Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. list	[Personally Identifiable Information] [partial] (1 page)	06/22/1994	b(6)
001b. list	[Personally Identifiable Information] [partial] (1 page)	05/24/1994	b(6)

COLLECTION:
Clinton Presidential Records
Chief of Staff
Harold Ickes (Health Care Files)
OA/Box Number: 8104

FOLDER TITLE:
Waivers

2022-0433-S
rs3716

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Waivers hc

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

Florida waiver - ghosted

July 15, 1994

MEMORANDUM

TO: Carol Rasco
Christine Varney

FROM: Kevin Thurm

SUBJECT: Florida Waiver Update

Attached please find an update on the Florida waiver provided to me today. I understand Governor Chiles will be calling Leon Panetta and/or seeing the President over the weekend.

If you have any questions, please do not hesitate to call me.

Attachment

July 15, 1994

STATUS OF HCFA NEGOTIATIONS ON THE FLORIDA WAIVER

The State of Florida is seeking a waiver to implement the Florida Health Security (FHS) program, which would provide insurance to 1.1 million uninsured persons at or below 250% of the poverty level.

After several weeks of discussion, HCFA and the State have resolved a large number of issues. There are now two issues outstanding:

- **Budget Neutrality**: We are endeavoring to agree on a methodology to ensure that Florida spends no more under the waiver than it would have in the absence of a waiver. This would essentially create a cap on Medicaid spending. HHS and OMB have been concerned that Florida's estimate of what they would spend in the absence of a waiver is too high, creating a significant Federal budget risk. The President raised this issue with the Governor at their meeting last month.

  In computing the baseline costs that determine the spending cap, the State insists on using an estimate of the future growth rate rather than actual growth. However, the growth rate has slowed substantially in the past year, from 21% to 14% or even less. On Thursday, HCFA offered to lock in a 17.75% growth rate, which would be a favorable arrangement for the State. The State had been insisting on 18.5% and has not yet responded to this offer.

  Should Florida reject this offer, HCFA is prepared to make the State another offer using an alternate methodology.

- **Use of Insurance Agents**: Florida plans to use insurance agents to sell health plans under its FHS program. However, the Justice Department has indicated that Florida's plan would violate the Medicare/Medicaid anti-kickback statute. This statute addresses the policy concern that insurance plans could out-bid one another in offering remuneration of commissioned agents, and result in Medicaid patients being "steered" to plans offering the most lucrative commissions to the agent. There is considerable Congressional interest in this issue, with Rep. Waxman investigating whether some abusive, high-profit Medicaid managed care plans obtain enrollees by offering high commissions.

  Florida continues to argue that their plan does not violate the law. The Justice Department and the HHS Inspector General are once again explaining our position to the State.

The Secretary does have the authority to create a safe harbor from the statute, in "consultation" (interpreted by DOJ and OMB as "approval") with the Attorney General, if the HHS IG finds that the plan in question does not raise fraud and abuse concerns. We do not believe that the Justice Department or the HHS IG are prepared to make such an assurance at this time. In addition, issuing a safe harbor regulation for Florida would take several months at least, since it would require a proposed rule in the Federal Register, a public comment period, and a final regulation that responds to public comments. Such a timetable would be a problem for Florida.

It appears that Florida must alter their plan in order for it to be judged acceptable by the HHS IG and Justice, but they have so far shown no flexibility in doing so, citing political concerns.

Waivers
hc

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco

SUBJ: Waivers

DATE: July 24, 1994

FLORIDA: Following my last message to you about the impending call Attorney General Reno would make to Governor Chiles, I had a call late Friday evening from Governor Chiles' DC staff member who said they are all VERY appreciative of the work of the White House. AG Reno called the Governor's office and not only told them she felt the matter could be closed by having a flat commission for the insurance agents, but that she would like to have Justice Dept. officials sit down with Florida's legal advisors to discuss the matter fully for one last time. Jay Peterson who serves as Chiles' legal counsel is to meet by midweek this coming week with John Hogan of Justice who is also formerly from Florida. The parties know each other, trust each other and fully recognize they are looking at legal issues, not policy issues. I have asked Bruce Lindsey to call Buddy McKay as a follow up to his discussions with Buddy last week to make certain Buddy is aware of these latest developments.

NINTH CIRCUIT: HHS has advised Justice they do not feel there is a need for an appeal. I have attached the HHS memo outlining the rationale. In the meantime, HHS is confident they have in this administration created the necessary record in granting waivers and on the broader issue of public notice in rule making/waiver granting, HHS has been working on that issue with NGA/others anyway. We will continue to monitor this situation to make certain it does not become a false impediment to timely issuance of waivers.

I will be giving you per your request a regular update on the waivers described on the "pending" chart in your briefing materials for the NGA meeting.

cc: Leon Panetta
Lloyd Cutler
Phil Lader
Harold Ickes ✓
Bruce Lindsey
Marcia Hale
Joel Klein

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

July 22, 1994

TO : Kevin Thurm
Chief of Staff

Through: ES Cleeley 7/22/94

FROM : Deputy General Counsel

SUBJECT: Beno v. Shalala - Whether to request rehearing

The Ninth Circuit Court of Appeals has decided Beno v. Shalala, which involved a challenge to the Department's 1992 approval of a welfare demonstration project pursuant to Section 1115 of the Social Security Act. Reversing a trial court, the appellate panel held that, under the facts of this case, the Department could not legally grant the waivers needed to implement the proposed demonstration in the absence of an adequate documentary record to support its decision. While the discussion in the opinion is broad-ranging, the actual decision is quite narrow. Specifically, the court held that because of the importance of the objections raised by critics of the demonstration and the "extraordinarily sparse administrative record" the Department must review the proposal further.

A request for a rehearing of this decision, either by the panel that decided the case or en banc by the full Ninth Circuit, must be made by Wednesday, July 27th.

The following reasons argue against requesting further review:

1. There is no basis for seeking a review only by the panel that decided the case. There are no issues that we could raise that were not addressed in the decision.

2. Successful requests for hearing en banc generally require a strong factual case, where the holding of the court raises important issues of law or the threat of significant harm to the losing party. The facts in this case may not meet this test.

   Moreover, the precise legal holding is quite limited. It only requires the Department to create some administrative record to support its decision. To make a credible case for hearing en banc, however, DOJ might need to refer to the broad language in the decision and to characterize the decision as

having wider implications than a careful reading of the specific holding of the court would require. For example, it might be necessary to argue that the decision incorrectly requires the Department to develop an extensive administrative record supporting the approval of any demonstration. Filing papers that read the opinion broadly would be very undesirable since, if a rehearing is not granted, the Department would have made unnecessary concessions in this regard.

3. Because the specific holding is narrow, the Department should be able to comply with the mandate without a substantial change in policies or procedures and without increasing the time needed to review applications.

4. In fact, the standards for waiver review specified by the court are similar to those already adopted by the Department in the Section 1115 Policy Principles adopted last August. The procedures specified by the court generally are consistent with Section 1115 Procedural Principles currently being considered for adoption by the Department.

5. There is a possibility that an en banc review could result in a decision that is adverse to the Department on issues that were argued before, but not decided by, the current panel.

6. Even if the Circuit just affirmed the decision, this could expand the impact of the decision.

Michael S. Wald

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. list	[Personally Identifiable Information] [partial] (1 page)	06/22/1994	b(6)

COLLECTION:
Clinton Presidential Records
Chief of Staff
Harold Ickes (Health Care Files)
OA/Box Number: 8104

FOLDER TITLE:
Waivers

2022-0433-S
rs3716

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Waivers

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

HHS ATTENDEES
MEETING WITH GOVERNOR CHILES AND THE PRESIDENT
JUNE 23, 1994, 2:15 P.M., OVAL OFFICE
BRIEFING 2:00 P.M., OVAL OFFICE

NAME	DATE OF BIRTH	SOCIAL SECURITY NO.
Kevin Thurm		
John Monahan		
Judy Feder	(b)(6)	
Bruce Vladeck		
Kenneth Apfel		

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 22 1994

To: Kevin Thurm
Chief of Staff

From: Bruce Vladeck
Administrator

Subject: Update on Florida's Section 1115 Waiver Application

Purpose

This note provides an up-to-date summary of our discussions with the State of Florida on their proposed 1115 Medicaid waiver.

Proposal

The Florida Health Security (FHS) Program, submitted on February 10, uses a managed competition model to provide health insurance for 1.1 million low-income Floridians. The Florida waiver differs from other previously approved State-wide 1115 health care reform waivers in that the Florida Medicaid program, except for coverage of the medically needy, remains intact. FHS is a voluntary program for the non-Medicaid uninsured that allows employers and individuals with incomes below 250 percent of the poverty level to buy modified community rated insurance which is subsidized by the State and Federal government. Particular features include:

- Any family unit with gross annual income below 250 percent of poverty, irrespective of the value of their assets, will be eligible to apply.
- Insurance will be provided through Community Health Purchasing Alliances (CHPAs) that currently provide policies for the small employer market.
- Individuals and firms must be uninsured for 12 months prior to joining the CHPA.
- Purchase is entirely voluntary both on the part of the individual and employer.
- Medicaid eligibles, except for the medically needy who will be grandfathered into FHS, are ineligible for FHS and will remain in Medicaid.
- Licensed agents sell insurance policies through the CHPAs and receive commissions from the Accountable Health Partnerships.
- The benefit package is the Florida Department of Insurance (DOI) package used in the small employer market. It contains both managed care and indemnity packages, which contain significant cost sharing and fewer benefits than Medicaid.

The Florida legislature has not given final legislative approval to the proposal as the Senate is deadlocked 20-20 along party lines. Governor Chiles has already called one inconclusive special legislative session this summer and plans to call another shortly. Resolution of outstanding issues in the waiver application would presumably give the legislature additional impetus to act.

One unusual feature of FHS has made the evaluation of this waiver application more difficult than usual. FHS would use Medicaid savings to subsidize what the State considers a private sector program. Since our statutory authority is designed "...to assist in promoting the objectives of title XIX...", and FHS is designed for an uninsured low-income population, a major issue is the extent to which FHS must contain Medicaid-type features. The State wants FHS to mirror the small employer market and include many features of that market, including limited benefits and high cost-sharing to guard against inappropriate use and unfavorable risk selection. Nevertheless, Federal Medicaid funds must be used for a program that is consistent with the purposes of Medicaid, provides Medicaid-type protections for enrollees, and does not in effect become a block grant.

While we have managed to reach agreement with the State in several areas in reconciling these apparently conflicting objectives, several of the remaining unresolved issues stem from this conundrum. For example, as a general policy, managed care plans that enroll Medicaid beneficiaries must have no more than 75% Medicare/Medicaid enrollees. If we consider the FHS population to be Medicaid, some current Medicaid managed care plans may no longer meet this test. Approval could also create a precedent for subsequent State waivers.

Progress to Date

We are now actively engaged in negotiations with the State on the remaining outstanding issues, and are hopeful that we will ultimately reach agreement on a waiver provided the State is prepared to meet us halfway on some of the remaining issues. We have made substantial progress in supporting the State's policy goals while at the same time assuring access, quality, and financial protections given both our statutory authorities and our goals on health care reform. We have reached agreement on several issues ranging from protecting certain vulnerable populations to the basic methodology for calculating budget neutrality. We continue to meet to establish key final baseline estimates that will guarantee appropriate federal contributions.

Major Outstanding Issues

1. <u>Matching of Premiums</u>

Whenever private premiums have been collected on behalf of Medicaid beneficiaries, our longstanding policy prior to the Tennessee

waiver was to provide Federal match on total premiums minus employer and individual payments; that is, we only match State contributions. Florida is requesting that Federal matching payments be based on gross premiums including a combination of employer, employee, and State contribution. This proposal would have the State share diminish as income class increases. For example, at 200% to 250% of the Federal poverty level, an individual and employer would each contribute $25, the State $1, and the federal government $65. The State proposes to cap the number of enrollees at this higher income level.

In the case of the Tennessee waiver, we agreed to match individual premiums on a limited basis. Until recently we took the position in the negotiations that we would not agree to a Tennessee-like solution, because of our concern about reinforcing that precedent. However, we are now discussing an option that would limit federal exposure and assure reasonable matching shares by adjusting Florida's cap on higher income enrollees. It remains to be seen whether the State will accept this approach. One question is whether we should match employer premiums, which might set a new precedent at a time when we have additional pending waiver requests to do so, some of which are far more extensive (e.g. Massachusetts). We are attempting to structure the terms and conditions in a way that will minimize this issue.

2. Insurance Brokers

Under FHS, insurance brokers, not alliances as under HSA, market policies to individuals and receive commissions from the AHPs. We believe that this practice may contain incentives for agents to enroll healthy individuals or individuals receiving minimal State subsidies in plans, and to stay away from such populations as the medically needy. The State has indicated that this provision reflected a difficult political compromise with insurance brokers within the State. General Counsel has informed the State that this practice would violate Federal fraud and abuse laws, which bar commissions and kickbacks in Medicaid-related programs. This is still an open issue pending a meeting with the State and the Justice Department to obtain further clarification. Nevertheless, even if such a policy is not technically illegal, we feel it would be damaging to permit Federal matching funds for this purpose. We have informed the State of our position, and they are attempting to accommodate our concerns by ensuring that Federal funds are not used for this purpose.

3. Encounter Data

In all State-wide Medicaid waivers, we have required 100 percent encounter data in order to track and evaluate the demonstrations, especially to ensure access and quality for vulnerable populations. For Florida, we would use these data to estimate the impact of FHS on individuals who were insured through the demonstration, and to compare FHS's impact with those of other state-wide demonstrations.

Florida is opposed to providing 100 percent encounter data for physician services. They argue that such a requirement is extremely burdensome for managed care organizations and would undermine physician support for FHS. The State has offered to provide a one percent sample of physician encounters and says it is amenable to some increase in sample size. However, much of this data is already available, since most physicians, including many in managed care plans, are paid on an encounter basis.

We continue to believe that 100 percent encounter data is essential for several reasons. First, managed care arrangements create incentives for plans to restrict use of services. Second, such incentives are reinforced in the managed care and indemnity plans in FHS due to the high copayments. Third, because we are concerned about the impact of FHS on at-risk individuals located in various geographic areas and treated by different providers, we cannot specify all the samples we might need a priori. For example, it is possible that the underlying structure of FHS may deter appropriate levels of utilization for some groups (e.g., children with asthma living in underserved areas, pregnant women, persons with mental illness). Without 100% encounter data, we cannot evaluate such impacts. We are especially concerned with the civil rights dimension of a project such as Florida's, and we don't believe we can assure adequate compliance with civil rights laws without complete data. We are now attempting to write language for the terms and conditions of the waiver that would give beneficiaries necessary protection but also afford the State the appearance of a victory on this issue. We do not propose to make any substantive concessions on this issue at this time.

4. <u>Premium Rating Bands</u>

As in the small employer market, premiums under FHS are differentiated on the basis of age and sex. This will result in large differentials in premium rates by age (e.g. 5 to 1) and sex (e.g. 3 to 1). Since Federal and State premium subsidies are limited to a fixed percentage of a $116 benchmark premium, individuals in high premium bands (e.g. males 50-60) will face substantial out-of-pocket premium payments.

The State is willing to work with the Legislature to try to eliminate the rating factor by gender, but is not willing to drop the age factor. They argue that if they eliminate the age factor higher risk individuals will opt in while healthier younger people will not purchase FHS coverage. This will result in an increase in the baseline premium with the concomitant result of fewer individuals and employers buying coverage through FHS. The State is willing to consider narrowing the premium bands based on age over time. We believe that creating a disincentive for higher risk persons to obtain insurance is inconsistent with the principles of health care reform. We recommend a special term and condition that commits the State to a specific narrowing of the premium bands on

age, starting in the second year, be included as part of the waiver.

5. Copayments and Benefits

The high copayments in the managed care plans ($100 a day for the first five days of hospital care, $100 per visit for emergency care, and $10 per visit for prenatal and postnatal care) and indemnity plans (20 percent coinsurance) could create barriers to care. In a similar vein, benefits under FHS are far more limited than under Medicaid, especially with regard to EPSDT medically necessary follow-up services for children.

These features result from the FHS benefit package being conformed to the DOI small employer market package. The State has indicated that children in families with incomes below the poverty level will receive all necessary services through other State-sponsored programs, while women with infants who have incomes below 185 percent of poverty will be covered by Medicaid. Nevertheless, we still believe that these copayments and benefit limitations are inappropriate in a Medicaid demonstration where at least 60 percent of the enrollees will have incomes below 150% of the poverty level. We are attempting to structure a compromise whereby the State could subsidize some of the more egregious copayment and benefit gaps, especially for the traditionally high priority populations in the Medicaid program, e.g., the lowest-income enrollees, pregnant women, infants, and children.

Summary

We have made substantial progress to date. The State is now pushing hard to see draft final terms and conditions. We must proceed cautiously given the fact that any waivers provided to one State are immediately seen by all other states as a precedential minimum, and applications that are either already in house and impending contain very expensive expansions of these precedents. Further, Congressional unhappiness with the waiver process carries the risk of legislative restrictions on our authority under 1115 (if the District Court, in the NACHC lawsuit, doesn't impose such restrictions first). Nevertheless, we are still hopeful that we will be able to construct an agreement that will satisfy both parties.

cc: Ken Apfel
Judy Feder
Jerry Klepner
John Monahan

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 22 1994

To: Kevin Thurm
Chief of Staff

From: Bruce Vladeck
Administrator

Subject: Update on Florida's Section 1115 Waiver Application

Purpose

This note provides an up-to-date summary of our discussions with the State of Florida on their proposed 1115 Medicaid waiver.

Proposal

The Florida Health Security (FHS) Program, submitted on February 10, uses a managed competition model to provide health insurance for 1.1 million low-income Floridians. The Florida waiver differs from other previously approved State-wide 1115 health care reform waivers in that the Florida Medicaid program, except for coverage of the medically needy, remains intact. FHS is a voluntary program for the non-Medicaid uninsured that allows employers and individuals with incomes below 250 percent of the poverty level to buy modified community rated insurance which is subsidized by the State and Federal government. Particular features include:

- Any family unit with gross annual income below 250 percent of poverty, irrespective of the value of their assets, will be eligible to apply.
- Insurance will be provided through Community Health Purchasing Alliances (CHPAs) that currently provide policies for the small employer market.
- Individuals and firms must be uninsured for 12 months prior to joining the CHPA.
- Purchase is entirely voluntary both on the part of the individual and employer.
- Medicaid eligibles, except for the medically needy who will be grandfathered into FHS, are ineligible for FHS and will remain in Medicaid.
- Licensed agents sell insurance policies through the CHPAs and receive commissions from the Accountable Health Partnerships.
- The benefit package is the Florida Department of Insurance (DOI) package used in the small employer market. It contains both managed care and indemnity packages, which contain significant cost sharing and fewer benefits than Medicaid.

The Florida legislature has not given final legislative approval to the proposal as the Senate is deadlocked 20-20 along party lines. Governor Chiles has already called one inconclusive special legislative session this summer and plans to call another shortly. Resolution of outstanding issues in the waiver application would presumably give the legislature additional impetus to act.

One unusual feature of FHS has made the evaluation of this waiver application more difficult than usual. FHS would use Medicaid savings to subsidize what the State considers a private sector program. Since our statutory authority is designed "...to assist in promoting the objectives of title XIX...", and FHS is designed for an uninsured low-income population, a major issue is the extent to which FHS must contain Medicaid-type features. The State wants FHS to mirror the small employer market and include many features of that market, including limited benefits and high cost-sharing to guard against inappropriate use and unfavorable risk selection. Nevertheless, Federal Medicaid funds must be used for a program that is consistent with the purposes of Medicaid, provides Medicaid-type protections for enrollees, and does not in effect become a block grant.

While we have managed to reach agreement with the State in several areas in reconciling these apparently conflicting objectives, several of the remaining unresolved issues stem from this conundrum. For example, as a general policy, managed care plans that enroll Medicaid beneficiaries must have no more than 75% Medicare/Medicaid enrollees. If we consider the FHS population to be Medicaid, some current Medicaid managed care plans may no longer meet this test. Approval could also create a precedent for subsequent State waivers.

Progress to Date

We are now actively engaged in negotiations with the State on the remaining outstanding issues, and are hopeful that we will ultimately reach agreement on a waiver provided the State is prepared to meet us halfway on some of the remaining issues. We have made substantial progress in supporting the State's policy goals while at the same time assuring access, quality, and financial protections given both our statutory authorities and our goals on health care reform. We have reached agreement on several issues ranging from protecting certain vulnerable populations to the basic methodology for calculating budget neutrality. We continue to meet to establish key final baseline estimates that will guarantee appropriate federal contributions.

Major Outstanding Issues

1. <u>Matching of Premiums</u>

Whenever private premiums have been collected on behalf of Medicaid beneficiaries, our longstanding policy prior to the Tennessee

waiver was to provide Federal match on total premiums minus employer and individual payments; that is, we only match State contributions. Florida is requesting that Federal matching payments be based on gross premiums including a combination of employer, employee, and State contribution. This proposal would have the State share diminish as income class increases. For example, at 200% to 250% of the Federal poverty level, an individual and employer would each contribute $25, the State $1, and the federal government $65. The State proposes to cap the number of enrollees at this higher income level.

In the case of the Tennessee waiver, we agreed to match individual premiums on a limited basis. Until recently we took the position in the negotiations that we would not agree to a Tennessee-like solution, because of our concern about reinforcing that precedent. However, we are now discussing an option that would limit federal exposure and assure reasonable matching shares by adjusting Florida's cap on higher income enrollees. It remains to be seen whether the State will accept this approach. One question is whether we should match employer premiums, which might set a new precedent at a time when we have additional pending waiver requests to do so, some of which are far more extensive (e.g. Massachusetts). We are attempting to structure the terms and conditions in a way that will minimize this issue.

2. Insurance Brokers

Under FHS, insurance brokers, not alliances as under HSA, market policies to individuals and receive commissions from the AHPs. We believe that this practice may contain incentives for agents to enroll healthy individuals or individuals receiving minimal State subsidies in plans, and to stay away from such populations as the medically needy. The State has indicated that this provision reflected a difficult political compromise with insurance brokers within the State. General Counsel has informed the State that this practice would violate Federal fraud and abuse laws, which bar commissions and kickbacks in Medicaid-related programs. This is still an open issue pending a meeting with the State and the Justice Department to obtain further clarification. Nevertheless, even if such a policy is not technically illegal, we feel it would be damaging to permit Federal matching funds for this purpose. We have informed the State of our position, and they are attempting to accommodate our concerns by ensuring that Federal funds are not used for this purpose.

3. Encounter Data

In all State-wide Medicaid waivers, we have required 100 percent encounter data in order to track and evaluate the demonstrations, especially to ensure access and quality for vulnerable populations. For Florida, we would use these data to estimate the impact of FHS on individuals who were insured through the demonstration, and to compare FHS's impact with those of other state-wide demonstrations.

Florida is opposed to providing 100 percent encounter data for physician services. They argue that such a requirement is extremely burdensome for managed care organizations and would undermine physician support for FHS. The State has offered to provide a one percent sample of physician encounters and says it is amenable to some increase in sample size. However, much of this data is already available, since most physicians, including many in managed care plans, are paid on an encounter basis.

We continue to believe that 100 percent encounter data is essential for several reasons. First, managed care arrangements create incentives for plans to restrict use of services. Second, such incentives are reinforced in the managed care and indemnity plans in FHS due to the high copayments. Third, because we are concerned about the impact of FHS on at-risk individuals located in various geographic areas and treated by different providers, we cannot specify all the samples we might need a priori. For example, it is possible that the underlying structure of FHS may deter appropriate levels of utilization for some groups (e.g., children with asthma living in underserved areas, pregnant women, persons with mental illness). Without 100% encounter data, we cannot evaluate such impacts. We are especially concerned with the civil rights dimension of a project such as Florida's, and we don't believe we can assure adequate compliance with civil rights laws without complete data. We are now attempting to write language for the terms and conditions of the waiver that would give beneficiaries necessary protection but also afford the State the appearance of a victory on this issue. We do not propose to make any substantive concessions on this issue at this time.

4. <u>Premium Rating Bands</u>

As in the small employer market, premiums under FHS are differentiated on the basis of age and sex. This will result in large differentials in premium rates by age (e.g. 5 to 1) and sex (e.g. 3 to 1). Since Federal and State premium subsidies are limited to a fixed percentage of a $116 benchmark premium, individuals in high premium bands (e.g. males 50-60) will face substantial out-of-pocket premium payments.

The State is willing to work with the Legislature to try to eliminate the rating factor by gender, but is not willing to drop the age factor. They argue that if they eliminate the age factor higher risk individuals will opt in while healthier younger people will not purchase FHS coverage. This will result in an increase in the baseline premium with the concomitant result of fewer individuals and employers buying coverage through FHS. The State is willing to consider narrowing the premium bands based on age over time. We believe that creating a disincentive for higher risk persons to obtain insurance is inconsistent with the principles of health care reform. We recommend a special term and condition that commits the State to a specific narrowing of the premium bands on

age, starting in the second year, be included as part of the waiver.

5. Copayments and Benefits

The high copayments in the managed care plans ($100 a day for the first five days of hospital care, $100 per visit for emergency care, and $10 per visit for prenatal and postnatal care) and indemnity plans (20 percent coinsurance) could create barriers to care. In a similar vein, benefits under FHS are far more limited than under Medicaid, especially with regard to EPSDT medically necessary follow-up services for children.

These features result from the FHS benefit package being conformed to the DOI small employer market package. The State has indicated that children in families with incomes below the poverty level will receive all necessary services through other State-sponsored programs, while women with infants who have incomes below 185 percent of poverty will be covered by Medicaid. Nevertheless, we still believe that these copayments and benefit limitations are inappropriate in a Medicaid demonstration where at least 60 percent of the enrollees will have incomes below 150% of the poverty level. We are attempting to structure a compromise whereby the State could subsidize some of the more egregious copayment and benefit gaps, especially for the traditionally high priority populations in the Medicaid program, e.g., the lowest-income enrollees, pregnant women, infants, and children.

Summary

We have made substantial progress to date. The State is now pushing hard to see draft final terms and conditions. We must proceed cautiously given the fact that any waivers provided to one State are immediately seen by all other states as a precedential minimum, and applications that are either already in house and impending contain very expensive expansions of these precedents. Further, Congressional unhappiness with the waiver process carries the risk of legislative restrictions on our authority under 1115 (if the District Court, in the NACHC lawsuit, doesn't impose such restrictions first). Nevertheless, we are still hopeful that we will be able to construct an agreement that will satisfy both parties.

cc: Ken Apfel
Judy Feder
Jerry Klepner
John Monahan

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 22 1994

To: Kevin Thurm
Chief of Staff

From: Bruce Vladeck
Administrator

Subject: Update on Florida's Section 1115 Waiver Application

Purpose

This note provides an up-to-date summary of our discussions with the State of Florida on their proposed 1115 Medicaid waiver.

Proposal

The Florida Health Security (FHS) Program, submitted on February 10, uses a managed competition model to provide health insurance for 1.1 million low-income Floridians. The Florida waiver differs from other previously approved State-wide 1115 health care reform waivers in that the Florida Medicaid program, except for coverage of the medically needy, remains intact. FHS is a voluntary program for the non-Medicaid uninsured that allows employers and individuals with incomes below 250 percent of the poverty level to buy modified community rated insurance which is subsidized by the State and Federal government. Particular features include:

- Any family unit with gross annual income below 250 percent of poverty, irrespective of the value of their assets, will be eligible to apply.
- Insurance will be provided through Community Health Purchasing Alliances (CHPAs) that currently provide policies for the small employer market.
- Individuals and firms must be uninsured for 12 months prior to joining the CHPA.
- Purchase is entirely voluntary both on the part of the individual and employer.
- Medicaid eligibles, except for the medically needy who will be grandfathered into FHS, are ineligible for FHS and will remain in Medicaid.
- Licensed agents sell insurance policies through the CHPAs and receive commissions from the Accountable Health Partnerships.
- The benefit package is the Florida Department of Insurance (DOI) package used in the small employer market. It contains both managed care and indemnity packages, which contain significant cost sharing and fewer benefits than Medicaid.

The Florida legislature has not given final legislative approval to the proposal as the Senate is deadlocked 20-20 along party lines. Governor Chiles has already called one inconclusive special legislative session this summer and plans to call another shortly. Resolution of outstanding issues in the waiver application would presumably give the legislature additional impetus to act.

One unusual feature of FHS has made the evaluation of this waiver application more difficult than usual. FHS would use Medicaid savings to subsidize what the State considers a private sector program. Since our statutory authority is designed "...to assist in promoting the objectives of title XIX...", and FHS is designed for an uninsured low-income population, a major issue is the extent to which FHS must contain Medicaid-type features. The State wants FHS to mirror the small employer market and include many features of that market, including limited benefits and high cost-sharing to guard against inappropriate use and unfavorable risk selection. Nevertheless, Federal Medicaid funds must be used for a program that is consistent with the purposes of Medicaid, provides Medicaid-type protections for enrollees, and does not in effect become a block grant.

While we have managed to reach agreement with the State in several areas in reconciling these apparently conflicting objectives, several of the remaining unresolved issues stem from this conundrum. For example, as a general policy, managed care plans that enroll Medicaid beneficiaries must have no more than 75% Medicare/Medicaid enrollees. If we consider the FHS population to be Medicaid, some current Medicaid managed care plans may no longer meet this test. Approval could also create a precedent for subsequent State waivers.

Progress to Date

We are now actively engaged in negotiations with the State on the remaining outstanding issues, and are hopeful that we will ultimately reach agreement on a waiver provided the State is prepared to meet us halfway on some of the remaining issues. We have made substantial progress in supporting the State's policy goals while at the same time assuring access, quality, and financial protections given both our statutory authorities and our goals on health care reform. We have reached agreement on several issues ranging from protecting certain vulnerable populations to the basic methodology for calculating budget neutrality. We continue to meet to establish key final baseline estimates that will guarantee appropriate federal contributions.

Major Outstanding Issues

1. <u>Matching of Premiums</u>

Whenever private premiums have been collected on behalf of Medicaid beneficiaries, our longstanding policy prior to the Tennessee

waiver was to provide Federal match on total premiums minus employer and individual payments; that is, we only match State contributions. Florida is requesting that Federal matching payments be based on gross premiums including a combination of employer, employee, and State contribution. This proposal would have the State share diminish as income class increases. For example, at 200% to 250% of the Federal poverty level, an individual and employer would each contribute $25, the State $1, and the federal government $65. The State proposes to cap the number of enrollees at this higher income level.

In the case of the Tennessee waiver, we agreed to match individual premiums on a limited basis. Until recently we took the position in the negotiations that we would not agree to a Tennessee-like solution, because of our concern about reinforcing that precedent. However, we are now discussing an option that would limit federal exposure and assure reasonable matching shares by adjusting Florida's cap on higher income enrollees. It remains to be seen whether the State will accept this approach. One question is whether we should match employer premiums, which might set a new precedent at a time when we have additional pending waiver requests to do so, some of which are far more extensive (e.g. Massachusetts). We are attempting to structure the terms and conditions in a way that will minimize this issue.

2. Insurance Brokers

Under FHS, insurance brokers, not alliances as under HSA, market policies to individuals and receive commissions from the AHPs. We believe that this practice may contain incentives for agents to enroll healthy individuals or individuals receiving minimal State subsidies in plans, and to stay away from such populations as the medically needy. The State has indicated that this provision reflected a difficult political compromise with insurance brokers within the State. General Counsel has informed the State that this practice would violate Federal fraud and abuse laws, which bar commissions and kickbacks in Medicaid-related programs. This is still an open issue pending a meeting with the State and the Justice Department to obtain further clarification. Nevertheless, even if such a policy is not technically illegal, we feel it would be damaging to permit Federal matching funds for this purpose. We have informed the State of our position, and they are attempting to accommodate our concerns by ensuring that Federal funds are not used for this purpose.

3. Encounter Data

In all State-wide Medicaid waivers, we have required 100 percent encounter data in order to track and evaluate the demonstrations, especially to ensure access and quality for vulnerable populations. For Florida, we would use these data to estimate the impact of FHS on individuals who were insured through the demonstration, and to compare FHS's impact with those of other state-wide demonstrations.

Florida is opposed to providing 100 percent encounter data for physician services. They argue that such a requirement is extremely burdensome for managed care organizations and would undermine physician support for FHS. The State has offered to provide a one percent sample of physician encounters and says it is amenable to some increase in sample size. However, much of this data is already available, since most physicians, including many in managed care plans, are paid on an encounter basis.

We continue to believe that 100 percent encounter data is essential for several reasons. First, managed care arrangements create incentives for plans to restrict use of services. Second, such incentives are reinforced in the managed care and indemnity plans in FHS due to the high copayments. Third, because we are concerned about the impact of FHS on at-risk individuals located in various geographic areas and treated by different providers, we cannot specify all the samples we might need a priori. For example, it is possible that the underlying structure of FHS may deter appropriate levels of utilization for some groups (e.g., children with asthma living in underserved areas, pregnant women, persons with mental illness). Without 100% encounter data, we cannot evaluate such impacts. We are especially concerned with the civil rights dimension of a project such as Florida's, and we don't believe we can assure adequate compliance with civil rights laws without complete data. We are now attempting to write language for the terms and conditions of the waiver that would give beneficiaries necessary protection but also afford the State the appearance of a victory on this issue. We do not propose to make any substantive concessions on this issue at this time.

4. <u>Premium Rating Bands</u>

As in the small employer market, premiums under FHS are differentiated on the basis of age and sex. This will result in large differentials in premium rates by age (e.g. 5 to 1) and sex (e.g. 3 to 1). Since Federal and State premium subsidies are limited to a fixed percentage of a $116 benchmark premium, individuals in high premium bands (e.g. males 50-60) will face substantial out-of-pocket premium payments.

The State is willing to work with the Legislature to try to eliminate the rating factor by gender, but is not willing to drop the age factor. They argue that if they eliminate the age factor higher risk individuals will opt in while healthier younger people will not purchase FHS coverage. This will result in an increase in the baseline premium with the concomitant result of fewer individuals and employers buying coverage through FHS. The State is willing to consider narrowing the premium bands based on age over time. We believe that creating a disincentive for higher risk persons to obtain insurance is inconsistent with the principles of health care reform. We recommend a special term and condition that commits the State to a specific narrowing of the premium bands on

age, starting in the second year, be included as part of the waiver.

5. Copayments and Benefits

The high copayments in the managed care plans ($100 a day for the first five days of hospital care, $100 per visit for emergency care, and $10 per visit for prenatal and postnatal care) and indemnity plans (20 percent coinsurance) could create barriers to care. In a similar vein, benefits under FHS are far more limited than under Medicaid, especially with regard to EPSDT medically necessary follow-up services for children.

These features result from the FHS benefit package being conformed to the DOI small employer market package. The State has indicated that children in families with incomes below the poverty level will receive all necessary services through other State-sponsored programs, while women with infants who have incomes below 185 percent of poverty will be covered by Medicaid. Nevertheless, we still believe that these copayments and benefit limitations are inappropriate in a Medicaid demonstration where at least 60 percent of the enrollees will have incomes below 150% of the poverty level. We are attempting to structure a compromise whereby the State could subsidize some of the more egregious copayment and benefit gaps, especially for the traditionally high priority populations in the Medicaid program, e.g., the lowest-income enrollees, pregnant women, infants, and children.

Summary

We have made substantial progress to date. The State is now pushing hard to see draft final terms and conditions. We must proceed cautiously given the fact that any waivers provided to one State are immediately seen by all other states as a precedential minimum, and applications that are either already in house and impending contain very expensive expansions of these precedents. Further, Congressional unhappiness with the waiver process carries the risk of legislative restrictions on our authority under 1115 (if the District Court, in the NACHC lawsuit, doesn't impose such restrictions first). Nevertheless, we are still hopeful that we will be able to construct an agreement that will satisfy both parties.

cc: Ken Apfel
Judy Feder
Jerry Klepner
John Monahan

Waivers
hc

M E M O R A N D U M

TO: H.I.

FROM: J.E.

DATE: 20 June 1994

RE: Florida - Chiles; - waivers

As you know, you are expected to make a decision on whether or not Gov. Chiles gets a meeting with the President. (Your staff of department heads has deferred this one to you, with the consensus being that Chiles should not meet with the President, but that the President will probably feel that he should...)

Marcia Hale has had a discussion with Kevin as have I.

Kevin will give you a more detailed account of his view, but the short answer is:

"If we decide not to grant the waiver, then the President should not see Chiles. If we decide to grant it, then he should..."

He feels that if Chiles comes in in advance of the decision, he may end up with "egg on his face" next week.

Although HHS is not scheduled to have a decision until next week, Kevin felt there would be some information on this by late today.

As you know, Gov. Chiles has called himself to speak to you.

Waivers
hc

MEMORANDUM

TO: HAROLD ICKES
CAROL RASCO
MARCIA HALE
FR: JOHN HART
DT: JUNE 10, 1994
RE: FLORIDA'S MEDICAID WAIVER REQUEST AND GOVERNOR CHILES' HEALTH CARE PROPOSAL

I. Summary

As you know, Governor Chiles has applied to the Department of Health and Human Services for a Medicaid waiver in order to fully implement his health care reform proposal. Governor Chiles called a special session of the Florida legislature this week to vote on final measures of his health care plan. On Thursday, June 9, 1994 the Florida Senate Health Committee voted 4 - 4 on party lines on Governor Chiles' proposal, killing the plan for the time being. The Governor's office has indicated they will return to Washington shortly to resume negotiations on their waiver application.

II. Special Session

An issue arose regarding the politicizing of the waiver review process and using customary questions and requests for information from the Health Care Financing Administration (HCFA) as indications that Governor Chiles' Waiver Application would not be granted. Lieutenant Governor Buddy MacKay and health policy advisors to Governor Chiles contacted the Administration to request some form of a statement from the Administration that Florida's waiver request was going through the customary channels at HCFA and that the application was being given the appropriate consideration. As you recall, I drafted a letter to Governor Chiles clarifying the process. I faxed that letter to Lt Gov Buddy MacKay late yesterday afternoon. Governor Chiles publicly blamed election year politics as the motivation of those Senators who voted against his proposal.

III. Next Action

Governor Chiles has stated that he may call another special session in August or September to revisit this issue. HCFA will continue their review process of Florida's waiver application. Governor Chiles' staff have indicated that they will return to Washington ready to negotiate their waiver request with HHS. I will continue to follow the process and keep you abreast of developments.

Meeting Tues 5/24 WAIVERS Kc

cc: Harold Ickes

CONFIDENTIAL

To: The President

From: Nancy Hernreich

Date: May 5, 1994

Re: Call from Lieutenant Governor Buddy McKay

Lieutenant Governor Buddy McKay called this morning to follow up on the conversations he had with you this weekend. He tried to get Sandy Friedman to reconsider. She was complimented, but said she could not do it. The best potential candidates in his opinion would be Jim Bacchus and John Hart. Baccus could be recruited if he could be guaranted help to raise money. McKay thinks Bacchus could win the election. John Hart is the County Commissioner of Broward County, where he could raise a lot of money, and he is electable. McKay's phone number is (904) 488-4711.

5/12/94 -

Nancy - I talked with McKay and have arranged ~~for~~ to meet with him -

Harold -

5/6

Return to Nancy H - ✓

Dave

Make copy for us first.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. list	[Personally Identifiable Information] [partial] (1 page)	05/24/1994	b(6)

COLLECTION:
Clinton Presidential Records
Chief of Staff
Harold Ickes (Health Care Files)
OA/Box Number: 8104

FOLDER TITLE:
Waivers

2022-0433-S
rs3716

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Janice:

Tuesday, May 24th
1:00 p.m.
Meeting with HI/Lt. Governor MacKay and Douglas Cook

Kenneth MacKay (Buddy)
dob:
ss#: (b)(6)

Douglas M. Cook
dob:
ss#:

contact: Jean Sadowski
Governor MacKay's office
904-488-4711

David -
Make sure these 2 are ~~[illegible]~~ waived in.

J.

1pm Tuesday

M E M O R A N D U M

TO: H.I.

FROM: J.E.

DATE: 23 May 1994

RE: Lt. Gov of Florida, Buddy McKay

You are scheduled to meet with McKay tomorrow (Tuesday) at the President's request (I believe).

Attached is a briefing memo from HHS (sent by Kevin Thurm, prepared by John Monahan).

In addition, John Hart called from the road to give me the following pointers:

- McKay will push hard fro Florida waivers
- you should defer to HHS and emphasize that they are giving this their full attention and will expeditious about it
- the WH is very much aware of the political problems that Gov. Chiles is enduring as a result of this situation

Finally, Marcia Hale warns that McKay will try and maneuver time for Chiles to come into meet with the President. (She thinks it is not a good idea and that certainly we are not ready for that to happen.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

TO: Carol Rasco
through CoS

FROM: Bruce Vladeck

RE: Florida's 1115 Waiver Proposal

DATE: May 23, 1994

I understand that the Lieutenant Governor of Florida will be at the White House tomorrow to discuss, among other items, Florida's 1115 waiver proposal, entitled the "Florida Health Security Program (FHSP)." It may be useful for you to have a better sense of the process and issues. We recommend that you listen to the State's concerns, but encourage the State to continue talking with HCFA.

Process

Florida submitted its waiver proposal to HCFA on February 10. HCFA has been engaged in an intensive review of it since then. To give you a sense of the scope of this effort, Florida's responses to our questions about the proposal occupied more than 1000 pages.

The Florida State Legislature goes into session to consider the FHSP on June 6, and HCFA will need some time to consider revisions, if any, made to the proposal during the legislative session. Otherwise, we're still on target for a decision in late June, which is when the 120-day deadline occurs, taking into account the weeks Florida took to respond to our questions. HCFA staff is meeting all day May 24 with the State of Florida to lay out its concerns with the waiver proposal which Florida has already submitted. We do not expect that all issues will be worked out at this meeting.

Summary of FHSP

The program will utilize a managed competition model and will provide voluntary health insurance for up to 1.1 million uninsured Floridians with income at or below 250% of the Federal poverty level. Health plans will be offered by Accountable Health Partnerships and sold by Community Health Purchasing Alliances. Medicaid will remain a separate program.

Major Issues

Some of the more serious problems with the Florida proposal are:

- While other states have sought 1115 waivers to finance eligibility expansions in their Medicaid programs, FHSP seeks to use Medicaid dollars to finance a program that is separate from Medicaid and that the state considers not to be subject to the same level of oversight that exists in Medicaid.

- Under the FHSP, the health plans would pay insurance agents to be the vehicle through which most people get information about available plans. This may be a violation of fraud and abuse amendments under Title XIX.

- HCFA's 1115 waiver authority was granted to run demonstrations which will help us to learn more about service delivery issues. Florida has said that it will not collect 100% encounter data, which is critical to our ability to evaluate the program and has been required in all demonstration programs.

- Due to elimination of the Medically Needy program, approximately 2000 individuals currently covered by Medicaid will lose health insurance coverage entirely.

- Florida is requesting federal match of employee and employer premium contributions.

- Florida is proposing a 6-month residency requirement for all Florida Health Security applicants. Our Office of General Counsel considers this provision to be clearly unconstitutional.

FHSP and Health Reform

Assuming we approve some version of the FHSP, the approval will likely be at the same time that key decisions on the ultimate shape of health care reform are being made on the Hill. If we approved the FHSP as proposed, the Administration could inadvertently be seen as sending signals that parts of the President's plan are not crucial to health care reform. Florida has claimed that its proposal is very similar to the Health Security Act (HSA). Some ways in which the FHSP differs from the HSA are:

- The FHSP does not mainstream Medicaid recipients.

- There is a 12 month pre-existing condition exclusion under the FHSP.

- Approximately 2000 persons currently on Medicaid will lose health insurance coverage.

- The benefits package under FHSP is less comprehensive than that offered under the HSA.

- Employers may limit which plans are offered to their employees under the FHSP.

cc: Harold Ickes

Lt Gov McKay - 5/23/94 -

+3

- BMc - thinks that HHS can accommodate Fla needs
- Fla legislature will adopt the new program -
- need political light
- largest private health expansion system in the country

Spend ~~saves~~

Financed by:

[- savings from medicaid
- private sector
-]

Fla Health Security - ~~for~~ if it succeeds will prove that readjustment can be made; that affordable coverage can be ~~so~~ made; & that savings can be made

Based on ~~alliances~~ (voluntary) alliances

*[Problem by HHS - use of medicaid $ for a private health system]

→ 500 - 600,000 of 1.1 million that could be insured will be in by 1996

- Have a 20/20 Senate
- Need some sound of support from HHS that waiver may be put to ~~cong~~ cong. convey -

→ Cover people up to 250% of poverty

Argument by ~~opponents~~ opponents (republicans) is that fed govt won't give the waiver - Therefore no need to pass health security act

(*) Use of medicaid $ for private health care solution

[Would be willing to do same as ~~Indians~~ Indians & Fla re ~~Everglades~~ Everglades]

Florida §1115 - waiver - 5/23/94

- Margaret Pugh

Waiver - wants to implement

- alternative to medicaid
- waiver of Social Security Act
- requires ratification by state legislature & then federal approval -
- we have done this a lot
- Gov chiles

- looks like a medicaid expansion; but really is an eligibility expansion to put existing medicaid recipients into a new state program -

• Never done before

(?) - also new evaluation system that would focus on [illegible] recipients

- Fla program would lose the federal medically needy program

• very limit choice

- concerns about the benefit package
- about a month to work it out
- proposal hasn't been ratified by Fla State legislature
- Policy people from Fla are dealing w/ policy people from HCFA & HHS

→ - 180 day deadline runs out end of June

- waiver expert presently [illegible] since Wednesday -

10 Feby 94

- Vladeck still not in the meeting at HHS
- HCFA doesn't believe it can approve the request yet & may never be able to approve -

- Try to ~~so~~ provide ^immune ~~[illegible]~~ to low income population

(John Morrison)

Differences: per Fla:

- Typically
- Paying voluntary allowance & use fed ~~[illegible]~~ $ to pay for the ~~the~~ allowance.
- Use fed ~~[illegible]~~ $ for quasi private initiative
- Using fed $ (not to initiate state $); rather using it to subsidize ~~gen~~ private sector program.

- Important to child's re-election
- child's calling a special session of the legislature
- No way of getting a waiver before 85 [illegible] special session
- If we can't resolve the issues, how can we save ~~[illegible]~~ face –

THE WHITE HOUSE
WASHINGTON

DATE: 02/07/94

TO: PHIL LADER
HAROLD ICKES
GEORGE STEPHANOPOULOS
MARK GEARAN
PAT GRIFFIN

FROM: **JOHN D. PODESTA**
Assistant to the President and Staff Secretary

FYI.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

94 FEB 7 P5:53

TO: Carol Rasco
Assistant to the President
for Domestic Policy

FROM: Kevin Thurm

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.

We received about 1,200 letters before the award was made. Virtually all were from providers or provider industry groups who objected to TennCare. Their complaints centered around the reimbursement levels proposed by the State, and a Blue Cross/ Blue Shield of Tennessee threat to exclude providers from their other products if they did not take TennCare patients. Since the approval of the demonstration, we have received a few phone calls and provider letters, and a handful of negative beneficiary letters, some of which were form letters that providers had encouraged their patients to send. We have received no negative calls or letters from beneficiary advocacy groups.

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.

Reports on Beneficiary Problems

There have been press reports indicating that it has been difficult for beneficiaries and providers to contact the State and MCOs. In response the State has added personnel to meet the demand and instituted an 800-number. Several MCOs have also instituted 800-numbers.

All reports HCFA has received about problems beneficiaries have had in getting care have been investigated by central or regional office staff, with the cooperation of State Medicaid staff. Tennessee newspapers have reported on two deaths. One was an AIDS patient who was transferred from a hospital not in his MCO to another 40 miles away. In that case, the attending physician was quoted as indicating that he would not have transferred the patient if he had known he was critically ill. The second death was an

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.