HIPAA contains several provisions that should make policies more affordable, including tax deductibility and inflation protection. The Governors hope these provisions will make long-term care insurance policies broadly accessible.

The Governors, with the state insurance commissioners, will work with the insurance industry, Congress, EMPLOYERS, and consumer groups to ensure that coverage is available for home- and community-based services, that consumer protection standards are followed, that policies are available that are reasonable in cost, that effective outreach is conducted regarding these policies, and that public education programs are available regarding the importance of early individual planning for long-term care needs.

ALTHOUGH LONG-TERM CARE INSURANCE WILL BE HELPFUL, PRIVATE LONG-TERM CARE INSURANCE IS NOT A COMPLETE SOLUTION FOR ALL THE NATION'S LONG-TERM CARE PROBLEMS. ~~The Governors recognize that private long term care insurance is not a panacea for the nation's long term health care problems.~~ In light of the longevity of the population, the growing need for home- and community-based care, the average length of stay for institutional care, and the fixed incomes of those most at risk of needing long-term care, the Governors further recognize that a solution is not easily achievable and that interventions that provide appropriate care, real protections, and fiscal guarantees must be crafted.

17.5

Conclusion

As the baby boom generation begins to retire in 2010, the population needing long-term care will grow dramatically. Federal and state action is needed ~~now to plan for this certainty.~~ Some time remains to develop and assess policies that could lead to cost-efficient, quality medical and support services. However, if this time is not used wisely, the costs in terms of quality of life for individuals and their families, and in state and federal spending, could be quite substantial.

Time limited (effective WINTER MEETING 1999–WINTER MEETING 2001 ~~Winter Meeting 1997~~
~~Winter Meeting 1999~~).

Adopted Winter Meeting 1995; revised Winter Meeting 1997.

Strengthening Health
Care

ADMINISTRATION ON AGING
President's Long Term Care Initiative

QUESTION:

Tell us about the President's Long Term Care Initiative?

ANSWER:

- Our proposal is the first long-term care strategy in our nation's history and it recognizes two truths:
 - ▶ First, as the number of seniors continues to grow rapidly so will the need for long-term care because with aging inevitably comes the disabilities of old age
 - ▶ Second, long-term care is primarily being provided at home, often by family members.
- The core of our five year \$6 billion initiative is a targeted \$1,000 long term-care tax credit for people with long-term care needs, or for their caregivers.
 - ▶ The tax credit will help offset the cost of both direct long-term care costs (e.g., adult day care, home health visits) and the indirect costs (e.g., the unpaid leave some caregivers must take).
 - ▶ The tax cut is paid for as part of our balanced budget.
- In a very practical way, this proposal will support caregivers, who are usually women in the work force, who are trying to care for their elderly or disabled loved ones as well as their spouses and children.
- Our initiative also includes a number of other items:
 - ▶ AoA will provide \$125 million annually for States to create the National Family Caregivers Support Program, a one-stop shop where caregivers can access community resources, find guidance, and obtain adult day care services.

- ▶ **HCFA** will inform all Medicare beneficiaries about long-term care options since most know very little about them. This project has a one-time cost of \$10 million.
- ▶ **OPM** will offer private long-term care insurance to Federal employees. As the nation's largest employer, the market leverage of the Federal Government will influence the private sector to develop options that better meet the needs of older Americans and their families.

KEY INFORMATION

The Long-Term Care Initiative consists of the following programs/initiatives:

- **Tax Credits** - Two million patients or their caregivers will be allowed a \$1,000 yearly tax credit to help compensate them for the burden of coping with the ravaging effects of Alzheimer's disease, strokes, physical disabilities and other conditions that render people unable to care for themselves.
 - ▶ Cost of \$5.5 billion over 5 years.
- **National Family Caregiver Support Program** - A new AoA formula grant will enable states to create "one-stop-shops" that provide: quality respite care and other support services; critical information about community-based long-term care services that best meet a families' needs; and counseling and support (e.g., model approaches for caregivers that are coping with new responsibilities, training for complex care needs).
 - ▶ \$125 million annually for a five year total of \$625 million.
- **Educating Medicare Beneficiaries About Their Options** - This new nation-wide campaign will would provide all 39 million Medicare beneficiaries with critical information about long-term care including what to look for in a quality long-term care policy and how to access information about home and community services that best fit beneficiaries needs.
 - ▶ Nearly 60% of Medicare beneficiaries are unaware that Medicare does not cover most long-term care.
- **Offering Quality Private Long-Term Care Insurance to Federal Employees** - We are requesting legislation to allow OPM to use its market leverage and set a national example by offering non-subsidized quality long-term care insurance to all Federal employees, retirees, and their families at group rates. OPM anticipates that approximately 300,000 Federal employees would participate.
 - ▶ Cost of \$15 million over five years.

ADDITIONAL INFORMATION:

- Over 5 million Americans require long-term care because of illness or disability.
 - ▶ Two thirds of these individuals are older Americans.
- The number of Americans 65 and older and the number of Americans 85 and older are both expected to double by 2030.

HEALTH CARE ACCESS FOR THE UNINSURED

New Initiative: Improving Health Care Access for the Uninsured

QUESTION:

Why do we need a new program? Isn't this the mission of Community Health Centers? Why shouldn't we just add these funds on to this existing program?

ANSWER:

- At \$25 million in FY 2000 and \$1.025 billion over five years, this Federal grant program is broader than just Community Health Centers.
- If we want to make a difference, we must create networks to foster comprehensive, coordinated care among all providers of free or low cost care, including health departments, public hospitals, and academic health centers.
- This new initiative addresses the health care delivery system serving the 32 million adult Americans still without insurance.
- Approximately 100 communities will receive funding over five years to:
 - ▶ Develop the infrastructure necessary to participate in networks or coordinated care arrangements, including financial, information, and telecommunications systems.
 - ▶ Address service gaps within such integrated systems, with a focus on primary care, mental health services, and substance abuse services.
- Model programs do exist. For example:
 - ▶ Sunset Park, a community health center, provides services to over 82,000 residents of SW Brooklyn, NY, every year. This multi-site system, operating as a managed care network, offers primary care facilities, a school health program, and a mental health center. The network includes ancillary and diagnostic services, rehabilitation, and early intervention programs, WIC nutrition, social services, comprehensive health promotion/disease prevention activities, substance abuse treatment and HIV counseling and testing.
 - ▶ Family Health Center (FHC) of Marshfield, Inc., serves 11 counties in rural north central Wisconsin. FHC offers such benefits as preventive, primary and secondary physician care, and prescription drugs, and works with rural hospitals to provide outpatient and emergency room services.

KEY INFORMATION:

During the first year, funds will be used for 10-20 grants for infrastructure development, primarily in

locations which have already begun organized community-based efforts to coordinate services provided to the uninsured. A small percentage of funding may also be devoted to service delivery at these or other sites where coordinated systems are being developed.

ADDITIONAL INFORMATION:

- In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured, in a grant program similar to what is being requested.
- Low-income uninsured workers will receive more efficient and higher quality care and gain entry into a more "seamless" system of care. Coordinated care will increase referrals for annual check-ups and other preventative services, so that people can learn how to control health conditions.
- In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it.
- Among those who did have a regular source of care, uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Cost Allocation



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

JAN -7 1999

Washington, D.C. 20201

To: The Secretary
Thru: DS [initials]
COS [initials] 1/13
ES [initials]
From: John J. Callahan [signature]
Assistant Secretary for Management and Budget
Subject: State-by-State Determinations for Food Stamp Administrative Costs under
Public Law 105-185 - Action

Issue. The Agricultural Research, Extension, and Education Reform Act of 1998 (P.L. 105-185) was signed by the President on June 23, 1998. It requires HHS to determine the amounts that were charged to the former AFDC program in each State's and the District of Columbia's TANF base year that could have been allocated to Food Stamps and Medicaid. The purpose of the legislation is to effectively recover, with respect to Food Stamps, the amounts that were funded in the TANF block grant that States can now charge to Food Stamps - in effect, a duplication of funding or reimbursement. The amounts determined for Food Stamps are to be recovered each year from FY 1999 - FY 2002.

This office, working with the Division of Cost Allocation of the Program Support Center, and in consultation with the Department of Agriculture, has developed for your "determination" (i.e. approval), a compilation of those amounts (see attachment).

Background. Giving rise to the passage of the Act was the realization that the TANF welfare reform legislation created a dual payment to the States for certain administrative costs inherent in the administration of the AFDC, Medicaid and Food Stamp programs. The Congressional Budget Office estimated this dual payment to be approximately \$500 million. Public Law 105-185 included language to adjust this dual payment anomaly and required these State-by-State determinations to be made within 180 days of enactment.

Following passage of the Act, we sent a guide to the States and the District of Columbia to assist them in estimating and proposing the amounts to be adjusted. Leading up to this point, we had worked extensively with the National Governors' Association and other organizations, as well as State officials themselves, in developing the guidance. The guidance allowed the States a fair measure of flexibility in proposing the amounts, while recognizing final determination authority rests with the Secretary of HHS.

The States proposed adjustments for Food Stamps of \$165 million. Based upon the DCA and ASMB review and analysis of these proposals, we have determined adjustments of \$227 million—a net increase of \$62 million. The States identified \$237

million for Medicaid and we have determined \$300 million—an increase of \$63 million. There is no legislation currently pending to make Medicaid adjustments.

- The Food Stamp adjustments will begin this April and are effective for the following three fiscal years (i.e. through FY 2002). We agreed with twenty-two of the State proposals, seven of which required no Food Stamp offsets. Of these, we reduced the amounts initially proposed by two of the States. With respect to the remaining twenty-nine States (including the District of Columbia), our adjustments were less than a million dollars in fifteen.

The cause of the \$62 million variance between the State proposals for Food Stamps and our determinations fall primarily into three categories. First, nineteen States submitted "zero" proposed adjustments. Of these, we identified only seven that were correct in taking this position. States falling into this category accounted for \$13.8 million.

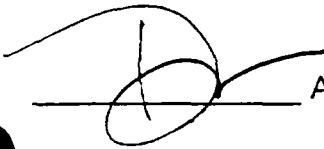
The second cause for the variance arose where States did not include all activities and costs that were subject to the adjustment. These ran the gamut from a failure to include indirect costs to excluding the local office income maintenance workers in the calculations. These States accounted for \$24.6 million of the variance.

Lastly, several States, while correctly computing the amounts for both Food Stamps and Medicaid, offset the amounts determined for Food Stamps by other adjustments outside the scope of the legislation and unrelated to the issue being addressed. We adjusted \$15 million for these States, of which Florida accounted for \$13 million.

New York was an anomaly in that \$6.2 million of our increasing adjustment of \$7.7 million fell outside the above categories. The State's initial proposal was \$62.2 million. In the process of providing additional documentation to the DCA, the State revised its proposal downward to \$55.6 million. The State's revision was based on technical arguments of "Federal reimbursements" in the base year vs. "amounts claimed." As the expenditures were subsequently allowed, paid, and included in the TANF base year used to compute the block grant, we took the position that they were subject to the adjustment. The remaining \$1.5 million upward adjustment that we made was attributable to activities omitted from the State's original submission.

The States have appeals rights to an Administrative Law Judge and then to the Departmental Appeals Board. We anticipate that where our differences with States are based on a lack of information which resulted in the imposition of a formula¹ for your determinations, we will have opportunities to reach negotiated settlements through mediation prior to administrative hearings.

Recommendation. On Thursday, December 17, 1998, we met with the Deputy Secretary and key departmental officials to review the requirements of the Act and the amounts proposed for the State-by-State determinations. On December 30, 1998 I held a follow-up meeting with IGA, ASPA and ACF to share this package with them, as revised by the guidance provided at the Deputy Secretary meeting. It is my recommendation, and the consensus of the officials consulted, that you approve these amounts. If you agree with this recommendation, as well as with the format of the letters by which these determinations will be conveyed to the governors, please indicate below, as well as sign the actual letters to California and New York, following which we will provide the remaining 49 letters to be signed.



Date

Disapprove

JAN 14 1999 Date

Attachments

¹In lieu of performing an in depth analysis, States were given the option of using a formula to compute the amounts for both Food Stamps and Medicaid. The formula was suggested by California during the aforementioned exposure process. As the formula was similar to the one we used to formulate our original estimates, it was incorporated into the guidance as an option. Four States opted for the formula, including California, which we accepted.

STATES FS ADJ PACKAGES AS OF January 12, 1999

	Final State Food Stamp Proposal	Recommended Food Stamp Adjustment	Final State Medicaid Proposal	Recommended Medicaid Determination	Total Final State Submission	Total Proposed Determination
A 1a	\$1.37	\$1.37	\$1.37	\$1.37	\$2.74	\$2.74
A	\$0.00	\$1.05	\$0.00	\$1.05	\$0.00	\$2.10
Ariz	\$5.68	\$5.68	\$5.68	\$5.68	\$11.36	\$11.36
Arkansas	\$1.61	\$1.61	\$1.61	\$1.61	\$3.22	\$3.22
California	\$58.85	\$58.85	\$68.80	\$68.80	\$127.65	\$127.65
Colorado	\$0.79	\$2.77	\$0.00	\$2.77	\$0.79	\$5.54
Connecticut	\$0.91	\$2.73	\$4.75	\$4.37	\$5.66	\$7.10
Delaware	\$0.00	\$1.00	\$0.00	\$1.00	\$0.00	\$2.00
Florida	\$1.41	\$14.41	\$27.40	\$14.41	\$28.81	\$28.82
Georgia	\$0.00	\$0.00	\$0.00	\$12.82	\$0.00	\$12.82
Hawaii	\$0.00	\$0.00	\$0.00	\$0.99	\$0.00	\$0.99
Idaho	\$0.00	\$1.50	\$0.00	\$1.50	\$0.00	\$3.00
Illinois	\$9.50	\$9.16	\$10.99	\$14.39	\$20.49	\$23.55
Indiana	\$0.95	\$1.11	\$3.25	\$4.61	\$4.20	\$5.72
Iowa	\$0.98	\$0.98	\$0.00	\$0.00	\$0.98	\$0.98
Kansas	\$0.99	\$1.60	\$0.99	\$1.60	\$1.98	\$3.20
Kentucky	\$0.00	\$4.30	\$0.00	\$4.30	\$0.00	\$8.60
Louisiana	\$0.00	\$1.10	\$0.00	\$1.10	\$0.00	\$2.20
Maine	\$0.60	\$0.60	\$0.76	\$0.76	\$1.36	\$1.36
Maryland	\$1.19	\$1.19	\$5.38	\$5.38	\$6.57	\$6.57
Massachusetts	\$2.58	\$2.08	\$6.90	\$9.84	\$9.48	\$11.92
Michigan	\$0.16	\$4.78	\$10.12	\$11.06	\$10.28	\$15.84
Minnesota	\$1.22	\$2.38	\$1.53	\$2.24	\$2.75	\$4.62
Mississippi	\$0.98	\$2.10	\$0.00	\$2.10	\$0.98	\$4.20
Missouri	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Montana	\$0.16	\$0.65	\$0.29	\$0.65	\$0.45	\$1.30
Nebraska	\$0.00	\$0.55	\$0.00	\$0.55	\$0.00	\$1.10
Nevada	\$0.00	\$1.78	\$0.00	\$1.78	\$0.00	\$3.56
New Hamp	\$0.76	\$0.88	\$0.76	\$0.88	\$1.52	\$1.76
New Jersey	\$8.67	\$9.13	\$13.02	\$14.61	\$21.69	\$23.74
New Mexico	\$0.00	\$1.42	\$0.00	\$1.42	\$0.00	\$2.84
New York	\$55.60	\$63.33	\$46.74	\$53.79	\$102.34	\$117.12
N Carolina	\$0.00	\$0.00	\$5.38	\$12.99	\$5.38	\$12.99
N Dakota	\$0.31	\$0.31	\$0.64	\$0.64	\$0.95	\$0.95
Ohio	\$0.21	\$5.84	\$0.33	\$5.84	\$0.54	\$11.68
Oklahoma	\$0.00	\$4.12	\$0.00	\$4.12	\$0.00	\$8.24
Oregon	\$2.48	\$5.37	\$1.03	\$5.37	\$3.51	\$10.74
Pennsylvania	\$0.10	\$0.10	\$0.00	\$0.00	\$0.10	\$0.10
Rhode Island	\$0.00	\$0.09	\$0.00	\$1.37	\$0.00	\$1.46
S Carolina	\$0.45	\$1.78	\$0.43	\$1.72	\$0.88	\$3.50
S Dakota	\$0.18	\$0.18	\$0.67	\$0.67	\$0.85	\$0.85
Tennessee	\$2.26	\$2.26	\$2.51	\$2.51	\$4.77	\$4.77
Texas	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Utah	\$1.14	\$1.14	\$1.14	\$1.14	\$2.28	\$2.28
Vermont	\$0.00	\$0.44	\$0.00	\$0.44	\$0.00	\$0.88
Virginia	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Washington	\$2.28	\$2.28	\$6.24	\$6.24	\$8.52	\$8.52
West Virginia	\$0.00	\$0.57	\$0.00	\$0.57	\$0.00	\$1.14
Wisconsin	\$0.00	\$0.00	\$6.96	\$6.96	\$6.96	\$6.96
V ing	\$0.38	\$0.39	\$0.38	\$0.39	\$0.76	\$0.78
L ol	\$0.63	\$1.62	\$0.63	\$1.62	\$1.26	\$3.24
To	\$165.38	\$226.58	\$236.68	\$300.02	\$402.06	\$526.60



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

LH-1

JAN 15 1999

The Honorable Don Siegelman
Governor of Alabama
Montgomery, Alabama 36130

Dear Governor Siegelman:

The Agricultural Research, Extension, and Education Reform Act of 1998 requires the Department of Health and Human Services to determine the amount of funds in each State's base year for the Temporary Assistance for Needy Families (TANF) block grant that was charged to the former Aid to Families with Dependent Children (AFDC) program for common administrative costs that could have been allocated to Food Stamps and Medicaid.

Based on our review of your State's proposal, HHS concurs with the proposed determinations of \$1,368,000 for Food Stamps and \$1,368,000 for Medicaid as the amounts that were charged to the AFDC program for administrative costs common to determining eligibility for those programs in the State's base year. The Act stipulates that the amounts determined for Food Stamps will be reduced annually from the allowable Federal share of Food Stamp administrative claims beginning on or after October 1, 1998, and through September 30, 2002. The Secretary of Agriculture will subsequently advise you as to how and when these adjustments will be made. While the Act required HHS to determine the amounts applicable to Medicaid, there is no current statutory requirement to make a similar adjustment for that program.

In accordance with the Act, the State may appeal these determinations to an HHS Administrative Law Judge within 60 days of this notice. Such an appeal should be sent to:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division
637D HHH Building
200 Independence Ave. SW
Washington, DC 20201

Not later than 60 days after the record is closed (i.e., no additional information is required from either party), the Administrative Law Judge will issue a final decision. Within 30 days after the receipt of that decision, the State may appeal the decision to the HHS Departmental Appeals Board.

Page 2 -The Honorable Don Siegelman

I wish to thank the Alabama staff for their assistance in meeting the compressed deadlines and data requirements imposed by this legislation. I look forward to our staffs working cooperatively to resolve any outstanding issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna E. Shalala". The signature is fluid and cursive, with the first name "Donna" being more prominent.

Donna E. Shalala

cc: The Honorable Dan Glickman, Secretary of Agriculture
Mr. James D. Connell, Director, Finance Division, DHR



Washington, D.C. 20201

FEB - 4 1999

Ms. Janet Clarke, Director
State of Alaska - Department of Health and Social Services
Division of Administrative Services
P.O. Box 110650
Juneau, Alaska 99811-0650

Dear Ms. Clarke:

The Agricultural Research, Extension, and Education Reform Act of 1998 requires the Department of Health and Human Services to determine the amount of funds in each State's base year for the Temporary Assistance for Needy Families (TANF) block grant that was charged to the former Aid to Families with Dependent Children (AFDC) program for common administrative costs that could have been allocated to Food Stamps and Medicaid. In her letter dated January 15, 1999, Secretary Shalala advised your Governor of her decision (copy enclosed).

As noted in that decision, the Secretary's determination differed with the State's proposal. Enclosed is an analysis of the State's proposal and the rationale for the Department's decision. In accordance with the Act, the State may appeal the Food Stamp, Medicaid or both determinations under procedures outlined in the letter to the Governor.

The January 15, 1999, letter to the Governor advised that the State may file an appeal of the determinations to an HHS Administrative Law Judge within 60 days of the receipt of that notice. The Department has determined to extend your appeal time so that any appeal must be filed within 60 days of the receipt of this letter transmitting our rationale. The reason for extending your appeal time is so that your State may have adequate opportunity to review the rationale for the Department's decision before deciding whether or not to file an appeal.

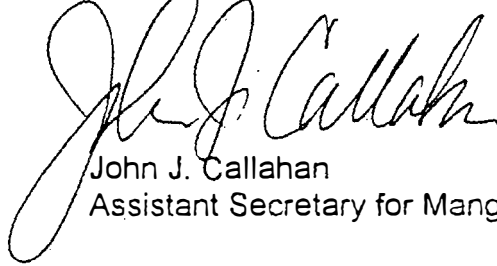
Your State must file an appeal in accordance with the extension of time noted above to preserve your statutory appeal rights. Your appeal may include a request for mediation. Mediation is a voluntary process, entered into by the parties' mutual agreement in an effort to achieve a negotiated resolution of the dispute. The mediator facilitates an agreement. The parties are bound only to outcomes that are reduced to a written agreement. Mediation discussions are confidential under the requirements of the Administrative Dispute Resolution Act which governs this process. Nothing from the mediation process will be added to the record in the appeal unless both parties agree. Neither party is precluded from returning to the appeal process before the Administrative Law Judge and the Departmental Appeals Board should there not be a mediated resolution.

Page 2 - Ms. Janet Clarke, Director

I recognize that your staff had only a limited amount of time to complete this legislatively mandated project. We are fully aware that this was not an easy task in that it required the reconstruction of dated documents and data. Your efforts are greatly appreciated.

Should you or your staff have any questions, please contact Joseph E. Cook, Jr., Director of Audit Resolution and Cost Policy, (202-401-2804), Room 522E HHH Building, 200 Independence S.W., Washington, D.C. 20201 or Ronald Speck, Senior Cost Policy Officer (202-401-2751).

Sincerely,

A handwritten signature in black ink, appearing to read "John J. Callahan". The signature is fluid and cursive, with the first name "John" and last name "Callahan" clearly distinguishable.

John J. Callahan

Assistant Secretary for Management and Budget

Enclosures

cc: Abigail Nichols, Director, PAD/FNS
Chuck Seed, Director, DCA/HHS