Reforming Medicaid

Essential Standards for State Waivers
REFORMING MEDICAID: ESSENTIAL STANDARDS FOR STATE WAIVERS

Position Paper of the American College of Physicians

by

Elizabeth Prewitt

March 13, 1995

A small scale revolution is underway in the states to control the cost of Medicaid and expand access to health care for low-income and uninsured populations. Most states are using Medicaid Section 1115(a) waivers as the vehicle for change. Without any change in federal law, the Medicaid program is undergoing sweeping change through a regulatory process that liberally interprets its statutory underpinnings. Furthermore, state legislative authorization is not always required to implement these changes.

There have been persistent complaints from Governors that something must be done about the budget-consuming Medicaid program, especially since states, unlike the federal government, must produce balanced budgets. While the Congress and the Administration struggled unsuccessfully to pass health care reform, states continued their individual reform initiatives. The '94 electoral sea change removed any doubt that sweeping health care reform had died at the national level and lost its appeal at the state level. The voting public made it clear that it wants less government, lower taxes and the "end to welfare as we know it." In this new environment, the Medicaid program with its linkage to Aid to Families with Dependent Children (AFDC) is expected to undergo intense scrutiny and face dwindling programmatic and financial support from the more conservative national and state leadership.

This paper will examine whether the Section 1115 waiver process is an effective vehicle for reform at the state level and what standards should be met by reform plans developed under the Section 1115 waiver process. Standards for other reform initiatives can be extrapolated from these criteria. For example, proposals to transform the entitlement nature of Medicaid into a block grant must meet the standards proposed in this paper. Our goal is to help physicians and others involved in the development of state waiver applications or the evaluation of these and similar projects.

While it is beyond the scope of this paper, it is important to be aware of a number of legislative proposals such as the balanced budget initiatives, deficit reduction plans and "unfunded mandates" restrictions that would have a significant impact on Medicaid financing and coverage. As it stands now, Medicaid provides coverage to less than half of all people with incomes below the poverty line and its reimbursement rates are universally considered below the cost of providing the service. Aggressive deficit reduction would exacerbate these already critical problems.
Ironically, "unfunded mandates" legislation could have the effect of making it procedurally more difficult to expand or shrink Medicaid. The Governors support unfunded mandates legislation as a way to reduce the financial burden of covering larger numbers of women and children and the regulatory burden of enforcing nursing home and other standards. In addition to making it more difficult to make categorical expansions of Medicaid, unfunded mandate legislation may also prevent cutbacks in federal contributions that are not paired with offsetting reductions for states. Reduction could be achieved by cutting benefits, categories of services, or repeal of the Boren Amendment that requires provider reimbursement to be set at levels that do not reduce access. Under legislation passed by the House and Senate, new procedures are required to clear the way for unfunded mandates, whether they are expanding or reducing federal requirements.

Other proposals such as Senator Nancy L. Kassebaum's (R-KS) Medicaid/Welfare swap bill would make fundamental programmatic changes in the Medicaid program. This legislation would give the federal government responsibility for a substantial portion of the Medicaid program in exchange for the states taking on welfare. Even more sweeping are proposals to replace the state-federal Medicaid partnership with a block grant program with few federal requirements. The Chairman of the Commerce Committee, Thomas J. Bliley, Jr. (R VA), described his perspective this way: "As we attempt to control costs, the Commerce Committee will look at the entire Medicaid program, including all mandatory federal requirements and conditions of participation. This could mean replacing the individual entitlement to Medicaid with states deciding who is entitled to receive benefits."

Finally, there is some concern among public health officials that suggested changes in existing public health programs could have a detrimental effect on Medicaid and low-income populations, particularly in prevention and treatment of tuberculosis and sexually transmitted diseases. This concern has been raised about Senator Kassebaum's bill to consolidate the 12 Centers for Disease Control and Prevention categorical grants into a "core functions of public health" grant program. Some believe that state flexibility is good in theory but could lead to a diminution of effective and needed programs, especially those that deal with stigmatized diseases or touch on issues that are politically sensitive.

*The federal/state Medicaid partnership.* The College previously opposed the expansion of Medicaid as a vehicle for reform and questioned whether it is a desirable way to reduce the number of uninsured.\(^1\) Results of the flawed structure and financing of the Medicaid program include: gaming by the states to reduce their financial contribution; reimbursement levels that make it difficult for providers to cover the cost of treating beneficiaries; and cumbersome eligibility determination and paperwork. However, in the absence of comprehensive health care reform, the College would support improvements to the Medicaid program and oppose cutbacks that would further weaken the program. As long as funding is adequate and federal

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standards are met, the Medicaid framework is a reasonable stopgap for the time being. Other approaches should be evaluated that rethink coverage for low-income and other uninsured populations. One example would be providing subsidies to low-income populations to buy private insurance through voluntary purchasing cooperatives.

What are Section 1115 waivers? Section 1115 of the Social Security Act authorizes research and demonstration programs relating to Medicaid, AFDC, and social services block grants. While the authority was contained in the original legislation passed thirty years ago, it was used only for very limited projects covering major medical services until 1993 when the Secretary of Health and Human Services substantially revised the process to allow statewide demonstrations of alternative programs with changes in eligibility, delivery of services and population served. Prior to 1993, community-based long term care waivers were predominant.

Waivers have been approved in seven states: in 1993, Hawaii, Rhode Island, Kentucky, Oregon, Tennessee; in 1994, Florida; and in 1995, Ohio. State legislative approval is needed in Florida and Kentucky before those programs can be implemented. Eight waivers are pending in Illinois, Missouri, Massachusetts, Louisiana, Oklahoma, New Hampshire, Minnesota, and Delaware. South Carolina's application was approved in principle but certain "milestones" must be met before the waiver itself is approved. Other states reportedly considering waiver applications are Texas, New York, Georgia, Louisiana, Montana, New Jersey and Utah.

These "demonstrations" generally expand eligibility to low-income and uninsurable populations through savings from Medicaid managed care plans. Modifications are allowed in payments to rural health clinics and federally qualified health centers and budget neutrality is required over the five years of the program. The U.S. Health Care Financing Administration (HCFA) oversees the demonstrations and is currently evaluating implementation in Tennessee, Rhode Island and Hawaii.

The authorization language establishing Section 1115 waivers limits them to experimental, demonstration projects of limited scope and duration. They were to be approved selectively and not expected to be statewide in operation. The post-1993 projects do not fit this profile. They are variations on a model that requires enrollees to be in managed care; expands access to uninsured populations with payment based on an income-related sliding scale; and applies statewide. Waiver applications are characterized by cookie-cutter uniformity, their approval is perfunctory, and there is no serious expectation that the projects will end after 5 years. The College believes waiver projects must be rigorously and independently evaluated during the first five years of operation, even if they are extended.

The College believes that managed care has the potential to improve quality and reduce costs of Medicaid coverage, but only if the standards that we outline below are met by states.

Federal standards for Medicaid Section 1115 Waivers. The pressure on Congress and the Administration is intense to give states enhanced flexibility and fiscal relief from the Medicaid program. Most statewide demonstration projects under Section 1115 waivers are touted as
reforms to expand access and improve quality. This assertion is met with skepticism by those who are unconvinced that hundreds of thousands of previously uninsured people can be covered without additional revenues either from the states or the federal government. With the exception of the controversial Oregon approach to prioritize services, other states retained existing benefits and simply set capitation rates at a level low enough to meet budgetary requirements. Even with low capitation rates and a significant amount of uncompensated services being provided, substantial shortfalls are anticipated in Tennessee.

The College has been concerned about the direction of Medicaid Section 1115 waivers based largely on its experience with the TennCare program. While ACP Chapters in other states have expressed serious concerns about the waivers in process in their states, TennCare dramatically raises a number of issues that are particularly important to internists and their patients. In the summer of 1993 the College began to examine the TennCare proposal and expressed its concerns to Health and Human Services Secretary Shalala and HCFA Administrator Bruce C. Vladeck, PhD through correspondence and in face-to-face meetings with principals and staff. College officers and staff actively pursued ACP policy objectives to improve the specific situation in Tennessee, to make recommendations that could help other states, and to ensure that the President's health care reform bill and other proposals gave states flexibility within a federal framework that ensures quality and access.

TennCare was drawn hastily by then-Governor Ned Ray McWherter without the involvement of the legislature. Legislators apparently were relieved to be unsaddled from the daunting fiscal challenges the Medicaid program presented. Almost everyone felt disenfranchised from the process--physicians, hospitals, advocates for low income beneficiaries, and beneficiaries themselves. Loud concerns were voiced about the soundness of TennCare's financing, the lack of public notice and involvement and the ability of HCFA to evaluate and monitor compliance with the waiver's "Terms and Conditions," especially as they related to plan certification. ACP expressed concern about the disruption of patient-physician relationships that occurred with the high-speed implementation schedule. In many ways, TennCare illustrated how managed care can go awry in publicly financed programs or in the private sector, under certain conditions.

The response by the administration and HCFA to the College's specific concerns has been very limited. The most tangible response is the HCFA regulation on public notice (described below). These do not have the force of law and rely on states to meet the spirit of HCFA's intent. Furthermore, the regulations were issued without allowing for a period of public comment.

We believe that there are sufficient commonalities among state reform initiatives to develop criteria that are generally applicable across-the-board. Much of the following discussion will be in the context of Section 1115 waivers but the principles apply more broadly. Extensive analysis and evaluation of these programs are now underway by the Kaiser Commission on the Future of Medicaid, the Milbank Fund, and the Robert Wood Johnson Foundation. In addition, a substantial amount of work has been done to assist advocates in making improvements to program proposals and mid-course corrections. This discussion will be
limited to those areas of greatest concern to the College.

Federal Standards for Section 1115 Waivers

The Congress and the states are seeking a new balance of power that responds both to the states' desire for more flexibility and less federal intervention and the desire of the Congress to assert its new agenda into local policy making when federal dollars are involved. The Medicaid program with its substantial state and federal interest provides a good case to test the new federalism now taking shape. As this policy tug-of-war unfolds, the guiding principle for the College is to foster state flexibility within a federal framework that ensures access and quality.

Public Notice Requirements: States must allow a sufficient time period so that meaningful public comments on significant aspects of Section 1115 waiver applications can be considered by the state before they are submitted to HCFA.

In the case of Tennessee, patients and providers were completely left out of the decision-making process as TennCare was designed and implemented. The legislature abrogated responsibility to the Governor who was finishing the final year of his term in office. The Tennessee Medical Association filed a suit against the state charging that the state did not provide advance notice nor opportunity to comment on TennCare rules and failed to allow notice of changes in payment for Medicaid. In a letter to the President, ACP stated that "the development and implementation of TennCare challenges the underlying assumption that states can be relied upon to act in good faith, competence and in a consultative manner." Similar complaints about a lack of public notice were heard from Kentucky and Hawaii.

In the fall of 1994, HCFA issued state notice procedures, outlining a process intended to facilitate public involvement and input. The Department suggested a number of processes that a state could follow including public hearings, a commission that holds public meetings, or legislation that outlines the proposal. The state can submit the plan for notification prior to submission of the waiver request or at the same time as the submission. If HCFA finds this process to be inadequate, the state can correct that by posting a notice of intent in general circulation newspapers. If the latter occurs, HCFA's time commitments on the application will be stopped until this process is completed. This notice procedure assumes that states will willingly comply with the spirit of its intent. We are skeptical after seeing the process unfold in several states where fiscal and political pressures motivated the state to act unilaterally.

The College believes that additional requirements are needed. In an amici curiae brief submitted as part of the suit brought by the National Association of Community Health Centers, the American College of Physicians, the Tennessee Medical Association, and others attribute many of the problems with TennCare to the lack of public notice and opportunity to comment. Only after the implementation of TennCare did the state publish rules setting forth

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the benefit package, eligibility standards, and other aspects of the program. We argue in the brief that the Administrative Procedures Act requires HCFA to provide "sufficient information about the factual and legal basis for the proposed demonstration to enable interested parties to make an informed 'adversarial critique' of the proposal." Prior to final approval, the Secretary should publish the Department's detailed project specifications developed during the period of negotiation with the state and allow for comment. This requirement would ensure public notification in instances where states are complying with the letter of HCFA's procedures but not the spirit.

**Phase-in of Implementation:** Implementation must be paced to allow sufficient time for managed care infrastructure to develop and for a smooth transition for both patients and providers.

In Tennessee, where managed care is in its infancy, implementation was undertaken less than a month and a half after the waiver was approved. Medicaid recipients were asked to select a Managed Care Organization (MCO) even before the waiver was approved, giving the appearance that state officials expected all plans to be automatically certified by HCFA. HCFA took little time to certify all plans, raising questions about the care taken in reviewing their qualifications.

**Monitoring Compliance:** There must be thorough and verifiable compliance with the "Terms and Conditions" by HCFA.

It was our experience in a number of states that, while the HCFA "Terms and Conditions" may have provided adequate safeguards for providers and patients, HCFA failed to evaluate compliance. For example, in Tennessee, standards for numbers, types and distribution of physicians were not enforced. In testimony before the Physician Payment Review Commission, an official with the Health Care Financing Administration acknowledged that the surge of waiver requests has placed a burden on the staff responsible for monitoring Section 1115 implementation. Ongoing state monitoring of the solvency of MCOs is essential.

**Financing:** Sound financial underpinnings must be demonstrated before waiver approval. Capitated payments should be actuarially based on analysis of utilization and enrollment expectations of the covered population.

At a time when states are complaining bitterly about the cost of Medicaid, Section 1115 waivers would dramatically expand the number of people covered. Even though hundreds of thousands of new beneficiaries are being added, budget neutrality must be achieved over a five-year period. There is some fear that several programs are front-loaded and will have difficulty reaching the 5-year neutrality requirement. One observer asked if this was health care reform or smoke and mirrors.

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HCFA has abrogated responsibility for evaluating the adequacy of capitation rates, maintaining that changes in access will reflect whether or not the rates are adequate. We believe that there is an available, empirical way to make these judgments. Capitated payments should be actuarially based on analysis of utilization and enrollment expectations of the covered population. Capitated payments should cover the costs of providing covered services, including physician practice expenses and capital costs. Even though Medicaid law requires capitation rates to be actuarially sound, there is some question concerning the degree to which HCFA reviewed the capitation method used by the states. Questions concerning the financial integrity of a number of these proposals persist.

Quality of Care: Uniform quality of care standards for existing Medicaid beneficiaries and newly covered insured must be a mandatory part of statewide demonstrations.

The systemwide drive to save health care dollars makes the challenge of maintaining quality especially difficult under Medicaid managed care. As hospitals, physicians and other health care providers experience the financial squeeze of managed care, the ability to subsidize the care of Medicaid patients lessens. Even though Medicaid covers a relatively small segment of low-income people, statewide demonstrations under Section 1115 could have a significant impact beyond the Medicaid population in both the short-term and long-term.

The contractual arrangements between providers and MCOs can have a substantial impact on the quality of care received by Medicaid beneficiaries. HCFA has not been involved in setting standards for the contracts between providers and managed care organizations (MCOs) and does not typically review the contracts as part of the waiver process. The ability of physicians to be advocates for their patients is strengthened by fair and equitable contractual arrangements with the MCOs and likewise, is weakened if the physicians are made financially or ethically vulnerable.

An evaluation of provider contracts with MCOs by the Kaiser Commission is now underway with preliminary findings expected in the spring of 1995. Researchers have found the contracts to be strikingly similar and appear to be modifications of one basic contract. There is concern that physicians are being placed in untenable financial jeopardy and the survival of their practices over the long-term is at risk.

An essential element of quality is continuity of care and a strong patient-physician relationship. This element of quality was diminished in Tennessee by the unique policy of Blue Cross/Blue Shield requiring physicians to participate in TennCare in order to remain in the Tennessee Provider Network (TPN) that includes state employees. Some physicians dropped out of the TPN when given the ultimatum by Blue Cross/Blue Shield to sign on to the unfamiliar and hastily implemented TennCare program. The disruption to many Medicaid patients has been cushioned because some physicians have continued to care for long-standing and often chronically-ill Medicaid patients without compensation. It is likely that some of the cost savings reported from TennCare is actually the result of physicians providing uncompensated care, an arrangement that cannot be sustained indefinitely. State employees have been successful in expanding their choice to include an HMO, Healthsource. This has been an
appealing alternative for some state employees who were disgruntled when their providers dropped out of the TPN. The coercive arrangement should be reversed as promised by Tennessee Governor Sundquist and its legality examined by the U.S. Department of Justice.

On paper, the quality assurance programs detailed in Section 1115 waiver applications are impressive. One observer said TennCare would need the RAND Corporation to implement its quality assurance program. Specific quality assurance standards must be backed by a strong monitoring system by HCFA that coordinates the responsibilities of the state, external review organizations, and MCOs. Making quality standards mandatory should be given serious consideration. The standards developed by HCFA, Health Care Quality Improvement Systems (HCQIS) for Medicaid Managed Care, provide one model.

Whatever quality assurance system is adopted, it should use practice pattern data -- of processes and outcomes -- as well as quality improvement methods to improve medical care. Toward that end, the College has supported legislation that requires health plans to "rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review." The College believes that the existing systems of oversight, involving routine reliance on individual case review, are ineffective, intrusive, and costly. Absent a federal law that applies across-the-board, HCFA should require MCOs to follow specific quality standards.

Individuals insured under demonstration programs should receive information on quality that is meaningful and accurate. For them to be able to use this information effectively to compare health plans, standardized performance goals and measures must be developed.

To ensure that all Americans receive the highest quality of care, it is critical to keep treatment decisions in the hands of patients and their physicians. Through rules and procedures, managed care organizations often make decisions about a patient's medical treatment. It is troubling that the so-called "utilization review" criteria by which these decisions are made are often kept secret from doctors and patients, vary by health plan, are not scientifically based, and often focus exclusively on cost and ignore issues of quality.

In addition to the faulty criteria used, these reviews focus on an individual patient cared for by a particular physician. This intrudes on the doctor-patient relationship, wastes time and money since the physician may be forced to justify his or her decisions, and most importantly, can hurt the quality of care provided to the patient.

The ACP recommends that HCFA require that utilization review criteria be disclosed to physicians and patients, that the criteria be based on reasonable, timely medical evidence, and that they be consistently applied. In addition, physicians should supervise the review decisions, including determinations of the medical appropriateness of any denial, as well as an appeals process. Finally, mechanisms should be established to evaluate the effects of the utilization review program -- including provider and patient satisfaction data.

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5 Cleaveland C. letter to Donna Shalala, Secretary of Health and Human Services, February 2, 1993.
Conclusion

In calling for the "transformation" of Medicaid and Medicare, the Speaker of the House and some committee chairs have cited "managed care" as the pathway to efficiency and value. Because the populations served do not fit the typical managed care patient profile, many issues must be addressed before capitated managed care is applied wholesale in these programs. If managed care provides preventive and coordinated care by appropriate providers in appropriate settings, low-income and elderly populations would certainly benefit. The lessons on TennCare teach us that "managed care" must be more than a means of financing care based on capitation rates set to meet a budget goal. Managed care requires an infrastructure of physicians, nurses, hospitals, and other providers who can provide care for the specific populations being covered. Factors related to age and socio-economic status should be considered. Availability of providers, solvency of health plans, and quality must be assured.
Appendix


3) Cleaveland, C., letter to Donna Shalala, Secretary of Health and Human Services, February 2, 1995.
THE MEDICAID PROGRAM AT A GLANCE

What is Medicaid?

Medicaid is the nation's major public financing program for providing health and long-term care coverage to millions of low-income people. Initially enacted in 1965 to pay for the health care of recipients of welfare assistance and certain other needy people, by 1993, 32.1 million people -- over 1 in 10 Americans -- were covered by Medicaid at a cost of $124.9 billion.

Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program financed by state and federal government and administered by the states. Federal guidelines place requirements on states for coverage of specific groups of people and benefits. States that meet the federal eligibility and benefit guidelines receive federal matching payments based on the state's per capita income. Matching rates range from 50-80% of annual outlays.

Because states establish their own financial eligibility criteria, there are large state to state variations in income eligibility thresholds.

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1993

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Who Is Covered by Medicaid?

Being poor does not automatically qualify an individual for Medicaid. Only persons who fall into particular "categories" such as people receiving cash assistance or low-income children or pregnant women are eligible. Although Medicaid is increasingly the vehicle used to expand coverage to the low-income population, it covers only 62 percent of poor Americans. Millions of uninsured low-income people remain beyond the program's reach.
Of the $124.9 billion Medicaid spent in 1993:

- Acute care services comprised less than half (46 percent) of spending.
- Long-term care services accounted for 36 percent of expenditures. Medicaid pays for half of total nursing home care and nearly one fourth of all home health spending in the United States.
- Payments for hospitals serving a disproportionately large share of indigent patients (DSH) comprised 13 percent of total expenditures.
- Payments for Medicare Part B and HMO premiums accounted for the remaining 5 percent.

How Is Care Delivered Under Medicaid?

As states try to expand insurance coverage to low-income people, improve access, and contain costs, many are adopting new care delivery and financing arrangements under Medicaid. While traditional fee-for-service still predominates, an increasing number of states are enrolling their Medicaid populations in managed care programs.

As of June 1994, 8.1 million Medicaid beneficiaries were enrolled in managed care, up dramatically from 2.7 million in 1991. Medicaid managed care models range from HMOs using prepaid capitated care to loose networks contracting selected providers for discounted services and gatekeeping to control utilization. States have initially targeted AFDC populations for enrollment rather than the aged or disabled.

Recently states have been using waivers of the federal statutory requirements of Section 1115 of the Social Security Act to undertake statewide, mandatory managed care demonstration programs and broaden coverage. Presently, seven states (AZ, OR, TN, HI, KY, RI, and FL) have been granted waivers and eight more have applied and are awaiting approval from HCFA.

Long-term care is a major component of Medicaid. Presently, over three-fourths of Medicaid spending for long-term care is on institutional services. States can provide long-term care services through Home and Community-Based Services (HCBS) waivers. These programs provide opportunities for states to shift service delivery away from costly nursing home care to less expensive community based services when appropriate. Although all states have HCBS waivers, most projects are limited in scope and the population served remains small.

Recent Beneficiary and Expenditure Growth

After remaining relatively stable for many years, Medicaid enrollment has risen dramatically in recent years, reaching 32.1 million in 1993 -- up considerably from 22.3 million in 1988. Growth has been mostly attributable to legislation enacted by Congress to expand Medicaid coverage to low-income pregnant women and young children, as well as an increase in the number of blind and disabled beneficiaries.

Medicaid has become a major budgetary commitment for both the federal and state governments. In recent years, Medicaid expenditures have escalated rapidly, more than doubling between 1988 and 1992. The rise in spending in that period was attributable to a combination of health care inflation, increase in state use of alternative financing mechanisms, and a rise in enrollment. Only a small fraction of spending growth was attributable to the expansions in coverage of low-income pregnant women and children.

The rate of growth in Medicaid spending has now dropped back to historical levels -- 11 percent from 1992 to 1993 -- suggesting that legislation enacted to limit states' capacity to raise funds through provider taxes and donations has had a substantial effect in slowing spending growth.

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Medicaid has been consistently shown to improve access to health care for the population it serves. Low-income people without insurance coverage have been found to use care at considerably lower levels than those with Medicaid coverage. As Medicaid struggles to meet multiple responsibilities under severe fiscal pressure, it continues to play a critical and expanding role providing acute and long-term care services to our nation's most vulnerable people.
January 17, 1995

The Honorable Richard M. Daley
Mayor, City of Chicago
City Hall, Room 507
121 N. LaSalle
Chicago, IL 60602

Dear Mayor Daley:

As your advisor on public health matters, I would like to stress my serious concerns about the Medicaid restructuring passed by the General Assembly in July and described in the Illinois Department of Public Aid’s waiver proposal to the U.S. Department of Health and Human Services Health Care Financing Administration. Given that over 600,000 Medicaid recipients live in Chicago, I am sure that you are committed to this population receiving quality and accessible health care. I am fearful that this will not occur under the State’s proposed MediPlan Plus. A summary of my concerns follows:

1. The State’s ability to implement a massive Medicaid restructuring is quite questionable. A 1990 GAO study of HMO’s found significant shortcomings in IDPA’s managed care program. Many of the issues have never been addressed by IDPA. The Chicago Department of Health reports that large numbers of managed care enrollees, because of dissatisfaction with their managed care providers, seek care at public clinics and federally-funded community health centers that cannot deny care.

2. The State’s goal of enrolling 70%-90% of Cook County’s nearly 700,000 eligible clients within one year is totally unrealistic. For that goal to be met, managed care capacity would have to triple. IDPA has had trouble attracting most Illinois HMOs to the Medicaid program, and preliminary evidence does not suggest that task will be made any easier through MediPlan Plus.

3. The monitoring mechanisms are severely deficient. IDPA has allocated insufficient staff to monitor and evaluate program effectiveness and quality of care, and there is no evidence that adequate data processing and management information systems have been - or will be - put into place to properly monitor and administer such a large and complex program as MediPlan Plus. Due to persistent concerns that many of us in Illinois have had regarding the quality of care offered by some of the currently participating HMO’s and private providers, it is imperative that any Medicaid restructuring proposal explicitly delineate quality assurance and monitoring mechanisms that go beyond existing systems.
4. *MediPlan Plus* has the potential to weaken the public health system in Illinois, as there is an expectation that managed care entities will assume more responsibility for assuring preventive services. It is unrealistic to expect managed care entities to take on preventive care. Any decrease in state funding for preventive services essentially constitutes an unfunded mandate, as local health department departments are required by law to provide prevention programs and will have to continue to do so for managed care patients without the benefit of state funding.

To date, HCFA has raised many issues to IDPA and it is evident that they are scrutinizing Illinois’ application very carefully. However, in this new political climate, we cannot make any assumptions on the outcome of their review.

The Board appreciates your efforts in assuring that the State adequately addresses the concerns raised above and others raised by Commissioner Lyne and other health providers in Chicago before DHHS approves the State’s waiver.

Thank you.

Sincerely,

Whitney W. Addington, MD
President

cc: Commissioner Lyne
    Members, Chicago Board of Health
February 2, 1995

The Honorable Donna E. Shalala
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Madam Secretary:

On behalf of the 83,000 physician members of the American College of Physicians, I am writing to inform you of an alarming case of potential patient abuse by TennCare. This case highlights critical ethical and clinical issues that must be addressed as managed care is relied on more and more to contain health care costs in the private sector as well as by states through Section 1115 waivers. We support efforts to expand coverage and experiment with new delivery systems at the state level, but only with appropriate federal standards and oversight to protect patients whose options are limited by poverty or the circumstances of their employment. As you must know, the ACP has repeatedly voiced its concerns regarding significant shortcomings of the TennCare program and its rush to implementation.

The patient in question is being cared for by a hematologist, Dr. Winston Caine who is not a TennCare participant, and is hospitalized at Erlanger Hospital for sickle-cell anemia. This is a life-threatening situation characterized by severe, generalized pain. She is enrolled in the Phoenix MCO, one of several newcomers providing services under TennCare. Hospitalization is critically necessary for pain control and to safeguard life during a dangerous clinical crisis. Because of the very real potential for drug overdosing resulting in severe injury or death, or drug addiction, these patients must be hospitalized until their crisis resolves. The MCO instructed the provider to discharge the patient with a prescription of demerol. This was opposed by the physician because it would place the patient’s life in grave danger. Accepted medical protocol for this condition would not support a decision to discharge this patient.

There are elements in this case that have broad implications for patients who are now enrolled in managed care under Section 1115 and future enrollees:

--Because managed care is driven by cost considerations, the potential for patient abuse is ever present. Managed care organizations must be carefully certified and monitored by the state and HCFA. This is especially important for managed care organizations that do not have a longstanding performance track record such as Phoenix.
--Medicaid patients under managed care are especially vulnerable to system shortfalls. They are less likely to have an established relationship with a primary care physician who would act as their advocate and generally are less experienced in navigating bureaucracies to resolve grievances. Without the care and attentiveness of this particular physician, the patient would have been unaware of the dangers of being discharged under these circumstances.

--Finally, this case presents very graphically the ethical dilemma faced by physicians who are instructed by a managed care organization to act in a way that is utterly contradictory to fundamental precepts of patient care. Physicians must be sensitive to cost considerations but never place the patient at risk in order to save money for the stockholders. Hospitalization was necessary in this case to protect life. It would have been untenable for the physician to follow the MCO’s instructions.

We urge you to investigate this case and examine the clinical and ethical ramifications it presents for the entire Section 1115 waiver program. Quality of care must be an integral part of managed care for all patients under Medicaid, Medicare or in the private sector.

Sincerely,

Clifton R. Cleaveland

Cc: Bruce C. Vladeck, PhD.
    The Honorable Don Sundquist
REFORMING MEDICAID:
ESSENTIAL STANDARDS FOR STATE WAIVERS
Summary of Key Points

- States are seeking to curb the cost of Medicaid and expand coverage through Section 1115 (a) waivers administered by the Health Care Financing Administration (HCFA). To date, HCFA has approved seven waivers and is processing an additional seven. Soon a substantial portion of the major medical-type coverage under Medicaid will be part of these statewide "demonstration" programs.

- Based largely on its involvement with the TennCare demonstration, the College has been increasingly alarmed by the way these waivers are being implemented. The Tennessee program was designed hastily with little public consultation and rushed to implementation. In a state where managed care is in its infancy, Medicaid beneficiaries and thousands of uninsured were enrolled in managed care organizations within weeks of the waiver approval.

- This paper distills the lessons learned from the Tennessee experience and suggests a number of standards that should be met by states seeking Section 1115 waivers. The criteria could also be adapted to apply under different scenarios such as replacing Medicaid with block grants.

- The guiding principle for the ACP is that reform proposals should give states flexibility within a federal framework that ensures quality and access. These criteria are offered as a tool for ACP chapters to evaluate proposals being considered in their states and to help clarify an appropriate federal role in statewide reforms, whether or not they are implemented under Section 1115 demonstration projects.

- The development of criteria should not be seen as an endorsement of the current Medicaid program or any approach that creates a two-tiered system of health care. These criteria are developed with a recognition that the states and the federal government are operating under significant fiscal pressures and that the current political environment is not receptive to an increased federal role in health care.

- The criteria include:

---Public Notice Requirements: States should be required to solicit comments on significant aspects of Section 1115 waiver applications before they are submitted to HCFA.

---Phase-in of Implementation: Implementation must be paced to allow sufficient time for managed care infrastructure to develop and for a smooth transition for both patients and providers.

---Monitoring Compliance: There must be thorough and verifiable compliance with the "Terms and Conditions" by HCFA.

---Financing: Sound financial underpinnings must be demonstrated before waiver approval. Capitated payments should be actuarially based on analysis of utilization and enrollment expectations of the covered populations.

---Quality of Care: Uniform quality of care standards for existing Medicaid beneficiaries and newly covered insured must be an integral part of statewide demonstrations.