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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Diana Fortuna from Phyllis Landrieu re: Request for Appointment (partial, DOB) (1 page)	08/28/1995	b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Diana Fortuna
OA/Box Number: 12027

FOLDER TITLE:
Louisiana Choice Demo

2018-0525-S
ry2259

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
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THE WHITE HOUSE

WASHINGTON

April 15, 1996

TO: Phyllis Landrieu

FROM: Diana Fortuna DF

Thanks for your note about HHS/HCFA's plans to announce the final selections for the Medicare Choices demonstration. As I have mentioned when we met, I have not participated in or sought to affect HHS's decision-making process. But I have certainly appreciated the chance to learn more about Tenet's proposal as it relates to the Administration's policy on increasing managed care choices for Medicare beneficiaries.

Thank you for keeping me informed. I am sure there will be many developments in this area over the next several months.

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TO DIANA FORTUNA

FROM PHYLLIS LANDRIEU

COPY RICHARD FREEMAN

DATE APRIL 9, 1996

SUBJECT: TENET CHOICES 65

I have been notified by Ms. Barbara Cooper's office that Secretary Bruce Vladick will announce the Medicare Demonstration Project final selections next week.

I am asking you to please make sure Mr. Vladick is reminded of your support for Tenet Choices '65 plan. We are prepared to immediately implement the program which will save Medicare beneficiaries money.

Your continued help and support are deeply appreciated.

Phyllis Landrieu
4600 Venus Street
New Orleans, LA 70122
504 286-0935
FAX 504 282-5437

Status of the Medicare Choices Demonstration

March 7, 1996

- The objective of the Medicare Choices Demonstration is to test a broad range of managed care delivery system options and payment methods for Medicare. The ultimate goal is to provide Medicare beneficiaries with more **delivery system choices** and to provide HCFA with information on **alternative payment arrangements**.

- HCFA received **372 pre-applications**.

- A total of **52 pre-applicants** were invited to submit full applications.

- In December 1995, a total of **37 proposals** were received:

  21 were from **provider sponsored networks (PSNs)** or **providers with HMO/insurer partners or subsidiaries**

  16 were from **HMOs, PPOs, or other managed care organizations**

  30 proposed some type of **point of service (POS)** plan

  8 are in **rural areas**

  6 are current **Medicare Risk Contractors** and an additional 4 have applications pending

- Applications have been reviewed by HCFA panel members with expertise in research, managed care operations, and quality assurance programs. Criteria used for final site selection include demonstration design, organizational capabilities, availability of clinical services, and quality assurance programs.

- Demonstration site selections will be announced by the end of March 1996.

-Following HCFA site visits and plans' completion of start-up activities, the operational phase of the demonstration will begin. **We anticipate that some sites will be operational as early as August 1996.**

18-24

CHAPTER I - EXECUTIVE SUMMARY

A. The New Orleans Regional Physician Organization, d/b/a Peoples Health Network (PHN) was established in March 1994 as a non-profit taxable Louisiana Corporation. PHN is a management services organization providing managed care administrative services to six acute care hospitals owned by Tenet Healthcare Corporation and five affiliated Independent Practice Associations (IPAs). PHN is governed by a ten-member board equally representing the physician and hospital participants. The five affiliated IPAs total approximately 470 physicians representing all medical specialties. A sixth Tenet-owned system, Mercy+Baptist, consisting of two hospitals and an affiliated IPA, will be added to the network by the spring of 1996.

PHN currently services approximately 1,100 commercial HMO members, 2,900 Medicare Risk HMO members, and 5,000 ERISA lives. PHN provides medical management, provider relations, member services, MIS, finance, and claims and capitation processing to its member providers.

PHN represents a cohesive network of providers oriented to providing managed care services to a wide variety of patients and payors. The centralized management functions allows PHN to bring a higher level of staff and systems to the IPAs and hospitals than they could establish on their own. The staff advises the IPA and hospital members about new programs and contracts. The financial structure dictates that all managed care funds flow to the providers. A reserve is held for administrative costs, with any surplus flowing back to the provider members. PHN is able to effectively track capitation payments being made by the health plans to the providers, and has the capacity to reimburse through a variety of mechanisms including capitation, RBRVS, case rates, and other modified fee-for-service schedules. Strong financial management combined with medical management and effective reimbursement mechanisms has enabled the providers to generate incentive revenues for distribution. The governance structure enables the provider members to have a voice in the operations of the entity and to gain from the experience of their member partners. The medical management function within PHN brings a cohesive focus to the health services delivery aspects of the network. The medical director and medical management staff work with each IPA's utilization management and quality assurance committee to coordinate their activities and to offer guidance and expertise in carrying out these processes. Medical management has been extremely effective in helping the providers to achieve utilization rates far better than managed care norms.

Effective managed care administration requires coordination between all aspects of the staff including finance, medical management, provider relations, member services, and claims. PHN succeeds in bringing about this level of cohesiveness and has experienced growth in managed care enrollees as well as in provider members.

B. The proposed service area is the greater New Orleans metropolitan area, which includes the parishes of Orleans, Jefferson, Plaquemines, and Eastern St. Tammany. This area is unique in that the Mississippi River, Lake Pontchartrain and the Industrial Canal present significant

physical barriers to mobility. The Parishes of Orleans and Jefferson are urban and densely populated. Conversely, Plaquemines is rural and has no hospitals and few physicians. St. Tammany is a bedroom community and has two major population centers, Slidell in the east and Mandeville/Covington in the west. PHN is pursuing a relationship with a PHO that serves 18 rural parishes including: Beaureguard, Allen, Evangeline, St. Landry, Calcasieu, Jefferson Davis, Acadia, St. Martin, Cameron, Vermillion, Lafayette, Iberia, St. Mary, Assumption, St. James, Lafourche, Terrebonne and St. Charles. This PHO would benefit from PHN's management infrastructure and its referral network of acute and tertiary providers, and PHN would benefit by being able to reach a larger Medicare population with the proposed demonstration program product through an extension of its provider network.

C. PHN is proposing to use its current provider network as the delivery system for the Choices demonstration project. The network is made up of five IPAs and six hospitals that provide excellent coverage in the proposed service area. This network will also be enhanced with the addition of the Mercy+Baptist hospitals and IPA. These hospitals are primarily small community centered facilities throughout the New Orleans metropolitan area. One facility combines an uptown and mid-city campus into a 1,470 bed tertiary hospital capable of providing services not available in the smaller hospitals. This network has extensive experience in providing services to managed care and ERISA enrollees.

The managed care product being proposed by PHN for the demonstration project is a three-tiered Point-of-Service program. This product, to be called "Tenet Choices 65" will offer Medicare beneficiaries the enhanced benefits and coordination of care found in an HMO while allowing them the option of seeking care outside the network. Tier 1, the HMO benefit, offers the highest level of coverage. Members pay a low fixed co-payment and are required to access care through a primary care physician "Care Manager." All specialty referrals must be authorized through a primary care physician. Under Tier 2, the PPO-like benefit option, the beneficiary has open access to network physicians, without primary care physician referral and management. The PPO-level benefit option provides some freedom of choice, somewhat reduced ability to effect medical management, and places a percentage coinsurance and a copayment responsibility on the Medicare beneficiary. Under Tier 3, the Out-of-Network benefit, members are offered unrestricted choice of providers at standard Medicare benefit levels.

Out-of-pocket costs increase and benefits decrease as the member moves from the HMO-like benefit, to the PPO tier, to the out-of-network option, motivating the member to obtain services in network. Medicare beneficiaries will be also be encouraged to join the plan to receive benefits that are greater than those received in the standard fee-for-service Medicare program, such as a prescription drug plan and a vision plan. Ease of use should further attract members. Providers are familiar and accessible to the members, and claims submission is eliminated in Tiers 1 and 2.

The proposed model is designed to fill a critical void in the array of plans available to the Medicare population. It will overcome one of the greatest perceived shortcomings of Medicare Risk HMOs -- lack of freedom for the beneficiary to seek care either outside the HMO network

or within the network without stopping for primary care authorization. This model also offers much more of a managed care approach than Medicare Select plans. PHN will assume full risk for all Medicare covered and supplemental benefits, in contrast to Medicare Select plans, which merely take risk for wrap-around coverage. Tenet Choices 65 will also feature the involvement of primary care physician care managers, an element absent from Medicare Select.

PHN's unique structure brings physicians and hospitals together forming a strong commitment to manage and deliver quality cost-effective healthcare services. The organization provides physician-controlled quality and medical management programs, excellent access throughout the New Orleans metropolitan area, and a team of experienced professional managed care administrators. PHN hospitals and physicians clearly understand the needs of the senior population as a result of their history of participation in both traditional and at-risk delivery models. This fully integrated healthcare system has demonstrated the ability to manage utilization while ensuring quality and beneficiary satisfaction.

D. PHN does not have a contract with HCFA to serve Medicare beneficiaries as a risk plan, cost plan, or HCPP. For this demonstration there are approximately 155,836 Medicare recipients in the primary service area, and another 145,817 in the rural parishes that this product may potentially serve if a relationship is established with the rural PHO.

E. The proposed Point-of-Service plan offers the beneficiary the option of receiving services through an HMO-like option, a PPO-like plan, or out-of-network. Under Tier 1, the HMO option, there are no deductibles or coinsurance for Part A services. Part B benefits have a $5.00 copay for office visits and a $20.00 copay for outpatient mental health visits with an annual maximum of 20 visits. For Tier 2, the PPO option, Part A services have no deductible and a 10% coinsurance requirement. Part B PPO coverage has a $10.00 office copayment and a 20% coinsurance requirement for office visits, and a $20.00 copay and 20% coinsurance for the maximum of 20 outpatient mental health visits per year. Both the HMO and the PPO option offer a pharmacy benefit package with a $5.00 copay for generic drugs and a $10.00 copay for brand name drugs. The monthly maximum for pharmacy benefits is $45.00 which is cumulative during member's enrollment up to an annual maximum of $540.00. Vision benefits have a $10 copay in the HMO and PPO tiers. Tier 3, out-of-network services follow a standard Medicare fee-for-service benefit structure with the deductibles, copayments, and benefit limits of a traditional Medicare plan. Tier 3 does not provide prescription drug, vision, or mental health benefits.

F. The pricing arrangement being proposed will be 90% of the AAPCC. Rather than a retrospective risk sharing arrangement with HCFA, PHN is proposing that reimbursement for future years be based on the average of the current year's percentage reimbursement and the actual experience as a percentage of the AAPCC. The maximum will be 95% of the AAPCC. For example, in 1996 reimbursement will be based on 90% of the AAPCC. If results available in the fall of 1996 indicate that actual experience is 86%, then the 1997 reimbursement from HCFA

will be 88% of the AAPCC. Likewise, if the fall 1996 results indicate actual experience at 94% of the AAPCC then reimbursement from HCFA for 1997 will be at 92%.

G. PHN is in the process of converting from the STAT managed care system to AMISYS managed care system. The conversion will be completed by January 2, 1996. AMISYS is a member-based system with the following capabilities: claims processing, membership, premium billing and accounts receivable, benefits management, medical management and authorizations, provider and credentialing data, pricing management, TPA fund management, liability recovery/COB, correspondence generation, customer service/phone log, flexible security, and 1099 processing. PHN will time share the AMISYS system through a lease agreement with Perot Systems Corporation (PSC). PSC also has committed the resources to provide any custom enhancements, reports, and data interfaces required by PHN. PSC will assist in customizing the system to manage the Tenet Choices 65 point-of-service product. The system will be able to provide encounter data in a format acceptable for HCFA, and the system will track the out-of-network claims information at the detail level required.

H. PHN's quality improvement approach is based on continuous monitoring of medical services. In order to achieve the goal of providing cost-effective health care while protecting quality and continually improving the clinical process for all enrollees, PHN has implemented a formal comprehensive quality improvement and protection program. The goals of program are to:

- Identify important aspects of health care for PHN members.
- Establish standards to measure the quality of these services.
- Measure all aspects of medical care delivery, including access, medical appropriateness, resource utilization, patient satisfaction and confidentiality.
- Intervene where quality standards are not met.
- Document all quality assurance activities leading to improved health care delivery for our enrollee population.

The program provides a foundation of information upon which the plan can build its continuous quality improvement process.

Each IPA has its own quality assurance committee consisting of five members, the majority being primary care physicians. The local basis of the committees enables the physicians to develop standards that apply in their own market, and to use their relationships with fellow physicians to supply the necessary peer review. All committees receive support from PHN's medical management department and receive input and guidance from PHN's medical director. While the chairman of each committee has responsibility to see that program goals are accomplished, PHN's governing board of directors has the ultimate responsibility for the program's success.

The approach used includes: early identification and confirmation of the problem's existence, assessment of the cause and scope of the problem, development and implementation of the problem's remedy and ongoing monitoring to ensure resolution. PHN plans to implement greater clinical management of specific high-intensity/high frequency procedures common to the Medicare population. Efforts will include monitoring sentinel events, development of treatment protocols, and targeted physician education in identified areas where opportunities for clinical improvement exist.

TENET
HEALTHCARE CORPORATION

September 14, 1995

Ms. Diane Fortuna
Sr. Political Analyst
Domestic Policy Office, Rm. 224
Old Executive Office Bldg.
Washington, D.C. 20500

Dear Ms. Fortuna:

I appreciated the opportunity to meet with you on Wednesday, September 6, 1995 in Washington. Your interest in and support of constructive reform of both the Medicare and Medicaid programs is always appreciated.

As we discussed with you last week, the healthcare industry, and Tenet healthcare Corporation specifically, has a deep concern about another round of arbitrary reductions in reimbursement for various components of the Medicare program. While we recognize and support the noble effort to balance the Federal budget, reduce health care costs, and provide tax breaks, the burden to Medicare and Medicaid seem both disproportionate and damaging.

In the meetings we had with our Congressmen, we urged that they make a concerted effort to achieve the needed reductions in healthcare expenditures by reorganizing the overall Medicare program in a manner which will insure delivery of a quality medical service in a more efficient manner without jeopardizing those efficient healthcare providers who are both willing and prepared to operate under the new paradigm.

In particular, we strongly support the following positions;

> Rapid movement of the Medicare program into a managed care environment which recognizes and rewards efficient systems by sharing the savings with the Medicare beneficiaries who choose such systems.
>
> Continued increases in fee-for-service delivery, the most expensive and least restrictive delivery method, should be passed on to beneficiaries who insist on this level of choice.

Louisiana Regional Office • 111 Veterans Boulevard, Suite 1424 • Metairie, LA 70005 • Tel 504.833.1495 • Fax 504.833.5320

Expansion of Medicare demonstration projects to allow accredited PHO's (Physician/Hospital Organizations) to contract for capitated Medicare patients and eliminate the administrative overhead of an HMO when not needed.

No changes to the current methodology for reimbursing legitimate Medicare Bad Debts unless the base payment for DRG reimbursement is revised to include average Medicare Bad Debt costs in that number.

The future of the Medicaid program is of grave importance to Louisiana. We feel that the Medicaid waiver process needs to be streamlined and simplified to allow states the flexibility to provide a basic benefit package through capitation wherever possible. Contracting as many Medicaid services as possible through a capitated contract significantly reduces the opportunity for fraud and abuse, a major problem for the current fragmented Medicaid program.

Again, thank you for your continued support. Our staff remains at your disposal for any assistance you may need in evaluating the potential affect of any proposed changes to these vital programs. Please do not hesitate to contact my office if we can be of assistance to you.

I hope you enjoy the taste of Louisiana.

Sincerely,

George J. Saucier
Regional Director, Integrated Health Services

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TO MRS. DIANA FORTUNA
SENIOR POLICY ANALYST
DOMESTIC POLICY OFFICE, ROOM 224

FROM PHYLLIS LANDRIEU

DATE AUG 28

SUBJECT REQUEST FOR APPOINTMENT

I wonder if we can possibly change our meeting from Wednesday, September 7, at 8:30 am to Tuesday, September 6 at 8:30 am or after 3:00 pm on Tuesday.

Richard Freeman, Vice President of Operations, Orleans Region, Tenet Healthcare Corp. D/O/B (b)(6)

George Saucier, Director, Tenet/LSU Project, Tenet Healthcare Corp. D/O/B (b)(6)

Phyllis Landrieu, Lobbist, Tenet Healthcare Corp. D/O/B (b)(6)

[001]

Thank you very much.

Phyllis Landrieu

4600 Venus Street

New Orleans, LA 70122

504 286-0935

FAX 504 282-5437

Senator Breaux Team

Talking Points on
Medicaid and Medicare
Meeting with Tenet Healthcare Corporation Executives
August 1995 State Trip

- I believe we must balance the federal budget, but in the case of health care, I think the Republicans have put the cart before the horse.

- They set the budget targets -- saving of $270 billion in Medicare and $182 billion in Medicaid over seven years -- before looking at what kind of health care system that will give us.

- I think the cuts in Medicaid and Medicare are too much too soon. They are four times larger than any the Congress has ever made.

- These cuts will hurt seniors, the disabled, and their families as well as those who provide them with health care.

- If these cuts are enacted, Louisiana will get $10 billion less for health care over the next seven years.

- Most of these cuts would not be necessary without the Republicans' $245 billion tax cut -- more than half of which will go to Americans making $100,000 or more.

The Proposed Cuts will Hurt Families

The GOP would give seniors Medicare vouchers whose value won't keep up with rising costs. As a result:

- Seniors will have to pay an additional $3,300 over 7 years out of their own pockets.

- Louisiana's seniors will pay even more than those in other states -- $4,073 more per person over seven years.

- Most seniors can't afford to pay more -- 77 percent of seniors in Louisiana live on annual incomes of less than $15,000 a year.

· The GOP plan also cuts Medicaid -- above and beyond the $1 billion the state had to cut from the program this year. This will hurt families:

- 98,000 Louisiana seniors rely on Medicaid. Medicaid pays for more than half of all nursing home care.

- More than one in four children in Louisiana receives health insurance through Medicaid.

<u>The Cuts will Hurt Hospitals and Health Care Providers Too</u>

The GOP plan may take half the cuts -- $135 billion over seven years -- from hospitals, doctors, and other providers. That would be a $35 billion cut in the year 2002 alone.

- Medicaid and Medicare already pay providers far below cost. A 1993 survey by the American Hospital Association found:

  - Medicare pays hospitals only 89% of costs
  - Medicaid pays hospitals only 93% of costs

- Thus, hospitals are losing 7 to 11 cents for every dollar they spend on these patients!

- Until now, hospitals have made up the difference by shifting costs to private payers. (In fact, the American Hospital Association found private insurance pays 129% of cost.) But we all know that with increased managed care and other cost saving measures, it's getting harder and harder to shift costs.

- Right now, one in four hospitals are operating in the red. The proposed cuts could force them to close or cut services.

- The cutbacks could be particularly devastating in rural areas. Already, more than half our parishes have a shortage of medical personnel. In some areas, the local hospital is the largest employer.

The GOP Medicare Cuts Fund Tax Breaks for the Wealthy

Republicans claim they need to cut $270 billion from Medicare to prevent it from going bankrupt. That's just not true:

- Only $89 billion in cuts are needed over the next seven years to extend the life of the hospital insurance trust fund until the end of 2006.

- The GOP has proposed a $270 billion cut -- three times more than what's needed. 40% of the GOP cuts come from Part B (doctors' payments) and do nothing to strengthen the Medicare Hospital Insurance Trust Fund (Part A).

- The GOP wouldn't need to cut $270 billion from Medicare if their budget didn't include a $245 billion tax cut -- more than half of which would go to families making more than $100,000 a year.

- While the GOP plan cuts Medicare to pay for tax breaks, it does not assure the long-term solvency of the program. Their proposal does not address the very serious drain on the Hospital Trust Fund that will occur when the baby boomers begin to retire in 2010.

- We do need to make reforms to contain spirally health care costs in both the public and private sector. But the GOP budget plan is not the way to do it.