

DRAFT

TALKING POINTS

Issues in Kentucky's Proposed No-Choice Medicaid Model

- *Once an exception is made, the principle is lost.* It is the Department's experience that once we grant one state an exception to long-standing Administration policy, other states no longer view the policy as firm, and they inevitably press for the same treatment under their proposed demonstrations. This loss of policy ground has important consequences for our latitude in upcoming negotiations in the Medicaid budget fight.
- *We need to conserve negotiating chips for the Medicaid legislative debate.* The Medicaid budget fight will be one of the most difficult -- and important -- of the budget reconciliation issues. We will have to be prepared to negotiate in important areas ranging from the budget total to choice to coverage of key groups (children, pregnant women, elders and disabled). We will undoubtedly need to make concessions in that context -- and the choice principle is one bargaining point. If we give up the choice principle in Kentucky, we will not have it to negotiate with in the legislative debate, and we will sacrifice the ability to extract something substantial in return for it.
- *Why sacrifice the principle when likelihood of implementation is virtually zero?* The Governor's term ends in December. Furthermore, the Partnerships have not yet been developed. Finally, numerous previous efforts by the Governor to implement the demonstration have failed. In short, there is only a vanishing probability that the demonstration will ever be implemented. It would be a strategic error to give up the choice principle -- a decision other states will quickly exploit -- for a project that may not even materialize.
- *Quality protection* - Plan choice is a mechanism for assuring that individuals who are dissatisfied with the care they are receiving can "vote with their feet" by opting into another delivery system. If beneficiaries cannot leave the plan, we lose a crucial indicator of poor or mediocre quality. At the same time, plans' incentive to be responsive to their enrollees may be diminished since there is no risk of losing market share to a competitor. Both these results reinforce the possibility that beneficiaries in a no-choice model will remain in inferior systems of care.
- *Choice as a substitute for agency.* Some have argued that it is unfair to require plan choice for Medicaid beneficiaries when many workers don't have plan choice. First, we favor plan choice for workers too. Second, this argument fails to realize that, in the case of workers, the employer -- who purchases coverage on behalf of its employees -- does choose from an array of plans. In addition, the employer can act as an agent for employees, responding to a pattern of employee complaints about quality by taking its business to another health plan. (Indeed, HMOs report that employers are increasingly using outcome and other quality indices to assess quality in choosing plans for their workers.)
- *Access.* A one-plan model potentially limits the provider supply available to a



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DRAFT

TO: Carol Rasco

SUBJECT: Kentucky's Medicaid Demonstration Proposal

Although I know the President has talked with Governor Jones about Kentucky's proposed Medicaid demonstration and is supportive of the state's approach, I wanted to talk to you about the vital importance of maintaining beneficiary choice of health plans in the Medicaid program.

If the Governor calls us today, we plan to see if he would accept a compromise. Under this compromise, Kentucky could enroll Medicaid beneficiaries in the regional partnership plans. Beneficiaries would then have the option to disenroll for cause into a fee-for-service plan or other arrangement such as a primary care case management system after some period of time. We believe this alternative would allow Kentucky to test an innovative regional delivery system while preserving choice for the beneficiary. This represents a very significant compromise from our preferred position, which is that beneficiaries should have choice of plans when they first enroll.

As you know, we are at a very critical stage with proposed Medicaid legislation in both the House and the Senate. I would like to discuss with you today or over the weekend both the policy and strategic implications of our decision on beneficiary choice as we engage in legislative discussions.

Donna E. Shalala

Donna end of w; P far
legal - pull out of hat - Mary Beth
DS → Gov COB - opt servs

Want to know -
w/ or again
for
ag
no other

Joan - form w/ funders
- wk w/ her on mtg
- Robbie

Elements of L.A. County Medicaid Agreement

- o A Federal waiver would allow the county to receive Federal reimbursement for indigent care at the clinics, and facilitate the restructuring of the county health system. (\$40 million)**
- o A memorandum of understanding between the state and the county revising funding for indigent care would change the treatment of these funds under Medicaid. (\$92 million)**
- o A recalculation of Medicaid costs consistent with Federal law (\$82 million)**
- o Delaying a portion of the annual payment from the county to the state (\$125 million)**
- o A package of PHS grants (requires Presidential declaration of emergency) (\$25 million)**

TOTAL: \$364 million

C+2

TO: Bruce Vladeck
John Monahan
Lu Zawistowich

FROM: Diana Fortuna

This is something faxed to me by Kentucky, but I'm afraid no one there may have seen it because they sent it to OMC.

This letter is in response to my point to Masten Childers that, while I wasn't sure HHS would agree to no choice of plan, if HHS did do so it would be very reasonable for HHS to require the state to make a lot of assurances on accountability and access, since beneficiaries couldn't disenroll. I am not sending the extensive attachments because they are pages pulled from their application or other backup materials they have already sent HCFA.

You also need to decide whether competitive bidding is really a legal obstacle here. I think Nan Hunter may be checking with Darrel and staff here.

You need to respond to the Governor's request for some kind of action by close of business today. Let me know.

ASAP

TP - today conversation with
2 tracks - Note / call - CR - disconsolate
- Leon??
- Hunt returned call / authorized info
- 3mo disconsolate - not official rep.
- 2-3 yr prot for P.



THE SECRETARY FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY

FRANKFORT 40621-0001

(502) 564-7130

(502) 564-7573 FAX

BRERETON C. JONES
GOVERNOR

September 19, 1995

MASTEN CHILDERS II
SECRETARY

Ms. Rita Johnson-Mills
Director
Health Care Financing Administration
Office of Managed Care
Medicaid Managed Care Team
7500 Security Blvd.
Woodlawn, Maryland 21244

Dear Ms. Johnson:

Please accept this correspondence as a supplement to Kentucky's Medicaid 1115 Waiver Application which emphasizes our commitment to accessibility and accountability. The Kentucky Department for Medicaid Services recognizes that in a sole source environment it must assume a stronger patient advocacy role. Let me assure you that our commitment to the patient will be incorporated into every level of the system. Furthermore, the Department will concentrate and integrate its resources toward ensuring that Partnerships perform at a level comparable to that found in a competitive environment.

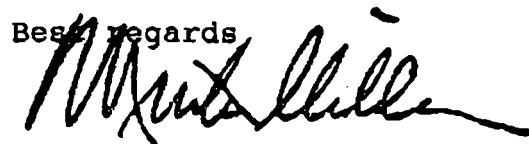
Specifically, the Department for Medicaid Services will operate extensive quality assurance oversight systems employing as necessary not only the resources available within the Department for Medicaid Services but also those of other Cabinet for Human Resources agencies, i.e., the Department for Mental Health/Mental Retardation Services, the Department for Social Services, the Department for Social Insurance and, most especially, the Department for Health Services which oversees the operation of our 120 county health departments. In addition, outside consultants and professional review organizations will be recruited to this effort. Extensive onsite monitoring and satisfaction surveying also will be an integral part of this process. Attached are certain extracted portions of our waiver amendment which address issues of access, quality, and partnership performance standards.

Ms. Rita Johnson-Mills
Page two
September 19, 1995

We would also like to stress that our waiver features a highly visible beneficiary information and grievance system including provisions for a toll-free line manned by consumer advocates and an extensive hearing and appeals process. The Partnerships will be required to maintain similar appeals systems. Furthermore, the Department is currently considering the development of an incentive and penalty system for Partnerships with extremely high or low beneficiary satisfaction ratings. In certain extraordinary circumstances where it is both feasible and in the best medical interest of the beneficiary, the Medicaid Commissioner may approve assignment of the beneficiary to a partnership outside his/her normal managed care service area.

We are committed to assuring that the Partnerships make services available, accessible, and acceptable to our beneficiary population in a sole source environment. Our ultimate safeguard, of course, is that each Partnership will understand that its status as a sole source Medicaid managed care entity is contingent upon continued compliance with established quality of care and patient satisfaction standards. Thank you for your assistance in this matter. We are open to any suggestions what will expedite approval of our waiver.

Best regards



Masten Childers II
Secretary

/pm

Attachment

Governor's Office for Policy and Management 284 Capitol Annex, Frankfort, Kentucky 40601

FAX

Date: 09/19/95 *Wes*Number of pages including cover sheet: 22**To:**Diana Fortuna

_____Phone: (202) 456-5570Fax phone: (202) 456-7431

CC: _____

From:Diane Hancock

_____Phone: (502) 564-7300Fax phone: (502) 564-6684**REMARKS:**☐

Urgent

☐

For your review

☐

Reply ASAP

☐

Please comment

Dear Ms. Fortuna:

Please find the attached communication Secretary Childers transmitted to HCFA after your conversation on Friday. If you have any questions or further advice, let me know as Secretary Childers will be out today due to a death in his family.

Thanks again for all your help and patience.

Sincerely,

Diane Hancock

:ms\0719

Because the Commonwealth's goal is to provide the covered population with the greatest choice possible, each Health Care Partnership panel will include any provider in the service area that is willing to accept the conditions stipulated in the provider contract. In addition to the private providers included in the network, linkages will be established with local health departments, Federally Qualified Health Centers (FQHC), and the Commission for Children with Special Health Care Needs (Title V agency) to provide primary, secondary, and preventive care to the Medicaid population as appropriate. The Medical Schools at the University of Kentucky and the University of Louisville will play an active role in both the design and/or the administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the partnerships, particularly those in rural areas by providing staff technical support and tertiary care.

2. Health Care Partnership Formation and Administration

Each partnership should have sufficient administrative staff and organizational components to operate an extensive service delivery network. Although a preliminary draft of a partnership contract has been provided (see Exhibit 6), each region will develop a contract geared both to the needs of the Medicaid population and the available health care infrastructure in the region. HCFA will review and approve each region's contract prior to its execution. The requirements under the contract will include each of the functions noted under items a and b below. The functions should be staffed by qualified persons in numbers appropriate to the partnership's enrollment or projected enrollment.

Each partnership may combine functions or split the responsibility for a function across multiple departments. Similarly, the Commonwealth or the partnership may contract with a third party (subcontractor) to assist in the formation of the partnerships and to perform one or more of these administrative functions.

a. Executive Management

Each partnership will have an executive management function with authority over all of the administrative functions.

b. Other Administrative Components

Each partnership will have each of the administrative functions listed below, conforming to program standards which will be described in the contract executed by the Commonwealth. The required functions are:

- Medical Director's Function
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, utilization management, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function

- Claims Processing Function
- Management Information Function

3. Assignment of Primary Care Providers (PCPs)

Partnerships will be required to have written policies and procedures for assigning each of its assigned beneficiaries to a primary care provider (PCP). PCPs typically are family practitioners, general practitioners, pediatricians, obstetricians, gynecologists, internal medicine practitioners, primary care centers, and local health departments. In some cases, however, a specialist may serve as a PCP if it is medically appropriate. The procedures will include a process for automatically assigning a PCP if a member does not select a PCP and ensuring maximum PCP to member ratios are not exceeded. This process can take into consideration such factors as current provider relationships, language needs (to the extent they are known), and area of residence.

Partnerships will be required to have written policies and procedures allowing beneficiaries to select or be assigned to a new PCP when such a change is mutually agreed to by the partnership and beneficiary, when a PCP is terminated from the plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding.

a. PCP Responsibilities

Partnerships will be required to have written policies and procedures for assigning every member to a PCP. The PCP will serve as the member's initial and most important point of contact.

Although PCPs may be given responsibility, the partnerships will retain responsibility for monitoring PCP actions to ensure they comply with partnership and program policies.

b. PCP Sites

If the partnership's primary care network includes Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), or local health departments, such organizations may be able to designate these sites as a PCP.

c. Member-to-PCP Ratios

To ensure PCP accessibility for program recipients, the Commonwealth may require certain member-to-PCP ratios to be included in the Partnership Contract. Experience gained from the KenPAC program has demonstrated that the maximum member-to-PCP ratio should not exceed 1:1500. This will likely be the minimum standard for health care partnerships. However, this requirement may be waived for good cause for limited periods of time in underserved areas. Appendix A14 of the KenPAC Waiver Renewal Request provides some relevant information about existing PCP capacities through that program (see Attachment I). The Commonwealth anticipates that the availability of participating PCPs will increase dramatically through the partnership concept.

4. Physician Specialists

Due to the large number of physician specialties that exist, partnerships may not be required to maintain specific member-to-specialist provider ratios. However, it must provide adequate access to physician specialists for PCP referrals, and to employ or contract with specialists in sufficient numbers to ensure specialty services could be made available in a timely manner and locally accessible when feasible.

5. Mainstreaming

The Commonwealth considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be an important program objective. Therefore, the partnerships must ensure that network providers do not intentionally segregate program members in any way from other persons receiving services.

6. Network Changes

Health care partnerships will be required to notify the Commonwealth promptly of any changes to the composition of its provider network that materially affected the plan's ability to make available all capitated services in a timely manner. Partnerships will also be required to have procedures to address changes in its network that negatively affect the ability of members to access services. Material changes in network composition that negatively affect member access to services could be grounds for contract termination.

7. Service Accessibility Standards

Health care partnerships will be required to provide coverage, either directly or through its PCPs, to members on a twenty-four hours per day, seven days per week.

8. Beneficiaries Services

Partnerships must staff an Ombudsman or Beneficiary Service function. This will include a toll-free telephone number for beneficiaries to access services, secure information, and file grievances within response time standards that will be specified in the partnership contract. This service will be staffed by consumer advocates to assure that enrollees receive adequate representation when seeking to expeditiously resolve grievances.

9. Provider Services

Health care partnerships will be required to staff a Provider Services function. This function will include a toll-free telephone number for providers to use to obtain information and guidance regarding health service issues.

10. Transitioning Members Between Plans

It may be necessary to transition members between regional partnerships. Partnerships will be required to have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. Partnerships will be required to have similar procedures for integration of their services with other managed care systems operated by the Commonwealth for Medicaid recipients.

11. Member Disenrollment**a. General Authority**

The Commonwealth may have sole authority for disenrolling beneficiaries from partnerships, subject to the conditions described within the partnership contract with the Commonwealth. The partnership may have sole authority for disenrolling members from its subcontracted providers.

b. Disenrollment Effective Dates

Beneficiary disenrollments from the partnership will be effective on the date specified by the Commonwealth.

12. Medical Management and Quality Assurance by the Commonwealth

The Department of Medicaid Services regulates the utilization review and quality assurance (UR/QA) functions of all licensed providers. Health care partnerships, therefore, will comply with all Department for Medicaid Services UR/QA standards in addition to specific program standards. Section V describes reporting and monitoring requirements that will support the Cabinet's quality assurance program in relation to health care partnerships.

13. Utilization Review and Quality Assurance (UR/QA) System

Health care partnerships will be required to have their own written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its network.

a. Medical Director's Office

Health care partnerships must designate a Medical Director responsible for the development, implementation and review of the internal quality assurance program.

b. Confidentiality

Health care partnerships will be required to have written policies and procedures for maintaining the confidentiality of data.

c. Commonwealth and Federal Reviews

Health care partnerships must make available to the Commonwealth and/or its outside reviewers on a periodic basis, medical and other records (subject to confidentiality constraints) for review of quality of care and access issues, according to the Health Care Financing Administration's (HCFA's) guidelines as set forth in Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States.

The Cabinet or HCFA may also designate outside review agencies to conduct an evaluation of the program and its progress toward achieving program goals. Partnerships must make available, to the Cabinet's or HCFA's outside review

agency, medical and other records (subject to confidentiality constraints) for review as requested.

d. Provider Credentialling

Health care partnerships will be required to have written credentialling and re-credentialling policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the Commonwealth and qualified to perform their services. The partnerships will also be required to have written policies and procedures for monitoring its providers and for disciplining providers who were found to be out-of-compliance with the plan's medical management standards.

e. Operational Data Reporting

HCFA has stipulated that adequate data reporting capabilities are critical to its ability to effectively evaluate Medicaid managed care programs.

To measure the program's actual accomplishments in the area of access to care, medical outcomes, health status, and satisfaction, partnerships must provide the Commonwealth with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis. They also must cooperate with the Commonwealth in carrying-out data validation activities.

The Commonwealth will develop report formats and variable definitions for the health plan or partnership to use in providing operational data. The data required could include utilization data on both a personal level and on an aggregate basis.

1) Data Format

Partnerships will be required to submit quarterly data in an electronic or tape format that conforms to the Commonwealth's specifications. The precise nature of these specifications would be finalized in cooperation with all partnerships.

2) Data Validation

Health care partnerships will assist the Commonwealth in its validation of utilization data.

3) Grievance and Appeals Data

Partnerships will be required to submit a quarterly grievance and appeals report that conforms to the Commonwealth's specifications.

4) Quality Assurance Report

Health care partnerships will be required to submit a quality assurance report. The report may include EPSDT and other preventive visit compliance rates.

Partnerships will make available on a periodic basis clinical data in areas of concern to the Commonwealth, such as asthma rates, sexually

transmitted disease rates, etc. In addition, health care partnerships must provide such outcome-based clinical data as may be requested by the Commonwealth.

5) Member Satisfaction Report

Health care partnerships must collect or assist the Commonwealth in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members. The format for the instrument and research design is not yet finalized.

6) Presentation of Findings

Partnerships must obtain the Commonwealth's approval prior to publishing or making formal public presentations of statistical or analytical material based on its program membership.

f. Grievance and Appeals

The Commonwealth will establish a Grievance and Appeals function through which providers and members could seek redress against partnerships, and through which partnerships could seek to disenroll members who are habitually non-compliant or who posed a threat to plan employees or other members. Partnerships will be required to develop written policies and procedures detailing member complaints grievance methodology. Consumer advocates will play a significant role in representing eligibles at the initial stages of any complaint to assure that enrollees receive adequate representation and that grievances are expeditiously resolved.

Partnerships may seek disenrollment of a member under certain conditions that would be specified in the Partnership Contract.

14. Financial Structure

a. Payments to and from Plans

1) Contract Period

The Commonwealth anticipates that the initial contract period with the partnership will not exceed two (2) years. After the initial contract period, the Commonwealth reserves the right to extend the contract for a period of up to three (3) years or to competitively procure another managed care entity to perform the duties and responsibilities outlined in this document.

2) Acceptance of Commonwealth Capitation Payments

Health care partnerships will be capitated for all in-plan services. The Commonwealth will make capitation payments to partnerships on a monthly basis. Partnerships must accept capitation payments in the manner specified by the Commonwealth (e.g., electronic fund transfer) and will be required to have written policies and procedures for receiving and processing capitation payments.

V. REPORTING AND MONITORING

The Commonwealth intends to expand the service utilization and monitoring plan approved in the 1115 Demonstration Waiver to include the managed care services that will be provided in the fully capitated program. Health care partnerships will be required to provide certain information that will allow the Commonwealth to manage and oversee the program, measure utilization, track results, assess quality, and ensure health care partnership compliance with the program (see Section II-B.13.e.). To accomplish this, the state will require the health care partnerships to submit the following types of information on a quarterly basis:

- Encounter data reflecting the performing provider and the services rendered (See Exhibit 13);
- Selected outcome data reflecting overall experience of the beneficiary population;
- Summary utilization reports by categories of service and enrollment; and
- Financial reports (see Section IV).

In addition, the Commonwealth will require access to medical records, quality assurance proceedings and action, grievance proceedings, results of recipient surveys, supporting data for financial statements, and provider contracts and agreements. Attachment I, Section B, provides some relevant KenPAC information pertaining to the oversight systems which may be employed for partnerships as well.

Detailed encounter data will be captured and maintained in the special MMIS element that will be developed for this purpose. The new system will pass the encounter information to the MARS and SURS subsystems for consolidated claims and encounter reporting. The managed care system will also capture the summary utilization reports submitted by the health care partnerships and the financial reports. This information will be consolidated, compared and reported.

Two areas will be of particular interest in reviewing and evaluating utilization under the health care partnership program. First, primary care services rendered will be compared to the similar set of services covered under the KenPAC program. Reports will be developed to track well-patient care, EPSDT periodicity schedules, and prenatal visits and will compare the results under the fully capitated model to the KenPAC model when appropriate.

Secondly, the utilization variables defined for the KenPAC program will also be measured and tracked for the managed care partnership program as follows:

- Emergency room visits;
- Physician referrals;
- Hospital admissions;
- Laboratory procedures;
- Pharmacy services; and
- Office visits.

This information will be obtained from summary utilization reports that will be required from each of the health care partnerships. The Commonwealth will compile the results, prepare state-wide norms, compare each partnership to the norm and feedback the results to the partnership. Where a partnership varies from the state-wide average by a certain threshold (plus or minus), the partnership will be required to provide an explanation and, if appropriate, an action plan detailing how the partnership will monitor areas of high/low utilization.

Federal requirements regarding reports on eligibility data, characteristics, and expenditures, etc., will be met in a manner similar to other Medicaid eligibles. Partnerships will be required to develop procedures and maintain data to support specific federal requirements for family planning services, abortions, sterilizations, and EPSDT screenings.

The partnerships will also be required to routinely report their aggregate beneficiary experience with regard to targeted outcomes designated by the Chief State Health Officer. Some of the outcomes currently being contemplated include:

- Pediatric immunizations;
- Pap smear -- annual;
- Mammography rate -- annual for women age 50-75;
- C-section rate;
- Low birth weight;
- Asthma in-patient rates;
- Cholesterol screening -- adults age 40-64;
- Prenatal care in first trimester; and
- Diabetic retinal exams.

This information will be used in part to reward partnerships that aggressively pursue and achieve outcomes that meet targets established by the Chief State Health Officer. Such incentive payments will be paid as capitation rate add-ons (See Section III-K).

:ms\0519

reasonable schedule of operating hours. The Department shall have the right to periodically review the adequacy of Service Locations and hours of operation, and may require corrective action to improve Member access to services.

6.3 Choice of Health Professional

Each Member shall be allowed to choose his or her health care professional from among all the available Partnership Providers, to the extent reasonable and appropriate. A Member who has received prior authorization from the Contractor for referral to a specialist or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Partnership, to the extent reasonable and appropriate.

6.4 Facilities and Resources

The Contractor shall maintain at all times during the term of this Contract the following minimum levels of staff and equipment:

6.5 Health Care Partnership Formation and Administration

Each partnership should have sufficient administrative staff and organizational components to operate an extensive service delivery network and provide the functions noted under items a and b below. The functions should be staffed by qualified persons in numbers appropriate to the Partnership's enrollment or projected enrollment.

Each Partnership may combine functions or split the responsibility for a function across multiple departments. Similarly, the Commonwealth or the Partnership may contract with a third party to perform one or more of these administrative functions.

6.6 Executive Management

Each Partnership will have an executive management function with authority over all of the administrative functions.

6.7 Other Administrative Components

Each Partnership will have each of the administrative functions listed below, conforming to program standards which will be described in the contract executed by the Commonwealth. The required functions are:

- Medical Director's Function
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, utilization management, prior authorization, concurrent medical review/discharge planning, and retrospective medical review

- Grievance and Appeals Function
- Claims Processing Function
- Management Information Function

Other specific requirements are as follows:

- a. one FTE primary care physician per 1,500 enrollees in an Individual Practice Association (I.P.A.) and per 2,500 enrollees in a group or staff model Plan. The ratio may be increased by one-half for each FTE certified nurse practitioner or physician assistant affiliated with the physician as a provider in the practice;
- b. one fully-accredited general acute care hospital bed per 275 enrollees;
- c. licensed pharmacies that are open and available to Members during normal Partnership hours of operation; that are geographically accessible
- d. one licensed pharmacist per 2,500 enrollees in a staff or group model;
- e. designated emergency service facilities providing care 24 hours a day, seven days a week. Each emergency service facility shall have one or more physicians qualified to render emergency care and one or more registered nurses on duty in the facility at all times;
- f. facilities at all Service Locations which meet the requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures, applicable to health care facilities;
- g. appropriate foreign language interpreters and Member materials printed in each language spoken by ten percent (10%) or more of the Members in each Service Area;
- h. telecommunications with sufficient local and toll-free lines and a call distribution system sufficient to meet the needs of the Members;
- i. a designated Partnership administrator, qualified by training and experience, to administer the day-to-day business activities conducted pursuant to this contract;
- j. sufficient support staff to conduct daily business in an orderly manner, as determined through management and medical reviews;
- k. a licensed physician to serve as medical director to oversee and be responsible for the proper provision of covered Services to Members;
- l. a designated health care practitioner, qualified by training and experience, to serve as quality assurance director;
- m. a designated person, qualified by training and experience, to be responsible for the medical record system;
- n. a designated person, qualified by training and experience, to be responsible for data processing and the provision of accurate and timely reports to the Department; and
- o. designated staff, qualified by training and experience, to be responsible for ensuring that all Partnership Providers, and all outside Providers to whom Members may be referred, are properly licensed in accordance with federal and State law and regulations.

6.8 Orientation of New Members

The contractor shall provide each new Member, within fourteen (14) days following enrollment, written information respecting the following:

- a. qualifications of Partnership Providers and the procedures for selecting an individual physician and scheduling an initial health assessment;
- b. each Service Location including the address, telephone numbers, office hours, and procedures for scheduling appointments;
- c. benefits and services included in Covered Services and any limitations or exclusions applicable to covered Services;
- d. Member rights and responsibilities;
- e. referral policy for specialty care;
- f. provisions for after-hours and emergency care;
- g. procedures for obtaining emergency and non-emergency transportation available under the Partnership;
- h. the right to formulate advance directives;
- i. the right to receive Family Planning Services and supplies from outside Providers;
- j. policies regarding the appropriate treatment of minors, including information respecting EPSDT services;
- k. any limitations that may apply to services obtained from Outside Providers
- l. procedures for notifying Members of the termination or change in any benefits, services, or Service Locations;
- m. procedures for voicing complaints and grievances or recommending changes in policies and services; and
- n. procedures for appealing adverse determinations affecting coverage, benefits or enrollment to the Department.

6.9 Member Information Materials

All written materials provided to Members, including all Partnership booklets, descriptions and information, policies and procedures, disclosures, and notices, shall be written in language that is readable, easily understood, consumer tested and published in each language spoken by 10% or more of the Members residing in each Service Area.

6.10 Member Rights and Responsibilities

The contractor shall have written policies and procedures which are designed to protect the rights of Members, including without limitation, the right to voice grievances about the Contractor or the care provided, to be informed about the Contractor, its services and the qualifications of all providers, to participate in health care decision making and to be treated with respect in recognition of their dignity and need for privacy, to access their medical records and to formulate advance directives. The Contractor shall also have policies addressing the responsibility of each Member to cooperate with those providing health care services by supplying information essential to the rendition of optimal care, following instructions and guidelines given by those providing health care services, and avoiding rude or disruptive behavior. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members. A copy of the Contractor's policies and procedures shall be provided to all Partnership providers and any outside Providers to whom Members may be referred.

6.11 Case Management

The Contractor shall be responsible for the management and continuity of medical care for all Members through the following minimum functions:

- a. each Member will be allowed to choose his or her health professional to the extent reasonable and appropriate. Continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Member requests otherwise;
- b. appropriate referral and scheduling assistance for Members needing specialty health care services, including those identified through EPSDT;
- c. documentation of referral services in each Member's medical record;
- d. monitoring and treatment of Members with ongoing medical conditions according to appropriate standards of medical practice;
- e. documentation in each medical record of all emergency encounters and any medically indicated follow-up care;
- f. coordination of hospital and institutional admissions and discharges including discharge planning;
- g. determination of the need for noncovered services and referral of Members to the appropriate service setting, utilizing assistance as needed from the Department; and
- h. documented effort by the Contractor to contact each new Member at least two (2) times, if necessary, within ninety (90) days following enrollment to schedule an initial health assessment and the provision of services indicated by such assessment. Members known or appearing to be pregnant shall be screened within thirty (30) days of enrollment, and if pregnant, referred for appropriate prenatal care.

6.12 Family Planning Services

Each Member shall have the right to freely choose a provider or providers of Family Planning Services and supplies. Such services may be obtained from outside Providers without a referral or prior authorization from the Contractor. Family Planning Services and supplies provided by Outside Providers shall be covered by the Partnership.

6.13 EPSDT - Early Periodic Screening Diagnosis and Treatment

The Department believes it is essential that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Kentucky citizens. Toward that end, the contractor shall provide EPSDT Services as defined in, and in accordance with, the Department's policies and procedures for EPSDT and the provisions of this Contract, which shall be deemed cumulative. Such services shall include, without limitation, health screenings (except dental screening) and appropriate and up-to-date immunization of all Members under age 21, in accordance with the Periodicity Schedule established for EPSDT Services. The Contractor shall endeavor to identify and immunize all Members whose medical records do not indicate up-to-date immunizations.

6.14 Referrals for Noncovered Services

The Contractor shall refer Members to providers enrolled in the Medicaid fee-for-service or other managed care programs for all medically necessary noncovered services. The Contractor shall consult with the Department to identify appropriate methods of assessment and referral of Members requiring long term institutional services such as those provided by skilled nursing facilities, hospital swing bed units, intermediate care facilities or intermediate care facilities for the mentally retarded or mentally ill.

The contractor shall have written policies and procedures for the referral of Members for noncovered services which shall provide for the smooth transition to outside providers and assistance to Members in obtaining a new primary care physician, if appropriate. These procedures shall be applicable to the referral of Members to outside providers upon disenrollment, irrespective of the reasons for disenrollment.

6.15 Payment of Outside Providers

The Contractor shall reimburse outside Providers for the following covered Services:

- a. specialty care for which the Contractor has referred the Member to an outside Provider;
- b. Emergency Medical Services which could not be provided by a Partnership Provider because the time to reach a Partnership Provider capable of providing such services would have meant risk of serious damage to the Member's health;
- c. Family Planning Services and supplies provided by an outside Provider in accordance with the Department's policies and procedures respecting such services; and
- d. certain Medicare covered services.

The Contractor shall pay or deny each claim within thirty (30) days following the date the claim is submitted. Claims shall be paid at the applicable Medicaid fee-for-service rate, in the absence of an agreement otherwise. The Contractor shall submit to the Department its criteria for authorization or denial of payment for services rendered by outside Providers. The Department shall review all such criteria for conformity with Medicaid policy and must approve the criteria prior to implementation by the Contractor. The Contractor shall distribute its criteria for approval or denial of outside services to all outside Providers to whom Members may be referred and shall distribute its criteria for approval of outside Emergency Medical Services to all emergency care providers known to the Contractor and located within the Service Area or within a thirty (30) mile radius of the Service Area. All criteria shall be kept current.

The contractor shall consider each claim for reimbursement for Emergency Medical Services provided to Members by Outside Providers based upon its own merits and the requirements of this Section and shall not routinely deny such claims based upon the failure to obtain prior authorization. Requests to provide Emergency Medical Services must be approved or denied within sixty (60) minutes following the time the Contractor is notified that a Member requires Emergency Medical Services. Approval of Emergency Medical Services provided by an Outside Provider shall not be later withdrawn unless there is clear evidence that the medical necessity for the services has been misrepresented by the emergency care provider.

The Contractor shall have written policies and procedures, in form and content acceptable to the Department, providing a mechanism for Outside Providers to appeal the denial of claims by the Contractor. If a claim is denied following completion of the Contractor's internal appeals procedure, the Contractor shall provide written notice of the denial to the outside Provider and the Department. Notice to the outside Provider shall include: a statement that the provider may appeal the determination to the Department; the procedure for submitting an appeal to the Department; and any forms required for an appeal. The Department shall make the final determination as to whether the Contractor is obligated to pay a claim pursuant to this Section and shall provide written notice to the Contractor and the outside Provider setting forth its determination. The Contractor shall pay each claim within thirty (30) days following the date of each notice by the Department indicating that it has made a final determination requiring payment of the claim by the Contractor.

SECTION 7 - QUALITY ASSURANCE

7.1 Quality Assurance System

The Contractor shall implement and operate an internal quality assurance system that:

- a. provides for review by appropriate health professionals of the process followed in providing covered Services to Members;
- b. provides for the maintenance of sufficient encounter data to identify each practitioner providing services to Members, specifically including the unique physician identifier for each physician;
- c. provides for systematic collection of performance and patient outcome data;
- d. provides for interpretation and dissemination of performance and outcome data to Partnership Providers and outside Providers approved for referrals for specialty care;
- e. provides for a system of utilization management consistent with the Department's policies and procedures for HCP Services; and
- f. ensures the prompt implementation of modifications to the Contractor's policies, procedures and/or processes for the delivery of Covered Services as may be indicated by the foregoing.

The Contractor shall have written policies and procedures setting forth the organizational arrangements and processes of the quality assurance system, all of which shall be submitted to and approved in writing by the Department prior to implementation and annually at the request of the Department.

Adequate resources and appropriate staff shall be dedicated to quality assurance functions.

7.2 Standards

The quality assurance system shall provide for continuous performance of accessibility and quality of care studies, and other monitoring activities based upon objective, measurable and current standards for access to services and quality indicators or pre-established practice parameters. These guidelines shall be reviewed by providers, updated periodically and communicated to providers whose performance will be measured against them. Individuals responsible for the studies and other activities shall be clearly identified and qualified by training and experience. Data collected through monitoring and evaluation activities shall be analyzed by appropriate clinicians through a peer review process to evaluate clinical performance of practitioners in the provision of health services. Nonclinical issues shall be analyzed using multi-disciplinary teams as indicated. The quality assurance methodology shall monitor patient outcomes in a manner consistent with existing health care technology.

7.3 Credentialing

The contractor shall verify that all Partnership Providers and any Outside Providers to whom Members may be referred are properly licensed in accordance with all applicable State law and regulations, and have in effect such current policies of malpractice insurance as may be required by the contractor and the Department. The process for verification of Provider credentials and insurance, and periodic review of provider performance shall be embodied in written policies and procedures, approved in writing by the Department. The contractor shall maintain a file for each provider containing a copy of the provider's current license issued by the State and such additional information as may be specified by the Department.

7.4 Internal Audit Annual Report

The Contractor shall annually review, evaluate and modify as necessary, the quality assurance system, including the medical record system, data collection system and system for checking provider credentials, as well as all quality assurance policies and procedures, clinical care standards, practice guidelines and patient protocols, and Member utilization, access to Covered Services and treatment outcomes. The contractor shall prepare a report to the Department, detailing the annual review, completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative and Member satisfaction surveys conducted during the immediately preceding year. The report shall set forth any proposed modifications to the quality assurance system or policies and procedures. Any such modifications shall be approved in writing by the Department prior to implementation.

7.5 Studies

The Contractor shall conduct an annual Member satisfaction survey. A description of the methodology to be used in conducting the survey, the percentage of the Members to be surveyed and a sample questionnaire shall be submitted to the Department for prior approval. The results of the survey must be filed with the Department within ninety (90) days following completion. The contractor shall also perform a minimum of two focused studies of preventive care services

each year, with one focusing on EPSDT Services. Such studies shall be performed in accordance with the Department policies and procedures for HCP Services.

The contractor shall maintain and make available to the Department, and upon request to HCFA, all studies, reports, protocols, standards, work plans, work sheets, committee minutes, committee reports to the board of directors, medical records, and such further documentation as may be appropriate, concerning quality assurance activities and corrective actions.

7.6 Annual Medical Audit

The Department shall have the right to conduct periodic medical audits of the Partnership during which the Department will identify and collect management data including information on the use of services and reasons for enrollment and disenrollment, and may review any of the Contractor's policies and procedures for compliance with the terms of this contract and the policies and procedures for HCP Services. The Department shall also have the right to procure an annual external review of the quality, appropriateness and timeliness of health care services provided by or on behalf of the Contractor, by an independent peer review organization under contract with the Department or a private accreditation body, which evaluation shall be based solely upon the documentation present in each medical record and any complaints received from Members or providers.

7.7 EPSDT Audit, Refunds

In conjunction with the annual medical audit, a sample of medical records will be evaluated to determine compliance by the contractor with the requirements of this contract respecting the provision of EPSDT Services to all Members under age 21. This evaluation shall be based solely- upon the documentation present in each medical record and the claim forms submitted by the Contractor to the fiscal agent. As a minimum standard, at least eighty percent (80%) of the medical records reviewed must show that the Member has received all appropriate immunizations and EPSDT. Should the review indicate that the Contractor did not meet the minimum standard, the percentage of records falling short of the standard shall be extrapolated to the entire population of Members under age 21 who were enrolled in the Partnership during the review period. The number of Members enrolled in the Partnership during the review period shall be determined by dividing the total number of enrollment months for Members under age 21 by the total number of months in the review period. This number shall be multiplied by the percentage of Members in the sample for whom the Contractor failed to meet minimum requirements for EPSDT Services. The Contractor shall refund to the Department the sum of \$100 multiplied by the resulting number. The Department shall provide notice in writing to the contractor setting forth its findings and the amount of the refund, if any, due pursuant to this Section. The Contractor shall refund such amount to the Department within thirty (30) days following the date of such notice.

7.8 Grievance and Appeals Procedures

The Contractor shall have a timely and organized system, and written policies and procedures for resolving complaints and formal grievances filed by Members, which shall conform to the

requirements as promulgated by HCFA and the Department for a Medicaid managed care program.

SECTION 8 - REPORTS AND DATA

8.1 Record System Requirements

The contractor shall maintain detailed records evidencing the administrative costs and expenses incurred pursuant to this Contract; Member enrollment status; provision of covered Services; and all relevant medical information relating to individual Members, for the purpose of audit and evaluation by the Department and other federal or state personnel. All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. All records shall be maintained at a central office designated by the Contractor and approved by the Department.

8.2 Reporting Requirements

The Contractor is responsible for complying with the reporting requirements set forth in this Section and Attachment V, and for assuring the accuracy, completeness and timely submission of each report. The Contractor shall provide such additional data and reports as may be reasonably requested by the Department. The Department will furnish the Contractor with the appropriate reporting formats, instructions, timetables for submission and such technical assistance in filing reports and data as may be permitted by the Department's available resources. The Department reserves the right to modify from time to time the form, content, instructions and timetables for the collection and reporting of data. In the event that the contractor fails to submit any data or report required pursuant to this Section accurately and within the specified time frame, the Department shall have the right to withhold one percent (1%) of the next monthly capitation payment pending receipt of the respective data or report by the Department.

8.3 Financial Reports

The Contractor shall file, within four (4) months following the end of each fiscal year, annual audited financial statements as of the end of such fiscal year, prepared by an independent Certified Public Accountant (CPA) on an accrual basis, in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA). The Contractor shall also file, on or before March 15th of each year, certified copies of the annual statement and reports as prescribed and adopted by the office of the Insurance Commissioner, Commonwealth of Kentucky. The Department may request information in the form of a consolidated financial statement.

The Contractor shall file on or before forty-five (45) days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners (NAIC).

The contractor shall file with the Department, within seven (7) days after issuance, a true, correct and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the Office of the Insurance Commissioner, Commonwealth of Kentucky.

Attachment V includes a detailed description of the financial reports that will be required of each successful contractor.

8.4 Ownership and Financial Disclosure

The Contractor shall provide true and complete disclosures of the following information to the Department, HCFA, and/or their agents or designees, in form and content designated by the Department, at the time of each annual audit, each Medicaid survey, prior to each renewal term of this Contract, prior to entry into a new contract with the Department, and within 35 days following the date of each written request for such information:

- a. the name and address of each person with an ownership or control interest in the contractor or in any subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;
- b. the name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection a, above, has an ownership or control interest;
- c. the same information requested in subsections a and b, above, for any subcontractors or suppliers with whom the Contractor has had business transactions totaling more than \$25,000 during the immediately preceding twelve (12) month period;
- d. a description of any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the immediately preceding 5-year period;
- e. the identity of any person who has an ownership or control interest in the Contractor, any subcontractor or supplier, or is an agent or managing employee of the contractor, any subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs; and
- f. the name of any officer, director, employee or agent of, or any person with an ownership or control interest in the Contractor, any subcontractor or supplier, who is also employed by the Commonwealth of Kentucky or any of its agencies.

8.5 Notice of Legal Action

The Contractor shall provide written notice to the Department of any legal action or notice listed below, within ten (10) days following the date the Contractor receives notice of:

- a. any action, proposed action, suit or counterclaim filed against it;
- b. any administrative or regulatory action or proposed action respecting its business or operations;

- c. any notice received from the Office of the Insurance Commissioner or the Department of Human Resources;
- d. any claim made against the Contractor by a Member, subcontractor or supplier having the potential to result in litigation related in any way to this contract;
- e. the filing of a petition in bankruptcy by or against a principal subcontractor or the insolvency of a principal subcontractor; and
- f. the conviction of any person who has an ownership or control interest in the Contractor, any subcontractor or supplier, or who is an agent or managing employee of the Contractor, any subcontractor or supplier, of a criminal offense related to that person's involvement in an program under Medicare, Medicaid, or Title XX of the Act.

The notice to the Department shall be accompanied by a complete copy of all documents, filings or notices received by the Contractor. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to the Department within ten (10) days following the date the Contractor receives such documents.

8.6 Enrollment Reports

The contractor shall submit to the Department information respecting all new enrollments, disenrollments, reinstatements and circumstances affecting the enrollment status of Members, as received by the Contractor, in a submission format approved by the Department. The Contractor shall review each Member Listing report upon receipt and shall submit all corrections to the Department on or before the fifteenth (15th) day of the month for which the Member Listing report is issued. Adjustments will be made to the next Member Listing report to reflect corrections, and the enrollment or disenrollment of Members reported to the Department (and approved by the Department in case of involuntary disenrollment for cause) on or before the fifteenth (15th) day of each month.

8.7 EPSDT Reports

The Contractor shall submit an EPSDT reporting form to the Department's Fiscal Agent for each Recipient who receives EPSDT services. The data on each form will be used for the automated EPSDT periodic notification system and to facilitate the collection of statistical data required by the federal government.

8.8 Medical Records

The contractor shall maintain current, detailed, organized medical records for each Member sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to this Contract. Medical records shall be accessible by each provider and made available to the provider for each Member visit. Medical Records shall be maintained in such form and content as may be specified from time to time by the Department.

8.9 Confidentiality of Records

The Contractor shall treat all information, including that relating to Recipients and providers, which is obtained by the Contractor through its performance under this Contract as confidential information and shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights hereunder. The Department, the State Attorney General, the State Department of Audits, authorized federal or state personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Department, HCFA, or its Fiscal Agent shall have access to all confidential information in accordance with the requirements of this contract and State and federal law and regulations pertaining to such access. The Department shall have absolute authority to determine if and when any other party has properly obtained the right to have access to such information. The Contractor shall adhere to the statutes, laws, and regulations of the Commonwealth of Kentucky and the Rules of the Department of Medical Assistance, governing the release of information respecting Members.

8.10 Access to Records

The contractor shall make all of its books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Department, the State Attorney General, authorized federal or state personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Department, HCFA, or its Fiscal Agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office at the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense at the Contractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Department shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor and in any way relating to this Contract.

SECTION 9 - CAPITATED PAYMENTS

9.1 Monthly Payment

On or before the tenth (10th) day of each month during the term of this Contract, the Department shall remit to the Contractor the capitation rate specified in Attachment VI for each Member listed on the Member Listing report issued for that month. Payment is contingent upon satisfactory performance by the Contractor of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers, the cost of which shall be borne by the Contractor. The Contractor shall set up the necessary bank accounts and provide written authorization to the Department's Fiscal Agent to generate and process monthly payments through internal billing methods, in form and substance designated by the Department.

FAX TRANSMITTAL



COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
275 EAST MAIN STREET
FRANKFORT 40621-0001
502-564-7130
FAX 502-564-7573

MASTEN CHILDERS II
SECRETARY

TO: HONORABLE DIANA FORTUNA

202-456-7431 *Endiv*

FROM: MASTEN CHILDERS II, SECRETARY

DATE: SEPTEMBER 14, 1995

RE: HEALTH CARE PARTNERSHIP

PAGES: 14

(including cover sheet)

Please deliver to addressee as soon as possible.
If there is any problem in the transmittal, please call 502-564-7130.

Act rates P

P's pymt rates to provide

Bene - if algo bad

Hypothesis

1. get outside advice - try to resolve

2. If not, appeal common
Monitoring P

~~MASTEN~~

*→ Why is it to say
on doc access*



THE SECRETARY FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY

FRANKFORT 40621-0001

(502) 564-7130

(502) 564-7573 FAX

BRERETON C. JONES
GOVERNORSeptember 14, 1995
VIA TELECOPIERMASTEN CHILDERS II
SECRETARY

Honorable Diana Fortuna
Domestic Policy Council
Old Executive Office Building, Rm. 224
Washington, D.C. 20515-1706

Dear Ms. Fortuna:

Please accept my sincere appreciation for the time you gave us yesterday to discuss the many advantages of the Commonwealth of Kentucky's request to establish health care partnerships among members of the public and private Medicaid provider communities. Notwithstanding anticipated cuts of future federal funding to the Medicaid Program, we believe that the President's support of Governor Jones's plan will, in addition to the potential savings of millions of dollars to be credited to Kentucky's Medicaid Trust Fund for future expansion of the eligibility base, allow us to: (i) maintain current mandatory and optional benefits; (ii) enable public health departments to serve all of Kentucky's 120 counties; and (iii) enable Kentucky's 59 acute care hospitals with 100 beds or less to remain viable institutions, since the closure of any such institution would seriously jeopardize access in those communities where closure occurred.

Also, consistent with our discussion yesterday, enclosed please find documents we hope are responsive to some of your questions relating to accessibility and accountability. As promised, Diane Hancock will be calling you today to discuss them in more detail.

In closing, this morning I informed Governor Jones of the progress I thought we made yesterday and he requested that I communicate his sincere thanks for your help.

Best regards,

A handwritten signature in dark ink, appearing to read "Masten Childers II".
Masten Childers II
Secretary

cc: Governor Brereton C. Jones

Under this plan the Commonwealth would develop a state-wide system of health care partnerships. A health care partnership is a coalition of medical providers in both the public and private sectors that provides a comprehensive medical service package through an integrated service delivery network to Medicaid beneficiaries residing in a designated state managed care region. Managed care partnerships participate in the Medicaid Program as comprehensive risk-based entities that are paid on an actuarially sound capitated basis. Providers will be granted the option to design a service delivery network that reflects their region's health care infrastructure and is geared to the unique needs of the region's Medicaid population. The Commonwealth believes that with this local focus, the Health Care Partnership concept will produce savings equivalent to those achieved through other aggressive approaches to managed care while retaining stability and continuity of care for the recipient population.

Eight regional partnerships (see Exhibit 3) will be established consolidating the services of Medicaid-participating providers into a single managed care entity. It is envisioned that the medical schools at the University of Kentucky and the University of Louisville would play an active role in both the design and administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the health care partnerships in rural areas, by providing staff, technical support, and tertiary care. The local health departments, Federally Qualified Health Centers (FQHC), and the Commission for Children with Special Health Care Needs, (a Title V agency), will also be invited to play a key role in each health care partnership by providing primary, secondary, and preventive care to the Medicaid population when appropriate. Mental health services may be delivered to the Medicaid population through the 14 regional mental health centers via a separate Medicaid behavioral health carveout. [If the behavioral health carveout is not implemented, these services will also be included in the partnership service package. The Commonwealth may seek a separate waiver to implement this component of the plan.] Long-term care services will ultimately be consolidated under a separate managed care waiver. In the event that the Commonwealth cannot enter into a satisfactory partnership arrangement with providers in any region, the Commonwealth will invite competitive bids from Health Maintenance Organizations (HMO's) to serve that region.

Any administrative support services that the providers might require on a regional level may be available through the state, so that each partnership can take advantage of statewide economies of scale while crafting services they provide to meet the health care needs peculiar to each region's Medicaid population. An incentive pool will be established to provide performance rewards for those partnerships that meet goals established by the State's Chief Health Officer for such long-range health investments as immunizations, cervical cancer screenings, mammograms, and low birthweight babies. As authorized by Kentucky House Bill 250, Section 92, (see Exhibit 2), an Indigent Care Trust Fund will be established so that any savings realized through the managed care initiative will be reserved for future Medicaid expansions.

C. Comparison of Approved 1115 Waiver to the Requested Amendment

Exhibit 4 provides a point-by-point comparison of the major provisions of the approved 1115 Demonstration waiver to those of the requested amendment.

:ms0516

II. HEALTH CARE PARTNERSHIP PROGRAM DESIGN

A. Designated Managed Care Regions

The Commonwealth has designated eight (8) managed care regions through which the statewide managed care program will be implemented. The program will be initiated in regions 3, 6, and 5. However, ultimately a health care partnership will serve the Medicaid beneficiaries of each of these 8 regions. Exhibit 3 is a map of Kentucky that identifies the counties that are included in each managed care region. These regions were designed to both incorporate recognized service delivery areas and to comprise a sufficient beneficiary base to be actuarially sound. Wherever possible, the regions incorporated medically underserved areas together with those that have a high provider density. This is expected to promote a reallocation of resources to the medically underserved areas. The Commonwealth reserves the right to make those minor changes to the identified managed care boundaries which are necessary to ensure cost effectiveness.

In the event the Commonwealth cannot enter into a financially sound agreement that will provide greater access and high quality health care to Medicaid beneficiaries, the Commonwealth will invite competitive bids from HMOs to serve the region. Satisfactory financial agreements will be determined by the Commonwealth's actuaries for the partnerships on the same basis as they would use for a competitive bid process. If the HCP does not meet these financial standards then a competitive bid process will be used.

The Commonwealth may, if a competitive bid process is used, offer two or more HMOs per managed care region. This decision will be made by taking into account financial considerations as well as access to care and network viability in each managed care region. The Commonwealth also will be concerned with maintaining access to health care should one or more HMOs not meet the standard of care and financial solvency required prospectively. The Commonwealth will be guided by network capacity and financial standards of the HMOs in each region in determining how many HMOs should be awarded a contract.

B. Participating Provider Provisions

1. Partnership Concept

The proposed waiver amendment will enable providers in a given managed care region to coalesce into a system of health care partnerships. A health care partnership is a coalition of medical providers in both the public and private sectors that provides a comprehensive medical service package through an integrated service delivery network to Medicaid beneficiaries residing in a designated state managed care region. Health care partnerships participate in the Medicaid Program as comprehensive risk-based entities that are paid on an actuarially sound capitated basis. Exhibit 5 illustrates the relationship between the various components of the Health Care Partnership System. Providers will be granted the authority to design an integrated service delivery network that reflects their region's health care infrastructure and is geared to the unique needs of the region's Medicaid population.

Each partnership will be required to establish and maintain provider networks in geographically accessible locations. Such networks will be composed of hospitals, physicians, pharmacies, emergency transportation, etc., in sufficient numbers to make covered services reasonably available. The Commonwealth anticipates that partnerships will expand the number and array of on-site specialty services available to Medicaid beneficiaries on the local level by bringing physicians to the region physically or through telemedicine technology.

Because the Commonwealth's goal is to provide the covered population with the greatest choice possible, each Health Care Partnership panel will include any provider in the service area that is willing to accept the conditions stipulated in the provider contract. In addition to the private providers included in the network, linkages will be established with local health departments, Federally Qualified Health Centers (FQHC), and the Commission for Children with Special Health Care Needs (Title V agency) to provide primary, secondary, and preventive care to the Medicaid population as appropriate. The Medical Schools at the University of Kentucky and the University of Louisville will play an active role in both the design and/or the administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the partnerships, particularly those in rural areas by providing staff technical support and tertiary care.

2. Health Care Partnership Formation and Administration

Each partnership should have sufficient administrative staff and organizational components to operate an extensive service delivery network. Although a preliminary draft of a partnership contract has been provided (see Exhibit 6), each region will develop a contract geared both to the needs of the Medicaid population and the available health care infrastructure in the region. HCFA will review and approve each region's contract prior to its execution. The requirements under the contract will include each of the functions noted under items a and b below. The functions should be staffed by qualified persons in numbers appropriate to the partnership's enrollment or projected enrollment.

Each partnership may combine functions or split the responsibility for a function across multiple departments. Similarly, the Commonwealth or the partnership may contract with a third party (subcontractor) to assist in the formation of the partnerships and to perform one or more of these administrative functions.

a. Executive Management

Each partnership will have an executive management function with authority over all of the administrative functions.

b. Other Administrative Components

Each partnership will have each of the administrative functions listed below, conforming to program standards which will be described in the contract executed by the Commonwealth. The required functions are:

- Medical Director's Function
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, utilization management, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function

4. Physician Specialists

Due to the large number of physician specialties that exist, partnerships may not be required to maintain specific member-to-specialist provider ratios. However, it must provide adequate access to physician specialists for PCP referrals, and to employ or contract with specialists in sufficient numbers to ensure specialty services could be made available in a timely manner and locally accessible when feasible.

5. Mainstreaming

The Commonwealth considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be an important program objective. Therefore, the partnerships must ensure that network providers do not intentionally segregate program members in any way from other persons receiving services.

6. Network Changes

Health care partnerships will be required to notify the Commonwealth promptly of any changes to the composition of its provider network that materially affected the plan's ability to make available all capitated services in a timely manner. Partnerships will also be required to have procedures to address changes in its network that negatively affect the ability of members to access services. Material changes in network composition that negatively affect member access to services could be grounds for contract termination.

7. Service Accessibility Standards

Health care partnerships will be required to provide coverage, either directly or through its PCPs, to members on a twenty-four hours per day, seven days per week.

8. Beneficiaries Services

Partnerships must staff an Ombudsman or Beneficiary Service function. This will include a toll-free telephone number for beneficiaries to access services, secure information, and file grievances within response time standards that will be specified in the partnership contract. This service will be staffed by consumer advocates to assure that enrollees receive adequate representation when seeking to expeditiously resolve grievances.

9. Provider Services

Health care partnerships will be required to staff a Provider Services function. This function will include a toll-free telephone number for providers to use to obtain information and guidance regarding health service issues.

10. Transitioning Members Between Plans

It may be necessary to transition members between regional partnerships. Partnerships will be required to have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. Partnerships will be required to have similar procedures for integration of their services with other managed care systems operated by the Commonwealth for Medicaid recipients.

11. Member Disenrollment

a. General Authority

The Commonwealth may have sole authority for disenrolling beneficiaries from partnerships, subject to the conditions described within the partnership contract with the Commonwealth. The partnership may have sole authority for disenrolling members from its subcontracted providers.

b. Disenrollment Effective Dates

Beneficiary disenrollments from the partnership will be effective on the date specified by the Commonwealth.

12. Medical Management and Quality Assurance by the Commonwealth

The Department of Medicaid Services regulates the utilization review and quality assurance (UR/QA) functions of all licensed providers. Health care partnerships, therefore, will comply with all Department for Medicaid Services UR/QA standards in addition to specific program standards. Section V describes reporting and monitoring requirements that will support the Cabinet's quality assurance program in relation to health care partnerships.

13. Utilization Review and Quality Assurance (UR/QA) System

Health care partnerships will be required to have their own written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its network.

a. Medical Director's Office

Health care partnerships must designate a Medical Director responsible for the development, implementation and review of the internal quality assurance program.

b. Confidentiality

Health care partnerships will be required to have written policies and procedures for maintaining the confidentiality of data.

c. Commonwealth and Federal Reviews

Health care partnerships must make available to the Commonwealth and/or its outside reviewers on a periodic basis, medical and other records (subject to confidentiality constraints) for review of quality of care and access issues, according to the Health Care Financing Administration's (HCFA's) guidelines as set forth in Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States.

The Cabinet or HCFA may also designate outside review agencies to conduct an evaluation of the program and its progress toward achieving program goals. Partnerships must make available, to the Cabinet's or HCFA's outside review

agency, medical and other records (subject to confidentiality constraints) for review as requested.

d. Provider Credentialling

Health care partnerships will be required to have written credentialling and re-credentialling policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the Commonwealth and qualified to perform their services. The partnerships will also be required to have written policies and procedures for monitoring its providers and for disciplining providers who were found to be out-of-compliance with the plan's medical management standards.

e. Operational Data Reporting

HCFA has stipulated that adequate data reporting capabilities are critical to its ability to effectively evaluate Medicaid managed care programs.

To measure the program's actual accomplishments in the area of access to care, medical outcomes, health status, and satisfaction, partnerships must provide the Commonwealth with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis. They also must cooperate with the Commonwealth in carrying-out data validation activities.

The Commonwealth will develop report formats and variable definitions for the health plan or partnership to use in providing operational data. The data required could include utilization data on both a personal level and on an aggregate basis.

1) Data Format

Partnerships will be required to submit quarterly data in an electronic or tape format that conforms to the Commonwealth's specifications. The precise nature of these specifications would be finalized in cooperation with all partnerships.

2) Data Validation

Health care partnerships will assist the Commonwealth in its validation of utilization data.

3) Grievance and Appeals Data

Partnerships will be required to submit a quarterly grievance and appeals report that conforms to the Commonwealth's specifications.

4) Quality Assurance Report

Health care partnerships will be required to submit a quality assurance report. The report may include EPSDT and other preventive visit compliance rates.

Partnerships will make available on a periodic basis clinical data in areas of concern to the Commonwealth, such as asthma rates, sexually

transmitted disease rates, etc. In addition, health care partnerships must provide such outcome-based clinical data as may be requested by the Commonwealth.

5) Member Satisfaction Report

Health care partnerships must collect or assist the Commonwealth in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members. The format for the instrument and research design is not yet finalized.

6) Presentation of Findings

Partnerships must obtain the Commonwealth's approval prior to publishing or making formal public presentations of statistical or analytical material based on its program membership.

f. Grievance and Appeals

The Commonwealth will establish a Grievance and Appeals function through which providers and members could seek redress against partnerships, and through which partnerships could seek to disenroll members who are habitually non-compliant or who posed a threat to plan employees or other members. Partnerships will be required to develop written policies and procedures detailing member complaints grievance methodology. Consumer advocates will play a significant role in representing eligibles at the initial stages of any complaint to assure that enrollees receive adequate representation and that grievances are expeditiously resolved.

Partnerships may seek disenrollment of a member under certain conditions that would be specified in the Partnership Contract.

14. Financial Structure

a. Payments to and from Plans

1) Contract Period

The Commonwealth anticipates that the initial contract period with the partnership will not exceed two (2) years. After the initial contract period, the Commonwealth reserves the right to extend the contract for a period of up to three (3) years or to competitively procure another managed care entity to perform the duties and responsibilities outlined in this document.

2) Acceptance of Commonwealth Capitation Payments

Health care partnerships will be capitated for all in-plan services. The Commonwealth will make capitation payments to partnerships on a monthly basis. Partnerships must accept capitation payments in the manner specified by the Commonwealth (e.g., electronic fund transfer) and will be required to have written policies and procedures for receiving and processing capitation payments.

Because many of the data cells are small and health care claims expense is so volatile, outliers inevitably appear. The actuary will be expected to exercise his or her best judgement and reject those historical results that would not be appropriate assumptions for future results.

The intent of the UPL methodology is to ensure that the managed care program pays no more than an actuarially equivalent FFS population or more than in a capitated HMO environment. However, it is not desirable to pass into UPLs all random variations found in the FFS data. The purpose of this model is to adjust for any random variation that may occur within the base FFSE and ensure that Kentucky Medicaid pays no more for managed care than it would in fee-for-service care.

To address these issues; upper payment limits and the risk of the managed care population, the actuary will input the FFSEs into a relational cost model. The relational cost model adjusts the relationships within the various geographic regions and categories of assistance to ensure that they adequately address the risk of the managed care population.

The relational cost model ensures that the UPLs are not exceeded by reapportioning the existing expenditure among the various regions and COEs. Thus, the upper payment limits have not been changed in aggregate and the risk of the managed care population is more appropriately addressed.

K. Capitation Rate Structure

After determining the appropriate rate setting methodology for the Commonwealth, the actuary will assist Kentucky Medicaid with implementation.

The capitated rate structure implemented by the Commonwealth is expected to be based on rate ranges rather than strict rate setting. Rate ranges give the Commonwealth the flexibility to recognize managed care delivery systems that vary in design.

In a prospectively capitated environment that Kentucky plans to use for its managed care program, it is critical that the health care partnerships have standards by which to manage the care of their enrollees. The Commonwealth may use the CRCS format as the basis for the rate negotiation process. Partnerships may be required to fill out the CRCS with its assumed utilization and unit cost figures by eligibility category, geographic region, and category of service.

Is this possible?
The Commonwealth will evaluate the partnership proposal against the rate ranges provided by the actuary that are structured in an identical manner. The Commonwealth will then negotiate with the partnership regarding any unrealistic assumptions in the final capitation rate and to assure that partnership capitation rates are comparable to those the actuary would expect in a competitive HMO managed care model..

The Health Care Partnership could then use the completed CRCS as a management tool to judge the effectiveness and ultimately the profitability of its program. The CRCS format will give the partnership a blueprint for its management reporting needs and standardize the management reporting among all the plans. The Commonwealth will reap the benefits of this standardized management reporting by comparable quarterly and year-end financial reports from partnerships.

The capitation rate ranges will also provide the Commonwealth flexibility in providing incentive payments to partnerships that meet or exceed quality of care standards or target outcome goals. Based on where the partnership falls within the rate range, the Commonwealth can provide a percentage adjustment or fixed dollar incentive payment if the partnership successfully exceeds certain quality

care standards or target outcome measures within its contract. The rate range will allow the Commonwealth to pay partnerships with lower capitation rates higher incentive payments, thus enticing partnerships to strive for lower capitation rates while still maintaining a consistently high level of care.

:ms0523

**Evaluation Plan
Analysis
Study Issue: Access**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project result in improved access to health care?	Partnerships will expand the number and array of on-site specialty services available to Medicaid beneficiaries.	- MMIS Utilization Data - Partnership encounter data	Pre-post analysis of health care providers relative to the number of specialty providers.
<i>explicitly part of hypothesis</i>	Partnerships will give Medicaid beneficiaries the greater choice as compared to other aggressively managed care alternatives.	- Partnership encounter data - Partnership panels - Non-Medicaid HMO panels - Recipient surveys	Analysis of non-Medicaid HMO panels as compared to Partnership panels
	Partnerships will retain stability and continuity of care for the recipient population	- KEPAC physicians participants - Partnership physician participants - MMIS utilization data - Partnership encounter data - Recipient surveys	Analysis of providers either accessed by or available to Medicaid eligibles with their regions.

:dj/0347

**Evaluation Plan
Analysis
Study Issue: Quality of Care**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project affect the quality of care and health of Medicaid eligibles?	Recipient health status, as reported by recipient/patients and based on health outcomes will improve as a result of the demonstration.	- Medical records - MMIS utilization data - Partnership encounter data - Performance awards	Pre-post survey of quality of care and health status of Medicaid beneficiaries and specific case studies representing a cross-sectional, as well as, longitudinal approach.
			State Health Officer will establish annual long-range investment goals, i.e. immunizations, cancer screenings, mammograms, low birthweight babies, etc., that will be used to establish performance rewards. Incentive payments will be awarded annually to partnerships that meet these goals.
To what extent does the project impact utilization of primary care or preventative services by Medicaid recipients?	Utilization of medical services, particularly primary and preventative care will improve as a result of the demonstration. Managed care will: - reduced hospital admissions - increase use of primary physician visits - reduce usage of emergency room for non-emergent care - increase the use of preventative treatment - reduce self-referral and other referral specialist visits	- Medical records - MMIS utilization data - Partnership encounter data - MMIS expenditure data	Pre-post survey of the quality of care and health status of Medicaid eligibles and specific case studies representing a cross-sectional, as well as, a longitudinal approach.

:dj/0348

**Evaluation Plan
Analysis
Study Issue: Constraint of Costs**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project impact total Medicaid expenditures?	Savings are equivalent to those achieved through other aggressive approaches to managed care.	- MMIS expenditure data - Partnership capitation rates - Expenditure data from other states using competitive HMO model	Pre-post comparison of total and per capita expenditure on the Kentucky Medicaid population. Comparison against other states using competitive HMO model.

**Evaluation Plan
Analysis
Study Issue: Provider and Patient Satisfaction**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project improve the provider and patients perception of the Medicaid program?	Partnerships will improve patient satisfaction and empower Medicaid providers.	-Provider surveys -Recipient surveys	Pre-post provider and recipient satisfaction survey

**Evaluation Plan
Analysis
Study Issue: Medically Underserved Areas**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project enhance health care services in medically underserved areas?	Partnerships will improve health care services in medically underserved areas by bringing physicians and other providers to the region physically or through telemedicine technology.	-MMIS utilization data -Partnership encounter data -Medically underserved area survey	Pre-post analysis of locally accessible health care services in medically underserved areas.

THE WHITE HOUSE
WASHINGTON

CR:

+ talk to

FAX COVER SHEET HHS

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-2216 PHONE
(202)456-2878 FAX

TO:

Maria Fortuna

FAX #:

6-7028FROM: CAROL H. RASCO

NUMBER OF PAGES (including cover sheet):

7

COMMENTS:

For 12:00 pm call

* call Jelma COB Tues
w/ update
(don't wait till last minute)
CR will brief POTUS early next wk.
(Reread basic description of w)
* Only 1 HMO S.W. or
in various places
CR - rural angle
Compelling

If you have any problems with the fax transmission, please call Pat at
(202)456-5565 2249

The document accompanying this facsimile transmittal sheet is intended only for the use of the individual or entity to whom it is addressed. This message contains information which may be privileged, confidential or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any disclosure, dissemination, copying or distribution, or the taking of any action in reliance on the contents of this communication is strictly prohibited.

Gov Jones

Indigent care TF

Srgs → TF

8 partnerships

AMA favors

wid & rural hosp, use public clinics

(CR: vac)

Out Dec 11

Health Policy Bd - blows whistle on MHS
- not popular w/ AMA

* Call - why not let comid compete?
- Children's? Jelma?
- Monahan/HCA re plans.
- When/how to offer
alternatives?



HEALTH CARE FINANCING ADMINISTRATION



SEP - 5 1995

ADDRESSEE: <i>Carol Rosco</i>		FROM: <i>Bure Vladeck</i> OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201 PHONE: 202-690-6726 FAX : 202-690-6262	
PHONE: _____	TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
REMARKS: <i>This is the memo you asked for regarding Kentucky and the issue of competition. Let me know if you have any questions.</i>			

BENEFICIARY CHOICE AND OPEN COMPETITION IN SECTION 1115 MEDICAID DEMONSTRATIONS

September 5, 1995

PURPOSE

This paper outlines the Department's rationale for requiring that, in comprehensive section 1115 demonstrations, states provide Medicaid beneficiaries a choice of health plans and use a competitive bidding process to contract with managed care entities.

BACKGROUND

The Department is currently faced with two issues that arise from tension between fundamental principles in the Medicaid program and states' desire for greater programmatic flexibility. Specifically, three states (Alabama, Kansas and Kentucky) have submitted demonstration proposals that are inconsistent with Medicaid policy on (1) beneficiary choice of health plans and (2) competitive bidding. The position we take in these states will either reinforce existing policy or establish new precedents certain to be watched by other states.

Chris More importantly, our decision on these issues will affect our negotiating position in upcoming discussions with the Congress about the degree and nature of state flexibility in Medicaid. If, in order to protect quality and access, we wish to insist that states provide a choice of at least two plans to Medicaid beneficiaries -- *a policy consistent with the Administration's emphasis on choice in the health care reform debate* -- then acceding to a no-choice model in these demonstration proposals would significantly weaken our position. Likewise, approving a sole-source contracting model in a demonstration context would fuel state pressure for flexibility to use non-competitive procurement on a regular basis.

Following is a discussion of our deliberations concerning Kentucky's proposal, although the arguments can be also be applied to situations in Alabama and Kansas.

KENTUCKY

In June 1995, Kentucky submitted an amendment to its demonstration project, in which a *single* system of eight regional provider "partnerships" would be the delivery system for all Medicaid beneficiaries. The partnerships, comprised of all the interested traditional Medicaid and public providers throughout the State, would set their own provider payment rates and assume the financial risk of furnishing services to non-institutionalized Medicaid beneficiaries.

Basic Description of W.

Why 1 plan

only in certain areas?

History of comm

Key things Choice of plan gets you

PCCM?

Discussion

Beneficiary Choice

Kentucky wants to restrict Medicaid beneficiaries to a single capitated health system with no choice of health plans. That is, beneficiaries would have access to only one plan, the Partnership, and would have no alternative means of receiving health services if, for some reason, they wished to disenroll from the Partnership. The State has indicated that since the Partnership would include all providers who have traditionally served the Medicaid population, choice of providers would be maintained or increased. The Department thinks, for the reasons listed below, that it is important to sustain choice of health plan for Medicaid beneficiaries.

Just Kentucky
Protects Quality of Care - With all comprehensive section 1115 Medicaid demonstrations, the Department has required that beneficiaries be offered a choice of health care delivery systems. The Department has insisted on health system choice to protect Medicaid enrollees from being offered poor quality care and to prevent beneficiaries from being locked into plans they may be dissatisfied with. Because of financial incentives inherent in capitated managed care, Medicaid enrollees could be at risk for being denied medically necessary services. But if beneficiaries can "vote with their feet" by choosing among delivery systems or by opting out of poor quality health plans, we think managed care organizations will have an incentive to compete for beneficiaries on the basis of quality. We particularly want to avoid a repeat of the "Medicaid Mills" that offered inferior care to Medicaid enrollees during the 1970s. This concern is exacerbated whenever we waive the 75/25 enrollment composition requirement and permit states to lock beneficiaries into managed care plans for one year (as Kentucky has proposed to do). The Department believes that, if we are to waive these other quality protections, it is crucial to retain beneficiary choice of plan as a mechanism for assuring quality.

The Governor has argued that since state employees are only offered one choice of health plan there is no reason to treat Medicaid beneficiaries any differently. Kentucky state employees actually do have a choice among various HMOs and other health insurance plans. Regardless, the Governor's view is incompatible with the Administration's commitment to choice during the health care reform debate. If the Health Security Act had been implemented, even low income Americans would have had a choice of health plans.

Kentucky Has Limited Experience With Managed Care - Beneficiary choice of plan is especially essential in Kentucky because neither the State nor the Partnership providers have experience with capitated managed care approaches and techniques. We are concerned that the State may have difficulty establishing and managing the Partnership. Further, existing tensions between the State and providers could jeopardize the

development of the provider network because the State is being sued by physician and ancillary provider groups on the basis of low payment rates.

Competitive Bidding

The Partnership contract would be awarded on a non-competitive, sole-source basis. Kentucky already has lined up the providers who would comprise the Partnership, and there would be no open competition with other health plans potentially interested in furnishing services to the Medicaid population. Following is the rationale for our position that a competitive bidding requirement be preserved.

Required by Federal Regulation - Competitive bidding is a tool for promoting low cost, high quality goods and services. For that reason, Federal procurement regulations require States to follow competitive bidding procedures to the maximum extent practical when awarding a contract, although a single entity may ultimately be selected. This regulation cannot be waived under section 1115 authority. While a State following a competitive bidding process could potentially award a contract to one managed care organization, we would still require that beneficiary choice be maintained through either a fee-for-service or other managed care arrangement. However, Kentucky would like to sole-source its contract under the Partnership without following a competitive process.

For the District of Columbia's demonstration proposal involving disabled children, the Department is considering allowing a sole-source contract for the first two years, followed by an open procurement process. Competitive bidding would not be practical initially for the District, whose project is on a much smaller scale and involves a more limited population than the statewide reforms being contemplated in other states.

Would Not Necessarily Undermine Public Health Delivery System - A sole-source contract eliminates any opportunity for other managed care organizations to bid to provide services to Medicaid beneficiaries. In Kentucky, it is likely that private HMOs would compete for the Medicaid business. The State has argued that opening up the contract process would allow large private HMOs to take over the Medicaid population, thereby undermining the public health delivery system. However, the Department thinks that, if the competition were structured to reward high quality care provided by traditional Medicaid providers, a competitive process should not threaten the viability of public providers.

Prior Discussions with Kentucky

Prior to receiving Kentucky's amendment in June, Department staff had numerous conversations with Kentucky Medicaid staff and representatives from the Governor's office about these issues. We suggested to the State a number of alternatives that would preserve the one-plan approach and still allow choice. For example, the State could offer beneficiaries either a primary care case management system (Kentucky has

operated KenPAC, an almost State-wide PCCM, for about ten years), or a fee-for-service alternative. The State has repeatedly rejected these suggestions.

Impact on Other States

Both Kansas and Alabama have submitted similar demonstration requests to the Department that would restrict beneficiary choice to a single provider system, and that would not be competitively bid. Recently, in a letter from the Governor to Secretary Shalala, Kansas expressed willingness to concede on the beneficiary choice issue by allowing beneficiaries to choose between the proposed managed care network and a primary care case management system. But Kansas has asked the Department to reconsider the open competition requirement. We have had preliminary discussions about these issues with other states that are developing demonstration proposals.

Other section 1115 demonstration states have integrated the Medicaid population into "mainstream" managed care plans and increased choice, rather than limited it. We are concerned that future demonstration States, particularly those with large Medicaid populations, may seek similar "no choice" arrangements if the precedent is established in Kentucky.

say testing it? 1x

OPTIONS

Beneficiary Choice

Preferred Option--

- o In addition to the single health plan, the State would offer Medicaid beneficiaries health system choice (for example, the KenPAC primary care case management system) at both the point of enrollment and the point of disenrollment. To increase the State's flexibility under this option, we could also:

- + Allow the single health plan to offer an enhanced service package to Medicaid beneficiaries, i.e., services not covered in the regular State plan.

- + Permit the State to "default" individuals into the single health plan who, when offered a choice of the health plan or some other arrangement, do not make a choice.

- + On a case-by-case basis, consider a single system such as the Partnership in rural areas.

incentive

lot of people 30 years

set aside

offer to state?

Other Option--

- o Allow the State to enroll all beneficiaries into the Partnership with no "upfront" choice, but allow enrollees to opt out at periodic intervals (for example, every 3 months during the first year, and annually thereafter) into some other delivery system (such as KenPAC).

Competitive Bidding

Preferred Option--

- o Require states to competitively bid for all managed care contracts to the maximum extent practical.

Other Option--

- o Identify certain situations where we believe competitive bidding might not be practical and establish procedures for states to demonstrate that competition is impractical. Allow states to sole-source in these situations. Examples of such situations could include: in a rural area when only one contractor is clearly interested in providing services, or when a contractor is uniquely qualified to provide a specialized set of services to a limited population.

9/11

1. Choice of plan vs. provider

KB - low rate - people formally in it
but not really

75/25

disenfranchisement on demand

2. Brought it up on many occasions - ^{known not legal} comp bidding
OMB has toughened

was OK when agency OK'd

now, max est ^{practical} 8/94

→ First application

Johnson -
why not agree?
extra prod fresh?

PCCM - mgd care from client's perspective
RFS

Ky - says not as much; providers won't enroll
didn't count

Why 1 plan:

- concerned re 2 hospo
- docs to rural areas

Paying more - > upper payment limit

8 regions

Comp bidding

Additional Information on Kentucky Medicaid Demonstration

1. Why is it "bad" to have only one plan and why is choice of plan more important than choice of providers?

One plan precludes beneficiary choice. If beneficiaries have difficulty accessing care (primary or specialty), or if they believe they are receiving poor quality care, they have little recourse other than the appeals process. Choice of plan is particularly important in 1115 demonstrations when we waive beneficiary protections for access to quality care, such as 75/25 enrollment composition and the lock-in provisions. Kentucky, too, has asked for these waivers.

While a single plan with a wide choice of providers can address access concerns, it forces all beneficiaries to enroll under the same guidelines and structure, regardless of their specific needs and preferences.

Other arguments for beneficiary choice of plan include:

Mainstreaming - Having only one plan approaches segregated medical assistance.

no worse than now

Access - One plan eliminates potential additional supply of providers to a population which resides in typically medically underserved areas.

choice

Quality - Lack of competition potentially allows poor or mediocre performers to maintain their status quo.

all current providers? Cb issue

Negotiating Ability - Having only one plan could reduce the State's ability to negotiate competitive rates.

Cb issue

If the One Plan Fails - If the one plan were to fail, for example, as a result of bankruptcy, the State would need to set up another system of care, whereas in a multiple plan system, the other plans generally can furnish care to the former plan's enrollees.

but public

Health Security Act - Under the Health Security Act all enrollees would have had a choice of delivery systems.

2. Have we had discussions with the State about the ways to competitively bid?

The State submitted a draft concept paper in March 1995 and an official

application in June 1995. We had a number of conference calls with State officials and discussed several concepts:

We informed Kentucky that, in structuring a request for proposal, they could specify criteria in the contract selection process which would embrace their "managed cooperation" model and permit the State to effectively target plans like the Partnership.

As detailed more fully in the response to Question 4, we clarified that, generally the State may have a single contract, that is, it may contract with a single entity after it has gone through the open procurement process and as long as beneficiaries are offered another choice, such as a fee-for-service alternative.

3. Can we waive competitive bidding rules? Have we talked with the State about this?

HCFA has no authority under section 1115 to "waive" the regulation requiring that competitive bidding be used to the "maximum extent practical." We have discussed our understanding of these open procurement regulations with the State.

Below is OGC's opinion:

The authority in section 1115 only permits the Secretary to "waive" state plan requirements in section 1902, or to regard expenditures as federally-matchable notwithstanding the fact that they do not conform to the requirements for such matching in section 1903. The requirement at issue is not even set forth in the Medicaid statute, but implements a government-wide OMB rule involving federal grantees generally (including states receiving Medicaid funds). Thus, HCFA's discretion under this rule is no greater in the context of a demonstration than it would be for a non-demonstration state.

Although HCFA cannot "waive" this rule under demonstration authority, it does have discretion in determining how flexible it will be in deciding whether a state has made the case that competitive procurement would not be "practical" under the factual circumstances at hand. Such a state case might involve, for example, the assertion that the proposed contractor is "uniquely qualified" to do the job, or the contention that no other potential bidders would be interested in contracting under the terms in question (e.g., an "any willing provider" clause, or obligation to pay FQHCs full costs).

At one end of the spectrum, HCFA could defer to such state arguments on practicality, and accept them at face value. (In such a case, the non-competitive

award could potentially be subject to legal challenge by a would-be bidder on the grounds that the impracticality standard was not met.) At the other end of the spectrum, HCFA could state that it is only in the rarest case that HCFA would find it "impractical" to competitively bid, and that even then, extensive documentation of this fact would be required. At bottom, the question of whether a given entity is "uniquely qualified" involves subjective judgments upon which reasonable persons may differ. HCFA thus has considerable leeway in deciding how to proceed. It is important to bear in mind, however, that any decision HCFA makes in the context of a demonstration project would establish a precedent for all other states, whether operating under a demonstration or not.

4. Under what circumstances would we allow a contract not to be openly procured?

While HCFA has theorized about the possible circumstances under which we would determine that competition is not practical, we have not yet granted any state an exemption under the new open procurement regulations. Also, as stated in Question 3 above, any decision HCFA makes in the context of a demonstration project would establish a precedent for all other states, whether operating under a demonstration or not. Possible circumstances include:

is that what it is?

Extraordinary circumstances - We believe extraordinary circumstances could arise which would preclude the open procurement process. For example, if a natural disaster occurred, and the State needed to award an emergency contract on a temporary basis, we believe it would be appropriate to circumvent the open procurement process.

Competition Not Possible - If the State could demonstrate to HCFA that competition could not exist, for example, in a rural area of the State, we believe it would be appropriate not to follow a competitive process.

Uniquely Qualified Provider - Also, we would consider a non-competitive approach for a limited or specialized services package for which the contractor is uniquely qualified. (This is the determination HCFA is likely to make for the District of Columbia's demonstration for special needs children.)

Also, we would permit Kentucky to award a single contract as a part of its open procurement request for proposals. That is, we would allow the State to notify all interested players that a single contract would be granted to the winning bidder. Of course, in this instance, as stated in Question 2, the State would still be required to offer beneficiaries a choice of plans, such as a fee-for-service alternative.

Chandra

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

11-Sep-1995 04:59pm

TO: Laura A. Oliven
FROM: Diana M. Fortuna
 Domestic Policy Council
CC: Mark E. Miller
SUBJECT: competitive bidding

Do you work on or know anything about the federal reg issued by OMB that requires federal grantees, including states, to use competitive bidding "to the maximum extent practical"? Apparently you guys toughened this up about a year ago; it used to read that agencies could just make this call on their own.

The state of Kentucky wants a Medicaid waiver to do managed care, and they want to pick one entity to be the managed care plan for all Medicaid business in the state, without competitively bidding it. HHS general counsel says the waiver authority they have under section 1115 of the social security law doesn't allow them to waive this requirement. So they have to decide what "maximum extent practical" means and apply it here. They said they haven't had to make a determination yet under the revised regs.

EXECUTIVE OFFICE OF THE PRESIDENT

12-Sep-1995 06:00pm

TO: Diana M. Fortuna
FROM: Laura A. Oliven
Office of Mgmt and Budget, OIRA
CC: Mark E. Miller
SUBJECT: RE: competitive bidding

I did some research on your competitive bidding question. Apparently, you are citing the wrong OMB guidance on bidding - A-110, which only applies to universities and non-profit organizations.

The policy that applies to States is A102, the Grants Management Common Rule, which says that all States will employ full and open competition for their contracts. Note that this does not include qualifying language, "to the extent practicable." In other words, they MUST compete their contracts.

Please let me know if you need more information. Also Barbara Kahlow, in the OMB Office of Financial Management is our expert.

Regulation

only realized in Jan

Criticized → Publishing rule w/o OMB approval?

→ ag compet. even if practical std

*OMB unaware of reg; stated in Fed Reg does apply to MA
def std was to apply (re entitlement)
till now, this std applies*

*This
turned
out to be
wrong*

How to cabin for CFA
Split public in 2
Disenrollment ^{Privates more indig}
Cap commercial ^{Ken Pac argument}
Special pymts to publics
(requiring
indigent role)
Problems w/ plan: cost too low
Understand structure of
partnerships

MEDICAID COVERED SERVICES*

Type of Service	Enacted Budget SFY 1995	Enacted Budget SFY 1996
(Mandatory)		
INPATIENT HOSPITAL	\$333,064,524	\$363,404,346
PHYSICIAN SERVICES	244,718,478	\$267,010,618
NURSING FACILITIES	382,090,584	\$416,896,362
OUTPATIENT HOSPITAL	180,561,360	\$197,009,236
HOME HEALTH	52,050,708	\$56,792,163
DURABLE MEDICAL	22,616,400	\$24,676,596
FAMILY PLANNING	12,837,201	\$14,006,580
SCREENING	1,255,548	\$1,369,920
LAB	7,935,357	\$8,658,212
DENTAL (Under 21)	34,537,692	\$37,683,834
TRANSPORTATION:		
Non-Emergency	20,836,560	\$22,734,625
Emergency	11,722,815	\$12,790,681
VISION CARE (Under 21)	7,266,387	\$7,928,304
HEARING CARE (Under 21)	153,216	\$167,173
PRIMARY CARE/RURAL HEALTH	33,699,135	\$36,768,890
MEDICARE/INSURANCE PREMIUMS	58,766,427	\$64,119,637
QMB/MEDICARE SERVICES	402,714	\$439,398
EPSDT RELATED SERVICES	3,563,976	\$3,888,629
NURSE MIDWIFE/PRACTITIONER	453,747	\$495,080
Subtotal	1,408,532,829	1,536,840,285
(Optional)		
ICF/MR	64,521,483	\$70,398,938
PHARMACY	219,954,951	\$239,991,307
COMMUNITY MENTAL HEALTH	54,105,117	\$59,033,714
MENTAL HOSPITALS	37,180,440	\$40,567,318
RENAL DIALYSIS SERVICES	4,672,725	\$5,098,378
PODIATRY	719,076	\$784,579
AIS/MR WAIVER SERVICES	27,356,265	\$29,848,229
AMBULATORY SURGICAL CTRS	6,926,568	\$7,557,530
HCB WAIVER SERVICES	19,285,404	\$21,042,169
ADULT DAY CARE	805,599	\$878,983
NURSE ANESTHETIST	1,315,467	\$1,435,297
KENPAC	10,291,482	\$11,228,964
HOSPICE	12,646,773	\$13,798,805
PREVENTIVE	20,265,205	\$22,111,223
HANDICAPPED CHILDREN	2,659,183	\$2,901,416
EMOTION. DISTURBED CHILD.	3,347,424	\$3,652,351
CASE MANAGE. MENTALLY ILL	4,312,659	\$4,705,512
Subtotal	490,385,821	535,034,715
TOTAL/AVERAGE	1,898,898,650	2,071,875,000
DISPROPORTIONATE SHARE	74,401,350	85,125,000
DRUG REBATE	(42,000,000)	(44,000,000)
FUNDED EXPANSION	4,356,700	11,094,100
GRAND TOTAL	1,935,656,700	2,124,094,100

*TOTAL MATCHES ENACTED BUDGET - DOES NOT MATCH CURRENT PROJECTED EXPENDITURES

Combining public + private \$, will allow rural areas - Urban - rural

Learn more re: Increase does

other states aren't as great

In partnerships, trigger for comp bidding? Carrots & threats - Recps on committees Reserve for stop-loss

in the some bene protections

Raised compet. Bidding

MA transp.

3, 5, 6 only at

Peer review (instead of legal services - imbedded in the process)

Accountability

Strike in junky plan

who decides pymt rates

Also re act. to sound pymt rates - notes show comp bid 12/20/97

BV - Alabama - go back for 2-3 days x find other

FAX TRANSMITTAL



COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
275 EAST MAIN STREET
FRANKFORT 40621-0001
502-564-7130
FAX 502-564-7573

MASTEN CHILDERS II
SECRETARY

*What did org w say
re this?*

TO: Diana Fortuna 202-456-7431

FROM: Master Childers II, Secretary

DATE: Sept. 12, 1995

RE: Waiver Summary

PAGES: 25

(Including cover sheet)

Please deliver to addressee as soon as possible.
If there is any problem in the transmittal, please call 502-564-7130.

*Please give me a call to let me know if
you receive all pages.*

Thanks

Pat

502-564-7130

**Commonwealth of Kentucky
Medicaid Access and Cost Containment Demonstration Project
1115 Waiver Amendment Proposal**

History

In December, 1993, the Commonwealth was granted approval to implement a Section 1115 Medicaid Demonstration Project that expanded Medicaid eligibility to all Kentuckians at or below the poverty level. The cost of the additional eligibles was to be underwritten through a variety of program modifications and cost management strategies focused around a Medicaid managed care system. All non-institutionalized recipients were to be enrolled in a strengthened Kentucky Patient Access and Care Program (KENPAC), a fee-for-service plan, while capitated risk-based systems were developed throughout the state.

Before the Demonstration Project could be implemented, however, the Kentucky General Assembly took action in June, 1994, to prohibit the expansion of the program beyond those groups covered by Kentucky Medicaid on January 1, 1994 (see Attachment A). This action led to the Waiver's suspension. The legislature did encourage the Administration to pursue the managed care components of the 1115 Waiver and established an Indigent Care Trust Fund so that savings realized through the managed care initiative could be banked for future Medicaid expansions.

Kentucky Medicaid Health Care Partnership Demonstration Project - Overview

Since June, the Jones Administration has been reviewing its options for carrying out the objectives of the original 1115 Waiver. It has concluded that it would be in the best interests of the Medicaid program to focus on the implementation of the cost containment features of the plan while reserving the eligibility expansion option for some future date. The Commonwealth has determined that Section 1115 Waiver authority provides the most flexibility to develop the unique managed care system that has been envisioned. Waiver authority under subsection 1915(b) does not permit the Commonwealth to implement the desired managed care system. Therefore, the Commonwealth proposes that the Health Care Financing Administration (HCFA) grant Kentucky

the authority to implement only the cost containment features of the Demonstration Project. Under this plan the Commonwealth would develop a state-wide system of capitated, comprehensive-risk managed care partnerships. Providers will be granted the authority to design a service delivery network that reflects their region's health care infrastructure and is geared to the unique needs of the region's Medicaid population. The Commonwealth believes that with this local focus, the Health Care Partnership concept will offer the savings equivalent to those achieved by the other aggressive approaches to managed care while retaining stability and continuity of care for the recipient population.

Eight regional partnerships (see Attachment B) would be established consolidating the services of all Medicaid-participating providers into a single managed care entity. It is envisioned that the medical schools at the University of Kentucky and the University of Louisville would play an active role in both the design and administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the health care partnerships particularly in those rural areas, by providing staff, technical support, and tertiary care. The local health departments and federally qualified health centers will also be invited to play a key role in each health care partnership by providing primary and preventive care to the Medicaid population when appropriate. Mental health services will be delivered to the Medicaid population through the 14 regional mental health centers via a separate Medicaid carveout. (The Commonwealth will seek a separate waiver to implement this component of the plan).

Any administrative support services that the providers might require on a regional level will be available through the state, so that each partnership can take advantage of statewide economies of scale while crafting services they provide to meet the health care needs peculiar to each region's Medicaid population. An incentive pool will be established to provide performance rewards for those partnerships that meet goals established by the State's Chief Health Officer for such long-term health investments as immunizations, cervical cancer screenings, mammograms, and low birthweight babies. As authorized by House Bill 250 (see Attachment C), an Indigent Care Trust Fund will be established so that any savings realized through the managed care initiative could be reserved for future Medicaid expansions.

Kentucky Medicaid Health Care Partnership Demonstration Project - Detailed Proposal

The Commonwealth requests authority to initiate its approved 1115 waiver beginning July 1, 1995, with the following modifications:

1. Suspend until further notice all eligibility expansion aspects of the waiver.
2. Expand and strengthen the KenPAC system as previously described in the approved waiver document. However, this system would be replaced by or integrated into the comprehensive-risk managed care system as it becomes operational on a regional basis.
3. Develop a unique, comprehensive-risk managed care system for essentially the entire Medicaid population which employs regionalized managed care partnership organizations. At the time the waiver was suspended, the Commonwealth was in the process of modifying the waiver to accommodate such a system. This system would have the following features:
 - a. A single partnership would operate in each of the eight designated regions and would consolidate the efforts of all participating Medicaid providers in the region. Attachment B is a map of the proposed managed care regions. Attachment D provides an estimate of the number of Medicaid eligibles in each of the proposed regions.
 - b. The system would be implemented incrementally beginning in Regions 3, 5, and 6.
 - c. Participation by Medicaid beneficiaries residing in a region where the system is operational would be mandatory.
 - d. The Commonwealth would seek the authority to guarantee the eligibility of Medicaid beneficiaries enrolled with the managed care partnerships for an initial period of six months.

- e. The state medical teaching universities would administer partnerships in their respective regions. These Health Science Centers will also anchor many of the Health Care Partnerships, particularly in rural areas by providing staff, technical support, and tertiary care.
- f. Preventive services would be emphasized and such preventive health agencies as local health departments and federally qualified health centers (FQHCs) would be involved with the plan.
- g. Mental health and long-term care services would not initially be included in the system. The Commonwealth will seek a separate waiver to implement a statewide risk-based mental health managed care system.
- h. Performance rewards would be granted for partnerships that meet goals established by the State's Chief Health Officer. These rewards provide an incentive for partnerships to invest profits in services that may not result in savings during the life of the contract, but should result in federal and state savings both within the Medicaid program and in other federally subsidized programs. Outcome based parameters would be established for such factors as number of immunizations, number of cervical cancer screenings for older women, number of low birthweight babies, etc. The reward amount would be predetermined annually and be funded from prior year savings.
- i. Capitation rates would fall within actuarial rate ranges established by an actuarial consultant retained by the Commonwealth.

Kentucky Medicaid Health Care Partnership - Estimated Savings

The Commonwealth estimates that \$1.3 billion of the projected \$2.1 billion fiscal year 1996 Medicaid Benefits budget will be included in the 1115 Waiver. Services that will be included and associated expenditures are itemized on Attachment E. Although savings in each region may vary, the Commonwealth projects that it will achieve annual statewide savings in the 4 percent to 7 percent range when the program is implemented statewide.

- e. The state medical teaching universities would administer partnerships in their respective regions. These Health Science Centers will also anchor many of the Health Care Partnerships, particularly in rural areas by providing staff, technical support, and tertiary care.
- f. Preventive services would be emphasized and such preventive health agencies as local health departments and federally qualified health centers (FQHCs) would be involved with the plan.
- g. Mental health and long-term care services would not initially be included in the system. The Commonwealth will seek a separate waiver to implement a statewide risk-based mental health managed care system.
- h. Performance rewards would be granted for partnerships that meet goals established by the State's Chief Health Officer. These rewards provide an incentive for partnerships to invest profits in services that may not result in savings during the life of the contract, but should result in federal and state savings both within the Medicaid program and in other federally subsidized programs. Outcome based parameters would be established for such factors as number of immunizations, number of cervical cancer screenings for older women, number of low birthweight babies, etc. The reward amount would be predetermined annually and be funded from prior year savings.
- i. Capitation rates would fall within actuarial rate ranges established by an actuarial consultant retained by the Commonwealth.

Kentucky Medicaid Health Care Partnership - Estimated Savings

The Commonwealth estimates that \$1.3 billion of the projected \$2.1 billion fiscal year 1996 Medicaid Benefits budget will be included in the 1115 Waiver. Services that will be included and associated expenditures are itemized on Attachment E. Although savings in each region may vary, the Commonwealth projects that it will achieve annual statewide savings in the 4 percent to 7 percent range when the program is implemented statewide.

Attachment A

House Bill 2



GENERAL ASSEMBLY

COMMONWEALTH OF KENTUCKY

SPECIAL SESSION 1994

HOUSE BILL NO. 2

(AS ENACTED, PARTIALLY VETOED, AND REENACTED)

WEDNESDAY, JUNE 22, 1994.

94 SS HB 2VC

1 disproportionate share hospital payments in each fiscal year of the biennium shall be used
2 solely to make payments for indigent care services provided in that fiscal year. The funds
3 appropriated in each fiscal year shall not lapse and shall be carried forward into a new
4 fiscal year, but not counted against the new fiscal year appropriation, to pay for indigent
5 care services provided in the prior fiscal year but reported in the subsequent fiscal year.

6 d. Scope of Medicaid Services: Notwithstanding any provision of KRS 205.560 or
7 KRS Chapter 205 to the contrary, the Cabinet for Human Resources shall not expand the
8 scope of services or categories of eligible Medicaid recipients beyond those receiving
9 services on January 1, 1994, unless the expansion of the scope of services or eligible
10 recipients is mandated by the federal government; or the expansion of the scope of
11 services or eligible recipients is specifically authorized by the General Assembly. The
12 provisions of this paragraph shall not prevent the Cabinet for Human Resources from
13 petitioning the federal government for waivers to expand or alter the state Medicaid
14 program.

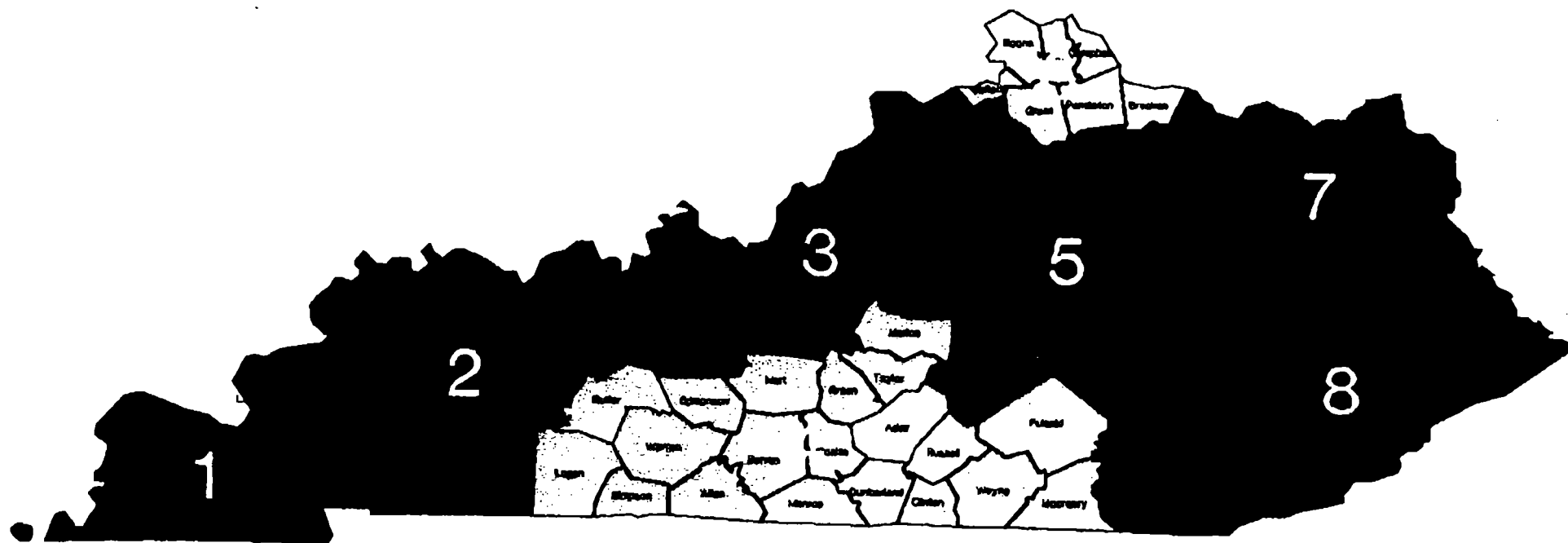
15 The Cabinet for Human Resources shall notify the Legislative Research Commission
16 in writing prior to petitioning the federal government for any waiver or petitioning for the
17 amendment of any waiver that will expand or alter the state Medicaid program. The
18 notification shall describe the expansion or amendment sought and the estimated fiscal
19 impact of the waiver if granted. Any waiver granted that has the effect of expanding the
20 scope of services or eligible recipients shall not be implemented until specifically
21 authorized by the General Assembly. These restrictions shall apply to any waivers that
22 have been granted but not implemented as of June 30, 1994, as well as any new waivers or
23 amendments to existing waivers obtained on or after June 30, 1994.

24 e. Medicaid Fraud Control Units: Notwithstanding the provisions of Section 9 of
25 House Bill 127 (1994 Kentucky Acts Chapter 316), the reasonable costs incurred by the
26 state Medicaid Fraud Control Unit in the enforcement of any criminal violation of KRS
27 Chapter 205 shall be directly recoverable by the state Medicaid Fraud Control Unit.

Attachment B

Map

Medicaid Health Care Partnerships Proposed Managed Care Regions



Attachment C

House Bill 250

94 RS HB 250/EN



GENERAL ASSEMBLY COMMONWEALTH OF KENTUCKY

REGULAR SESSION 1994

HOUSE BILL NO. 250

(AS ENACTED)

FRIDAY, APRIL 15, 1994

94 RS HB 250/EN

1 Section 91. KRS 216.885 is amended to read as follows:

- 2 (1) It is unlawful to operate or maintain a PPEC center without first obtaining a
3 certificate of need from the Kentucky Health Policy Board ~~{Commission for Health~~
4 ~~Economics Control in Kentucky}~~ and a license for the PPEC center from the cabinet.
5 The cabinet is responsible for licensing PPEC centers in accordance with the
6 provisions of KRS Chapter 216B.
- 7 (2) Separate licenses are required for PPEC centers maintained on separate premises,
8 even though they are operated under the same management. Separate licenses are
9 not required for separate buildings on the same grounds.
- 10 (3) The Cabinet for Human Resources may deny, revoke, modify or suspend a license in
11 accordance with KRS 216B.105.

12 PART 13

13 MISCELLANEOUS PROVISIONS

14 SECTION 92. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
15 READ AS FOLLOWS:

- 16 (1) The secretary of the Finance and Administration Cabinet, after consultation with
17 the secretary for the Cabinet for Human Resources, shall on a quarterly basis,
18 certify to the Interim Committee on Appropriations and Revenue the general
19 fund savings realized from the procedures required by Sections 72 to 83 of this
20 Act and any other procedures adopted by the Cabinet for Human Resources or
21 the Kentucky Health Policy Board to control the cost of health care.
- 22 (2) The certification shall indicate the following:
- 23 (a) The means by which savings were achieved, including a description of the
24 discrete procedure used to achieve the savings; and
- 25 (b) The amount saved as a result of the specific procedure, including an
26 explanation as to the calculations and assumptions used in determining the
27 amount.

42 RS HB 250/EN

- 1 (3) The amount certified by the secretary under this section shall be transferred to a
2 trust account to be utilized by the secretary of the Cabinet for Human Resources
3 to provide health care coverage for additional categories of citizens, but the funds
4 in the trust account shall not be spent until appropriated by the General
5 Assembly. The funds in the trust account shall not lapse. The secretary shall give
6 priority in utilizing any appropriated trust account funds to matching available
7 federal funds in the Medicaid program.
- 8 (4) Savings in the general fund appropriation for the Medicaid program shall be
9 determined as follows:
- 10 (a) To the extent that the average cost per month per eligible actually
11 experienced by the Medicaid program is less than the average cost per
12 month per eligible reflected in the enacted budget, the savings attributable
13 to that difference shall be deemed to be eligible for certification under this
14 section.
- 15 (b) To the extent that the number of eligibles actually participating in the
16 Medicaid program is less than the number reflected in the enacted budget,
17 the savings attributable to that difference shall be deemed not eligible for
18 certification under this section.
- 19 (5) Savings in the general fund appropriation to the Department of Mental Health
20 shall be determined by certifying the amount of Medicaid payments received by
21 the department and the entities it funds that would not have been received under
22 the eligibility requirements for the Medicaid program in effect for the 1993-1994
23 fiscal year.
- 24 (6) Savings in the general fund appropriation to the Department of Health Services
25 shall be determined by certifying the amount of Medicaid payments received by
26 the department and the entities it funds that would not have been received under
27 the eligibility requirements for the Medicaid program in effect for the 1993-1994

94 RS HB 250/EN

1 fiscal year.

2 (7) Savings in the general fund appropriation to the Department of Social Services
3 shall be determined by certifying the amount of Medicaid payments received by
4 the department and the entities it funds that would not have been received under
5 the eligibility requirements for the Medicaid program in effect for the 1993-1994
6 fiscal year.

7 (8) Only those savings that can be certified as being recurring shall be transferred to
8 the trust fund.

9 PART 14

10 STATE EMPLOYEE HEALTH CARE PLAN BUY-IN

11 SECTION 93. A NEW SECTION OF KRS 18A.225 TO 18A.229 IS CREATED
12 TO READ AS FOLLOWS:

13 (1) Any citizen of the United States, who has been a Kentucky resident for at least
14 one (1) year prior to purchasing coverage under this section, shall be permitted to
15 purchase health insurance coverage provided to state employees pursuant to KRS
16 18A.225 and 18A.2281, under the same terms and conditions as state employees
17 until the Kentucky Health Purchasing Alliance created pursuant to Section 47 of
18 this Act becomes operational. The premium charged for coverage for high risk
19 individuals as defined by the Kentucky Health Policy Board shall not exceed two
20 hundred percent (200%) of the premium paid by the Commonwealth for state
21 employees. Policies issued under this section shall be valid for a period of one (1)
22 year, and at the time of the policy's expiration the insured shall be eligible for
23 participation in the Kentucky Health Purchasing Alliance created pursuant to
24 Section 47 of this Act.

25 (2) The secretary of the Finance and Administration Cabinet and the secretary of the
26 Cabinet for Human Resources shall provide for a system to enroll any citizen
27 who elects to purchase health insurance coverage under subsection (1) of this

Attachment D

Beneficiaries by Region

**MEDICAID BENEFICIARIES
FISCAL YEAR 1994**

REGION 1	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
BALLARD	290	514	804
CALLOWAY	702	1,621	2,323
CARLISLE	193	299	492
CRITTENDEN	355	728	1,083
FULTON	635	1,119	1,754
GRAVES	1,367	2,391	3,758
HICKMAN	229	399	628
LIVINGSTON	300	641	941
LYON	191	326	517
MARSHALL	632	1,543	2,175
MCCRACKEN	2,021	4,581	6,602
TOTAL	6,915	14,162	21,077

REGION 2	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
CALDWELL	519	1,073	1,592
CHRISTIAN	2,004	5,073	7,077
DAVISS	2,284	6,956	9,240
HANCOCK	209	513	722
HENDERSON	1,160	3,179	4,339
HOPKINS	1,591	4,296	5,887
MCLEAN	297	732	1,029
MUHLENBURG	1,204	3,039	4,243
OHIO	902	2,458	3,360
TODD	538	908	1,446
TRIGG	425	681	1,106
UNION	303	1,133	1,436
WEBSTER	421	1,097	1,518
TOTAL	11,857	31,138	42,995

REGION 3	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
BRECKINGRIDGE	772	1,780	2,532
BULLITT	768	3,121	3,889
CARROLL	471	1,048	1,519
GRAYSON	1,157	2,196	3,353
HARDIN	2,051	6,104	8,155
HENRY	495	1,310	1,805
JEFFERSON	16,865	51,401	68,266
LARUE	482	1,118	1,600
MEADE	374	1,635	2,009
NELSON	1,039	2,538	3,577
OLDHAM	313	1,091	1,404
SHELBY	756	1,402	2,158
SPENCER	231	606	837
TRIMBLE	176	567	742
WASHINGTON	499	599	1,098
TOTAL	26,448	76,496	102,944

REGION 4	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
ADAIR	1,103	1,341	2,444
ALLEN	863	957	1,820
BARREN	1,651	2,273	3,924
BUTLER	595	1,129	1,724
CLINTON	1,009	1,383	2,392
CUMBERLAND	748	897	1,645
EDMONSON	509	1,126	1,635
GREEN	646	708	1,354
HART	976	1,758	2,734
LOGAN	1,167	1,776	2,943
MARION	999	1,489	2,488
MCCREARY	1,799	3,929	5,728
METCALFE	683	834	1,517
MONROE	1,080	1,089	2,169
PULASKI	3,179	4,765	7,944
RUSSELL	1,193	1,565	2,758
SIMPSON	486	961	1,447
TAYLOR	1,190	1,840	3,030
WARREN	2,809	6,026	8,635
WAYNE	1,925	2,834	4,759
TOTAL	24,410	38,680	63,090

REGION 5	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
ANDERSON	296	602	898
BOURBON	617	1,306	1,923
BOYLE	969	1,601	2,570
CASEY	1,279	1,536	2,815
CLARK	992	2,615	3,607
ESTILL	1,125	2,105	3,230
FAYETTE	4,815	13,058	17,873
FRANKLIN	1,199	2,652	3,851
GARRARD	491	917	1,408
HARRISON	609	1,161	1,770
JACKSON	1,327	2,211	3,538
JESSAMINE	725	2,225	2,950
LINCOLN	1,412	2,175	3,587
MADISON	2,214	4,658	6,872
MERCER	592	1,199	1,791
MONTGOMERY	1,100	2,254	3,354
NICHOLAS	383	694	1,077
OWEN	370	969	1,339
POWELL	848	1,714	2,562
ROBERTSON	130	215	345
ROCKCASTLE	1,120	1,947	3,067
SCOTT	726	1,967	2,693
WOODFORD	351	908	1,259
TOTAL	23,690	50,689	74,379

REGION 6	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
BOONE	727	2,516	3,243
BRACKEN	323	745	1,068
CAMPBELL	1,650	5,626	7,276
GALLATIN	208	541	749
GRANT	561	1,351	1,912
KENTON	2,768	9,154	11,922
PENDLETON	348	1,180	1,528
TOTAL	6,585	21,113	27,698

REGION 7	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
BATH	782	1,493	2,275
BOYD	1,878	4,326	6,204
CARTER	1,623	3,427	5,050
ELLIOTT	531	1,189	1,720
FLEMING	700	1,150	1,850
GREENUP	1,249	3,010	4,259
LAWRENCE	1,120	2,597	3,717
LEWIS	913	1,530	2,443
MASON	637	1,509	2,146
MENIFEE	419	756	1,175
MORGAN	974	1,996	2,970
ROWAN	947	1,927	2,874
TOTAL	11,773	24,910	36,683

REGION 8	AGED, BLIND, & DISABLED	AFDC & AFDC RELATED	TOTAL
BELL	3,039	5,013	8,052
BREATHITT	2,262	3,377	5,639
CLAY	3,129	5,069	8,198
FLOYD	2,821	7,438	10,259
HARLAN	2,603	6,367	8,970
JOHNSON	1,693	3,606	5,199
KNOTT	1,699	3,889	5,488
KNOX	2,810	6,357	9,167
LAUREL	2,469	5,975	8,444
LEE	779	1,575	2,354
LESLIE	1,278	2,406	3,684
LETCHER	1,916	4,709	6,625
MAGOFFIN	1,389	2,955	4,344
MARTIN	1,109	3,009	4,118
OWSLEY	869	1,342	2,211
PERRY	2,418	5,944	8,362
PIKE	3,669	8,793	12,462
WHITLEY	2,532	5,586	8,118
WOLFE	1,055	1,493	2,548
TOTAL	39,339	84,903	124,242

Attachment E

Medicaid Covered Services

MEDICAID COVERED SERVICES*

Type of Service	Enacted Budget SFY 1995	Enacted Budget SFY 1996
(Mandatory)		
INPATIENT HOSPITAL - Psy. Wings 95%	\$316,411,298	\$366,791,613
PHYSICIAN SERVICES - Psychiatric 95%	232,482,554	269,499,387
OUTPATIENT HOSPITAL	180,561,360	198,845,532
HOME HEALTH - 95%	49,448,173	57,321,515
DURABLE MEDICAL	22,616,400	24,906,603
FAMILY PLANNING	12,837,201	14,137,133
SCREENING	1,255,548	1,382,688
LAB	7,935,357	8,738,914
DENTAL (Under 21)	34,537,692	38,035,080
TRANSPORTATION:		
Non-Emergency	20,836,560	22,942,972
Emergency	11,722,815	12,909,902
VISION CARE (Under 21)	7,266,387	8,002,203
HEARING CARE (Under 21)	153,216	168,731
PRIMARY CARE/RURAL HEALTH	33,699,135	37,111,608
QMB/MEDICARE SERVICES	402,714	443,495
EPSDT RELATED SERVICES - 95%	3,385,777	3,924,875
NURSE MIDWIFE/PRACTITIONER	453,747	499,695
Subtotal	936,005,934	1,065,661,946
(Optional)		
PHARMACY	219,954,951	242,228,233
RENAL DIALYSIS SERVICES	4,672,725	5,145,899
PODIATRY	719,076	791,892
AMBULATORY SURGICAL CTRS	6,926,568	7,627,973
NURSE ANESTHETIST	1,315,467	1,448,675
HOSPICE	12,646,773	13,927,422
PREVENTIVE	20,265,205	5,222,880
HANDICAPPED CHILDREN	2,659,183	2,911,554
Subtotal	269,159,948	279,304,528
TOTAL	1,205,165,882	1,344,966,474
DRUG REBATE	(42,000,000)	(44,000,000)
GRAND TOTAL	1,163,165,882	1,300,966,474

*NOTE: This table displays an estimation of services to be provided under a managed acute care program. Mental Health, Mental Retardation and Long Term Care services have been excluded to a major extent from this display. This estimation represents a trended continuation of actual expenditures from FY 1994.

**Medicaid Health Care Partnerships
Proposed Managed Care Regions**

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Ballard Calloway Carlisle Crittenden Fulton Graves Hickman Livingston Lyon Marshall McCracken	Caldwell Christian Daviess Hancock Henderson Hopkins McLean Muhlenberg Ohio Todd Trigg Union Webster	Breckinridge Bullitt Carroll Grayson Hardin Henry Jefferson Larue Meade Nelson Oldham Shelby Spencer Trimble	Adair Allen Barren Butler Clinton Cumberland Edmonson Green Hart Logan Marion McCreary Metcalfe Monroe Pulaksi Russell Simpson Taylor Warren Wayne	Anderson Bourbon Boyle Casey Clark Estill Fayette Franklin Garrard Harrison Jackson Jessamine Lincoln Madison Mercer Montgomery Nicholas Owen Powell Robertson Rockcastle Scott Washington Woodford	Boone Bracken Campbell Gallatin Grant Kenton Pendleton	Bath Boyd Carter Elliott Fleming Greenup Lawrence Lewis Mason Menifee Morgan Rowan	Bell Breathitt Clay Floyd Harlan Johnson Knott Knox Laurel Lee Leslie Letcher Magoffin Martin Owsley Perry Pike Whitley Wolfe

09-Mar-95

ELIGIBLES BY MANAGED CARE REGION

	ABD	AFDC	TOTAL
Region 1	6,915	14,162	21,077
Region 2	11,857	31,138	42,995
Region 3	26,448	75,743	102,191
Region 4	24,410	38,680	63,090
Region 5*	23,690	50,524	74,214
Region 6	6,585	21,113	27,698
Region 7	11,773	24,910	36,683
Region 8	39,339	84,903	124,242

*Does not match RFI due to addition of Rockcastle county.

Ky? a bit of movement on line protection
bottom line → tell them

tell H/H sooner > later

CR → Kern; quick movement.

Friday POPS will ask re Ky +

Chart; other D's W's under review

also R's: Denis heat

AFSCME NY

1 page: list / chart / sideways
Got in heat

state
key issues
timeline - 120 days

(Dick Batcheller)

Add (John)

→ 1955 - NY, Cal.

→ LA County

**MODIFICATION TO
FHHS Payor Agreements
Risk**

1. A new Section 8.16, Insolvency, will be added as follows:

8.16 INSOLVENCY Upon FHHS's insolvency herein defined, Payor will automatically assume all provider Agreements and obligations to said providers. Such assumption of Agreements and obligations will not be deemed to release FHHS from financial damages to Payor as may be provided under law. FHHS will be obligated to provide evidence to Payor, with sufficiency of evidence to be mutually agreed upon, that prepayment or capitation is being distributed in a timely way to providers under contract to FHHS. Failure to provide such evidence within five (5) business days of Payor's request will be prima facie evidence that FHHS is insolvent. Payor, upon request of two or more providers may request evidence of solvency from FHHS, provided that the request of the providers stems from alleged non payment of capitation or other pre-paid contractual obligations. Notwithstanding any of the above failure of FHHS to pay capitation to providers, or to pay any other prepaid arrangement within 30 days of the due date of such payment, based on membership information received from Payor, will be defined as insolvency regardless of any notices for provider to Payor, or complaints lodged with the Payor by the provider with the date of insolvency being the date payment was due.

*Fla Dept of Ins.
Advanced to NAHC*



THE SECRETARY FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY

FRANKFORT 40621-0001

(502) 564-7130

(502) 564-7573 FAX

BRERETON C. JONES
GOVERNOR

September 14, 1995
VIA TELECOPIER

MASTEN CHILDERS II
SECRETARY

Honorable Diana Fortuna
Domestic Policy Council
Old Executive Office Building, Rm. 224
Washington, D.C. 20515-1706

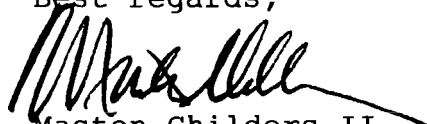
Dear Ms. Fortuna:

Please accept my sincere appreciation for the time you gave us yesterday to discuss the many advantages of the Commonwealth of Kentucky's request to establish health care partnerships among members of the public and private Medicaid provider communities. Notwithstanding anticipated cuts of future federal funding to the Medicaid Program, we believe that the President's support of Governor Jones's plan will, in addition to the potential savings of millions of dollars to be credited to Kentucky's Medicaid Trust Fund for future expansion of the eligibility base, allow us to: (i) maintain current mandatory and optional benefits; (ii) enable public health departments to serve all of Kentucky's 120 counties; and (iii) enable Kentucky's 59 acute care hospitals with 100 beds or less to remain viable institutions, since the closure of any such institution would seriously jeopardize access in those communities where closure occurred.

Also, consistent with our discussion yesterday, enclosed please find documents we hope are responsive to some of your questions relating to accessibility and accountability. As promised, Diane Hancock will be calling you today to discuss them in more detail.

In closing, this morning I informed Governor Jones of the progress I thought we made yesterday and he requested that I communicate his sincere thanks for your help.

Best regards;


Masten Childers II
Secretary

cc: Governor Brereton C. Jones

Under this plan the Commonwealth would develop a state-wide system of health care partnerships. A health care partnership is a coalition of medical providers in both the public and private sectors that provides a comprehensive medical service package through an integrated service delivery network to Medicaid beneficiaries residing in a designated state managed care region. Managed care partnerships participate in the Medicaid Program as comprehensive risk-based entities that are paid on an actuarially sound capitated basis. Providers will be granted the option to design a service delivery network that reflects their region's health care infrastructure and is geared to the unique needs of the region's Medicaid population. The Commonwealth believes that with this local focus, the Health Care Partnership concept will produce savings equivalent to those achieved through other aggressive approaches to managed care while retaining stability and continuity of care for the recipient population.

Eight regional partnerships (see Exhibit 3) will be established consolidating the services of Medicaid-participating providers into a single managed care entity. It is envisioned that the medical schools at the University of Kentucky and the University of Louisville would play an active role in both the design and administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the health care partnerships in rural areas, by providing staff, technical support, and tertiary care. The local health departments, Federally Qualified Health Centers (FQHC), and the Commission for Children with Special Health Care Needs, (a Title V agency), will also be invited to play a key role in each health care partnership by providing primary, secondary, and preventive care to the Medicaid population when appropriate. Mental health services may be delivered to the Medicaid population through the 14 regional mental health centers via a separate Medicaid behavioral health carveout. [If the behavioral health carveout is not implemented, these services will also be included in the partnership service package. The Commonwealth may seek a separate waiver to implement this component of the plan.] Long-term care services will ultimately be consolidated under a separate managed care waiver. In the event that the Commonwealth cannot enter into a satisfactory partnership arrangement with providers in any region, the Commonwealth will invite competitive bids from Health Maintenance Organizations (HMO's) to serve that region.

Any administrative support services that the providers might require on a regional level may be available through the state, so that each partnership can take advantage of statewide economies of scale while crafting services they provide to meet the health care needs peculiar to each region's Medicaid population. An incentive pool will be established to provide performance rewards for those partnerships that meet goals established by the State's Chief Health Officer for such long-range health investments as immunizations, cervical cancer screenings, mammograms, and low birthweight babies. As authorized by Kentucky House Bill 250, Section 92, (see Exhibit 2), an Indigent Care Trust Fund will be established so that any savings realized through the managed care initiative will be reserved for future Medicaid expansions.

C. Comparison of Approved 1115 Waiver to the Requested Amendment

Exhibit 4 provides a point-by-point comparison of the major provisions of the approved 1115 Demonstration waiver to those of the requested amendment.

:ms\0516

II. HEALTH CARE PARTNERSHIP PROGRAM DESIGN

A. Designated Managed Care Regions

The Commonwealth has designated eight (8) managed care regions through which the statewide managed care program will be implemented. The program will be initiated in regions 3, 6, and 5. However, ultimately a health care partnership will serve the Medicaid beneficiaries of each of these 8 regions. Exhibit 3 is a map of Kentucky that identifies the counties that are included in each managed care region. These regions were designed to both incorporate recognized service delivery areas and to comprise a sufficient beneficiary base to be actuarially sound. Wherever possible, the regions incorporated medically underserved areas together with those that have a high provider density. This is expected to promote a reallocation of resources to the medically underserved areas. The Commonwealth reserves the right to make those minor changes to the identified managed care boundaries which are necessary to ensure cost effectiveness.

In the event the Commonwealth cannot enter into a financially sound agreement that will provide greater access and high quality health care to Medicaid beneficiaries, the Commonwealth will invite competitive bids from HMOs to serve the region. Satisfactory financial agreements will be determined by the Commonwealth's actuaries for the partnerships on the same basis as they would use for a competitive bid process. If the HCP does not meet these financial standards then a competitive bid process will be used.

The Commonwealth may, if a competitive bid process is used, offer two or more HMOs per managed care region. This decision will be made by taking into account financial considerations as well as access to care and network viability in each managed care region. The Commonwealth also will be concerned with maintaining access to health care should one or more HMOs not meet the standard of care and financial solvency required prospectively. The Commonwealth will be guided by network capacity and financial standards of the HMOs in each region in determining how many HMOs should be awarded a contract.

B. Participating Provider Provisions

1. Partnership Concept

The proposed waiver amendment will enable providers in a given managed care region to coalesce into a system of health care partnerships. A health care partnership is a coalition of medical providers in both the public and private sectors that provides a comprehensive medical service package through an integrated service delivery network to Medicaid beneficiaries residing in a designated state managed care region. Health care partnerships participate in the Medicaid Program as comprehensive risk-based entities that are paid on an actuarially sound capitated basis. Exhibit 5 illustrates the relationship between the various components of the Health Care Partnership System. Providers will be granted the authority to design an integrated service delivery network that reflects their region's health care infrastructure and is geared to the unique needs of the region's Medicaid population.

Each partnership will be required to establish and maintain provider networks in geographically accessible locations. Such networks will be composed of hospitals, physicians, pharmacies, emergency transportation, etc., in sufficient numbers to make covered services reasonably available. The Commonwealth anticipates that partnerships will expand the number and array of on-site specialty services available to Medicaid beneficiaries on the local level by bringing physicians to the region physically or through telemedicine technology.

Because the Commonwealth's goal is to provide the covered population with the greatest choice possible, each Health Care Partnership panel will include any provider in the service area that is willing to accept the conditions stipulated in the provider contract. In addition to the private providers included in the network, linkages will be established with local health departments, Federally Qualified Health Centers (FQHC), and the Commission for Children with Special Health Care Needs (Title V agency) to provide primary, secondary, and preventive care to the Medicaid population as appropriate. The Medical Schools at the University of Kentucky and the University of Louisville will play an active role in both the design and/or the administration of these managed care entities, particularly in the Central Kentucky and Louisville metropolitan areas. These Health Science Centers will also anchor many of the partnerships, particularly those in rural areas by providing staff technical support and tertiary care.

2. Health Care Partnership Formation and Administration

Each partnership should have sufficient administrative staff and organizational components to operate an extensive service delivery network. Although a preliminary draft of a partnership contract has been provided (see Exhibit 6), each region will develop a contract geared both to the needs of the Medicaid population and the available health care infrastructure in the region. HCFA will review and approve each region's contract prior to its execution. The requirements under the contract will include each of the functions noted under items a and b below. The functions should be staffed by qualified persons in numbers appropriate to the partnership's enrollment or projected enrollment.

Each partnership may combine functions or split the responsibility for a function across multiple departments. Similarly, the Commonwealth or the partnership may contract with a third party (subcontractor) to assist in the formation of the partnerships and to perform one or more of these administrative functions.

a. Executive Management

Each partnership will have an executive management function with authority over all of the administrative functions.

b. Other Administrative Components

Each partnership will have each of the administrative functions listed below, conforming to program standards which will be described in the contract executed by the Commonwealth. The required functions are:

- Medical Director's Function
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, utilization management, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function

4. Physician Specialists

Due to the large number of physician specialties that exist, partnerships may not be required to maintain specific member-to-specialist provider ratios. However, it must provide adequate access to physician specialists for PCP referrals, and to employ or contract with specialists in sufficient numbers to ensure specialty services could be made available in a timely manner and locally accessible when feasible.

5. Mainstreaming

The Commonwealth considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be an important program objective. Therefore, the partnerships must ensure that network providers do not intentionally segregate program members in any way from other persons receiving services.

6. Network Changes

Health care partnerships will be required to notify the Commonwealth promptly of any changes to the composition of its provider network that materially affected the plan's ability to make available all capitated services in a timely manner. Partnerships will also be required to have procedures to address changes in its network that negatively affect the ability of members to access services. Material changes in network composition that negatively affect member access to services could be grounds for contract termination.

7. Service Accessibility Standards

Health care partnerships will be required to provide coverage, either directly or through its PCPs, to members on a twenty-four hours per day, seven days per week.

8. Beneficiaries Services

Partnerships must staff an Ombudsman or Beneficiary Service function. This will include a toll-free telephone number for beneficiaries to access services, secure information, and file grievances within response time standards that will be specified in the partnership contract. This service will be staffed by consumer advocates to assure that enrollees receive adequate representation when seeking to expeditiously resolve grievances.

9. Provider Services

Health care partnerships will be required to staff a Provider Services function. This function will include a toll-free telephone number for providers to use to obtain information and guidance regarding health service issues.

10. Transitioning Members Between Plans

It may be necessary to transition members between regional partnerships. Partnerships will be required to have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. Partnerships will be required to have similar procedures for integration of their services with other managed care systems operated by the Commonwealth for Medicaid recipients.

11. Member Disenrollment

a. General Authority

The Commonwealth may have sole authority for disenrolling beneficiaries from partnerships, subject to the conditions described within the partnership contract with the Commonwealth. The partnership may have sole authority for disenrolling members from its subcontracted providers.

b. Disenrollment Effective Dates

Beneficiary disenrollments from the partnership will be effective on the date specified by the Commonwealth.

12. Medical Management and Quality Assurance by the Commonwealth

The Department of Medicaid Services regulates the utilization review and quality assurance (UR/QA) functions of all licensed providers. Health care partnerships, therefore, will comply with all Department for Medicaid Services UR/QA standards in addition to specific program standards. Section V describes reporting and monitoring requirements that will support the Cabinet's quality assurance program in relation to health care partnerships.

13. Utilization Review and Quality Assurance (UR/QA) System

Health care partnerships will be required to have their own written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its network.

a. Medical Director's Office

Health care partnerships must designate a Medical Director responsible for the development, implementation and review of the internal quality assurance program.

b. Confidentiality

Health care partnerships will be required to have written policies and procedures for maintaining the confidentiality of data.

c. Commonwealth and Federal Reviews

Health care partnerships must make available to the Commonwealth and/or its outside reviewers on a periodic basis, medical and other records (subject to confidentiality constraints) for review of quality of care and access issues, according to the Health Care Financing Administration's (HCFA's) guidelines as set forth in Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States.

The Cabinet or HCFA may also designate outside review agencies to conduct an evaluation of the program and its progress toward achieving program goals. Partnerships must make available, to the Cabinet's or HCFA's outside review

agency, medical and other records (subject to confidentiality constraints) for review as requested.

d. Provider Credentialling

Health care partnerships will be required to have written credentialling and re-credentialling policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the Commonwealth and qualified to perform their services. The partnerships will also be required to have written policies and procedures for monitoring its providers and for disciplining providers who were found to be out-of-compliance with the plan's medical management standards.

e. Operational Data Reporting

HCFA has stipulated that adequate data reporting capabilities are critical to its ability to effectively evaluate Medicaid managed care programs.

To measure the program's actual accomplishments in the area of access to care, medical outcomes, health status, and satisfaction, partnerships must provide the Commonwealth with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis. They also must cooperate with the Commonwealth in carrying-out data validation activities.

The Commonwealth will develop report formats and variable definitions for the health plan or partnership to use in providing operational data. The data required could include utilization data on both a personal level and on an aggregate basis.

1) Data Format

Partnerships will be required to submit quarterly data in an electronic or tape format that conforms to the Commonwealth's specifications. The precise nature of these specifications would be finalized in cooperation with all partnerships.

2) Data Validation

Health care partnerships will assist the Commonwealth in its validation of utilization data.

3) Grievance and Appeals Data

Partnerships will be required to submit a quarterly grievance and appeals report that conforms to the Commonwealth's specifications.

4) Quality Assurance Report

Health care partnerships will be required to submit a quality assurance report. The report may include EPSDT and other preventive visit compliance rates.

Partnerships will make available on a periodic basis clinical data in areas of concern to the Commonwealth, such as asthma rates, sexually

transmitted disease rates, etc. In addition, health care partnerships must provide such outcome-based clinical data as may be requested by the Commonwealth.

5) Member Satisfaction Report

Health care partnerships must collect or assist the Commonwealth in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members. The format for the instrument and research design is not yet finalized.

6) Presentation of Findings

Partnerships must obtain the Commonwealth's approval prior to publishing or making formal public presentations of statistical or analytical material based on its program membership.

f. Grievance and Appeals

The Commonwealth will establish a Grievance and Appeals function through which providers and members could seek redress against partnerships, and through which partnerships could seek to disenroll members who are habitually non-compliant or who posed a threat to plan employees or other members. Partnerships will be required to develop written policies and procedures detailing member complaints grievance methodology. Consumer advocates will play a significant role in representing eligibles at the initial stages of any complaint to assure that enrollees receive adequate representation and that grievances are expeditiously resolved.

Partnerships may seek disenrollment of a member under certain conditions that would be specified in the Partnership Contract.

14. Financial Structure

a. Payments to and from Plans

1) Contract Period

The Commonwealth anticipates that the initial contract period with the partnership will not exceed two (2) years. After the initial contract period, the Commonwealth reserves the right to extend the contract for a period of up to three (3) years or to competitively procure another managed care entity to perform the duties and responsibilities outlined in this document.

2) Acceptance of Commonwealth Capitation Payments

Health care partnerships will be capitated for all in-plan services. The Commonwealth will make capitation payments to partnerships on a monthly basis. Partnerships must accept capitation payments in the manner specified by the Commonwealth (e.g., electronic fund transfer) and will be required to have written policies and procedures for receiving and processing capitation payments.

Because many of the data cells are small and health care claims expense is so volatile, outliers inevitably appear. The actuary will be expected to exercise his or her best judgement and reject those historical results that would not be appropriate assumptions for future results.

The intent of the UPL methodology is to ensure that the managed care program pays no more than an actuarially equivalent FFS population or more than in a capitated HMO environment. However, it is not desirable to pass into UPLs all random variations found in the FFS data. The purpose of this model is to adjust for any random variation that may occur within the base FFSE and ensure that Kentucky Medicaid pays no more for managed care than it would in fee-for-service care.

To address these issues; upper payment limits and the risk of the managed care population, the actuary will input the FFSEs into a relational cost model. The relational cost model adjusts the relationships within the various geographic regions and categories of assistance to ensure that they adequately address the risk of the managed care population.

The relational cost model ensures that the UPLs are not exceeded by reapportioning the existing expenditure among the various regions and COEs. Thus, the upper payment limits have not been changed in aggregate and the risk of the managed care population is more appropriately addressed.

K. Capitation Rate Structure

After determining the appropriate rate setting methodology for the Commonwealth, the actuary will assist Kentucky Medicaid with implementation.

The capitated rate structure implemented by the Commonwealth is expected to be based on rate ranges rather than strict rate setting. Rate ranges give the Commonwealth the flexibility to recognize managed care delivery systems that vary in design.

In a prospectively capitated environment that Kentucky plans to use for its managed care program, it is critical that the health care partnerships have standards by which to manage the care of their enrollees. The Commonwealth may use the CRCS format as the basis for the rate negotiation process. Partnerships may be required to fill out the CRCS with its assumed utilization and unit cost figures by eligibility category, geographic region, and category of service.

The Commonwealth will evaluate the partnership proposal against the rate ranges provided by the actuary that are structured in an identical manner. The Commonwealth will then negotiate with the partnership regarding any unrealistic assumptions in the final capitation rate and to assure that partnership capitation rates are comparable to those the actuary would expect in a competitive HMO managed care model..

The Health Care Partnership could then use the completed CRCS as a management tool to judge the effectiveness and ultimately the profitability of its program. The CRCS format will give the partnership a blueprint for its management reporting needs and standardize the management reporting among all the plans. The Commonwealth will reap the benefits of this standardized management reporting by comparable quarterly and year-end financial reports from partnerships.

The capitation rate ranges will also provide the Commonwealth flexibility in providing incentive payments to partnerships that meet or exceed quality of care standards or target outcome goals. Based on where the partnership falls within the rate range, the Commonwealth can provide a percentage adjustment or fixed dollar incentive payment if the partnership successfully exceeds certain quality

care standards or target outcome measures within its contract. The rate range will allow the Commonwealth to pay partnerships with lower capitation rates higher incentive payments, thus enticing partnerships to strive for lower capitation rates while still maintaining a consistently high level of care.

:ms\0523

**Evaluation Plan
Analysis
Study Issue: Access**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project result in improved access to health care?	Partnerships will expand the number and array of on-site specialty services available to Medicaid beneficiaries.	- MMIS Utilization Data - Partnership encounter data	Pre-post analysis of health care providers relative to the number of specialty providers.
	Partnerships will give Medicaid beneficiaries the greater choice as compared to other aggressively managed care alternatives.	- Partnership encounter data - Partnership panels - Non-Medicaid HMO panels - Recipient surveys	Analysis of non-Medicaid HMO panels as compared to Partnership panels
	Partnerships will retain stability and continuity of care for the recipient population	- KEPAC physicians participants - Partnership physician participants - MMIS utilization data - Partnership encounter data - Recipient surveys	Analysis of providers either accessed by or available to Medicaid eligibles with their regions.

**Evaluation Plan
Analysis
Study Issue: Quality of Care**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project affect the quality of care and health of Medicaid eligibles?	Recipient health status, as reported by recipient/patients and based on health outcomes will improve as a result of the demonstration.	- Medical records - MMIS utilization data - Partnership encounter data - Performance awards	Pre-post survey of quality of care and health status of Medicaid beneficiaries and specific case studies representing a cross-sectional, as well as, longitudinal approach.
			State Health Officer will establish annual long-range investment goals, i.e. immunizations, cancer screenings, mammograms, low birthweight babies, etc., that will be used to establish performance rewards. Incentive payments will be awarded annually to partnerships that meet these goals.
To what extent does the project impact utilization of primary care or preventative services by Medicaid recipients?	Utilization of medical services, particularly primary and preventative care will improve as a result of the demonstration. Managed care will: - reduced hospital admissions - increase use of primary physician visits - reduce usage of emergency room for non-emergent care - increase the use of preventative treatment - reduce self-referral and other referral specialist visits	- Medical records - MMIS utilization data - Partnership encounter data - MMIS expenditure data	Pre-post survey of the quality of care and health status of Medicaid eligibles and specific case studies representing a cross-sectional, as well as, a longitudinal approach.

**Evaluation Plan
Analysis
Study Issue: Constraint of Costs**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project impact total Medicaid expenditures?	Savings are equivalent to those achieved through other aggressive approaches to managed care.	- MMIS expenditure data - Partnership capitation rates - Expenditure data from other states using competitive HMO model	Pre-post comparison of total and per capita expenditure on the Kentucky Medicaid population. Comparison against other states using competitive HMO model.

**Evaluation Plan
Analysis
Study Issue: Provider and Patient Satisfaction**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project improve the provider and patients perception of the Medicaid program?	Partnerships will improve patient satisfaction and empower Medicaid providers.	-Provider surveys -Recipient surveys	Pre-post provider and recipient satisfaction survey

**Evaluation Plan
Analysis
Study Issue: Medically Underserved Areas**

Question	Hypotheses	Data Source	Analytic Method/Data Analysis
To what extent does the demonstration project enhance health care services in medically underserved areas?	Partnerships will improve health care services in medically underserved areas by bringing physicians and other providers to the region physically or through telemedicine technology.	-MMIS utilization data -Partnership encounter data -Medically underserved area survey	Pre-post analysis of locally accessible health care services in medically underserved areas.

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco

SUBJ: Governor Brereton Jones phone call

DATE: July 14, 1995

I returned a call for you to Governor Jones last evening and was able to actually speak with him in person this morning. He is eager to visit with you and knows that you had a fundraiser last night and a full morning of consultations and a visit to CIA.

He is calling you because of a medicaid waiver he wishes to have approved. This is a waiver obtained by Kentucky quite some time ago which was set aside by Kentucky when their universal health care plan failed in the legislature; they now want to alter the waiver to place all medicaid recipients in a single managed care plan and use the savings to enable them to continue to provide optional services to the medicaid population like some prescription drug coverage, dialysis, etc. He says without this waiver provision many optional services will have to be cut.

HHS has firmly held to the premise of consumer choice which was a centerpiece of the Health Security Act. Gov. Jones counters that within the managed care plan agreed to by the providers the consumer has the choice of providers. He also argues that factory workers or most any worker in business who has insurance through that business gets no choice of plan but very likely a choice of provider within the single plan. HHS counters to that argument that a person in a business chosen plan does not have the protection of law like the medicaid recipient which allows legally for choice. The waiver is the mechanism for lifting that choice requirement. I would add here that HHS has told Kentucky that a simple solution would be to still offer a fee for service plan which would give the choice element desired. Kentucky says no.

As a matter of policy I feel it is wrong to force Medicaid recipients into a single plan even with the choice of provider within that plan. We fought hard for choice in HSA.

Gov. Jones has been very blunt in his reminder to persons in HHS and to myself as to when he endorsed you for the Presidency, down to what the headline of the day was on the day he endorsed you.

Governor Jones argues that HHS should at least allow his one state to try this in pilot fashion. While HHS would love to work something out with him, they remind us that the next two states in the health waiver pipeline are Kansas and Montana, both of whom want to do this very type thing, i.e., put all medicaid recipients into a single managed care plan.

I would suggest that you call Gov. Jones today or over the weekend, tell him I have briefed you on his concerns and that you have directed me to work with HCFA to see what can be done. I think you are the most appropriate person to outline to him the bind on this:

a. You and your administration fought hard for health care reform with a primary theme under which you led that fight being CHOICE of plans.

b. We can't justify under the waiver provisions allowing just one state to try this "one managed care plan only" without then approving that provision down the road in future plans.

I will await further instruction.

Thank you.

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

14-Jul-1995 05:37pm

TO: Diana M. Fortuna
TO: Anna Winderbaum
TO: Emily Bromberg
TO: John B. Emerson

FROM: Carol H. Rasco
 Economic and Domestic Policy

SUBJECT: Kentucky waiver

Attached is the briefing piece I did for the President after my conversation with Governor Jones. Before I sent this to the President I talked with Secretary Shalala and she had Bruce Vladeck on the line as I wanted to warn them the President might call them over the weekend once he calls Governor Jones back.

Some of us may get a call as well. If any of you hear from the President, please have me paged and let's talk about this...I think it is a very, very tricky one and I think the President is going to want to do something on this. The Governor is being very blunt in reminding HHS and me about his endorsement of POTUS as a Presidential candidate on the day Ms. Flowers (NOT what the Governor called her!) went public.

Thanks.

2000/11/11

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

21-Jun-1995 06:42pm

TO: Diana M. Fortuna

FROM: Carol H. Rasco
 Economic and Domestic Policy

CC: Jeremy D. Benami

SUBJECT: RE: kentucky

The President agreed with me entirely about the choice issue and says he will stand firm. We do not promise meetings...Monahan should simply tell them that the most recent waiver states have been asked to meet with Rasco and that is what they will be offered. Make sure intergovernmental knows this is the stance. We can then reserve Leon in case it gets ugly and we can then say to Kentucky the meeting can be with Leon and me.

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

13-Sep-1995 12:44pm

TO: Carol H. Rasco

FROM: Diana M. Fortuna
Domestic Policy Council

SUBJECT: Update on Kentucky Medicaid Waiver

I just met for an hour and a half with the Secretary of health, Masten Childers, and an aide. He is a very strong advocate for his plan. I told him my goal was to try to understand why there didn't seem to be any room for compromise between HCFA and the state, and apologized if I was asking them to go over territory they had already been over before. He got very exasperated a few times, saying why are we going over something we've been over a thousand times, but I think that is his way of doing business, and at the end he seemed to think it had been a productive meeting and said he understood I was trying to be helpful. He is obviously anxious about the timeline, hoping we are days rather than weeks away from a resolution.

Substantively, I did my best to explain that HCFA's issue with choice of plan revolves around not wanting Medicaid benes locked into a bad plan. They had a lot of good arguments as to why that won't happen and why things will be much worse if the next Governor lets competition between commercial hmo's destroy the public health system there. Fundamentally what they want to do is shield the public clinics, health departments, and major academic medical centers from competition with commercial hmos because they think the commercial hmos will destroy the public infrastructure.

My gut is that we will end up deciding to give them what they want, with a lot of extra protections written in for beneficiaries so that we or they can pull the plug if benes are getting bad care. I have to follow up with the state and HHS on some more questions, but the state does not seem open to compromise at all.

Kentucky Medicaid Waiver

The purpose of the Administrator's e-mail message to HCFA staff was to sketch out the outline of the agreement reached on the Kentucky Medicaid waiver. His message was intended as guidance to staff so that staff work on the waiver can proceed as fast as possible. The Administrator indicated that HCFA has agreed to the State's proposal to enroll all Medicaid beneficiaries in a single network. The demonstration in Kentucky will be designed to test how beneficiary choice can be maximized within a single network. In negotiating the terms and conditions of the waiver, HCFA will seek to assure that beneficiaries are given sufficient information to make informed choices concerning choice of provider at the time of enrollment and periodically thereafter. HCFA will also seek to assure that quality standards are embedded in the terms of the waiver. HCFA looks forward to working with the state to test a new model of choice.

Kentucky Medicaid Waiver

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 6 1995

The Honorable Brereton C. Jones
Governor of Kentucky
Frankfort, Kentucky 40601

Dear Governor Jones:

I am pleased to inform you that the Department of Health and Human Services has reached an agreement on Kentucky's request to amend its existing health care reform demonstration project to create health care partnerships. By October 12, we will forward to you the formal award letter which will include the revised special terms and conditions for conducting the demonstration. These terms are designed to ensure that the demonstration provides high quality health care services to eligible Medicaid beneficiaries and maintains Federal cost neutrality.

I understand as part of your commitment to improving health care in the State, that all net savings derived from the implementation of this waiver shall be maintained in a Medicaid Trust Fund established by The Commonwealth of Kentucky to fund the expansion of the delivery of health care services to low income persons. The application of the net savings for the use of expanding health care services to Kentucky's low income population is a material term of the conditions of approval of the waiver, and non-compliance with this term shall result in the revocation of this waiver.

I look forward to following the progress of the Kentucky Health Care Partnership Plan. Congratulations.

Sincerely,

Donna E. Shalala

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

OCT 23 1997

To: _____

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

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

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

CC: DIANA



Kentucky Medicaid Waiver

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

BRERETON C. JONES
GOVERNOR

THE CAPITOL
700 CAPITAL AVENUE
FRANKFORT 40601
(502) 564-2611

October 18, 1995

Ms. Carol H. Rasco
Assistant to the President for Domestic Policy
Domestic Policy Council
The White House
2nd Floor, West Wing
Washington, D.C. 20500

Dear Carol:

Thank you and your assistant, Diana Fortuna, for all of your help during the last few weeks. As you know, we invested a great deal of time and effort into our waiver application. We are absolutely convinced that it represents the best alternative for Kentucky.

We were extremely pleased when Sec. Donna Shalala called to inform us the waiver had been granted. Your willingness to discuss this issue and to provide us with advice and guidance was extremely meaningful to me and to the people of Kentucky. Thanks again for all that you did.

With best regards, I am

Sincerely,

A handwritten signature in black ink, appearing to read "Brereton C. Jones", written over a horizontal line.

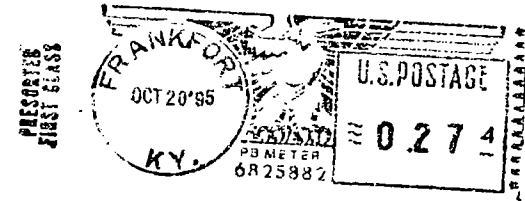
Brereton C. Jones

/src



COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR
700 CAPITAL AVENUE
FRANKFORT
40601

One small vote
can make one
difference **big**



Ms. Carol H. Rasco
Assistant to the President for Domestic Policy
Domestic Policy Council
The White House
2nd Floor, West Wing
Washington, D.C. 20500

