

TennCare Information from
1993 has been sent to records
management

(Waiver info.
welfare reform info.
HHS info)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

File: Jenn Care FEB 7 REC'D

FACSIMILE

DATE FEB 7 1994

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

*1 cc in
Ank. trip
file
(orig wld
be fine)*

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 5

COMMENTS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FEB 7 1994

TO: Carol Rasco
Assistant to the President
for Domestic Policy

FROM: Kevin Thurm *KT*

SUBJ: TENNCARE

Attached please find the update on TENNCARE from HCFA. If you have any questions, please do not hesitate to call me or Bruce Vladeck.

HCFA MONITORING OF TENNCARE DEMONSTRATION

Terms and Conditions of the Waiver

The waivers were awarded on November 18, 1993 and the program was implemented on January 1, 1994. In approving the demonstration, HCFA imposed 35 special terms and conditions on the award relating to a wide range of financial, data, access and quality issues. Thirteen of these conditions were required to be satisfied before implementation.

Because access to care was a critical concern, HCFA imposed requirements on the State to protect beneficiaries from unnecessary disruptions in care.

- In areas where provider participation was not sufficient, the fee-for-service delivery system would be maintained.
- Pregnant women were allowed to continue with their physicians until the baby was delivered and for 60 days thereafter. Other seriously ill individuals would be able to continue with their physicians for up to 30 days after the waiver, or until they could be reasonably and safely transferred to a managed care organization (MCO).
- Since none of the MCOs had contracts with the State when the original beneficiary plan assignments were made, HCFA required Tennessee to permit all enrollees to have an additional 45 days to change to another MCO, if desired. Of the approximately 690,000 Medicaid beneficiaries in the State, only about 80,000 chose to do so.

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On-Site Review

To ascertain that the 13 pre-implementation terms and conditions of the award had been met, a team from HCFA central and 3 regional offices, along with a Public Health Service representative, visited Tennessee on December 12-17.

The site visit team performed the following review activities during the December trip to Nashville:

- Review of contracts between the State and MCOs to determine if all required provisions were included;
- Analysis of State plans for monitoring, evaluating, and taking action as necessary to improve the delivery of care;
- Review of State's minimum data set and plans to monitor collection of data;
- Certification that each geographical area in the state had sufficient provider capacity; and
- Tests related to the financial integrity of the TennCare project, including review of State budget documents, conditions for supplemental payments to providers, internal and external audits, and plans to monitor the financial viability of MCOs.

A particular emphasis of the site team was the review of provider capacity. A random selection of providers in the Blue Cross network (the largest of two State-wide networks) was contacted by phone to ascertain their participation in TennCare. When a significant number indicated that they would not participate, two review team members flew to Blue Cross headquarters in Chattanooga to have them run a new provider list, which was again tested for accuracy. The results indicated that the Blue Cross State-wide network alone had eight times the number of primary care providers needed to serve the Medicaid population. Of the 12 geographic areas of the state, even the one with the least capacity had almost 5 times the number of primary care providers needed.

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infant whose mother claims that she was unable to find a provider for the child. The State, the hospital involved, and the HCFA regional office are investigating. A preliminary report should be available by Friday, February 11.

We are continuing to closely monitor the implementation of TennCare by sending Regional Office reviewers to the State. A financial management specialist visited during the week of February 1, a quality review team will visit during the week of February 14, and a combined regional and central office team will visit during the week of February 28 to do extended review of new documentation related to access and capacity. The team will also assess whether phone access to the State and MCOs has improved. Additional visits are scheduled at least quarterly.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FEB 7 1991

TO: Carol Rasco
Assistant to the President
for Domestic Policy

FROM: Kevin Thurm

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File: TennCare

THE WHITE HOUSE

WASHINGTON

Paul F. Griner, MD, FACP
President
Rolf M. Gunnar, MD, FACP
Chair, Board of Regents
American College of Physicians
Suite 250, 700 Thirteenth Street, NW
Washington, DC 20005

February 15, 1994

Dear Dr. Griner and Dr. Gunnar;

The President has asked me to respond to your letter dated January 31, 1994, concerning health reform initiatives at the state level through the HCFA waiver process, and, in particular, the TennCare program in Tennessee.

Your letter questions the extent to which TennCare has, in fact, complied with the terms of the HCFA waiver. Secretary Shalala has advised me that, pursuant to its statutory duty and the conditions of the waiver, the Department of Health and Human Services will closely monitor the implementation of TennCare. In December, HCFA conducted a site visit in Tennessee. HCFA teams will be visiting Tennessee throughout this month to perform an extended review of new documentation related to access and capacity. Additional visits will follow quarterly. Because the specific concerns expressed in your letter relate to determinations by HCFA and enforcement of HCFA waiver provisions, I am forwarding your letter to Secretary Shalala for any further appropriate action.

Your letter also questions the legality of the participation by Blue Cross/Blue Shield of Tennessee in TennCare. Specifically, your letter suggests that physicians have been told that unless they participate in TennCare, they will not be allowed to care for patients in Blue Cross/Blue Shield's Tennessee Provider Network. Because such legal concerns are appropriately addressed by the Department of Justice, Bernard Nussbaum, Counsel to the President, is forwarding your letter to the Attorney General for any appropriate action.

Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Carol H. Rasco
Carol Rasco

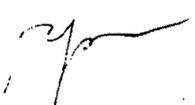
Assistant to the President for Domestic
Policy

Carol -

I've cleared this letter on TennCare with Steve Neuwirth. If you think it's ok, it just needs to be signed. If not, I will make any changes. In addition, Steve is preparing transmittal letters to send to DOJ and DHHS. I expect these will be ready for tomorrow.

Note: because the VP's office has an interest in TennCare as well, I have shared the letter with Charlotte Hayes.

Lynn

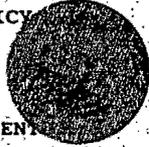


FEB 16 REG'D

OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

CAROL H. RASCO
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY



TO: _____

DRAFT RESPONSE FOR POTUS AND
FORWARD TO CHR BY: _____

DRAFT RESPONSE FOR CHR BY: _____

PLEASE REPLY DIRECTLY TO THE WRITER
(COPY TO CHR) BY: _____

PLEASE ADVISE BY: _____

LET'S DISCUSS: _____

FOR YOUR INFORMATION: _____

REPLY USING FORM CODE: _____

FILE: _____

SEND COPY TO (ORIGINAL TO CHR): _____

SCHEDULE 7 : ACCEPT PENDING REGRET

DESIGNEE TO ATTEND: _____

REMARKS:

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7-10-64
file*

*I signed ltr I need
cc of letter I signed
also source*

THE WHITE HOUSE

WASHINGTON

February 16, 1994

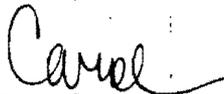
Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

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I am forwarding this correspondence to you for any appropriate action.

Sincerely,



Carol Rasco
Assistant to the President
for Domestic Policy

file

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Suite 250, 700 Thirteenth Street, NW
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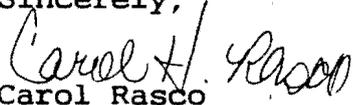
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Sincerely,


Carol Rasco

Assistant to the President for Domestic
Policy



American College of Physicians

January 31, 1994

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

The American College of Physicians is deeply concerned about health reform initiatives at the state level through the HCFA waiver process during the period of transition to full implementation of systemwide reform. We are very discouraged by the course of events in the state of Tennessee and cannot reconcile the difference between the goals of the Health Security Act--goals which ACP supports--and the debacle of TennCare.

We have elaborated at length and repeatedly to HCFA, in letters and meetings, our concerns with the Tennessee program. To summarize briefly the current situation: There has been no credible evidence presented that the state has met the conditions of the waiver. Despite HCFA assurances that managed care plans would be approved gradually under a carefully phased transition, all plans suddenly were certified as of January 1, leading to enormous confusion among patients and physicians. Patients did not know who their doctors were and doctors did not know whether or not they were authorized to treat patients. Throughout the entire process, before and after waiver approval, the state has refused to consult in a meaningful way with physicians and other providers.

Because we feel so strongly about what is now happening in Tennessee and what may develop in other states in the near future, we cannot support the substantial authority granted to states in your proposed legislation unless the Administration can demonstrate that HCFA-approved state initiatives are consistent with the core principles of the Health Security Act.

We ask that you take the following two actions:

- Request the Secretary of HHS to provide you an immediate report on the implementation of TennCare, demonstrating with data the extent of compliance or non-compliance with the terms of the waiver.
- Request an opinion from the Attorney General on the legality of the link claimed by Blue Cross/Blue Shield of Tennessee between their existing Tennessee Provider Network (covering state employees, including teachers) and participation in TennCare. Physicians have been told that, if they do not participate in TennCare, they will not be allowed to care for patients in the TPN program.

The TennCare waiver has disturbing implications for broader questions of health reform. The flexibility given to states now under the HCFA waiver process and in the Health Security Act is substantial. This degree of latitude and responsibility presumes a high level of competence to design and administer a complex system and in a manner that enfranchises a variety of groups and individuals who are affected by the changes being contemplated. The development and implementation of TennCare challenges the underlying assumption that states can be relied upon to act in good faith, competence and in a consultative manner.

State responsibilities under the Health Security Act are substantial--for example, to establish health alliances, to guarantee payments to alliances, and to certify the quality and financial solvency of health plans. States must nevertheless meet these responsibilities under explicit federal guidelines. The final version of the Health Security Act must retain this balance between state flexibility and a strong federal framework and oversight.

Our greatest concern now is the transition period before and after health reform legislation is passed. The College urges the Administration to issue specific and rigorous guidelines that will assure that states move in a direction consistent with the principles of the Health Security Act. Otherwise, the ACP believes that irreparable harm may be done in the many states now considering health reform initiatives.

We urge you to provide assurances that the Administration will exercise its prerogatives in the waiver process to assure that state initiatives in fact, and not just in rhetoric, implement the principles of health care reform, including universal coverage, comprehensive benefits, adequate financing, an emphasis on preventive and primary care, fairness in negotiations between insurers and providers, and freedom of choice for patients and providers. Another TennCare disaster would seriously undermine the mutually held goals of the Administration and the College.

Sincerely,



Paul F. Griner, MD, FACP
President



Rolf M. Gunnar, MD, FACP
Chair, Board of Regents



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FEB 7 1994

TO: Carol Rasco
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for Domestic Policy

FROM: Kevin Thurm

KT - JH

SUBJ: TENNCARE

if not already in files

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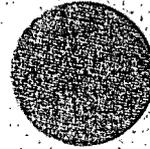
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THE WHITE HOUSE FEB 18 RECD
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy



To: sent 2/22

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): Hale, Mason, Way, Hart

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: Hart: Pls. make sure all
appropriate persons w/ Health Reform
see this! Thank you!



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

FEB 18 REC'D Washington, D.C. 20201

FACSIMILE

DATE FEB 18 1994

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 7

COMMENTS:

file



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FEB 18 1994

MEMORANDUM TO CAROL RASCO

From: Kevin Thurn *Kevin Thurn*

Re: TennCare

Attached is an update on TennCare. Please give me a call if you have any questions.

TENNCARE UPDATE**Background**

ABC News, 60 Minutes, Cable News Network, and USA Today are currently in Tennessee interviewing Tennessee officials, physicians, and others about the TennCare demonstration, which was implemented January 1, 1994. We understand that they are interested in investigating the deaths of two TennCare enrollees and in potentially comparing Tennessee's health reform approach with the Health Security Act proposal.

Additionally, Congressman Dingell's staff has informed HCFA that the Congressman has asked the General Accounting Office to do an investigation of TennCare.

Investigations of Deaths of Two TennCare Enrollees

As we reported last week, both the State and the HCFA regional office have investigated the two deaths. In the case of the AIDS patient, the physician indicates that he would not have transferred the patient if he had known he was critically ill; it appears that the physician ordered the transfer believing that it was appropriate.

In the other case, involving a baby, the regional office has investigated the mother's complaint that the hospital involved, Jackson Memorial Hospital, had initially turned her away because it does not participate in TennCare. The regional office was unable to find any violation in this case of the "anti-dumping" rules, which require hospital emergency rooms (ERs) to treat any seriously ill patient, regardless of insurance coverage. Despite normal ER procedure, which would have patients logged in for services, the hospital ER had no record of a visit by the mother of the baby on the date claimed.

The State has further investigated the mother's allegations that she was refused treatment at a non-participating clinic. The State's report is currently with the Commissioner of Health for Tennessee and is expected to be released soon. Separately, the HCFA regional office met several times during the week of February 14 with Blue Cross Blue Shield of Tennessee, the managed care organization (MCO) in that area of West Tennessee, to determine if the TennCare enrollee would have had an easy-to-access means of finding a participating physician or clinic.

Because of concern about possible access problems in west Tennessee, the HCFA regional office is calling every TennCare participating physician to verify that adequate numbers of physicians are participating, particularly primary care

physicians. That effort should be completed in the next few days.

TennCare and the Health Security Act

Issues have been raised to our attention concerning the consistency of the Health Security Act and TennCare. For example, in a recent letter, the American College of Physicians made specific requests of the President with respect to this issue (see attached).

The TennCare waiver has some elements that are consistent with the Health Security Act, including covering the uninsured and an emphasis on more managed care. Fundamentally, though, TennCare is a much more limited reform, focusing on changing the health care delivery system for Medicaid eligibles and the uninsured rather than broader reform. Some significant elements of HSA are not included; for example, there are limited choices of providers and plans in many of the areas and the plans do not bear risk under the current waiver.

Many of the problems of beneficiary confusion and provider opposition may have arisen because of the short timeframe for implementation and enrollment of providers and beneficiaries. In addition, providers, particularly physicians' groups, object to the State's alleged unwillingness to work with them in developing the proposal. They also object to contract provisions of Tennessee Blue Cross/Blue Shield that require physicians to participate in TennCare as a condition of continuing in the BC/BS provider network.

FEB-18-1994 17-18 FROM HHS

Suite 250, 1013 Thirteenth Street, N.W., Washington, DC 20004. Telephone: (202) 455-1450 or (202) 455-2400

Handwritten signature

HCFA 89402140302

American College of Physicians

ORD: ACTION
CC: Vladeck; Saitz
AAC; AAP; AAM; AAO; OLP; G
Portuna; Somsak; Schmidt; S.
ADMIN. SIG. DUE 2/24

4
39

February 1, 1994

Bruce C. Vladeck, PhD
Administrator
Health Care Financing Administration
314-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20293

Dear Bruce:

I am forwarding a copy of our letter to the President on the question of the TeamCare waiver, which continues to be a serious concern in its own right and in relation to health care reform. Actions taken by the Administration on the two requests made in the letter will be important in addressing the concerns of our leadership. We hope to have an indication of what the Administration's response to these requests will be as soon as possible.

Thanks very much for your consideration of these requests.

Sincerely,

John R. Ball

John R. Ball, MD, JD, FACP



The TennCare waiver has disturbing implications for broader questions of health reform. The flexibility given to states now under the HCFA waiver process and in the Health Security Act is substantial. This degree of latitude and responsibility presumes a high level of competence to design and administer a complex system and in a manner that enfranchises a variety of groups and individuals who are affected by the changes being contemplated. The development and implementation of TennCare challenges the underlying assumption that states can be relied upon to act in good faith, competence and in a consultative manner.

State responsibilities under the Health Security Act are substantial—for example, to establish health alliances, to guarantee payments to alliances, and to certify the quality and financial solvency of health plans. States must nevertheless meet these responsibilities under explicit federal guidelines. The final version of the Health Security Act must retain this balance between state flexibility and a strong federal framework and oversight.

Our greatest concern now is the transition period before and after health reform legislation is passed. The College urges the Administration to issue specific and rigorous guidelines that will assure that states move in a direction consistent with the principles of the Health Security Act. Otherwise, the ACP believes that irreparable harm may be done in the many states now considering health reform initiatives.

We urge you to provide assurances that the Administration will exercise its prerogatives in the waiver process to assure that state initiatives in fact, and not just in rhetoric, implement the principles of health care reform, including universal coverage, comprehensive benefits, adequate financing, an emphasis on preventive and primary care, fairness in negotiations between insurers and providers, and freedom of choice for patients and providers. Another TennCare disaster would seriously undermine the mutually held goals of the Administration and the College.

Sincerely,



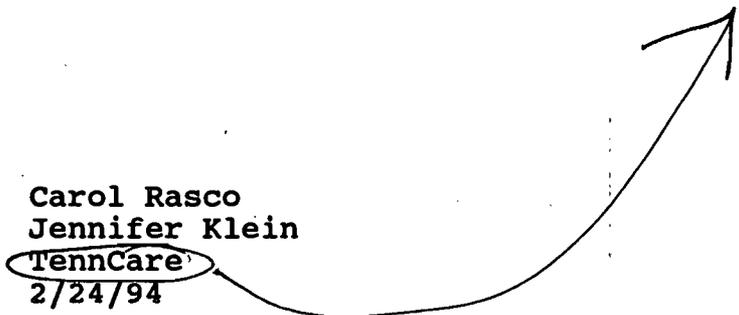
Paul F. Griner, MD, FACP
President



Rolf M. Gunnar, MD, FACP
Chair, Board of Regents

FEB 24 REC'D

TO: Carol Rasco
FROM: Jennifer Klein
RE: TennCare
DATE: 2/24/94



Just a note to let you know that HHS called to ask me to help them answer this letter. I spoke with Steve Neuwirth who agreed that I should simply tell HHS that they should respond to the letter as they think appropriate.

02/23/94

15:09

202 401 7321

HHS ASPE/HP

THE WHITE HOUSE
WASHINGTON

February 16, 1994

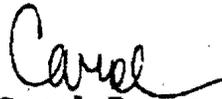
Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

The President has received the enclosed correspondence concerning health reform initiatives at the state level through the HCFA waiver process, and, in particular, the TennCare program in Tennessee.

I am forwarding this correspondence to you for any appropriate action.

Sincerely,



Carol Rasco
Assistant to the President
for Domestic Policy

THE WHITE HOUSE

WASHINGTON

Paul F. Griner, MD, FACP
President
Rolf M. Gunnar, MD, FACP
Chair, Board of Regents
American College of Physicians
Suite 250, 700 Thirteenth Street, NW
Washington, DC 20005

February 15, 1994

Dear Dr. Griner and Dr. Gunnar;

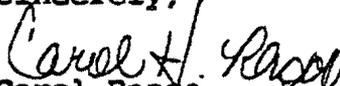
The President has asked me to respond to your letter dated January 31, 1994, concerning health reform initiatives at the state level through the HCFA waiver process, and, in particular, the TennCare program in Tennessee.

Your letter questions the extent to which TennCare has, in fact, complied with the terms of the HCFA waiver. Secretary Shalala has advised me that, pursuant to its statutory duty and the conditions of the waiver, the Department of Health and Human Services will closely monitor the implementation of TennCare. In December, HCFA conducted a site visit in Tennessee. HCFA teams will be visiting Tennessee throughout this month to perform an extended review of new documentation related to access and capacity. Additional visits will follow quarterly. Because the specific concerns expressed in your letter relate to determinations by HCFA and enforcement of HCFA waiver provisions, I am forwarding your letter to Secretary Shalala for any further appropriate action.

Your letter also questions the legality of the participation by Blue Cross/Blue Shield of Tennessee in TennCare. Specifically, your letter suggests that physicians have been told that unless they participate in TennCare, they will not be allowed to care for patients in Blue Cross/Blue Shield's Tennessee Provider Network. Because such legal concerns are appropriately addressed by the Department of Justice, Bernard Nussbaum, Counsel to the President, is forwarding your letter to the Attorney General for any appropriate action.

Please do not hesitate to contact me if I can be of further assistance.

Sincerely,


Carol Rasco

Assistant to the President for Domestic
Policy

American College of Physicians

January 31, 1994

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

The American College of Physicians is deeply concerned about health reform initiatives at the state level through the HCFA waiver process during the period of transition to full implementation of systemwide reform. We are very discouraged by the course of events in the state of Tennessee and cannot reconcile the difference between the goals of the Health Security Act—goals which ACP supports—and the debacle of TennCare.

We have elaborated at length and repeatedly to HCFA, in letters and meetings, our concerns with the Tennessee program. To summarize briefly the current situation: There has been no credible evidence presented that the state has met the conditions of the waiver. Despite HCFA assurances that managed care plans would be approved gradually under a carefully phased transition, all plans suddenly were certified as of January 1, leading to enormous confusion among patients and physicians. Patients did not know who their doctors were and doctors did not know whether or not they were authorized to treat patients. Throughout the entire process, before and after waiver approval, the state has refused to consult in a meaningful way with physicians and other providers.

Because we feel so strongly about what is now happening in Tennessee and what may develop in other states in the near future, we cannot support the substantial authority granted to states in your proposed legislation unless the Administration can demonstrate that HCFA-approved state initiatives are consistent with the core principles of the Health Security Act.

We ask that you take the following two actions:

- Request the Secretary of HHS to provide you an immediate report on the implementation of TennCare, demonstrating with data the extent of compliance or non-compliance with the terms of the waiver.
- Request an opinion from the Attorney General on the legality of the link claimed by Blue Cross/Blue Shield of Tennessee between their existing Tennessee Provider Network (covering state employees, including teachers) and participation in TennCare. Physicians have been told that, if they do not participate in TennCare, they will not be allowed to care for patients in the TPN program.

The TennCare waiver has disturbing implications for broader questions of health reform. The flexibility given to states now under the HCFA waiver process and in the Health Security Act is substantial. This degree of latitude and responsibility presumes a high level of competence to design and administer a complex system and in a manner that enfranchises a variety of groups and individuals who are affected by the changes being contemplated. The development and implementation of TennCare challenges the underlying assumption that states can be relied upon to act in good faith, competence and in a consultative manner.

State responsibilities under the Health Security Act are substantial—for example, to establish health alliances, to guarantee payments to alliances, and to certify the quality and financial solvency of health plans. States must nevertheless meet these responsibilities under explicit federal guidelines. The final version of the Health Security Act must retain this balance between state flexibility and a strong federal framework and oversight.

Our greatest concern now is the transition period before and after health reform legislation is passed. The College urges the Administration to issue specific and rigorous guidelines that will assure that states move in a direction consistent with the principles of the Health Security Act. Otherwise, the ACP believes that irreparable harm may be done in the many states now considering health reform initiatives.

We urge you to provide assurances that the Administration will exercise its prerogatives in the waiver process to assure that state initiatives in fact, and not just in rhetoric, implement the principles of health care reform, including universal coverage, comprehensive benefits, adequate financing, an emphasis on preventive and primary care, fairness in negotiations between insurers and providers, and freedom of choice for patients and providers. Another TennCare disaster would seriously undermine the mutually held goals of the Administration and the College.

Sincerely,



Paul F. Griner, MD, FACP
President



Rolf M. Gunnar, MD, FACP
Chair, Board of Regents

February 23, 1994

NOTE TO JO IVEY BOUFFORD

At the Indian Health briefing today, I asked Cliff Wiggins from the IHS when he expected the consultant's report on the actuarial study on American Indians. He said it should be out in the next week or two. I suggested that he contact your office to arrange a briefing for you and Phil (if he's interested). Unless you tell me otherwise, I will assume that you would like to be involved. You should hear from IHS fairly soon.

Question for the day:

How does the Health Security Act differ in its treatment of American Indians and veterans?

Answer:

The Department of Veterans Affairs gets over \$3 billion in startup funding.

Seriously, the questions I hear from the Hill have to do with: 1) the 1995 budget and FTE reductions; and 2) concern about startup for the Indian plans. (They haven't figured out offsets yet.)

Let me know if you need any additional information.

cc: Bill Corr
Susanne Stoiber

MEMORANDUM

TO: ROY NEEL
✓ CAROL RASCO
IRA MAGAZINER
CHARLOTTE HAYES

FROM: JOHN HART

DATE: JUNE 15, 19993

RE: TENNESSEE AND HEALTH CARE REFORM

=====

Attached is the briefing memo in preparation for the President's meeting with Governor McWherter tomorrow on the Tennessee Waiver Request. I have consulted with relevant officials at H.H.S. and in Tennessee. If you have any questions, please call.

June 15, 1993

MEETING WITH TENNESSEE GOVERNOR NED RAY MCWHERTER

DATE: June 16, 1993
LOCATION: Oval Office
TIME: 4:30 to 5:00 p.m.
From: John P. Hart

I. PURPOSE

Governor McWherter has requested a meeting with you and the First Lady to discuss "TennCare," Governor McWherter's health care reform proposal, and to formally present the Administration with its Medicaid waiver request. Following this meeting, Governor McWherter will meet with Secretary Shalala at HHS.

II. BACKGROUND

A. Waiver Discussions with Clinton Administration

Tennessee is one of a growing number of states that are preparing comprehensive waiver requests as part of their state health care reform efforts. The waiver will be set forth in papers you will receive at your meeting, and Governor McWherter would like a 45 to 60 day time frame for a decision on the waiver.

On March 24, 1993 the Governor's office sent a "concept paper" to HHS that outlined their idea for a waiver. HHS responded the next week, and several communications ensued, concluding with a May 27 telephone conversation between Secretary Shalala and Governor McWherter.

The White House Intergovernmental Affairs Office has worked with Tennessee state officials and officials at HHS over the past several weeks to facilitate Tennessee's waiver request.

B. Health Care Reform

As you are aware, in addition to the several briefings conducted to date between Ira Magaziner, Judy Feder, and members of the bipartisan panel of Governors, gubernatorial staff members have had extensive discussions with members of the working groups in an attempt to resolve state-federal issues.

Governor McWherter will be one of the ten Governors attending DGA's Vermont Issues Conference on Thursday (June 17). The Issues Conference will focus exclusively on health care reform, and Governor McWherter will be joined there by Governors Romer (CO), Chiles (FL), Carnahan (MO), Walters (OK), Roberts (OR),

Rosello (PR), Sundlun (RI), Dean (VT), and Wilder (VA). The Administration will be represented there by The First Lady, Ira Magaziner and John Hart.

III. PARTICIPANTS

The President
The First Lady
Governor McWherter
Governor's Aide (possible)

(Governor McWherter will drop-by to visit the Vice President after the Oval Office meeting.)

IV. PRESS PLAN

No Press.

V. SEQUENCE OF EVENTS

Open thirty-minute discussion.

VI. REMARKS

We recommend that you tell Governor McWherter that (1) you will ask HHS to give serious and timely consideration to the waiver request, (2) HHS will work closely with the Governor's office on it, and (3) you will ask HHS to review the request on an expedited basis, but you should not commit to a specific time frame for a decision.

In closing, it would be helpful both to remind Governor McWherter of our important federal/state partnership, as evidenced by the extensive consultations between him, his staff, and the Administration, and to stress the need for his support of our reform legislation.

VII. ADDITIONAL MATERIALS

Attached is biographical information on Governor McWherter, as well as background information on health care reform in his state and the proposed Medicaid waiver.

GOVERNOR NED RAY MCWHERTER (D - TENNESSEE)

(widower; two children)

A. Background

Governor McWherter was born in Palmersville, Tennessee in 1930 and grew up during the Depression on a small farm, where his parents were sharecroppers. He later operated several small businesses and a farm, and was elected to the Tennessee House of Representatives in 1969. He served there until he was elected Governor in November 1986, with a record seven consecutive two-year terms as House Speaker.

B. "TennCare"

Background: In an address to a joint session of Tennessee's General Assembly on April 8, 1993, Governor McWherter unveiled his proposal for health care reform in Tennessee, which he has called "TennCare." TennCare is a managed competition proposal that would replace Medicaid and provide insurance to the one million current Medicaid recipients, as well as to an estimated 500,000 uninsured working poor in Tennessee. It uses community rating and prohibits pre-existing condition exclusions.

The plan, which would require a Medicaid waiver, would allow citizens to choose from participating TennCare provider networks which would include the present Blue Cross network for state employees, the HMOs presently operating and planned for the Medicaid program, and other qualifying plans. Health care providers would be required to accept TennCare as a condition of participation in any state or state-administered federal health care program.

Enrollment: Employers would be encouraged (no mandate) to enroll and provide payroll deduction of premiums for all of their employees and dependents (full and part-time), to the extent they are not eligible for coverage in an employer sponsored health plan. State government would enroll all citizens who are eligible for Medicaid, all eligible recipients of unemployment compensation who are not covered under another health plan, and Tennesseans who were not covered by employers as of March 1, 1993. Community Health Agencies ("CHAs") would enroll eligible citizens who were not enrolled by state agencies as described above.

Cost: The individual cost for TennCare would be approximately \$1600 annually (premiums and co-pay). Participants at or below the federal poverty level would not pay; participants between 100% and 400 to 500% of the poverty level would pay on a sliding scale (at 200% of the poverty level, participants would

pay 20% of the full cost (\$320)). Benefits would be the same as under the state group insurance plan, but the deductible would be \$1,000 -- considerably more than the state plan, and no deductibles or co-pay would be required for preventive services.

Global Budget: TennCare tries to set a global budget for health care. Each community would be separately rated and all private health insurance plans would be encouraged to limit the amount their premiums (including deductibles and co-pay) could grow in future years to a rate not exceeding growth in the state's economy. Each plan within a community would be given a per capita spending target, with any plan that exceeds its target expenditure prorated back to the target. (Any plan producing a savings would be permitted to distribute the savings among its providers.)

Funding: State funding would be increased each year at a rate equal to the growth in state tax revenue, less any dedicated tax increase, not to exceed the rate of growth in the economy. Local government funds would be frozen at their current level. Federal and other funds would grow at a rate not to exceed Medicaid expenditures, which are currently increasing at 8.3% annually. In addition, TennCare "pools" all of the state's health care programs for the poor, in order to avoid "fragmenting resources."

Reducing Taxes: Currently, Tennessee hospitals pay a services tax of 6.75% of gross patient charges (\$140 million annually). The TennCare proposal begins with a recommendation that this tax be eliminated on April 1, 1994. Governor McWherter calls the tax "disruptive," and has said that "from that day forward, Tennessee will pay for indigent health care with the same conservative financial policy we use for all programs of state government."

Conclusion: Governor McWherter sees TennCare as "blending very nicely" with the Clinton Administration's plan; he is convinced that TennCare will work, and that it will save the federal government money. He will also stress that Tennessee has no viable (practical?) alternative - those being huge tax increases and/or massive cuts in health care, at a time when the trend is toward more comprehensive care.

HHS, on the other hand, has several concerns about TennCare, including: (1) questions about Tennessee's figures for budget neutrality; (2) concern that the state uses savings it expects to receive as a proposed source of revenue (if the plan does not work well, who will fund it?); (3) eligibility is not limited - if TennCare attempts to cover all uninsured, regardless of income level, it could give employers an excuse to not cover their employees; (4) the \$1,000 deductible might unfairly limit participation in TennCare; and (5) regarding proposed Medicaid co-payments, there is a question as to whether HCFA can legally

waive provisions of the law that prohibit imposing any form of co-payments on Medicaid beneficiaries.

C. Tennessee's Medicaid Waiver Request

In order to implement TennCare, Tennessee will need a Section 1115 Demonstration Waiver from HHS, an extensive waiver, similar to the waiver Oregon received in March 1993. The waiver will be expressly set forth in papers you will receive at your meeting with Governor McWherter.

Governor McWherter would like a 45 to 60 day time frame for a decision on the waiver.¹ (He wants to implement TennCare beginning January 1, 1994.) This is seen as a rather tight timetable for HHS, given that it is currently reviewing waiver requests for Hawaii and Kentucky, and it expects requests soon from Florida and Minnesota.

We recommend that you tell Governor McWherter that (1) you will ask HHS to give serious and timely consideration to the waiver request, (2) HHS will work closely with the Governor's office on it, and (3) you will ask HHS to review the request on an expedited basis, but you should not commit to a specific time frame for a decision.

¹ By way of comparison, Oregon made its waiver request to the Bush Administration in August 1991 and re-submitted the request in November 1992. The request was approved on March 19, 1993 - - two months after President Clinton took office.

File: TennCare

DEC - 3 REC'D



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVID L. MANNING
COMMISSIONER

November 24, 1993

Mr. Bruce Vladeck
Administrator
Department of Health and Human Services
200 Independence Ave. S. W.
Washington, D. C. 20201

Dear Bruce:

I want to take this opportunity to thank you and your staff for your cooperation and assistance as we successfully worked through the issues associated with the TennCare Waiver. Having served in government for an extended period of time, I am well aware of the difficulties associated with a new Administration's first year in office. Given the complexity of our waiver, the number of other waiver requests you had pending and your efforts to reorganize your staff, I know this has been a challenging time and I am particularly appreciative of the personal attention that you gave to TennCare.

I look forward to continuing to work with you as we implement TennCare in a manner which will better serve the people of this state and reflect well upon both of our governments. I wish you the best as you and your staff continue to deal with the issues of health care reform.

Sincerely,

A handwritten signature in cursive script that reads "David L. Manning".

David L. Manning

DLM:ep
a19

cc: Governor Ned McWherter
Secretary Donna Shalala
Ms. Carol Rasco



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVID L. MANNING
COMMISSIONER

November 29, 1993

Ms. Kathi Way
Special Assistant to the President
for Domestic Affairs
Old Executive Office Building
Room 218
The White House
1600 Pennsylvania Avenue, N. W.
Washington, D. C. 20500

Dear Kathi:

Please accept our sincere appreciation for your assistance as we successfully negotiated the TennCare Waiver. It was very comforting to know that we had someone in the White House who both understood the President's health care objectives and the state's need for flexibility in addressing this enormous issue.

If I may be of assistance to you, please do not hesitate to call on me.

Sincerely,

A handwritten signature in cursive script that reads "David L. Manning".

David L. Manning

DLM:ep
a25

cc: Governor Ned McWherter
✓ Ms. Carol Rasco

THE WHITE HOUSE

WASHINGTON

~~CONFIDENTIAL~~

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: Rw DATE: 4/14/04

TO: Mack McLarty
Roy Neel
Kathi Way
Nancy Hernreich

FROM: Carol H. Rasco

SUBJ: Tennessee

DATE: November 4, 1993

Attached is a very thorough memo on the Tennessee situation for those of you who want to read this much detail. In summary, HCFA has made what I consider based on my knowledge a very fair offer back to Tennessee. I say fair based on financial integrity, client protection, and the protection of our health care reform efforts. HCFA is waiting now on answers/questions from Tennessee.

I will continue to keep you posted and hope you will do the same should you hear from any of the parties. Many thanks!



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

November 4, 1993

NOTE TO CAROL RASCO

FROM: Bruce C. Vladeck 
Administrator, Health Care Financing Administration

SUBJECT: TennCare Waiver Proposal -- Status

~~CONFIDENTIAL~~

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: BW DATE: 4/14/84

As you know, HCFA has been reviewing a proposal from the State of Tennessee that would waive Federal Medicaid requirements in order to provide coverage to Medicaid eligibles and uninsured in the State. While we are making every effort to provide maximum flexibility to states as they redesign their health care delivery systems, we have been concerned about the financing approach, beneficiary confusion, and the implementation schedule that the State has promoted. The State has provided responses to a number of our questions about TennCare, most recently on October 29. The Governor is pressing for a positive decision right away.

Last night we laid out for Tennessee the conditions under which we would approve a waiver. (Attached is the material we faxed to them.) The following are the key features of our offer, along with the reactions I expect from the State:

- o HCFA Offer: Our approach reflects significant movement on our part in three areas since the State's original proposal. We have agreed to (1) provide limited Federal matching funds for a new form of Certified Public Expenditures (CPE); (2) provide limited Federal matching funds for services provided to residents of institutions for mental diseases (IMDs), consistent with the Health Security Act, and (3) allow certain premium payments by patients who would not otherwise be eligible for Medicaid to count as the State's share of Medicaid costs. We have endeavored to limit the precedent these three developments might set in other states, although it is probably not possible to eliminate it.

Expected Reaction: The State should regard the first item as a positive development, and will perceive some improvement on the second item. On the third item, we had previously communicated our position to them, but they had argued against the very reasonable limitation we had placed on them. Our most recent response reiterates our position, which they will not regard as progress.

- o HCFA Offer: We clarified to the State that we will not provide Federal match for capitation payments for individuals who are eligible for TennCare but not enrolled in the program. However, I should note that we are prepared to match the costs of uncompensated care (similar to disproportionate share payments) to the extent that these are actual State cash expenditures that account for costs borne by participating providers.

DETERMINED TO BE AN
 ADMINISTRATIVE MARKING **CONFIDENTIAL**
 INITIALS: Tw DATE: 4/14/04
 2

Expected Reaction: As we discussed in our meeting the other day, the State's latest proposal suggests that they may regard this a new and significant restriction, even though it should have been obvious to them based on all our previous statements. Tennessee may be interested in our alternative, but may have difficulty raising the State resources to support this approach.

- o HCFA Offer: Rather than dictating an implementation date to the State, we outlined for them the process we would require prior to implementation. In addition, we will require them to repeat the enrollment/plan selection process after contracts with providers have been signed and approved by HCFA.

Expected Reaction: We are mildly optimistic that the State will react positively to this approach.

- o HCFA Offer: We had previously argued that Tennessee must increase the capitation rate to providers because it is not adequate to ensure access and quality of care. (This is the core issue that has prompted 100-200 letters to us per day from Tennessee physicians.) In our new approach, we agree that HCFA should not be in the position of dictating Medicaid rates to states (a position with which we were never entirely comfortable), but we require that the State be able to assure access and monitor quality in the TennCare program.

Expected Reaction: Should be positive.

Finally, it is important to note that, even if Tennessee concurs with all of our conditions, the State still has a shortfall of funds for the program. Estimates of the magnitude of the shortfall can vary widely depending upon assumptions about the number of enrollees, treatment of CPE, capitation rates, and the need for any supplemental pools, but it is in the range of \$100-\$350 million per year.

The State will probably view the limitations that we have listed as significant. Nevertheless, these limitations are essential to assure that we maintain the current percentage shares of financing borne by the Federal and State governments and to protect beneficiaries during the transition.

We are preparing additional background documents and talking points on these issues for you to share with your colleagues.

cc: Kevin Thurm

HCEA POSITION ON TENNCARE ISSUES

The following provides details of our position on TennCare financing. These details reflect our longstanding view that we may only match allowable costs, rather than the originally-proposed block grant approach. We also provide further specification of our matching policy for certified public expenditures. In addition, we provide additional clarification on several non-financing issues.

Financing Issues

- o We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to the Managed Care Organizations (MCOs) for each TennCare enrollee.
- o We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing service to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.
- o These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.
- o We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- o We will provide FFP at the applicable matching rates (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.
- o We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.
- o Premium revenues must be offset on an individual by individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

~~CONFIDENTIAL~~ *By*

2

Non-financing Issues

- o We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.
- o Substantial changes have been made in the TennCare project, from agreements reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.
- o Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in Federal spending related to TennCare.
- o The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.
- o The State will repeat the enrollment/plan selection process after contracts with MCOs and providers have been signed.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

Sent
4/29
OC

CAROL H. RASCO
Assistant to the President for Domestic Policy

cc to Way John Felt
K. Mason

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule? Accept Pending Regret

Designee to attend: _____

Remarks: _____



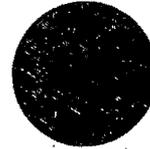
DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

APR 29 REC'D

FACSIMILE



DATE APR 29 1994

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 12

COMMENTS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

APR 29 1994

MEMORANDUM TO CAROL RASCO

FROM: KEVIN THURM *KT*

SUBJ: TENNCARE

Per my efforts to keep you informed of ongoing developments with TENNCARE, attached please find a memorandum from Bruce Vladeck with a press release by the National Association of Public Hospitals criticizing Tennessee's 1115 waiver.

I don't know whose underlining and markings are on the press release. Please call me if you have any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

To: Kevin Thurm
From: Bruce Vladeck
Re: TennCare
Date: 4/29/94

A handwritten signature in black ink, appearing to be "B. Vladeck", written over the "From:" line.

The National Association of Public Hospitals released a report yesterday which not only harshly criticizes Tennessee's 1115 waiver demonstration, but draws lessons from it for Health Care Reform. NAPH's press release and excerpts from the executive summary are attached.

HCFA has already received an inquiry from one of the health care newsletters, and we expect that media interest in the story will continue into the next week.

Please call me if I can provide you with additional information.

Attachment

cc: John Monahan

N A P H

HOLD FOR RELEASE
 Until 10:00 AM (EST)
 Thursday, April 28, 1994

For more information contact:
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**TENNESSEE'S HEALTH SYSTEM THREATENED BY PRECIPITOUS SHIFT
 TO MANAGED CARE FOR POOR: MOVE HAS SERIOUS IMPLICATIONS
 FOR OTHER STATES AND NATIONAL REFORMS**

"TennCare," Tennessee's new managed care system for the poor and uninsured, is deeply flawed, according to a report released today by the National Association of Public Hospitals (NAPH). TennCare, which requires sweeping federal waivers of current protections for low income patients and the providers that have traditionally served them, is theoretically intended to serve as a model for health reform on both the state and national levels. But NAPH's assessment of TennCare's design and first three months of implementation uncovered serious problems that have broad implications for Tennessee and other states considering similar reforms. "With less than 6 months of planning in a state with virtually no previous managed care experience, Tennessee has abandoned its Medicaid program to shoehorn the poor and uninsured into hastily contrived, largely untested, managed care schemes," remarked Larry Gage, President of NAPH, in announcing the release of the report. "With over a quarter of the state's entire population involved, if problems are not corrected immediately, this plan could lead to a serious deterioration of Tennessee's entire health system," said Gage.

The NAPH report includes numerous recommendations for improving TennCare, directed to both the state and the federal Health Care Financing Administration (HCFA), which approved the program and which now must monitor its implementation. The report



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also includes recommendations for other states seeking to adopt similar programs, and for federal decision-makers now considering health reform proposals in Washington, DC.

NAPH conducted its evaluation of TennCare to determine its effect on Medicaid recipients and other low income populations and the providers that traditionally serve them.

Among NAPH's findings are the following:

- The implementation schedule for TennCare was far too ambitious. TennCare was first conceived in the Spring of 1993, an application was submitted to the Health Care Financing Administration ("HCFA") in June, HCFA approved it in November, and TennCare took effect on January 1, 1994. This hasty schedule provided insufficient time for the state to develop adequate administrative structures or management systems, or for new managed care organizations ("MCOs") to be developed in a state with a previous managed care enrollment of less than six percent.

- As a result, the provider networks established by the fledgling MCOs are largely insufficient to provide the necessary level of preventive, primary and hospital services to TennCare enrollees. Patients have considerable difficulty accessing services through many of the new organizations and when they turn in confusion or frustration to the providers they have relied on in the past, those providers have no way of knowing whether or not they will be paid for providing the needed care.

- The TennCare enrollment process has been seriously flawed. Potential enrollees received very little substantive information on the MCOs, despite the fact that most MCOs were newly created, previously unknown organizations. In their rush to enroll large numbers of individuals quickly, some MCOs engaged in questionable, and possibly even illegal marketing practices. Such practices have allegedly included offering life insurance policies

 and secured credit cards as inducements, paying agents on commission, and providing turkeys, hams or even cash to individuals for enrolling.

- TennCare provides insufficient safeguards to ensure that the highest risk patients are not all concentrated in a few MCOs or providers.
- Funding levels for plan premiums are seriously inadequate for plan providers. MCOs are paid a fixed amount (set by the State with no bidding or negotiation) for each individual they enroll, but the amount of this payment underestimates the cost of providing services by 25 percent or more. In addition, the amount paid assumes unrealistically that providers will continue to provide a certain amount of charity care, resulting in a further discount on MCO premiums. Because of this inadequate funding, some MCOs are at risk of failure.
- TennCare has lost a significant amount of goodwill among providers. Physicians are embittered toward TennCare because of their treatment by MCOs, their lack of input into the development of TennCare, and projected payment levels. As a result, many physicians who participated in Medicaid have dropped out of TennCare, and the Tennessee Medical Association is suing the State to block further implementation of TennCare.
- Hospitals and clinics also face significant payment reductions, well below previous Medicaid levels. Moreover, those providers who had traditionally served a disproportionate volume of Medicaid and uninsured patients have found little or no attention paid to the broad range of unfunded health and social needs of many low income patients.

NAPH found that several of these shortcomings were preventable. Several states have experimented in the past with managed care systems for low income populations, and their experiences have provided well-documented lessons for other states. These lessons were ignored in the rush to develop TennCare.

"With respect to national health reform, TennCare teaches us above all that managed care in and of itself is no panacea," said Mr. Gage. "Properly designed and thoughtfully implemented managed care plans can be of major benefit in improving access to primary and preventive care for low income patients. On the other hand, if managed care is implemented too hastily, designed primarily for cost containment purposes, and targeted only on the poor, such dubious reforms can threaten the infrastructure of the entire health system. In particular, HCFA and the State have failed adequately to address TennCare's impact on the State's public health and social service infrastructure -- including many specialized services such as trauma, burn, and neonatal intensive care that are essential to the entire community, not just the poor. Other states, and the federal government, must provide for a period of careful planning and transition to any new system," concluded Mr. Gage.

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EXCERPTS FROM EXECUTIVE SUMMARY OF REPORT

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- **Ensuring Adequate Provider Contracts:** HCFA should require the State to submit and make public all written contracts between MCOs and providers.
- **Case Management:** The State should require all MCOs to implement case management or gatekeeper functions. Each TennCare enrollee should be assigned to a primary care case manager. MCOs that cannot meet this requirement should be required to pay for primary care services provided by non-plan providers.
- **Facilitating Prior Authorization:** All MCOs should be required to have adequately staffed 24-hour prior authorization telephone lines.

The failure to address the problems targeted by these recommendations will severely jeopardize the future of TennCare. In particular, ignoring the insufficiencies in MCO and provider payments will threaten the very infrastructure on which TennCare depends. The consequences could be a failure of the entire experiment. At the very least, because several of the problems noted in this report (such as the failure of MCOs to establish written provider agreements and the failure to comply with the Boren Amendment) and elsewhere (such as the insufficiencies in the entire Medicaid waiver process) invite litigation in a court of law. Rather than flirting with such destructive outcomes, the State and HCFA should work with providers, patients, MCOs and other interested parties to develop solutions to the problems that have developed, so that the TennCare experiment can be turned into a success.

2. Policy Implications for Other State Waivers and Demonstrations

NAPH's assessment of TennCare is relevant not only to the ongoing experiment in Tennessee, but to other states considering managed care related alternatives to or modifications of their Medicaid programs. In addition to all of the specific TennCare recommendations listed above (which may be equally relevant to programs devised by other states), NAPH has the following general recommendations:

• **Allow Adequate Implementation Time:** The most obvious lesson from TennCare is that such a radical revision of the health care delivery system cannot be achieved overnight. States must allow adequate time for health plans to develop the provider networks and other infrastructure required to serve the expected patient population, and to prepare realistic enrollment plans to solicit eligible individuals. Designers of such plans should spend sufficient time to give adequate consideration to all of the legal, technical, administrative and financial implications of the proposed experiment, and to review similar experiences in other states.

• **HCFA Monitoring:** HCFA should increase the resources devoted to monitoring 1115 and 1915(b) waivers, including TennCare. HCFA's Office of Research and Demonstrations and its Medicaid Managed Care Office, which have responsibility for these kinds of experiments, should be exempted from federal hiring freezes and should receive additional funding commensurate with the additional burdens they are being asked to assume. With respect to the Medicaid Managed Care Office, which has been without a director for several months, the appointment of a new director should be expedited both within HCFA and within the Clinton Administration as a whole.

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Soliciting and Facilitating Public Input: The development of any Medicaid demonstration or experiment should be done in the open, with ample opportunity for input from providers, patients, health plans, and other interested members of the public. While in the past States have been required to publish proposed state plan amendments with far less impact, HCFA has tended to treat waiver requests almost as if they were proprietary trade secrets. This situation must change if the waiver and demonstration process is to result in good public policy and a positive movement toward health reform. States should be required to publish their waiver applications, subject to a notice and comment period for the public. Similarly, HCFA should make all documentation relevant to such waivers or demonstrations readily available to the public, both before and after approval.

Ensuring Access: The federal government should consider some process to evaluate the impact of a Medicaid waiver on access to care for the poor so that such access (which is already limited under Medicaid) is not further restricted in the name of experimentation. Such a process could take the form of an "access impact assessment" akin to the environmental impact assessments required in other contexts. Such an assessment should be undertaken by independent evaluators.

3. Conclusion: Lessons for National Health Reform

In conclusion, it is possible to draw from the TennCare experience to date – and similar previous experiences in other settings – a number of important implications for national health reform.

- **Budget-cutting vs. Real Reform:** As a threshold matter, TennCare demonstrates beyond a shadow of doubt that policymakers cannot automatically assume that "managed care" is a panacea in every part of the country for meeting the needs of Medicaid patients and the uninsured in a cost-effective manner. While simply dictating a discounted per-capita premium to managed care organizations, as Tennessee has done, can clearly reduce costs in the short run, there should be no illusions that this is "reform", as opposed to simply cutting the Medicaid budget (or reducing the rate of growth of that budget).
- **Prior Managed Care Experience:** In particular, it is necessary to recognize that different states have vastly different managed care experiences and capabilities. Prior to TennCare, less than 6 percent of all Tennessee residents were enrolled in any kind of managed care organization. In fact, the State had experienced the recent HCFA termination of another, more limited, Medicaid managed care waiver, in part due to this inexperience. There are a number of other states that are in a similar situation.
- **Adequate Phase-In Time:** Another conclusion to be drawn from TennCare is that adequate start-up time is an essential component of any successful effort at widespread reform, especially if (like TennCare) wholesale changes are to be required in the very structure of a statewide health system. This need for a longer phase-in of major reforms can be illustrated by the much more sensible and cautious approaches being taken in states like Hawaii and Minnesota which have a more significant tradition of health reform.

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than Tennessee. Even in these states, however, new reforms have been implemented in careful stages, and with a willingness to postpone implementation if the system is determined not to be ready for a particular phase.

State HCFA Capabilities: Similarly, national health decision-makers must recognize the limitations of both state governments and HCFA itself in developing, implementing and monitoring major new reforms. Our impression is that Tennessee (in part by moving much too rapidly) was in way over its administrative head from the beginning — and that HCFA was spread so thinly administratively by other waivers and demonstrations that there was little ability to do more than accept the State's representations as to its own readiness and ability to meet HCFA conditions.

- **MCO and Provider Preparedness:** Much greater care must also be taken to assure that health plans and providers are themselves ready to implement even desirable reforms — that health plans are financially viable, have adequate provider networks, management, information systems, case management arrangements, and the ability to supply needed data to the State and federal government and other purchasers of care. Moreover, reforms often dramatically affect pre-existing provider relationships, such as between low income patients and public hospitals or community health centers. These types of essential providers must receive considerable transitional assistance in developing the necessary networks and organizations to compete in a "reformed" health system.

- **Sanctions for Abuses:** Attention must also be paid to the great potential for abuse of the reform process by new or existing health plans or managed care organizations that may respond to state or national reforms. Clearly, the experience with TennCare and in other states indicates that such abuses can take many forms, from redlining or other types of discrimination, to cream-skimming only the healthiest patients, to paying bribes, kickbacks, commissions, or "premiums" to salespeople or to enrollees themselves. Tough sanctions against such behavior must be included in any national plan, as well as by states, and consideration should be given to greatly restricting certain kinds of direct marketing of health plans to enrollees.

- **MCO Qualifications:** Similarly, the qualifications of plans and plan sponsors must be carefully assessed, from their financial viability to the adequacy of their provider networks and the quality and range of services they offer.

- **Adequate Provider Payments:** The adequacy of premiums and provider payments must also be taken into account, since a large scale "reform" centered around grossly inadequate payments will in essence bankrupt the entire system. Both standard payment methodologies (whether risk-based or point-of-service based) and the availability of supplemental payments to plans enrolling or providers serving large numbers of low income or other vulnerable patients must be carefully defined.

- **Protections for Vulnerable Populations:** Attention to the many needs of vulnerable populations generally is also an essential part of reforms — especially if the nature of the

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services covered or the providers participating dramatically changes. TennCare's dismal experience to date with the mentally ill population illustrates the concern that must be addressed for a wide range of vulnerable patient populations, including the homeless, AIDS patients, addicted or substance abusing patients, chronically ill or disabled adults and children.

○ Protections for Providers: Finally, TennCare clearly illustrates the need for stable, predictable payments (even after "reform") to those providers who continue to serve a high volume of vulnerable patients, including those, such as undocumented immigrants, who may fall through the cracks. TennCare has already demonstrated that these patients will require many services (above and beyond a "standard benefit package") whether or not they enroll in new health plans or managed care organizations.

EXCERPT FROM REPORT DETAILING ISSUE OF MEDICAID RULES

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* Over the course of NAPH's on-site evaluation of TennCare, we discovered the following facts relating to the provider networks as they exist in these early phases. Most MCOs did not begin to pursue provider contracts aggressively until HCFA finally approved the waiver. Since HCFA did not require the MCOs to submit detailed provider lists, the incomplete networks were not evident upon agency review.²⁰ To date, most MCOs are still trying to fill out their provider networks.

Moreover, many of the provider networks that the MCOs claim are in place often turn out to be illusory. When patients have been able to obtain a listing of participating providers, they frequently find that the providers no longer participate in the program, do not accept new patients or are not available to provide treatment. One woman in Shelby County received a list of 10 gynecologists from her MCO, but found that none of the physicians listed were accepting new patients. Indeed, some of the providers on her list were dead.

Upon the circulation of widespread reports of inaccurate provider lists, the Tennessee State Employees Association audited the December 14, 1993 Blue Cross/Blue Shield TPN physician list in six counties to determine if listed physicians were actually participating in TPN and available to provide services. Their research revealed gross inaccuracies in the lists. For instance, in Anderson County, the audit found that of the 27 physicians listed as participating in TPN, only 15 were still available to receive

²¹ One of the conditions for approval of the waiver application required the State to submit copies of individual provider agreements with the MCOs if HCFA requested them. To date, HCFA has made no such request. The widespread absence of executed written contracts between MCOs and providers may well constitute a violation of federal regulations promulgated under Section 1902(a)(4) and 1903(m) of the federal Medicaid statute. In particular, they may violate the Title XIX regulations (1) requiring all HMO subcontracts to be in writing (42 C.F.R. §§434.6(6), 434.50) and (2) directing state Medicaid agencies to obtain proof from each HMO of its ability to provide comprehensive medical services in an efficient, effective and economical manner (42 C.F.R. §§434.6(a)-(b)).

It is well-established that contracts can arise if there is a meeting of the minds on certain key terms, even if those terms are not reduced to writing. Hence, with respect to the current practice of many TennCare HMOs of referring enrollees to providers in the absence of a written subcontract, a legal subcontract nonetheless still exists between the HMO and provider since they will have negotiated services to be delivered, reimbursement, and other key terms. Given the existence of this legal contractual relationship, the arrangement must be in written form in order to comply with the federal regulations governing subcontracts.

The reason for requiring all subcontracts to be in written form relates directly to the other federal regulation directing state Medicaid agencies to obtain proof of an HMO's ability to provide the full range of services to which an enrollee is entitled under the HMO's benefits package. A state would encounter significant difficulties in verifying the adequacy of an HMO's capabilities unless the HMO's reliance on outside providers is laid out in writing. For this reason, state Medicaid agencies generally would not contract with an HMO unless they have had an opportunity to review and approve the HMO's subcontracts. In addition, each subcontract must contain certain mandatory provisions such as the population to be covered, procedures for enrollment and disenrollment, and maintenance of an appropriate records system. Tennessee's failure to conduct pre-contract reviews of HMO provider agreements is potentially a violation of the federal regulation requiring proof of HMO capabilities.