

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Paula Brooks to Chris Jennings re: phone number (partial) (1 page)	02/17/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20464

FOLDER TITLE:

Health Care Financing Administration Issues [Folder 1]

2012-0463-S

rc769

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

②

HCFA Update

OMB & Senator Graham

DOJ, IG, HCFA & OMB;
getting IG to work w/ everything
else doesn't work → but that's
integral to HCFA position.

talking to DOJ soon → next week.

Information campaign →

QAO report 22nd March.

CHRIS TO CALL JOHN B.

MIKE TO SCHED. MTG FOR RESOLUTION
mtg end of the week next wk?
ROLL OUT.

②

LA County

they want waiver extension
authority to extend yes
w

③

GRIMALVA MTG

next few weeks. (2 or 3)
Elena & Counsel.

④

ED HOWARD ALLIANCE FOR

HEALTH REFORM; Media, trade,

etc, press → no to discuss Med

HCFA Catch-up

hearings

gao dispute

risk adjustment

① Nursing Homes

outstanding issues & specifications
for legislative authority

NAMH feels that IG & DOJ negotiated
the language in POTUS initiative -

DOJ doesn't have anything in there on
initiation of action upon referral.

Independent federal stat. authority in

DOJ is → referral to HCFA enforcement.

HCFA wants referral; authority
the same as what they currently
have.

Greenbelt.

DOJ doesn't want to use False Claims
Act, conspiracy statute? that's
really hard to prove.

tension btwn DOJ & HCFA & IG
referral

who defines egregious.

State Survey agencies discover
complaints. → HCFA RO.

IG investigates themselves (the
majority of cases. → IG

RO refer to DOJ

RO refer to IG

DOJ

US Atty.

Testimony

Before the Subcommittee on Health, Committee on Ways
and Means, House of Representatives

For Release on Delivery
Expected at 2:30 p.m.
Thursday, February 11, 1999

HCFA MANAGEMENT**Agency Faces Multiple
Challenges in Managing Its
Transition to the 21st
Century**

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Health Care Financing Administration's (HCFA) ability to meet its new and growing responsibilities. HCFA pays for health care coverage for nearly a quarter of the population. Two of the programs HCFA administers cost federal and state taxpayers about \$370 billion in fiscal year 1998—\$193 billion for Medicare and \$177 billion for Medicaid—and represent an ever growing proportion of the federal budget—currently about 18 percent. Because of the size and complexity of its programs, we have been reviewing HCFA's operations since the agency was created more than 20 years ago. Over the years, we have reported on problems in HCFA's management that weakened the fiscal integrity of these programs—leading to increased monetary loss from fraud, abuse, and erroneous payments. We have also reported on management problems that have led to poor-quality care provided to vulnerable beneficiaries. In 1990, we developed a list of agencies and programs that were "high risk" because of their vulnerability to waste, fraud, abuse, and mismanagement. We included Medicare on our original list, and it remains on the list to this day.

The long-term financial condition of Medicare is now one of the nation's most pressing problems. Recent legislation gave HCFA substantial new authorities and responsibilities for reforming Medicare in order to extend the solvency of Medicare's Hospital Insurance Trust Fund beyond 2008. This legislation also established the Bipartisan Commission on the Future of Medicare to develop more long-term solutions for further ensuring Medicare's integrity and solvency. Because of your concern about HCFA's preparedness to implement these new authorities and administer its programs, you asked us to review HCFA's management capacity and to testify before this Subcommittee last January. You asked us to report today on our updated assessment of HCFA's progress—focusing on the agency's ability to meet its increasing workload in the short term. Specifically, you asked us to review HCFA's progress in (1) addressing its most immediate priorities and (2) strengthening its internal management to effectively discharge its major implementation and oversight responsibilities.

We relied on our substantial body of past and ongoing work to assess HCFA's performance in meeting its current responsibilities.¹ We supplemented this work by interviewing 28 agency managers and officials, including the Administrator and Deputy Administrator. In addition, we conducted small focus groups attended by 46 senior and midlevel managers and 20 staff, and reviewed agency documents.

In summary, HCFA is facing an unprecedented set of challenges. The Balanced Budget Act of 1997 (BBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were designed, with considerable input from the administration, to

¹See Related GAO Products at the end of this statement.

strengthen HCFA's ability to prevent fraud and abuse and constrain spending growth in the Medicare program. These laws added substantial new authorities and programmatic responsibilities to HCFA's ongoing management of Medicare and Medicaid. In response to these mandates and program responsibilities, HCFA's accomplishments have been impressive. However, measured against the magnitude of challenges it faces, HCFA's progress seems more modest. The immediacy and resource demands associated with meeting the Year 2000 computer system challenges—coupled with HCFA's late start in addressing them—have put a tremendous burden on the agency this past year and have affected the timing and quality of its work on many other projects. For example, it has delayed needed systems modernization and computer changes that implement new payment systems intended to slow program cost growth. It has also slowed efforts to improve the oversight of ongoing operations, such as financial management and Medicare fee-for-service claims administration, which desperately need attention. Even where HCFA has made progress—such as in implementing a number of the mandated HIPAA and BBA requirements—we believe that more work, and many refinements, are still needed.

HCFA must meet these challenges with an aging workforce. In fact, almost one quarter of its staff—most with managerial and technical experience—will be eligible to retire in the next 5 years. HCFA has taken a number of steps internally to capitalize on its staff's strengths to deal with a rapidly changing health care marketplace and growing responsibilities. For example, HCFA has developed a strategic plan that better articulates its future direction, has progressed in its customer-focused reorganization by moving staff to their new organizational units, and has hired more staff with needed skills. On the other hand, in focus groups we conducted, HCFA managers and staff discussed issues that continue to hamper effective agency operations. For example, HCFA's reorganization slowed the agency's decision-making process so that even travel funds were not allocated until well into the middle of the fiscal year. Managers also stated that the performance and awards systems neither motivate staff nor hold staff accountable for achieving program results.

To further strengthen HCFA's ability to effectively manage its employees and programs, the administration has proposed new authorities for contracting and new flexibility in hiring in the President's budget for fiscal year 2000. It also proposes new mechanisms to enhance agency accountability, with biannual reports to the Congress and an advisory board to help the agency streamline internal and program management. HCFA senior officials have taken concrete steps to improve agency management this year but will need to maintain the momentum over the next several years to overcome the agency's current and future challenges. This will be especially difficult in an agency that for years has been plagued by external pressures and management problems.

BACKGROUND

HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for administering much of the federal government's multibillion-dollar investment in health care—primarily the Medicare and Medicaid programs. Rapid increases in Medicare program costs, coupled with increasing concern about fraud and abuse in the program, led the Congress to enact legislation—HIPAA and the BBA—to strengthen Medicare. HIPAA established the Medicare Integrity Program, which ensures increased funding for Medicare program safeguard efforts and authorizes HCFA to hire specialized antifraud contractors. The BBA made the most significant changes to Medicare in decades, designed to reduce the growth of Medicare spending. The law requires HCFA to implement new payment methodologies, expand managed care options, and strengthen program integrity activities. At the same time, these laws also added entirely new responsibilities—such as oversight of private health insurance and implementation of a new state children's health insurance program—to HCFA's historic mission to administer Medicare and Medicaid.

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than \$193 billion. Most of these beneficiaries receive health care on a fee-for-service basis, in which providers are reimbursed for each covered service they deliver to beneficiaries. HCFA contracts with about 60 insurance companies to process the high volume of fee-for-service claims—numbering about 900 million in fiscal year 1997—submitted by about a million health care providers for payment. Medicare's managed care program, the other principal component, covers the growing number of beneficiaries who have chosen to enroll in prepaid health plans, where a single monthly payment covers any needed services. About 6.8 million people—about 17 percent of all Medicare beneficiaries—were enrolled in more than 450 managed care plans as of December 1, 1998.

Medicaid, a \$177 billion federal and state grant-in-aid entitlement program administered by states, finances health care for about 36 million low-income families and blind, disabled, and elderly people. At the state level, Medicaid operates as a health insurance program covering acute-care services for most recipients, financing long-term medical care and social services for elderly and disabled people, and funding programs for people with developmental disabilities and mental illnesses. In addition, the BBA created the state-operated Children's Health Insurance Program, which provides federal grants to states to provide basic health insurance coverage for low-income, uninsured children. Through this program, states have a choice of either expanding their Medicaid programs or developing a separate program to insure children.

Under HIPAA, HCFA also has a completely new responsibility for ensuring that private health insurance plans comply with federal standards. In five states that did not pass legislation conforming to key provisions of HIPAA, HCFA has direct

responsibility for enforcing HIPAA standards for individual and group insurance plans. In addition, HIPAA, along with the BBA, provides HCFA more opportunities to improve its fraud and abuse identification and prevention programs in Medicare.

HCFA had about 4,100 staff as of October 1998. About 65 percent were located in the central office and the remainder worked in the agency's 10 regional offices. In addition to its workforce, HCFA oversees Medicare claims administration contractors who employed an estimated 22,000 people in fiscal year 1997.

HCFA HAS MADE SOME PROGRESS ADDRESSING ITS HIGHEST PRIORITIES, BUT MANY PROBLEMS REMAIN

Last year, we told you that substantial program growth and greater responsibilities appeared to be outstripping HCFA's capacity to manage its existing workload. Today, the message is a more complicated one. HCFA has made great strides in addressing many of its immediate priorities—including readying critical computer systems for the year 2000 and implementing many provisions of HIPAA and the BBA. But the number and complexity of the BBA's requirements and the urgency of systems changes, coupled with a backlog of decades-old problems associated with HCFA's routine operations, make it clear that much more needs to be accomplished.

HCFA Made a Concerted Effort on Y2K, but Critical Tasks Are Incomplete

Over the past year, HCFA has made a concerted effort to deal with its most pressing priority—the Year 2000 computer systems problem—commonly referred to as Y2K.² If uncorrected, Y2K problems could cause computer systems that run HCFA's programs to shut down or malfunction, resulting in serious disruptions to payments to Medicare providers and services to Medicare beneficiaries. Addressing Y2K is a formidable task for HCFA, because the Medicare program uses 6 standard claims processing systems, about 60 private contractors, and financial institutions nationwide to process about 900 million Medicare claims each year for about 1 million hospitals, physicians, and medical equipment suppliers.

In September 1998, we reported that time was running out for HCFA to modify Medicare systems to handle Y2K.³ HCFA was severely behind schedule in repairing

²This problem stems from the use in many computer systems of a two-digit dating system for indicating the year. With this abbreviated format, the year 2000 is indistinguishable from 1900.

³Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy (GAO/AIMD-98-284, Sept. 28, 1998).

and testing its systems and in developing contingency plans to handle system failures. Until 1997, HCFA was attempting to develop the Medicare Transaction System—which would be Y2K compliant—to replace its existing Medicare claims processing systems. But the project was halted because of design problems and cost overruns. This left HCFA with multiple, noncompliant Medicare claims processing systems that needed modernization. Compounding this difficult task was HCFA's failure to adequately direct and monitor its Y2K project. We recommended changes to better manage its Y2K efforts, and HCFA agreed to implement our recommendations as soon as possible.

HCFA recently reported to HHS that as of December 31, 1998, it had completed renovating 5 of the 6 standard systems used by its contractors to pay claims and all 25 of its mission-critical internal systems. We are now monitoring HCFA's progress in implementing the recommendations in our September 1998 report, and we are reviewing the agency's progress in addressing the critical areas of Y2K testing and business continuity and contingency planning. We will testify on these issues to the Congress in the next few weeks. Furthermore, although HCFA is not directly responsible for state Medicaid enrollment and payment systems, agency officials said they are concerned that some state systems may fail. To help prevent this, the agency has begun to work with states on their Y2K problems.

HCFA's progress on the Y2K front is tempered by one unfortunate reality: some of the systems HCFA is expending so much energy and resources to modify to achieve Y2K compliance are obsolete and will need to be replaced soon after the year 2000. Y2K presented an immediate problem with an inflexible end point, which has forced HCFA to shelve its efforts to consolidate its Medicare claims processing systems and modernize other systems. After the termination of the Medicare Transaction System, HCFA decided to consolidate the number of systems that pay claims to reduce systems maintenance costs and streamline efforts to implement required systems changes. But systems consolidation could not go forward while HCFA and its contractors were renovating and testing their systems for Y2K readiness. As a result, it is spending millions to renovate certain systems for Y2K readiness that it plans to stop using soon after 2000.

HCFA Has Made Some Progress but Is Still Struggling With HIPAA and BBA Implementation

HCFA has completed many major tasks this past year and has implemented significant portions of HIPAA and the BBA, but progress remains slow. For example, HCFA has taken steps to allocate HIPAA funding and to implement authorities to combat waste and abuse in the Medicare program. HIPAA provided additional funds for HCFA's Medicare claims processing contractors to use to detect fraudulent and abusive billing practices. The claims administration contractors use these funds to hire and retain staff knowledgeable in conducting provider audits, claims reviews, and payment data analyses, among other activities. HCFA promptly issued the contractors'

fiscal year 1999 budget allocations, unlike the situation in fiscal year 1998, when HCFA did not provide this funding to the contractors until a third of the year had passed.

As part of HIPAA, the Congress also gave HCFA the authority to contract with specialists to perform payment safeguard activities. HCFA is now reviewing the submissions it received in response to its September 1998 solicitation for bids to become a program safeguard contractor. Such a contract could be awarded by May 1999, but the scope will be limited and will not provide many of the benefits initially envisioned from using a specialty contractor.

As part of its work on BBA-mandated Medicare+Choice,⁴ HCFA issued interim final regulations for health maintenance organizations and other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations) to participate and took several steps toward implementing the new National Medicare Education Program last year. The regulations, published in June 1998, represented a massive undertaking accomplished within a very short time period. In rushing to reach the deadline, however, some of the provisions were developed without full consideration of their impact on managed care organizations. For example, the regulations required that managed care plans assess the health status of all new Medicare members within 90 days of enrollment, but this requirement would include existing plan members for whom the plan may already have comprehensive information. Similarly, the regulations require each managed care organization's chief executive officer to certify that the encounter data provided to HCFA are 100-percent accurate. To managed care plans, such a standard seems unreasonable because these data are generated from many sources not directly under their control, including contracting physicians, hospitals, and other providers. In addition, managed care plans are concerned that other requirements cannot realistically be accomplished in the required time frames, may be duplicative of existing accreditation and reporting requirements, and could create disincentives to work on more difficult quality improvement projects. HCFA has agreed to reconsider a number of items and is planning to change the standard for data accuracy so that plans' chief executive officers will certify to the best of their knowledge that the data provided to HCFA are accurate.

⁴Medicare+Choice widens beneficiary and health plan participation in Medicare managed care by (1) guaranteeing plans a minimum payment level, intended to encourage plans to locate in areas they had previously not served; (2) expanding the types of plans eligible to contract with Medicare to include—in addition to health maintenance organizations—preferred provider organizations and provider-sponsored organizations; and (3) informing beneficiaries of the plan choices in their area through a national information campaign.

For the new National Medicare Education Program, HCFA established an eight-point plan for educating beneficiaries about their new managed care options; implemented an Internet site for providing comparative managed care plan information; and has begun phasing in its toll-free call center and its mail-out of a revised Medicare handbook to beneficiaries in five states, which foreshadowed the nationwide mail campaign planned for this fall. The effort to produce Medicare handbooks was more complicated than the agency originally expected. Of the 15 comparative handbooks mailed to beneficiaries in different geographic areas, 12 were inaccurate because HCFA published them before managed care plans finalized their Medicare participation decisions. The Congress' efforts to encourage the growth of Medicare managed care could be thwarted if plans refuse to participate and if beneficiaries are confused, instead of enlightened, about their many health care choices.

HCFA officials acknowledge they were slow to realize that the complexity and magnitude of the Y2K problem would stall implementation of key BBA requirements. The BBA mandated the design and implementation of new payment methods called prospective payment systems (PPS), which pay providers—regardless of their costs—fixed, predetermined amounts that vary according to patient need. To meet BBA targets, HCFA has to design and implement four PPS systems:

- a skilled nursing facility (SNF) PPS by July 1, 1998;
- a home health agency PPS by October 1, 1999, which was delayed by later legislation until October 1, 2000;
- a hospital outpatient PPS by calendar year 1999; and
- an inpatient rehabilitation PPS by fiscal year 2001.

The SNF PPS was implemented on July 1, 1998. However, to prevent additional complications during system renovation and testing for Y2K, the agency has missed deadlines to make systems changes needed for beginning the hospital outpatient and home health agency prospective payment systems. These delays could affect both budgetary savings and Medicare beneficiaries themselves. The Congressional Budget Office had estimated that new payment methods for home health and outpatient services would save Medicare about \$23 billion between fiscal years 1998 and 2002. In addition, the hospital outpatient PPS would have reduced the amounts elderly patients pay for such services. HHS estimated that between January 1999 and April 2000, senior citizens will have to pay an extra \$570 million in higher copayments over what they would have paid if the hospital outpatient PPS had been implemented on time. While many Medicare beneficiaries have some sort of third-party coverage for costs that Medicare does not cover—referred to as “Medigap” policies—they are likely to be

indirectly affected because premiums for Medigap policies are increasing in line with rising Medicare costs.

Although HCFA officials were tracking both BBA and Y2K implementation, top agency officials did not inform the Congress until July 1998 that the agency would be delayed in instituting the new payment methods. HCFA officials attributed their late awareness of this problem to communications breakdowns at three levels. First, they believe operations and policy staff at headquarters responsible for designing the program changes were not consulting with each other and with others who were responsible for implementing them in the field. Second, they stated that top agency officials did not immediately find out what lower-level HCFA managers knew—how long it would take to implement complex BBA changes and how that could complicate Y2K testing of the systems. Finally, officials believe that there was inadequate consultation with Medicare contractors responsible for making the actual programming changes to their systems.

While some parts of the BBA implementation were put on hold, HCFA moved quickly to implement a new SNF PPS.⁵ However, we believe that the SNF PPS has design flaws, and coupled with a lack of adequate planned oversight, this may diminish the anticipated reduction in Medicare costs that prospective payment was supposed to create. Savings depend on developing an appropriate daily payment (per diem) rate to reflect patients' needs. The new daily payment rate is based on the average daily cost of providing all Medicare-covered skilled nursing services, adjusted to take into account the patient's condition and expected care needs. We are concerned that the new SNF PPS' design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services, since the amounts paid still depend heavily on the number of therapy and other services patients receive. Furthermore, HCFA has not planned sufficient oversight to prevent fraud and abuse. For SNFs, a facility's own assessment of its patients will determine whether a patient is eligible for Medicare coverage and how much will be paid. When Texas implemented a similar payment method for Medicaid, its on-site reviewers found that nursing homes' assessments were often inflated. Despite Texas' experience, HCFA does not currently have plans to monitor facilities' assessments to ensure they are appropriate and accurate. Nor has it ensured that the Medicare

⁵The prior payment method reimbursed providers on the basis of their costs, with capital costs and ancillary services virtually unlimited. Because providing more services generally triggered higher payments, facilities had no incentive to provide only necessary services or to improve efficiency. Prospective payment is intended to slow spending growth by paying providers fixed, predetermined amounts that vary according to patient need, regardless of providers' actual costs.

contractors—who pay the facilities' claims—will have timely information on patients to determine whether the rate to be paid is appropriate.

The last major BBA implementation challenge we want to highlight is the Children's Health Insurance Program—the largest health care investment in children since Medicaid was created in 1965. Although states are given broad flexibility in tailoring programs to meet their own circumstances, HCFA is responsible for approving each state's plan, providing technical assistance to the states, and ensuring that programs meet statutory requirements designed to guarantee meaningful health coverage. HCFA has initiated (1) a comprehensive effort with the states, private companies, advocacy organizations, the Health Resources and Services Administration, and others to promote this initiative and (2) an outreach effort to find those children who are eligible for health insurance under the Children's Health Insurance Program or Medicaid but are not enrolled. Since passage of the act, HCFA has approved 46 state plans, after providing extensive guidance and interim instructions to states. We are currently studying HCFA's and the states' efforts to implement the Children's Health Insurance Program and will report on the results later this year.

HCFA's Handling of Ongoing Responsibilities
for Financial Management and Routine
Oversight Raises Serious Concerns

Over the last several years, HCFA has been lax in managing critical ongoing program responsibilities, such as financial management—particularly by Medicare claims administration contractors—and oversight of nursing home compliance. For example, our work on high-risk programs such as Medicare highlighted the need for major federal financial management reforms, which the Congress initially enacted in the 1990 Chief Financial Officers Act and later expanded in the 1994 Government Management Reform Act. Under this legislation, the 24 major departments and agencies such as HCFA must now produce annual financial statements subject to independent audit, beginning with those for fiscal year 1996.

Since 1996, in conjunction with its audit of HCFA's financial statements, the HHS Office of Inspector General (OIG) has estimated the error rate for improper payments made by Medicare claims administration contractors. For fiscal year 1998, the OIG estimated that about 7 percent of Medicare fee-for-service payments for claims—\$12.6 billion—did not comply with Medicare laws and regulations. This represents an improvement over fiscal year 1997, when the OIG estimated that Medicare contractors made \$20.3 billion in improper payments—about 11 percent of all claims. However, the difference from 1997 to 1998 was almost entirely attributable to better documentation provided to the auditors, rather than to a substantive reduction in improper payments in categories such as "lack of medical necessity," "incorrect coding," and "noncovered services."

HCFA has made progress in strengthening its financial oversight. Nevertheless, serious weaknesses remain for both Medicare and Medicaid. Many of the financial weaknesses in Medicare relate to its oversight of Medicare claims administration contractors, which process over \$700 million in Medicare fee-for-service claims each working day. In its audit of HCFA's 1997 financial statements, HHS' OIG found material weaknesses in managerial control over contractor operations, and, as a result, HCFA may not be collecting millions of dollars in overpayments from providers. The fiscal year 1997 audit identified one contractor transitioning out of the program that reported transferring \$266 million in accounts receivable to other contractors, but neither HCFA nor the auditors could determine whether these receivables had been transferred onto the new contractors' books. HCFA depends on contractors' financial reports to provide information for its financial statement because HCFA lacks an integrated accounting system that can capture financial information at the contractor level. Moreover, the OIG found indications that HCFA's central and regional office oversight of operational and financial management controls was inadequate to ensure that contractor-provided financial information was consistent and accurate.

Similarly, the OIG found that security for contractor and HCFA information systems was inadequate, imperiling the confidentiality of Medicare beneficiary personal and medical data. While HCFA had corrected some weaknesses found during the audit for fiscal year 1996, it was still possible for an unauthorized user to gain access to HCFA's database and modify sensitive beneficiary files. HCFA has recognized the need to protect the security of its information systems and, starting in 1997, began revising security policy and guidance, and implementing corrective action plans. Because of the need to focus on Y2K modifications, however, HCFA probably will not address many of these weaknesses in the near term.

Medicaid financial management also is in need of reform. The OIG's 1997 audit revealed that HCFA had limited information on the federal portion of Medicaid accounts receivable and payable. In fiscal year 1997, HCFA relied on survey information from the states to estimate the amounts to record in the financial statements, and because the survey data were so limited, the OIG could not verify their accuracy. In addition, the audit noted that HCFA regional offices were not providing sufficient oversight of states' Medicaid claims processing and reporting, including states' efforts to deter fraud and abuse and collect overpayments.

HCFA's oversight of the quality of care Medicare and Medicaid beneficiaries receive also needs improvement. HCFA is responsible for defining requirements for certain providers, such as nursing homes and home health agencies, to participate in the Medicare and Medicaid programs and certify that their enforcement is adequate to protect the health and safety of Medicare and Medicaid beneficiaries. HCFA contracts with state agencies to review nursing homes and home health agencies for their adherence to these federal requirements. Our work has shown that HCFA's policies and oversight have been insufficient to ensure quality of care for nursing home

residents or home health patients, and serious problems have resulted. One in nine nursing homes in the country were cited in both of the last two inspections for harming residents or putting residents' health and safety in immediate jeopardy—but such homes often faced no federal sanctions. In response, HCFA began taking actions to improve state inspection practices, revise state oversight activities, and strengthen enforcement for nursing homes. HCFA has also added requirements that home health agencies demonstrate experience and expertise in home care by serving a minimum number of patients before initially certifying them as Medicare providers. However, these steps may not go far enough to protect vulnerable beneficiaries. We are now reviewing HCFA's oversight of state nursing home complaint investigations and inspections and will report to the Congress on these issues this year.

HCFA HAS MADE CHANGES TO ENHANCE ITS MANAGEMENT CAPACITY, BUT PROBLEMS PERSIST

Because its mission has been rapidly growing and changing, HCFA officials have worked hard to strengthen the agency's management capabilities. Despite these efforts, problems remain that hamper effective agency operations. While HCFA has developed a new focus on planning, including publishing a strategic plan, it does not require units to develop detailed plans to carry out day-to-day operations. The agency has completed its reorganization, but the resulting structure has contributed to various communication and coordination problems. Last year, HCFA lacked sufficient trained staff with the skills to effectively implement its top priorities. It hired more staff with needed skills in 1998, but it has not completed a long-term strategic approach to meet its future human resource needs. HCFA staff and managers are also concerned that its performance and award systems are not well linked to accomplishing its mission and that many managers are overburdened and lack managerial skills. These types of problems are found in other agencies, but HCFA still must be diligent in addressing them. The President's budget for fiscal year 2000 proposes a reform initiative for HCFA that is designed to increase its flexibility in the human resources area and to increase the agency's accountability.

Tactical Planning Is Limited

In December 1998, HCFA published its strategic plan, which focused on the organization as a whole and communicated the agency's vision, mission, and broad approaches to realizing that vision. This plan was developed to help HHS respond to requirements in the Government Performance and Results Act of 1993. In its strategic plan, HCFA clearly states that serving beneficiaries is its primary mission and, in doing so, the agency must be a prudent purchaser of health care. In addition to its overarching strategic plan, HCFA has also produced draft strategic plans for such significant areas as information technology and program integrity.

Strategic plans are an important first step; to be useful, however, they must be implemented. Tactical plans, which identify specific, measurable, desired outcomes; time frames; and assignments of responsibilities for task completion, are critical. Last year, we reported that HCFA was not planning its activities on a tactical level. Although tactical planning has been used in some specific instances during the past year, such as to help track implementation of BBA requirements, HCFA has still not institutionalized this level of planning in its day-to-day operations.

In our interviews and focus groups, a pervasive theme was the need to work in a crisis mode, made worse by a lack of planning. For example, a staff member stated that she was being pulled from one "hot project" to another—which caused her to lose efficiency because she barely managed to master one subject before she was tasked with another. A manager told us that since the reorganization, little planning has taken place in his division, making even simple tasks harder. He said, as an example, that the divisions did not know how much travel money was available until the middle of the fiscal year and that routine trips had to be written up as emergencies to get approval. We heard similar concerns from managers and staff working on data systems and coverage policy.

Reorganization Has Created Coordination Problems

HCFA's July 1997 reorganization established a totally new structure designed to better focus the agency as a "beneficiary-centered purchaser" of health care. The reorganization created new centers that were intended to respond directly to HCFA's customers—the Center for Beneficiary Services, the Center for Health Plans and Providers, and the Center for Medicaid and State Operations—and to provide additional resources to Medicare's growing managed care program.

In our January 1998 testimony, we noted that the agency's staff had not yet moved to the actual location of their new organizational units, which tended to exacerbate problems with internal communication and coordination. Almost a year after the reorganization, between June and August 1998, HCFA completed the physical relocations, placing staff within their new organizational units. Relocation was a major undertaking because HCFA had made dramatic shifts of groups and people. An estimated 80 percent of HCFA central office staff, along with their computers, files, and shared office equipment, were relocated during the move. Managers told us that the physical move was implemented well, minimized work disruptions, and enhanced HCFA's operational efficiencies.

The 1997 reorganization set out to eliminate HCFA's "stovepipes" by placing policy and operations staff together in specific customer-focused centers to enable them to work more closely together. We found that HCFA is still in the process of learning how to make its new organization work. Several managers said that they

believe the quality of decision-making will be enhanced because input from many individuals and groups is required. But other managers and staff reported substantial internal and external communication problems as a result of the reorganization. For example, they said that the organization's decision-making process has become slow and cumbersome because it is more difficult to identify the key decisionmakers and find meeting times that can fit their busy schedules. We also were told that even identifying appropriate points of contact is sometimes difficult because new organizational titles are confusing. Finally, some managers and staff were concerned that when accountability for issues was shared by more than one center or office, tasks could "fall through the cracks" unless responsibilities were more clearly defined. Agency officials recognize that coordination is a problem and that there is sometimes a lack of accountability for decision-making. In response, they indicated that they are establishing teams on priority projects where key participants are identified and accountability for project completion is placed on one person.

HCFA's reorganization and emerging role as a health care purchaser and beneficiary advocate have also led to changes in the way HCFA communicates with those outside the agency. Some changes, such as those brought on by the Medicare +Choice program and the availability of Medicare and Medicaid information on the Internet, have increased interaction with providers, provider groups, and beneficiaries, according to several HCFA employees. Some staff we spoke with expressed concern about this increased workload and their inability to readily refer people to appropriate HCFA entities because the new organizational lines of responsibility are still unclear. Also, we found that although the Internet means that HCFA is "open 24 hours a day" and can communicate differently through this new medium, neither senior staff nor agency plans have fully addressed the impact of the Internet on HCFA's workload and how managers might need to reallocate responsibilities.

Maintaining Experienced and Appropriate Staff Will Continue to Be a Long-Term Need

Last year, we reported that HCFA lacked sufficient staff with needed skills to effectively implement top-priority tasks. Today, managers are somewhat less concerned about staffing shortages because, during the year, HCFA hired more than 400 new employees—a net gain of more than 250 after accounting for attrition. Of the new staff, a little over one-half were hired as GS-7s through GS-12s and about one-third were health insurance specialists. Senior agency officials told us that the new staff, with skills in areas such as managed care, private insurance, and market research, should help HCFA meet its new and growing responsibilities.

We believe that HCFA's focus on attracting new employees needs to be long term and continuous because it will continue to lose staff whose expertise must be replaced or supplemented. Over the next 5 years, almost a quarter of HCFA's staff—who make up a large part of the agency's management and technical expertise—will be eligible to

retire. In addition, managers say HCFA will need staff with "real world" expertise in private industry, including those who know how to purchase care competitively. While HCFA has not fully assessed its long-term human resource needs, senior officials told us that the agency is taking initial steps toward developing a long-term plan for investing in its human resources. HCFA currently has a draft human resources plan that covers the years 1999 through 2003.

Performance System, Awards Program, and Flexible Work Hours Affect Agency Productivity

HCFA managers and staff discussed a variety of factors that hamper agency operations and limit effective management. Although we believe that HCFA is not unique in experiencing these problems, mitigating them could improve agency performance. These include a pass/fail performance rating system where virtually all staff pass, an awards program that does not necessarily reward superior performance, and flexible work schedules and locations that limit staff availability. Participants in our focus groups believed that HCFA's performance appraisal system for nonexecutive staff does not allow managers to meaningfully assess and report on staff performance because virtually everyone receives a passing grade. Staff believed that the pass/fail system is demoralizing to hard workers because no adverse action is taken for unsatisfactory performance. Similarly, according to managers and staff, the performance appraisal system does not give staff a sense of satisfaction when they perform well because it fails to recognize outstanding efforts. Some cited the prior performance system as preferable because exceptional performers could benefit by receiving more rapid pay increases.

The Administrator found that the performance appraisal system for executives was also not useful in holding managers accountable and made changes this year to better differentiate senior managers' performance. The executive appraisal system has changed to a system with five levels of performance. Each executive manager has a performance agreement that is linked to performance goals for his or her set of responsibilities.

Many managers and staff members also told us that the current awards program is not working. Although the program is intended to motivate staff, the opinions we gathered suggest that it may have just the opposite effect. Each unit establishes its own panel that makes award decisions and controls award amounts. Panels consist of an equal number of union-appointed and management-appointed representatives. Each panel sets its own criteria for making awards and determining the portion of its awards budget to give to managers for "on-the-spot" awards, which are awarded directly to staff for performance on specific projects throughout the year. Managers told us that they would like to be able to distinguish among the accomplishments of staff members and reward them accordingly, but both managers and staff perceive the awards process as lacking equity and integrity. Any staff member can nominate

another for an award, and we were told that staff members sometimes nominate themselves and friends nominate each other. Managers also told us that sometimes almost all nominees in a unit receive awards because panels find it difficult to distinguish among nominees' performance. One manager who served as a panel member said that during the last fiscal year, about 250 employees were nominated for an award in his center—about two-thirds of all that center's employees. He said that only five of the nominees did not get an award. Last fiscal year, panels awarded about \$678,000 to about 2,200 employees in grades 1 through 15—an average of about \$300 per awardee. Managers also directly awarded about \$213,000 through on-the-spot awards that can range from \$50 to \$250.

While staff were highly critical of the performance appraisal and awards processes, they approved of the flexibility to set their own work hours and work locations. HCFA's personnel rules provide for flextime—in which employees may arrive at work at different times each day within core periods or work longer hours in a day and earn time off—and flexiplace—which allows employees to work at alternative locations. Under these rules, however, staff who work in the office only 4 days a week may be off when their managers need them to be in the office. Managers also told us that more time can be taken up with administrative matters as a result of more flexible work arrangements. They said that managing staff is more complicated, noting that planning the work, managing resources, and scheduling meetings is difficult, for instance, when all of the staff are only required to be in the office during a core period from Tuesday through Thursday—3 days a week. Employees need special approval to begin flexiplace, and a senior manager told us that they are now only approving about half of such applications.

Managers and Staff Express Concerns About Management Capacity and Training

Some managers and staff discussed their concerns about supervisors' span of control and the lack of adequate training. They said that they believe some managers are responsible for supervising too many employees and do not have enough time to work with people who could benefit from on-the-job training. They also stated that some managers are not skilled at managing people, which they attribute largely to HCFA's tradition of promoting staff with excellent technical skills to the managerial level, and not rewarding them for developing their staff. Some also cited the lack of training provided to managers to improve their supervisory skills.

Many managers and staff agreed that HCFA does not provide enough training opportunities to help them do their work. We were told that new staff get little orientation to the agency's organization, programs, goals, and mission. Focus group participants added that limited training and travel funds prevented them from attending seminars and receiving training. Each HCFA staff member received an

average of 8 hours of training last year. New staff, who generally were hired within the last year, averaged even fewer hours.

HCFA's senior management has identified management and other training as an area where HCFA must improve. The agency is developing a "model management initiative," which focuses on matching a manager's competencies with the specific skills that a manager needs for a given position. If approved by the Administrator, this model will be tested in the Office of the Chief of Operations. Then, if the initiative proves effective, it will be implemented in other parts of HCFA. HCFA is identifying better approaches to providing technical training and has doubled its training budget for next year—from about \$800,000 in fiscal year 1998 to about \$1.6 million in 1999.

HCFA Has New Proposals to Strengthen Management

To strengthen HCFA's ability to meet growing responsibilities, the President's fiscal year 2000 budget proposes several reform initiatives. The budget seeks more personnel and pay flexibility to allow HCFA to recruit high-level staff with specific, needed skills, such as physicians and executives with managed care plan operational experience. Coupled with such flexibility, HCFA is seeking authority to selectively offer buy-outs to some staff members. In addition, HCFA is seeking new authority that would allow it to contract competitively for its Medicare claims administration contractors. To improve agency performance, HCFA is proposing to add an advisory board of corporate executives and management experts for advice on improving its business practices. Finally, HCFA wants to increase its accountability to the Congress by providing biannual reports on its progress.

CONCLUSIONS

As HCFA moves into the 21st century, its challenges will continue to become more numerous and complex. Once it has finished preparing for Y2K, HCFA must face tasks it has had to put aside or has not fully addressed. Several immediate challenges lie ahead. HCFA must finish and then refine program changes to fully realize the benefits expected from the BBA. It also needs to renovate antiquated, and streamline redundant, computer systems. Furthermore, it needs to strengthen its financial management and efforts to preserve program integrity.

Added to these responsibilities will be potential additional challenges associated with any restructuring of Medicare that follows the deliberations of the Bipartisan Commission on the Future of Medicare. Even if no major changes are introduced, HCFA's continuing challenges are taxing—strong leadership and management will be required to meet them. More effective planning, new staff with needed skills, and better accountability could help HCFA address these challenges and better ensure

quality health care for the elderly, poor, and disabled. A true measure of HCFA's success will be its ability to maintain current momentum as it enters the 21st century.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

RELATED GAO PRODUCTS

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO/OCG-99-7, Jan. 1999).

High-Risk Series: An Update (GAO/HR-99-1, Jan. 1999).

Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy (GAO/AIMD-98-284, Sept. 28, 1998).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives (GAO/T-HEHS-98-214, July 16, 1998).

Medicare: HCFA's Use of Anti-Fraud and Abuse Funding and Authorities (GAO/HEHS-98-160, June 1, 1998).

Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T-HEHS-98-162, May 6, 1998).

Financial Audit: 1997 Consolidated Financial Statements of the United States Government (GAO/AIMD-98-127, Mar. 31, 1998).

Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93, Mar. 20, 1998).

Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85, Jan. 29, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997).

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse (GAO/HEHS-98-59R, Dec. 3, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation (GAO/T-HEHS-98-41, Oct. 29, 1997).

(101782)

[Guidebook on A & B]
Does it have a title?

INTRODUCTION

The last two years have witnessed a profound transformation of the American welfare system. A booming national economy combined with steadily declining welfare caseloads and innovative state policies and investments have helped millions of low-income Americans to make the transition from dependence to self-sufficiency. An essential element of family self-sufficiency is the ability to get and keep health insurance coverage ~~for parents and their children.~~

Until recently, many low-income families obtained health insurance through their eligibility for cash assistance programs. Under the old Aid to Families with Dependent Children (AFDC) program, poor families automatically received Medicaid coverage when they qualified for cash assistance. The Personal Responsibility and Work Opportunity Act of 1996 replaced AFDC with a new state-run Temporary Assistance for Needy Families (TANF) program and ~~broke the link~~ *ended automatic* between eligibility for cash assistance and eligibility for Medicaid.

To preserve Medicaid coverage for low-income families with children, the welfare reform law established a new Medicaid eligibility category. Under the new "Section 1931" group, any family that would have qualified for Medicaid under a State's old AFDC program is eligible for Medicaid now — regardless of whether or not the family receives TANF-funded assistance. The law also provided States with \$500 million in enhanced matching funds to support the system changes and outreach necessary to address the effects of "de-linking" Medicaid from welfare.

Beyond preserving ~~the extent of~~ *eligibility as it was prior to welfare reform, new options have been created.* Medicaid coverage under the old AFDC program, Section 1931 *also provides* States with authority to expand Medicaid coverage to more low-income families. *And* In 1997, seeking to extend free or affordable health coverage further to reach uninsured children in low-income families, *President Clinton and* Congress enacted the Children's Health Insurance Program (CHIP).

The dramatic changes in welfare laws and policies, and the challenges and opportunities they continue to present, require that states establish new strategies and procedures to ensure that as many children and families as possible retain or obtain health care coverage under Medicaid or CHIP. To achieve this, we need to find new ways to reach children and families with these programs — outside as well as through the welfare system.

This guidebook has three major purposes:

- ▶ First, *it* ~~to~~ ⁵ assist state policy-makers and others in understanding what the Medicaid statute and regulations require of states in terms of Medicaid eligibility, enrollment, redetermination, notice and appeal rights, and other program and policy areas. It includes information on the ways in which states can work within the statute to strengthen their outreach efforts, simplify their application process, and broaden Medicaid coverage to low-income families with children independent of TANF.

() States may cover higher income families at their option. Also, as a result of the "100-hour rule" regulation published in August 1997, states can expand to two-parent, working families through 1931.*

- ▶ Second, it discusses the Medicaid requirements and ^{options under} ~~opportunities~~ for three common scenarios: 1) when families seek TANF-funded assistance; 2) when families leave TANF-funded assistance; and 3) when families have no contact with the TANF program.
- ▶ Third, ^{it} ~~the guidebook~~ points the reader to the various sources of funding that are available to states to pay for outreach, training, and other activities to increase health insurance coverage for low-income families with children.

This guide is organized into four sections: ~~Families Who Seek TANF Assistance, Families Who Leave TANF Assistance, Families Who Neither Receive Nor Seek TANF Assistance, and Outreach Funding Opportunities.~~ In each section, ~~we provide both short-term and long-term strategies for states, consumers, and advocates.~~ ^{that} ~~we~~ ^{key} ~~provide~~ ~~both short-term and long-term~~ ~~strategies for states, consumers, and advocates.~~

Reaching Families Who Seek TANF Assistance. This section addresses the specific needs of families seeking TANF assistance. It outlines the Medicaid and CHIP requirements that states must meet when receiving and processing applications from these families, and identifies practices and techniques that states may wish to consider in designing their TANF programs, application processes, and enrollment methods to ensure maximum enrollment of families.

Reaching Families Who Leave TANF Assistance. This section focuses on the needs of families that leave the TANF system. It outlines applicable Medicaid legal requirements and options, and strategies and techniques that states may wish to consider in designing their Medicaid programs and the administration of their TANF programs to ensure maximum continued eligibility for Medicaid and CHIP.

Reaching Families Outside the TANF System. This section focuses on the ways in which states can help low-income families who are not seeking TANF assistance to obtain health insurance either through Medicaid or CHIP. States can design, finance and market health coverage to these families as an independent support. This section also emphasizes the need to reach out to low-income families and inform them of the health coverage opportunities available to them and their children under Medicaid and CHIP.

Outreach Funding Opportunities. The final section identifies pools of funds that are available to states to pay for outreach, training, and other activities to help identify low-income families with children who are eligible for health benefits.

(States that have questions about this Guide, or need further technical assistance should contact their DHHS Regional Director, or the HCFA or ACF Regional Administrator for their state.)

SECTION I

Reaching Families Who Seek TANF Assistance

Families seeking cash assistance under the Temporary Assistance for Needy Families (TANF) program typically first complete an application. All states currently report that they use joint applications for TANF and Medicaid. Therefore, the degree of coordination between TANF and Medicaid has a critical impact on whether or not eligible low-income families obtain Medicaid coverage. *agencies [application processing?]*

Not every person seeking TANF assistance actually completes the application process. In some states, for example, completion of an application is delayed until a parent conducts a job search. In other cases, the individual may decide not to apply for TANF after all because she secured employment or for other reasons. Many of these individuals and families do not realize that, regardless of their eligibility for or receipt of TANF-funded assistance, they, or at least their children, may be eligible for Medicaid or CHIP. In such cases, TANF offices can be instrumental in ensuring that eligible families get enrolled in Medicaid or CHIP.

This section outlines the statutory and regulatory requirements under TANF and Medicaid that states must follow in establishing coverage of low-income families, as well as the application and enrollment processes to be used. To help state officials and others considering implementation issues, this section also identifies short-term administrative steps and longer-term programmatic strategies designed to promote the maximum enrollment of families.

A. State Eligibility Requirements and Options under Federal Medicaid Law

Mandatory Eligibility Requirements

Section 1931 of Title XIX of the Social Security Act establishes rules for Medicaid eligibility for low-income families based on the income and resources of the family. All ~~states~~ ^{have} ~~must~~ ^{amended} *[?]* their Medicaid ~~state~~ plans to include the Section 1931 group. [#] Under Section 1931, ~~states~~ must provide Medicaid coverage to families with a dependent child living with them whose income and resources would have qualified them for AFDC benefits under the ~~state~~ plan in effect on July 16, 1996. Therefore, Medicaid eligibility is no longer tied to or based on eligibility for TANF-financed assistance. ~~Not can states limit Medicaid eligibility to families receiving~~ *Similarly, cannot* *[make 1st sentence of this paragraph]*

Section 1902(a)(17) of the Social Security Act requires states to establish eligibility standards for a given Medicaid group that are the same for all members of that group. In other words, in

establishing its Medicaid eligibility rules (except with respect to earned income disregards, as under the AFDC program), a State may not differentiate between TANF and non-TANF families. For example, if a state disregards assets under Section 1931 for families receiving TANF assistance, the State must also apply the same policy to families not receiving such assistance.

Optional Eligibility Standards

Section 1931 of the Social Security Act also gives States flexibility to modify their July 16, 1996, AFDC State plan requirements by amending their State plans in the following ways:

Liberalized financial methodologies. States can use more liberal income and/or resource methodologies to determine Medicaid eligibility than those in effect under the July 16, 1996 AFDC State plan. For example, a state could choose not to count such assets as cars, homes, or businesses in determining whether a family met its resource standard. Similarly, a State could choose not to count amounts of earned income in calculating income for purposes of meeting the state's income standard.

Liberalize dependency requirements (repeal of "100-hour" rule). Under regulations published August 7, 1998, DHHS gave States increased flexibility to define the dependency requirements for Medicaid eligibility. Prior regulations prohibited States from providing Medicaid eligibility to two-parent families if the principal wage-earner worked more than 100 hours per month. The new regulation removes the 100-hour limitation and instead allows States to set a reasonable standard based on hours of work and/or dollar amounts that may take into account family size and/or time elements. For example, ^{This allows a State to treat} ~~a State does not have to differentiate between~~ one-parent and two-parent low-income families ^{when} ~~in providing Medicaid even if such a distinction existed in~~ its 1996 AFDC and Medicaid plans. ^{the same} Also, States can provide Medicaid coverage for two-parent families where the principal wage earned worked more than 100 hours per month even if its 1996 AFDC and Medicaid plans barred such families. [Isn't this saying the same thing?]

Liberalize income and resource eligibility standards. States can raise their income and resource standards by as much as the rise in the Consumer Price Index since July 1, 1996. Section 1931 also allows States to use income and resource eligibility standards that are lower than the July 16, 1996, AFDC standard but no lower than those in place in May 1988. For example, a State may pass legislation indexing its income and asset standards for Section 1931 families without seeking a waiver and without regard to its TANF policies.

Continuation of Certain AFDC Waivers. Finally, states are allowed to continue to operate waiver programs that were in effect prior to July 16, 1996, that relate to income and resource methodologies, dependency, and the requirement that a child live with a specified relative. Section 1931 provides that these waivers ^{AFDC} may be continued for Medicaid purposes even after the ~~AFDC~~ date the waiver expires. However, waiver provisions establishing time limits and sanctions, and, in most cases, any AFDC provisions that were more restrictive than those in place for Medicaid, cannot be continued for Medicaid purposes beyond their expiration.

B. Application and Enrollment Requirements

◆ Opportunity to Apply

Medicaid regulations (42 CFR 435.906) require states to provide the opportunity for families to apply for Medicaid without delay. Thus, states using joint TANF-Medicaid applications in their TANF sites must furnish a Medicaid application immediately upon request and may not impose a waiting period before providing the application for Medicaid or processing it. These Medicaid requirements also apply to CHIP programs that are Medicaid expansions. States are encouraged to apply them in the same manner for non-Medicaid CHIP programs, as well.
to provide applications

**[didn't you say earlier that all states have joint applications?]*
In states that use joint TANF-Medicaid applications or utilize the state TANF agency to make the Medicaid eligibility determinations, the TANF office is considered a Medicaid office. Therefore, these ~~states~~ *offices* must immediately furnish the application (or a separate Medicaid application) upon request. In states where TANF application or eligibility is delayed (i.e., families receive diversionary assistance, are required to conduct an up-front job search, or face any other initial administrative steps), the state must make a separate Medicaid application available immediately upon request or process the joint application immediately to determine Medicaid eligibility. The evaluation of the Medicaid application and the Medicaid eligibility determination must be made by ~~State~~ personnel who are authorized to perform these functions.

◆ One-Stop Shopping Application Sites

Several states have taken advantage of new administrative flexibility to allow low-income families to apply for and obtain TANF, Medicaid, CHIP, and other benefits in one place. For example:

South Dakota. In South Dakota, TANF and Medicaid are directly administered and supervised by the same operating division and staff are located in the same place. The state uses a joint application form for TANF and Medicaid, with the same case management staff administering both. However, computer systems involved in eligibility determination for TANF financial assistance and Medicaid assistance are completely separated. This assures that when a TANF financial assistance case is closed, Medicaid benefits continue to be provided.

Connecticut. In Connecticut, state TANF staff determine eligibility for TANF, Medicaid, and Food Stamps. The state provides automatic transitional Medicaid for 24 months for individuals leaving TANF. The state's CHIP program (Healthcare for Uninsured Kids and Youth or HUSKY) is also linked to the Medicaid program, health services for children in higher-income families, and a supplemental program for children with intensive physical and behavioral health needs. The HUSKY Plan provides continuous eligibility, which allows children to remain eligible for up to a year after their eligibility is determined, regardless of whether they actually remain eligible during that period. The HUSKY Plan is free or low-cost, depending on the

family's size and income. For example: a family of four with income under \$30,433 is eligible for free coverage; a family of four with income between \$30,433 and \$38,657 does not pay premiums but makes some co-payments; and a family of four with income between \$38,658 and \$49,350 pays a monthly premium of between \$30 and \$50 (depending on the number of children) and some co-payments. In addition, a family with higher income can get a group rate for children's health insurance through HUSKY.

Connecticut is presently undertaking a collaborative marketing and outreach effort to get children enrolled in HUSKY. As part of this, plans are being developed to distribute information through the media; Federal agencies such as IRS, Social Security Administration and HUD; and through day care centers and schools. Also, community-based outreach grants are available to non-profit providers.

? Connecticut is a NE state; I don't think this adds much / suggest deleting
New England States. The New England States have adopted the option under Section 1931 of the Social Security Act to use less restrictive criteria than were in effect for the AFDC program on July 16, 1996, for determining eligibility for medical assistance, and have made them identical to their TANF criteria. Consequently, eligibility determinations for Medicaid and CHIP are made automatically for TANF families. Also, families leaving TANF are automatically enrolled by the TANF agency in transitional Medicaid. The Medicaid agency follows up to redetermine eligibility.

Time Frames for Medicaid Eligibility Determination. Federal regulations (42 CFR 435.911) require that Medicaid eligibility for most families and children must be determined within 45 days from the date of application. A few limited exceptions are allowed, such as an administrative or other emergency beyond the state's control. States may grant eligibility retroactive to the date of application, or the first day of the month of application. Eligibility must be granted three months retroactive to the month of application if the applicant received services during that period and would have been eligible if an application was made.

◆ **Medicaid Denial Notice and Appeal Rights**

Federal regulations (42 CFR, Part 431, Subpart E and 42 CFR 435.912) require that applicants who are denied Medicaid eligibility or individuals who are terminated from Medicaid receive timely notices informing them of the denial, the reasons for the denial, and the appeal rights. Medicaid coverage continues during the appeal. States are encouraged to include in their denial notices language informing the family that they remain or may be eligible for Medicaid.

Short-Term Administrative Strategies and Considerations

Effective implementation of the new Medicaid rules requires procedures that assure that eligibility for Medicaid is considered when TANF-funded assistance is provided, denied, delayed or terminated. State procedures should assure that caseworkers are proactive in offering families the opportunity to apply. It should not be left to the family to take the initiative to ask about
expected that will

^{and CHIP}
Medicaid. Families who come to TANF offices should be asked about their health coverage needs and informed of the process for applying for Medicaid and CHIP. Following are suggestions for how to assure such an outcome:

◆ **Assuring that Families ^{Receive} ~~are Evaluated for~~ Medicaid ^{and CHIP} at the ~~Application Stage~~**

Families who inquire about or apply for TANF should also receive information about Medicaid and CHIP, including how to apply for these programs and how to receive assistance. TANF agency personnel should be trained to inform those who inquire about Medicaid and CHIP. Making available both joint Medicaid/TANF applications and Medicaid-only applications is an important step toward assuring that families get connected with Medicaid or CHIP no matter what decision they ultimately make about seeking TANF assistance.

◆ **^{Facilitating Enrollment in} Making Medicaid and CHIP Applications Available**

^(is this a "suggestion"? required, and said already / delete)
States Using Joint Applications. TANF offices are a logical site for low-income families to apply for Medicaid and CHIP. In states that use a joint TANF/Medicaid application, or where the TANF agency makes the eligibility determination for Medicaid, the opportunity to apply for Medicaid must be provided without delay whether the family applies for TANF or receives diversionary payments, or any other assistance. The TANF office must provide a joint application or a separate Medicaid application immediately upon request. The family cannot be told to come back another time or be sent elsewhere to obtain the application.

^{Again, are there any states? see p. 3, first sentence}
States Using Separate Applications. In states where joint applications are not used, the state should ensure that Medicaid applications are available at all TANF sites. For states with non-Medicaid CHIP programs, the state should also ensure that CHIP applications are available at TANF sites.

Placing Medicaid/CHIP Workers in TANF Offices. States ~~also~~ are encouraged to place Medicaid and CHIP eligibility workers at TANF offices to take applications and assist in their preparation. This practice is especially important at sites where low-income people are, by state or local policy, ~~often~~ directed to job searches, receive diversion payments, or otherwise receive assistance that may not result in them filling out an application for TANF-funded assistance.

^{? This is a good strategy, but does it belong in a section on people applying for TANF?}
Placing Medicaid/CHIP Workers in Communities. The opportunity to apply for Medicaid or CHIP can be enhanced by placing personnel in locations where they are likely to interact with low-income families who are eligible for those programs (e.g., hospitals, community and migrant health centers, community action agencies, schools, community colleges, Head Start programs, and one-stop career centers).

^{and/or pregnant women}
Using Presumptive Eligibility. States can further enhance people's ability to receive Medicaid benefits by adopting the option to establish presumptive Medicaid eligibility for children. Under this option, children can get Medicaid benefits for a temporary period while they apply for

^{or pregnant women}

regular Medicaid and receive a full Medicaid eligibility determination. Families must file a complete Medicaid application before the end of the following month. *States may also use this option in CHIP.*

◆ ~~Adhering to Medicaid Eligibility Determination Requirements~~ *[no new heading, use heading on previous page about "Facilitating Enrollment"]*

It is very important that an application for Medicaid be processed quickly and not be delayed by any TANF requirement. For example, when a family applies for Medicaid and TANF through a joint application but does not qualify for TANF assistance because of a TANF requirement that does not relate to Medicaid (e.g., the living arrangements for teens), the state must proceed to make a timely determination of Medicaid eligibility based on the joint application. Similarly, when a family is no longer eligible for TANF because the parent finds a job, Medicaid eligibility must still be evaluated. Even though the family may be over the income limits for TANF, some or all of the family members may still be eligible for Medicaid. *or CHIP*

◆ **Training Staff**

States can send a strong and clear message to their employees about the importance of Medicaid and CHIP eligibility through special staff training, supervisor reviews, and other mechanisms. Such efforts should call attention to differences between the TANF rules and Medicaid and CHIP program requirements and to the procedures needed to ensure that Medicaid and CHIP eligibility is considered. States should also consider offering similar training to hospitals, clinics, health providers, child care centers, Head Start, WIC, community-based organizations, and other agencies that come into contact with low-income families and children.

◆ **Informing Families** *Early in the Application Process*

Informing families early on in the ^{TANF} application process and regularly thereafter about how the Medicaid and TANF rules differ and reminding them that Medicaid eligibility is not tied to TANF receipt can help encourage families to submit Medicaid applications. For individuals facing language barriers, states should consider developing culturally-appropriate materials in languages other than English.

◆ **Simplifying Application Forms**

States have considerable flexibility under Medicaid and CHIP to simplify the enrollment and application process. HCFA has provided states with suggestions on how to simplify Medicaid and CHIP application and enrollment processes. A copy of that letter, dated September 10, 1998, can be found on the HCFA website (www.hcfa.gov).

Many states have simplified their application and enrollment processes for children under Medicaid and CHIP by shortening application forms, allowing the use of mail-in application forms, reducing or eliminating verification and documentation requirements that go beyond Federal requirements, and speeding up processing of applications. States also should consider

allowing low-income families who are not applying for TANF to apply for Medicaid using a simplified application form like the ones generally in use now for children.* This would provide an easy entry point to Medicaid and CHIP for low-income working families who are not seeking TANF assistance.

Eligibility reviews can also be simplified. To avoid time-consuming face-to-face meetings and help working parents avoid missing work, states can be kept informed of changes in family circumstances by telephone or mail. States can respond to requests for eligibility reviews, through simplifying the review process in much the same way that states have simplified their Medicaid applications for children. Redetermination forms can be shortened, most of the necessary information can be filled in by the state based on the information on hand, and the family can be asked to send in the signed form with any changes noted.

◆ ~~Information~~ *Activities*
Including TANF in Outreach Strategy
OU

The key to any effort to identify and enroll eligible children and families is outreach strategy. Success in identifying and enrolling Medicaid and CHIP eligible children and families must involve TANF offices and personnel. Efforts to promote health care coverage should also complement and enhance state welfare reform efforts. The historic linkage between cash assistance and Medicaid was often seen as an inequitable and counterproductive feature of the old system. When families learn that they can receive Medicaid coverage without having to receive welfare, they may be less likely to turn to welfare in the first place or to return to the welfare system in the event that they have significant health care needs. The “de-linkage” provides a special opportunity for states to promote their Medicaid and CHIP programs as an independent support for low-income working families.

States have adopted several useful approaches to help them locate children and facilitate their enrollment in Medicaid and CHIP. They include:

- ▶ implementing an 800 hotline number for enrollment information;
- ▶ placing billboards and posters in locations frequented by low-income families; and
- ▶ producing public service advertisements for radio and television;
- ▶ distributing information through other public and private programs designed for low-income families (e.g., child care, Head Start, food pantries, one-stop centers, and community-based organizations);
- ▶ outstationing eligibility workers in places frequented by low-income families such as TANF, WIC, hospitals, and one-stop centers); and,
- ▶ working with local community-based organizations to develop creative outreach programs.

◆ *allow asking families enrolling their children in the school lunch program if they are interested in health coverage information*
Reaching out to Families

It is important that families understand that Medicaid eligibility is no longer tied to welfare

eligibility. There is strong evidence that one reason low-income families may not sign up for Medicaid is that they are under the mistaken impression that Medicaid eligibility depends on welfare eligibility. Therefore, states should make clear in all of their informational materials about TANF that coverage under Medicaid and CHIP programs does not require welfare eligibility and that no matter whether or not they apply for or receive TANF assistance, they are encouraged to apply for Medicaid or CHIP for themselves or their children.

LONGER TERM PROGRAM OPTIONS AND STRATEGIES

In addition to the steps described above, states can take several steps to expand Medicaid and CHIP coverage of low-income children. They include:

◆ Amending the State Plan

Most states have amended their state Medicaid Plans to add the new Section 1931 eligibility group for low-income families that replaces the former AFDC recipient eligibility group. Any states that have not yet done so should submit a state Medicaid plan amendment as soon as possible.

◆ Coordinating TANF and Medicaid Section 1931 Eligibility Requirements

The alignment of TANF and Medicaid eligibility requirements for low-income families can greatly facilitate families' participation in Medicaid. Medicaid and TANF requirements can be aligned by taking advantage of the flexibility in Medicaid to define financial methodologies, to liberalize the dependency requirements for two-parent families, and to continue former AFDC waivers. By using this flexibility, states can provide automatic Medicaid eligibility for TANF recipients as they did for AFDC recipients under the pre-welfare reform statute.

States have begun to take advantage of the flexibility to harmonize TANF and Medicaid eligibility in several ways. Many states have exercised the flexibility to define Medicaid financial methodologies to align their Medicaid eligibility rules under the Section 1931 group with new TANF income and resources rules to allow families that benefit from expanded TANF disregards and more generous TANF resource rules to also qualify for Medicaid. The more generous rules must also be applied under the Section 1931 group to low-income families that do not receive TANF benefits.

For example, several states have adopted earnings disregards in their TANF programs that are more generous than the old AFDC earnings disregards. In order to ensure that TANF recipients also qualify for Medicaid, many of the states that have adopted expanded earnings disregards or other less restrictive rules for determining financial eligibility in TANF have adopted those same disregards and rules in Medicaid under the Section 1931 eligibility group.

States can also adopt different earned income disregards under the Section 1931 eligibility

group for Medicaid beneficiaries as compared to Medicaid applicants because the July 1996 AFDC rules also treated applicants different than beneficiaries with respect to earned income disregards.

◆ **Eliminating or Easing the Medicaid Resource Test**

Most states have dropped the Medicaid resource test for children and now, under Section 1931, states have the ability to drop or liberalize the resource test for parents as well. This not only makes it easier to establish Medicaid eligibility, it provides another way to make Medicaid rules more compatible with welfare reform initiatives. States that have not dropped their resource requirements under Section 1931 have made their resource rules less restrictive, for example, by exempting the value of a car. States can then align their asset rules in Medicaid with the asset rules under their TANF programs.

SECTION II

Reaching Families Who Leave TANF Assistance

This section focuses on the statutory and regulatory requirements states must comply with in providing Medicaid to adults and children in families leaving the welfare rolls. This section also identifies administrative practices that would increase the likelihood that adults and children who leave welfare will continue to receive Medicaid/CHIP.

STATUTORY AND REGULATORY REQUIREMENTS AND OPTIONS

◆ Continuing Medicaid Coverage For Families

Under Section 1925 of the Social Security Act, states must provide extended Medicaid benefits (“transitional Medicaid”) to families who, because of hours or income from employment (or loss of the earned income disregard), lose their eligibility for Medicaid under the Section 1931 group. It is important to note that it is the loss of coverage under Section 1931 — not the loss of TANF assistance — that is the trigger for transitional Medicaid under current law. States are required to provide an initial six-month period of transitional Medicaid and have the option to offer an additional six-month period of coverage. (Some states provide a longer period of transitional Medicaid under Section 1115 waivers.) In order to receive this benefit, a family must have received Medicaid under Section 1931 in three out of the preceding six months before losing Medicaid coverage. If states utilize a three-month retroactive eligibility process, States could provide transitional Medicaid to families who seek assistance at the same time they begin working and earning income.[HCFA, please review]

No income limit applies to families receiving the initial six-month period of transitional Medicaid. The optional second six-month period is, however, limited to families whose income (less necessary child care expenses) does not exceed 185% of the Federal poverty level for the size of the family.

◆ Exhausting All Avenues of Eligibility Before Denial or Termination

[Under Section XXX of the Social Security Act,] States may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF or loses eligibility under any single Medicaid eligibility category. States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted. Some or all members of a family that fails to meet TANF eligibility criteria may nonetheless be eligible for Medicaid. Families that lose Medicaid eligibility under Section 1931 because of earnings or hours of employment (and are not eligible under any other group) may be eligible for transitional Medicaid.

◆ Termination for Failure to Meet TANF Work Requirements

States may terminate Medicaid coverage for a TANF recipient (excluding all pregnant women and children who are not the head of a household) who refuses to cooperate with TANF work requirements. But a state cannot terminate Medicaid benefits for other family members who did not lose them because of such a refusal. [Monahan raises the following question: I thought the Medicaid sanction was adult-only even if the kids were in the TANF assistance unit.]

◆ Medicaid Payment of Premiums and Cost Sharing for Employer-Based Health Coverage

Under Section 1906 of the Social Security Act, states have the option to pay a low-income worker's share of the premium for employer-sponsored health insurance along with any cost-sharing, if such action would be cost-effective relative to providing Medicaid for that person. In other words, the cost of those premiums and cost-sharing must not exceed the cost to the state to provide Medicaid benefits. The family or individual must be otherwise eligible for Medicaid and must agree to enroll in the employer-based health insurance as a condition of Medicaid eligibility.

SHORT TERM ADMINISTRATIVE STRATEGIES AND CONSIDERATIONS

States may also want to consider the following short-term administrative strategies to maximize enrollment in Medicaid and CHIP:

◆ Assuring That Families That Lose TANF-Funded Assistance Are Considered for Transitional Medicaid

States must assure that families that lose TANF-funded assistance are considered for transitional Medicaid if they are no longer eligible for regular Medicaid. To be eligible for transitional Medicaid, a person or family must have been receiving Medicaid for at least three of the previous six months before losing coverage under Section 1931. By utilizing a three-month retroactive eligibility process, States could provide transitional Medicaid to those families who seek assistance at the same time they begin working and earning income. [HCFA, please review]

this is a requirement that has already been described - i'd delete

◆ Encouraging Medicaid Application When the TANF Application Process Halts

States should assure that the Medicaid application process is completed when the family does not qualify for TANF-funded assistance or abandons the application process. It is important to inform families early on in the application process about the different eligibility rules for TANF and Medicaid. Otherwise, families may not understand that even though they don't qualify for TANF, their Medicaid application can and should be processed and could well be

This is the Section on Families Leaving TANF?

i'd delete

approved.

In a typical example, a person who applies for TANF might be required to meet an up-front job search requirement before becoming eligible for cash assistance. That person's TANF application might be suspended, but he or she should proceed with the application for Medicaid. As another illustration, a parent might not carry through with a Medicaid application if he or she finds a job, thinking that the family is no longer eligible for coverage. Rather than just accepting a withdrawal of a TANF-Medicaid application, a state should send the family a letter pointing out that the family or some of its members might still be eligible for Medicaid coverage, laying out the steps the family needs to take to complete the Medicaid aspects of the application and urging them to consider applying.

◆ Preventing Inappropriate Medicaid Denials or Terminations

States also need to assure that Medicaid is not ^[Repeating requirement] inappropriately denied or terminated when TANF assistance ends due to employment, time limits, sanctions, or for any other reason. States need to assure that all avenues of Medicaid eligibility are explored before denying an application or terminating Medicaid. Therefore, Medicaid cannot be denied automatically because TANF is denied or terminated or a TANF sanction imposed (with the exception of terminating Medicaid for failure to comply with work requirements if the state has chosen that option).

Even when a TANF case is closed, the family may continue to qualify for Medicaid or qualify for transitional Medicaid. Children and pregnant women in these families may continue to qualify under other Medicaid eligibility groups or (with respect to children) under CHIP. The key to ensuring that Medicaid-eligible families continue to receive Medicaid after their TANF benefits have been terminated is the set of procedures used by the state to prevent inappropriate Medicaid terminations. In no event should closure of a TANF case automatically call for closure of a Medicaid case.

One way states can help families understand that their Medicaid benefits are not affected by the action taken in their TANF case is to make sure that the TANF case-closing notices state this very clearly. In many situations, the state will have all the information it needs to determine whether Medicaid eligibility for a family should continue. In some situations, families will need to be informed that they must provide additional information to allow the state to evaluate ongoing Medicaid eligibility.

[Any more examples of how states do this?]

◆ Assuring Proper Notification of Action and Appeal Rights

States should make certain that notices comply with applicable Medicaid, CHIP and TANF ^[? Again, seems more applicable to people applying] requirements, and that individuals are informed of any applicable appeal rights. For example, when a family applies for Medicaid and TANF through a joint application and the family ends up not qualifying for TANF, the denial notice should inform the family that the TANF denial

does not mean the family is ineligible for Medicaid. Likewise, when a family is denied Medicaid, the state should assure that timely notification of the denial is sent, along with an explanation of the reasons for denial and applicable appeal rights.

◆ **Delinking Medicaid and TANF Redeterminations**

To avoid inappropriate Medicaid termination, states can establish different redetermination periods for Medicaid and TANF, and thereby “delink” Medicaid and TANF eligibility reviews. Under the Medicaid statute, States must conduct redeterminations at least every 12 months.[HCFA, please review]

Also, states have the option under Medicaid and CHIP for continuous eligibility (explan)

◆ **Reviewing Closed Cases**

A state review of TANF cases that have been closed and in which Medicaid was not continued may identify families likely to be eligible for Medicaid.

[example of who's done this, details]

LONGER TERM PROGRAM STRATEGIES

Finally, states may wish to pursue some or all of the following longer-term program strategies to maximize enrollment in Medicaid and/or CHIP.

◆ **Expanding Medicaid Coverage for Low-Income Working Families**

States have the flexibility to liberalize financial methodologies and standards, as well as dependency requirements, to expand Medicaid to cover more working families. (See page xxx for...) States taking such a step would provide critical support to families who have made or are making the transition to self-sufficiency. States can extend Medicaid coverage in this way by using the authority under section 1931 to disregard larger amounts income and/or assets in determining eligibility, and by substituting for the “100-hour rule” a more liberal definition of unemployment, enabling more two-parent families to qualify.

While transitional Medicaid provides for a temporary extension of Medicaid coverage for families whose improved financial circumstances push them over Medicaid’s income eligibility criteria, states can use the flexibility in section 1931 to provide Medicaid to these families without any durational limits. When states liberalize eligibility for ~~regular~~ Medicaid by taking this route, families at the higher income levels remain eligible as long as their income does not exceed the Medicaid income threshold and they meet other applicable requirements.

◆ **Paying Private Health Insurance Premiums and Cost-Sharing**

States can help cover low-income working families who are eligible for Medicaid by paying the family’s share of premiums for employer-sponsored health insurance, along with deductibles,

coinsurance, and other cost-sharing. States can exercise this option when they determine it is cost-effective relative to covering the families directly under Medicaid. Use of this option (authorized under Section 1906 of the Medicaid law) gives families an incentive not to drop employer-sponsored insurance, preserving continuity in health coverage for families with access to employer-sponsored insurance, and supporting their employment. The approach also builds on the private insurance system, and may result in savings to the state.

◆ **Using Income and Asset Disregards to Maintain Medicaid Coverage**

Income and asset disregards can be used both to maintain Medicaid coverage and to support welfare initiatives, particularly in states that choose not to expand Medicaid coverage of working families more broadly because of budget or other considerations. For example, more than 20 states have adopted policies in their TANF programs by which eligible families are offered lump-sum “diversion” payments in lieu of recurring cash assistance if it seems that with the diversion payment, the family could get on its feet. To prevent these lump-sum payments from making the family ineligible for Medicaid, states can use Section 1931 to disregard them as either income or resources when they determine eligibility under this section. This limited change in Medicaid rules ensures that such payments do not cause families to lose Medicaid coverage and helps states make their Medicaid policies consistent with and supportive of their TANF initiatives.

Income disregards under the Section 1931 eligibility group can also be used to help ensure access to transitional Medicaid. For example, a state could disregard all earnings below the poverty line for 12 months. A low-income working family would be eligible for Medicaid under the section 1931 eligibility group for 12 months and then could qualify for transitional Medicaid for up to an additional 12 months. Alternatively, a state could disregard income for three months, enabling families to obtain Medicaid eligibility under Section 1931 for the three-month period necessary for the family to qualify for transitional Medicaid.**[HCFA, please review]**

SECTION III

Reaching Families Outside the TANF System

This section deals with ways to ensure coverage for low-income families who do not come in contact with the TANF system. As states succeed in helping families move to self-sufficiency, more families will remain outside the welfare system. Thus, it is critical that new strategies for reaching families outside the TANF system be developed and implemented.

This section emphasizes the importance of information and outreach efforts, and of simplifying the application and enrollment processes as means of identifying and enrolling low-income families and children into Medicaid and CHIP. This section also highlights the historic opportunity to utilize Medicaid and CHIP to offer health insurance to an increased number of uninsured low-income families with children. We encourage states to respond to this opportunity by designing, financing, and marketing health insurance as a support to low-income families, including many working families who never received welfare or who have made the transition from welfare to self-sufficiency.

STATUTORY REQUIREMENTS AND OPTIONS

◆ Flexibility to Expand Coverage Under Section 1931

As explained on page XXX, Section 1931 of the Social Security Act provides states with tremendous flexibility to expand Medicaid to cover more low-income families. Section 1931 authorizes states to use financial standards and methodologies for this eligibility group that are more liberal than the standards and methodologies in effect on July 16, 1996. Section 1931, together with the new flexibility to define dependency requirements (e.g., by substituting another definition of unemployment for the 100-hour rule), permits states to take two significant actions. First, states can equalize their treatment of single- and two-parent families for Medicaid purposes. Second, they can expand coverage of these families as far as state budgets and policy climates permit. States can accomplish these policy changes through amendments to their Medicaid state plan; they do not require Federal waivers.

check - isn't this only done as 115?
States receive enhanced federal matching funds under Title XIX (section 1905 (u)(2)(B)) for children in low-income families under expansions that provide coverage under the section 1931 eligibility group for children who do not have health insurance coverage and would not qualify for Medicaid coverage under the Medicaid State plan in effect on March 31, 1997. However, the enhanced funding reduces the State's CHIP allotment. In order to claim enhanced funding, States must have a means of identifying children who are uninsured and otherwise qualify for

enhanced federal match for the medical assistance they receive.

◆ **Coverage of Children Under CHIP**

Under CHIP, funds are available to states to provide coverage for uninsured children who are not eligible for ~~regular~~ Medicaid. *under the state plan in effect in the Spring of 1997.* Coverage can be provided through a Medicaid expansion, a separate CHIP program, or a combination of both. Under Medicaid expansions, the usual Medicaid eligibility rules apply. Under a separate CHIP program, states have ~~considerable~~ flexibility to establish eligibility requirements.

◆ **Family Coverage Under CHIP**

CHIP also grants states the authority to purchase family coverage that includes coverage of CHIP children if the state can demonstrate to HCFA that the cost to the CHIP program of purchasing the family coverage is less expensive than the cost of obtaining CHIP coverage for the children alone, and that the family coverage will not otherwise substitute for other health insurance coverage for the children. Coverage of children and family coverage under CHIP is implemented through a state plan process administered by HCFA.

◆ **Continuous Eligibility for Children**

Under Section 1902 (e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months even if there is a change in family income, assets, or composition. Under this option, eligibility is granted for a period of up to one year without regard to changes in circumstances. States may also grant continuous eligibility under CHIP. Therefore, ~~states~~ can allow working families to apply once per year for 12 months of health coverage for their children. To achieve this, states need to amend their Medicaid plan.

◆ **Presumptive Eligibility for Children**

States have the option (through a Medicaid ~~State~~ plan amendment) to provide presumptive eligibility to children under Medicaid. ~~Under~~ Section 1920A of the Social Security Act, a “qualified entity” can determine, based on preliminary information, whether the family income of a child is within the state’s income eligibility limits for Medicaid. If it is, the child can be granted temporary eligibility for Medicaid. The family then has until the end of the following month to submit a full Medicaid application for the child. A similar approach may be used under a separate CHIP program. This option provides the opportunity to grant immediate health care coverage without first requiring a full Medicaid eligibility determination.

Under the law, “qualified entities” include: Medicaid providers, entities that determine eligibility for Head Start, WIC, and child care subsidies under the Child Care and Development Block Grant, and other entities designated by the state. While TANF offices are

not specifically mentioned in the statute, a TANF office can be a qualified entity if it determines eligibility for one of the programs listed.

◆ Application Sites and Outstationing

7
Medicaid law and regulations do not specify locations where Medicaid applications must be offered and taken other than to require that states provide an opportunity for children under 19 and pregnant women to apply for Medicaid at locations other than welfare offices. Medicaid permits only authorized state eligibility workers to evaluate the information on the application and supporting documentation and to make eligibility determinations. However, other individuals, including volunteers, provider and contractor employees, and TANF workers may take applications at outstation locations and perform initial processing activities, including interactions with applicants. Again, the evaluation of application information and the eligibility determination itself must be performed by state personnel who are authorized by the state to perform these functions.

? What about TANF offices?

Spill out
States are required to have outstationing arrangements at facilities that are designated as "disproportionate share hospitals" and Federally Qualified Health Centers (FQHCs). HCFA regulations (42. CFR 435.904) permit alternative outstationing arrangements under certain conditions, and allow states to use additional sites where children and pregnant women receive services. States are urged to utilize their authority to outstation workers at sites such as WIC, CSE, CBOs, child care, and Head Start. States are always free to station state Medicaid eligibility workers at any location to take application, provide assistance, and, if authorized, evaluate applications, and make eligibility determinations.

States have even greater flexibility to determine the sites where CHIP applications may be taken and who may conduct initial application processing activities and make the eligibility determination.

SHORTER-TERM ADMINISTRATIVE STRATEGIES AND CONSIDERATIONS

States may want to consider some or all of the following shorter-term administrative strategies and other measures to expand health coverage to low-income families.

◆ Providing Transitional Medicaid to Low-Income Families Who Do Not Receive TANF Assistance

X
Concerns about including (1) cannot selectively give Transitional Medicaid to those not on TANF; (2) it's a requirement, Delete.
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the rules governing transitional Medicaid. Prior to its enactment, the qualifying trigger for transitional Medicaid was receipt of AFDC in three of the six months preceding loss of AFDC. Under the new law, the qualifying trigger is eligibility under the Section 1931 eligibility group for three out of the previous six months. In other words, the trigger for transitional Medicaid now relates to eligibility under Section 1931, not to loss of TANF

receipt. While in practice, many of the families who qualify for transitional Medicaid will be families leaving TANF as a result of their income, some low-income families who don't receive TANF may also be eligible for transitional coverage.

◆ **Educating Low-Income Families About the Availability of Medicaid/CHIP Coverage**

It is important that low-income families understand the coverage that is available under Medicaid and CHIP for families and children, and that coverage is not linked to receipt of TANF-funded assistance. Misunderstanding about the relationship between eligibility for TANF-funded assistance and Medicaid is widespread and the belief that Medicaid eligibility is linked to TANF is quite common. A vigorous educational effort is needed to correct such misunderstanding so that enrollment in Medicaid and CHIP can be maximized.

◆ **Undertaking Outreach Efforts**

It is critical that aggressive outreach be conducted to provide Medicaid and CHIP information to low-income families. As noted on page XXXX, states have used a variety of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and CHIP. Similar strategies should also be used to reach out to low-income families as a whole.

[Add examples]

◆ **Increasing the Number of Application Sites**

In addition to taking steps to ensure that low-income families are aware of the health coverage available under Medicaid and CHIP, it is important to make it easy for low-income families to apply for these programs. One way to do this is to increase the number of application sites through use of the outstationing authority and the placement of state eligibility workers at locations that are frequented by low-income families. Another strategy is to keep application sites open during evening hours and on weekends to make it more convenient for working families to apply.

◆ **Simplifying the Application and Enrollment Process**

The application and enrollment process should not be a barrier to low-income families applying for Medicaid. As noted on page XXXX, states have taken several steps to simplify the application and enrollment process for children under Medicaid and CHIP, including simplifying application forms, reducing documentation requirements, and allowing mail-in applications. (HCFA's guidance on simplifying the Medicaid and CHIP application and enrollment process is provided in a Dear State Letter dated September 10, 1998 which can be found on the HCFA website (www.hcfa.gov).)

LONGER-TERM PROGRAM STRATEGIES

Finally, states should consider the following long-term program strategies to expand health coverage of low-income families and children.

◆ **Assuring Continuous Eligibility for Children**

Many families fall in and out of income eligibility for Medicaid due to job changes or fluctuations in paychecks. One way to minimize the loss of health insurance coverage for children in these families is to grant children under age 19 as much as 12 months of continuous Medicaid coverage without regard to changes in circumstances. This also has the advantage of allowing a parent to apply once and receive a full year's insurance.

◆ **Adopting Presumptive Eligibility for Children**

Another way to facilitate Medicaid coverage for children is to adopt the presumptive eligibility option for children under Medicaid. This option offers the advantage of providing immediate temporary Medicaid coverage while the full application for Medicaid is being evaluated. Presumptive eligibility also provides the advantage of providing additional "entry points" into the Medicaid system because health care providers and others can perform the determination on the spot when eligible children go to receive health care services and other forms of assistance.

◆ **Expanding Family Coverage Under Medicaid**

States can help more low-income families to obtain Medicaid coverage by easing their financial requirements for the Section 1931 eligibility group and liberalizing the dependency requirements by eliminating the 100-hour rule. States can implement these expansions through a state plan amendment without a waiver. States are urged to consider how they may use Section 1931 to cover as many uninsured low-income working families as possible. For example, two states have already taken advantage of the option to expand Medicaid eligibility for low-income working families to 185 percent and 200 percent of the Federal poverty level. These states used the flexibility for states to define financial methodologies under Section 1931 to adopt expanded income disregards to, in effect, raise their income eligibility thresholds for Medicaid. In addition, both states have dropped the resource test for families covered under Section 1931.

Recognizing that Section 1931 coverage expansions will require additional state expenditures for their share of the Medicaid match, it should also be noted that states have the flexibility under Medicaid to expand coverage to low-income working families can be as extensive or as limited as state resources permit and other considerations allow. Examples of state policies that provide incremental Medicaid expansions under Section 1931 include:

◆ **Levels of Income and Resource Disregards**

Through the use of income and resource disregards, states can cover families up to 100 percent of the poverty level, 125 percent, 150 percent, or even higher. This flexibility affords states the opportunity to maximize the use of their resources and to support welfare reform objectives by providing more working families with health security.

? how this impact it on previous page?

◆ **Phased-In Expansion of Family Coverage Under Medicaid**

Another option available to States is to phase in expansion. States can evaluate the results of an expansion and determine how well it is succeeding not only in meeting welfare reform objectives, but in reducing the number of uninsured families and children in the state, and then consider broadening the expansion further.

put under Expansion of Family Coverage

◆ **Expanding Coverage of Children Under CHIP**

Nearly all States have approved CHIP plans and are implementing their programs. States should consider further expansions of coverage for uninsured children; such expansions promote both health care coverage and welfare reform goals by improving health security and providing needed support to low-income working families.

◆ **Expanding Coverage to Two-Parent Families**

States can replace the 100-hour rule and [?] dependency requirements that were vestiges of the AFDC program. As a result, they can provide two-parent families with Medicaid coverage on the same terms afforded single-parent families.

put under Expanding Family Coverage

More integrated health + social

service systems. States should

aim to connect the programs that serve low-income families to ensure that they run to ensure that

the education and application processes

families to ensure that families receiving services learn about and apply for Medicaid & CHIP.

SECTION IV

FUNDING OPPORTUNITIES FOR OUTREACH

This section sets out the funding sources available under Medicaid, CHIP, and TANF for outreach activities. States have several options for claiming Federal matching funds for their spending on efforts to find and enroll families and children in Medicaid and CHIP. The Medicaid and CHIP funds for outreach were described in detail in a January 23, 1998, letter to State health officials (available at www.hcfa.gov) highlighting new and existing opportunities for outreach to uninsured children. In addition, there are options to receive Federal funds for outreach spending are available under TANF. These options are described below.

◆ Medicaid Funds

Medicaid law does not limit the amount of money a state can spend on outreach efforts to enroll people in Medicaid. The Federal government will match such spending dollar for dollar. In addition, a special \$500 million Medicaid fund was created under the welfare reform law to help states with the additional administrative costs of eligibility determinations resulting from the delinking of cash assistance and Medicaid and the establishment of Section 1931. States have three years from the time their TANF program went into effect to draw down these funds, which are available at either a 75 percent or a 90 percent federal matching rate, depending on the activity. (For more details, see 62 CFR 26545, May 14, 1997). [HCFA, please review citation]

Each state has an allocation from the \$500 million fund from which it can claim matching funds at the enhanced rate of 90 percent for certain activities. These activities include communicating to beneficiaries and outstationing eligibility workers. States also may claim enhanced federal matching from their allocation for efforts related to eligibility determinations for individuals covered under Section 1931, even if such activities result in enrolling individuals whose Medicaid eligibility is not related to Section 1931. A chart including each state's allocation of the \$500 million fund and the amount expended as of XXXX is included in the Appendix. [WHAT APPENDIX?]

we should think about whether this chart helps / hurts. Also, mention PB proposal?

◆ CHIP Funds

State spending on CHIP-related outreach activities is matched from the state's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and State) on non-benefit activities, including outreach. These expenditures are matched at the enhanced CHIP matching rate.

Outreach activities related to a CHIP Medicaid expansion can be matched either from

the state's CHIP allotment or under regular Medicaid, at state option. If a state elects to claim Federal matching for its outreach expenditures from the CHIP allotment, the Federal payments count against 10 percent limit and the CHIP allotment. If the state exceeds either limit, it may then claim matching at the regular Medicaid matching rate under the Medicaid program.

(Add PB proposal?)

◆ TANF Funds

States can also use their TANF or maintenance-of-effort (MOE) funds for outreach and training activities for Medicaid and CHIP. While Section 408 (a)(6) of the Social Security Act prohibits the use of Federal funds to provide medical services, except for pre-pregnancy family planning services. TANF funds can be used for non-medical services, such as outreach to ensure medical coverage. Certain substance abuse services, and mental health and domestic violence screening and counseling services **[are these included here because they are opportunities for outreach??]** can also be covered as non-medical services. In effect, since the statute does not define medical services, a state may use TANF funds to pay for anything that does not fall within its own definition of medical services.

FUNDING OPPORTUNITIES FOR OTHER COORDINATION ACTIVITIES AND PROCEDURES

◆ Medicaid

The \$500 million fund noted above is available to cover not only outreach costs, but also other administrative costs of establishing eligibility under Section 1931. The funds can be used for a wide range of investments, including developing new educational materials for TANF and Medicaid applicants and beneficiaries, staff training, reprogramming computer systems, and revising applications and updating notices.

401
7321

3/9

L.C. & E.W. v. Olmstead

- In L.C. & E.W. v. Olmstead, two patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program.
- The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting, and remanded the case for a determination of whether community placements could be made without fundamentally altering the State's programs.
- The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.
- The State of Georgia is now serving L.C. and E.W. under one of the State's home and community-based services waivers. Nevertheless, the State has appealed the decision of the Eleventh Circuit to the Supreme Court.
- The Federal government is filing an amicus brief in support of the position taken by L.C. and E.W. This brief, which is due to the Supreme Court by Monday, March 8, is being written by the Department of Justice (DOJ) with the Assistance of the Department of Health and Human Services (Office of General Counsel, Office of Civil Rights, Office of the Assistant Secretary for Planning and Evaluation, and the Health Care Financing Administration (CMSO).)
- Comments were last provided to DOJ on March 2; the Department is expecting a final version to comment on at any moment.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

REVISED Department Clearance Final: 2/19/99

*go on
Friday*

Dennis P. Whalen
Executive Deputy Commissioner
State of New York Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Mr. Whalen:

I am responding to your letter to Nancy-Ann Min DeParle regarding implementation of the terms and conditions of New York's section 1115 waiver, The Partnership Plan. Specifically, I am responding to the issue of determinations made by individual physicians that services are not needed for Medicaid beneficiaries of any Medicaid managed care plan, and whether such determinations are subject to the State fair hearings process. You state that you do not believe such a policy is constitutionally or statutorily mandated, or administratively prudent. You also believe that such a policy would promote poor medical care.

Section III.E.3.a. of the Special Terms and Conditions (STCs) state that *"The State must assure that all MCOs have approved internal complaint and appeal procedures in place and that these, along with LDSS and State-level complaint and appeal processes, are in accordance with Federal regulations on grievance procedures at 42 CFR 434.32 and with Federal Regulations on Fair Hearings at 42 CFR 431, Subpart E."* In exercising our discretion under section 1115(a) of the Social Security Act, as a condition of the State's demonstration under the 1115, it is our interpretation of existing terms and conditions that New York must allow a service denial to be eventually subject to the State fair hearing process. This interpretation of the terms and conditions was discussed with New York State DOH and New York City DOH during our conference call on November 25, 1998.

While the decision of the MCO grievance/appeal process is subject to a fair hearing, New York may require the beneficiary to exhaust the internal MCO grievance and appeal process prior to requesting an external State fair hearing. We note that during our site visit for the "1115 New York City Readiness Review," the MCOs' understanding of State policy was that beneficiaries could use the internal MCO grievance process to appeal a denial of service and then proceed to a State fair hearing based on the outcome of the MCO's decision. In addition to using the internal MCO grievance process, a beneficiary may complain to the New York State DOH at any time during the process.

Page 2 - Dennis P. Whalen

We believe this policy is an efficient use of administrative resources and preserves the rights of Medicaid beneficiaries to proceed to a State fair hearing. If you have any additional concerns on this issue, please contact Estelle Chisholm of my staff on 410-786-3286.

Sincerely,

**Sally K. Richardson
Director**

cc: Ellen Anderson



STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

Dennis P. Whalen

Executive Deputy Commissioner

February 16, 1999

Nancy Ann Min DeParle, Director
Health Care Financing Administration
200 Independence Avenue SW, Room 310G
Washington, D.C. 20201

Dear Ms. Min DeParle:

Recent discussions between our two agencies regarding implementation of the terms and conditions of New York's 1115 waiver have stalled on the issue of fair hearing rights for enrollees. It is our understanding that HCFA wants New York State to extend this due process right to any enrollee of any Medicaid managed care plan any time that enrollee complains about any denial of any requested service.

We do not believe that such a policy is constitutionally or statutorily mandated, or administratively prudent. Further, it promotes poor medical care. A diagnosis and initial determination of medical necessity by a plan physician is a private medical decision, not a state action. We agree that Medicaid managed care enrollees should have a means of effectively questioning and challenging these medical decisions and believe that the combination of the state-mandated plan internal complaint process, the state's external review process and the Department of Health's review and mediation of complaints provides that means.

Attempting to resolve all such disputes through the fair hearing process will be costly, time consuming and inappropriate. Such a policy will place judges and lawyers in the position of having to make decisions regarding medical necessity--decisions they lack the training and experience to make.

It is dismaying to receive such an unprecedented and unduly burdensome mandate from HCFA, while, at the same time, HCFA is advancing these same arguments in its brief before the U.S. Court of Appeals for the Ninth Circuit with regard to its Medicare+ Choice managed care programs.

I am sure we all agree that qualified medical professionals should be the ones making medical decisions. I hope you will reconsider HCFA's position on fair hearings and move onward to finalizing implementation of New York State's Partnership Plan.

Very truly yours,



Dennis P. Whalen
Executive Deputy Commissioner

*reg is interim final & publication
req @ clearance form survey instrument*

Talking points: Outcome and Assessment Information Set (OASIS)

Why are we implementing OASIS? How is quality improved under OASIS?

- Home health agencies that serve Medicare patients have always been required by law to conduct a complete assessment of all their patients. OASIS standardizes the assessment process to ensure the quality of care and services provided. We're also using data from OASIS to help design and then operate a prospective payment system (delaying OASIS will prevent the implementation of the home health prospective payment system by October 1, 2000, as the law requires).
- The primary purpose of OASIS data is to assure that home health agencies meet Medicare's Conditions of Participation requiring quality services for patients. Home health agencies submit OASIS data to HCFA and these data are analyzed and used to develop aggregate performance information for each facility. This summary "performance report" will be used by HCFA to compare the HHA's performance to the average state and national performance levels. This is similar to what we are currently doing for managed care organizations which received wide praise from consumers.
- In the future, we may include certain performance standards in the ^{proposed reg} home health Conditions of Participation. If home health agencies do not meet these standards, HCFA would identify the problems and ensure the agency takes corrective actions, or decertify the home health agency from the Medicare program. Similar to HEDIS data, we are working to make sure that OASIS data is accurate so that eventually the aggregate performance information will be available to the public to compare agencies.

like in MC + choice using HEDIS

What are the statutory underpinnings?

- OASIS was first developed in 1993 to implement section 1891(a) of the Social Security Act that requires as part of the home health assessment, a survey of the quality of care and services furnished by home health agencies using a standardized, reproducible assessment instrument. Doctors and clinicians designed OASIS to include key indicators of quality.
- Section 1891(b) also requires that Medicare's Conditions of Participation for home health agencies apply for all patients that they serve, not just Medicare patients. The law is designed to ensure that all patients receive quality care and the Conditions of Participation apply largely to all the patients of a provider.
- The Balanced Budget Act of 1997 (section 4603) requires the Secretary to develop a prospective payment system for home health agencies. HCFA decided to use the OASIS for this purpose as well, to reduce the burden on home health agencies.

How is information transmitted and how is privacy protected at every step?

- Medicare consistently safeguards confidential information, and we demand that states and providers take the same kinds of precautions. The collection and transmission of this information is secure at all times, and access is strictly controlled to prevent any unauthorized use.
- Home health agencies perform an OASIS assessment for each of their clients. The information is entered into their computer, and they must protect that confidential information -- as they protect other confidential information -- in accordance with federal and state privacy requirements. At all times, the data -- whether in hard copy or electronic form -- must be controlled and secure.
- HHAs transmit the data to the states using a private dial-up network based on a direct telephone connection from the HHA. The states compile the data and send it to HCFA, where it is subject to the requirements of the Federal Privacy Act. Access is strictly controlled at HCFA and the information can only be used under the narrow circumstances allowed under the Privacy Act.
- The Privacy Act has been effective in ensuring confidentiality of Medicare data. HCFA has historically used Medicare data only for the limited program purposes for which it was collected and other compatible purposes as specified in our privacy act system notices. If a person or an entity violates the Privacy Act by misusing OASIS data, he or she will face civil or criminal penalties. The civil penalty is \$1,000 for each incident of misuse and the criminal penalty is \$5,000 for each incident of misuse.

collecting it for all ^{patients} ~~beneficiaries~~, not just
Medicare beneficiaries
conditions of participation
quality for every goes

Prepared by HCFA,
Office of Legislation
March 11, 1999

Medicare Patient-Assessment Data for Home Health Agencies
March 11, 1999

Background: The Washington Post ran a story today in which privacy experts question why Medicare is collecting patient-specific data from home health agencies that serve Medicare beneficiaries. In January, the Health Care Financing Administration published a final regulation that changes the conditions of participation for home health agencies that serve Medicare beneficiaries. These conditions require home health agencies to blend their current patient assessment process with a new assessment tool known as OASIS, or the Outcome and Assessment Information Set, to assess the health care needs of all their patients, Medicare and non-Medicare alike. The data will be used to develop quality measures and improve care. It also will be used to develop a prospective payment system, which the Balanced Budget Act required in order for Medicare to pay more appropriately.

Talking points:

- We take privacy concerns very seriously. Medicare consistently safeguards confidential information, and we demand that states and providers take the same kinds of precautions.
- The collection and transmission of this information is secure at all times, and access is strictly controlled to prevent any unauthorized use.
- By law, Medicare's Conditions of Participation for home health agencies -- as well as for hospitals, nursing homes and others -- apply for all patients that they serve. The law is designed to ensure that all patients receive quality care and that different groups aren't subject to a double standard of care.
- Home health agencies that serve Medicare patients have always been required to conduct a complete assessment of all their patients. OASIS standardizes the assessment process to ensure the quality of care and services provided. We're also using OASIS to help design a prospective payment system.
- Nursing homes use a similar assessment tool, called the Minimum Data Set, which has been used (since June) for the prospective payment system now in place for Medicare nursing homes. Again, the Conditions of Participation require nursing homes to collect such information about all patients.
- Generally, Medicare beneficiaries make up between 80 and 90 percent of all patients served by Medicare-participating home health agencies. Home health agencies often have separate agencies that serve non-Medicare patients. And for some non-Medicare clients, such as pregnant women, children, or people receiving only services such as housekeeping, OASIS wouldn't be an appropriate assessment tool at all and may not be necessary or required.

Q: Why does the government need to collect names or other identifiable information?

A: The main reason that we collect this information is to improve the quality of care for all people who receive home health services as part of our broader quality initiative. The information allows us to get definitive answers about quality of care and patient outcomes. We need to be able to analyze patterns in agencies and across agencies to develop performance measures and to promote higher-quality care for all people served.

Q: Why are you asking sensitive information of all patients served by home health agencies?

A: By law, Medicare conditions of participation apply to all individuals served by Medicare-approved agencies. This ensures quality of care for everyone -- Medicare and non-Medicare patients -- being served by any Medicare-approved agencies. The same is true for hospital, nursing homes and other institutional providers.

While OASIS is helping us develop a case-mix adjustment system for the home health prospective payment system, its primary purpose is to help ensure that all patients served by Medicare home health agencies get comprehensive assessments.

Q: Can people opt out and not have the agency send information to the government?

A: OASIS is an assessment tool, not a questionnaire for patients to answer or fill out. The law requires that Medicare-participating home health agencies comply with all the Conditions of Participation for all their patients. For home health agencies, that means performing an OASIS assessment for all appropriate patients.

It is important to note that OASIS may not be an appropriate assessment tool for some patients -- such as pregnant women, children or those receiving only services such as housekeeping -- and therefore may not be necessary or required. And Medicare's conditions of participation do not apply to non-Medicare providers.

Q: How are patients' privacy rights protected when collecting and transmitting OASIS data?

A: We're taking every step to protect patient privacy and confidentiality. We expect all home health agencies to protect the confidentiality of patient-specific information in accordance with Federal and State privacy requirements, and we obviously will do the same.

Home health agencies perform an OASIS assessment for each of their clients. The information is entered into their computer, and they must protect that confidential information -- as they protect other confidential information -- in accordance with federal

and state privacy requirements. At all times, the data -- whether in hard copy or electronic form -- must be controlled and secure.

HHAs transmit the data to the states using a private dial-up network based on a direct telephone connection from the HHA. The states compile the data and send it to HCFA, where it is subject to the requirements of the Federal Privacy Act. Access is strictly controlled at HCFA and the information can only be used under the narrow circumstances allowed under the Privacy Act.

Q: I've heard that OASIS asks questions about patients' religion, number of weapons they may own, and their drinking habits. Is this true?

A: That is not true. OASIS does not include information about patients' religion or the number of weapons they may own. Like any thorough health assessment, OASIS does ask about high-risk factors that may affect patients' health, including whether they are alcohol-dependent, but it does not require specifics such as how often someone drinks.

SH in Capital
NAPH position

April 6, 1998

Nancy Ann Min DeParle
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Copy for
Meg, Anne,
ing CS.
quit

Dear Ms. DeParle:

I am writing on behalf of the National Association of Public Hospitals & Health Systems (NAPH) and the National Association of Children's Hospitals (NACH) to urge you to interpret provisions in the Balanced Budget Act of 1997 (BBA) regarding the Medicaid Disproportionate Share Hospital (DSH) program in a manner that will maximize the program's assistance for our nation's safety net hospitals. In particular, NAPH and NACH request that the requirement that states make DSH payments directly to hospitals for managed care enrollees (Section 4721(d)) be applied broadly with only a limited exception for current payment arrangements. Without such a broad application of the provision, the DSH program will be engulfed by the exception, and hospitals will see their DSH payments whittled away to nothing as managed care continues to proliferate. In addition, we want to ensure that any upcoming guidance you issue also addresses the DSH targeting provision included in the BBA.

NAPH represents approximately 100 metropolitan area safety net hospitals across the country, serving predominantly Medicaid, uninsured and Medicare patients. As such, Medicaid DSH payments comprise 12 percent of the total revenues of these hospitals, which rely on such payments to support 40 percent of their care to underinsured and uninsured patients. NACH represents more than 100 free-standing children's hospitals and children's hospitals organized within large hospitals. They devote nearly half of their care to children who are assisted by Medicaid or who are uninsured; many of them have complex and chronic conditions.

With the proliferation of Medicaid managed care in recent years, many of our hospitals have seen their DSH payments erode as managed care revenues comprise an increasing share of their Medicaid reimbursement. We advocated strongly for the "direct pay" provision leading up to the enactment of the BBA, and we hope to see it implemented in a manner that addresses the concerns that were raised when Congress adopted our proposal.

The Exception for Current Payment Arrangements Applies to Currently Effective Contracts Until They Are Terminated or Renewed.

Last fall each of our associations sent you a letter addressing a variety of DSH implementation issues, including the direct pay provision. (Copies attached.) In our

letters, both NAPH and NACH strongly recommended that the exception for any "payment arrangement in effect on July 1, 1997" should apply only to contracts that were in effect on that date. The term "payment arrangement" is not further defined in the law, but given its common and accepted meaning it refers to arrangements between a payor (in this case, the state) and an entity receiving payments (a managed care organization -- MCO). All such arrangements are embodied in a written contract. Thus, any contract that was in effect on July 1, 1997 is excepted from the direct pay requirement. Once that contract is no longer effective -- either because it is terminated or it expires -- the exception no longer applies. Whether or not that contract is subsequently renewed is irrelevant for purposes of applying the exception; the contract or "payment arrangement" that was in effect on July 1, 1997 is no longer in effect.

Some have argued that the term "payment arrangement" refers to Medicaid waivers. Waivers are arrangements that are in effect between a state and HCFA, not between a payor and payee. It is the state-MCO contract that embodies the payment arrangement that includes the DSH adjustments that Congress now wants to have made directly to hospitals. Moreover, if Congress intended the exception to apply to waivers, it would have simply referred to waivers directly, as it did elsewhere in the statute (Section 4710(c)).

The exception clearly terminates at the end of any contract term, and a simple renewal of a contract is not sufficient to prolong the exception. Any other interpretation of the provision would transform this limited exception into a permanent grandfathering of an allowance to eliminate DSH payments to hospitals for an ever-increasing managed care population. As more and more Medicaid recipients are enrolled into managed care plans, such a reading of the statute would effectively decimate the DSH program in the affected states. Congress was attempting to prevent such a de facto elimination of DSH payments by enacting this provision. An overly broad grandfathering of the exception would thwart that intent.

purposes of such effect on Congress' exception for current payment arrangements may pose some logistical difficulties for HCFA and/or states, particularly when individual MCO contract terms are not simultaneous. If, for example, some but not all contracts in a given waiver program predate the July 1, 1997 cutoff, a state could find itself in a situation where the direct pay requirement applies to some but not all of its MCO payments. This discrepancy, however, is due more to the fact that the state does not have uniform contract terms rather than to the congressional dictate. Indeed, in any case where contract terms do not completely overlap, it is likely that the more recently negotiated or renewed contracts may have different requirements, including different reimbursement provisions, than the older contracts. This logistical difficulty is neither insurmountable nor irreconcilable with the statutory dictate.

In addition, we recommended in our earlier correspondence that HCFA require states to count service and payment shortfalls for Medicaid managed care enrollees in calculating DSH qualifications and payments to eligible hospitals.

HCFA's Upcoming DSH Guidance Should Also Address DSH Targeting.

The BBA also included a requirement that by October 1, 1998 state plans describe their methodology for identifying DSH hospitals and making payments to them. It also requires states to provide an annual report to the Secretary describing their DSH programs. Our previous letters to you discussed in detail the data elements each of our associations recommended that HCFA should require states to provide under this new authority. We hope that whatever guidance you are currently preparing on remaining DSH issues also addresses these data collection issues.

We reiterate our offer to work with you on defining which elements should be collected and on clarifying the legal basis for your authority to require such data. We believe that obtaining such uniform national data is going to be key to any future attempts to reform DSH.

* * *

As usual, we thank you for your assistance and for your concern for our nation's safety net hospitals and the patients they serve. If you have any questions, please contact Lynne Fagnani at 202-414-0101 or Bruce Lesley at 703-684-1355.

Sincerely,

Larry S. Gage *ff*

Larry S. Gage
President

Peters Willson *ff*

Peters Willson
Vice President for Public Policy

Attachments

Y2K AND THE 1999 ROUTINE UPDATES

October 1 Updates

not # impact

On schedule:

- * Hospital PPS, TEFRA, GME and other hospital rule updates
- * Hospice rates and wage index
- * SNF PPS rates
- * Interest rate update for Medicare overpayments and underpayments (quarterly)
- * HHA per visit and per beneficiary limits, including revised interim rates

Cancel:

- * Correct coding initiative (CCI) and COTS coding edits (quarterly)
- * ICD-9-CM annual update
- * Physician fee schedule database corrections (quarterly)
- * DME fee schedule (quarterly)

January 1 Updates

deals oriented
to part B except

ICD-9-CM

no budget

impacts ? until

October

Delay:

- * Coinsurance and deductibles updates
- * Physician Fee Schedule annual update (until February or March)
- * Radiology and other diagnostic tests for OP hospital payment
- * Physician Participation Enrollment (PARDOC) annual update
- * Screening mammography limit update
- * Lab fee schedule update (0% for 2000)
- * Annual DME fee schedule update
- * ASC annual update
- * CCI and COTS coding edits (quarterly)
- * Inherent reasonableness update (national)

Assumptions

- * Schedule assumes that Y2K compliance testing means that there will be no 1999 releases after July 1999.
- * This represents the "best case" scenario, assuming Y2K compliance proceeds on schedule without major setbacks.

no CPT As AMA grow.

could say same we did on hosp side.

20%

- * The "best case" scenario is achievable only if there are no coding changes to payment systems, because those would require systems changes.

- (*) A legislative temporary suspension of the 14 day payment floor would ease cash flow for physicians and other providers subject to delays and give HCFA time to correct any systems failures should they occur in the first few weeks of January.

get cash flow out quicker
get us out of 1/2000 prob.

do actuaries assume that
these delays will occur.

DRAFT

MEDICARE COMPETITIVE PRICING DEMONSTRATION FACT SHEET

Background: The Medicare Prepaid Competitive Pricing Demonstration Project was created by the Balanced Budget Act of 1997 to test a new method of paying Medicare+Choice health care organizations. Currently, the Health Care Financing Administration, which administers Medicare, uses a congressional mandated formula to pay private HMOs a monthly amount for each beneficiary receiving health care. This is known as administered pricing methodology. Under competitive pricing the health plan would submit a bid to tell HCFA how much it costs to provide the care. HCFA would then use the bids to set a Medicare payment level. *voted down FFS*

Competitive Pricing Advisory Committee

attention of demos overwhelms & in premiums viewed as positive;
The Balanced Budget Act established two types of advisory committees, the Competitive Pricing Advisory Committee (CPAC) and the Area Advisory Committee (AAC). As created in the BBA, the CPAC must "make recommendations on a range of demonstration design considerations including benefit design, methods for setting the price to be paid to plans, providing and disseminating information and evaluation methods." The CPAC must also designate up to seven demonstration sites, four of them in the first two years, including one rural site.

CPAC members were appointed on March 12, 1998. The advisory committee met five times, focusing on the experience of competitive pricing in the private sector, quality measures for Medicare+Choice managed care plans, lessons learned from earlier government competitive pricing demonstration projects and attributes of desirable demonstration sites.

Demonstration Design

The CPAC has agreed on a demonstration design for a community project that

- Includes all Medicare+Choice plans, except for medical savings accounts,
- Requires mandatory rather than voluntary plan participation,
- Allows different benefit packages to be offered to employer group retirees,
- Offers a standard benefit package for all other beneficiaries, and
- Provides that plans must offer limited prescription drug coverage (with a \$500 cap).

Plans in the demonstration communities must also adhere to the following features:

- The price must be set at the median bid or enrollment-weighted average,
- High bidders must charge a premium, low bidders can add benefits,
- Standard risk adjustment may be delayed for one year, and
- An incentive pool will be created to reward plans that meet quality improvement goals.

Cf: a \$500-\$600 benefit seems on low end; thought cap was higher; HCFA: this is national floor - but they haven't specified.

budget neutral across demos rather than w/in each site; supplement & bonus \$ poss.

bidding on what HCFA has determined to be floor; committee may add other; design not been finalized.

\$600 or \$800

cap on drug benefit, payments. was standard floor.

Dan: quality; clinical mgmt criteria

Az has CB experience

gm & Ford in KS will be working
w/ them there.

Site Selection

The CPAC selected criteria to use in the selection of potential demonstration sites. These include:

- level of current Medicare payment in the community,
- penetration of managed care in the Medicare and commercial marketplace,
- the market share of health plans in the community,
- number of Medicare beneficiaries in the community,
- the characteristics of health resources such as hospital and physician availability, and
- socioeconomic characteristics of beneficiaries in the area such as the proportion living in poverty, disabled, over age 85 and non-white.

These criteria were applied to all metropolitan statistical areas (MSAs) in the United States and a list of potential sites was produced. In order to facilitate selection on the basis of technical consideration, no MSAs were initially identified by name. The CPAC then considered additional information, including the:

- proximity to other managed care market areas,
- number of recent Medicare managed care non-renewals in the area,
- relative influence of hospital and physician contracting organizations,
- financial status of plans,
- size of employer group retiree enrollment,
- insurance and regulatory issues,
- Medicaid issues, and
- resources of beneficiary counseling organizations in the community.

Using the above criteria, the CPAC identified the following geographic areas as potential demonstration sites on October 28, 1998:

Akron, Ohio
Baton Rouge, Louisiana
Jacksonville, Florida
Orlando, Florida
Sacramento, California

Atlantic City, New Jersey
Cleveland, Ohio
• Kansas City, Missouri
• Phoenix, Arizona

At the subsequent meeting on January 6, the CPAC considered additional detailed and updated information on each potential site and prioritized each site. Kansas City ranked the highest as an emerging market in managed care and Phoenix, the highest, as a mature managed care market.

Area Advisory Committees

The second advisory committee called for in the BBA is an Area Advisory Committee, established in each demonstration community. Similar to the CPAC, members are appointed by the HHS Secretary and are representatives of health plans, providers and Medicare beneficiaries. The members of the AAC will be announced shortly.

AACs are required to operate for the duration of the pilot project in the demonstration area.

The AAC is charged with making recommendations on: (1) the appropriate level of local enhancements to the national minimum benefit package, (2) the method of setting the government's contribution to premiums, (3) whether to delay using health based risk adjustment in year one of the demonstration, and (4) whether health plans should bid on one or more counties in the service area. The AAC cannot alter any CPAC-approved design decision.

HCFA expects the bidding process to take place during the summer of 1999 with plan payments to begin on January 1, 2000.

DRAFT

Roll Out Strategy for Medicare Competitive Pricing Demonstration -- Kansas City and Phoenix

CHPP and the Kansas City and San Francisco Regional Offices have developed the following roll-out strategy for the implementation phase of the Medicare Competitive pricing demonstration. At the January 6 Competitive Pricing Advisory Committee meeting, Kansas City and Phoenix were designated as the two demonstration sites.

1. Final CPAC Report to the Secretary Early February

- o The report is being revised to reflect the January 6 CPAC comments. It will also incorporate a letter from the CPAC to Congress regarding the budget neutrality requirement.
- o Upon completion, it will be formally transmitted by members of the CPAC to the Secretary.

2. Media Contacts Ongoing

The Press Office distributed a fact sheet about the demonstration to some media in both Kansas City and Phoenix on January 7. There have been a few press interviews. One article appeared in the Kansas City Star.

3. Notify/Brief Kansas, Missouri, and Arizona Congressional Delegation/State Officials as well as Key Senate and House Committees January 6-February 1

Delegations and authorizing committee staff were notified immediately after the January 6 decision meeting. The first briefing was held with staff of Kansas City and Phoenix delegations on January 19. The fact sheet, list of CPAC members, and design report have been made available. Telephone contacts are also being made with district office Congressional staff. Letters from the Administrator describing the demo and site selection are being prepared for each member of Congress representing demonstration sites; they may be followed up with telephone calls from the Administrator to key members of Congress.

4. Arrange Courtesy Calls with AAHP, HIAA, BCA, Bipartisan Commission, MedPAC February 1-March 1

All are aware of the initiative. Briefings will provide more detailed information and schedules. Both MedPAC and the Commission have expressed interest in a briefing.

5. Appoint Members of the Area Advisory Committee Mid-February

Section 4012 of the BBA specifies the composition of the AAC: representatives of health plans, providers and Medicare beneficiaries. Compile a list of recommended names and gain approval from the Administrator. Members must be considered Special Government Employees but will receive no pay. Solicit recommendations from congressional delegations, governors, regional offices, and others. In order to meet the January 1 implementation date, the AAC members should be appointed by February 15.

6. Roll Out the AAC in Each Site and Announce the AAC Process Late February

- o Introduce AAC members at town hall meeting
- o Separately meet with all health plans
- o Meet with local editorial board

The CPAC chair and co-chair and several CPAC members should be present along with high level DHHS officials. Invitations should be sent to Congressional and other elected officials. Introduce a local well-known and respected advocate of competitive pricing. Utilize key messages pointing out the advantages of competitive pricing in each community.

7. Schedule and Conduct the First AAC Meeting Early March

- o Federal Register announcement must give 15 day advance notice.
- o CPAC Chairs and Executive Director will open the meeting and present the timeline for specific activities:
 - Benefit Package Design
 - Selection of Cutoff Amount
 - Training and Education on Bidding and Risk Adjustment
 - Bidding on County or Entire Service Area
- o Define any other implementation activities to be specifically addressed by the AAC. The BBA specifies that the AAC is to advise on marketing and pricing of the plan and other salient factors.
- o Establish AAC subcommittees and spokespersons responsible for each activity
- o Establish AAC contacts for collection of all inquiries and requests for information
- o Establish tentative agenda and schedules for all meetings.
- o Create an internet resource for sharing information on AAC activities
- o Report all AAC activities to CPAC members on a periodic basis

8. Schedule and Conduct the Second AAC Meeting **Early April**

Between meetings, subcommittees must discuss and develop recommendations for the AAC.

9. Schedule and Conduct the Third AAC Meeting **Early May**

The third meeting should produce the final recommendations and advice on implementation. A report will be sent to the Secretary. Although there will be periodic updates available on progress by the AAC, there should be a press conference and public meeting that presents the final demonstration implementation plan. Again the CPAC Chairs should be present.

RHODE ISLAND "CHOICES"

BACK UP PLAN SHOULD ONLY ONE MANAGED CARE ORGANIZATION (MCO) EMERGE FROM AN OPEN COMPETITIVE PROCUREMENT

BACKGROUND: The State of Rhode Island is seeking to implement an 1115 waiver that will integrate physical health and community based supports and services for the entire (3500) adult population with developmental disabilities currently eligible for and receiving Medicaid services. They are currently "carved out" of RItE Care, the comprehensive 1115 waiver serving other Medicaid eligibles. They receive health care on a fee for service basis, and community based supports and services through a home and community based services waiver. We have concluded budget neutrality negotiations with OMB and have resolved all program issues. We are currently fine-tuning the special terms and conditions.

ISSUE: Because of the uniqueness of what the State is trying to demonstrate in this waiver, they did not choose to simply modify existing RItE Care contracts to accept the population of adults with developmental disabilities. Rather, they chose to construct a separate set of requirements for MCOs to serve this population. **The State will engage in an open competitive procurement process, and fully intends to contract with at least 2 MCOs. This is NOT a sole source procurement request.** However, again, because of the uniqueness of the demonstration and the population, the State is concerned that they may only achieve 1 MCO from the open competitive process. We designed a term and condition that first requires that beneficiaries have a choice of plans, but second, provides that should only one emerge from an open competitive process, the State could implement the program with 1 MCO for up to 12 months while the State searches for a second MCO, after which, the State would be in violation of the terms and conditions. **OMB objects to this "back up" plan because they say that it violates the choice principle and would set a precedent for other States seeking to "sole source" physical (acute) health services.** We steadfastly disagree. The Administrator approved our approach to this issue on December 18, but OMB has been unmoved.

You asked that we respond to 4 questions:

1. What are the issues that have been resolved on sole source?

The BBA did not alter our authority to waive provisions of Medicaid law under sections 1915(b) and 1115. Thus, we have affirmed that should we choose to do so, we can - as a matter of policy - waive choice of plans in 1115 waivers, and choice in PHPs in 1915(b) waivers, paving the way for sole source procurements. We expect to continue to waive choice of plans on a case by case basis for "carved out" services in prepaid health plans (PHPs). Pennsylvania's recent 1915(b) is an example. These less than comprehensive programs include behavioral health services, and now (in Michigan) community based supports and services for adults with developmental disabilities.

2. Where are we with sole source in general?

With only 2 known exceptions (one city in Alabama and 8 regions in Kentucky), HCFA has held firm to the principle of choice of health plans for **physical (acute) health services**. When choice

of plans could not be achieved, we insisted either on voluntary participation (D.C. Disabled Children) or an MCO and PCCM option, or simply PCCMs. However, in recognition of the nature of "carved out" services and populations, like behavioral health and developmental disabilities, we have routinely granted waivers that specifically limit choice to one PHP for NON-physical (acute) health services. In other words, it has been acceptable to limit a person with a mental illness to one managed behavioral health company, while insisting that the same person have a choice of physical health MCOs. The District of Columbia, which was forced to make their disabled children's program voluntary because they wanted to sole source the contract, has found that the highest cost children remained in fee for service and they are currently working on a new plan to approach financing care for these children a different way. In summary, then, our historic and current policy relative to physical health services in managed care is to insist on choice of plans, which means that waiver requests predicated on sole source procurements for physical health services are generally not approved; however, we have routinely approved 1915(b) waivers that do provide for sole source procurement, including both open competitive (Montana) and non-competitive sole source (Washington State) procurements. OMB does not object to competitive sole source procurements in PHP "carve-outs", but is strenuously opposed to NON-competitive sole source procurements in PHP "carve-outs." Yet, they are strenuously opposed to limiting choice in physical (acute) health waivers, or put another way, opposed to sole source of any kind in physical (acute) health waivers.)

3. How is RI different from States where we have disapproved sole source procurement for physical health services?

- o Rhode Island fully intends (and is under great internal State pressure) to achieve 2 MCOs in an open competitive procurement. Other States (Texas-Dallas) sought sole source procurement to begin with. We are requiring in our terms and conditions that RI provide choice of MCOs to participants. Our "back up" plan only provides the State with a 12 month implementation window in which they can operate with 1 MCO while they work to develop a second MCO **should only one MCO emerge from the open competitive procurement.** We insist that this back up plan fully upholds the principle of choice because it does not relieve the State in any way from achieving a second MCO before they fall out of compliance with the terms and conditions. We also argue that we have full authority - as a matter of policy and law -- to waive choice of plans altogether should we think it in the best interests of the beneficiaries in this case (as we so often do in carve outs under 1915(b)). In other words, we do not even have to require choice of plans in the first place if we do not want to. Yet, we and the State have taken the opposite tack -- we and they insist that there will be choice of plans, even if they can't get there by "opening day" of the waiver implementation.
- o It is essential that the State be able to move ahead with implementation if only one MCO emerges from an open competitive procurement because the State cannot make budget neutrality nor the program integration features of the demonstration work if participants can voluntarily enroll, leaving some in FFS and others in the program. We believe that for this innovative, comprehensive, integrated program that will serve a difficult-to-serve population of adults with mental retardation to fail solely because the State could not

achieve 2 MCOs at the starting gate would be a major blow to our efforts to demonstrate to the developmental disabilities community that the 1115 route is a good way to go to put together a truly integrated system of care for this population.

- o It is not possible to simply distribute participants to existing Rite Care plans (though Rite Care plans are welcome to compete) because (a) the program will provide an expanded set of services (e.g., dental and behavioral health) not available in the regular Rite Care program, (b) participating MCOs must meet higher contract standards (e.g., specialized providers, all staff interacting with participants must have special training and skills), and (c) the MCOs must integrate physical health services with community based supports and services in as seamless a program as possible.

Thus, the fact that the State will employ an open competitive procurement process, coupled with the uniqueness of the population, the small size of the State and the population to be served, the uniqueness of the integrated program of physical and community based supports and services being offered and the need to demonstrate budget neutrality (thus requiring mandatory enrollment), all lead to a specific set of circumstances that we believe set this apart from other States where we have disapproved sole source. We continue to maintain that this is not a sole source procurement and that the back up plan at issue does not violate our principle of choice, since it only buys the State 12 months while they achieve a second MCO, should they not be successful on the first go round. In essence, as well, this waiver, even though it includes physical health, is far more like a "carve out PHP" (where we have routinely granted waivers limiting choice) than it is like the big comprehensive waivers where choice has been so important.

4. Why is OMB ^{upset} where they are on this issue?

OMB simply believes that despite our assurances and arguments above (all of which have been relayed to OMB), that in fact, if only one MCO emerges, and the State is allowed to begin the waiver, even with the limitation of the 12 month window to achieve a second MCO, that we will violate the principle of choice in the BBA and our own proposed rule (though the preamble clearly states that we retain authority to waive under 1115 and 1915(b)), and that while they are supportive of what RI is trying to do, the precedent it will set will open the door to other States to seek sole source procurement for physical health services.

PREPARED BY: Wayne Smith, CMSO\DEHPG 02.10.99 c:\wayne\ri-new.wpd

OMB saying sole
in RI, but you're vulnerable —
as long as Mike is okay;
OMB — wants them to think about

It

advocates

him

• YZK / PPS Update

minimum \$s in rule; routine blend,
they could do this — update by 10/1;
would require a legislative change.
could do this w/o any coding changes.
need legislation to postpone past 1/1/00
options are 10/1 → or Jan; what
do you think → to Hill

potential cost on physician side
aim for budget neutrality by FY2000;
last cost over 1st 3-4 months.

pipeline issue? hold 2 prices in their
system; can't hold 3. every issue
for last 1/4 of 98

physicians as well as hospitals?

CMRO says yes as long as there's
no coding changes.

congress wait to legislation early.

Jan: float → CMTS & cycle back in a
day or so.

Jeanne: talk to Bill V. or Katie H.
Hill give as stand alone legislation?
prob not.

• Hospital Updates

talking pts on this
mural hosp. hit hard.

Frank Lautenberg

Wyden

other mural members → Sec for
hearing.

Rich: doesn't want to defend a
policy that's not going anywhere
Jack, Sylvia, Chris & Dan & Podesta
have all used our line.

check w/ Chris.

We want to work with you.

conscious decision not to put that
in.

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Paula Brooks to Chris Jennings re: phone number (partial) (1 page)	02/17/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20464

FOLDER TITLE:

Health Care Financing Administration Issues [Folder 1]

2012-0463-S

rc769

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

McTIGUE & BROOKS

Attorneys at Law

Donald J. McTigue
Paula L. Brooks
Melissa L. Wilburn

Also admitted in
Washington D.C.

4921 Dierker Road
Columbus, Ohio 43220
614/457-1010
FAX 614/457-1018

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: RLC DATE: 04/06/12
2012-0463-S

~~CONFIDENTIAL~~

FAX COVER SHEET

PLEASE DELIVER THE FOLLOWING PAGE(S) IMMEDIATELY

TO: Chris JenningsDATE: 2/17/99AT: Domestic Policy CouncilTIME: 5:13 pmFAX: (202) 456 - 5557

COMMENTS: This is a bipartisan Ohio Congressional delegation letter which will be signed and sent to HCFA tomorrow. At 3:00 pm on Thursday, a conference call, involving PRS' CEO, Board Chairperson and M.D. Clinical Director, will take place with Jeff Kang, M.D., Steve Jencks and Hank Koehler. Ellie Dehoney (Congressman Sherrod Brown) and I will also be on the call. Since Jeff worked in the White House, I am asking for a little advice on how to handle this call. I assume that he is very clinically oriented, but concerned about policy as well. Thanks for any pointers you can give. I know you will be on the road. Phone numbers (w) 614/457-1010 (h) [REDACTED] Email [601] PBrooks53@aol.com.

FROM: Paula L. Brooks, Esq.
Phone: 614-457-1010
Fax: 614-457-1018

TOTAL # OF PAGES
INCLUDING THIS PAGE _____

The information contained in this facsimile message is attorney-client privileged and/or confidential information intended for the use of the individual or entity name above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify us by telephone, and return the original to us at the above address via the U.S. Postal Service. If you do not receive all pages, please notify our office at 614-457-1010 as soon as possible. Thank you.

X

Original will not follow

Original will follow

February 17, 1999 (4:49PM) DRAFT

Ms. Nancy-Ann Min DeParle
Administrator, Health Care Financing Administration
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Min DeParle:

We write to request your attention to a matter involving a notice of non-renewal for Ohio's Peer Review Systems, Inc. (PRS), the Ohio PRO (peer review organization) contract. It appears that communication problems, inconsistent interpretations and other issues may have interfered with the successful review of this particular PRO.

We request two things: 1) PRS be afforded a complete opportunity to receive and review all of the information upon which this decision has been made, and 2) a stay of this decision pending your further review and receipt of answers to serious questions regarding the process and conclusions relied upon by your staff.

PRS has indicated to us that it relied on a February 27, 1998 communication from Dr. Peter Boxsein regarding performance standard reviews. PRS further relied on "approval" of certain predetermined project performance criteria from its HCFA Kansas City-based project officer --- these criteria were later substantially changed without appropriate notice. As a result, PRS was well down one path when it was told to pursue another. This situation is inconsistent with PRO review protocol. Furthermore, the final conclusions contradict previous reports referencing the Ohio PRO as an industry "benchmark" as a result of its success with former projects.

Dr. Boxsein's letter of February 27, 1998 assured the PROs that the *totality* of their work "through" the 28th month would be considered and we ask you to keep the word of the agency in this regard. Correspondence from your agency (please reference Edward Hughes letter of February 11, 1999) indicates that comprehensive consideration in fact did not occur. Since, the Ohio PRS review was the first group in a three-tier review process, should HCFA fail to establish a standard process of review then this scenario will only prove to repeat itself. We ask that fundamental fairness prevail.

Over 1.9 million Medicare beneficiaries have benefitted from health care services provided by Ohio physicians and medical staff affiliated with the PRS. However, as a result of the delay in resolving this matter, 8,000 diabetics await care administered by one of the PRS's pilot programs. The postponement of an immediate solution threatens the well-being of Medicare beneficiaries as well as the livelihood of health care providers in Ohio.

Your prompt attention to this matter would be greatly appreciated. We look forward to a final resolution and full explanation of this matter by February 25, 1999. Thank you.