AFL-CIO
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Washington, D. C. 20006

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Date: 6-13-96

FAX To: Jennifer O'Connor

FAX Phone Number: 456-7929 or 2464

From: Jerry Shea

Department:

Comments:

There is/are 1 page(s) following this cover sheet.

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AFL-CIO
President's Office
202/637-5237

We can automatically receive transmissions 24 hours a day.

Our FAX number is 202/508-6946

FEDERAL OK SOUGHT

Waiver could displace workers

Part of W-2 request surprises some officials

By Jorl Dresang
of the Journal Sentinel staff

Welfare recipients required to work for their benefits under the Wisconsin Works (W-2) plan would be allowed to displace existing Wisconsin workers in some cases, according to the state's federal waiver request.

The displacement provision — among 88 federal welfare law waivers sought in Wisconsin's 400-page request — surprised the top legislator behind W-2 and could not be readily explained by a leading welfare administrator.

Specifically, the provision seeks federal permission to let those on W-2 work assignments:

- Partially displace current workers.
- Impair existing contracts for services or collective bargaining agreements.
- Infringe on the promotional opportunities of current workers.
- Fill established vacancies.

David Newby, president of the Wisconsin State AFL-CIO, said Monday that he was surprised by the provision. The provision illustrates why Congress and the White House need to be deliberate in considering the W-2 waivers, he

Please see **W-2** *page 13*

From page 1

said.

"It just shows that a blanket approval of whatever the (Thompson) administration asked for is just ludicrous," Newby said. "This is precisely the sort of thing that should have scrutiny on the federal level."

W-2 was signed into law April 25 and is scheduled to take effect by late 1997. However, W-2 cannot be carried out without a change in federal laws or waivers from existing legislation. The process allows governors to request the waivers they think they need to enact their reform plans.

Last week, the Republican-controlled House of Representatives approved legislation that would grant Wisconsin's requests without administrative review. It now will go to the Senate.

Gov. Tommy Thompson has challenged President Clinton, who has spoken favorably of W-2, to approve the request as submitted and quickly. An official 30-day comment period on the request began Monday.

"I'm not sure why it's in there," Gary Kuhnen, director of the Bureau of Welfare Initiative in the state Department of Health and Social Services, said of the provision. "Our intent is not to interfere with any union contracts or to displace workers or to infringe upon promotional opportunities."

Kuhnen said late Monday that he would have to confer with officials who wrote the waiver request to learn why the displacement provision was there.

Rep. John Gard (R-Peshtigo), chairman of the Assembly Welfare Reform Committee, said he noticed the provision when he read through the request last week and wondered whether it had been a mistake or a peculiar technicality.

"I'd be stunned if it's not," Gard said Monday. He said he thought the W-2 package passed by the Legislature protected workers from such displacements.

In fact, W-2 included some protections against supplanting workers. Essentially, it made sure that an employer couldn't get rid of an employee to open a job for a W-2 participant, or hire a W-2 worker to replace a worker on strike, laid off or involved in a labor dispute. Those protections do not necessarily conflict with the exemptions sought in the waiver request.

"You can say it goes beyond what is addressed in the legislation," said Carol Medaris, project attorney for the Wisconsin Council on Children and Families.

John Matthews, Thompson's chief of staff, declined to comment specifically on the request's displacement provision.

"What I can say in general is that we need these workers to be treated as much as possible like general workers in the workplace. We can't have them discriminated against because they're W-2 workers," Matthews said.

For instance, Matthews reasoned, if an employer feared that hiring a W-2 participant might affect an existing employee's promotion, "then hardly anybody would be able to hire a W-2 worker."

Newby contended the provision would let employers of low-wage workers favor government-subsidized W-2 workers.

"If you're going to push workers out of low-wage jobs just to make room for welfare participants to work, it doesn't make any sense," Newby said.

Like Gard, Kuhnen and Newby, Marjorie Morgan, chairwoman of the Milwaukee Coalition to Save Our Children, expressed surprise at the displacement request.

"You can't accomplish anything by displacing the current work force," Morgan said. "I can't believe anyone in good conscience would support that."

Milwaukee Journal Sentinel
6/11/96

OFFICE OF INTERGOVERNMENTAL AFFAIRS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Room 630F
Washington, DC 20201

FAX COVER SHEET

DATE: 6/13/96

TO: Jennifer O'Connor **PHONE:**
FAX: 456-7929

FROM: John Monahan
Director

PHONE: (202) 690-6060
FAX: (202) 690-5672

RE:

CC:

Number of pages including cover sheet: 3

Message:

Fax to:
Bruce Rand
MJ Bond
Melissa S.
Jennifer O'Connor

ON WISCONSIN NEWS

On Wisconsin Main Page
On Wisconsin News Main Page

Waiver could displace workers

By Joel Dresang
of the Journal Sentinel staff

June 11, 1996

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E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

28-May-1996 04:59pm

TO: Jennifer M. O'Connor

FROM: Kenneth S. Apfel
Office of Mgmt and Budget, HR

CC: Bruce N. Reed

SUBJECT: RE: welfare reform and Boren amendment

I haven't heard any rumors on adding Boren to Welfare, but according to Nancy Ann Min, the President has been quite public in his support for repealing (or dramatically rewriting) Boren. I can't imagine that we would oppose this if it's added to the welfare bill.

OFFICE OF INTERGOVERNMENTAL AFFAIRS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Room 630F
Washington, DC 20201

FAX COVER SHEET

DATE:

TO: Jennifer O'Connor **PHONE:**
FAX:

FROM: John Monahan **PHONE:** (202) 690-6060
Director **FAX:** (202) 690-5672

RE:

CC:

Number of pages including cover sheet:

Message:

Wisconsin--W2

- I was pleased to hear that the state of Wisconsin has recently submitted a bold welfare reform plan to the federal government.

- While we don't yet have sufficient detail to judge all the parts of the plan, I am excited by its basic thrust.

- Instead of simply providing cash to a family that applies for benefits, the state would guarantee work along with the necessary supports such as child care to enable work. We look forward to working with the state to realize a vision of welfare based on work, that protects children and is fair to families that work.

- Work in the private sector would of course be the primary objective, but where that was not available, the state would provide work that the recipient would be required to perform to get assistance.

- Just as I urged two weeks ago, to better prepare young parents for their responsibilities, the Wisconsin plan would strengthen its current requirements for minor parents to be in school with tougher rules for requiring them to live at home.

- Work with necessary supports, rather than unconditioned welfare certainly represents my values and the values of the American people.

Talking Points: President's Visit to Wisconsin

- My Administration is committed to working with States to allow flexibility in the design of new approaches to their local welfare problems while assuring that proposals are legally allowable and meet Federal standards.

- Supporting, encouraging, and requiring employment should be the keys to any serious approach to reform welfare. The essential elements of Wisconsin's proposed amendments to their current welfare reform demonstrations, Pay For Performance and Work Not Welfare, appear to aim for those objectives.

- Expanding necessary supports such as child care for working families and those struggling to join the work force is a critical element of significant welfare reform, and I applaud Wisconsin's intention to do this.

- I am especially pleased that Wisconsin is following my directive to the States to require teenage parents on welfare to live with their parents or with other responsible adults. Parents or other caring adults should assist, support, and guide their parenting teenage children, and Wisconsin appears ready to put such a plan into action.

- We are aware that there is some controversy surrounding elements of Wisconsin's most recent plan. We have already heard from state legislators including members of Wisconsin's Black legislative caucus; religious organizations including the Archdiocese of Wisconsin and the Interfaith Conference of Greater Milwaukee; and the American Federation of State, County, and Municipal Employees. Our welfare reform application process includes a 30-day public comment period, and we are committed to considering public comments on all welfare reform proposals.

- Our staff at the Department of Health and Human Services has already begun to work with staff at the Wisconsin Department of Health and Social Services to discuss elements of the proposed waiver amendments.

  Issues to be further discussed and resolved include the following:

  - The proposal does not appear to ensure that individuals who, through no fault of their own, cannot obtain or maintain employment would be allowed an extension to the AFDC time limits. This Administration has approved time limits as part of state welfare reform demonstrations only when we are convinced that they protect children and do not punish families in which the adults are playing by the rules.

- It appears that benefit levels for parents who are disabled may be lower than those for other participants. This would be unfair and would violate the Americans With Disabilities Act.

- Many labor and religious organizations have contended that work might be at less than the minimum wage.

- We are concerned that larger AFDC families in Wisconsin would experience a benefit reduction at the same time that these parents are required to increase their work efforts to ready themselves and their families for unsubsidized employment.

- There are potential legal and policy issues related to required co-payments for child care.

- Further, we are concerned that the State would deny children's benefits in the first instance when an adult does not comply with the program. Other states have implemented more progressive sanction schedules so that children's benefits are not be jeopardized when an individual is first sanctioned.

- Finally, there is a legal problem with the proposal to provide foster care benefits rather than AFDC benefits to a child who is eligible for AFDC.

o My Administration is proud of the way we have worked with States to implement and test alternative approaches and policies to the current welfare system. I am committed to trying to resolve these issues and any others that arise.

o We will work with Wisconsin in a spirit of partnership as we continue to identify sound approaches for aiding low income families and children to attain their full potential.

Labor-
Waivers

FAX TRANSMITTAL SHEET

RECEIVER TELECOPIER # (202) 456-2464

TO: HAROLD ICKES

FROM: MICHAEL KERR

DATE: August 8, 1995 TIME: 3:20pm

PAGE NUMBER ONE OF 3 PAGES.

TRANSMITTER TELECOPIER: 202-219-8822

ADDITIONAL COMMENTS:

IF YOU HAVE QUESTIONS RE THIS FAX CALL: Cynthia @ 219-4503

U.S. DEPARTMENT OF LABOR

DEPUTY SECRETARY OF LABOR
WASHINGTON, D.C.
20210

MEMORANDUM FOR KEVIN THURM

FROM: THOMAS GLYNN
LESLIE LOBLE

DATE: AUGUST 8, 1995

SUBJECT: COMMENTS ON AUGUST 3, 1995
HHS MEMORANDUM ON HEALTH CARE WORKERS

Thank you for sending us a copy of the August 3rd memorandum on health care workers and the medicaid waiver process. We were pleased to see that some of our comments were reflected in this new draft, but we appear to still be at odds over some fundamental issues that forestall final resolution of this matter. These issues are summarized below.

The primary thrust of our involvement in this matter is the obligation the federal government has to provide assistance to workers who are dislocated as a result of government actions. In this case, we have argued that the medicaid waiver reliance on managed care delivery systems accelerates the shift of public funds away from public and non-profit hospitals towards HMOs, costing health workers their jobs. The government's responsibility for providing assistance to workers dislocated as a result of its actions is supported in 27 statutes. While this argument is articulated at the beginning of the paper, it gets dropped in the final consideration of recommendations suggesting a lack of consensus between the agencies and omitting important precedents for action.

Another variance between the agencies is the notion that if HHS directly took account of worker protections in its medicaid waiver process, the President would compromise a 1993 commitment made to the governors to ensure that the Medicaid process is flexible and streamlined. We believe that worker protections can be accommodated within these guidelines since many of the issues addressed by the waiver application, such as quality of health care, are in turn affected by the quality of the healthcare workforce providing such care. The initial proposal by the unions outlined how the medicaid waiver application procedure could accommodate worker interests under the categories of financial reimbursement, quality of care and research. This de-linking of quality of care from employment issues results in a memo that positively frames only one initiative that would benefit health workers, and even this initiative is at best merely a suggestion to the states, not a requirement. The other recommendations related to worker training and protections are presented in the memorandum as stand-alone directives to the states, implying that the recommendations may very well require legislation.

At this juncture, we would recommend a meeting with Harold Ickes to discuss these outstanding issues. Perhaps guidance from the White House on the relative weight of these different points would assist in resolving these matters.

cc: Harold Ickes
Jennifer O'Connor

file
#-HHS—
Medicaid
waivers

OFFICE OF INTERGOVERNMENTAL AFFAIRS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Room 630F
Washington, DC 20201

FAX COVER SHEET

SPECIAL

DATE: 1/22/96

TO: ① Diana Fortuna — **PHONE:**
White House/Domestic Policy — **FAX:**
② Emily Bromberg / WH-IGA
③ Jennifer O'Connor / WH - Dep. CoS

FROM: John Monahan — **PHONE:** (202) 690-6060
Director — **FAX:** (202) 690-5672

RE: Approval of CA 2 Plan Medicaid Wainer
CC:

Number of pages including cover sheet: ~~2~~ 10

Message:

CA - 2 Plan Medicaid
Wainer approval documents.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care

JAN 22 1996

Mr. John Rodriguez, Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Mr. Rodriguez:

We are pleased to inform you that the Health Care Financing Administration (HCFA) has approved California's request for waiver authority under sections 1915(b)(1), 1915(b)(2), 1915(b)(3), and 1915(b)(4) of the Social Security Act (the Act), in order to implement the "Two-Plan Model" program. Thus, California is granted a waiver of sections 1902(a)(1), 1902(a)(10)(B), and 1902(a)(23) of the Act in order to begin mandatory enrollment of certain Medicaid beneficiaries into managed care in each Two-Plan Model county, which include: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

This decision is based on the evidence submitted to HCFA demonstrating that the State's proposal is consistent with the purposes of the Medicaid program and will meet all statutory and regulatory requirements for assuring beneficiaries access to care, quality of services, and waiver cost-effectiveness for section 1915(b) waiver programs. Please note that this approval is contingent upon several factors.

1. As agreed to by the State in its October 23, 1995 response to HCFA's request for additional information, full implementation of the Two-Plan Model will not commence in any given county until HCFA has conducted satisfactory on-site "readiness" reviews in that county which will focus on beneficiary enrollment, access, quality, and financial solvency concerns. The details and time frames for these reviews will be worked out between the State and HCFA as each county approaches full implementation of both plans.

2. The State must demonstrate that it has allocated sufficient and appropriate staff to all areas of responsibility, particularly with regard to set-up and monitoring of a large and complex program such as the Two-Plan Model. We are concerned that each individual county adequately demonstrate its own operational readiness and that the State demonstrate its broader overall capability to deal with the significantly increased workload this will generate. We ask that each designated DHS county contract manager work closely with HCFA Regional Office staff to review the State's acceptance of plan deliverables in all areas.

3. The State must ensure that information systems in each county under the Two-Plan Model are adequate and ready to accommodate full operations. This should include management information system capabilities, as reflected by complete system testing results (e.g., successful data transmissions, member eligibility file downloads, written documentation of each plan's member roster/report production capabilities, ability to process and pay claims, ability to collect/store/retrieve data required by DHS (including encounter data)).

4. In an effort to address the need for flexibility in accessing medically necessary services for individuals with complex medical conditions (e.g., HIV/AIDS), the State is expected to meet this need through a medical exemption process that is sensitive to their special health care needs. A beneficiary who receives Medi-Cal benefits through a mandatory aid category and who is under treatment with a provider who is not participating in the Two-Plan Model would be eligible for an exemption from enrolling in Two-Plan. If the provider is a member of one of the Two-Plan networks or if the beneficiary is not undergoing treatment, the beneficiary would be required to enroll in Two-Plan. During the first six months that Two-Plan is fully operating in a given county, the State must provide HCFA with quarterly reports on the medical exemption process that contain, at a minimum, the following information: the number of beneficiaries applying for medical exemption during the reporting period, the diagnosis of the beneficiaries' condition (e.g., HIV/AIDS), whether the medical exemption was approved or denied, and any grievances/complaints that have been filed related to the medical exemption process.

5. Consistent with the requirements of Section 1902(a)(30)(C) of the Act, the State must enter into a contract with an external quality review organization (EQRO) by July 1996 for the purposes of conducting annual medical reviews and focused clinical studies on all Two-Plan providers. It should be noted that if the EQRO contractor is not ready to begin its plan review activities by January 1, 1997, HCFA will re-assess the agreed upon schedule of onsite "readiness" reviews for those counties that have not begun full implementation of Two-Plan at that point in time.

6. The State must arrange for an independent evaluation of the waiver with respect to access to care, quality of services and cost effectiveness. The results of this evaluation are to be submitted to HCFA no later than 3 months before the expiration of this waiver authority.

7. HCFA's approval of the Two-Plan Model is made with the understanding that the funding sources associated with this waiver do not duplicate payments included under other existing Section 1915(b) waiver authorities or with the proposed Section 1115 Research and Demonstration waiver currently under development for Los Angeles County and 23 other California counties, including 10 of the 12 Two-Plan counties.

HCFA has decided to grant the State's request for an exception to the competitive procurement requirements for Local Initiative contracts under the Two-Plan Model. HCFA accepts the State's contention that in order to protect the continuation of existing relationships between clinical

providers and the patients under their care, the State had to find an approach to include safety net and traditional providers. The Local Initiative Plan provides a framework for these and other providers to develop an alternative managed care option based on the specific circumstances in each county. HCFA believes it is in the public interest to allow this initiative to proceed as it is designed. HCFA also supports the State in its efforts to develop innovative ways to permit safety net and traditional providers to fully participate in Medicaid managed care activities.

HCFA's approval of the Two-Plan Model program includes approval of the capitation rates and rate setting methodology developed specifically for this initiative. This does not imply that HCFA has resolved the outstanding issues surrounding the State's SFY 1995 PHP capitation rates.

HCFA recognizes and appreciates the good faith negotiations that took place with the State during the six-month review of the Two-Plan Model and wishes to build upon this foundation as all parties move toward the more difficult task of implementing the Two-Plan Model in each county. To this end, it is our expectation that HCFA, the State, and the affected counties will engage in ongoing discussions and will provide meaningful opportunities for input from other interested parties, relating to the implementation of the Two-Plan Model in each county.

In accordance with your request, this approval grants the State of California waiver authority under sections 1915(b)(1), 1915(b)(2), 1915(b)(3) and 1915(b)(4) of the Act for a period of two years, from January 23, 1996 through January 22, 1998. California may request that this authority be renewed at the end of this period.

If you have any questions regarding this action, please feel free to contact Mr. Richard Chambers, Associate Regional Administrator of the Division of Medicaid in Region IX, at (415) 744-3568.

We wish you success in the implementation of the Two-Plan Model program.

Sincerely,

Bruce Merlin Fried
Director
Office of Managed Care

cc: Richard Chambers, Associate Regional Administrator, Region IX

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Monday, Jan. 22, 1996

Contact: HCFA Press Office
(202) 690-6145

APPROVAL OF CALIFORNIA'S TWO-PLAN MODEL FOR MEDICAID MANAGED CARE

HHS Secretary Donna E. Shalala today announced approval of California's Two-Plan Model to expand Medicaid managed care in 12 counties. The Two-Plan Model will be implemented on a county-by-county basis, and it is expected to be fully implemented over the next two years. Once implemented, this will be the largest Medicaid managed care initiative in the nation.

Secretary Shalala stated, "California's Two-Plan Model serves as an example of the administration's continued commitment to work with states in the development and implementation of innovative health care delivery systems designed to meet their specific needs."

The Two-Plan Model is unique to the characteristics of California's health care financing and delivery system in its utilization of both existing private and county health care providers. Twelve counties in California have been designated to implement the Two-Plan Model. These counties are: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Medicaid beneficiaries in these 12 counties will be offered a choice of two managed care plans. One will be a "Mainstream Plan" offered by a commercial HMO and selected by the state. The other plan will be a "Local Initiative Plan" which will include existing

- More -

county hospitals and health care facilities, as well as other local providers.

Bruce C. Vladeck, administrator of the Health Care Financing Administration, said that "The Two-Plan Model is an ambitious Medicaid managed care initiative, which resulted from six months of intensive review and dialogue between HCFA and the state of California. By providing Medicaid beneficiaries the choice between private and public providers, it will allow California's existing health care delivery system to be used in a new and unique fashion." Vladeck added, "This is a very important initiative, and we will be watching it closely."

Both the state and HCFA must ensure that the plans meet all access, quality and financial requirements before the Two-Plan Model can become operational in any county.

All Aid to Families with Dependent Children (AFDC) and AFDC-related Medicaid beneficiaries will be required to enroll in the program. Enrollment will be voluntary for other Medicaid beneficiaries. It is expected that once the Two-Plan Model is fully implemented, 3.3 million Medi-Cal beneficiaries will be enrolled.

Medicaid beneficiaries will be informed about the Two-Plan Model and the changes in their health care delivery through an independent enrollment contractor. The contractor will inform beneficiaries of their rights and responsibilities under the Two-Plan Model, including the need to choose a health plan and the range of services and providers available through each health plan.

###

CALIFORNIA TWO PLAN
FACT SHEET

The Health Care Financing Administration (HCFA) has approved California's request to implement the State's Medicaid managed care program known as the **Two-Plan Model**. As approved, and once it is fully implemented over the next two years, the **Two-Plan Model** will be the largest and most ambitious Medicaid managed care initiative ever approved by HCFA.

The **Two-Plan Model** represents the culmination of more than two years of strategy, planning and discussion by the State and HCFA to expand Medicaid managed care. It is unique to the characteristics of California's health care financing and delivery system, utilizing both private and county health care providers. The key elements of the **Two-Plan Model** are as follows:

- The twelve counties designated to implement the **Two-Plan Model** are: *Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare*.
- Medicaid beneficiaries (henceforth referred to as "Medi-Cal" beneficiaries) in twelve counties will be offered a choice of two managed care plans - a "Mainstream Plan", which is a commercial HMO, and a "Local Initiative Plan."
- The commercial plans were selected based on a competitive bidding process.
- The county organized Local Initiative Plan will include existing County hospitals and health care facilities, as well as other local providers.
- The **Two-Plan Model** will not become operational in any given county until the State has certified, and HCFA has assured through on-site reviews, that access and quality requirements can be met by both the Mainstream and Local Initiative Plans.
- Enrollment will be mandatory for Medi-Cal beneficiaries who are eligible for the Aid to Families with Dependent Children (AFDC) program and AFDC-related categories and voluntary for aged, blind, and disabled individuals.
- Once it is fully implemented in each county, a total of 3.3 million Medi-Cal beneficiaries are expected to enroll, of whom 2.4 million will be enrolled on a mandatory basis.

Medi-Cal beneficiaries will be informed about the **Two Plan Model**, and the changes in how they will receive their health care services, through the State's use of an independent enrollment contractor. The contractor will inform beneficiaries, in a culturally and linguistically appropriate manner, of their rights and responsibilities under the **Two Plan Model**, including the need to choose a health plan and the range of services and providers available through each health plan.

CALIFORNIA TWO PLAN
CONDITIONS OF APPROVAL

The Health Care Financing Administration (HCFA) has determined that California's Medicaid managed care waiver program, known as the **Two Plan Model**, is consistent with Medicaid's goals and meets statutory and regulatory requirements with respect to access, quality and cost effectiveness. Specifically, the State provided HCFA with documentation that demonstrates beneficiary access to Medi-Cal services would be enhanced, that the quality of Medi-Cal services provided would improve and that systems would be in place to monitor quality indicators on a routine basis, and that the program would be cost-effective (e.g., the waiver program would not cost more than the current system and over time would generate savings due to the more efficient and effective delivery of health care services under managed care).

HCFA and California have reached agreement that implementation of the **Two Plan Model** will not commence in any given county until:

1. HCFA has conducted satisfactory onsite "readiness" reviews in that county which will focus on beneficiary enrollment, access, quality and financial solvency concerns; and,

In addition to the county-specific onsite "readiness" reviews:

2. the State has selected a qualified organization for the federally-mandated external quality review; and,
3. the State has demonstrated to HCFA's satisfaction that it has allocated sufficient and appropriate staff to all areas of responsibility, particularly with regard to set-up and monitoring of a large and complex program such as the **Two-Plan Model**; and,
4. the State must ensure that management information systems in each county are adequate and ready to accommodate full operations; and,
5. in an effort to address the need for flexibility in accessing medically necessary services for individuals with complex medical conditions (e.g., HIV/AIDS), the State is expected to meet this need through the use of a medical exemption process; and,
6. the funding sources for this program will not duplicate payments under other existing Section 1915(b) waiver authorities or with the proposed Section 1115 Research and Demonstration waiver currently under development for L.A. County and 23 other California counties, including 10 of the 12 Two-Plan counties.

LIST OF APPROVED MEDICAID MANAGED CARE (SECTION 1915(b)) PROGRAMS IN THE STATE OF CALIFORNIA

COUNTY ORGANIZED HEALTH SYSTEMS (COHS)

These county-based programs, commonly referred to as Health Insuring Organizations, automatically enroll all beneficiaries residing in the county. Beneficiaries have a choice of primary care physician. Federal law limits the number of these programs to the existing five which are described below:

Santa Barbara Health Initiative (SBHI) - SBHI contracts with the State to arrange for the provision of Medi-Cal services to Santa Barbara County's eligible Medi-Cal population. SBHI operates as a primary care network which emphasizes case management as a means of encouraging physician participation, improved access to care, high quality medicine, and efficient treatment patterns. Current waiver authority expires October 26, 1996. Projected number of enrollees is 43,007. This waiver was initially approved by HCFA in 1983 as an 1115 Research and Demonstration waiver and then as a 1915(b) waiver in 1989.

Health Plan of San Mateo (HPSM) - HPSM administers a capitated, comprehensive, case managed health care delivery system. This system is responsible for utilization control, claims administration, and Medi-Cal covered health care services to all Medi-Cal beneficiaries who are residents of San Mateo County. Current waiver authority expires February 21, 1996. Projected number of enrollees is 51,856. This waiver was initially approved by HCFA in 1987.

Solano Partnership Health Plan (SPHP) - SPHP administers a capitated, comprehensive, case managed health care delivery system. This system is responsible for utilization control, claims administration, and delivery of Medi-Cal covered health care services to all Medi-Cal beneficiaries who are residents of Solano County. Current waiver authority expires March 31, 1996. Projected number of enrollees is 44,295. This waiver was initially approved by HCFA in 1994.

California Orange Prevention and Treatment Integrated Medical Assistance (CalOPTIMA) - Under the CalOPTIMA program, beneficiaries who reside in Orange County are enrolled in CalOPTIMA and select their primary care physician and the health plan through which they receive primary care services and referrals for all necessary

will enter into a contract with one contractor in each pilot area. Eligible Medi-Cal beneficiaries residing in the MCN service area will automatically be enrolled in the program. Current waiver authority expires March 31, 1997. Projected number of enrollees is 50,000. This waiver was initially approved by HCFA in 1995.

Dave Dana Emily FYI -Jen

FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

cc: Emily Bromley Diana Fortuno

To: Jennifer O'Connor

sent 11/2

Organization: White House

From: John Monahan (Pat Woods)
Intergovernmental Affairs

Date: 11/1/95

fax HHS-1915b waiver

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Remarks: Re: New York - 1915(b) Waiver
New Qs + As developed in response to the state of NY's declining of our conditional approval.

Q: What implications, if any, does the fact that New York declined to accept HCFA's conditional approval of the Section 1915(b) demonstration have on the consideration of the Section 1115 waiver?

A: The two waivers submitted by New York must be reviewed separately.

These are different types of waivers, operating under separate provisions of the law, with different purposes and requirements.*

There are, of course, issues that we examine in any waiver application. These include access and quality of care for beneficiaries, as well as projected costs for the federal government. However, these issues present themselves differently under the particular conditions of a given waiver.

In accordance with the law, we examine each waiver on its own terms and merits, and we work collaboratively with states to accommodate their needs and agree on an outcome that provides benefits to beneficiaries, states and the federal taxpayer.

(* For example:

-- 1915(b) waivers are limited to persons already covered by Medicaid. 1115 waivers can include expanded populations. This difference between the two types of waivers can involve very different issues.

-- 1915(b) waivers apply to mandatory managed care only. 1115 waivers can involve a variety of non-traditional techniques. The scope of an 1115 waiver is much broader.

-- 1915(b) waivers must be reviewed within a specified (90-day) time frame. 1115 waivers involve negotiation and agreement on terms, with no statutory time limit.

-- 1115(b) waivers typically extend for a 5-year period. 1915 waivers are shorter-term.

-- 1115 waivers are granted for demonstration purposes to test innovative approaches to delivering health services. 1915(b) waivers have a more narrow focus -- permitting the state to implement mandatory managed care in an appropriate fashion.)

Q: Aren't the conditions of implementation HCFA spelled out in its conditional approval of the New York 1915(b) waiver classic examples of excessive bureaucratic interference with New York's attempt to improve care for Medicaid beneficiaries? Don't HCFA's actions just reinforce the need for block grants?

A: No. The President is opposed to block grants primarily because they strip needy individuals of any entitlement to benefits. He supports increased state flexibility as long as beneficiaries are adequately protected. The conditions HCFA wanted New York to meet in the 1915 waiver are consistent with the standards we have applied in other states and entirely appropriate in light of the severe problems uncovered in the state. The state's own review and published reports in various media revealed severe marketing abuses by some plans, widespread misinformation among beneficiaries and a system of enrollment and disenrollment that simply did not work. The conditions HCFA required of the state were necessary to assure that beneficiaries' interests are protected and that they have access to care.

The state itself embraced the notion of slowing the phase-in, as evidenced by its decision to halt voluntary enrollment in managed care because of marketing abuses. In fact, most of the time frames for implementation in HCFA's conditions were derived from a timetable supplied by the state. HCFA was surprised to learn that the state wanted to further slow the phase-in.

Q: How is the Section 1115 waiver review process different from the 1915(b) review process?

The normal course of reviewing 1115 waivers is different. Under the 1115 process, states submit proposals to test innovative health care delivery systems. HCFA then engages in discussions with the state to develop waiver terms and conditions consistent with HCFA's goals of encouraging state flexibility, assuring access and improving quality.

The 1115 waiver process is also different from 1915(b) waivers in that 1115 waivers are much broader in scope and subject to stricter scrutiny because they must meet a test of budget neutrality and because they are approved for a 5-year period.

Under the 1915(b) process, HCFA reviews state applications to assure that they meet statutorily-defined criteria of quality, access and cost-effectiveness. HCFA's view is limited to the statutory standards and is designed to facilitate state expansion of managed care in an appropriate fashion.

By law, HCFA is required to approve or disapprove 1915(b) waivers within 90 days. Normally, as with 1115 waivers, all issues are worked out before a decision is announced. Although HCFA had reached closure with New York on all issues, it appears from the state's and city's responses that they believe differently. HCFA was surprised by their response because its conditional approval reasonably balanced state flexibility with the need to assure access to quality care for all affected beneficiaries.

Q: Hasn't HCFA already dragged its feet on the New York 1115 review process?

A: No. When the state first sent in its 1115 waiver request, it was largely conceptual in nature. Since its submission, HCFA has worked closely with the state, in a collaborative effort, to flesh out the details of the State's proposal and to examine key elements common to all waivers, such as budget neutrality and eligibility expansions. At this point, HCFA is waiting for the state to provide financial data and trend factor information for budget neutrality. HCFA will make a decision on the 1115 waiver as soon as possible, but cannot do so before all issues are addressed.

Key dates:

HCFA received waiver proposal -- March 20, 1995

HCFA sent state major issues letter -- April 28, 1995

Questions sent to the state -- June 30, 1995

State's response to questions received -- August 4, 1995

Face-to-face meeting to discuss budget neutrality -- September 7, 1995

Face-to-face meeting to discuss programmatic issues -- September 28, 1995

Phone meetings -- October 23, 24 and 25, 1995

FAX TRANSMISSION

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Office of the Secretary

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Date: 11/1/95

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Remarks: updated summary of Dept actions re D.C. 1915(b) Medicaid Waiver

THE NEW YORK MEDICAID MANAGED CARE DEMONSTRATION PROPOSALS

- On October 27, 1995 the Department of Health and Human Services (HHS) conditionally approved New York's Medicaid 1915(b) proposal to expand its three year old mandatory managed care Southwest Brooklyn demonstration project to all of New York City. With its approval, HHS included terms and conditions that protected Medicaid beneficiaries' access to quality care as they were enrolled in mandatory managed care.

- On October 30, 1995 the state withdrew its request for this waiver expansion to the entire city, alleging that the terms and conditions were inconsistent with the understandings reached in negotiations and reflected micromanagement. The state decided to abandon its 1915(b) proposal in order to focus its efforts on its voluntary managed care enrollment program, and on obtaining approval for its statewide Medicaid 1115 demonstration proposal, the Partnership Plan.

- The original 1915(b) Southwest Brooklyn managed care expansion proposal as submitted on February 23, 1995 proposed a major and rapid expansion of mandatory managed care to the entire city. Under the revised proposal, if fully implemented, the project could increase the city's enrollment in mandatory managed care coverage through phases by an estimated 275,000 additional AFDC and AFDC-related Medicaid beneficiaries from the 50,000 currently enrolled in the project.

- As required by statute, HHS conducted a review to determine if there was sufficient provider capacity in the city's managed care system to ensure that mandatorily enrolled beneficiaries would retain adequate access to quality health care. HHS was concerned about the city's ability to expand managed care because of information from recent independent reviews of managed care in New York, from press reports, from state legislative hearings, as well as the city's own decision in late July to suspend managed care enrollment.

- HHS determined that adequate access could only be assured under three conditions. *First*, that the city phase in its mandatory program as it developed additional provider capacity. *Second*, that the city implement a program to counsel beneficiaries on selecting an appropriate plan. *And finally*, that the city allow chronic illness groups, such as HIV/AIDS patients, to continue with their current care if appropriate specialists are not available within the managed care network.

- HHS and New York are working on similar access concerns as well as budget issues with respect to the statewide Medicaid section 1115 demonstration proposal, the Partnership Plan. This statewide plan would subsume the existing Southwest Brooklyn 1915(b) project and would enroll approximately 3.5 million individuals into managed care by 1998, including the remainder of New York's Medicaid population (excluding the elderly and institutionalized disabled) and its Home Relief population (those that are financially needy but not Medicaid eligible).

Monahan

① status of union memo

② Ohio
- problem from AFSCME

③ LA County
- they need cash
- we're trying to create a basis of $ estimate over next few yrs to frontload the $
- will be adjustments to Medicaid

- They ≠ respond favorably to deal b/c thought promised cash

- we offered cash in short run but had to be paid off in long run

- Monahan said "our policy has not been to have labor protection conditions in the waiver.

No conditions in offer now

But said to Supervisors we were convinced we [illegible] had talked to SEIU