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VIA FEDERAL EXPRESS

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

Dear Secretary Shalala:

In seeking the approval of the Secretary of Health and Human Services for TennCare, the State of Tennessee is once again attempting to avoid its legal responsibility to share in the cost of furnishing medical assistance to Medicaid recipients.

The Governor of Tennessee proposed TennCare as a replacement for what he has aptly described as a "hocus-pocus" tax. See Governor Ned McWherter, Address to Tenn. Gen. Assembly (Apr. 8, 1993). The focus-pocus tax -- nominally the Services Tax -- will expire on December 31, 1993, "if the State of Tennessee receives, by December 30, 1993, a federal Medicaid waiver pursuant to Section 1115(a) of the Federal Social Security Act."¹ 1993 Tenn. Pub. Acts. 492 § 1.

Tennessee has been one of the most aggressive states in adopting provider donation and tax programs, euphemistically referred to as funding mechanisms.² Although born elsewhere, these funding mechanisms were nurtured and raised to maturity in Tennessee. For federal fiscal year 1993, Tennessee will receive more provider-specific tax revenue than any other state. See Bond Buyer's Public Finance Watch 4, 6 (Mar. 15, 1993). In the end, TennCare is nothing more than a continuation of the very beggar-thy-neighbor fiscal policies Congress designed Medicaid to constrain.

¹ By the terms of the tax's own enabling legislation, the Services Tax will be "null and void" from its inception if the revenues derived from it fail to qualify for federal financial participation. See 1992 Tenn. Pub. Acts 913 § 15. The Health Care Financing Administration is still reviewing the permissibility of the Services Tax.

² "At first, [state] legislative leaders were calling it a scam, they then began calling it a scheme, and now they are calling it a funding mechanism." See Office of the Inspector General of the U.S. Department of Health and Human Services, The Use of Medicaid Provider Tax and Donation Programs Needs to be Controlled at 2 (July 1991) (quoting a state legislative staffer).

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TennCare, however, is fatally flawed. It meets neither the legal requirements of section 1115 of the Social Security Act, 42 U.S.C. § 1315, nor the congressional objectives underlying it. To approve TennCare, the Secretary would have to overlook that its capitation rate is actuarially unsound. Moreover, the Secretary would have to do what she cannot do, i.e., waive the statutory limitations on federal financial participation (FFP).

Although Tennessee supports its request with the rhetoric of global budgeting, market incentives, managed care, preventive care incentives, welfare disincentives, cost sharing, and quality control, TennCare is not financially viable. Providers participating in TennCare would be caught between the horns of the dilemma. They would either have to reduce dramatically the quality of care to Medicaid recipients,³ engage in massive revenue shifting, or some combination of both.

Were this research and demonstration project request to come from any state other than Tennessee, no one can doubt that it would not be taken seriously.⁴ The Tennessee Medicaid providers we represent urge the Secretary to require Tennessee to fund TennCare adequately. If Tennessee refuses, the Secretary must deny Tennessee's request. Even if Tennessee complies, the Secretary should nevertheless require Tennessee to phase-in TennCare.

I. TENNCARE'S CAPITATION RATE IS ACTUARIALLY UNSOUND

As Tennessee acknowledges: "Because of the nature of the federal dollar commitment sought, it is most critical that the Year One estimates be valid." TennCare Proposal at 81. Unfortunately, the state's estimates miss the mark.

It is critical that the Secretary require Tennessee to account for actuarially relevant factors and provide sufficient support for its rate setting assumptions. The state appears to seek to cover not only its current Medicaid populations with both additional benefits and extended coverage periods, but also to extend coverage to the uninsured with only an 8.3% increase in federal funds.

The rate structure, however, only partially funds both groups and will only exacerbate current cost shifting. Half a loaf is still half a loaf, no matter how it is cut. Accurately determined rates must include the impact of accrued liabilities, benefit changes, and increases

³ Given the absence of a resource-based malpractice standard, providers might run a significant risk were their quality reductions too dramatic.

⁴ TennCare's genealogy cannot be gainsaid. Assuming Tennessee's earliest donation and tax programs were a "scam," e.g., Office of the Inspector General of the U.S. Department of Health and Human Services, The Use of Medicaid Provider Tax and Donation Programs Needs to be Controlled at 2, and the Services Tax the "Son of Scam," e.g., Tenn. J. at 3 (Mar. 30, 1992), TennCare is the "Grandson of Scam."

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in coverage if TennCare and its managed care organizations are to be financially viable entities. In the absence of such, TennCare is a prescription for failure.

A. TennCare's Capitation Rate Is Artificially Low

Tennessee has provided no documentation to support the \$1,474.16 per capita cost for TennCare's base year, precluding both the Secretary and the public from subjecting its proposal to serious scrutiny.

1. Tennessee Has Significantly Overstated the Number of Medicaid Eligibles

To calculate TennCare's per capita rate, Tennessee used state fiscal year 1992 MR-0-95 to determine that the number of Medicaid eligibles is 878,981. For the same fiscal year, however, the Tennessee General Assembly Fiscal Review Committee concluded that 654,719 were Medicaid eligible, *see*, Attachments A and B at 34, which produces a per capita rate of \$1,864.51⁵ -- a per capita difference of \$330.35. Assuming TennCare has no more than 1 million enrollees, Tennessee has understated TennCare's cost by one-third of a billion dollars.

2. Tennessee's Cash Accounting Method Understates TennCare's Cost

TennCare's capitation rate appears to have its origin in Tennessee's cash accounting methodology. Nevertheless, when one uses Tennessee Medicaid's only annual cash report, MR-0-95, replicating the rate is still not possible.

Tennessee's cash method of accounting is misleading. When, as here, this method is not adjusted it becomes grossly misleading.

In SFY '92 MR-0-95, Tennessee uses a cash method of accounting to report eligibles and recipients, and accumulate their enrollee months within the eligibility category they are found at the time the report is generated.⁶ Accordingly, Tennessee fails to accurately attribute enrollee months to the eligibility group for which they are reported, in turn inaccurately stating the true outlays related to the various categories of medical assistance.

⁵ This per capita rate closely approximates the per capita rates that similar Southern states, such as Kentucky, report.

⁶ Reporting eligibles in this manner provides only a snapshot of one's eligibility, not the requisite moving picture. For example, a handicapped child who at the beginning of a state fiscal year becomes eligible under the Supplemental Security Income (SSI) program and subsequently loses SSI status because of a change in parental income may nevertheless retain eligibility because of his poverty level income status (PLIS). Tennessee would report all expenditures in its MR-0-95 report related to the child within the PLIS category, masking the presence of a handicapping condition, a significant actuarial factor in determining accurate and adequate capitation rates.

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MR-0-95 does not reflect all financial activity affecting the cash reporting of the state. MR-0-95 omits critical outlays, e.g., hospital pass-through payments, as well as other adjustments, e.g., cost report settlements, pharmacy rebates, and certified public expenditures. See generally Fiscal Review Committee's Annual Fiscal Review Report to the Tennessee General Assembly (adjusting total cash outlays for SFY '92) at Attachment B.⁷

Tennessee's failure to use available accrual accounting reports, Tenn. MR-0-80 and -90, to develop a per capita rate is inexplicable. Although MR-0-80 and -90 do not total expenditures for certain eligibility groups,⁸ analysis of the reports demonstrates that the proposed capitation rate is artificially low. By both excluding (Accrual 1),⁹ see Attachment C, and including (Accrual 2),¹⁰ see Attachment D, the untotaled expenditures and the eligibles and eligible months related to these untotaled expenditures, one can obtain a more accurate projection of the per capita rate.

Accrual 1 more closely approximates the Fiscal Review Committee's determination of the number of Medicaid eligibles. Accrual 2 more closely approximates the Bureau of Medicaid's determination of the number of Medicaid eligibles. As shown in Table 1,¹¹ when the effect of the dually eligible on the capitated costs is excluded, the deficiencies of the proposed rate are more dramatic.

⁷ Only by using the Fiscal Review Committee's Annual Fiscal Review Report can Tennessee's proposed capitation rate be replicated. Unfortunately, Tennessee has not reflected in its research and demonstration project request the need for this report.

⁸ The absence of totals likely indicates that expenditures for certain subgroups of eligibles are also reported within another category.

⁹ Accrual I equals all expenditures for all Medicaid eligibility categories for which Tennessee reports totals.

¹⁰ Accrual II adds eligibles and eligible months for which Tennessee does not report totals. Accrual rates have not been adjusted to reflect the effect of unallocated expenditures, pharmacy rebates, cost-settlements, and certified public expenditures.

¹¹ We have adjusted the costs in all tables to reflect capital and teaching pass-throughs, and the costs do include any amounts related to noncovered services, e.g., long-term care, HCBS waivers, and QMB-only expenditures.

**TABLE 1: EFFECT OF EXCLUDING DUALY INSURED MEDICAID ELIGIBLES
 ON TENNCARE SFY '92 PER CAPITA COSTS BY STATE ACCOUNTING
 METHODOLOGY**

	ACCRUAL 1 Per Capita Cost	ACCRUAL 2 Per Capita Cost	TennCare Per Capita Cost
All Covered Eligibles	\$ 1,512.28	\$ 1,412.32	\$ 1,474.16
Medicaid Only Eligibles	\$ 1,677.09	\$ 1,524.26	\$ 1,491.73

Accrual 1 produces a per capita rate based on accrued liabilities of \$1,512.38, 2.6% higher than Tennessee's proposed rate. Accrual 2 produces a rate of \$1,412.32, 4.2% less than the proposed rate. Since, however, "Medicare cost sharing are outside of the demonstration," HCFA Tennessee's Response to HCFA's Questions at 3, these costs and eligibles must be excluded. The effect of this exclusion is to increase all per capita rates, both cash and accrual, above that proposed by Tennessee.

The use of per capita expenditures for comparison and budgeting, however, is grossly misleading. The accepted actuarial approach is to develop rates that reflect costs related to the actual months of participation in the program, calculating a per-member-per-month (PMPM) rate, as shown in Table 2.

**TABLE 2: EFFECT OF EXCLUDING DUALY INSURED MEDICAID ELIGIBLES
 ON TENNCARE SFY '92 PER MEMBER PER MONTH COSTS BY STATE
 ACCOUNTING METHODOLOGY**

	ACCRUAL 1 Per Member Per Month Cost	ACCRUAL 2 Per Member Per Month Cost	TennCare Per Member Per Month Cost
All Covered Eligibles	\$ 155.18	\$ 149.60	\$ 140.45
Medicaid Only Eligibles	\$ 176.35	\$ 165.47	\$ 144.59

As Table 2 demonstrates, Tennessee's cash methodology significantly understates the cost of care when, as is appropriate, the dually-eligible are excluded. The state, however, appears to have recognized the accepted actuarial rate-setting method in its September 2, 1993, letter to potential TennCare managed care organizations, e.g., Attachment E, proposing statewide PMPM rates. Table 3 compares the proposed rates with those developed in the Accrual 1 and 2 analyses.

TABLE 3: COMPARISON OF TENNCARE PROPOSED RATES FOR SFY '94 BY STATE ACCOUNTING METHODOLOGY

	SFY '94 PER MEMBER PER MONTH ACCURAL 1	SFY '94 PER MEMBER PER MONTH ACCURAL 2	SFY '94 PER MEMBER PER MONTH CASH	SFY '94 PER MEMBER PER MONTH TennCare PROPOSED RATE	PER MEMBER PER MONTH VARIANCE CASH (-) / ACCURAL 2
Aged 65 + NQMB	\$86.51	\$86.30	\$108.00	\$67.19	(\$ 16.11)
Medicaid QMB	\$70.27	\$70.33	\$102.93	\$80.97	\$ 10.64
Blind & Disabled < 1 Year	\$325.68	\$335.69	\$340.54	\$315.74	(\$ 19.95)
Ages 1 -13	NA	NA	NA	\$145.25	NA
Ages 14 - 44 Male	NA	NA	NA	\$50.60	NA
Ages 14-44 Female	NA	NA	NA	\$92.80	NA
Ages 45 - 64 AFDC PMPM	NA	NA	NA	\$153.32	NA
	\$128.14	\$145.29	\$115.54	\$161.12	NA
				NA	NA

Based on Table 3,¹² it is obvious that Tennessee has underfunded those eligibles for which the managed care organizations will be responsible and potentially overfunded the PMPM rate for the dually-eligible for whom Tennessee appears to be responsible for Medicare cost-sharing payments.¹³

Both accrual and cash rates include the frozen hospital capital and teaching pass-throughs reflected below in Table 4.¹⁴

¹² The rates are adjusted using the state's proposed inflation factor of 5.5% (compounded).

¹³ We assume that the blind and disabled rate would apply irrespective of age to all SSI and medically needy recipients identified as such, but not apply to higher income blind and disabled look-alikes.

¹⁴ The source for Table 4 is the Office of the Tennessee Comptroller's SFY '92 L-SORT file.

TABLE 4: TENNESSEE SFY '92 HOSPITAL PASS-THROUGHS

	DSH	Capital & Teaching	TOTAL
GENERAL ACUTE	\$410,573,691	\$92,079,111	\$502,652,802
PSYCHIATRIC	9,372,801	4,370,886	13,743,687
TOTAL	\$419,946,492	\$96,449,997	\$516,402,489

B. TennCare's Capitation Rate Fails To Reflect Existing Court Orders And Significant Programmatic Changes That TennCare Would Effectuate

1. Pending Court Actions

Tennessee has failed to apply an inflation factor to account for the effect of existing federal court orders that will affect the cost of TennCare. E.g., Bailey v. Tennessee Dept. of Public Health, No. 3:79-3107 (M.D. Tenn. Aug. 31, 1992) (agreed order granting non-emergency transportation); and Daniels v. Luna (agreed order requiring notice of denied claims and opportunity for hearing). Tennessee has also failed to account for one significant pending federal court action, Brewster v. White, No. 3:91-106 (M.D. Tenn. filed December 30, 1991) (challenging OB access and payment).

2. Significant Programmatic Changes

Tennessee has failed to apply any inflation factor to reflect the effect of continuous full-year coverage for eligibility categories that have historically participated in Medicaid for less than a full state fiscal year. Table 5¹⁵ illustrates these differences in the largest eligibility categories, Aid to Families with Dependent Children (AFDC) and AFDC-related eligibles.

¹⁵ The source for this table is Tennessee Medicaid Report SFY '92 MR-O-95 (July 17, 1992) (reported statistics are for eligibles at the time the state generated the report; coverage months may include eligible months derived from periods spent in other eligibility categories).

**TABLE 5: MEDICAID COVERAGE BY SELECTED ELIGIBILITY GROUP
 TENNESSEE STATE FISCAL YEAR 1992**

ELIGIBILITY GROUP	TOTAL ELIGIBLES	% WITH FULL- YEAR COVERAGE	AVG. NO OF MONTHS PARTIAL COVERAGE
AFDC W/O CASH ASST	43,279	83.9	6.4
AFDC WITH CASH ASST	242,906	79.2	6.5
OBRA '86 CHILD < 18	105,160	62.9	6.3
MEDICALLY NEEDY/AFDC	80,688	53.9	5.8
OBRA '86 MOMS	<u>32,793</u>	<u>42.5</u>	<u>5.9</u>
	568,699	70.8	6.2

As Table 5 illustrates, only 71% of the AFDC and AFDC-related eligibles in SFY '92 were eligible for the full fiscal year. Tennessee's failure to account for the effect of full-year coverage under TennCare seriously understates the TennCare's cost.

In addition, Tennessee failed to account for the effect on the capitation rate of TennCare's lifting the following benefit restrictions on services to recipients over the age of twenty-one:

- 24 Physician Office Visits Per Year
- 7 Prescriptions Per Month
- 30 Lab and X-Rays Per Year
- 30 Outpatient Hospital Visits Per Year
- 60 Home Health Visits Per Year

TennCare's capitation rates reflect no inflation factor to account for any increases in services in a state that has failed to meet the federally mandated early and periodic screening, diagnosis, and treatment (EPSDT) targets. Tennessee also failed to account for the effect of the required EPSDT outreach and tracking it proposes to require of the managed care organizations. These costs are reflected in the Medicaid administration cost center and Tennessee has not included them in its base-year calculations.

Nor has Tennessee reflected the payment changes and increased service levels mandated by the OBRA '89 EPSDT Amendments. Tennessee has neither performed the necessary payment studies nor implemented any increase in pediatric payment rates since 1986 (based on 1984 charges) as mandated by OBRA '89. HCFA rejected Tennessee's pediatric payment State Plan Amendment, but permitted the state to reschedule its appeal of the HCFA decision for over 18 months. Recently, Tennessee withdrew its appeal in anticipation of approval of the TennCare Proposal by HCFA.

Tennessee has never advertised the covered services increases mandated by the EPSDT provisions of OBRA '89. Moreover, Tennessee requires allied health professionals, e.g.,

psychologists, to bill through another provider, either a physician or a mental health center. Tennessee Medicaid covers speech and audiology services only through the Title V inter-agency agreement and are not part of MMIS. Physical therapy is restricted to a very few clinics or through home health agencies in which case the child must meet the test for a skilled home health nursing visit as well.

Obviously, Tennessee has not warmly embraced the statutory requirement that states pay for EPSDT services "whether or not covered by the state plan" if performed by health care professionals "licensed pursuant to state law." See 42 U.S.C. § 1396d(r). The managed care organizations would not be able to withstand demands from these professionals for inclusion in TennCare pursuant to the mandated TennCare EPSDT provision.¹⁶

C. Tennessee Has Improperly Reduced The Already Artificially Low Capitation Rate

Tennessee has applied the following offsets to the proposed per-member-per-month capitation rate:

Local Government Contributions	(\$ 2.35)
Charity Care	(\$27.96)
Copayments	<u>(\$ 5.35)</u>
TOTAL	(\$35.65)

1. Local Government Contributions

Tennessee's four metropolitan counties are the primary contributors of local government contributions, and all of their contributions go directly to a few county hospitals and local health departments. Although Tennessee originally proposed that these contributions would be deducted from the capitation rate for the entire geographic area in which the contributions occur, it now appears that Tennessee will spread the local contributions evenly across the state. The effect of such a policy would be to protect a few providers from the offsets that should accrue from the full benefit of the contributions they receive. In contrast, the capitation rates of the other providers (receiving no local government contributions) are unfairly reduced.¹⁷

¹⁶ Any adjustments to the rate structure to reflect the OBRA '89 requirements would obviously force TennCare's expenditures to exceed the projected maximum growth rate of 8.3%.

¹⁷ Tennessee has no authority to require the continuation of such contributions.

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2. Charity Care

Assuming arguendo that charity care would be eligible for FFP, Tennessee has improperly spread the charity care offset against the proposed statewide rates.¹⁸

In view of the announced rate structure, provider charity should be renamed managed care organization charity because it is from the managed care organizations that it will be collected. There exists no reporting source in the state, other than individual IRS Income Tax forms that can be used to estimate the amount of charity care physicians and others give. Much of the losses reported by physicians, and similarly hospitals, and other providers, are contractual adjustments from PPOs and other coverage and discount arrangements with third-party insurers.

3. Copayments

Tennessee also proposes an offset it estimates providers would receive in recipient copayments. The predominant source of this cost-sharing are the TennCare enrollees whose incomes exceed 200% of the federal poverty level. Nevertheless, it remains to be seen whether the lure of TennCare will be sufficient to induce these higher-income persons to enroll. By offsetting projected payments from the capitation rates, Tennessee shifts the burden of the cost-sharing across all TennCare enrollees, the majority of whom - those at 100% or less of the federal poverty level - have no cost-sharing obligations of any consequence, by reducing the funding available for their care.

4. Additional Potential Offsets

In response to a question pertaining to the Children's Plan and services for the chronically mentally ill, Tennessee said:

Managed care organizations will be asked to contract with the entities responsible for providing these services to assure that the individuals receiving these services experience no disruption in their care.

¹⁸ Although Tennessee requests FFP for the amount it otherwise would pay hospitals as a disproportionate-share adjustment, Tennessee's response to HCFA Questions at 6, much of the DSH payment is for charity care. In contravention of federal law, Tennessee's DSH methodology permits recognition of Medicare bad debts, discounts, and charity. E.g., The Joint Annual Report for Hospitals at Attachment F (no distinction between as to the sources of bad debt and charity and no information on discounts).

It appears Tennessee seeks to garner FFP for the value of the charity-like DSH payments. The real source of hospital charity under TennCare will be the indemnity health plans to which Tennessee would shift the uncompensated costs produced by TennCare.

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Tennessee's Response to HCFA's Questions at 3. Such a requirement essentially places managed care organizations at risk for the actions of a third party, violating the very principles of managed care. Tennessee has told at least one community mental health center that this requirement will be met by offsetting the capitation rate for individuals in an institute for mental diseases by approximately \$22 PMPM.

III. THE SECRETARY MAY NOT WAIVE THE FEDERAL FINANCIAL PARTICIPATION REQUIREMENTS

A. The Secretary May Not Regard As A State Expenditure Costs That Tennessee Would Not Incur

42 U.S.C. § 1315(a)(2) permits the Secretary to regard as a medical assistance expenditure otherwise nonincludable costs. For example, the Secretary could so regard Tennessee's proposed medical assistance payments for the uninsured who exceed the income limitations of 42 U.S.C. § 1396b(f).¹⁹

Tennessee asks the Secretary to do more, however. Specifically, Tennessee asks the Secretary to regard as an expenditure costs Tennessee would not incur! Among other things, Tennessee seeks FFP for \$595.5 million in charity care Tennessee says providers would otherwise give but for the existence of TennCare. See TennCare Proposal 82 and 96.

While it is one thing to regard as an expenditure otherwise nonincludable costs, it is quite another to so regard nonincurred costs.²⁰ That 42 U.S.C. § 1315(a)(2) authorizes the Secretary to regard nonincurred costs as a state expenditure is -- shall we say -- a novel idea.

For the same reasons, FFP would be unavailable for the amount providers would receive from TennCare recipients, as well as amounts they would receive directly from other government entities.²¹

¹⁹ Although § 1315(a)(2) also gives the Secretary authority to include as an expenditure Tennessee's cost attributable to institutions for mental diseases, it would be imprudent for her to do so given the long history of strenuous congressional objection to the federal government's paying for such costs.

²⁰ Given providers would already be receiving payment for the medical assistance they would be giving those who otherwise would be uninsured, Tennessee can hardly argue that the \$595.5 million payment reduction is an expenditure the state would incur.

²¹ Were, however, local government subsidies to go directly to the state and be available to providers generally, Tennessee would be able to certify the subsidies as public expenditures for which FFP is available.

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B. The Secretary May Not Waive The Limitations On Federal Financial Participation

Even were Tennessee to spend \$595.5 million for charity care (not otherwise included as medical assistance payments for the uninsured that are not eligible for Medicaid), its reducing the TennCare payment rates accordingly would ipso facto require an FFP reduction. 42 U.S.C. § 1396b(w)(1)(A) requires the Secretary, in determining FFP, to reduce the amount a state spends on medical assistance by the revenue the state receives from such provider transfers.

Neither the text nor legislative history of 42 U.S.C. § 1315(a)(2) offer any support for permitting a state to avoid its fiscal responsibility for its medical assistance program. Section 1396b(w)(1)(A) requires expenditure reductions reflecting the revenue a state receives from impermissible provider transfers. In contrast, section 1315(a)(2) has nothing to do with expenditure reductions. It pertains solely to the Secretary's waiving compliance with what may be included as an expenditure in the first instance.

Similarly, there is nothing in the text or legislative history of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, § 2, 1991 U.S.C.C.A.N. (105 Stat.) 1793-99 (codified at 42 U.S.C. § 1396b(w)), that would remotely support the notion that the Secretary has authority to waive the statutory FFP limitations on provider-related donations and nonbroad-based health care related taxes. See, e.g., H.R. Conf. Rep. No. 409, 102d Cong., 2d Sess. (1991), reprinted in 1991 U.S.C.C.A.N. 1441.

The policy underlying the nonwaivability of the statute is obvious: even assuming TennCare were otherwise meritorious, Tennessee must convince its own taxpayers to dig deeper into their pockets if Tennessee is to dig deeper into the pocket of the United States.

IV. TENNESSEE'S HEALTH CARE INFRASTRUCTURE IS INADEQUATE TO SUPPORT TENNCARE

Only Tennessee's AFDC Medicaid eligibles currently have available to them a managed care program, the Tennessee Managed Care Network, a Medicaid HMO that began in 1984, and currently serves 30,000 individuals in selected counties in the state. Blue Cross and Blue Shield of Tennessee operates a statewide PPO and has indicated that it has the capacity to serve all TennCare eligibles even though it currently does not use its PPO primary care providers as gatekeepers. Tennessee is giving Blue Cross three years to install the gatekeeper function.

Managed care infrastructures, necessary to serve up to 1.775 million Tennesseans currently do not exist and will have to be assembled and negotiated, and contracts executed by January 1, 1994. Although the state distributed draft contracts in early August to potential managed care organizations, the state has yet to respond to their questions. Before

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such infrastructures will be created and contracts executed, however, several questions must be answered.²²

A. Insufficiency Of Providers.

The Tennessee Health Facilities Commission reported in its profile entitled "Tennessee's Health: Picture of the Present Part I, 1992," that seventy-five of Tennessee's ninety-five counties are obstetrical shortage areas and thirty-four are primary care shortage areas, with three additional counties - the state's three metropolitan counties - being partial primary care shortage areas. Furthermore, twelve counties are without a hospital and twenty-five counties have no hospital providing obstetrical services. See Attachment G.

It is difficult to determine from the state's response to HCFA's question on physician participation in TennCare just how many of Blue Cross's Physician Network are specialists, but we suspect that many are and that the majority of the Blue Cross Network practices are in urban locations. Many of the 2,095 primary care physicians participating in Tennessee Medicaid reported on page 16 of Tennessee's Response submit between one and five claims per month. Although the "State also assumes that the managed care organizations will use extended role nurse practitioners and physician assistants when possible," Tennessee's Response to HCFA's Questions at 16, the Blue Cross Network does not pay mid-level practitioners, including certified nurse midwives. Of even greater concern is the failure of Blue Cross to pay other related healthcare practitioners, e.g., physical therapists, psychologists and speech and hearing audiologists, practitioners needed by many of the disabled.

It is difficult to see just how TennCare would assure that all TennCare enrollees are within fifteen minutes of a medical provider and have access to 24-hour, 7-day-per-week care as stated in the Proposal given the current distribution of providers, and just how managed care organizations would recruit the additional physicians needed given TennCare's inadequate rate structure.

B. Ability Of Managed Care Organizations To Enforce Negotiated Provider Payment Rates On Nonparticipating Providers.

Tennessee has adopted a Uniform Administrative Procedures Act, which requires that any state entity restricting public access or payments must do so only on promulgation of regulations explicitly setting forth all restrictions and requirements. The state, however, has told HCFA:

The State does not anticipate the need for extensive rules for the TennCare program. We believe that the delivery of health care should be delivered in the

²² The absence of a final contract has made it impossible for managed care organizations to give meaningful comments to the state or the Secretary.

The Honorable Donna E. Shalala
September 14, 1993
Page 14

private market place with minimal regulation from the State. Most of the TennCare requirements will be spelled out in the contracts between the State and the Managed Care Organizations. The few rules that may be necessary are currently being developed.

See Tennessee's Response to HCFA's Questions at 22.

A mere contract between two parties generally does not bind a third party.

C. Capital And Teaching Pass-Throughs.

Currently, payments of capital and teaching pass-through are made outside of the MMIS in monthly payments representing 1/12th of the established amount for each facility. The state has not presented any information in their proposal as to how these payments will be made.

V. THE SECRETARY SHOULD NOT WAIVE COMPLIANCE WITH THE BOREN AMENDMENT

In 1981, Congress enacted the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173(a)(1)(B)-(C), 1981 U.S.C.C.A.N. (95 Stat.) 357, 808-09, amending the Medicaid statute's payment provisions for inpatient hospital services to give states the same flexibility in developing payment methodologies for hospitals that Congress had given states to develop payment methodologies for skilled nursing and intermediate care facilities in the Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 1980 U.S.C.C.A.N. (94 Stat.) 2,599, 2,650-51.

In enacting what is commonly known as the Boren Amendment (codified as amended at 42 U.S.C. § 1396a(a)(13)(A)), Congress mandated that a state plan provide for payment of hospital services

Through the use of rates . . . [1] which . . . take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . . [2] which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . [a] to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and [b] to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality.

(emphasis added). In establishing the reasonable and adequate standard, Congress require the Secretary to allowing states to develop payment systems free of oppressive federal oversight. Thus, the Boren Amendment provides states enormous flexibility in setting their own rates, allowing them to set payment rates to encourage efficiency reduce the rate at which Medicaid

The Honorable Donna E. Shalala
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outlays would otherwise increase. That Tennessee has used its flexibility inappropriately can hardly be blamed on federal mandates.²³

Were the Secretary to waive compliance with the Boren Amendment and its implementing regulations, Tennessee would have carte blanche. It is no secret how Tennessee would use its unfettered authority. Even were TennCare's capitation rates actuarially sound, Tennessee would be no more than a marginal-cost purchaser under TennCare.

Imagine what would happen to the cost and quality of groceries were Tennessee to require grocery stores to sell a substantial portion of their goods at marginal cost. Tennessee's vision of "traditional market forces . . . assur[ing] acceptable levels of price, quantity and quality of services," see TennCare Proposal at 2, is simply out of focus.

One does not need a degree from the London School of Economics to see that serious market distortions occur when the government becomes a marginal-cost purchaser of goods and services. In the Tennessee health care market, such distortions would be aggravated by the lack of a resource-based malpractice standard on which providers may rely. The absence of effective cost-sharing requirements contributing to responsible decisions from recipients also would aggravate the distortions.²⁴

The Boren Amendment is a minimalist standard, merely requiring that payment rates (to hospitals) be reasonable and adequate. There is no policy justification for the Secretary's permitting Tennessee to use unreasonable and inadequate rates for efficiently and economically operated providers.

CONCLUSION

The Secretary should disapprove TennCare unless Tennessee commits to the state expenditures required to fund TennCare adequately.

²³ For example, Tennessee Medicaid has classified 137 out of 159 Tennessee acute care hospitals as disproportionate share hospitals (DSH). This, of course is conceptually impossible; it would be like saying everyone in the class is an "above average student" within the context of that class.

²⁴ On the one hand, Tennessee would not impose even the most minimal cost-sharing requirements on those below 101% of the federal poverty level. On the other hand, a significant amount of the onerous copayments Tennessee proposes for those 101% and 200% of the federal poverty level likely would be uncollectible. Although Tennessee proposes reducing the capitation rate based on its optimistic view of copayment collection, providers, and not the state, bear this risk of the state's projections.

The Honorable Donna E. Shalala

September 14, 1993

Page 16

Even if Tennessee makes this commitment, the Secretary should nevertheless require Tennessee to phase-in TennCare, starting with the AFDC and AFDC-related populations and later phasing-in, in substate regions, the SSI population. Only after Tennessee has demonstrated the financial viability of the TennCare in the existing Medicaid recipients should the Secretary permit Tennessee to expand coverage to the uninsured.

Requiring Tennessee to phase-in its research and demonstration project would allow managed care organizations to establish the necessary infrastructures and regulatory bases necessary to meet the medical needs of the current Medicaid recipients and allow the state time to establish accounting mechanisms necessary to assure adequate and realistic rate development prior to inclusion of the uninsured."

The requisite infrastructure does not currently exist statewide, and it remains to be seen whether any commercial carriers, other than Blue Cross, would participate in TennCare. Even were TennCare's capitation rate otherwise actuarially sound, wholesale implementation of TennCare on January 1, 1994, would be a prescription for failure, providing no benefit to a President seeking to reform the nation's health care system.

We look forward to discussing further our concerns with you and your staff.

Very truly yours,



Thomas Lewis Nelson

c: The Honorable Bruce C. Vladeck
The Honorable Alice M. Rivlin
Darrrel J. Grinstead, Esq.

CC

THE WHITE HOUSE

WASHINGTON

TO: Mack McLarty
Roy Neel
Jack Quinn
Maggie Williams
Marsha Hale
John Hart
Kathi Way

FROM: Carol H. Rasco

SUBJ: Tennessee Medicaid Waiver Request

DATE: September 14, 1993

Secretary Shalala will notify Governor McWherter this week prior to his requested deadline of September 17 that HHS must deny the Tennessee Medicaid Waiver request. Tennessee will NOT be happy. I have the definitive memo on this and will be happy to discuss it with any of you, but, in short, it is indeed a waiver that cannot be approved in present form without causing serious harm to the HHS budget as well as health care reform.

Earlier Gov. McWherter indicated that should this be denied he will make an appeal directly to the Vice President and then the President. We must all be prepared to stand firm and state that Tennessee must work with HHS with HHS very willing to negotiate on this. The hope is that Tennessee will agree to an extension in the timeline and become serious in the negotiations with HHS. This only has a chance of happening if the White House sends the same signals as HHS.

Please again let me know if you wish further briefings on this matter.

Thank you.

cc: Joan Baggett

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Please again let me know if you wish further briefings on this matter.

Thank you.

cc: Joan Baggett

Note to Jack: Will you please alert the Vice President to this matter? Thanks.

cc

THE WHITE HOUSE

WASHINGTON

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Roy Neel
Jack Quinn
Maggie Williams
Marsha Hale
John Hart
Kathi Way

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Please again let me know if you wish further briefings on this matter.

Thank you.

cc: Joan Baggett

Note to Maggie: Will you please alert the First Lady to this matter? Thanks.

cc

THE WHITE HOUSE

WASHINGTON

TO: Mack McLarty
Roy Neel
Jack Quinn
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Kathi Way

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Please again let me know if you wish further briefings on this matter.

Thank you.

cc: Joan Baggett

NOTE to Mack: Since I do not have a briefing with the President today and understand he is to be out of town tomorrow, would you please alert him to this issue?

CC

THE WHITE HOUSE

WASHINGTON

TO: President Clinton
FROM: Carol H. Rasco
SUBJ: Tennessee Medicaid Waiver
DATE: September 15, 1993

Per my phone conversation with Bruce this morning, here is the memo I received yesterday about the Tennessee waiver. I at that time did a memo to several divisions within the White House on the matter and because I did not have a briefing scheduled with you yesterday, I asked Mack to relay the message to you.

Obviously today in a meeting HHS had with Tennessee officials, Tennessee got the message they needed to negotiate in good faith. In a conversation with Roy Neel earlier this afternoon, McWherter's chief aide indicated they were quite willing to extend the date...the aide said they never imposed the date, HHS did....not true but that is beside the point somewhat in that the date is extended. HHS is now in the process of calling the aide to confirm the extension and negotiations will continue.

As you read this I would ask that if you wish to discuss it you do so with me before trying to call departmental officials or even more importantly, please do not try to talk with the Governor yet. I have a regular briefing time scheduled tomorrow with you in the afternoon and we can discuss it then.

As to Wisconsin, I had a long meeting with HHS officials on it this afternoon and will bring those issues to you directly in my briefing tomorrow.

Thank you.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Facsimile Cover Sheet

To: Carol RoccoOrganization: 456-2216From: John MonahanDate: 9/17/93

Intergovernmental Affairs
200 Independence Ave., SW
Room 630 F
Washington, DC 20201
phone: (202) 690-
fax: (202) 690-5672

Recipient's Fax Number: 456-2878Number of pages including this sheet: 2

Remarks:



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

SEP 16 1993

The Honorable Ned McWherter
Governor of Tennessee
State Capitol
Nashville, Tennessee 37219-5081

Dear Governor McWherter:

I am writing to advise you that, while we have been engaged in ongoing discussions with your staff on the TennCare proposal, there are very substantive issues that remain. We would like to continue working with you to resolve them. Thus, continuing discussions beyond September 17 would be in our mutual interest.

I will keep you advised of our progress.

Sincerely,


Donna E. Shalala



SEP 10 1993

MEMORANDUM FOR CAROL RASCO AND MARCIA HALE

This memorandum will describe our current position with respect to the State of Tennessee's TennCare proposal as well as possible next steps. The Department has promised the State a decision on the waiver request by September 17th.

The proposal cannot be approved without major revisions. The State has only recently shown any willingness to compromise. Tennessee officials have presented TennCare as a statewide reform plan consistent with national health reform. It includes cost containment through managed competition and significant expansion in coverage of the uninsured. It also includes major cost shifting to the Federal government caused by a significant decrease in legitimate State matching funds. The Department's general counsel has concluded that central elements of the proposal's financing arrangements could not legally be approved. Even if the financing were to be restructured to our satisfaction, the plan raises additional concerns about potential problems in quality and access to care.

Given the complexities of the Tennessee proposal and the financial and programmatic deficiencies, a compromise would be difficult to fashion. However, the Department remains committed to work with the State to help it amend the proposal to meet our concerns. If we are able to compromise, it would probably be necessary for the State to agree to an extension of the September 17th deadline. A description of the background and Qs & As are attached.

ISSUES

The following issues will require major adjustments in the plan:

1. Cost Shifting from the State to the Federal Government

Tennessee's severe fiscal problems figure prominently in this proposal, which effectively increases the Federal match from 67 percent to over 85 percent. The State accomplishes this in two steps. First, it takes an aggressive approach to defining the baseline for Federal Medicaid funding and then converts these funds into a block grant that inflates by up to 8.3 percent per year. Next, Tennessee will cut its actual contribution from tax dollars in half in the first year, from \$920 million to \$480 million. The

State makes up for this reduction by labeling existing charity care, anticipated beneficiary coinsurance and deductibles, and local government subsidies as State share which should be matched.

However, charity care does not qualify legally as a source of matching funds, and the Secretary does not have the legal authority to waive the statutory matching rate through a Section 1115 waiver. Moreover, if this approach were approved, it would set a precedent that other States would rapidly emulate, and the cost to the Federal budget would be many billions of dollars (and, given the entitlement caps, potentially quite dangerous).

The State misses the point by arguing that it would hold the Federal government harmless for the cost of its reform proposal. TennCare will simply increase the Federal share of a less expensive Medicaid program, achieved through overly optimistic assumptions about managed care savings and reliance upon various unacceptable non-State revenue sources.

2. Block Granting Medicaid is Incompatible With Health Reform

Major goals of reform include moving all persons (not just Medicaid beneficiaries) into a universal system of financing, cost containment, and service delivery. But a block grant, by definition, confers on the State broad flexibility to alter eligibility and benefits, reconfigure service delivery, and to identify, raise, and distribute non-Federal funding. This flexibility could produce differential treatment that works against the principles of health reform.

Tennessee proposes to use this flexibility to cap participation in a manner that could deny certain otherwise eligible persons the right to participate; to provide differing benefits to different beneficiary groups; and to redefine State financial effort to include beneficiary copayments that may not be received and charity care from all providers. This latter effort by the State to substantially reduce its real contribution to health care undercuts the state maintenance of effort requirement under health reform. Other states could exercise the flexibilities inherent in a block grant approach with similar sorts of results.

The statement of Section 1115 waiver principles sent to the National Governors' Association stated in part that "the Department ... reserves the right to disapprove or limit proposals on policy grounds;" we believe that a block grant approach should be ruled inappropriate on this basis. If, to overcome these problems and to protect beneficiaries, we were to agree to block grant Medicaid with numerous and detailed restrictions, we would probably not achieve what is the principal goal of 1115 demonstrations -- that is, to draw significant and policy-valuable lessons about the block grant approach per se.

Tennessee has indicated that they may be willing to drop the block grant approach if we are able to identify satisfactory state matching funds.

3. Questionable Federal Baseline Costs

The level of baseline Federal funding in the plan assumes existing provider taxes on nursing homes and hospitals will be found acceptable under the recently issued "Donations and Taxes" regulations. These two taxes alone generate over \$1 billion in Tennessee's current Federal match.

Preliminary determinations are that the hospital tax may be problematical and that the nursing home tax appears to be unacceptable. The State may litigate this matter once we have made a determination on these taxes, which means that essential elements of our baseline contribution could remain unresolved for well over a year. This is obviously not a reasonable basis from which to begin exploring the possibility of block grant funding.

The following concerns, while serious, could very likely be dealt with through mechanisms such as phased implementation after more extensive State consultation with consumers and existing providers:

4. Reduced Payments to Health Plans and Providers are Likely to Adversely Affect Access and Quality

Under TennCare, the State plans to reduce payment to providers by about 25 percent. This "discount" reflects the State's assumption that other resources "in the system" can subsidize State payments (e.g., charity care, local government funding, and patient cost-sharing revenues). Most State managed care programs set capitation rates at 90-95 percent of Medicaid fee-for-service (FFS) levels. Medicaid is often criticized for setting FFS payment levels so low that access to care is restricted and providers are forced to rely on other resources to supplement Medicaid rates. It seems unlikely that expanded services can be provided at 75 percent of Medicaid FFS levels.

The problems with the 25 percent discount are compounded by the State's faulty financial assumptions. The plan assumes full payment of premiums, coinsurance, and deductibles by beneficiaries. To the extent there are shortfalls in these collections, providers will receive even less payment than the 75 percent FFS, and may reduce services to beneficiaries.

The State has not made provisions for the protection of essential primary care providers, such as public hospitals and Federally Qualified Health Centers. The proposal does not address how its managed care delivery system will assure continued access to these providers.

The State has not adequately considered the impact of the proposal on its medical schools which include East Tennessee State, one of the country's leaders in producing primary care physicians, and Meharry, one of the nation's major black medical schools (although Meharry does not oppose TennCare). We believe some adjustment, similar to that made in Health Reform, should be established to provide for educational costs.

5. Insufficient Managed Care Infrastructure and Experience

Only 5.5 percent of Tennessee's insured population was in HMOs in 1992, and the Medicaid program currently has only one contract with an HMO, which enrolls about 4 percent of the Medicaid population. In December 1992, Tennessee was denied a renewal of its Medicaid primary care case management waiver because of poor performance. The State does not have the necessary experience or health care infrastructure to implement such an ambitious program without some kind of phased implementation.

OUTSIDE INTEREST IN TENNCARE

The State initially produced statements of support for TennCare from a number of organizations, including the Tennessee Hospital Association, the Tennessee Health Care Campaign (a consumer advocacy group), Blue Cross/Blue Shield of Tennessee, and several hospitals that want to participate as providers. However, since then we have received over 300 letters either in opposition to the plan, or expressing serious reservations notably from the Tennessee Medical Association, the American College of Physicians, East Tennessee State University, and the Tennessee Academy of Family Physicians. The State's hospital association and primary care association have urged that stringent conditions be imposed on the proposal, including a less aggressive phase-in, and the Association of Academic Health Centers has also expressed concern.

Senator Sasser, Chairman of the Budget Committee, sent the only Congressional letter in support of the waiver application. Signs of strong Congressional opposition have come from staff of both the full Energy and Commerce Committee and the Subcommittee on Health. In addition, Congressman Dingell's staff indicated that the Chairman is considering holding an oversight hearing on the matter.

Other states are closely following TennCare's progress. Some states have informally told Department staff that, while they recognize that Tennessee's waiver request is essentially a new approach to shifting costs to the Federal government, they would apply for a similar waiver were we to approve it.

NEXT STEPS

We are eager to work with Tennessee to develop a revised proposal that would be acceptable to both parties. The fiscal consequences of not approving the application would be severe for the State. The provider tax on hospitals is scheduled to expire shortly, and the State faces a major fiscal crisis without the Federal funding levels proposed here. Approximately \$1 billion in Federal funds are at stake. The State might respond to a denial by raising new revenues (including possibly reinstating their hospital tax), cutting back on Medicaid eligibility, coverage or provider payments, reducing other State expenditures, or some combination of the above.

In meetings to date, State officials have recently expressed a willingness to compromise. However, State officials have stated that they will explore all political channels in their effort to gain approval of the waiver. Nevertheless, if the Department and the White House speak with one voice, it is still possible that the State will engage in substantive negotiations with us.

Although a compromise would be difficult to design, the best possible outcome would be an agreement on significant changes that would still preserve a TennCare program in some less expansive form but meet our objections. If we are to develop a compromise, it would probably be necessary for the State to agree to an extension of the September 17 deadline. We will keep you informed of our progress.



Kevin Thurm

Attachments

Background on TennCare Proposal

On June 17, 1993, Tennessee submitted a proposal for a 5-year managed care demonstration project requiring several waivers to Medicaid program requirements. The Department has committed to make a decision on Tennessee's request by September 17, 1993. The State intends to implement the new program on January 1, 1994.

- o TennCare's intent is to provide health care benefits statewide to Medicaid beneficiaries, uninsured State residents and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,775,000, one million of whom are current Medicaid eligibles. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled, while the currently uninsured group enrollment will be limited.
- o Managed Competition/Managed Care Features: Although Tennessee does not have a track record of enrolling vulnerable populations in managed care, all enrollees will be immediately enrolled in capitated managed care plans that are either health maintenance organizations (HMO) or preferred provider organizations (PPO). Initially, Tennessee intends to develop a community capitation rate to pay plans; thereafter, the State will develop annual capitation rates based on the lowest cost managed care organization meeting its quality standards within each community.

Managed care organizations will be required to provide detailed information on provider and recipient activity, including encounter data, types of care provided, levels of care provided and outcomes of care. Health care plans will compete for enrollment based on quality of service.

A standard benefit package will be provided by managed care organizations. Long term care is not included in the managed care plan.

Each managed care plan within a community will be given a spending target based on number of enrollees. Plans may elect not to be at full risk, in which case they may retain 5 percent of savings achieved. If the spending target is exceeded, plans would be required to pro rate provider reimbursement back to the target.

Community Health Agencies (CHA) will be the geographic unit of delivery. The 12 CHAs in the State are governed by a community-based board.

- o Cost Sharing: TennCare requires cost-sharing in the form of premiums, deductibles, and co-payments based on income. All adults and children with incomes above 100 percent of the Federal poverty level would be required to pay, except those in mandatory Medicaid eligibility groups. To encourage their use, no deductible or copayment will be required for preventive services.

- o Budget: Rather than requesting the regular Federal match for Title XIX costs incurred by the State, Tennessee is asking for a commitment from the Federal government to contribute in the first year of the demonstration what the State estimates the Federal share would have been under the current system (\$2.267 billion). The Federal contribution in future years would be increased by the minimum of: (1) actual increase in costs; or (2) 8.3 percent (the historical per capita cost trend). Federal funding would essentially be a modified block grant.

QUESTIONS AND ANSWERS ON TENNCARE

Q. The TennCare proposal will save the Federal Government money. Isn't it irresponsible to turn it down?

A. Whether or not there are savings in Tennessee depends on how you count and where you start counting from. The State's estimates are all for future years and are based on assumptions that TennCare will increase more slowly than its conventional Medicaid program. In addition, the Federal "savings" assume very high Federal payments to start with; we disagree with the State's assumptions about appropriate Federal payments for 1994, and believe they will be lower.

The State also does not mention that in the past 2 years Tennessee's Medicaid costs have been escalating faster than those of almost every other state in the union -- 26 percent between 1992 and 1993 and 24 percent between 1993 and 1994. Only Florida and Louisiana have had similar increases in this period. With such a high base rate of inflation, it is not hard to show out-year savings from cost controls.

Many states have already achieved much greater control over their costs and ours than Tennessee proposes to accomplish in this demonstration. If you exclude the twelve fastest growing states from the analysis, the average increase in Federal share between 1993 and 1994 for the 38 states that remain is only 7.1 percent, considerably lower than the 8.3 percent cap TennCare promises.

The real Federal fiscal impact of this waiver, however, would not be in Tennessee but in the demands from other states that they be treated equally. The Federal budget impact of only one of the controversial financial arrangements -- the request that existing "charity care" be used in lieu of tax dollars as a State contribution -- would be somewhere in the vicinity of \$13 billion, or an overall increase in Federal Medicaid costs of 14 percent.

We certainly agree with Tennessee that their costs need to be brought under control and have a number of successful demonstrations and waivers underway which they can use as models.

Q: Why can't Tennessee claim the value of charity care as part of the State match under TennCare?

A: In 1993, the State is using revenue from a tax on hospitals to fund its State share of Medicaid expenditures. The tax will expire in December 1993 if TennCare is approved. As a substitute for the lost revenue, the State asserts that charity care valued at almost \$300 million will be provided in 1994, and that this amount is available to the State as its match.

However, charity care is not State revenue, or even arguably revenue that could be available to the State. Rather charity care represents the amount of revenue that hospitals would have received had patients paid their bills. It is not cash, but rather an accounting device used to portray the amount to be deducted from gross hospital charges to calculate net revenue.

The State may be asserting that charity care is a donation rather than a cash payment, but this argument does not withstand scrutiny. Under certain circumstances, donated services can be counted as part of the non-Federal share for matching purposes. However, the difference between last year's Medicaid rate for a service and this year's 25 percent lower rate is not a "donation" by the provider. Indeed, such a mandatory reduction seems the antithesis of a donation.

Q: If TennCare is rejected, the State faces a serious fiscal crisis. Shouldn't this make you more willing to accept the proposal?

A: The State's fiscal crisis comes as a result of rapid increases in Medicaid costs coupled with the repeal of the hospital tax. We are prepared to work with the State to address their problems, but Federal taxpayers should not be held responsible for this crisis.

Q: You have promised us State flexibility under Health Care Reform; why aren't you living up to the promise?

A: We have promised State flexibility within established guidelines, not unlimited ability to do whatever States want. We have approved innovative waiver proposals in Hawaii, Oregon, and other states, and want to foster more such experimentation in the future. However, flexibility to decrease State payments by shifting costs to the Federal government is not on the list of acceptable actions.

Q: Our proposal moves towards managed competition and resembles national health reform. Why aren't you more supportive?

A: The proposal differs from health reform in some very critical ways. For example, under national health reform states will have to meet maintenance of effort requirements. In addition, health reform acknowledges the responsibility of all payors to support the costs of graduate medical education. We plan to link that support to the production of more primary care physicians. Tennessee has not adequately protected the teaching programs of its medical schools; we are particularly concerned about potential harm to Meharry Medical College, a leading Black

school, and to East Tennessee State, one of the national leaders in the production of primary care physicians.

In addition, we do not believe that the "managed competition" proposed in this plan could be implemented immediately on a statewide basis given the low penetration of HMOs in Tennessee and the lack of previous Medicaid HMO experience. A phase-in period would be much more consistent with our intent nationally.

Q: Why are you forcing Tennessee to cut benefits and drop beneficiaries?

A: In recent years, Tennessee has greatly expanded its Medicaid coverage. The primary source of funds for this expanded coverage has come from the unpopular hospital tax and the resulting Federal match dollars. The Tennessee legislature has now repealed this tax, and is responsible for developing feasible fiscal solutions. We are prepared to work with the State to develop appropriate and innovative approaches to preserve essential health coverage.

Q: It doesn't sound like you want Tennessee to do anything in this plan. Is that true?

A: No. We believe that better control over Medicaid costs is an essential element in the long term solution to the State's fiscal problems. We would like to work closely with you to develop a Medicaid managed care proposal which could be approved and which will control your costs and ours in future years. At present, Tennessee is tied for second place nationally in terms of the inflation rate in the Federal costs of its Medicaid program. We are just as eager as you are to get those costs under control. Many of the elements of this plan could be incorporated in a new proposal based on different financial and timing assumptions.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

*cc: Alice Rivlin
Kathi Way*

Executive Secretariat

EXPEDITE

FACSIMILE

**PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION
TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:**

Name: CAROL RASCO

Address: ASSISTANT TO THE PRESIDENT
DOMESTIC POLICY

Telephone: (202)456-2216 (FAX) (202) 456-2878

Number Of Pages Being Transmitted (Including This One) 2

FROM: JACQUELYN WHITE
DEPUTY EXECUTIVE SECRETARY, HHS

FAX NUMBER: _____
OFFICE NUMBER: 690-5627

ATTACHED FOR CLEARANCE, IS THE LISTING OF DHHS PARTICIPANTS FOR MEETING
SCHEDULED FOR TUESDAY, SEPTEMBER 21, 1993, 1:15-2:00PM, WHITE HOUSE WEST WING
SECOND FLOOR, SUBJECT - TENNCARE. PLEASE OBTAIN CLEARANCES. THANK YOU.

EXPEDITE

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THE FOLLOWING PAGE HAS HAD MATERIAL REDACTED. CONSULT THE
WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER FOR FURTHER
INFORMATION.

LIST OF ATTENDEES FOR CLEARANCE

CAROL RASCO MEETING, TENNCARE
WHITE HOUSE WEST WING, SECOND FLOOR
TUESDAY, SEPTEMBER 21, 1993, 1:15-2:00 PM

HHS PARTICIPANTS

SSN# & DOB

KEVIN THURM
CHIEF OF STAFF

JOHN MONAHAN
DIRECTOR
OFFICE OF INTERGOVERNMENTAL AFFAIRS

DAVID ELLWOOD
ASSISTANT SECRETARY FOR PLANNING &
EVALUATION

BRUCE C. VLADECK
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HEALTH, ASL

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DAVID CADE
POLICY COORDINATOR (HEALTH)

PATRICIA WOODS
OFFICE OF INTERGOVERNMENTAL AFFAIRS

P6/(b)(6)



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE CAPITOL
NASHVILLE, TENNESSEE 37243-0285

DAVID L. MANNING
COMMISSIONER

September 30, 1993

OCT 1 REC'D

Mr. Bruce C. Vladeck
Administrator
Health Care Financing Administration
Department of Health and
Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Vladeck:

Re: TennCare

We appreciate your continued attention to the TennCare proposal and the frank expression of HCFA's positions on the issues that we have been discussing that are raised by our proposal. It remains our strong desire to resolve these issues in discussions with you, so that TennCare can move forward immediately and begin to realize its potential for greater access to health care and a more efficient and economic system.

In light of the position papers that HCFA has supplied to us and our discussions of earlier this week, we have once again reviewed our proposal. As a result of this review, we are offering revisions that should provide a basis for HCFA to recommend approval of the waiver. The purpose of this letter is to describe the modified proposal and to explain in brief why we believe it warrants your support, as well as to comment on the other issues raised by HCFA.

The HCFA position paper of September 17 set forth seven issues to be resolved. This letter summarizes briefly our response to each of those issues. Attachments to this letter elaborate further on the financing issues, the adequacy of the capitation, the time frame for implementation and the enrollment cap, and the terms of proposed conditions that would deal with the various issues.

• Financing -- Our modified proposal reduces the size of the program by lowering the maximum number to be

served. This results in a significantly lower federal contribution. The state contribution will not be reduced, but we have revised the manner of identifying certain elements of that contribution to bring the proposal more in line with traditional Medicaid funding methods.

The modified financial proposal is set forth in Attachment 1. The key points are the following:

-- The maximum number of enrollees will be reduced to 1,500,000.

-- Tennessee will accept the HCFA baseline as established by the Regional Office (\$2,107,775,000 for SFY 94).

-- The cap on the growth of the federal contribution to TennCare will be modified to incorporate our original proposed cap of 8.3 percent per year or the President's proposed Medicaid growth caps under health reform, whichever is lower.

-- We will not ask HCFA to match the charity care discount element of the capitation payments or the patient copay and deductible element.

-- We will take into account for matching purposes the funds of public facilities used to provide uncompensated care, consistent with federal regulations on certification of public expenditures.

With these modifications, we believe our proposal meets your stated requirement that the federal contribution be based on the match rate principle, and should overcome the obstacle to approval of the TennCare waiver.

● Enrollment Cap -- Tennessee accepts the previously agreed methodology for addressing this issue and our suggested language is attached to this letter. (Attachment 2)

● Federally Qualified Health Centers -- Tennessee accepts your proposed condition.

● Public Health Service Grants -- Tennessee accepts your proposed condition.

● State Matching Funds for PHS Grants -- Tennessee accepts your proposed condition.

● Adequacy of Capitation -- Tennessee believes the capitation presented in our original proposal is adequate and is completely consistent with, although not as aggressive as,

the President's savings assumptions upon which the national health care reform proposal is based. We believe that both the President's and Tennessee's assumptions are reasonable and deserve HCFA's support. (Attachment 3)

• Implementation Schedule -- We believe that delaying implementation would cause far more disruption than proceeding with the proposed schedule. Therefore, we request that our original schedule be approved. (Attachment 4)

We do welcome your suggestion that a team of federal representatives come to Tennessee in the near future to monitor the state's implementation plan and, we hope, to be reassured that the present implementation schedule is feasible. Please be in touch with me so that a site visit can be arranged.

I want to emphasize that we continue to believe that our original proposal was sensible, legal, and consistent with federal policy goals, particularly those that underlie the President's health reform proposal, and we would be willing to go forward with that proposal, modified to incorporate the federal baseline figure and the more restrictive limits on increases in federal financial exposure that are outlined above. That proposal embodied a "match-based" grant approach, for which there is a clear precedent in HCFA's prior approval of the Arizona Section 1115 waiver. There can be no doubt of HCFA's legal authority to grant Tennessee's requested "match-based" proposal, given the explicit Congressional intent stated in the Senate report on the bill that enacted Section 1115, which was expressed in these words:

"The bill would permit the Secretary of Health, Education, and Welfare to waive any State plan requirement which he deemed necessary for pilot or demonstration projects designed to improve the public assistance programs and would provide alternative methods of financing such projects out of public assistance appropriations." (Emphasis supplied.)

But we understand the concerns that you and your staff have raised about our original proposal, and we have tried to address those concerns in our modified proposal. I hope we have done so in a satisfactory manner. The opportunity for substantial federal savings in Medicaid outlays remains a prime feature of our modified proposal. Although the maximum participation would be somewhat smaller, the modified proposal would also substantially expand coverage to those who have been uninsured, would change the emphasis to primary and preventive care, would retain choice for all

participants, would retain the extensive quality control features of the original proposal, and would engage market forces to help control the soaring costs of health care. We do not see a downside to federal endorsement of this modified proposal.

We are aware that some have expressed concern that other states might seek waivers that mirrored the Tennessee proposal. We cannot find a reason why HCFA should not welcome such proposals since they would clearly further President Clinton's health reform objectives, including strict adherence to Medicaid spending caps that are a fundamental element of the President's financing proposal. They would also result in faster coverage for the uninsured that could be easily transitioned into the national plan when it is adopted by Congress. Finally, they will reduce the federal cost of Medicaid for as long as the present program remains in place.

Mr. Martins and I are available to discuss our revised proposal at your convenience. It is my hope to resolve all outstanding issues prior to Governor McWherter's return around October 8. To the extent that we cannot resolve all issues, the Governor will be available for consultations in Washington as described in his letter of September 23, 1993, to Secretary Shalala.

We look forward to your response.

Sincerely,


David L. Manning

AM

cc: Secretary Donna E. Shalala
Ms. Carol H. Rasco

FINANCIAL PROPOSAL

The principal issue from the commencement of our discussions has been Tennessee's financial proposal. HCFA has questioned the baseline figures, the State's growth projections were Medicaid to continue unchanged, and the State's financial contribution under the waiver. We believe our modified proposal responds to all of these points.

First, for purposes of the baseline, we would agree to accept the HCFA Regional Office estimate of \$2,107,775,000 as the federal share of Tennessee Medicaid program expenditures for state fiscal year 1994 (July 1993-June 1994). This figure is approximately \$160 million less than the figure used in the State's original proposal.

Second, Tennessee is proposing a modification to the cap on the growth of the federal contribution to TennCare over the five-year life of the demonstration. The initial proposal was to cap the rate of growth at 8.3 percent per year. We are willing to modify this to be consistent with the growth trends used in the President's health care reform plan. The President's proposal projects a declining rate of growth assuming adoption of the reform plan, which reaches 5.1 percent by calendar year 1998. Our proposal is to cap the federal contribution to TennCare at either 8.3 percent, or the applicable growth rate predicted in the President's proposal, whichever is lower for the year in question. This means that

in the first three years, we are committing to hold the federal contribution to a much lower growth rate than the Medicaid growth rate predicted in the President's plan.

Third, Tennessee has modified its proposal so as to satisfy the match rate method of financing that HCFA has insisted upon. To accomplish this, it is necessary to reduce the maximum number of program participants. The new cap will be 1,500,000 enrollees, rather than 1,775,000 as in the original proposal.

Under the modified proposal, the total state contribution (including local funds) would equal or exceed the state's Medicaid share using the FMAP percentage. In this connection, we are taking into account all sources of state funds that will be available to TennCare. This includes state appropriated funds (including those raised from the nursing home tax), local governmental funds certified as having been expended for TennCare services, other state grant funds (except for those used to earn PHS matching funds), premiums paid by the uninsured enrollees (which the state will guarantee to the health plans), and certified public expenditures by public hospitals applicable to care of the uninsured.

The latter category is authorized by Section 433.51 of the HCFA regulations, which authorize consideration of public funds as the state's share for FFP purposes where the

public funds are certified by the contributing public agency as representing expenditures eligible for FFP. Hospital cost reports show the charges applicable to uncompensated care and the portion of total charges that uncompensated care represents. The certification of public hospitals of their expenditures for the uninsured provides the basis for FFP.

The initial determination of the certified public expenditure amounts has been derived from the most recent Joint Annual Reports for hospitals, covering 1992. For purposes of ascertaining the proper amounts, disproportionate share payments have been netted out from gross uncompensated care costs. We anticipate that public hospitals will continue to utilize their funds for the care of TennCare eligibles and that that portion of the capitation rate to health plans will be in the form of certified expenditures by the public hospitals. It is the state's intention to spread the cost represented by the certified public expenditures among all TennCare providers.

Under our modified proposal, the federal contribution each year will be tied to the increase in the capitation rates established for the health plans. Thus, if the weighted average increase in capitation is, as we anticipate, 5 percent, the federal contribution would increase five percent, as would the overall state contribution. If for any reason the capitation increases by more than 8.3 percent,

or by more than the predicted Medicaid inflation rate included in the President's proposal, the federal contribution would increase by no more than the lower of these two amounts.

The schedule appended to this attachment sets forth in tabular form the modified financial proposal for TennCare. Note that in the first year, when TennCare will be in place for only six months, we are assuming a maximum of 1,300,000 enrollees. Thereafter, we assume the maximum 1,500,000 enrollees. To the extent that enrollment does not reach these levels in any year, the funds that otherwise would have been devoted to capitation payments would be pooled and disbursed to providers who deliver care to non-enrolled TennCare eligibles and who incur uncompensated costs for catastrophic care. We have outlined for you how these funds would be distributed and we would be pleased to elaborate on our plans for this supplemental fund.

We have also included a reserve fund each year, to allow for additional costs that are experienced in the transition from the current system to TennCare and to provide additional protection to providers for non-enrollees. To the extent these funds are not expended, we would not seek the federal matching share attributable to them.

We have also eliminated as funding sources for TennCare the previously-identified federal grants as well as the state grants that are used to earn matching federal

grants. At no time had we sought federal matching funds attributable to these sources. Nonetheless, the continued identification of these funds as available to the state to fund TennCare was obviously troublesome to some of your staff, and we have therefore decided to eliminate them from all consideration.

We continue to show on the schedule the charity care that will be contributed to the system by participating providers. This is not intended, however, to indicate any intention to seek federal matching for this component.

Our schedules assume a five percent annual increase in TennCare costs and in federal and state funding. While we provide for federal participation increases up to 8.3 percent or the President's reform rate of growth, whichever is less, we remain convinced that we can confine year-to-year increases to five percent.

We also include a schedule comparing the results under this modified proposal with expected Medicaid expenditures had there been no waiver. The schedule shows the financial results at an assumed growth rate of 5% per year (which is Tennessee estimate of expected program growth) and at 8.3% per year, or the President's reform proposal, whichever is lower (which is the maximum federal expenditure under this proposal). These results are compared with estimated expenditures for a continued Medicaid program

starting with the Regional Office baseline and projecting growth using the two proposals contained in the President's proposal -- the first is the Medicaid baseline proposal and the second assumes implementation of the Reform Program. Against either of these assumed scenarios, TennCare shows a significant federal savings even if the maximum federal expenditures is assumed. If TennCare's growth experience is as the state anticipates, the federal savings will be huge. These schedules demonstrate that the modified TennCare proposal goes far beyond the principle of budget neutrality applicable to waiver applications.

Revised TennCare Proposal

September 30, 1993 - 2

	Fiscal Year 1993 - 1994	Fiscal Year 1994 - 1995	Fiscal Year 1995 - 1996	Fiscal Year 1996 - 1997	Fiscal Year 1997 - 1998	Five Year Total
Eligibles	1,300,000	1,500,000	1,500,000	1,500,000	1,500,000	
TennCare Cost	\$1,067,300,000	\$2,584,500,000	\$2,713,500,000	\$2,848,500,000	\$2,991,000,000	\$12,204,800,000
Regular Program (7/93-12/93)	\$1,200,840,400	\$0	\$0	\$0	\$0	\$1,200,840,400
Long Term Care, Administration & Medicare	\$938,696,000	\$985,631,000	\$1,033,246,400	\$1,084,992,400	\$1,139,325,200	\$5,181,891,000
Reserve Fund	\$89,128,750	\$66,592,300	\$69,880,800	\$73,250,700	\$76,927,000	\$375,779,550
GRAND TOTAL EXPENSES	\$3,295,965,150	\$3,636,723,300	\$3,816,627,200	\$4,006,743,100	\$4,207,252,200	\$18,963,310,950
State Funding						
State Core	\$383,049,300	\$394,540,700	\$408,376,900	\$418,568,200	\$431,125,200	\$2,033,660,300
Patient Revenue	\$20,858,200	\$101,082,300	\$108,136,400	\$111,443,200	\$117,015,300	\$456,535,400
Broad Based Tax	\$202,176,000	\$0	\$0	\$0	\$0	\$202,176,000
Certified Public Expenditures	\$248,804,700	\$297,971,800	\$324,639,700	\$352,994,100	\$383,128,900	\$1,607,539,200
Local Government Appropriations	\$25,000,000	\$52,500,000	\$55,125,000	\$57,881,000	\$60,775,000	\$251,281,000
Other State Appropriations	\$77,969,650	\$159,971,000	\$184,091,000	\$168,301,000	\$172,602,000	\$742,934,650
Nursing Home Tax	\$80,300,000	\$84,000,000	\$88,200,000	\$92,610,000	\$97,241,000	\$442,351,000
TOTAL STATE FUNDING	\$1,038,157,850	\$1,090,065,800	\$1,144,569,000	\$1,201,797,500	\$1,261,887,400	\$5,736,477,560
Federal Funding						
Title XIX	\$2,107,775,000	\$2,213,163,800	\$2,323,822,000	\$2,440,013,100	\$2,562,013,800	\$11,646,787,700
Other Funding						
Charity	\$150,032,300	\$333,493,700	\$348,236,200	\$364,932,500	\$383,351,000	\$1,580,045,700
GRAND TOTAL FUNDING	\$3,295,965,150	\$3,636,723,300	\$3,816,627,200	\$4,006,743,100	\$4,207,252,200	\$18,963,310,950

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Tennessee
Medicaid Program/TennCare
Comparison

September 30, 1993

	Base Line Fiscal Year 1993 - 1994	Fiscal Year 1994 - 1995	Fiscal Year 1995 - 1996	Fiscal Year 1996 - 1997	Fiscal Year 1997 - 1998	Five Year Total
Tennessee's Projection with No Reform	\$3,145,704,000	\$3,677,032,000	\$4,314,042,000	\$5,077,839,000	\$5,993,751,000	\$22,208,368,000
State	\$1,037,929,000	\$1,216,081,000	\$1,426,748,000	\$1,677,084,000	\$1,978,412,000	\$7,335,254,000
Federal	\$2,107,775,000	\$2,460,951,000	\$2,888,294,000	\$3,400,755,000	\$4,015,339,000	\$14,873,114,000
Tennessee's Expected Projection - Revised TennCare Proposal	\$3,145,704,000	\$3,302,989,000	\$3,468,138,000	\$3,641,545,000	\$3,823,622,000	\$17,381,998,000
State	\$1,037,929,000	\$1,089,825,000	\$1,144,316,000	\$1,201,532,000	\$1,281,608,000	\$5,735,210,000
Federal	\$2,107,775,000	\$2,213,164,000	\$2,323,822,000	\$2,440,013,000	\$2,562,014,000	\$11,646,788,000
Tennessee's Maximum Projection - Revised TennCare Proposal	\$3,145,704,000	\$3,406,797,000	\$3,689,561,000	\$3,933,072,000	\$4,145,458,000	\$18,320,592,000
State	\$1,037,929,000	\$1,124,077,000	\$1,217,375,000	\$1,297,722,000	\$1,367,798,000	\$6,044,902,000
Federal	\$2,107,775,000	\$2,282,720,000	\$2,472,186,000	\$2,635,350,000	\$2,777,659,000	\$12,275,690,000
President's Medicaid Projection with No Reform	\$3,145,704,000	\$3,630,142,000	\$4,102,060,000	\$4,579,950,000	\$5,102,084,000	\$20,559,920,000
State	\$1,037,929,000	\$1,197,770,000	\$1,353,480,000	\$1,511,160,000	\$1,683,432,000	\$6,783,771,000
Federal	\$2,107,775,000	\$2,432,372,000	\$2,748,580,000	\$3,068,790,000	\$3,418,632,000	\$13,776,149,000
President's Medicaid Projection with Reform	\$3,145,704,000	\$3,630,142,000	\$4,025,827,000	\$4,291,532,000	\$4,523,275,000	\$19,616,480,000
State	\$1,037,929,000	\$1,197,770,000	\$1,328,326,000	\$1,415,998,000	\$1,492,460,000	\$6,472,481,000
Federal	\$2,107,775,000	\$2,432,372,000	\$2,697,501,000	\$2,875,536,000	\$3,030,815,000	\$13,143,999,000

ENROLLMENT CAPS

HCFA has raised questions concerning the enrollment cap and its fairness since the TennCare program proposes no income limit for enrollment. HCFA's expressed concern was that, if the enrollment cap were reached, low income individuals could be excluded from the program as well as those who would have qualified under the Medicaid program.

After careful consideration of HCFA's concern on enrollment, Tennessee agrees that there could be a potential problem with respect to low income individuals. To alleviate HCFA's concerns, Tennessee proposes to initiate a carefully designed monitoring system that will continuously monitor enrollment. Tennessee believes that the process described will assure equity in the enrollment process.

Tennessee will continuously monitor the total number of individuals enrolled in the TennCare Program. As Tennessee reaches the point where total enrollment is 85% of the maximum enrollment (target) in any given year, an enrollment priority system will automatically be implemented. This process will assure that equity will exist in the enrollment process.

When total enrollment reaches 85% of the target, the following system of priority will be established:

<u>Band</u>	<u>Target</u>	<u>Enrollment</u>
1.	85% to 90% of target	Medicaid/Uninsurable and 200% of poverty or below
2.	90% to 95% of target	Medicaid/Uninsurable and 150% of poverty or below
3.	95% to 100% of target	Medicaid/Uninsurable

If enrollment stays within band one or band two for more than three months, persons with income above the limit for that band will be allowed to enroll based on date of application until the enrollment percentage reaches the next band.

Persons who are Medicaid eligible or uninsurable may enroll at any time without regard to any enrollment limitation.

CAPITATION RATE

Tennessee has historically paid providers well through its Medicaid program. A study done in 1987 has Tennessee listed as third in the nation in its payments to hospitals and second in the nation in payments to physicians. Since 1987, Tennessee payments have continued to keep pace with inflationary increases in the health care marketplace. Thus, it is reasonable to assume that Tennessee is sufficiently reimbursing providers for services rendered under the Medicaid program.

The \$1,641 TennCare capitation rate was developed by utilizing the actual average cost for the Medicaid program on a per capita basis for services included in TennCare for the calendar year ending December 1992 trended forward to January 1994 by an index of 5.5 percent each year. These rates exclude MDSA payments to hospitals. HCFA has not argued the adequacy of the \$1,641 but has suggested that the TennCare method of paying the rate results in an inadequate capitation payment. HCFA proposes that Tennessee cash payments to Managed Care Organizations (MCO's) should be 95 percent of what Medicaid would have paid for the same services on a fee-for-service basis, since that is the basis of capitation for most Medicaid Managed Care Plans.

The full capitation of \$1,641 under TennCare is based on historic Medicaid fee-for-service costs. Experience has shown that nationally most capitation plans can conservatively save 15 percent of what would otherwise have been expended. The weighted average cash payments to MCO's under TennCare will be \$1,306 in the first year (approximately \$28 comes from local government funds and \$48 from copayments and deductibles required to be collected by the MCO's; the balance is paid by the state). A reduction of 15 percent applied to the \$1,641 capitation would result in an average cash payment of \$1,395 per year. The difference between this amount and the amount of cash to be paid to the MCO's (\$1,306) is more than made up by the fact of payment for those uninsured who had previously been cared for on a charity basis. Another way of viewing this is that the difference is more than made up by the expenditures of public hospitals made for care that is otherwise uncompensated.

Moreover, external data confirm the adequacy of the rate even if only the cash portion is considered. According to the Tennessee Managed Care Magazine, the average capitation rate for HMO employer plans in Tennessee is \$1,300 per year. This again compares closely with the average cash received by MCO's under TennCare of \$1,306. In Arizona, where outside studies have confirmed the high quality of the program compared to fee-for-service programs, the average annual

capitation across categorical programs for FFY 1994 is \$1,525 per year. Given the higher cost of living and health care in Arizona, and the inclusion in TennCare of a substantial number of uninsured whose health care needs as a group are considerably less extensive than the Medicaid eligible population, the TennCare capitation, even if only the cash portion is considered, is valid.

The savings from the combination of managed competition and managed care that are built into the TennCare capitation (if only the cash portion is considered) mirror the savings contemplated in the President's plan upon implementation of similar policies nationwide. We are confident that the savings implicit in TennCare (which is another way of measuring the charity care contribution), like the savings that underlie the President's plan, can and will be achieved.

Many responsible organizations have advised the State of their intention to participate in TennCare on the basis of the capitation rates that have been announced. Given the intention in TennCare to rely much more on market forces to rationalize the pricing aspects of the system, the willingness of responsible entities to participate on the announced terms is a strong endorsement of the capitation rates.

For these reasons, we believe that the capitation rates that have been announced are reasonable and fear that

effort to increase the rate at the outset could undermine important components of the TennCare project.

IMPLEMENTATION DATE

HCFA suggests that the implementation process to move all Medicaid recipients into managed care by January 1, 1994, will lead to confusion of Medicaid recipients and providers and therefore should be delayed so that ample time to test the modified system and to educate these groups would be available.

Tennessee has worked aggressively with advocacy groups as well as provider groups and Medicaid recipients to assure that they are aware of the major reforms to be implemented in Tennessee's health care system. This process has been accomplished through many months of informational meetings with provider groups and patient advocates. In addition, brochures have been mailed to Medicaid recipients explaining TennCare and toll-free lines have been set up to answer any questions that recipients have. The response to this has been very positive. Ballots have been mailed to Medicaid recipients to enable them to select the managed care organizations in which they want to participate. Responses to the ballots have been requested by the beginning of November.

Tennessee expects that any transition of this magnitude will result in some confusion and problems. However, Tennessee believes that delaying implementation of TennCare at this time, at least for the Medicaid population,

would provide only marginal value in easing implementation, and would not be worth the loss of momentum and the additional disruption that would likely result from delay.

In this connection, we note that we are not requiring that plans implement a full primary care case management system at the outset (although we do not preclude a plan from doing so). The initial plans will most likely be on the PPO model (Blue Cross Blue Shield will offer such a plan) in which all providers will be free to participate. The most significant potential dislocations (such as redirecting patients from emergency rooms to primary care providers) will occur whenever the plan is implemented. Because of all the work that has already been done, and because of the strong and active support and involvement of the advocacy community, we feel confident that TennCare will be successfully launched in January without serious disruption (although we fully recognize that there will be many problems whenever the change is made).

Particularly given the adverse fiscal implications of delaying the start-up, and the need in such an eventuality to maintain the services tax on hospitals and possibly to reduce optional services, the balance of considerations favors implementation in January.

On the other hand, we have always assumed that enrollment of the uninsured group would be more gradual. The uninsured have a particularly acute need for coverage, so that

we would not want to put off their right to participate. In anticipation of the gradual enrollment of the uninsured, we are projecting only 1,300,000 in enrollment for the first six months of TennCare.

Call Alice

LAW OFFICES

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October 14, 1993

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Thomas Lewis Nelson
(615) 252-2344

VIA EXPRESS MAIL

REC'D
OCT 15 1993

The Honorable Carol Hampton Rasco
Assistant to the President for Domestic Policy
The White House
Washington, D.C. 20500

Dear Ms. Rasco:

We are representing pediatric services providers who are concerned that were the Secretary of Health and Human Services to approve the State of Tennessee's request for the research and demonstration project known as TennCare, she would unwittingly undermine the President's efforts to reform the nation's healthcare system.

Under the proposed American Health Security Act, states would continue to be responsible for sharing in the cost of furnishing medical assistance to those who would otherwise be Medicaid recipients. TennCare represents a wholesale repudiation of this fundamental Medicaid tenant and, as such, is antithetical to the President's reform proposal.

Were the Secretary to approve TennCare, there is little question what the result would be. Other states would take similarly aggressive measures to swap state funding for federal funding, exacerbating the stress on the federal budget and making healthcare reform impossible.

Moreover, the proposed payment rates from Blue Cross and Blue Shield of Tennessee, the only managed care organization that has thus far committed to participate in TennCare, are so woefully inadequate that access to healthcare for those least able to afford it would be in serious jeopardy. The state's unwillingness to fund TennCare adequately is directly at odds with studies of the National Governors' Association documenting that adequate payment rates are a prerequisite to access, especially for poor pregnant women and children.

That a significant number of providers would participate in a government healthcare program that fails to pay the marginal cost of furnishing services to the program's beneficiaries strains credulity. Those providers who do participate in TennCare would either have to reduce dramatically the quality of care to TennCare recipients, engage in massive

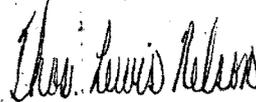
The Honorable Carol Hampton Rasco
October 14, 1993
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revenue shifting, or some combination of both. Simply stated, TennCare is beyond the bounds of a rational shifting of capitated risks to providers.

The pediatric services providers we represent applaud the Clinton Administration's encouraging state ingenuity in solving the intractable problem of skyrocketing Medicaid costs. The only problem TennCare would solve, however, is Tennessee's unwillingness to do what every other state must do -- share in the cost of funding its Medicaid program adequately.

Our clients wish the President success in his reform efforts and would be happy to help in any way they can.

Very truly yours,



Thomas Lewis Nelson

c: The Honorable Donna E. Shalala
The Honorable Bruce C. Vladeck
The Honorable Laura D. Tyson
The Honorable Alice M. Rivlin

TLN/cmr



Xc: KWay
arg REC'D
OCT 18

Tennessee Medical Association

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Nashville

October 13, 1993

Bruce Vladeck, Ph.D., Administrator
Health Care Finance Administration
200 Independence Avenue SW
Washington, DC 20201

Dear Dr. Vladeck:

The TMA cannot advise its members about participating in TennCare or signing any TennCare contracts. We would never contemplate collective economic action by our membership. However, we continue to be afraid that large numbers of physicians will refuse to participate in TennCare for various reasons, financial and otherwise. The state of Tennessee and Blue Cross Blue Shield continue to assert that there will be adequate numbers of providers and further claim no significant defections from Blue Cross' Tennessee Provider Network (TPN). We fear that the numbers provided by the state and Blue Cross are extremely soft.

TMA wishes to point out that physicians who do not wish to remain in the TPN may delay their decisions until November 1, 1993, by simply exercising the 60-day notice for cancellation as contained in the original contracts. From a business standpoint, waiting until that date would appear to be the most prudent course of action. Crucial information such as actual rates, withhold amounts and payment schedules, and other critical details, such as whether or not federal approval would be granted, would dictate that physicians delay this important decision. Why could they be expected to prematurely cut themselves off from this significant segment of the commercial market? If mass defections occur, we again insist that such will be much closer to the November 1 deadline.

As to other MCOs, we question whether they will attract enough patients or providers once deadlines are imposed. TMA believes that many of these companies remain in the formative or even

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exploratory stages and continue to linger merely as a means of keeping their options open. Again, due to the harsh terms imposed on providers due to low capitation rates, it is doubtful that they will be able to form adequate networks.

TMA continues to hear rumblings from its membership - that physicians in certain areas are refusing to agree to the Blues' and others' contractual terms. The Jackson Clinic, the state's largest group practice, has announced that they will not accept the TPN amendments. Please refer also to the Chattanooga Times article noting that of 250 Chattanooga area physicians surveyed, only 17% will participate in TennCare.

The TMA staff stands ready to provide additional information to HCFA as it becomes available. And we appreciate the opportunity to do so.

Sincerely,

Charles W. White M.D.

Charles W. White, M.D.
President

Enclosures



Tennessee Medical Association

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October 11, 1993

The Honorable Carol Hampton Rasco
Assistant to the President for Domestic Policy
The White House
Washington, DC 20500

Dear Ms. Rasco:

During the last week, members of the Tennessee General Assembly have been literally bombarded with telephone calls from worried Medicaid recipients. So have physicians. Patient care in many Tennessee Medical Association (TMA) member physicians' offices has slowed virtually to a halt due to the sheer volume of these calls. Numerous TMA members have had to explain to tearful mothers with sick children that the state and managed care organizations (MCOs) simply have not provided doctors with enough information for them to make an intelligent decision about which, if any, TennCare plans to join. Medicaid patients have, in turn, conveyed their concerns to state legislators. These patients are worried that their doctors may not be a part of the plan that they choose or that the state chooses for them.

We believe that these fears are justified. For example, in one area of the state, doctors have been contacted by only two MCOs, though Medicaid recipients were asked to choose from seven different carriers. What will happen to patients who select a network that has no providers in that area? Patients who choose networks in which their doctor is not a participant will not be able to change plans for a full year. What if too few physicians participate in any one plan? The TMA shares these patients' worries.

Why are doctors so reticent about TennCare participation? First, because of the lack of information. We believe this is no accident, rather, that the administration has released important data on a piecemeal basis in hopes that federal approval would be achieved prior to the discovery of TennCare's many flaws. The TMA and MCOs have yet to see the second draft of the contract between the state and prospective TennCare carriers, despite the administration's

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The Honorable Carol Hampton Rasco

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promise that the contract would be available six weeks ago. This contract is crucial because it may alter significantly some of the terms of the MCO contracts physicians are now being asked to sign.

Physicians still do not know how much they will be paid for their services. Obviously, this a crucial piece of information. While Blue Cross/Blue Shield (BC/BS) has provided a sample fee schedule, there is still no information about what the terms of the "withhold" will be. The withhold amount is the key to determining whether there is adequate cash flow in a medical practice to cover overhead costs.

Based upon the scant information available, it appears that physician reimbursement will be substantially below what is now paid by Medicaid. Such inadequate reimbursement undermines previous joint efforts by the TMA and the state to assure access to Medicaid patients by paying reasonable rates to primary care providers. In fact, many primary care providers who practice in low income, rural, and inner city areas may not be able to keep their doors open. In turn, the impact of ridiculously low TennCare payments will make it practically impossible to recruit physicians to practice in underserved areas.

Physicians also have objected to the heavy handed manner adopted by the state and by BC/BS in program implementation and contract negotiations. In this context, the phrase "contract negotiations" is little more than a joke. The TMA's efforts to effect modifications have been met with scant results. Enclosed you will find a copy of our analysis of the TennCare amendments to the Blue Cross Tennessee Provider Network contract. Please review the terms of the BC/BS agreement as noted in the analysis, and determine if you would agree to its terms.

The TMA cannot advise its members about participating in TennCare or signing any TennCare plans. The TMA would never contemplate collective economic action by its membership. However, we are afraid that large numbers of physicians will refuse to participate in TennCare for various reasons, financial and otherwise. We also would point out that physicians who do not wish to participate in the Tennessee Provider Network may delay their decisions until November 1, 1993, by simply exercising the 60-day notice for cancellation. If this happens, the recent round of frantic phone calls will seem inconsequential compared to the chaos that will ensue.

This confusion is regrettable not only because it could have been avoided, but also because it will only intensify if TennCare is implemented on January 1, 1994. Physicians are convinced that this confusion will pose a serious threat to their patients. Even President Clinton's health care reform package recognizes the need for a phased-in transition period.

Fair or not, we also are concerned that TennCare will be considered a model for the President's plan because it contains elements of "managed competition," a standard benefits package, global budgets, and universal coverage. Rightly or wrongly the President's plan probably will be

The Honorable Carol Hampton Rasco

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judged by TennCare's success or failure. Without major modifications, including a phased-in implementation, a probation on the transfer of all financial risks to hospitals and physicians, and adequate provider reimbursement, TennCare is at worst doomed to fail and at best is faced with a protracted and difficult transition with its recipients' health care at stake.

Like Governor McWherter, we realize the need for fundamental health reform, both in Medicaid and at the national level. We stand ready to work with HCFA, the McWherter administration, and the Tennessee General Assembly to develop a viable TennCare plan.

Thank you for your consideration.

Sincerely,

Charles W. White M.D.

Charles W. White, M.D.

President

CWW/js

Oct. 13, 1993

Few willing to operate under plan

By Pam Sohn
The Chattanooga Times

Nearly half the physicians in the Chattanooga area say they will not participate in the state's new health plan for the poor. Another third is undecided.

Among more than 250 local doctors surveyed in the past month, only 17 percent said they would put a pen to the state's dotted line.

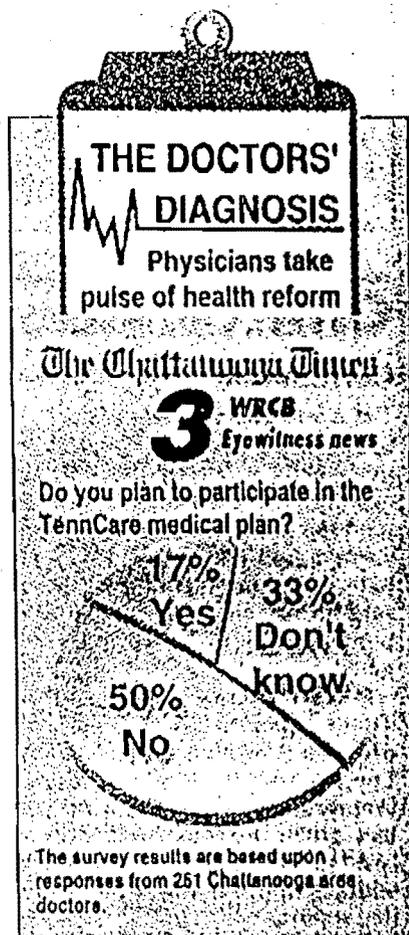
Since doctors have to participate for the plan to work, the high number of "nos" could spell real trouble for Gov. Ned McWhorter's proposed state health reform. It could also mean real confusion in the health-care market, since refusal to take TennCare amounts to dropping Blue Cross' plan that covers teachers and other state employees.

"I read the TennCare contract sent by Blue Cross and only a lunatic would sign it," says Chattanooga neurologist Sharon Farber.

"For instance, under the contract, you couldn't refuse to see patients," Dr. Farber says. "Well, you can't really see enough TennCare patients under the current payment schedule to actually pay your office staff and keep your office open. But you can't refuse to see them and there are only so many hours in a day. So they could keep you from seeing your other patients."

But Manny Martins, director of the state's Bureau of Medicaid, says he thinks doctors will change their minds when the state's TennCare plan gets the go-ahead from the federal government.

"I think a number of physicians are waiting to see if the waiver is approved or not. If the waiver is approved, I think that number of



— Chuck Cleveland/The Chattanooga Times

- TennCare confusion was expected, McWhorter says. A3
- What Chattanooga doctors say about TennCare. A3
- Just how will payments under TennCare be split? A3

nos would probably be different. So, I don't anticipate that to be a

Please see Doctors, A3

Doctors

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real reflection of what the situation is."

Blue Cross' Glen Watson, senior vice president of marketing and legislative affairs, agrees. And he says of Blue Cross' 7,000 physicians statewide in the Tennessee Provider Network, fewer than 100 had canceled their contracts as of Monday.

Watson says the insurance community will bring to the system the managed-care concept that should result in less-expensive health care for the poor. He says in the five years, health-care costs in the TPN network rose about 5 percent while costs in the Medicaid program have risen 22 percent.

But Andrew McGill, director of the Chattanooga and Hamilton County Medical Society, thinks the state may be overly optimistic. He thinks doctors will only sign up to take TennCare if the federal government forces extensive changes in the plan.

McGill says changes doctors would like to see include getting rid of TennCare's tie to the state employee health plan. Currently, Blue Cross is telling physicians, who are under contract to the Tennessee Provider Network, that they must accept TennCare or lose their "preferred provider" status to teachers and other state employees.

Another change McGill says doctors want to see is better payments, or at least a guarantee that they'll receive full payment for all the services they provide to a TennCare patient.

Currently, the state plans to allow insurers to withhold part of the payments — perhaps as much as 40 percent — to ensure the program doesn't run out of money.

The state's contract for insurers says the groups are to divvy up the withholdings at the end of a fiscal

THE DOCTORS' DIAGNOSIS
Physicians take pulse of health reform

Do you expect TennCare will mean more patients for you, fewer patients for you or make no difference in your practice?

More patients	39%
Fewer patients	20%
Make no difference	41%

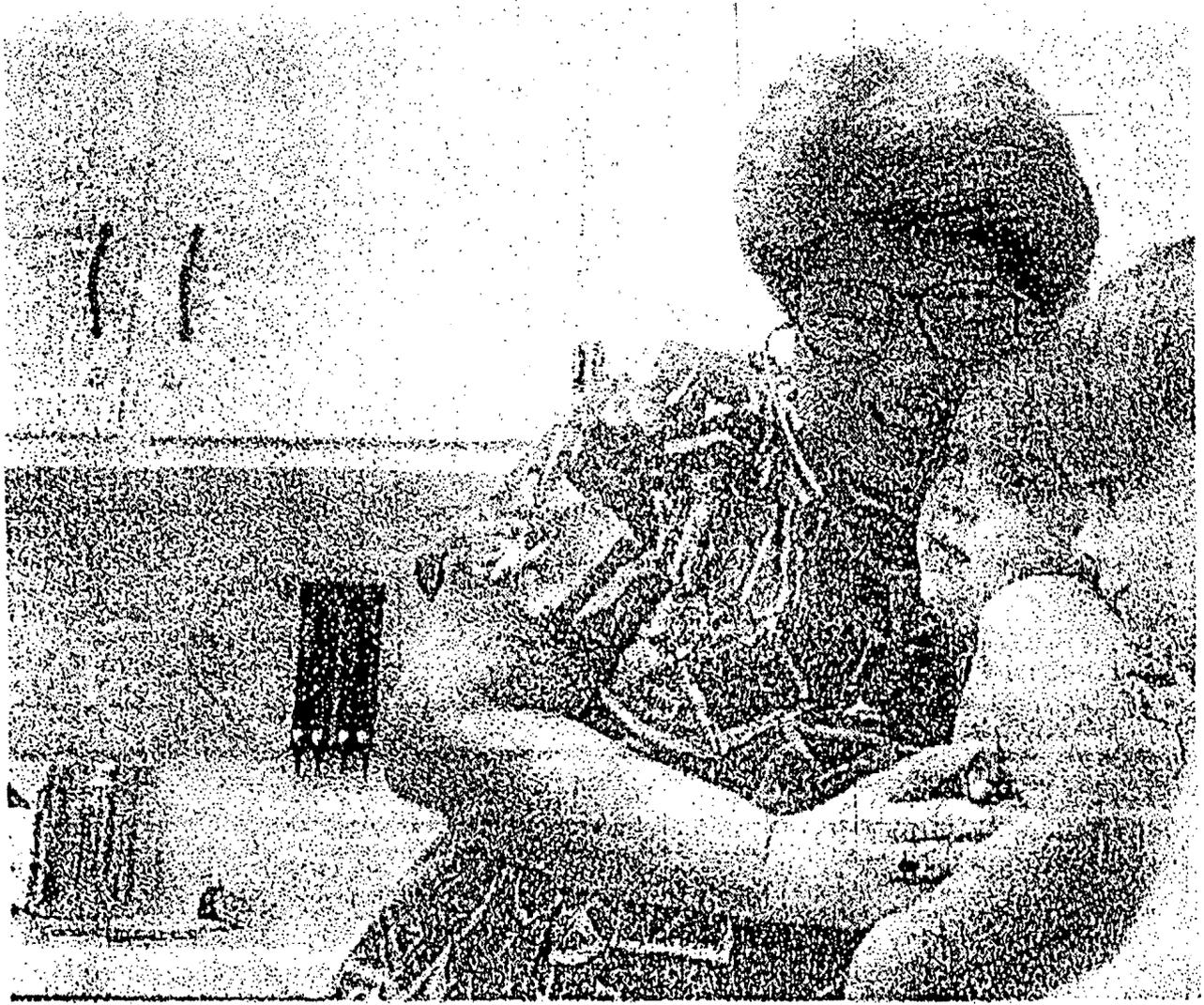
Do you think TennCare will mean better care for your patients, worse care for your patients or make no difference in patient care?

Better care	1.2%
Worse care	75%
Make no difference	23%

—Chuck Cleveland/The Chattanooga Times

period for unpaid bills. But the contract doesn't guarantee payment and the insurers are not responsible for bills remaining unpaid once the allocation is gone. Doctors and hospitals say that leaves them with all the financial risk.

"If the walver comes back with some modifications that make it more acceptable and more workable, that could turn it around," says McGill "But am I confident of that happening? No. At this point, if nothing extreme changes, I think that 49 percent of doctors saying they won't participate will just get higher."



Dr. Iris Snider, a pediatrician in Athens, Tenn., gets a hug as she treats Heather and Haley Hughes. When the girls' father was a boy, he was also treated by Dr. Snider. — Lois Sohn/The Chattanooga Times

Doctor fears 'my kids' will pay a high price under TennCare

By Pam Sohn
The Chattanooga Times

ATHENS, Tenn. — Pediatrician Iris Snider is now doctoring a second generation of children. Some 18 years ago, when she began her practice in McMinn County's largest small town, she treated the father of twins Heather and Haley Hughes. Last week, the toddlers sniffled into her office for a cure.

But as one of five pediatricians treating children in the five rural counties north of Hamilton and

Bradley, Dr. Snider says she fears a coming 30 percent cut in the care available to "my kids."

The cuts she says she's talking about are called reform by state officials. That reform — TennCare — will replace Medicaid and extend state-insured care to as many as 750,000 uninsured Tennesseans if the federal government approves the state's plan.

In Athens and other rural areas, that means a lot of people. Children under age 1 are eligible for Medicaid if their parents' income

is less than 185 percent of the poverty level, so infants in families with an income of about \$20,000 a year are covered by Medicaid if the family has no other insurance.

Certainly, no doctor frowns on the prospect of more accessible health care for the state's unemployed and working poor. But Dr. Snider and many of her colleagues say TennCare, as it's now structured, won't provide better care.

Rather, says Dr. Snider, what

Please see **TennCare, A3**

TennCare

Continued from A1

TennCare mostly will provide is a cut of what has been used for Medicaid money to a new set of middlemen in the charity-care business. Those new middlemen are insurers.

Ranking at the image of money-grabbing doctors worried about losing income, Dr Snider instead accuses insurers of "smelling money" in the care of 15 percent of the state's population that they've never before been able to cash in on.

"This is one of the biggest travesties of the program," she says, "to pay 10 or 15 or 25 percent off the top to an insurance company to manage this. These insurance companies are not in this out of the goodness of their heart. They are in here for one reason — to make money. If they were going to lose money on this plan, they wouldn't be advertising on TV telling people to pick their plan."

Dr. Snider, with some 60 percent of her rural patients covered by Medicaid, offers this example of what she thinks the middlemen will mean to her office:

A visit to Dr. Snider, like those to most Tennessee pediatricians,

is billed between \$35 and \$40. Medicaid pays \$27, sent directly from the state to her office. Two would-be TennCare insurers want to work with Dr. Snider. One may pay only \$12 and the other \$18.

She says Blue Cross' stated rate for an office visit is \$23.06, but she believes that after administrative fees and "withholds" that rate could be cut to \$12. Heritage National has offered to pay about \$24, which she believes will become \$18.

The withholds provide a kind of insurance for the insurers. Blue Cross will not initially pay its full stated rate. Depending on how the TennCare money has held out, the TennCare contract even allows insurers to collect refunds from doctors and hospitals if the insurer decides they've been overpaid.

"I can't keep my office open on \$18 an office call," says Dr. Snider. "Pediatric offices, because of the number of kids we see in the course of a day, are very labor-intensive. We have a nurse per doctor and a front office employee per doctor on average. And a lot of us have a lab. Our labs aren't money-makers, as they are for hospitals. They are a convenience."

Actually, the labs are more than a convenience. The in-office lab keeps children with winter 104 fevers from having to be redressed

and taken to a hospital for lab work, then carried back to the doctor's office an hour later for the report and prescription. And, says Dr. Snider, most pediatricians' lab charges are about half those of a hospital lab.

"So we're also saving money for the patient."

Still, she says, overhead in most pediatricians' offices runs \$24 to \$27 a visit. With an \$18 payment, each TennCare child's visit would mean a \$6 or \$9 loss for the office.

And she says her office is just one of many that will be affected.

As sketchy details began to emerge about TennCare pay rates, Dr. Snider and her colleagues in the Tennessee Pediatric Society surveyed rural pediatricians.

Their effort found that 53 percent to 60 percent of those doctors' patients are Medicaid patients.

"So what are we going to do?" asks Dr. Snider. "I can close my office and go to work in an emergency room and make more than I do now, but where are my kids going to go? I think we're looking real hard at not playing. But I've got 60 percent of my kids out there that I've raised. What am I going to do with them? Am I going to tell them to die?"

"This isn't a matter of finances for a lot of us. It's a matter of our obligation to the community," she says. "Don't they (state officials) know that they're actually going to take care away from these kids?"

What some area doctors are saying about TennCare

"I don't think TennCare has enough money behind it. TennCare is going to be a real foulup. But I will participate in it."

Dr. Joseph Zuckerman,
pediatrician

"I definitely do think doctors saying they will not participate in TennCare is a serious threat. I've been talking to an acquaintance who's a family practitioner and he says the amount TennCare would pay him would only cover about three-fourths of his actual cost, let alone any sort of profit. So they're going to opt out. I think the governor must figure the threat of losing those TPN patients (state employees) from Blue Cross is going to drive doctors into taking TennCare patients. But I think he's wrong."

Dr. Michael Kosanovitch,
pathologist

"This current reform is insane. They expect you to take care of twice the number of patients for half the amount of money. And some of the plans I've heard have just really wacky limitations on the money. That would mean the people would get no care, in essence.

"Plus, you have to realize that when you're dealing with low-income people, you're dealing with a population that has a higher amount of health-care-related problems be-

cause of poor nutrition, often smoking, drinking and poor prenatal care. All the plans assume you're dealing with healthy people and they budget very little money for the actual care."

Dr. Sharon Farber, neurologist

"This is a very underfunded system and there's a lot of education that needs to take place before this system can work. My position is to wait and see if they get the waiver and if there are more details about TennCare. Then you can really make an intelligent decision.

"But right now we think it's not a fair system and it's being implemented in a very haphazard manner. There's a Jan. 1 start-up date for it and patients are calling and asking what plan are you on and we have not even gotten any information from anybody. That doesn't give you a very confident or good feeling about it."

Dr. Lonnie Boaz III,
gastroenterologist

"TennCare is underfunded and that's why it means worse care. I couldn't get 60 patients in there a day to make my overhead. I don't see how anybody can see 60 patients a day and give good quality care. It just doesn't seem possible. You're going to not ask a question or not look at something.

"It means a lot of doctor offices

probably will close. You can't operate on less money while everything else continues to go up. Rent's not being paid by the state or by these people (on Medicaid). It's still there. Salaries aren't going down. Doctors, too, are having to insure their employees, so benefits are going to go up. I don't think they've thought it through.

"But I will play in TennCare. I have no choice. I'm a minority physician and I already see a lot of Medicaid patients because in Chattanooga a lot of minorities are on Medicaid and if you don't see them, it's like you're turning your back on the people you went to school to help."

Dr. Cassell Jordan, pediatrician

"A lot of people are thinking about just dropping TPN (the state employee plan tied to TennCare). See, Blue Cross has a lot of different plans and TPN is just one of them.

"Doctors basically are slow to anger . . . but when things get to this point, that's when doctors start seeing commonality. They would have ignored the TennCare situation completely. It would have been an academic issue. But when Blue Cross said, 'We're going to get these patients and every one of you (doctors) is going to take these patients, that's revolutionary.'"

Dr. Henry Francis, obstetrician

Just how will payments under TennCare be split?

The Chattanooga Times

Under TennCare, insurance groups will get a set amount of money from the state to pay for a patient's care — roughly \$1,200 a year per patient. Off the top, insurers will take their "administrative cost."

State officials have put no minimums or maximums on that cost and the state's Director of the Bureau of Medicaid, Manny Martins, says the state wants to stay out of the fees and charges debate, letting the marketplace make those determinations.

The fees and rates may vary among insurers and, like many other details of TennCare, aren't yet definite. Doctors and

hospitals say they have not yet been told and the largest insurer, Blue Cross, hasn't finalized details.

One benchmark is TennCare's model program, the Tennessee Provider Network, which covers state employees. Blue Cross manages that plan and charges an administrative fee of 10 percent.

With the remaining money, insurers will pay doctors after they "withhold" some amount for a rainy day — when more patients need more care than there is money. The "withhold" figure thrown out by the state in early months of TennCare discussion was 40 percent.