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This calls for some action — can we offer profile of Pres. concern on physician errors?

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Podesta

Nation Is Falling Short Of Health Goals for 2000

But Some Progress Is Also Being Reported

By PHILIP J. HILTS

BOSTON, June 10 — The United States has met only about 15 percent of its health goals for the year 2000, set 20 years ago, the Department of Health and Human Services reported today, but progress has been made on 44 percent.

For about 20 percent of the objectives, the nation is getting less healthy and is moving away from the goals, Surgeon General David Satcher said at a news conference at Harvard Medical School in Boston.

"In some ways we are doing well," Dr. Satcher said, "and in others we still have challenges and more to do."

In Washington, Donna E. Shalala, the Secretary of Health and Human Services, said, "As the century draws to a close, we can be proud that we have made significant strides in improving the health of Americans."

Dr. Shalala said the progress report "lets us measure the overall progress we have achieved in preventing disease and promoting health."

The report, Healthy People 2000 Review, outlined 319 different health goals for the nation that were set at the start of 1979 and reviewed in 1989. They include progress on such disparate measures as infant mortality, the rate of dental cavities, average physical activity, teen-age pregnancy, hearing impairment and the rates of a variety of diseases.

Among the areas where goals have been met are reductions in infant mortality, childhood mortality and breast cancer deaths. Among those where the report showed the nation was getting worse were in the level of physical activity, the number of children taking physical education and the number of people overweight or obese.

Dr. Julius Richmond, who as Surgeon General established the Healthy People 2000 program, said watching the change in health patterns over the past 20 years had produced some surprises. Among the most surprising is a 35 percent drop in heart disease and a 65 percent decline in strokes.

"That just came unexpectedly," Dr. Richmond said, "and we are still not sure of all the factors that contributed to it."

A disappointment among the data is that while infant mortality has continued to decline, and is almost at the goal, there remains a great disparity between the rate for whites and for blacks. The death rate among black infants is about twice that for whites, Dr. Richmond said. "and has been that way for decades."

Dr. Satcher said other health disparities among ethnic groups were also troubling. Hispanics are twice as likely as whites to be diabetic and

Declines of 35% in heart disease and 65% in strokes.

African-Americans have a disproportionately high death rate from diabetes. African-Americans are also much more likely than whites to be hospitalized or die from asthma.

Dr. Satcher also noted that some of the most important challenges were in diet and fitness.

For example, he said, the percentage of overweight Americans was about 26 in the mid-1970's. The Government established a goal of 20 percent of the population for the year 2000, and many people believed that it might be achieved as more Americans appeared to become interested in nutrition and fitness over the past 15 years. But instead, the number of people overweight rose to 35 percent by 1995, the latest year for which data was given in the report.

In the 1970's, about 15 percent of adolescents were overweight, Dr. Satcher said, and that figure has risen to 24 percent.

"And there are several categories in which more than half the adults are overweight," he said, "for example Hispanic and African-American women."

Dr. Anne Becker of the Harvard Medical School and the Harvard Eating Disorders Center said there was a paradox in the latest data.

"Americans are spending $33 billion a year on dieting products and services," Dr. Becker said. "There has been a proliferation of weight loss programs and pills. One would think that would have some effect on losing weight."

Another figure in the report suggested that while diet pills and plans may be widespread, sensible weight-loss plans are declining. The report noted that "sensible weight loss practices among overweight people 12 years and older" had dropped substantially, to 15 percent of people using them in 1995 from 25 percent of people using them in 1985. The goal for 2000 was 50 percent.

A sample of figures given in the report, the last one before the Government begins work on its Healthy People 2010 goals and data, include these:

¶Average daily intake of vegetables, fruits and grains among those older than 2: in 1989, an average of 4.1 servings; in 1996, an average of 4.7 servings. The goal for 2000 is 5.

¶Breast-feeding shortly after birth: 54 percent of women did so in 1988; 62 percent did in 1997. The goal is 75 percent.

¶Mothers who die in childbirth: it was 6.6 per 100,000 live births in 1987; it rose to 7.5 in 1997. The goal is 3.3.

¶Proportion of students, grades 9-12, who took part in daily school physical education: it was 42 percent in 1991; it declined because of budget cuts to 27 percent in 1997. The goal is 50 percent.

¶Proportion of children using seat belts and safety seats: it was 48 percent in 1988; it rose to 61 percent in 1996. The goal is 70 percent.

¶Infant mortality: It was 10.1 in 1987; it dropped to 7.1 in 1997. The goal is 7.

The goals were set by groups of experts from Federal, state and local governments, as well as outside experts, who passed their recommendations to a steering committee of officials in the Department of Health and Human Services for approval.

The New York Times

FRIDAY, JUNE 11, 1999

Sarah Farnsworth
3110 Fairview Park Dr.
12th Floor
Falls Church, VA 22042
Direct: 703-205-6506 Fax: 703-205-6505

ValueOptions

Fax

cc: Chris Jennings
I sent you a note about this — can we talk? SF

To:	Nancy Hernreich	**From:**	Sarah Farnsworth for Ronald Dozoretz
Fax:	202-456-6703	**Pages:**	
Phone:		**Date:**	6/1/99
Re:	Arkansas	**Phone:**	703-205-6506 Pager: 888-422-9147

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Nancy:

Attached is some information regarding your conversation with Dr. Dozoretz. I spoke with Mary Beth Donohue (Sec. Shalala's Chief of Staff) regarding this topic last week – she has this information, too.

Please let me know if you need anything, please let me know....

Ron can be reached at 703-205-6500.

Hope all is well and hope to see you soon. Thanks.

Arkansas

FHC Health Systems

Memorandum

To: Ronald I. Dozoretz, MD

From: Lawrence B. Goldman, DMD

Date: May 21, 1999

Re: Benefit Arkansas

Info:

For almost three years, ValueOptions has been working with both the state of Arkansas (through the Division of Mental Health) and the community based provider system to implement a state of the art behavioral health care program for children. This program, called Benefit Arkansas, would be first statewide initiative to enhance the delivery of needed behavioral health care services to Medicaid eligibles, under age 21. To create this program, ValueOptions developed a joint venture partnership with all of the behavioral community providers in the state, called Arkansas Behavioral Care. This partnership formalized its relationship in January 1998 after almost a full year coordinated joint development efforts.

The culmination of these efforts was a successfully written proposal to the state and successful contract negotiations during the summer of 1998. Everything was ready to begin program implementation; the only missing ingredient was the necessary waiver from the Health Care and Financing Administration (HCFA). The state of Arkansas, through its Division of Medicaid, was responsible to create the waiver application and be responsive to questions and issues raised by the Federal Government.

A lengthy and cumbersome process was started in the Fall of 1998. Due to many reasons, the initial application was withdrawn by the state, upon HCFA's recommendation, issues resolved, and ultimately re-submitted in February 1999. Each waiver submission has a 90 period in which approval must be received. The state (with appropriate support from Arkansas Behavioral Care) responded diligently and fully to all written requests by HCFA. In early May 1999 verbal responses indicated that all issues had been addressed and waiver approval should be expected.

As the last 90 day clock was winding down, on the last day prior to expiration, the state of Arkansas was informed that the HCFA Central office (Sally Richardson, as the principal involved) would not approve the waiver because there was a requirement that

"special needs children" have special consideration in order for them to be covered in a capitated program. (apparently as stated in the Balanced Budget Act 1997). The only recourse for the state would be to withdraw their application, address these issues (if they were not already addressed in the application) and resubmit. This would entail another 90-waiver approval timeframe.

The obvious impact of this bureaucratic delay is that the health care programs needed by the children of Arkansas were not being implemented. The bureaucratic delay is denying these children the benefits from programs geared to expand access to services. The bureaucratic delay is denying families exposure to an expanded array of services distributed around the state to meet the needs of their children. The bureaucratic delay stopped the implementation of quality monitoring programs to ensure that the best available care be delivered to those who need it most, underprivileged children.

Dr. Dozoretz, in these days of turmoil in the youth of America, we cannot stand by and let unnecessary regulatory processes deny the best available services to children. Our social responsibility to help ensure that the best possible health care is delivered to those in need. Benefit Arkansas could become a model program through out our nation.

I urge you to communicate this need at the highest levels of our government.

Arkansas

Sarah-
FYI-
Larry

The Children's Vanguard

THE CHILDREN'S SERVICES MANAGEMENT ADVISOR

VOLUME 2, ISSUE 11 FEBRUARY 1999

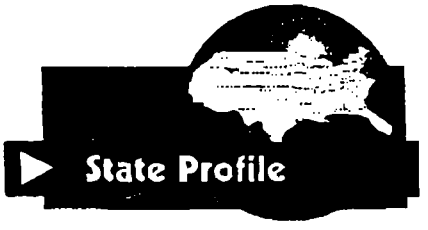
Arkansas' Children's Program Put on Hold

Implementation Underway Despite Delay of Waiver Approval by HCFA

Last August, Arkansas Behavioral Care, (ABC) a joint venture between ValueOptions and Summit Community Network, L.L.C., signed a contract with the Arkansas Department of Human Services to provide managed behavioral health services and therapeutic foster care services to youth, 20 years of age and under, and their families throughout the state. The service population includes:

- All children who are Medicaid eligible
- All children in the custody of the Division of Children and Family Services
- All children covered by the special program designation "ARKids First" (this population includes children up through 18 years of age)
- Substance abuse treatment for children without a mental health diagnosis may be added later at the Division's discretion

The contract, which is worth approximately $340 million ($96 million annually), was to begin service provision to approximately 130,000 Medicaid eligible enrollees, 40,000 ARKids First enrollees, and 3,000 children in the custody of the Division on December 15, 1998. However, Arkansas has still not received approval of its waiver to proceed with the program from the Health Care Financing Administration (HCFA). According to Anne E. Wells, interim director of Managed Care, Arkansas Department of Human Services, HCFA has not stalled approval of the waiver because of the program's design, but is looking closely at the capitation rates to ensure that everything is in line. The State believes that it is very close to getting the waiver. Ms. Wells said. "At the point we do have the waiver, the State and ABC will come to a decision as to what is the most beneficial start date.



Arkansas Behavioral Care was the only entity to respond to the Request for Proposal (RFP) for Benefit Arkansas, the State's behavioral health managed care program, which was released in December of 1997. Summit Community Network, a coalition of 15 community mental health centers (CMHC) and two additional behavioral health agencies, interviewed several managed behavioral health organizations, including Green Spring Health Services and Value Behavioral Health (VBH) before it chose *OPTIONS* Health Care as its managed care partner (VBH and *OPTIONS* have now merged). ABC was originally awarded the contract in the spring of 1998, and there was a rumor throughout the industry that *OPTIONS* might pull out of the contract negotiations. "This was total rumor," according to Larry Goldman, DMD, ValueOptions' executive vice president, business and development. "*OPTIONS* has been committed to the project since day one. The contract was awarded last spring and finalized in early fall, and I have been involved with it personally for almost 20 months," Dr. Goldman said. Pete Kennemer, chairman of Summit Community Network, added that the development of the ABC partnership has been an ongoing process. "We made the decision to bid jointly, we responded to the RFP jointly, and we've been in negotiations, looking for opportunities to strengthen our partnership — not only with *OPTIONS*, but with the State," he said.

Even without waiver approval from HCFA, Arkansas Behavioral Care has moved forward with the implementation. Jim Davis, vice president of implementation at ValueOptions, mentioned that team leads for the various content areas have been identified, and that ABC has begun the process of meetings and looking at deliverables for bringing the program up. "We began the implementation with a goal of going full speed ahead as soon as we

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February 1999
Volume 2, Issue 11

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receive waiver approval," he said. "We are trying to do as many things as possible in order to stay organized and get things rolling once the waiver is approved."

The various content areas referred to by Mr. Davis include care delivery, care management and utilization management, clinical oversight, quality management, management information systems (MIS), legal, medical policy, communications, customer service, complaints and grievances, risk management, finance and underwriting, network maintenance and credentialing, enrollment and eligibility, claims administration, and reporting. Summit Community Network, which is comprised of 15 community mental health centers and two provider organizations that have traditionally served the under 21 Medicaid population will be involved in care delivery. However, Anne Wells pointed out that Arkansas is an "any willing provider" state. "This means that any provider who meets ABC's credentialing requirements, agrees to the fee schedule, and is contracted to participate in ABC's network will be eligible to deliver care in this program," she said.

As the managed care administrator, ValueOptions will be responsible for all other content areas — from care management to reporting — and will operate the program on both a statewide and regional-basis. According to Larry Goldman, ABC has set up a regionally based care delivery system that will coordinate its efforts with a central service center located in Little Rock. The central point of intake will be at the Little Rock service center, but members also will be able to access care through regional offices, CMHCs, and the provider system. Jim Davis added that plans are already in the works to open five regional offices in addition to the Little Rock service center. "In those offices, we'll have regional grievance officers who will work in conjunction with peer and family advocates in the local communities, regional care managers who will be an extension of the care management and utilization management functions at the Little Rock service center, and regional quality coordinators who will coordinate with ValueOptions corporate quality management program," he said. "There will be a lot of regional presence," added Larry Goldman, "but not every single service-such as residential care-will be duplicated in every region."

"We began the implementation with a goal of going full speed ahead as soon as we receive waiver approval." "We are trying to do as many things as possible in order to stay organized and get things rolling once the waiver is approved."

Jim Davis, Vice President, of Implementation, ValueOptions

In describing ABC's implementation efforts to date, Jim Davis pointed out that the implementation teams were developed in "the true spirit of the partnership." "The State, ValueOptions, and the Summit Community partners are all represented in the various action areas, including clinical, quality, MIS, and networks," he said. "Together, we have developed a work plan, we've identified deliverables based on performance standards, and we've prioritized our work around making sure we can achieve all the performance standards in the RFP." Mr. Davis also mentioned that a site has been found for the Little Rock Service Center and that recruitment of key management personnel has already begun. In addition, ABC will utilize Electronic Data Systems (EDS) to handle claims administration. The State has an existing contract with EDS to pay Medicaid claims. According to Jim Davis, the company has already done extensive work on the interfaces

between ValueOptions information system, which will handle authorizations, and EDS to ensure smooth claims processing. "Data warehouse uploads from our system to EDS will provide daily updates," he said, and "reporting data will come off of the EDS platform."

ABC has also done some work in developing a fee schedule and credentialing criteria in preparation for the application and contract mailings that will occur once the waiver is approved. Mr. Davis mentioned that the Clinical Advisory Council, composed of provider and consumer representatives in each of the state's five regions, had already participated in meetings with team leads from ValueOptions, Summit Community Network, and the State. "We are currently looking at drafts of level of care criteria and diagnosis based treatment guidelines," he said. "We wanted to maintain the spirit of consumer and provider involvement, and not take something off the shelf. Most of the criteria on the shelf these days are adult related, and we want to make sure that our criteria is tailored to the under 21 population and to the specific needs of Arkansas."

Ensuring that the program meets the specific needs of Arkansas and its under 21 Medicaid population has been the State's primary concern since the design of the RFP, according to Anne Wells. "The project has been in the making for several years," she said. "The design of the RFP, the program, covered services, and things like that included a great deal of input from consumer and advocacy groups, such as the Arkansas Federation of Children and Families, and the Alliance for the Mentally Ill. Task groups involving representatives from these organizations were set up for each of the areas in the RFP — from financial to information systems to actual program development. We also have an oversight committee, involving consumers and their families, that will provide ongoing input regarding how the project is going, changes that might be needed, and how the project is being perceived in each of the communities. Our major emphasis has been on the development of non-traditional, wraparound services — services that were once not reimbursable such as respite care, but will better meet the needs of the consumer within a community setting. In addition, our definition of medical necessity is very broad and includes psychosocial factors that might be necessary to treat a covered diagnosis. Basically the program is designed to provide whatever children need within the community to keep them from being institutionalized."

Larry Goldman expanded on the "teamwork" concept in his description of the relationship among the partners of ABC and the State. According to Dr. Goldman, ABC is a joint venture between ValueOptions and Summit Community Networks in which ValueOptions has 51% ownership and Summit has 49%. "The model we used to develop the partnership is based on Florida Health Partnership model — a model that recognizes the strengths of each partner in the relationship," he said. "We look to the various partners to bring their best expertise to the table, recognizing that providers bring not only care delivery systems, but also their own internal administrative knowledge for ensuring good functioning of their centers. Then, we combine that expertise with the more standard functionality that ValueOptions brings as an administrator of these kinds of programs, to pull together a core structure that is committed to the overall vision of providing a program that will enhance and change the face of care delivery for children in the state of Arkansas. We have a very collaborative relationship that has evolved over 20 months, during which we've grown together as partners to produce a program that I think will be extraordinarily functional and that everybody can be proud of. I also want to stress that there is something very unique about this relationship. There is a really great sense of partnering that we've developed collectively with the State. The State approached the development of this program from the perspective of maximizing all the available resources to impact the system of care. This has fostered a strong three-way relationship among ValueOptions, the providers, and the State."

"We look to the various partners to bring their best expertise to the table, recognizing that providers bring not only care delivery systems, but also their own internal administrative knowledge for ensuring good functioning of their centers.

Larry Goldman, D.M.D.
Executive Vice President
Business and Development,
ValueOptions

All parties involved in the Arkansas program agree that the key to its success lies in their close collaboration — a team effort that has occurred since the planning stages of the program. According to Anne Wells, this is one of the factors that makes the Arkansas program unique, and may help the State to avoid some of the pitfalls encountered by other states that have developed similar programs. She added that other initiatives such as developing new and expanded medical necessity criteria reinforce the "uniqueness" of the program. Finally, she noted that the program has been set up so that a certain percentage of any savings resulting from good care management are reinvested in expanding or improving services for children. "If there are any savings at the end of the year in the 91 percent of the capitation rate that has been designated for services, ABC and the State will determine what is the best way to put the money back into the service system," she said. "Our performance standards for this program are based on quality care for children and their families, rather than cost savings."

For more information, contact Jim Davis, Vice President Implementation, Interim Executive Director, ValueOptions, 3110 Fairview Park Drive, Falls Church, Virginia 22042, 703-205-7077, fax: 703-208-8850; Larry Goldman, Executive Vice President Business & Development, ValueOptions, 240 Corporate Blvd., Norfolk, Virginia 23502, 757-459-5239, fax: 757-461-4327; Pete Kennemer, President and Chief Executive Officer, Summit Community Network, Western Arkansas Counseling & Guidance Center, 311 South 70th Street, PO Box 11818, Fort Smith, Arkansas 72917-1818; or Anne E. Wells, Director of Managed Care, State of Arkansas Department of Human Services Division of Mental Health Services, Administration Building, 3rd. Floor, 4313 West Markham Street, Little Rock, Arkansas 72205-4096, 501-686-9489, fax: 501-686-9035.

Benefit Arkansas Behavioral Health Managed Care Program

Review of Request for Proposal

Contracting Agency: Arkansas Department of Human Services, Division of Mental Health Services

Eligible Bidders: Proposer/contractor may be a business organization that includes individual providers and groups of providers. The proposer/contractor may not have a controlling interest in any provider or groups of providers, nor may any provider or group of providers have a controller interest in the proposer/contractor. No third party is allowed to have a simultaneous controlling interest in both the proposer/contractor and a provider. Unity of control over the proposer/ contractor and providers is strictly prohibited. The contract is contingent upon the contractor obtaining an HMO license with the Department of Insurance.

Program: Behavioral health managed care program and therapeutic foster care services

Service Area: Entire State of Arkansas divided by counties into five regions, including:

Region 1: Baxter, Benton, Boone, Carroll, Crawford, Franklin, Logan, Madison, Marion, Newton, Polk, Scott, Searcy, Sebastian, Washington

Region 2: Clay, Cleburne, Craighead, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, Van Buren, White, Woodruff

Region 3: Conway, Faulkner, Johnson, Lonoke, Perry, Pope, Prairie, Pulaski, Yell

Region 4: Calhoun, Clark, Columbia, Dallas, Garland, Hempstead, Hot Spring, Howard, Lafayette, Little River, Miller, Montgomery, Nevada, Ouachitsa, Pike, Saline, Sevier, Union

Region 5: Arkansas, Ashley, Bradley, Chicot, Cleveland, Crittendon, Cross, Desha, Drew, Grant, Jefferson, Lee, Lincoln, Monroe, Phillips, St. Francis

Service Population: The service population includes:

- All children in the custody of the Division of Children and Family Services
- All children covered by the special program designation "ARKids First" (this population includes children up through 18 years of age)
- Substance abuse treatment for children without a mental health diagnosis may be added later at the Division's discretion

The service population represents approximately 130,000 Medicaid eligible enrollees, 40,000 ARKids First enrollees, and 3,000 children in the custody of the Division on December 15, 1998.

Contract Start Date: The contract was to begin October 1, 1998 and extend through June 30, 1999, However Arkansas still has not received approval of its waiver by the Health Care Financing Administration. As soon as the waiver is approved, the Division and the contractor will agree on a start date.

Contract Term: If the contractor's performance is acceptable, the contract will be renewable for three additional one-year terms at the Division's option.

Pricing: Capitated. The program will be capitated with rates fixed by the Division. Unspent capitation payments will be directed toward providing services for children in need. Unspent capitation payments are any monies left in the contractor's direct services reserve account after the allowable deduction of 9% in the first contract period and 8% in the second contract period for administration, the payment of services to providers, and any additional amounts allocated to the contractor by the Division.

Scope of Services: At a minimum, the following services will be provided:

- Routine Case Management
- Community Based Services
- Inpatient Services
- Community Based Outpatient Services

- Crisis Services
- Services for Persons Dual Diagnosis - Developmental Disabilities
- Services for Persons Dual Diagnosis - Substance Abuse
- Intensive Case Management
- Services to Children in Foster Care

Proposals Due: Close of Business, **February 2, 1998**

Scoring:

	Maximum	**Minimum**
Section One:		
Proposer Qualifications/Experience	120 points	60 points
Section Two:		
Program Development/Implementation	70	35
Section Three:		
Administration	40	20
Program Structure	40	20
Quality Management/Improvement	70	35
Utilization Management	70	32
Covered Services	100	50
Access	70	35
Integration of Services	50	25
Providers and Staff	70	35
Grievances and Appeals	40	20
Prevention and Education	40	20
Management Information System	60	30
Community Participation	45	20
Customer Service/Satisfaction	40	20
High Cost Enrollees/ Custodial Children	75	40
TOTAL POSSIBLE POINTS	1,000	

Issues:

1. **Ability to accept shared financial risk.** The Division is **fixing** the capitation rates for various populations and may change those rates at its discretion
2. **Proposal Bond:** Proposals must be accompanied by a Bid Warranty in the amount of $50,000, which is to be forfeited to the State if the successful proposer fails to negotiate a contract within (30) days after selection of the successful proposer.
3. **Performance Bond:** The contractor will furnish a performance bond in the amount of $6.5 million to the Department of Human Services contract administrator within (14) after the selection of the successful offeror is made.
4. **NCQA Accreditation:** The contractor must have scheduled a review for accreditation by the National Committee for Quality Assurance (NCQA) according to Managed Behavioral Health Organizations standards by the contract startup date.
5. **Performance Standards:** The contractor must meet performance standards in 19 areas: covered services, access, integration of services, providers and staff, network management, prevention, awareness and education of enrollees, general awareness, ensuring the provision of services, management information systems, continuous quality improvement program, utilization management, grievance procedures, community participation, customer service and satisfaction, therapeutic foster care, delivery of services in a safe and secure environment, ensuring that medical needs of therapeutic foster care and residential children are met, ensure that enrollee's educational needs are met in compliance with State laws, development of a service plan for children in therapeutic foster care and residential treatment.

The Division may impose one or more of the following sanctions on the contractor for failure to achieve acceptable performance:

- Contractor may be required to submit a corrective action plan within (10) working days. If the corrective action plan is unacceptable to DHS, the contractor may be required to revise the plan or the contract may be terminated.
- At the discretion of DHS, up to 10% of the contractor's monthly allowable administrative payment may be withheld pending acceptable performance/corrective actions taken to comply with the contract performance indicators.
- At the discretion of DHS, up to 10% of the contractor's monthly allowable administrative payment may be forfeited as a fee adjustment of unacceptable performance.
- The contract may be terminated for noncompliance at the discretion of DHS.

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6-4-99

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Chief of Panel Seeks Increase For Medicare

Move Would Restore Some of 1997 Cuts

By ROBERT PEAR

WASHINGTON, June 2 — The head of a Federal advisory commission, an influential Republican, said today that Congress should increase Medicare payments for certain nursing home and hospital services because budget cuts appeared to be harming the quality of care for some patients.

The statement, by Gail R. Wilensky, chairwoman of the Medicare Payment Advisory Commission, was a breakthrough for health care providers, who have been pleading with Congress to restore some of the money cut by the 1997 budget law.

Just three months ago, Dr. Wilensky, who ran the Medicare program under President George Bush and is respected by lawmakers of both parties for her technical knowledge of the program, said she had not seen enough evidence to justify increases in Medicare payments. She said then that it was too early to know whether the 1997 cuts were adversely affecting patients.

But today Dr. Wilensky said she agreed with some health care providers that certain patients were vulnerable, particularly those with complex medical problems who are in nursing homes and those needing outpatient hospital services or physical therapy. She spoke with reporters as the commission issued one of two annual reports to Congress.

Medicare accounted for a huge share of the law's savings, $116 billion of the $127 billion that was to be saved over five years. The law, in turn, was a major factor that helped balance the Federal budget in 1998, for the first time in three decades.

Congressional aides said today that Congress seemed likely to take Dr. Wilensky's advice. Medicare issues have traditionally been Democratic issues, but Republicans are aware that increasing numbers of the elderly now vote Republican, and in the last three years, Republican lawmakers have given hundreds of speeches insisting that they want to protect Medicare.

Dr. Wilensky said she was recommending "targeted and limited changes" in the Balanced Budget Act of 1997, not a wholesale revision or repeal of its Medicare provisions.

Paul Hosefros/The New York Times

Gail R. Wilensky, who heads the Medicare Payment Advisory Commission, says cuts may have affected the quality of care for some patients.

Specifically, Dr. Wilensky said, Congress should provide more money for physical therapy, eliminating what she described as an arbitrary limit of $1,500 a year in Medicare payments for physical therapy for any beneficiary.

In addition, Dr. Wilensky said, Congress and Medicare officials should devise some way of increasing payments to nursing homes for patients who need the most costly and extensive care. These patients include nursing home residents who are on ventilators, require infusion therapy, need prosthetic devices or have several medically complex conditions.

Some hospitals say they have had difficulty discharging these patients. Some nursing homes have refused to take such costly patients because the homes consider Medicare payments inadequate.

Finally, Dr. Wilensky said she tended to agree with hospitals that say Medicare is paying too little for outpatient services, which include a wide range of diagnostic tests, treatments and procedures.

As significant as what Dr. Wilensky said is what she did not say. She did not, at this time, endorse pleas by teaching hospitals for more money. And she did not endorse the pleas of home health agencies that say beneficiaries' access to home care has been impaired by the Medicare cuts.

Dr. Wilensky said she knew that some teaching hospitals had reported major reductions in revenue. "We have reports of a lot of hospitals suffering a lot of pain," she said, "but it's hard to know how much of that is due to Medicare." Many private insurers have also cut back payments to hospitals.

Likewise, in a report issued today, the Medicare commission said, "Preliminary data suggest that fewer Medicare beneficiaries are receiving home health care than in the recent past, and the number of visits per user has decreased."

But, the panel said, it is "impossible to assess the degree to which these changes are appropriate," because Medicare does not systematically evaluate the medical condition of patients who receive home care.

Moreover, Dr. Wilensky said, it is important to remember that the cutbacks made in 1997 followed "10 years of explosive growth" in Medicare spending for home health care. Spending soared to $18.1 billion in 1996, from $1.9 billion in 1986.

The General Accounting Office, an investigative arm of Congress, said that 14 percent of Medicare's 10,524 home health agencies had closed since October 1997, but that beneficiaries still appeared to have "appropriate access" to home health services.

The accounting office said that high-cost patients, including those with Alzheimer's disease or multiple sclerosis, might have more difficulty obtaining home health care in the future.

So far, Dr. Wilensky said, savings from the Balanced Budget Act appear to be "much greater than expected" in 1997.

Health care providers want a wholesale revision of the law, Dr. Wilensky said, but "I don't get any sense from Congress" that lawmakers will agree.

Indeed, she said, "The Balanced Budget Act is something we should not undo in haste."

The New York Times

THURSDAY, JUNE 3, 1999

Sarah Farnsworth
3110 Fairview Park Dr.
12th Floor
Falls Church, VA 22042
Direct: 703-205-6506 Fax: 703-205-6505

ValueOptions

Fax

Hi. Chris Jennings
I sent you a note about
this — can we talk? —
Ron

To:	Nancy Hernreich	**From:**	Sarah Farnsworth for Ronald Dozoretz
Fax:	202-456-6703	**Pages:**	
Phone:		**Date:**	6/1/99
Re:	Arkansas	**Phone:**	703-205-6506 Pager: 888-422-9147

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Nancy:

Attached is some information regarding your conversation with Dr. Dozoretz. I spoke with Mary Beth Donohue (Sec. Shalala's Chief of Staff) regarding this topic last week – she has this information, too.

Please let me know if you need anything, please let me know....

Ron can be reached at 703-205-6500.

Hope all is well and hope to see you soon. Thanks.

Arkansas

FHC Health Systems

Memorandum

To: Ronald I. Dozoretz, MD

From: Lawrence B. Goldman, DMD

Date: May 21, 1999

Re: Benefit Arkansas

Info:

For almost three years, ValueOptions has been working with both the state of Arkansas (through the Division of Mental Health) and the community based provider system to implement a state of the art behavioral health care program for children. This program, called Benefit Arkansas, would be first statewide initiative to enhance the delivery of needed behavioral health care services to Medicaid eligibles, under age 21. To create this program, ValueOptions developed a joint venture partnership with all of the behavioral community providers in the state, called Arkansas Behavioral Care. This partnership formalized its relationship in January 1998 after almost a full year coordinated joint development efforts.

The culmination of these efforts was a successfully written proposal to the state and successful contract negotiations during the summer of 1998. Everything was ready to begin program implementation; the only missing ingredient was the necessary waiver from the Health Care and Financing Administration (HCFA). The state of Arkansas, through its Division of Medicaid, was responsible to create the waiver application and be responsive to questions and issues raised by the Federal Government.

A lengthy and cumbersome process was started in the Fall of 1998. Due to many reasons, the initial application was withdrawn by the state, upon HCFA's recommendation, issues resolved, and ultimately re-submitted in February 1999. Each waiver submission has a 90 period in which approval must be received. The state (with appropriate support from Arkansas Behavioral Care) responded diligently and fully to all written requests by HCFA. In early May 1999 verbal responses indicated that all issues had been addressed and waiver approval should be expected.

As the last 90 day clock was winding down, on the last day prior to expiration, the state of Arkansas was informed that the HCFA Central office (Sally Richardson, as the principal involved) would not approve the waiver because there was a requirement that

"special needs children" have special consideration in order for them to be covered in a capitated program. (apparently as stated in the Balanced Budget Act 1997). The only recourse for the state would be to withdraw their application, address these issues (if they were not already addressed in the application) and resubmit. This would entail another 90-waiver approval timeframe.

The obvious impact of this bureaucratic delay is that the health care programs needed by the children of Arkansas were not being implemented. The bureaucratic delay is denying these children the benefits from programs geared to expand access to services. The bureaucratic delay is denying families exposure to an expanded array of services distributed around the state to meet the needs of their children. The bureaucratic delay stopped the implementation of quality monitoring programs to ensure that the best available care be delivered to those who need it most, underprivileged children.

Dr. Dozoretz, in these days of turmoil in the youth of America, we cannot stand by and let unnecessary regulatory processes deny the best available services to children. Our social responsibility to help ensure that the best possible health care is delivered to those in need. Benefit Arkansas could become a model program through out our nation.

I urge you to communicate this need at the highest levels of our government.

The Children's Vanguard
THE CHILDREN'S SERVICES MANAGEMENT ADVISOR
VOLUME 2, ISSUE 11 FEBRUARY 1999

Arkansas' Children's Program Put on Hold

Implementation Underway Despite Delay of Waiver Approval by HCFA

Last August, Arkansas Behavioral Care, (ABC) a joint venture between ValueOptions and Summit Community Network, L.L.C., signed a contract with the Arkansas Department of Human Services to provide managed behavioral health services and therapeutic foster care services to youth, 20 years of age and under, and their families throughout the state. The service population includes:

- All children who are Medicaid eligible
- All children in the custody of the Division of Children and Family Services
- All children covered by the special program designation "ARKids First" (this population includes children up through 18 years of age)
- Substance abuse treatment for children without a mental health diagnosis may be added later at the Division's discretion

The contract, which is worth approximately $340 million ($96 million annually), was to begin service provision to approximately 130,000 Medicaid eligible enrollees, 40,000 ARKids First enrollees, and 3,000 children in the custody of the Division on December 15, 1998. However, Arkansas has still not received approval of its waiver to proceed with the program from the Health Care Financing Administration (HCFA). According to Anne E. Wells, interim director of Managed Care, Arkansas Department of Human Services, HCFA has not stalled approval of the waiver because of the program's design, but is looking closely at the capitation rates to ensure that everything is in line. The State believes that it is very close to getting the waiver. Ms. Wells said. "At the point we do have the waiver, the State and ABC will come to a decision as to what is the most beneficial start date.

Arkansas Behavioral Care was the only entity to respond to the Request for Proposal (RFP) for Benefit Arkansas, the State's behavioral health managed care program, which was released in December of 1997. Summit Community Network, a coalition of 15 community mental health centers (CMHC) and two additional behavioral health agencies, interviewed several managed behavioral health organizations, including Green Spring Health Services and Value Behavioral Health (VBH) before it chose *OPTIONS* Health Care as its managed care partner (VBH and *OPTIONS* have now merged). ABC was originally awarded the contract in the spring of 1998, and there was a rumor throughout the industry that *OPTIONS* might pull out of the contract negotiations. "This was total rumor," according to Larry Goldman, DMD, ValueOptions' executive vice president, business and development. "*OPTIONS* has been committed to the project since day one. The contract was awarded last spring and finalized in early fall, and I have been involved with it personally for almost 20 months," Dr. Goldman said. Pete Kennemer, chairman of Summit Community Network, added that the development of the ABC partnership has been an ongoing process. "We made the decision to bid jointly, we responded to the RFP jointly, and we've been in negotiations, looking for opportunities to strengthen our partnership — not only with *OPTIONS*, but with the State," he said.

Even without waiver approval from HCFA, Arkansas Behavioral Care has moved forward with the implementation. Jim Davis, vice president of implementation at ValueOptions, mentioned that team leads for the various content areas have been identified, and that ABC has begun the process of meetings and looking at deliverables for bringing the program up. "We began the implementation with a goal of going full speed ahead as soon as we

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THE CHILDREN'S SERVICES MANAGEMENT ADVISOR

February 1999
Volume 2, Issue 11

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CWLA OPEN® MINDS

receive waiver approval," he said. "We are trying to do as many things as possible in order to stay organized and get things rolling once the waiver is approved."

The various content areas referred to by Mr. Davis include care delivery, care management and utilization management, clinical oversight, quality management, management information systems (MIS), legal, medical policy, communications, customer service, complaints and grievances, risk management, finance and underwriting, network maintenance and credentialing, enrollment and eligibility, claims administration, and reporting. Summit Community Network, which is comprised of 15 community mental health centers and two provider organizations that have traditionally served the under 21 Medicaid population will be involved in care delivery. However, Anne Wells pointed out that Arkansas is an "any willing provider" state. "This means that any provider who meets ABC's credentialing requirements, agrees to the fee schedule, and is contracted to participate in ABC's network will be eligible to deliver care in this program," she said.

As the managed care administrator, ValueOptions will be responsible for all other content areas — from care management to reporting — and will operate the program on both a statewide and regional-basis. According to Larry Goldman, ABC has set up a regionally based care delivery system that will coordinate its efforts with a central service center located in Little Rock. The central point of intake will be at the Little Rock service center, but members also will be able to access care through regional offices, CMHCs, and the provider system. Jim Davis added that plans are already in the works to open five regional offices in addition to the Little Rock service center. "In those offices, we'll have regional grievance officers who will work in conjunction with peer and family advocates in the local communities, regional care managers who will be an extension of the care management and utilization management functions at the Little Rock service center, and regional quality coordinators who will coordinate with ValueOptions corporate quality management program," he said. "There will be a lot of regional presence," added Larry Goldman, "but not every single service-such as residential care-will be duplicated in every region."

"We began the implementation with a goal of going full speed ahead as soon as we receive waiver approval." "We are trying to do as many things as possible in order to stay organized and get things rolling once the waiver is approved."

Jim Davis, Vice President,
of Implementation,
ValueOptions

In describing ABC's implementation efforts to date, Jim Davis pointed out that the implementation teams were developed in "the true spirit of the partnership." "The State, ValueOptions, and the Summit Community partners are all represented in the various action areas, including clinical, quality, MIS, and networks," he said. "Together, we have developed a work plan, we've identified deliverables based on performance standards, and we've prioritized our work around making sure we can achieve all the performance standards in the RFP." Mr. Davis also mentioned that a site has been found for the Little Rock Service Center and that recruitment of key management personnel has already begun. In addition, ABC will utilize Electronic Data Systems (EDS) to handle claims administration. The State has an existing contract with EDS to pay Medicaid claims. According to Jim Davis, the company has already done extensive work on the interfaces

between ValueOptions information system, which will handle authorizations, and EDS to ensure smooth claims processing. "Data warehouse uploads from our system to EDS will provide daily updates," he said, and "reporting data will come off of the EDS platform."

ABC has also done some work in developing a fee schedule and credentialing criteria in preparation for the application and contract mailings that will occur once the waiver is approved. Mr. Davis mentioned that the Clinical Advisory Council, composed of provider and consumer representatives in each of the state's five regions, had already participated in meetings with team leads from ValueOptions, Summit Community Network, and the State. "We are currently looking at drafts of level of care criteria and diagnostic based treatment guidelines," he said. "We wanted to maintain the spirit of consumer and provider involvement, and not take something off the shelf. Most of the criteria on the shelf these days are adult related, and we want to make sure that our criteria is tailored to the under 21 population and to the specific needs of Arkansas."

Ensuring that the program meets the specific needs of Arkansas and its under 21 Medicaid population has been the State's primary concern since the design of the RFP, according to Anne Wells. "The project has been in the making for several years," she said. "The design of the RFP, the program, covered services, and things like that included a great deal of input from consumer and advocacy groups, such as the Arkansas Federation of Children and Families, and the Alliance for the Mentally Ill. Task groups involving representatives from these organizations were set up for each of the areas in the RFP — from financial to information systems to actual program development. We also have an oversight committee, involving consumers and their families, that will provide ongoing input regarding how the project is going, changes that might be needed, and how the project is being perceived in each of the communities. Our major emphasis has been on the development of non-traditional, wraparound services — services that were once not reimbursable such as respite care, but will better meet the needs of the consumer within a community setting. In addition, our definition of medical necessity is very broad and includes psychosocial factors that might be necessary to treat a covered diagnosis. Basically the program is designed to provide whatever children need within the community to keep them from being institutionalized."

Larry Goldman expanded on the "teamwork" concept in his description of the relationship among the partners of ABC and the State. According to Dr. Goldman, ABC is a joint venture between ValueOptions and Summit Community Networks in which ValueOptions has 51% ownership and Summit has 49%. "The model we used to develop the partnership is based on Florida Health Partnership model — a model that recognizes the strengths of each partner in the relationship," he said. "We look to the various partners to bring their best expertise to the table, recognizing that providers bring not only care delivery systems, but also their own internal administrative knowledge for ensuring good functioning of their centers. Then, we combine that expertise with the more standard functionality that ValueOptions brings as an administrator of these kinds of programs, to pull together a core structure that is committed to the overall vision of providing a program that will enhance and change the face of care delivery for children in the state of Arkansas. We have a very collaborative relationship that has evolved over 20 months, during which we've grown together as partners to produce a program that I think will be extraordinarily functional and that everybody can be proud of. I also want to stress that there is something very unique about this relationship. There is a really great sense of partnering that we've developed collectively with the State. The State approached the development of this program from the perspective of maximizing all the available resources to impact the system of care. This has fostered a strong three-way relationship among ValueOptions, the providers, and the State."

"We look to the various partners to bring their best expertise to the table, recognizing that providers bring not only care delivery systems, but also their own internal administrative knowledge for ensuring good functioning of their centers.

Larry Goldman, D.M.D.
Executive Vice President
Business and Development,
ValueOptions

All parties involved in the Arkansas program agree that the key to its success lies in their close collaboration — a team effort that has occurred since the planning stages of the program. According to Anne Wells, this is one of the factors that makes the Arkansas program unique, and may help the State to avoid some of the pitfalls encountered by other states that have developed similar programs. She added that other initiatives such as developing new and expanded medical necessity criteria reinforce the "uniqueness" of the program. Finally, she noted that the program has been set up so that a certain percentage of any savings resulting from good care management are reinvested in expanding or improving services for children. "If there are any savings at the end of the year in the 91 percent of the capitation rate that has been designated for services, ABC and the State will determine what is the best way to put the money back into the service system," she said. "Our performance standards for this program are based on quality care for children and their families, rather than cost savings."

For more information, contact Jim Davis, Vice President Implementation, Interim Executive Director, ValueOptions, 3110 Fairview Park Drive, Falls Church, Virginia 22042, 703-205-7077, fax: 703-208-8850; Larry Goldman, Executive Vice President Business & Development, ValueOptions, 240 Corporate Blvd., Norfolk, Virginia 23502, 757-459-5239, fax: 757-461-4327; Pete Kemmet, President and Chief Executive Officer, Summit Community Network, Western Arkansas Counseling & Guidance Center, 311 South 70th Street, PO Box 11818, Fort Smith, Arkansas 72917-1818; or Anne E. Wells, Director of Managed Care, State of Arkansas Department of Human Services Division of Mental Health Services, Administration Building, 3rd. Floor, 4313 West Markham Street, Little Rock, Arkansas 72205-4096, 501-686-9489, fax: 501-686-9035.

Benefit Arkansas Behavioral Health Managed Care Program

Review of Request for Proposal

Contracting Agency: Arkansas Department of Human Services, Division of Mental Health Services

Eligible Bidders: Proposer/contractor may be a business organization that includes individual providers and groups of providers. The proposer/contractor may not have a controlling interest in any provider or groups of providers, nor may any provider or group of providers have a controller interest in the proposer/contractor. No third party is allowed to have a simultaneous controlling interest in both the proposer/contractor and a provider. Unity of control over the proposer/ contractor and providers is strictly prohibited. The contract is contingent upon the contractor obtaining an HMO license with the Department of Insurance.

Program: Behavioral health managed care program and therapeutic foster care services

Service Area: Entire State of Arkansas divided by counties into five regions, including:

Region 1: Baxter, Benton, Boone, Carroll, Crawford, Franklin, Logan, Madison, Marion, Newton, Polk, Scott, Searcy, Sebastian, Washington

Region 2: Clay, Cleburne, Craighead, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, Van Buren, White, Woodruff

Region 3: Conway, Faulkner, Johnson, Lonoke, Perry, Pope, Prairie, Pulaski, Yell

Region 4: Calhoun, Clark, Columbia, Dallas, Garland, Hempstead, Hot Spring, Howard, Lafayette, Little River, Miller, Montgomery, Nevada, Ouachitsa, Pike, Saline, Sevier, Union

Region 5: Arkansas, Ashley, Bradley, Chicot, Cleveland, Crittendon, Cross, Desha, Drew, Grant, Jefferson, Lee, Lincoln, Monroe, Phillips, St. Francis

Service Population: The service population includes:

- All children in the custody of the Division of Children and Family Services
- All children covered by the special program designation "ARKids First" (this population includes children up through 18 years of age)
- Substance abuse treatment for children without a mental health diagnosis may be added later at the Division's discretion

The service population represents approximately 130,000 Medicaid eligible enrollees, 40,000 ARKids First enrollees, and 3,000 children in the custody of the Division on December 15, 1998.

Contract Start Date: The contract was to begin October 1, 1998 and extend through June 30, 1999, However Arkansas still has not received approval of its waiver by the Health Care Financing Administration. As soon as the waiver is approved, the Division and the contractor will agree on a start date.

Contract Term: If the contractor's performance is acceptable, the contract will be renewable for three additional one-year terms at the Division's option.

Pricing: Capitated. The program will be capitated with rates fixed by the Division. Unspent capitation payments will be directed toward providing services for children in need. Unspent capitation payments are any monies left in the contractor's direct services reserve account after the allowable deduction of 9% in the first contract period and 8% in the second contract period for administration, the payment of services to providers, and any additional amounts allocated to the contractor by the Division.

Scope of Services: At a minimum, the following services will be provided:

- Routine Case Management
- Community Based Services
- Inpatient Services
- Community Based Outpatient Services

- Crisis Services
- Services for Persons Dual Diagnosis - Developmental Disabilities
- Services for Persons Dual Diagnosis - Substance Abuse
- Intensive Case Management
- Services to Children in Foster Care

Proposals Due: Close of Business, **February 2, 1998**

Scoring:

	Maximum	Minimum
Section One:		
Proposer Qualifications/Experience	120 points	60 points
Section Two:		
Program Development/Implementation	70	35
Section Three:		
Administration	40	20
Program Structure	40	20
Quality Management/Improvement	70	35
Utilization Management	70	32
Covered Services	100	50
Access	70	35
Integration of Services	50	25
Providers and Staff	70	35
Grievances and Appeals	40	20
Prevention and Education	40	20
Management Information System	60	30
Community Participation	45	20
Customer Service/Satisfaction	40	20
High Cost Enrollees/ Custodial Children	75	40
TOTAL POSSIBLE POINTS	**1,000**	

Issues:

1. **Ability to accept shared financial risk.** The Division is fixing the capitation rates for various populations and may change those rates at its discretion
2. **Proposal Bond:** Proposals must be accompanied by a Bid Warranty in the amount of $50,000, which is to be forfeited to the State if the successful proposer fails to negotiate a contract within (30) days after selection of the successful proposer.
3. **Performance Bond:** The contractor will furnish a performance bond in the amount of $6.5 million to the Department of Human Services contract administrator within (14) after the selection of the successful offeror is made.
4. **NCQA Accreditation:** The contractor must have scheduled a review for accreditation by the National Committee for Quality Assurance (NCQA) according to Managed Behavioral Health Organizations standards by the contract startup date.
5. **Performance Standards:** The contractor must meet performance standards in 19 areas: covered services, access, integration of services, providers and staff, network management, prevention, awareness and education of enrollees, general awareness, ensuring the provision of services, management information systems, continuous quality improvement program, utilization management, grievance procedures, community participation, customer service and satisfaction, therapeutic foster care, delivery of services in a safe and secure environment, ensuring that medical needs of therapeutic foster care and residential children are met, ensure that enrollee's educational needs are met in compliance with State laws, development of a service plan for children in therapeutic foster care and residential treatment.

The Division may impose one or more of the following sanctions on the contractor for failure to achieve acceptable performance:

- Contractor may be required to submit a corrective action plan within (10) working days. If the corrective action plan is unacceptable to DHS, the contractor may be required to revise the plan or the contract may be terminated.
- At the discretion of DHS, up to 10% of the contractor's monthly allowable administrative payment may be withheld pending acceptable performance/corrective actions taken to comply with the contract performance indicators.
- At the discretion of DHS, up to 10% of the contractor's monthly allowable administrative payment may be forfeited as a fee adjustment of unacceptable performance.
- The contract may be terminated for noncompliance at the discretion of DHS.

cc: Chris Jennings
Secretary

copied
Jennings

THE WHITE HOUSE

WASHINGTON

June 3, 1999

M. Christine Jacobs
Chairman, President, and CEO
Theragenics Corporation
5325 Oakbrook Parkway
Norcross, Georgia 30093

Dear Christine:

It was a pleasure to meet you recently, and thank you for following up on our conversation by sending your annual report. Your company is doing wonderful work.

If you see R.L. again, tell him I said hello. He is a great friend.

Best wishes, and thanks again for all you do.

Sincerely,

Bill Clinton

Glad you know RL — He did a wonderful job for me — and has been through a long health struggle recently. Let us know how we can help.

Thanks for your good work.

M. Christine Jacobs
Chairman, President, and CEO
Theragenics Corporation
5325 Oakbrook Parkway
Norcross, Georgia 30093

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THERAGENICS CORPORATION

May 18, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President,

I was honored to meet you last Wednesday at the Democratic Senators Fund Raiser as the guest of Georgia Senator Max Cleland. My brief conversation with you centered on prostate cancer. I have enclosed our Annual Report and other material should you ever have a need to know of our work in the cancer field.

Having only a moment to speak with you, I was unable to mention a mutual and long time friend, R.L. Qualls, Ph.D., of Little Rock who, as I'm sure you remember, worked in your cabinet during your first term as governor. As you know, R.L. is a widower. I flew to Little Rock as his date for a social event. R.L. is quite a fellow and his company, Baldor, is a leader in its industry.

If ever you have a need for information or help for a loved one concerned with, or experiencing prostate cancer, please call.

Thank you for the time you spent with Max and me.

Sincerely yours,

M. Christine Jacobs

M. Christine Jacobs
Chairman, President, and
Chief Executive Officer

Enclosed:
Annual Report
Congressional Report
Caregiver Article
Card of R.L. Qualls

5325 OAKBROOK PARKWAY, NORCROSS, GA 30093
phone 770.271.0233 fax 770.381.8447

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 105th CONGRESS, SECOND SESSION

Vol. 144 WASHINGTON, FRIDAY, JULY 31, 1998 No. 106

Senate

TRIBUTE TO CHRISTINE JACOBS

Mr. CLELAND. Mr. President, I rise today to honor the many accomplishments of Christine Jacobs of Norcross, Georgia. Chris is the President, CEO and Chairman of the Board of Theragenics Corporation which markets, sells and distributes the FDA-licensed medical device TheraSeed for treating cancer.

She has had many remarkable accomplishments during her career, but today I would like to call attention to yet another important milestone. On August 6, 1998 Chris will switch Theragenics from the NASDAQ exchange, which the company has been trading on publicly since 1986, to the New York Stock Exchange. Chris will become the first female CEO to enroll a company on the New York Stock Exchange. She will also be ringing the bell to open the exchange that morning.

Chris Jacobs is truly a remarkable and successful business-savy member of the Georgia business community. She also dedicates time to civic and medical organizations in Georgia including the Georgia Bio-Medical Partnership, the Board of Councilors of the Carter Center, the State's Small Business Taskforce and the Georgia Chamber of Commerce.

Chris Jacobs possesses the tenacity and vision that has changed the world as we have known it and paved the road to the next millennium in regard to medical treatment. I ask my colleagues in the Senate to join me in honoring the innumerable achievements of Chris Jacobs and her work at Theragenics, and wish her luck and much success on the New York Stock Exchange. She proves that if we can perceive it we can achieve it — Chris will continue to rewrite history and achieve unending successes.

S. 9621

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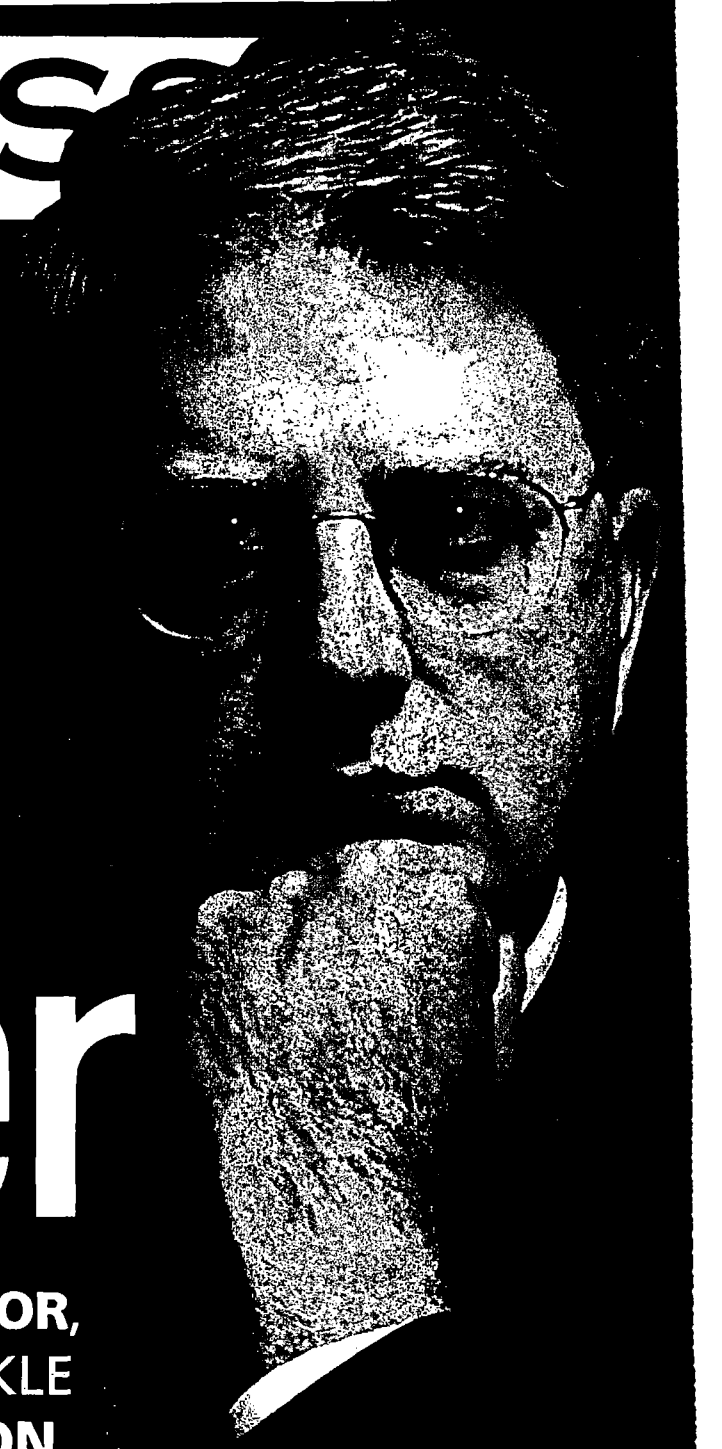

THERAGENICS' CEO

Christine Jacobs

FINDING A CURE FOR CANCER

The Insider

AS GEORGIA'S **NEW GOVERNOR,** ROY BARNES PLANS TO TACKLE **ATLANTA'S ISSUES HEAD ON.**

The ABCs

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cancer

Theragenics is making a difference in the cure of this disease!

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