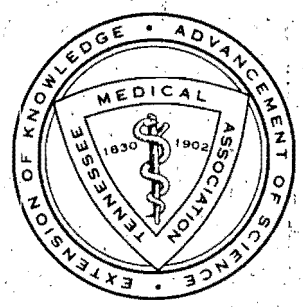

Tennessee Medical Association

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OCT 14 REC'D

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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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

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

Tennessee Medical Association

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Statement to the TennCare Oversight Committee

September 20, 1993

I am Richard Pearson, a Memphis urologist, and Chairman of the Board of Trustees of the Tennessee Medical Association. The TMA welcomes the opportunity to express some of our very real concerns about the program.

First, I would like to comment on Secretary Donna Shalala's most recent announcement that approval of the TennCare waiver application has been delayed. TMA and other health care provider groups have communicated extensively with HCFA about our concerns about the program. However, we have never criticized the 5% provider charity care withhold as a means to draw down increased federal matching funds. Based on our contacts with HCFA officials, we understand that the 5% charity care deduction is the primary federal concern: since other states are poised to file similar waiver applications if TennCare is approved. HCFA and the federal Office of Management and Budget are concerned that this provision, if extended to other states, would represent a significant drain on the federal treasury, just as have donated funds and earlier provider tax schemes. I must emphasize that TMA has not objected to this financing mechanism.

We have, however, met with the administration on numerous occasions and explained the very real problems which TMA sees with the proposal. Unfortunately, since these meetings met with only limited success, we felt we had no choice but to carry the following concerns to HCFA.

<u>We have urged that TennCare be phased-in.</u> The state intends to implement TennCare, virtually overnight, with no transition period whatsoever. A successful transition requires a massive education program, to assure patient compliance. No such program is in place. Further, many managed care networks are only now in their initial stages of development. We believe that

the ensuing chaos will endanger the lives and healthcare of thousands of Tennesseans. We have urged HHS to condition the waiver by requiring that TennCare begin by covering Medicaid recipients only, rather than approving coverage for enrollees up to 400% of the federal poverty level at state and federally subsidized rates. This first of its kind Medicaid overhaul needs fiscal and operational testing.

TMA strongly believes that Providers and Managed Care Organizations (MCOs) must not be forced to assume all of the financial risk. Presently, the plan shifts all of the financial risks to the MCOs and providers. The state, which is insisting on contractual indemnifications, is literally washing its hands of the consequences of what may be overly optimistic funding miscalculations. Further, Blue Cross, which is expected to be the dominant TennCare carrier, as well as other MCOs, will be utilizing a PPO type arrangement in order to shift 100% of the risk to providers. This risk pass through is outrageous and we believe it may significantly diminish physician participation.

TennCare must establish adequate capitation rates. The recently announced capitation rates have fallen well below virtually everyone's reasonable expectations. While this committee has been assured that the gross rates are adequate, particularly if stringent utilization management is imposed, the committee should look instead at the net rates. After TennCare deducts an average of $35.65 per month for charity care, we believe that the actual capitation rate for AFDC eligibles will be in the $60 range. Next, the state intends to deduct another approximate 20% withhold.

Then, MCOs will also subtract from this meager amount their own administrative charges and profits. On top of all of this, MCOs will deduct an additional 10 to 20% withhold which providers may never see. The money that is left must be used to pay for increased benefits for dental, vision, pharmacy, or mental health services, etc. Again, I would remind the committee that the net amounts paid to providers are what is the significant figure.

This ridiculously low payment amount may mean that some reimbursement falls below current Medicaid levels. And, many MCOs have expressed doubts that they could attract providers, cover expenses, and make a reasonable profit unless rates are substantially improved. TMA fears that primary care physicians may not be able to participate unless funding is set at a reasonable level.

Incredibly, the TennCare proposal talks about expected "surpluses!" Virtually no one expects first-year TennCare enrollment to reach its maximum projected level of 1,775,000; instead, 1.3 to 1.4 million individuals seems much more realistic. As the theory goes, if this estimate holds true, a substantial fund "surplus" of several hundred million dollars or more would exist. The state has announced its intention to distribute these excesses to providers to cover bad debt and charity care. Yet, nowhere in the plan is there a formula or discussion on how these excesses will be allocated. In actuality, the method in which these monies, if any, will be distributed will be at the discretion of the administration rather than through clearly defined outlines. TMA urges that auditing mechanisms be required to assure equitable distribution of these funds if they ever become available.

TMA believes that there must be an accelerated time frame to bring in "gatekeepers". While much has been made about the projected cost savings through "managed care" of TennCare, it could be up to three years before any gatekeeper arrangement will be established. With physicians assuming a disproportionate burden of financial risk, especially under Blues' plans, it is vital to implement gatekeeper systems at once. "Management" is a vital component of preventing emergency room abuse and assuring that appropriate levels of care are accessed. Without managed care, the dollars being projected that would be saved at the state and federal level will simply not be there. Once again, the providers are left with this bill.

TennCare needs a competitive environment to succeed. As Blue Cross has the only existing statewide network, they clearly control a dominant share of the non-Medicaid/Medicare market. While it would be extremely difficult to organize a network to compete with the Blues, relatively low capitation rates make it even more difficult. In addition, the Blues' announced intention to require TennCare participation as a condition of participation in the Tennessee Prefered Network is a further deterrent to competition. If the program funding is, as our junior U.S. Senator has suggested, a "cash cow" then why is the state relying on an inappropriate and possibly illegal coercive tie-in arrangement to assure participation?

TMA is also concerned that this tie-in arrangement, which we refer to as the "cram down", may result in dramatically reduced access for other Blue Cross customers including state employees and teachers if significant numbers of physicians opt not to participate.

TMA believes that it will be difficult to collect co-payments and deductibles. Under TennCare, physicians are expected to collect deductibles and co-payments from higher-income TennCare recipients. One troubling aspect here is the inability for physicians to selectively deny care for non-payment of these charges. While a recipient may be disenrolled from the program for a pattern of such failures, this process would take months. As the plan was designed, the co-payment and deductible schedule are based upon an enrollee's ability to pay. And, recipient payments are subject to federal matching funds. However, if this population learns that no payment is required, then they will have little incentive to do so. This will not further efforts to control utilization.

TennCare must include a mechanism to prevent medical practices from being overwhelmed by TennCare recipients. This is particularly important in low-income inner-city and rural areas where many primary care physicians are stretched to the limit with Medicaid patients. Also, how will TennCare patients be allocated to physicians who accept no new patients regardless of their financial status? Answers to these important questions have been virtually ignored by the state and MCOs in their provider contracts.

TMA believes that TennCare's withdrawal of direct and indirect medical education pass through under Medicaid places a severe hardship on teaching programs. How will we continue to train physicians unless these funds are replaced? This program, which must rely on primary care givers, cuts the funding to educate them.

An independent actuarial analysis is sorely needed. Practically every group has expressed serious reservations about the financial assumptions underlying TennCare. We have encouraged HCFA and the Oversight Committee to undertake a full-scale actuarial study prior to granting the waiver in order to assure the economic viability of the program. It's particularly important to see where the actual dollars are going in regard to capitation rates and "surpluses".

We understand that the exhibited actuarial analysis, prepared by Mr. Carlton Morris, with the management consulting firm of KPMG Peat Marwick (Appendix VI to TennCare Section 115 Waiver application), is not a substantive accounting review of the financial integrity of the TennCare program. Instead, it is merely an affirmation of the accounting process used by the McWherter Administration. We confirmed this conclusion by telephoning Mr. Morris. He

acknowledged that his analysis began with the assumption that the McWherter Administration's budget figures were accurate. He candidly noted that an actuarial analysis, which examined the program budget's accuracy, was well beyond the purview of his report. This only amplifies the hidden problem within the TennCare proposal of trying to add 750,000 people to a current Medicaid budget.

Further evidence to support the need for a full-scale actuarial study is a second actuarial study prepared by the same firm of KPMG Peat Marwick for Phoenix HealthCare Corporation. That second study, as reported in the Friday, September 17, 1993, Chattanooga Times, indicated that insurers doing business in the proposed TennCare market would have to operate at 43% less than what the state's Medicaid program has historically paid.

Peat Marwick, in a letter to Phoenix HealthCare, concludes that the states rates are based on a summary of Medicaid's 1992 costs. Not, as the state claims, "trended to 1994" - in other words, not rolled forward for the sake of future cost projections. Additionally, the letter said that the rates were based on just one year and did not include unpaid claims or any allowance for administration.

The second Peat Marwick study concluded that TennCare rates "do not appear to be developed on an autuarially sound basis" and "would not produce an adequate revenue level for most HMOs to provide the desired TennCare benefits".

TennCare suffers from an absence of any professional liability relief. In order for TennCare to work, physicians must be able to say no to additional testing, procedures, and referrals to specialists. Physicians are being faced with tremendous financial pressures to provide more conservative treatment while receiving absolutely no liability relief. Requests for such help have been futile. Physicians must have the confidence to say no to additional utilization in a successful managed care setting. In the absence of broad medical liability reforms, we strongly suggest that physicians be considered state employees for professional liability purposes when providing care to TennCare recipients. Ample precedent now exists since volunteer physicians providing free care are now so designated by local Community Health Agencies.

TennCare's problems are exacerbated by Cost-Shifting. While TennCare is being touted as a way to eliminate the problem of cost shifting, TMA contends that its low provider rates will actually compound the problem. This

is particularly true in areas with high concentration of low-income individuals.

TennCare will adversely impact Primary Care Providers. While the medical profession is frequently criticized for the income of some of its members, these complaints are seldom levied at primary care practitioners. Indeed, various incentives are being pushed to encourage more physicians of these types. Further, Medicare has instituted a relative value based system to improve payments to primary care doctors relative to other medical specialties. In many low-income rural areas, primary care doctors are literally at their wits end. Those who have high volume Medicaid practices are struggling to pay overhead and make a reasonable return for long hours of work. With TennCare threatening to extend Medicaid reimbursement (or much less) to an even higher volume of patients, and with no ability for these physicians to limit TennCare to a reasonable percentage of their overall caseloads, these doctors will be caught in an even greater squeeze. The family physicians, pediatricians, general internists, and obstetricians, which form the lynch-pins of TennCare, will all be significantly harmed by the program if it is left as is.

If during the coming weeks, the state should choose to significantly modify or resubmit the waiver application, TMA stands ready to offer its assistance. Provider involvement in the development of any alternatives would go a long way to assure its acceptance and, more important, its successful operation. We think that a primary weakness of TennCare is that it was developed from the top down, not the bottom up. Unfortunately, it is our patients who are caught in the middle.

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MEMORANDUM

TO: **TMA Member Physicians**

FROM: **Marc E. Overlock**
General Counsel

SUBJECT: **Brief Introduction To, And Analysis Of, Tennessee Blue Cross TennCare Amendment to TPN Network Agreement**

DATE: **21 September 1993**

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I. INTRODUCTION

This memo will give you a cameo overview of certain portions of the Blue Cross-Blue Shield Tennessee Provider Network (TPN) TennCare amendment which, in consultation with your own attorney, you may want to carefully consider. The TennCare agreement should be read in conjunction with your particular TPN agreement. The memo will also provide you with some information on TMA's efforts (often behind the scenes) to effect physician friendly changes in the TennCare proposal. Additionally, please note that the memo does not analyze the "numbers" in the agreement. TMA staff is trying to decipher the reimbursement rates set out by BC/BS in attachment 2 to the TPN amendment. I cannot underemphasize the importance of seeking independent legal advice from your own trusted counsel. Only your own attorney can give you particularized advice. This memo is for your information only. Feel free to share it with your attorney as a starting point for his or her analysis.

As TMA's Legal Department anticipated, when Blue Cross Blue Shield (BC/BS) of Tennessee last week sent out its TennCare amendment to its TPN contract agreement, many physicians were immediately faced with deciding whether to "sign" the agreement or eventually lose their TPN patient business. The importance of this point cannot be understated. TMA has termed this contractual requirement the "Cram Down" provision. TMA has written a letter of complaint to Department of Health and Human Services Secretary Donna Shalala arguing that this arrangement, whether it occurs within the BC/BS network or that of any other insurer, is

illegal under both the federal Medicaid and anti-trust laws.[1] In any event, the amendment does not require a physician's signature to become effective. All one need do is wait in silence and one becomes a TennCare provider within the BC/BS system.

Three weeks ago, TMA attempted to work with a TMA member who serves on the BC/BS Physician Advisory Committee. The physician had forwarded the TennCare Amendment for its TPN Network Agreement and requested that I comment on its various provisions. The BC/BS Physician Advisory Committee is charged with the responsibility of approving the contract for use with TPN member physicians. They met in Nashville and had the benefit of my memo criticizing the contract. As we understand it, when the committee rejected some of the clauses to the amendment, BC/BS officials informed them that the committee's approval was no longer necessary for the institution of the TennCare amendment.

The BC/BS TPN amendment ("agreement") is based, to some extent, on the first **draft** TennCare contract form sent out by the State for review and comment by providers and insurance companies that may participate in TennCare. Please note that the State's form contract was a first draft, with revisions to follow according to provider and insurer comments. TMA sent the State detailed comments which the State has taken under advisement. The State plans to issue a **second** draft which will again be sent to provider and insurer groups for review and comment. (The State had promised to give TMA the second draft some ten days ago.) The **most important victory** was the State's agreement that physicians should not have to indemnify (i.e., provide a legal defense, and pay liability judgments for) the State of Tennessee or for TennCare. BC/BS has deleted this requirement from their contract, but retained the requirement that TPN physicians buy liability and malpractice insurance for BC/BS. TMA assumes that all TennCare provider contracts will need to be amended **further** when the State issues its second draft TennCare provider contract. This assumption should hold true with BC/BS, **but you should check with any and all carriers you consider contracting with to provide TennCare services**.

Overall, the agreement brings into sharp focus TennCare's bleak financial/reimbursement picture. As with all TennCare carrier agreements which TMA has heard about (and which are based on the State's draft insurance company contract), all financial risks of underfunding are

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[1]Interestingly, although the State has indicated that they are leaving it up to BC/BS to decide whether it wants to require its TPN providers to treat TennCare patients, BC/BS officials stated (in the minutes of the July 30th Physician Advisory Committee meeting) that "comments from the State indicated no benefits for State Employees would be paid to providers if they refused to participate and accept TennCare patients." TMA has attempted to track down the source of the authority for the Cram Down requirement. State officials deny that they are requiring BC/BS or any other TennCare carrier to conduct a Cram Down. Instead, they have consistently indicated that it was totally up to the various TennCare carriers whether they would require that network physicians treat TennCare patients.

borne by providers. This means that in any one month if the TennCare claims exceed budgetary expectations, the ability of any carrier to reimburse claims will be severely limited. Additionally, in such instances there will be severe pressure on utilization review mechanisms to deny coverage so that there will be monies available in future months to pay claims. In lay terms what this means is that providers will be faced with an untenable choice: provide the care free or face the malpractice liability consequences for not providing care and having the patient have a bad result. BC/BS, like all other TennCare carriers, passes off this financial risk to providers. You will note the language in Section 4.3 on page 5:

> **To the extent and only to the extent that BCBST is provided with funds by the State for the payment of TennCare claims,** BCBST shall make payments to PHYSICIAN for Medical Services rendered to TennCare Enrollees pursuant to the provisions set forth in this Amendment and the TennCare Schedule of Payments.

Other Points To Consider:

1. There is neither a start up date nor an ending date for the agreement. Nor does BC/BS list a date by which a physician can accept or reject the agreement. Presumably, under Section 10.1 of the TPN Contract (not the TennCare agreement) member physicians will have 60 days to terminate their participation in the network. If you reject the contract, you may or may not be able to successfully reapply for reentry into the TPN thereafter. If you choose to not participate in the BC/BS TennCare plan (and, thus, the TPN network) <u>you must notify BC/BS in writing within 30 days of your receipt of the TennCare TPN Amendment. (See ¶11.7 to the TPN agreement.) In many cases this means during the first week of October, 1993. If you miss this deadline, and want to terminate the agreement thereafter, then under ¶10.2 you can invoke the 60 day notice period. Thus, if TennCare starts January 1, 1994, you must notify BC/BS by November 1st to begin the 60 day period. November 1st is the second deadline</u>. At TMA's request, BC/BS will clarify these deadlines in a letter to TPN providers in the near future.

2. The Department of Health and Human Services (HHS) has not yet approved a waiver for TennCare. TMA has advocated for a conditional waiver with a phased in period to slowly bring in uninsured patients. TMA has demanded that the Cram Down provisions be declared illegal under the antitrust laws and the Medicaid statutes. HHS stated it would respond to the waiver request by Friday, September 17th. This deadline has been put off, perhaps for another two weeks. What HHS says will be of critical importance and will help define the contractual rights physicians may gain with TennCare carriers. TMA will continue to notify you as we get updates.

3. No health insurance company has yet been certified as a TennCare provider. Presumably, BC/BS will be certified without any problem. But, contracting before that certification date may be premature.

4. TennCare providers cannot reasonably limit the number of TennCare patients they are required to see and treat. (See Section 3.8, on page 4.)

5. The State has prohibited BC/BS from implementing its "most favored nations" clause which requires that TPN providers give BC/BS their lowest treatment rates. In other words, if a physician agrees to give another carrier a lower rate than the one he or she negotiated with BC/BS, he or she must give the same rate to BC/BS. Again, there is <u>no</u> such requirement in this TennCare agreement.

6. Any time you read a contractual clause that indicates details are to be filled in later, or things are to occur or not occur in the "sole discretion" of the carrier, then you are at the mercy of the carrier to get those terms filled in at that later time. Courts call such contractual provisions illusory since they really are nothing more than an illusion. Ask your attorney for help in getting such clauses defined.

7. BC/BS requires that you provide it with liability and malpractice coverage for harm and liability claims for which it should be responsible. See Section 3.6. Before you agree to this provision, you may want to consult with your malpractice carrier to make sure such coverage is available and affordable.

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II. ANALYSIS

Due to time constraints, the following examination is limited to certain contractual provisions in the agreement. Again, this discussion is for reference only and must not be construed as legal advice.

Section I. – DEFINITIONS

¶1.11 "Withhold"- This term is defined as the percentage of each TennCare Enrollee's benefit payment withheld by BCBST to <u>ensure that total benefit costs</u> for each CSA (geographic service area) <u>do not exceed funds made available</u> by the State to BCBST under TennCare. This definition is illusory since there is no indication of what the withhold amount will be at any given point it time. Thus, any time the term is used in the agreement, there is no measure a physician can point to with accuracy to determine his or her actual reimbursement from one month to the next. Even BC/BS is in a difficult position since it has no idea whether the State's TennCare budget figures are accurate. Elsewhere in the contract, as noted below however, BC/BS bears no financial risk whatsoever since the TPN providers shoulder the financial burden of underfunding.

Section III. – PHYSICIAN SERVICES AND RESPONSIBILITIES

¶3.3- This clause requires that the physician allow BCBST and the State the right to monitor and evaluate the quality of services delivered, and to take corrective action as necessary. The physician is then required to "promptly comply" with the corrective action plans. Although this clause, to some extent, is standard managed care contract fare, it would be helpful if the phrase "prevailing standards" was deleted and the following wording inserted instead: "acceptable professional practice in the respective community in which the physician practices."

¶3.4- This clause requires that the physician allow BCBST, the State, and HCFA to conduct on-site inspections of the physician's offices. A reasonable notice provision should be inserted here so that the physician does not have to stop caring for patients simply because one of those entities decides to make a surprise office visit.

¶3.5- This clause requires that the physician permit BCBST, HCFA, and the State to review all TennCare records under the physician's control. Again, a reasonable notice provision should be inserted so that the physician can make arrangements to prepare for the on-site visit.

¶3.6- This clause requires that a physician carry malpractice insurance coverage as required by BCBST. Depending on the capitation rates physicians may have to cost shift to afford to purchase the kind of insurance required. Of critical importance here is the requirement that a physician carry liability and malpractice insurance, not only for TennCare enrollees, **BUT BC/BS AS WELL.** Then, BC/BS gets to "reasonably determine" how much insurance will be required. This clause should be clarified. Is the physician required to cover liability claims against BC/BS? For what? Would it not be more reasonable to have BC/BS insure itself for harm it causes? **REMEMBER** BC/BS's utilization review decisions may determine the extent of the care you can provide patients. Thus, if a patient does not get needed treatment because of a faulty UR decision (or one that is based merely on the fact that there are no funds available to pay for the care), your insurance must cover BC/BS's fault as well!

¶3.8- This clause, mentioned above, limits the ability of physicians to refuse to accept TennCare patients. Ordinarily, in HMO/PPO contracts one of the main benefits to participation is the increased patient load a physician can expect. In theory, with increased patient load comes an increase in gross income. With TennCare however, as currently proposed, reimbursement is tied to the number of claims in any one month and the availability of funds to cover the costs of the patient care delivered. Thus, also as noted above, if there is no money, providers bear the costs of patient care and can expect no reimbursement. In any event, this clause effectively prevents physicians from capping their TennCare patient loads as a reasonable method of conducting their ongoing businesses. Note that the escape clause, which states that physicians shall not be required to accept or continue treatment of patients with whom the physician feels he or she cannot establish or maintain a professional relationship, is limited (although not so in the contract) by the State's intended requirement of a grievance procedure. State officials candidly admit that the grievance review may take up to six months "to ensure due process..."

Section 4. -- COMPENSATION

¶4.3- As previously noted above and in other TMA TennCare alerts, TennCare only provides physicians with reimbursement after several different withholds are taken, the insurance carriers take their no risk management fee, and there is actually enough money left to cover the claims. As this particular clause indicates, BCBST, in essence, is responsible **only** for making payments to the physician when the State provides it with enough money to do so. It seems to suggest that payments will be regularly made according to the "TennCare Schedule of Payments." However, this is an illusory provision. If there is no money in the TennCare budget, BCBST is not required to make any reimbursement payments to network physicians.

¶4.4- This paragraph indicates that BCBST will be withholding an unstated percentage of benefit payments due the physician for treating TennCare enrollees "based on the TennCare enrollee's CSA of residence." The clause goes on to note that "the amount of Withhold will be computed on Negotiated Fees after consideration of deductibles and co-insurance." There is no indication as to when BCBST will pay the withhold or whether all services are covered. TMA has previously heard that Blue Cross plans to withhold up to 30% of each benefit payment which would otherwise be due the physician for treating a TennCare patient. This clause is followed by several other illusory provisions up through paragraph 4.7. Theoretically, physicians can negotiate their reimbursement levels with BC/BS. However, the cover letter and the agreement imply that no negotiation can or will occur. Either you agree to the terms, or you are out of the TPN network.

¶¶4.5-4.7- Clause 4.5 is illusory since BC/BS gets to determine in its <u>sole discretion</u> what the withhold percentage will be. Further, the withhold percentage will be gauged (apparently) "to the end that benefit payments for respective CSAs do not exceed funds made available to BC/BST by the state." Again, this is an example of a set of details to be filled in later by Blue Cross. TPN physicians will, if they execute this agreement, have to depend on the good faith of BC/BS to make regular payments and to return withheld amounts when due. The main difficulty is, as with the rest of the TennCare program, that unless funds are available from the TennCare program, physicians will not always be assured of getting paid for services rendered. BC/BS, on the other hand, gets its administrative fees no matter what.

Paragraph 4.6 continues the illusory provisions noting that amounts withheld "**<u>may be refunded if total CSA benefit payments do not exceed funds made available to BCBST by the state for this CSA</u>**." It is unclear how TPN physicians are supposed to be able to figure out whether and to what extent they will get any money whatsoever from BC/BS under the TennCare proposal.

Paragraph 4.7 notes that a physician will be entitled to receive "a portion" of any surplus funds within TennCare. The state's <u>first</u> draft contract limited this portion to 105% of a physician's negotiated fee. TMA heard from state officials that they may back off this incredibly low cap. Here, a physician is not even guaranteed the extra 5% since BC/BS uses the limiting phrase "a portion."

¶4.8- This section appears to allow a physician to bill patients for services which are not covered by TennCare. The difficulty with the clause is that it is hard to understand. Apparently, a physician can bill for services which are not covered by TennCare, including deductibles and co-insurance for services that are covered by TennCare, as long as BC/BS approves of the billing. This section should be clarified to state in plain English what is meant.

¶4.10- This section states that physicians who bill BC/BS for TennCare reimbursement are required to provide all necessary records without charge. It then notes that TennCare officials and BC/BS reserve the right to perform on-site audits "at any reasonable time" concerning the physician's records. The physician agrees to cooperate with such audits. This section should include a reasonable advance notice period so that physicians are not surprised by an on-site audit during a busy day of patient care.

¶4.11- Most Favored Nation's Clause. This paragraph prevents BC/BS from requiring TPN physicians to be reimbursed for other TPN services to non TennCare patients at the TennCare rate.

V. RECORDS, ACCESS, INSPECTION AND CONFIDENTIALITY

¶5.2- As with the criticisms noted above, this paragraph also requires that physicians allow on-site inspections and audits, including copying at no charge, of all TennCare related records. It is unclear why physicians are required to bear the costs of copying medical records for the TennCare program or for BC/BS during audit periods when the capitation rate will be unreasonably low and will in no way compensate them for the provision of such records. The same criticism applies to paragraph 5.5.

VI. CONCLUSION

Please note that this brief analysis is not meant to be used as a substitute for a review by an attorney of your choice. It certainly is not an exhaustive explanation of the legal implications of your agreeing to enter the TennCare contract with BC/BS as a TPN provider. There are many details yet to be worked out under TennCare both on the federal and state levels. All TennCare carriers are under intense pressure from the State to meet certain deadlines for participation in the program. This is one reason you may be being deluged with TennCare contracts. Consider each one carefully and look especially at the reimbursement rates, the liability insurance requirements, and the financial risk pass through. You may want to begin your own analysis with an examination of the actual cost you pay for staying in business. TennCare may or may not cover your overhead, let alone ensure you a modicum of profit. TMA will continue working to craft TennCare into as reasonable a program as possible. Alternatively, TMA has many other options in the legal and legislative arenas for relief if unreasonable terms continue to be forced on physicians. Please keep us apprised of your practice needs and situations in this context. Thank you.

Sequence of Events
TennCare Waiver

1. June 16, 1993

   Governor delivers TennCare waiver to Secretary Shalala in Washington

2. June 17, 1993

   MM met with HCFA staff in Baltimore

3. July 26, 1993

   Received questions from HCFA. Response needed within three weeks.

4. July, 30, 1993

   Governor and Secretary Shalala meet in Nashville. Secretary Shalala indicates that she will act on the waiver by September 17, 1993.

5. August 4, 1993

   Response to HCFA questions.

6. August 11, 1993

   Letter from Secretary Shalala confirming final action on Tennessee Waiver by September 17, 1993.

7. August 18-19-1993

   19th a.m. - DLM, MM met with Vic Zaffra of OMB and John Monahan of HHS

8. August 23-24, 1993

   24th a.m. - DLM, MM met with Bruce Vladeck. Requested follow-up provided September 1.

9. September 9-10, 1993

   9th - DLM, MM met with Bruce Vladeck. Requested follow-up provided September 14th.

   10th - DLM, MM met with HCFA staff.

10. September 14-17, 1993

16th - DLM, MM met with Bruce Vladeck's staff (Vladeck sick). Letter from Secretary Shalala indicating decision will be delayed.

17th - Numerous telephone discussions with HCFA staff awaiting their position paper. Position paper delivered.

11. September 22, 1993

DLM has telephone conference with Bruce Vladeck regarding clarification of HCFA's position paper.

12. September 23, 1993

Clarification of HCFA position paper delivered to State.

13. September 27-29, 1993

27th - DLM met with OMB;

29th - DLM met with Bruce Vladeck.

14. September 30, 1993

Revised TennCare proposal delivered to HCFA.

Office of the Vice President

Domestic Policy
Old Executive Office Building
Washington, DC 20501
(202) 456-6222

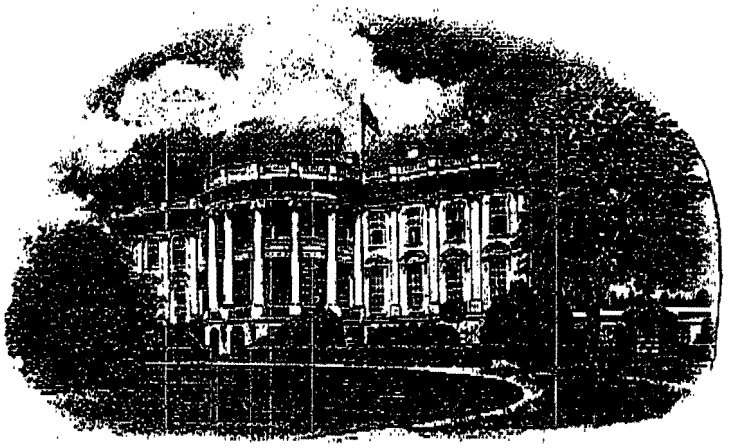
TO: ROZ 2878

FROM: CHARLOTTE

DATE: 5/21/93

number of pages including cover: _____

COMMENTS: PER OUR CONVERSATION FAX TO CAROL. THANK YOU!!



MEMORANDUM TO CAROL RASCO
MARLA ROMASH
GREG SIMON

DATE: April 21, 1993

FROM: Charlotte Hayes

SUBJECT: Tennessee Medicaid Waiver Proposal -- Update

BACKGROUND
As I indicated in my previous memo on the Tennessee waiver proposal issue, the state has papered Washington with a preliminary draft of its proposal **to opt out of all of the Medicaid program requirements** and restructure its internal financial approach to the state's obligation to match the federal government payments for Medicaid.

Since the beginning of April, the Governor has told a joint session to the legislature about the plan. He has said that he will complete the bulk of the state's changes by executive order the changes in definitions of eligibility by legislative action.

The scenario I sketched out earlier is playing out:

The Governor will file the waiver application soon and ask the state legislature to delay elimination of the hospital tax which is scheduled to expire March 31, 1994 in anticipation of the waiver approval. The tax would remain in effect unless repealed during the January 1994 session. The TN Medicaid program is still in the same fiscal position of being in the red by $764 million, because the program has continued to grow at an annual rate of 20% without any additional state funding being added. Hospitals fear this result . The only relief from this result would be the swift approval of the waiver. The Administration would be in the position of not being able to get a quick approval (even with this preview/notice provided by the Governor and despite the President's promises to the Governors), because the quickest such waiver out of HCFA has taken at least a year. In addition, the Vice President as a Tennessean would appear not to be able to take care of the state.

STATUS
I am receiving many reports that the Governor and state government personnel are saying that the waiver approval is a done deal, that the President has indicated it will be granted very quickly. This information follows the several news clips I sent to you from the Tennessean and others that the Governor said that the proposal was well received in Washington. As I said in my previous memo, no one at HHS or in the White House has indicated as such. Everyone who got the proposal was decidedly neutral, since we have not seen a final application with a full set of numbers, an assessment from outside parties, and therefore do not know what view the Vice President and the President would take on the matter.

QUESTION
What action if any should we take at this point in time?

file

"Tennessee
Medicaid Waiver"

I need it back to
read it -

Carol -

I just learned
that:
1. TN Hospital Assn
has had a consultant
look at proposal,
analyze it the way, and
2. Each hospital
very alarmed esp
ERLANGER, VANDERBILT,
THE REGIONAL MED
Charlotte

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

DAVID L. MANNING
COMMISSIONER

D R A F T 3-23-93

A PROPOSAL FOR HEALTH CARE REFORM IN TENNESSEE

BENEFITS OF THIS PROPOSAL INCLUDE:

- Comprehensive health insurance for <u>every</u> Tennessean;
- Eliminates the "medicaid problem" in the state's budget by assuring that future growth will not exceed the rate of growth in state tax revenue;
- Eliminates the need for the Hospital Services Tax;
- Saves the federal government an estimated $1.5 billion over the next five years;
- Eliminates "cost shifting" to the paying patient and the business community of the cost of indigent health care;
- Permits the market to limit total health care spending in Tennessee which would, if limited to the growth in our economy, save an estimated $6.5 billion by the year 2000; and
- Moves Tennessee in the direction of national health care reform.

Tennessee and the nation face critical decisions in health care reform. The President will make recommendations to the Congress in a few weeks which will result in a major national debate about how best to make and pay for the needed changes. The most optimistic time-frame for a decision by the Congress is late 1993 with a three to five year implementation period. Unfortunately, Tennessee does not have that much time. In fact, we must make critical decisions in the next thirty days.

If we make these decisions as they have been made in the past, we must either have a major tax increase or make major reductions in health care for the almost one million Tennesseans who are covered by the Medicaid program. In either case, the solution will be for one year with even greater tax increases and/or health care reductions required next year and in every

ɜding year until fundamental reform becomes a reality. ɜsident Clinton has indicated that he will give states the flexibility to design their own solutions through the waiver process. Obviously, any alternative approach that we pursue for Tennessee should move us toward reform, which is consistent with the objectives of national reform, including comprehensive universal coverage and cost control.

The most recent Congressional Budget Office study of health care and our own estimates of health care spending in Tennessee document an enormously inefficient health care system. The CBO study estimated that health care costs were over $800 billion in 1992 or about 13.6 percent of Gross Domestic Product (GDP). This is more than double the share of GDP which health care consumed in 1965. The CBO also projects that if the current system is not changed it will consume about 18 percent of GDP, or about $1.7 trillion, by the year 2000. In Tennessee, it is estimated that health care costs were approximately $13 billion in 1992. If present trends continue, health care will cost almost $27 billion in Tennessee by the year 2000 (Attachment A).

Using the State of Tennessee's Group Insurance Plan as an example of a comprehensive managed care plan, this problem can be clearly demonstrated. The state's group insurance plan is an aggressively negotiated Preferred Provider Organization covering in excess of 100,000 employees and dependents. The benefit structure compares very favorably with large, private sector plans. It's managed care provisions are primarily process oriented with preventive care and wellness programs in the mainstream of large, private sector plans. The average cost per covered person in FY 92 was $1463 ($1194.40 plan cost and $268.86 out-of-pocket). If the same level of coverage were provided for all Tennesseans the cost would be approximately $7.2 billion, in contrast to the $13 billion actually spent on health care. Approximately $1.4 billion of the difference is nursing home and dental expenditures, leaving an unexplained difference of $4.4 billion <u>after</u> considering the full cost of universal coverage.

It is doubtful if a substantial portion of this difference is explained by extraordinarily high cost among a portion of the insured population for at least two reasons. First, a group of the size of the state group insurance program has a diversity of risk which should reasonably represent the entire population. Secondly, the medicaid population includes a large number of our most medically fragile citizens and its cost was only $1,474 per eligible (excluding Nursing Home Care, Medicare Premiums and MDSA).

At the national level, the numbers are not significantly different. Adjusting the Tennessee costs to the national average (Attachment B), universal coverage would cost approximately $409.5 billion, in contrast to the $809 billion actually spent on health care. If you assume that the 37 million uninsured Americans pay no out-of-pocket costs (an unreasonable assumption

since the CBO study indicates that almost 40% of the uninsured have incomes above 200 percent of the poverty level) it would increase the cost by approximately $10 billion, leaving enormous financial flexibility for an "efficiently" managed system.

The answer to paying for universal coverage is not to put even more money into such a massively inefficient system, but instead to redirect public and private resources into large Health Insurance Purchasing Cooperatives at the community level with a mandate to cover all citizens living in their respective communities. An alternative, and perhaps transitional approach, is to pool certain public resources to purchase care for the combined medicaid and uninsured populations. It is this concept that Tennessee should seriously consider to address our immediate health care problems.

FINANCING HEALTH CARE REFORM IN TENNESSEE

Universal coverage for all Tennesseans can be accomplished by pooling certain public financial resources without the need to continue the hospital services tax. The public resources which should be pooled, include state and federal medicaid funds, other state and federal health care funds, the cost of charity care (including bad debt) already provided to the uninsured by health care providers and existing local government subsidies for indigent care. These funds should be combined with premiums (20% of total premium), coninsurance, co-pays and deductibles of individuals covered under the new program with incomes above the poverty level. The total of these resources is estimated to be over $3.8 billion (Attachment C), assuming the federal government contributes, for the first year of the plan, the same amount it would have contributed if the Medicaid program had continued without change. Total federal participation as a percentage of total funding, even without the hospital and nursing home taxes, would be less than the current federal participation level of 67%. These funds could provide for the cost of full coverage for almost 1,000,000 Tennesseans covered by the Medicaid Program and the uninsured population which is estimated to be between 14 and 16 percent of our population.

The plan, which would require a federal waiver, would work as follows:

(1) Expand the Tennessee Comprehensive Health Insurance Program (TCHIP) to include all Tennessean's now covered under the state's Medicaid Program and the entire uninsured population. Require, on an annual basis and at time of enrollment, citizens to choose any TCHIP option which would include the present Blue Cross plan, the HMO's presently operating and planned for the Medicaid Program and other qualifying plans (see Attachment D for requirements to be a TCHIP Plan).

(2) All participants in the program with family incomes above the poverty level would be required to pay 20 percent of the premium cost and co-insurance in the same amounts as those required under the state group health insurance plan. Individuals under 200 percent of the poverty level paying on a sliding scale based on their ability to pay. TCHIP's benefit structure would be the same as the benefit structure of the state group insurance plan with the exception of the deductible which would be maintained at the current TCHIP level of $1,000. No deductibles or co-pay would be required for preventive services. (Attachment E)

(3) All health care providers would be required to accept TCHIP as a condition of participation in any state or federal health care program.

(4) All employers would be encouraged to enroll and provide payroll deduction of premiums for all of their employees (full-time and part time) and employee dependents to the extent they are not eligible for coverage in an employer sponsored health plan under conditions existing on March 1, 1993.

(5) State government would enroll all citizens who are eligible for Medicaid, all recipients of unemployment compensation who are not covered under another health plan and all others, to the extent they qualify for coverage as described in Attachment F.

(6) Community Health Agencies (CHA's) would enroll all eligible citizens who were not enrolled by state agencies as described above. CHA's would also be responsible for: developing quality and cost information and making it available to the public, health care providers and employer health insurance sponsors. CHA's could also accept for enrollment referrals for TCHIP directly from health care providers.

(7) Health care providers would be required to track out of state patients separately and ensure, to the best of their ability, that profits at least covered any losses due to charity and bad debt.

(8) Each community would be separately rated and each plan within that community would be given a per capita spending target. Initial per capita spending targets and provider reimbursement would be based on the actual cost of hands-on care (i.e. the provider's marginal cost less charity care) plus the management fee, with the final spending target based on the final number of persons covered by each TCHIP plan. Final provider reimbursement would be based on a negotiated rate not to exceed their charge to their best customers, with the HMO or insurance company paid a management fee based upon the management fee paid under the

state employee group insurance plan. Each TCHIP plan within a community exceeding its target expenditure in total would be prorated back to the target, with any TCHIP plan producing a savings would be permitted to distribute the savings among its providers as long as final reimbursement does not exceed 105% of the provider's negotiated rate. Provider reimbursement, however, would never be less than the provider's marginal costs.

(9) The chronically mentally ill and children in state custody or at risk of state custody, would be enrolled in separate TCHIP plans which would continue to be administered by the state.

(10) The Nursing Home Program and services to mentally retarded citizens would continue under the present Medicaid Program.

(11) Public Health services would be continued and directed to assure services in areas which would otherwise be underserved and to assist all TCHIP Plans in providing preventive health services to help control long-term health care costs.

(12) State funding would be increased each year at a rate equal to the growth in state tax revenue, less any dedicated tax increase, not to exceed the rate of growth in the economy. Local government funds would be frozen at their current level. Federal and other funds would grow at the rate of growth in total plan expenditures, not to exceed the growth in the state's economy.

(13) All private health insurance plans (including deductibles and co-pay) would be encouraged to limit the amount their premiums could grow in future years to a rate not exceeding growth in the state's economy (Attachment G). The only exception would be private plans with benefits which are lower than the state group insurance plan, which would be encouraged to grow in excess of the rate of growth in the economy until their benefits are comparable.

HOW IS THIS POSSIBLE?

The obvious question is how can Tennessee finance universal converge without the hospital taxes, if we can't adequately finance Medicaid with those taxes? The answer lies in taking full advantage of all of the financial resources we have to serve the uninsured and placing them in an accountable, managed care system. Financial resources available for the uninsured include:

Medicaid Disproportionate Share Payments	$431 million
Charity Care	595 million
Co-Pay and Deductible from those above the poverty level	228 million
Local Government Funds	50 million
	$ 1,304 million

Based on the demographics of the uninsured and the cost of coverage under the Medicaid Program (using medicaid actuarial tables adjusted to 1994 levels) this represents more than an adequate amount to insure the entire group. The enormous growth of the Medicaid Program has been driven, for the most part, by the steady movement of these uninsured Tennesseans into the Medicaid Program. They have come under Medicaid coverage as a result of rising medical costs which force people to "spend down" their assets making them "Medicaid eligible" and federal mandates requiring states to extend Medicaid coverage to more of the uninsured population. Extending coverage to the entire uninsured population will both bring management to this group's health care cost and eliminate this major source of the Medicaid cost explosion, as well as control cost shifting to the private sector.

The other major reason this reform is financially feasible is the opportunity to manage the health care of those who are Medicaid eligible in the same way we manage the health care of other large groups. The State Group Insurance Program has successfully used the buying power of a large group to purchase health care on the " margin". The combined Medicaid and uninsured populations are a group which is almost eight times larger than the combined state employee, teacher and local government plans. This should permit the purchase of quality health care at the best price available in the market place. This buying power should enable us to both insure the entire Medicaid and uninsured population and control future costs much more effectively than we have been able to control these costs in the Medicaid Program.

CONCLUSION

Tennessee has little choice but to actively pursue health care reform on a faster time-frame than national reform. Our reform should be aligned, to the maximum extent possible, with the direction of national reform, and should focus on better management of existing funds. This proposal meets these objectives and, with timely federal approvals, can be implemented by early 1994.

In addition, the proposal will virtually eliminate "cost shifting", thus removing one of the most serious barriers to true business negotiation in health care. It will also limit the growth in health care spending to the growth in our state's economy and thus encourage competitive forces to restructure both the existing financial resources and new financial resources into a market driven health care system which provides quality, accessible health care for all Tennesseans.

Attachment A

Projected Tennessee Health Tax Sources

Sources of Funds	Health Tax Sources* Millions			
	CY1990	CY1992	CY1995	CY2000
Total	10,694	12,990	17,213	26,960
Offices and clinics of doctors of medicine	2,609	3,170	4,200	6,578
Offices and clinics of dentists	563	684	906	1,419
Offices and clinics of doctors of osteopathy	10	13	17	26
Offices and clinics of other health practitioners	208	253	335	525
Nursing and personal care facilities	593	721	955	1,496
Hospitals	5,927	7,199	9,540	14,941
Payments for medical services	5,116	6,214	8,234	12,896
Other amounts from providing services to patients	101	123	163	255
Governmental grants	22	26	35	54
Private grants	55	67	89	139
Investment income	67	81	107	168
Rents and commissions	4	5	7	11
Appropriations	540	656	870	1,362
All other sources	19	23	31	48
Contract research and rental of medical equipment	3	3	4	7
Other health services	783	951	1,261	1,974
Medical and dental laboratories	217	264	350	548
Home health care services	197	239	317	496
Kidney dialysis centers	16	20	26	41
Specialty outpatient facilities	214	260	345	540
Health and allied services	63	77	102	159
Other	76	91	121	190

* For 1992, 1995 and 2000 the national growth rate was assumed.

ATTACHMENT B-1

The cost per person should be adequate based on the average cost per employee of $1,194.40 for the State of Tennessee's Group Insurance Plan plus $268.86 out-of-pocket cost, adjusted to the national average of other large insured plans documented in the "Foster Higgins 1991 Health Care Benefits Survey". The adjustment is made by inflating the state plan's cost by the difference between the South Central region's cost and the average cost for all employers (i.e. $3,605 - $3,256 = 110.72).

The State of Tennessee's Group Insurance Plan is an aggressively discounted Preferred Provider Organization which should better reflect managed care cost than typical plans.

STATE OF TENNESSEE
INSURANCE ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
SUITE 1400, ANDREW JACKSON STATE OFFICE BUILDING
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0295

MEMORANDUM

TO: Commissioner Manning

FROM: Richard Chapman RLC

SUBJECT: State Plan Costs

DATE: December 22, 1992

You asked me to determine the per plan participant cost of the State Plan for FY 1991-92. This figure had not been calculated previously because the State has not maintained a count of participants (employees, spouses and dependent children) covered by the plan only monthly contracts.

To determine the average number of plan participants the November 1992 eligibility file was examined. During that month 135,074 lives we covered by 60,931 contracts, about 2.216 individuals per contract. During FY 1991-92 we averaged 59,845 contracts per month or about 132,667 individuals based upon the November 1992 ratio.

Blue Cross reported providing $158,457,300 in benefits during the period. Treasury cleared $162,423,788 in checks. The Treasury figure needs to be adjusted by about 3% which has been the normal value of workers compensation adjustments and refunds from Blue Cross which are accounted for separately. Based upon that fact, the adjusted Treasury figure would be $157,551,075.

Using what Blue Cross reported the benefit cost for 1991-92 was $1,194.40 per State Plan participant. The Treasury figure, when adjusted, was $1,187.57.

Should you have any questions or require additional information, please let me know.

RLC:ce

Comparison of Health Care Benefit Cost

Region	1991	% chg	1990	%chg	1989	%chg	1988	%chg
Pacific	$3,659	12.24%	$3,260	10.77%	$2,943	21.31%	$2,426	8.01%
Mountain	3,262	8.81%	2,998	10.91%	2,703	16.01%	2,330	21.99%
N Central	3,546	9.65%	3,234	14.60%	2,822	9.81%	2,570	24.46%
S Central	3,256	9.15%	2,983	18.80%	2,511	9.03%	2,303	20.39%
New England	3,918	16.57%	3,361	16.06%	2,896	30.69%	2,216	7.42%
Mid- Atlantic	4,066	14.44%	3,553	19.55%	2,972	28.83%	2,307	16.87%
S Atlantic	3,412	15.47%	2,955	22.72%	2,408	14.23%	2,108	18.29%
ALL EMPLOYERS	3,605	12.06%	3,217	17.07%	2,748	16.74%	2,354	18.59%

RGMDCST8
12-21-92

Tennessee is in South Central Region
Source: Foster Higgins 1991 Health Care Benefits Survey

Attachment C
Funding Available for Health Care Reform in Tennessee

FUNDS AVAILABLE:

$2,261,484,226	Federal Funds[1]
$383,049,300	State funds[2]
$188,264,100	Other Health Appropriations (State)
$64,649,800	Other Health Appropriations (Federal)
$50,000,000	Local Government Funds
$80,000,000	Nursing Home Tax[3]
$358,050,000	Hospital Charity Care[4]
$182,650,000	Physician Charity Care[5]
$54,800,000	Other Charity Care[6]
$85,356,160	Full co-pay and deductibles[7]
$94,560,000	Full 20 percent co-insurance[8]
$22,734,202	Sliding scale co-pay and deductibles[9]
$25,185,600	Sliding scale 20 percent co-insurance[10]
$3,850,783,388	Total Funds Available

LESS:

$67,325,000	Skilled Nursing Care
$548,935,000	ICF - Regular
$156,976,000	ICF-MR
$31,520,000	Medicare-Institutional
$41,883,000	Medicare-Professional
$92,057,000	Medicare-Premiums
$938,696,000	Total Deductions
$2,912,087,388	Available for medical coverage for 1.775 million citizens[11]
$1,641	Amount per capita available for medical coverage

[1]Federal Funds based on $3.4 billion total budget based on .6681% federal match

[2]State funds (excluding the Hospital Services Tax and the Nursing Home Tax) based on FY 94 Budget

[3]Nursing Home Tax is based on the existing provider tax for nursing homes.

[4]Hospital charity care based on 5% of gross revenue.

[5]Physician charity care based on 5% of gross revenue.

[6]Other charity care based on 5% of gross revenue.

[7]Full co-pay and deductibles for those above 200% poverty assuming 39.4% of the 800,000 uninsured are above 200% of the federal poverty level (based on March 1990 Current Population Survey) and the actual average co-pay and deductible for FY92 State Group Insurance Program of $268.86.

[8]Full 20 percent co-insurance(based on $1500 premium) for those above 200% of the poverty level.

[9]Sliding scale co-pay and deductibles for those between 100 and 199% of the poverty assuming 31.85 of the 800,000 uninsured are between 100% and 199% of the federal poverty level (based on the March 1990 Current Population Survey) and that they average 33% of the full cost of co-pays and deductibles.

[10]Sliding scale 20 percent co-insurance(based on $1500 premium) for those between 100 and 200% of the poverty level.

[11]Assume 25,000 are covered by Medicare.

Attachment D

Requirements for TCHIP Plans

To become an eligible TCHIP health plan the following minimum requirements must be met:

(1) Demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where it is offered, including preventive health services, primary care services, home health care services, pharmacy service, physician services and hospital services including comprehensive emergency services. Services shall, to the extent practical considering quality, accessibility and cost, be provided within the community served.

(2) Demonstrate the capability to provide case management services and, within three years, to establish primary care physicians as gate-keepers for all health care services provided to enrollees and as the case managers for all cases warranting intensive case management;

(3) Agree to provide such preventive health services are required by the TCHIP Board;

(4) Agree to such other requirements as the TCHIP Board may reasonably establish; and

(5) Demonstrate sufficient financial capital to ensure delivery of health care on a reimbursement basis.

STATE PLAN BENEFITS

	NETWORK	NON NETWORK
Deductible per calender year	<---------- $200 per individual ----------> $500 per family	
per emergency room use	$25	$25
Co - Payment how covered expenses are shared	Plan pays 90%	Plan pays 80%
Out of Pocket Maximum using eligible expenses except for treatment of behavior disorders	<---------- $1,000 per individual ----------> $2,000 per family	
Lifetime Maximum Benefit	<---------- $1,000,000 per individual -------->	
Benefits For Behavior Disorders		
Mental Illness Inpatient	Plan pays 90%	Plan pays 80%
	Up to 45 days a year	
Outpatient	Plan pays a percentage of allowable expenses for 45 sessions per year conducted by a psychiatrist, licensed psychologist, or LCSW 75% of UC for first 15 sessions 50% of UC for next 15 sessions 25% of UC for final 15 sessions	
Lifetime Maximum	<---------- $100,000 per individual --------->	
Substance Abuse Inpatient	Plan pays 90%	Plan pays 80%
	Limited to two treatment programs no longer than 28 days each plus two 5-day detox stays in a lifetime	
Outpatient	Limited to two treatment programs of not more than $3,000 each in a lifetime	
Lifetime Maximum	<---------- $30,000 per individual ---------->	

BENETBL5
2-20-93

Comparison of Medicaid and State Plan Benefits

SERVICE	MEDICAID BENEFIT	STATE PLAN BENEFIT
Hospital		
inpatient	Payment reduced to 60% of per diem after 20 days per FY Preadmission required Concurrent review	No limitation on days Preadmission required Concurrent review
outpatient	30 visits per FY	No limitation
Psychiatric Facility		
under 21	Preadmission required Concurrent review	Benefit limitation of 45 days per CY Preadmission required Concurrent review
21 to 65		Benefit limitation of 45 days per CY Preadmission required Concurrent review
Nursing Facility		
NF	Preadmission required	Generally not covered
ICF		Generally not covered
SNF		Up to 100 days following inpatient hospitalization
Physician Services		
outpatient	24 visits per FY	No limitation
inpatient services	20 visits per FY with transplant exceptions	No limitation
psychiatric inpatient	Corresponds to approved days	No limitation
psychiatric outpatient	Primarily through mental health centers	Reducing Benefit for up to 45 sessions
Lab & X-Ray (independent)	30 occasions per FY	No limitation
Hospice	210 days within 6 months of death	No limitation
Dental	Limitations depend on age	Generally not covered
Vision	Coverage for children	Generally not covered (limited follow-up after surgery)
Home Health Agency	60 visits per FY	No limitation

Comparison of Medicaid and State Plan Benefits

Pharmacy	7 prescriptions or refills per month	No limitation
Durable Equipment	Some require prior approval	No limitation
Medical Supplies	Covered for home use Some require prior approval	No limitation
Ambulance	Covered by court order	No limitation

Attachment F

Eligibility shall be limited to citizens who are not covered through any employer or other government sponsored health plan (either directly or through a family member) under terms and conditions existing on March 1, 1993 and those citizens meeting one of the following criteria:

1. Would have been Medicaid eligible under the Medicaid Program as it was administered during FY 92-93;

2. Eligible for unemployment compensation, without respect to weather benefits have been exhausted.

Eligibility shall cease when the person becomes eligible for participation in an employer sponsored plan, either directly or indirectly through a family member, or when eligibility for Medicare or other government health plan begins. However, in the event that such an individual had not enrolled in TCHIP within 90 days of initial eligibility, they would be responsible for the full amount of any premium for which they would have been responsible, for the lesser of the preceding year or back to their initial eligibility date.

Attachment G

Projected Cost of the Current Tennessee Health Care System
(Selected Calendar Years)*

Sources of Funds	Calendar Year 1990	1992	1995	2000
Private	$6,166	$7,081	$9,217	$13,954
Public:				
Federal	3,131	4,062	5,508	9,088
State and Local	1,397	1,847	2,489	3,918
Total, Tennessee	$10,694	$12,990	$17,214	$26,960

Projected Cost of Reformed Tennessee Health Care System
(Selected Calendar Years)**

Private	$6,166	$7,081	$8,477	$11,121
Public:				
Federal	3,131	4,062	4,864	6,386
State and Local	1,397	1,847	2,216	2,907
Total, Tennessee	$10,694	$12,990	$15,557	$20,414

Projected Savings
(Selected Calendar Years)***

Private	$0	$0	($740)	($2,833)
Public:				
Federal	0	0	(644)	(2,702)
State and Local	0	0	(273)	(1,011)
Total, Tennessee	$0	$0	($1,657)	($6,546)

NOTE: All dollar values are reported in millions.

* Source: U.T. Center for Business and Economic Research

** The rate of growth in GDP (Gross Domestic Product) is taken from the Congressional Budget Office study and applied to health costs in 1995 and 2000.

*** This is calculated as the projected cost of the current system less the projected cost of the reformed system.

Dear Carol

I thought you
should have a copy
of this

Charlotte

MEMORANDUM TO THE VICE PRESIDENT

DATE: April 6, 1993

FROM: Charlotte Hayes

SUBJECT: Tennessee Medicaid Waiver Proposal

BACKGROUND
David Manning, Commissioner of the TN Department of Finance and Administration came to Washington last week to tender a preliminary draft of a proposal for Tennessee **to opt out of all of the Medicaid program requirements** (under the same statutory authority as Oregon) and restructure its internal financial approach to the state's obligation to match the federal government payments for Medicaid. He also met with White House and HHS intergovernmental staff.

The basic proposal is scheduled to be released by the Governor in a joint session of the state legislature next week. The Tennesee Comprehensive Health Insurance program, the state employee program, would be expanded to provide universal coverage for Tenneseeans now covered under Medicaid or uninsured, by pooling certain state financial resources (including state health care funds and the cost of charity care already provided to the uninsured and existing local government subsidies for indigent care) and eliminating the hospital tax which has been so expensive for, and disliked by, the hospitals. There would be premiums and copayments for individuals above poverty level. The Governor plans to institute the necessary changes by executive order.

Commissioner Manning wanted to notify you that the state would be filing this waiver in the near future. He has apparently begun conversations with some TN providers, and will be briefing others today, e.g., Elliott Moore at the TN Hospital Alliance.

In the Sunday **Tennessean**, the Governor said that the proposal was well received in Washington (see attached clipping.) This is not correct, everyone who got the proposal was decidedly neutral, including myself since we had not had the opportunity to examine it and no one knew what view the Vice President and the President would take on the matter.

ACTION--CHARLOTTE
First, I indicated that the Vice President has no position as yet on the proposal.

Secondly, I gave a copy of the draft proposal to Judy Feder (Secretary Shalala's health reform aide). She will discuss the entire issue of these waivers and the approach the Department will take with Secretary Shalala, Carol Rasco, Ira Magaziner and Bruce Vladek (designee for HCFA administrator). They know that many waivers are on the way as states try to address deep fiscal problems with the Medicaid program and that HHS must assess waivers in light of the health reform plan we are working toward. Feder expressed concerns about whether the state can provide services and financially make this plan work, whether the vulnerable Medicaid population will have access and services delivery protected, and whether other

vulnerable populations such as people with disabilities are included in the plan.

I have met with Elliott Moore, Warren Gooch and William Lord who will see the plan today, but are concerned that it has been circulated in Washington with limited access in TN. They do not necessarily plan to oppose it, they simply have no idea what is in it.

I have talked to Gordon Bonnyman from Legal Services on Medicaid population issues. He indicated that he was supportive of the plan, but not uncritically so, because of concerns about funding for transition to the new system, funding for the regional medical center which provides access for Medicaid and uninsured, and funding for the Meharry/General merger.

STATUS

Of particular concern is the position of the Vice President and the White House since the Governor brought the proposal to Washington first.

A likely scenario is:

The Governor will file the waiver application in two to three weeks and ask the state legislature to delay elimination of the hospital tax which is scheduled to expire March 31, 1994 in anticipation of the waiver approval. The tax would remain in effect unless repealed during the January 1994 session. (The TN Medicaid program is still in the same fiscal position of being in the red by $764 million, because the program has continued to grow at an annual rate of 20% without any additional state funding being added.) Hospitals fear this result . The only relief from this result would be the swift approval of the waiver. However, the Administration may not be able to get a quick approval (even with this preview/notice provided by the Governor and despite the President's promises to the Governors), because the fastest waiver out of HCFA has taken at least a year. In addition, the Vice President as a Tennessean would appear not to be able to take care of the the state.

NEXT STEPS--CHARLOTTE

We expect a final waiver application from Tennessee will be submitted in the next two to three weeks. I will prepare a detailed memo assessing the application and will keep on top of the Department and TN DHS for their timelines and keep you informed of the status.

ACTION--THE VICE PRESIDENT

Should the Governor or state legislators contact you, this might be an opportunity to thank them for keeping you up to speed on this important matter and indicate your willingness to look closely at the detailed application in light of the health reform efforts of the Administration.

Should provider and the community sector contact you, this might be a good opportunity to get their thoughts (and refer them to Charlotte) on how to address the financial situation of Medicaid in Tennessee and what action they would recommend the federal government take with respect to the application.

Post-it™ brand fax transmittal memo

To	From
CHARLOTTE HAYES	ELLIOTT MARR
Co.	Co.
Off of V.P.	HAT
Dept.	Phone #
202-456-6281	615-254-1942

The Tennessean • Sunday/APRIL 4, 1993

Governor rebuilds Medicaid entirely

Plans to insure 750,000 more

By DUREN CHEEK
Staff Writer

Gov. Ned McWherter this week will take the wraps off what is expected to be a revolutionary plan of health care reform in Tennessee.

The governor's bold initiative is expected to provide coverage not only to the 900,000 Tennesseans who receive Medicaid but an additional 750,000 who have no insurance.

The plan would rely on a network of managed care plans to hold down costs and would be funded by pooling public funds with premiums, coinsurance, co-payments and deductibles. The hospital tax now used to provide almost half of the state funds for the program would be dropped.

Under the plan, which could be implemented early next year, the Tennessee Comprehensive Health Insurance Program would be expanded to include all Tennesseans now covered by Medicaid as well as those who are uninsured.

Universal coverage would be provided under a system of health maintenance organizations or preferred provider organizations.

The plan notes that the tremendous growth of Medicaid has been driven for the most part by the flow of uninsured Tennesseans into the program.

"Extending coverage to the entire uninsured population will both bring management to this group's health care cost and eliminate this major source of the Medicaid cost explosion as well as control cost shifting to the private sector," the plan says.

"The other major reason this reform is financially feasible is the opportunity to manage the health care of those who are Medicaid eligible in the same way we manage the health care of other large groups."

Work papers on the plan note that Congress is not expected to make a decision on national health care reform until late this year and there will be a three- to five-year implementation period after that.

Tennessee, the plan notes, cannot wait.

"If we make these decisions as they have been made in the past, we must either have a major tax increase or make major reductions in health care for the almost one million Tennesseans who are covered by the Medicaid program," the plan says.

State Finance Commissioner David Manning briefed Tennessee Hospital Association officials on the plan during a 15-minute conference call on Friday.

Participants in the call included THA chairman-elect Alan Guy of Knoxville, THA chairman J.D. Elliott of Nashville, preceding THA chairman Maurice Elliott of Memphis, and THA president Ira Lane of Nashville.

The administration was doing its best to keep a lid on the plan until the governor briefs legislative leaders on it and then makes a public announcement.

"It will come into much clearer focus next week," said Deputy Gov. Jim Kennedy. "There are decisions being made as we go along."

"I have some information but I can't talk about it," Gordon Bonnyman, a member of McWherter's Task Force on Medicaid Reform, told a reporter Friday afternoon.

"It would be some version of managed care as a major component, more dramatic than what they have been talking about," Bonnyman said.

At present, Tennessee's Medicaid recipients can go to any doctor or hospital that will treat them or obtain drugs that are prescribed for them from any pharmacist they wish.

Under managed care, the insured patient would go to a health care provider with which the state has contracted for services. Care would be monitored by a case manager or "gatekeeper" doctor.

Multiple PPOs or HMOs would operate in Nashville and the state's other major metropolitan areas. It appears that the state will contract with one company, possibly Blue Cross-Blue Shield, to provide coverage in rural areas.

Blue Cross-Blue Shield handles the Tennessee Group Insurance Plan, the PPO for more than 100,000 employees and dependents.

A draft of the proposal prepared by Manning said the state can provide coverage for all Tennesseans without continuing a hospital tax that provides almost half of the state support for Medicaid.

However, it appears the tax will continue until its scheduled expiration date next March 31.

"The obvious question is how can Tennessee finance universal coverage without the hospital taxes, if we can't adequately finance Medicaid with those taxes?" Manning wrote in the draft.

"The answer lies in taking full advantage of all of the financial resources we have to serve the uninsured and placing them in an accountable, managed care system."

Manning said other benefits of the plan would:

- Eliminate shifting the cost of indigent health care to paying patients and businesses.
- Eliminate yearly state cuts on Medicaid and tax increases to fund the program.
- Limit growth of the program to the growth of the economy.
- Save the federal government an estimated $1.5 billion over the next five years.

An estimated $2.9 billion would be available the first year for medical coverage of 1,775,000 residents who are now covered by Medicaid or have no coverage.

This would include $2.2 billion in federal funds, $383 million in state funds, $108 million in co-payments and deductibles, and $120 million in coinsurance.

Governor to turn Medicaid inside out

FROM PAGE 1A

"The obvious question is how can Tennessee finance universal coverage without the hospital taxes, if we can't adequately finance Medicaid with those taxes?"

DAVID MANNING
State Finance Commissioner
in draft report

Participants in the program with family incomes above the poverty level would be required to pay 20% of the premium cost.

McWherter took the new approach in the face of mounting problems of financing Medicaid, which has been growing at 20% a year and which now consumes more than one fourth of the state budget.

Medicaid now provides health services to approximately 900,000 needy Tennesseans at a cost $2.8 billion. That program is supported by $884 million in state taxes, of which $382 million comes from a 6.75% gross receipts tax on hospitals.

The Medicaid budget McWherter had proposed for the fiscal year beginning July 1 would have fallen $764 million short of the amount needed to fully-fund Medicaid.

It is not known whether McWherter has received federal approval for the plan, but it would not be much of a surprise if Tennessee were chosen for some sort of razzle-dazzle pilot program in President Clinton's efforts to reform health care nationally.

Vice President Al Gore of Tennessee is playing a role in the reform efforts.

McWherter, an early supporter of Clinton who remains close to the president, has made Medicaid very much a front burner item. Tennessee Medicaid Director Manny Martins is widely acknowledged to be one of the nation's leading experts on health care for the poor.

McWherter said recently he wants to scrap Tennessee's Medicaid system and start over. That's pretty much what private work papers from Hillary Rodham Clinton's Task Force on National Health Care Reform recommend.

As Drew E. Altman, president of the Henry J. Kaiser Family Foundation, told the *New York Times*:

"A separate program for poor people will always be a poor program, underfunded and neglected."

The direction the Clinton administration appears to be headed, according to the *Times*, is integrating low-income people into the same networks of doctors, hospitals and private insurance companies that serve more affluent people. ■

APRIL 5-9, 1993 • NASHVILLE BUSINESS JOURN

McWherter will eliminate Medicaid in '94, opts for privately managed health-care plan

By Bill Lewis and Joe Hall

Gov. Ned McWherter is planning this week to announce the state of Tennessee will replace the financially troubled Medicaid program in 1994 with a privately managed health-care plan.

Legislative sources said McWherter, who will enact the plan by executive order, will outline the program to Senate and House leaders Monday (April 5). The governor has called a special joint convention of the General Assembly for 9 a.m. Thursday (April 8) to provide details to lawmakers.

Legislators will be told the $2.8 billion Medicaid program will be eliminated in favor of a managed-care plan to be facilitated by one or more private insurers.

All or many of the 900,000 Tennesseans eligible for Medicaid benefits will be enrolled in a managed-care plan that will emphasize primary care, those briefed by the administration say.

General practitioners will be "gatekeepers" in the new system designed to prevent unnecessary use of more expensive services, such as those provided by specialized physicians and hospital emergency rooms.

McWherter's plan includes some of the national health-care reforms being considered by the Clinton administration intended to broaden access to health care.

"They are modeling it along with anticipated national health care reform," says one participant in the process.

"He (McWherter) said it is time for something radical. He's interested in getting us out of Medicaid as it is now," says one lawmaker who spoke with the governor at a reception hosted by Blue Cross Blue Shield of Tennessee last week.

Another senior lawmaker says "the executive order will completely obliterate the Medicaid program in the state of Tennessee."

The plan will include capitation of provider fees, meaning they will provide services for a set charge. It will not rely on existing provider taxes, and the tax on hospitals will be allowed to expire next march, the participant says.

Some of the thinking behind the plan is based on legislation submitted by Sen. Robert Rochelle, D-Lebanon, and Rep. Gary Odom, D-Nashville, that is intended to make insurance more affordable. It would standardize premiums for businesses that employ two to100 people.

Employees would be guaranteed coverage regardless of age, sex or preexisting condition.Several Capitol Hill sources believe Blue Cross will be selected to provide case management services for the replacement program, which essentially allows beneficiaries unlimited access to many health care services.

Blue Cross manages the preferred provider organization (PPO) that provides health-care services to 100,000 state employees. It is the largest PPO in Tennessee and extends across the state.

"They're the only ones who could do it on short notice," one senator says.

Blue Cross has received no indication it would be the only insurer selected to manage the new program, but the nonprofit company has "had consultations" with the administration, says a representative of the company who asked not to be named.

Selected representatives of the provider community — first physicians, then hospitals — were given outlines of the plan late last week. On April 2, McWherter administration officials held a day-long session to iron out further details.

McWherter will outline the plan to Senate and House leaders Monday, and then go into two and a half days of intensive planning with health-care providers before addressing the full General Assembly on Thursday, lawmakers say.

An 'ambitious' attempt

The managed-care plan, devised by McWherter administration officials in consultation with the U.S. Department of Health and Human Services in Washington, D.C., is described as "innovative" and "model" by several sources.

"It's bigger than Medicaid," says one Capitol Hill source. "It's very ambitious."

It is believed the McWherter administration is seeking a federal waiver, although one well-placed source says the Health Care Financing Administration has not made any commitment to the state of Tennessee.

McWherter has no plans to leave the Medicaid replacement plan for lawmakers to debate. Instead, the second-term governor will issue an executive order.

"It will speed up the process," a Capitol Hill source says. "The administration doesn't want to have the knock-down, drag-out of who has clout in the Legislature and who might be able to get special deals here and there.

"It will probably be a pure model if it's done by executive order."

Sources say the governor's plan calls for the current Medicaid funding mechanism — a 6.75 percent tax on hospitals and a bed tax on nursing homes which are combined to attract federal funds of $7 for every $3 — will be allowed to expire in March 1994.

Rising Medicaid costs

Since 1987, the program has tripled in cost, rising from $855 million to $2.8 billion this year. Medicaid is growing at a rate faster than any other item in the state budget, and, without cuts, would reach $3.3 billion in the next fiscal year.

The difficulty of funding Medicaid has grown in direct proportion to the rapidly spiraling cost.

Last year, the federal government ruled the state's funding mechanism — dubbed "funny money" by the Health Care Financing Administration — illegal, forcing the administration to find new funding sources.

The result was a tax on the two largest health-care providers of Medicaid.

While the nursing home industry has appeared satisfied with its share of the tax, the hospital industry, led by the Tennessee Hospital Association, has vehemently objected and earlier this year moved to have it eliminated.

As many as 40 hospitals are behind on tax payments, and the state Department of Revenue has filed liens against three facilities. Seven hospitals have filed suit against to the state.

Business concerns

Business people are worried that converting the program to managed care might result not in reform but artificial price controls. If that happens, health-care providers might be encouraged to

make up shortfalls in Medicaid reimbursement by increasing their charges to privately insured patients.

An insurance executive familiar with Blue Cross' discussions with the administration and with the company's aggressive style of negotiating reduced price contracts with hospitals says the company's involvement in the governor's plan may make health-care providers nervous.

Two years ago, the company was involved in a dispute with the hospital industry over its use of Most Favored Nation contract clauses, which require hospitals to give Blue Cross discounts at least as great as they give any other insurers.

"If you have the state do something similar with aggressive contracting, some folks are going to be unhappy," the executive says.

For the state to save money, it will have to reduce the amount of money it pays providers, he says.

To arrive at managed care savings, "you draw a target. How you get to that target is where the pain will come in," he says.

Passing the buck

Tennessee Business Roundtable executive director Dave Goetz says converting Medicaid to a managed-care program could be another way of giving business the bill unless health-care providers are held accountable for their costs.

"I haven't found any way of dealing with Medicaid yet that doesn't make business the ultimate payer. It's the business (insurance) plans that take it in the neck," Goetz says.

"The essential problem is that none of the providers have to live with the consequences" of being inefficient. They are able to cost-shift charges to patients with private insurance.

"The burden may take longer to get there, it may take a different route, but it gets back to business," he says.

Commissioner of Finance and Administration David Manning warned earlier this year the cost of Medicaid threatens to leave no new money for education reform.

The administration proposed cuts in next year's budget after disclosing the $2.8 billion would have grown by $763 million next fiscal year in the absence of cost containment, making it impossible for taxes on hospitals and nursing homes to keep pace. ■

TEL NO.615-254-1947 HPF 0.95 7:17 NO.001 P.07

THE TENNESSEAN • Tuesday/APRIL 6, 1993

State's health reform lacks U.S. approval

By DUREN CHEEK
Staff Writer

The "radical reform" in Tennessee's health care system that Gov. Ned McWherter will present to the legislature Thursday has not been approved yet by federal authorities.

The federal Health Care Financing Administration would have to approve "waivers" before the state could incorporate the 900,000 Tennesseans on Medicaid and 750,000 uninsured residents into one large health care provider system. HCFA is the agency gives the state $7 for every $3 the state puts up for Tennessee's multibillion-dollar Medicaid program.

The governor declined to discuss details of the plan, tagged the Tennessee Comprehensive Health Insurance Program, or TCHIP, but it is believed it would cost about $2.9 billion. That's about $300,000 more than his original budget for Medicaid next year.

"We are going to make a recommendation to the General Assembly to take us out of Medicaid and put us in a new program in Tennessee," McWherter said.

"I believe that whatever we need from Washington we will be able to get," McWherter said. "I hope that [federal officials] would look favorably on it."

"We at this point do not have a waiver approved nor have we asked for approval," the governor acknowledged after giving legislative leaders a private briefing on his plan.

McWherter said the Clinton administration will be asked to waive federal Medicaid regulations after he presents his plan to a joint session of the House and Senate at 9 a.m. on Thursday. He said he feels confident the waivers will be approved.

"I want to go to the General Assembly before we finalize the request for a waiver, but we have been encouraged to continue developing this concept in Washington," McWherter said.

Asked if President Clinton has personally encouraged him, McWherter replied: "Personally, no."

A draft of the proposal obtained by *The Tennessean* shows it would rely on a network of managed-care plans to hold down costs. It would be funded by pooling public funds with insurance premiums, coinsurance, co-payments and deductibles.

The hospital tax now used to provide almost half of the state funds for the Medicaid program would be dropped.

House Speaker Jimmy Naifeh praised the governor for taking an "innovative" approach to dealing with the mushrooming cost of the state's health care program for the poor.

"We are left with three alternatives," Naifeh said. "Raising taxes 20% per year to take care of the growth of Medicaid, cutting services 20% or coming up with an innovative program.

"I believe the governor and his staff have come up with a program that is very innovative."

Medicaid has been growing 20% per year. At $2.8 billion, the program now consumes more than a fourth of the state budget. ■

McWherter proposes health care fix

New partnership would replace Medicaid

By Bill Snyder
Banner Senior Medical Writer

Gov. Ned McWherter will this week propose a "reinvention" of the state's health care system, state officials say.

The proposal probably will be finalized shortly before it is presented to a joint session of the General Assembly at 9 a.m. Thursday.

It goes far beyond a revamping of the state's financially beleagered Medicaid program.

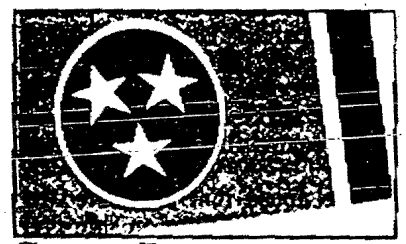
The plan may do away with Medicaid altogether, opting instead for a government-private partnership that will provide health coverage to an estimated 500,000 Tennesseans without insurance, as well as those currently on Medicaid.

And it will do that without costing more money, officials say.

"I do believe we'll be totally reinventing health care in Tennessee," Deputy Gov. Jim Kennedy says. "The governor's premise all along has been that there is enough money in the medical system in Tennessee; it's just not being spent in the correct fashion."

Details of the plan are sparse. But top-level discussions have involved the following:

■ Using the managed care plan for state employees and a catastrophic care plan as a model for covering 900,000 Tennesseans eligible for Medicaid, as well as an estimated 400,000 to 550,000 people without any health insurance coverage.



STATE LEGISLATURE

■ Competing HMOs, or health-maintenance organizations, could provide services in urban areas. Rural areas could be served by the Tennessee Provider Network, a Blue Cross/Blue Shield plan that covers roughly 133,000 state employees, teachers and their dependents.

■ The state could be the first in the nation to drop out of Medicaid, the joint federal-state health program for poor citizens.

Federal government now provides nearly $2 billion — matched to the state's $894 million — to provide Medicaid services, and the federal commitment has been rising by about 20 percent a year.

Federal funds still would be a major part of the new state health plan. But the state could "cut a deal" with Washington, promising to stop or severely restrict the rise in the federal share of the new health plan.

State finance commissioner David Manning and state Medicaid Bureau director Manny Martins were in Washington, D.C., last week to discuss details of the plan with federal officials and members of Hillary Rodham Clinton's health care task force.

Initial reviews of the plan were "favorable," but federal officials were "noncommittal" because the plan has not yet been submitted, state officials say.

■ Long-term care will not be part of the governor's proposal. A separate Medicaid program may be maintained for nursing-home services, which were expected to cost about $670 million this year.

■ The program would take effect in 1994. In the meantime, a tax on hospital revenues that is expected to generate around $400 million for Medicaid in the current fiscal year will be needed to help fund Medicaid through the end of 1993.

The Tennessee Hospital Association has been lobbying to repeal the tax on July 1, 1993, but state officials hope the association's opposition to the tax may fade if the new plan is adopted. The hospital tax is scheduled to expire at the end of March 1994.

Health policy experts in Tennessee say the governor's plan is very different from the state-chartered regional health cooperatives approved Saturday by the Florida Legislature.

"We're actually way ahead of any other state," says Dr. William Frist, a Vanderbilt University heart transplant surgeon who chairs the governor's task force on Medicaid reform.

The Florida plan has been touted as the first large-scale test of "managed competition," a method of health care reform being considered by the Clinton administration.

"We're in such an unusual situation (in Tennessee) with the tightly run Medicaid program — real good management at the state level — and appropriate political relationships in Washington, and some real creative people who are willing to take some risks," Frist says.

Deputy Governor Jim Kennedy agrees.

"That's not to say this program will be a panacea," he cautions. "Of the hundreds of thousands of problems out there, it won't solve every one of them."

But Kennedy says Tennessee's plan for health care reform will be "exciting and innovative" largely because of the expertise and leadership of people like the state finance commissioner and Medicaid director.

FAX COVER PAGE

Date:	Tue Sep 28, 1993 10:38 am EDT
To:	C.Rasco[EMS]
Destination Fax:	202-456-2878
From:	HN1810[EMS]/Connect, Inc.
Subject:	TennCare's Approval by Secretary Donna Shalala

Number of pages excluding cover page: 3.0

Number of delivery attempts: 1

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difficulties. In doing so, we urge you not to impose on the waiver any conditions which would have the effect of forcing the state either to impose greater financial burdens on consumers, or limit the program's coverage. Either approach would undermine the goal of broader, more affordable health coverage, which we know that you and President Clinton support.

We have also read published speculation that HCFA might suggest a delay, or phase-in, of TennCare's implementation. Any such delay would be contrary to the public interest. While we appreciate, and share, concerns regarding the short timetable for putting the plan into operation, the problems that would attend delay are much more troubling. The fiscal condition of the Medicaid program is such that any delay in switching to TennCare would jeopardize the coverage of the one million Tennesseans who now depend on the program. Moreover, hundreds of thousands of uninsured men, women and children will be forced to continue to live with insecurity and inadequate care until TennCare is able to enroll them. We know that you share our sense of urgency regarding the need to protect these families as soon as possible.

You have said, quite aptly, that the TennCare proposal raises the question of how much the federal government should trust the states. It is appropriate for your department, as a guardian of the public's health, to carefully scrutinize such a broad proposal to make sure that it merits such trust. On behalf of our organizations' members, and our own neighbors and relatives whose health will be so directly affected by its implementation, we have rigorously evaluated the proposal ourselves, over several months. We are confident that, when you conclude your review, you will conclude that Tennessee fully deserves your trust. TennCare will bring our state much closer to the health reform goals that President Clinton has so eloquently put before our nation.

Sincerely yours,

Dara Howe
President,
Tennessee Health Care Campaign

cc:Mr. Bruce Vladeck
Ms. Carol H. Rasco

Organizations Co-Signing Tennessee Health Care Campaign's Letter to Secretary Donna E. Shalala on September 27, 1993

AARP, Tennessee
Access Services of Middle TN
ADAPT of Tennessee
Alive Hospice of Nashville, Inc.
American Cancer Society, TN Division, Inc.
Battered Women, Inc.
Certified Nurse Midwives at MIC
Church Women United
Coalition for Tennesseans with Disabilities
Community Shares of Tennessee
Consumer Coalition for Health, Middle TN

Date: September 28, 1993 7:30 am PT Item: 500L5UA

From: HN1810 Tennessee Health Care Campaign

To: MCI @CONNECT-MCI Mail Gateway

Subj: TennCare's Approval by Secretary Donna Shalala

RE: TennCare

From: Dara Howe, President, Tennessee Health Care Campaign, Fax Number: (615) 292-1740.

Attached is a copy of the federal expressed letter to Secretary Donna E. Shalala, requesting that she approve TennCare and not impose on the TennCare waiver any conditions which would force the state to impose greater financial burden on consumers, or limit the program's coverage. This letter also ask Secretary Shalala not to delay or phase-in TennCare's implementation. Forty-two organizations, many of which are state-wide, co-signed this letter. Hundreds of thousands of uninsured men, women and children are depending on TennCare starting on January 1, 1993.

If for some reason you did not receive this letter by 10:30 a.m., September 28, 1993, I would appreciate being informed immediately. It was sent by Tony Garr, the Executive Director of the Tennessee Health Care Campaign.

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: TennCare

Dear Secretary Shalala:

We have read with interest and concern of your agency's request for additional time to consider our state's application for a Medicaid waiver. The waiver would make possible implementation of the new TennCare plan to broaden protection to current Medicaid patients, and to extend coverage to most of the 775,000 Tennesseans now without any insurance at all.

We appreciate the obvious care and attention that your staff is devoting to their review of the TennCare proposal. As you approach a final decision, we thought it important to reaffirm the importance of TennCare to Tennessee consumers, and to reassure you of the strong public support which TennCare enjoys in our state.

We have read that the Health Care Financing Administration has expressed reservations regarding the adequacy of the state's financial commitment to the plan. The technical aspects of that issue are beyond our competence, and we trust that your staff and state officials will be able to resolve any such

Council of Community Services
Easter Seal Society of TN
Epilepsy Foundation of Middle TN
Episcopal Diocese of TN
JONAH
Kelly Miller Smith Institute
League of Women Voters of TN
March of Dimes Defects Foundation
Meharry Institute on Health Care for the Poor and Underserved
Mid-South United Cerebral Palsy
NAACP, Nashville Branch
Nashville CARES
National Kidney Foundation of Middle TN
NOW, Nashville Chapter
People First of TN, Inc.
Regional Medical Center
Senior Citizens, Inc.
The Arc of Tennessee
The Farm Midwifery Center
TN Alliance for the Mentally Ill
TN Association of Mental Health Centers
TN Chapter of Natl. Assn. of Social Workers
TN Coalition for Nursing Home Reform
TN Commission on Aging
TN Commission on Children and Youth
TN Health Care Campaign
TN Hunger Coalition
TN Nurses Association
TN Psychological Association
TN School Health Coalition
TN Task Force Against Domestic Violence

HN1810
Tony Garr
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, TN 37208
(615) 321-0055
/

FEDERAL EXPRESS

QUESTIONS? CALL 800-238-5355 TOLL FREE.

AIRBILL PACKAGE TRACKING NUMBER 7532366365

7532366365

RECIPIENT'S COPY

1 Date: 9-17-93

From (Your Name) Please Print: TN Health Care Campaign
Your Phone Number (Very Important): 615 321-0055
Company: 2020 McHarney Blvd
Department/Floor No.:
Street Address: Nashville, TN
City: State: ZIP Required: 37208

2 To (Recipient's Name) Please Print: Carol H. Rasco
Recipient's Phone Number (Very Important):
Company: The White House, 2nd Floor
Department/Floor No.:
Exact Street Address (We Cannot Deliver to P.O. Boxes or P.O. Zip Codes.): 1600 Pennsylvania Ave
City: Washington State: DC ZIP Required: 20500

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City: State: ZIP Required:

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6 [X] FEDEX LETTER
12 [ ] FEDEX PAK
13 [ ] FEDEX BOX
14 [ ] FEDEX TUBE

Standard Overnight (Delivery by next business afternoon. No Saturday delivery†)
51 [ ] OTHER PACKAGING
56 [ ] FEDEX LETTER
52 [ ] FEDEX PAK
53 [ ] FEDEX BOX
54 [ ] FEDEX TUBE

Economy Two-Day (Delivery by second business day †)
30 [ ] ECONOMY

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46 [ ] GOVT. LETTER
41 [ ] GOVT. PACKAGE

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70 [ ] OVERNIGHT FREIGHT** (Confirmed reservation required)
80 [ ] TWO-DAY FREIGHT**

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HOLD FOR PICK-UP (Fill in Box H): 1 [ ] WEEKDAY or 31 [ ] SATURDAY
DELIVER: 2 [X] WEEKDAY or 3 [ ] SATURDAY (Extra charge) (Not available to all locations)
4 [ ] DANGEROUS GOODS (Extra charge)
5 [ ]
6 [ ] DRY ICE Dangerous Goods Shipper's Declaration not required. Dry Ice, 9, UN 1845 ____ X ____ kg. III
7 [ ] OTHER SPECIAL SERVICE
9 [ ] SATURDAY PICK-UP (Extra charge)
[ ] DESCRIPTION
12 [ ] HOLIDAY DELIVERY (If offered) (Extra charge)

6

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Total	Total	Total

DIM SHIPMENT (Chargeable Weight) [ ] ____ lbs.
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1 [ ] Regular Stop 3 [ ] Drop Box
2 [ ] On-Call Stop 4 [ ] B.S.C. 5 [X] Station

7 Release Signature:

Emp. No. Date
[ ] Cash Received
[ ] Return Shipment
[ ] Third Party [ ] Chg. To Del. [ ] Chg. To Hold
Street Address
City State Zip
Received By: X
Date/Time Received FedEx Employee Number

Federal Express Use
Base Charges: 13.00
Declared Value Charge:
Other 1: CGR
Other 2:
Total Charges: 13.00

REVISION DATE 6/92
PART #137205 GBFE
FORMAT #136
136

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In any event we will not be liable for any damages, whether direct, incidental, special or consequential, in excess of the declared value of a shipment, whether or not Federal Express had knowledge that such damages might be incurred including, but not limited to, loss of income or profits.

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We won't be liable for loss, damage or delay caused by events we cannot control, including but not limited to, acts of God, perils of the air, weather conditions, acts of public enemies, war, strikes, civil commotions, or acts or omissions of public authorities (including customs and quarantine officials) with actual or apparent authority.

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Part # 137204/137205
Rev. 6/92

SEP 28 REC'D

Tennessee Health Care Campaign

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: TennCare

Dear Secretary Shalala:

We have read with interest and concern of your agency's request for additional time to consider our state's application for a Medicaid waiver. The waiver would make possible implementation of the new TennCare plan to broaden protection to current Medicaid patients, and to extend coverage to most of the 775,000 Tennesseans now without any insurance at all.

We appreciate the obvious care and attention that your staff is devoting to their review of the TennCare proposal. As you approach a final decision, we thought it important to reaffirm the importance of TennCare to Tennessee consumers, and to reassure you of the strong public support which TennCare enjoys in our state.

We have read that the Health Care Financing Administration has expressed reservations regarding the adequacy of the state's financial commitment to the plan. The technical aspects of that issue are beyond our competence, and we trust that your staff and state officials will be able to resolve any such difficulties. In doing so, we urge you not to impose on the waiver any conditions which would have the effect of forcing the state either to impose greater financial burdens on consumers, or limit the program's coverage. Either approach would undermine the goal of broader, more affordable health coverage, which we know that you and President Clinton support.

We have also read published speculation that HCFA might suggest a delay, or phase-in, of TennCare's implementation. Any such delay would be contrary to the public interest. While we appreciate, and share, concerns regarding the short timetable for putting the plan into operation, the problems that would attend delay are much more troubling. The fiscal condition of the Medicaid program is such that any delay in switching to TennCare would jeopardize the coverage of the one million Tennesseans who now depend on the program. Moreover, hundreds of thousands of uninsured men, women and children will be forced to continue to live with insecurity and inadequate care until TennCare is able to enroll them. We know that you share our sense of urgency regarding the need to protect these families as soon as possible.

2020 Meharry Boulevard • Nashville, TN 37208 • (615) 321-0055

You have said, quite aptly, that the TennCare proposal raises the question of how much the federal government should trust the states. It is appropriate for your department, as a guardian of the public's health, to carefully scrutinize such a broad proposal to make sure that it merits such trust. On behalf of our organizations' members, and our own neighbors and relatives whose health will be so directly affected by its implementation, we have rigorously evaluated the proposal ourselves, over several months. We are confident that, when you conclude your review, you will conclude that Tennessee fully deserves your trust. TennCare will bring our state much closer to the health reform goals that President Clinton has so eloquently put before our nation.

Sincerely yours,

Dara Howe
President

cc: Mr. Bruce Vladeck
Ms. Carol H. Rasco

Organizations supporting THCC's position on TennCare: 9/27/93

FName	LName	Organization	Address1	Address2	City	ST	Zip	Area	OPhone	H Phone	Fax #
Don	Peterson	AARP						615	FAX		
Paul	Ford	Access Services of Middle TN						615	248-6733		
Diane	Coleman	ADAPT of Tennessee						615	248-6733		259-2536
Sarah	Gorodezky	Alive Hospice of Nashville Inc.						615	327-1083		
Margaret	Smith	American Cancer Society TN Division Inc.						615	255-1227ext3		
Marianne	Blevins	Battered Women, Inc.							800-641-3434		456-0162
Terry	Snell	Certified Nurse Midwives at MIC						615	383-1468		
Dorothy	Copple	Church Women United						615	329-3428		
Dara	Howe	Coalition for Tennesseans with Disabilities						615	297-3819		292-1740
Peggy	Matthews	Community Shares of Tennessee						615	522-1604		522-5281
Gene	TeSelle	Consumer Coalition for Health Mid TN						615	322-2773		
Rusty	Lawrence	Council of Community Services						615	385-2221		
Jayne	Perkins	Easter Seal Society of TN						615	251-0070		251-0068
Joyce	Whitmer	Epilepsy Foundation of Mid. TN						615	269-7091		
Lynn	Huber	Episcopal Diocese of TN						615	251-3322		251-8010
Shirley	Richmond	JONAH, Casey Bldg, Room 217						901	427-1630		
Forrest	Harris	Kelly Miller Smith Institute						615	322-2776		343-9957
Susan	Gutow	League of Women Voters of TN									320-0980
Monte	Butler	March of Dimes Birth Defects Fdn						615	399-3200		399-0039
Amy	Cato, Ph.D.	Meharry Institute on Health Care for the Poor			P6/(b)(6)			615	327-6565	P6/(b)(6)	
Diana	Reid	Mid-South United Cerebral Palsy						901	323-0190		
Sheila	Peters	NAACP, Nashville Branch						615			
Joseph	Bodenmillor,	Nashville CARES						615	385-1510		
Lou	Tate	National Kidney Foundation of Mid TN						615	383-3887		
Lynne	Cushing	Natl Org. for Women, Nashville Chpt						615	327-0039		
Ruthie	Beckwith,	People First of TN Inc.						615	297-2734		
Charlotte	Collins	Regional Medical Center						901	575-7930		575-6703
Janet	Jernigan	Senior Citizens, Inc.						615	327-4551		
Roger	Blue	The Arc of TN						615	327-0294		
Ina May	Gaskin	The Farm Midwifery Center									
Joyce	Judge	TN Alliance for Mentally Ill						615	531-8264		691-0103
Dick	Blackburn	TN Assn of Mental Health Centers						615	244-2220		
Jim	Akin, ACSW	TN Chapter Natl. Assn. of Social Workers						615	321-5095		
Karen	Franklin	TN Coalition for Nursing Home Reform						615	385-2221		
Emily	Wiseman	TN Commission on Aging						615	741-2056		741-3309
Linda	O'Neal	TN Commission on Children & Youth						615	741-2633		
Tony	Garr	TN Health Care Campaign						615	321-0055		327-6362
Clare	Sullivan	TN School Health Coalition						615			
Kathy	England	TN Task Force Against Domestic Violence						615	327-0805		
Jean	Stone	TN Hunger Coalition									
Frances	Edwards	TN Nurses Association									

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507 GENERAL GEORGE PATTON ROAD
NASHVILLE, TN 37221-2448
SEPTEMBER 27, 1993

TONY GARR
EXECUTIVE DIRECTOR
TENNESSEE HEALTH CARE CAMPAIGN
2020 MEHARRY BLVD.
NASHVILLE, TN 37208

DEAR TONY:

THE EXECUTIVE COMMITTEE ON BEHALF OF THE STATE LEGISLATIVE COMMITTEE OF AARP ENDORSES THE STATEMENT OF THE TENNESSEE HEALTH CARE CAMPAIGN AS RELATED TO TENNCARE. I AM WRITING THIS ON BEHALF OF OUR CHAIRMAN, RAY STOMER.

SINCERELY,

Don Peterson

DONALD O. PETERSON
COORDINATOR, CAPITAL
CITY TASK FORCE

TECHNOLOGY
ACCESS
CENTER
of Middle Tennessee

Fountain Square, Suite 126
2222 Metrocenter Boulevard
Nashville, Tennessee 37228
615/248-6733 • 800/368-4651
Fax 615/259-2536

September 30, 1993

Mr. Tony Garr, Director
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, TN 37208

Dear Mr. Garr:

Please be advised that the Board of Directors for Access Services of Middle Tennessee concur with the Tennessee Health Care Campaign support for TennCare. We endorse the letter being sent by the Campaign on this date to Health and Human Services Secretary Shalala expressing support for the TennCare proposal.

The Access Services of Middle Tennessee Board is made up of a majority of people with disabilities.

Cordially,

Paul Ford
Board President

A member of the
Alliance for
Technology Access
TAC is operated by
Access Services of
Middle Tennessee

ADAPT
1478 STAYTON ROAD
CUMBERLAND FURNACE, TN 37051
(615)789-5236

September 27, 1993

Care Of: Tennessee Health Care Campaign

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Shalala,

ADAPT of Tennessee is in support of the position of the Tennessee Health Care Campaign and endorses their letter to you dated September 27, 1993.

We strongly urge you to approve TennCare so that people with disabilities who are not eligible for federal or state medical insurance can receive health care insurance.

Sincerely,

Diane Coleman

Diane Coleman
President

AMERICAN CANCER SOCIETY® TENNESSEE DIVISION, INC.
1315 8th Avenue South, Nashville, TN 37203-5057

September 27, 1993

Mr. Tony Garr, Executive Director
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, TN 37208

Dear Tony:

This is to confirm that the Tennessee Division of the American Cancer Society is in full support of the THCC's letter of September 27, 1993, to Secretary Shalala.

Sincerely,

Alvin Mauer, M.D., President
Tennessee Division

Certified Nurse Midwives of MIC
72 Hermitage Ave.
Nashville, TN 37210
(615) 862-4233

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Care of: Tennessee Health Care Campaign

Dear Secretary Shalala,

The Certified Nurse Midwives at Maternal Infant Child Program (MIC) support the position as stated in the September 27, 1993 letter of the Tennessee Health Care Campaign.

As Certified Nurse Midwives we know the important of delivering prenatal care. We think that TennCare will enhance the current patch-work system and extend coverage to virtually all uninsured Tennesseans.

Sincerely,

Terry Snell
Certified Nurse Midwife

church women united

Nashville, Tennessee

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Tennessee Health Care Campaign

Dear Secretary Shalala,

On behalf of Churchwomen United in the state of Tennessee and in Nashville I am writing to advise you that we support the letter written to Donna Shalala on September 27, 1993.

Dorothy Copple

Dorothy Copple, Chair
Citizen Action

INSTV 3 3201289 P.01

COALITION
for Tennesseans with Disabilities

2416 Twenty-first Avenue South • Suite 206 • Nashville, TN 37212
phone: 615-297-3819 • fax: 615-292-1740

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: **TennCare**

Dear Secretary Shalala:

The Coalition for Tennesseans with Disabilities endorses the sentiments expressed in the letter by the Tennessee Health Care Campaign urging your approval of the TennCare waiver request.

The Coalition is a statewide alliance of more than thirty agencies and organizations committed to creating a society that includes, values, and supports people with disabilities.

Thank you for your consideration.

Sincerely,

Roger Blue
Chairperson

COMMUNITY SHARES
SUITE 203 517 UNION AVENUE
KNOXVILLE, TENNESSEE 37902-2129
(615) 522-1604 FAX (615) 522-5281

FIELD OFFICE
P.O. BOX 293084
NASHVILLE, TENNESSEE 37229-3084
(615) 321-0056

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East Tennessee
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Foundation

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WILLIAM E. SANDERS

Organizations listed for identification only

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Care of: Tennessee Health Care Campaign

Dear Secretary Shalala,

At its board meeting conducted on September 25, 1993, Community Shares endorsed the position of the Tennessee Health Care Campaign as stated in the letter dated September 25, 1993.

Sincerely,

Peggy Matthews

Peggy Matthews
Executive Director

Ch Consumer Coalition for Health
P.O. Box 120582, Acklen Station • Nashville, TN 37212

September 24, 1993

Mr. Tony Garr
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, TN 37208

Dear Tony:

The Consumer Coalition for Health supports the letter from the Tennessee Health Care Campaign in behalf of the TennCare plan. Our thanks to you for the Campaign's leadership in this.

Yours sincerely,

Gene

Eugene TeSelle
Secretary-Treasurer

September 27, 1993

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

Dear Secretary Shalala:

The Council of Community Services of Nashville, Tennessee is requesting that you approve TennCare and not impose on the waiver any conditions which would force the state to impose financial burden on consumers, or limit the program's coverage. Hundreds of thousands of uninsured men, women and children are depending on TennCare starting on January 1, 1993.

Thank you for your consideration.

Best Regards;

Rusty Lawrence
Executive Director

COUNCIL OF COMMUNITY SERVICES

2012 21st AVE. S.

NASHVILLE, TN

37212

615.385.2221

The Power To Overcome

Easter Seal Society of Tennessee, Inc.

1701 West End Avenue • Suite 300
Nashville, Tennessee 37203
615-251-0070 Fax: 615-251-0068
1-800-264-0077

September 27, 1993

TO: Tennessee Health Care Campaign
attn: Tony Garr

FROM: Jayne Perkins

This letter is to serve as confirmation of my support of your September 27 letter to Secretary of Health and Human Services Donna Shalala.

EASTER SEAL SOCIETY OF TENNESSEE, INC. BOARD OF DIRECTORS

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Charles H. Tharp
Jack J. Vaughn

Epilepsy Foundation of Middle Tennessee, Inc.
2002 Richard Jones Road, Suite 202 Nashville, Tennessee 37215 Telephone 615/269-7091

September 27, 1993

Ms. Dara Howe, President
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, Tennessee 37208

Dear Dara:

This is to convey our support of TennCare and the views expressed in your letter to Secretary Donna Shalala. If TennCare is approved, thousands of Tennesseans who have epilepsy and/or other chronic conditions would, for the first time, have access to health care.

Sincerely,

Joyce Whitmer
Executive Director

EPISCOPAL DIOCESE OF TENNESSEE
Office of Affirmative Aging
One LeFleur Bldg., Suite 100
50 Vantage Way
Nashville, Tennessee 37228

September 27, 1993

Mr. Tony Garr, Director
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, TN 37208

Dear Tony,

I am delighted to be a co-signor for your letter to Secretary Shalala regarding the TennCare plan. Thanks for taking this initiative.

Very sincerely yours,

Lynn W. Huber

Lynn W. Huber

". . . to build a people-powered organization

rooted in the Gospel of Jesus

so we can speak for ourselves and our community

and act upon our own future."

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Care Of: Tennessee Health Care Campaign

Dear Secretary Shalala,

JONAH, a grassroots organization in West Central Tennessee, supports the position of the Tennessee Health Care Campaign as stated in the letter to Secretary Donna E. Shalala on September 27, 1993.

TennCare is the only hope for health care for many residence in rural west Tennessee. I ask that you approve it as requested in the letter.

Sincerely,

Shirley Richmond

Shirley Richmond
Executive Director

JONAH, Casey Bldg., Room 217, 416 E. LaFayette St., Jackson, TN 38301 (901)427-1630

VANDERBILT UNIVERSITY

NASHVILLE, TENNESSEE 37240

TELEPHONE (615) 322-7311

Kelly Miller Smith Institute • The Divinity School • Direct phone 322-2776

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

This letter is a statement of support for the Tennessee Health Care Campaign. The TennCare program is intended to provide broader health care benefits for Tennessee's current recipients of Medicaid and to extend coverage to many Tennesseans who are currently without any health insurance.

As you know, the availability of affordable health care is a major concern for most Americans, and we appreciate your consideration of our efforts.

Sincerely,

Forrest E. Harris

Forrest E. Harris, Director
Kelly Miller Smith Institute

THE LEAGUE
OF WOMEN VOTERS
OF *TENNESSEE*

1701 21st Avenue South, Suite 425, Nashville, TN 37212-3797 615/297-7134 FAX: 615/383-6504

September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Shalala:

The League of Women Voters of Tennessee supports health care reform in Tennessee. We agree with the letter sent to you by the Tennessee Health Care Campaign dated September 27, 1993.

Please consider our concerns as you conclude your review of the TennCare proposal.

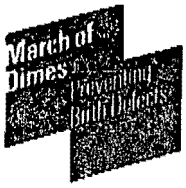
Thank you.

Sincerely,

Susan Gutow

Susan Gutow
President

March of Dimes
Birth Defects Foundation
402 BNA Drive, Suite 207
Nashville, Tennessee 37217
Telephone 615 399 3200
1 800 281 4832
Fax 615 399 0039



September 27, 1993

Honorable Donna Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Shalala,

The March of Dimes Birth Defects Foundation appreciate the time and attention your staff has given to the TennCare proposal and hope that the program will be implemented as quickly as possible.

We are encouraged by the new TennCare plan and the impact it will have on decreasing infant mortality and birth defects due to accessible and affordable prenatal care. The March of Dimes Birth Defects Foundation's focus and mission is the prevention of birth defects and infant mortality. Tennessee ranks 43rd in the nation for infant mortality rates. More than 250,000 babies are born in the United States each year with a birth defect; that's one out of every 12 newborns. The average cost of a normal delivery is approximately $4,900; the cost of a very low birthweight baby is approximately $150,000.

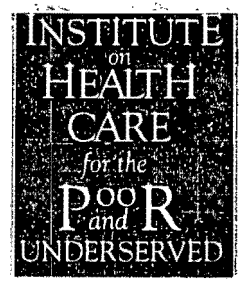
The statistics speak for themselves; we can no longer postpone implementing a solution to this devasting problem, therefore, we greatly encourage you to approve TennCare and not impose on the waiver that would cause greater financial burden on the consumers.

For Healthier Babies,

Montie Butler

Montie Butler
Director of Community Services

cc: Jacqueline Thomas-Suggs



Tony Garr
Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, Tennessee 37208

Dear Mr. Garr:

The Institute on Health Care for the Poor and Underserved fully supports the position of the Tennessee Health Care Campaign in regard to the approval of the TennCare proposal. As you know, one of the goals of the Institute is to seek solutions to the health problems of the poor, the elderly, those who face catastrophic illness, and the millions of Americans who are uninsured or underinsured. It is the position of the Institute that TennCare is an innovative program which will provide an opportunity for medically underserved Tennesseans to have access to much needed health care. We applaud the efforts of Governor McWerther in health care reform, and encourage Secretary Shalala to approve this proposal.

Sincerely,

Amy Cato

Amy Cato
Associate Director, IHCPU

MEHARRY MEDICAL COLLEGE • 1005 D.B. Todd Blvd., Nashville, TN 37208 • Phone (615) 327-6279 or 1-800-669-1269 FAX (615) 327-6362

UNITED CEREBRAL PALSY of the MID-SOUTH, INC. • *LIFE ENRICHMENT AND TRANSITIONAL CENTER*

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Program in Physical Therapy
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Judy Smrt

September 27, 1993

Mr. Tony Garr
Tennessee Health Care Campaign
2020 Meharry Blvd.
Nashville, TN 37208

FAX: 615-327-6362

Dear Tony:

I have read the letter written to Secretary Shalala, and as Executive Director of United Cerebral Palsy of the Mid-South, Inc., I wish to state that I am in support of the Tennessee Health Care Campaign's letter to Secretary Donna Shalala, dated September 27, 1993.

Our agency represents many persons, who, without TennCare's approval on an immediate basis will be un-insured.

Most Sincerely,

UNITED CEREBRAL PALSY OF THE MID-SOUTH, INC.

Diana Reid
Executive Director

DR:lw

cc: Dr. Wilson Dietrich, Chairman of the Board
Mr. George Brogdon, Vice-Chairman of the Board
Ms. Jeannie Townshend, Associate Director

3246 East Raines Road • Memphis, Tennessee 38118 • (901) 368-5433

END

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE
— NASHVILLE BRANCH —
1308 JEFFERSON STREET ● NASHVILLE, TENN. 37208 ● 615-329-0999

September 27, 1993

Tony Garr, Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, TN 37208

Dear Mr. Garr,

The Nashville Branch of the NAACP is in full support of Tennessee Health Care Campaign's position regarding the approval of TennCare. We urge Secretary Shalala to approve this proposal without any waiver conditions. Many Tennesseans are critically awaiting the opportunity and the right to become insured persons through this innovative program. We applaud the efforts of the Governor in the TennCare proposal and we hope Secretary Shalala well reward the state of Tennessee for its courageous efforts in health care reform.

Sincerely,

Sheila R. Peters

Sheila R. Peters, Ph.D., President
NAACP - Nashville Branch

nashville CARES

P.O. Box 25107
Nashville, TN 37202

700 Craighead St. Suite 200
Nashville, TN 37204

(615) 385-1510

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September 27, 1993

Honorable Donna E. Shalala
Secretary
Department of Health & Human Resources
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

We are writing to confirm our support of the proposed TennCare Program as a viable option to the state's existing Medicaid Program, given the following;

1.) That current CDC funds provided to the state for HIV programming remain separate from the TennCare system.

2.) That HUD funds provided to the state for HIV programming remain separate from the TennCare system.

3.) That funds provided to any portion of the state or local governments in Tennessee remain separate from the TennCare system.

We believe, given these exceptions that TennCare will provide the needed medical benefits that so many of our clients and Tennessee citizens lack.

Sincerely,

Joseph Bodenmiller

Joseph Bodenmiller, MSW/ACSW
Director of Client Services

jb:JB

cc: Sheri Wood
Executive Director

A United Way Member Agency

SEP-27-'93 16:54 T-CARES 385 1692 #138-02

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NATIONAL KIDNEY FOUNDATION OF MIDDLE TENNESSEE INC.

2120 CRESTMOOR ROAD • NASHVILLE, TN 37215-2613 • TELEPHONE: 615-383-3887

September 27, 1993

Mr. Tony Garr
Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, TN 37208

Dear Tony:

On behalf of the National Kidney Foundation of Middle Tennessee, I am writing to advise you that this organization supports the letter written to Secretary Donna Shalala dated September 27, 1993 by the Tennessee Health Care Campaign.

Sincerely,

Lou

Lou Tate (Mrs.)
Executive Director

LT:jb

gift of life® DONOR ORGANS FOR TRANSPLANT

PEOPLE FIRST OF TENNESSEE, INC.

September 27, 1993

Honorable Donna E. Shalala, Secretary
Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Shalala,

People First of Tennessee, Inc. is an self-advocacy organization run by and for people with disabilities. We have over 1,060 members with disabilities across the state of Tennessee. The vast majority of our members are currently medicaid recipients. For the past several years our members have actively supported efforts to assure access to health care services by all Tennesseans. We have also tried to stop proposals which would limit the services available to medicaid recipients. Many of our members have been able to increase their independence as the result of medicaid waivers for services for persons with disabilities. These waivers have added community based services as an alternative to institutions. We would like to see efforts like these expanded.

We would like to express our support of the TennCare proposal which will extend broaden coverage to current Medicaid recipients and extend coverage to more Tennesseans who do not have insurance now. We believe that making health care coverage available to all Tennesseans will reduce discrimination and prejudice toward current medicaid recipients and expand the health care choices people with disabilities have available in our state.

Sincerely,

Ruthie-Marie Beckwith, Ph.D.
Staff Advisor

cc: Linda Turner, President

P.O. BOX 121211 • NASHVILLE, TENNESSEE 37212-1211 • (615) 297-2734

SENIOR CITIZENS

SENIOR CITIZENS, INC.

1801 BROADWAY NASHVILLE, TENNESSEE 37203 (615) 327-4551 Fax 327-4554

"That which the fountain sends forth returns again to the fountain"
Henry Wadsworth Longfellow

TENNESSEE HELATH CARE CAMPAIGN
2020 Meharry Boulevard
Nashville, TN 37208

Dear Ms. Howe:

We have read a copy of your letter from Tennessee Health Care Campaign to Secretary Donna E. Shalala dated September 27, 1993. We wish to go on record as supporting the statements contained in that letter and supporting the TennCare proposal. We believe it is imperative that approval be made as quickly as possible for implementation of TennCare by January 1, 1994.

Sincerely yours,

Janet Jernigan

Janet Jernigan
Executive Director

United Way

The Arc of Tennessee

1805 Hayes Street, Suite 100 Nashville, TN 37203 (615) 327-0294 fax (615) 327-0827

September 27, 1993

To Whom it May Concern:

The Arc of Tennessee supports the letter of the Tennessee Health Care Campaign to Secretary Shalala endorsing approval of the Tennessee TennCare waiver.

Should you have questions about this endorsement, please feel free to contact our office at (615) 327-0294.

Sincerely,

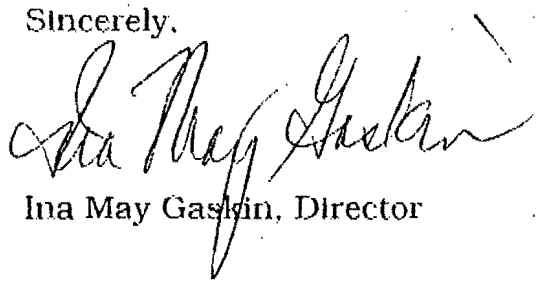
Glenda Bond

Glenda Bond
President

The Farm Midwifery Center
41, The Farm
Summertown
Tennessee
38483

The Farm Midwifery Center stands in support of the letter written by the Tennessee Health Care Campaign, Inc., to Secretary of Health and Human Services Donna Shalala.

Sincerely,



Ina May Gaskin, Director

TAMI
TENNESSEE ALLIANCE FOR THE MENTALLY ILL

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Clarksville
Columbia
Cookeville
Covington
Crossville
East Chattanooga
Gallatin
Greeneville
Johnson City
Knoxville
LaFollette
Loudon
Madisonville
Maryville
McMinnville
Memphis
Memphis S.W.
Murfreesboro
Nashville
Oak Ridge
Rockwood
Sevierville
South Fulton

September 24, 1993

Tony Garr, Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, TN 37208

Dear Tony:

The Tennessee Alliance for the Mentally Ill supports wholeheartedly your letter dated September 27, 1993, to Secretary Donna E. Shalala. At a meeting of the TAMI Board on May 1, 1993, we approved a resolution supporting the TennCare Plan as proposed by Governor McWherter. We took certain positions on details of the Plan as it affects persons with severe disabling mental illness, but we have been reassured that these points have been adequately addressed.

We certainly hope that the Health Care Financing Administration will not impose greater financial burdens on consumers or limit the coverage provided. We must not balance the budget on the backs of those least able to speak out.

Neither would we favor any phase-in that would delay the coverage of all uninsured persons. One of the important advantages of TennCare will be that it removes the disincentive for a person on Supplemental Security Income to seek employment.

Again, we support your letter and urge HCFA to provide the requested waivers so that Tennessee can begin a program of health coverage consistent with that proposed by President Clinton.

Sincerely,

William R. Busing

William R. Busing, President
Tennessee Alliance for the Mentally Ill

1900 North Winston Road, Suite 511, Knoxville, Tennessee 37919, (615) 531-TAMI
Affiliated with the National Alliance for the Mentally Ill, Partially funded by TN Dept. MH/MR

TENNESSEE COALITION FOR NURSING HOME REFORM

2012 21st Avenue South * Nashville, TN 37212 -4313 * (615) 297-2391

September 27, 1993

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

Dear Secretary Shalala:

I am writing on behalf of the Tennessee Coalition for Nursing Home Reform to voice our support for our state's application for a Medicaid waiver. We are also pleased to join with other organizations from around the State in signing the Tennessee Health Care Campaign's letter to you dated September 27, 1993.

The Coalition is obviously concerned about quality care for all Tennessee nursing home residents. We are also concerned that Tennesseans have access to appropriate community-based long term care. The new waiver does not address all our concerns in the above two areas, but we think it offers the best immediate option for ensuring quality long term care for Tennesseans.

The Coalition is pleased by the Administration's interest and commitment to reforming our health care system. Delaying the initiation of reform efforts in Tennessee by a year, or even a few months, though, can have a drastic impact on those most in need of assistance. Please do not delay action on the waiver.

Sincerely;

Karen L. Franklin

Karen L. Franklin
Chairperson

TENNESSEE COMMISSION ON AGING
NASHVILLE, TENNESSEE 37243-0860
Tel. No. (615) 741-2056
FAX (615) 741-3309

September 27, 1993

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

Dear Secretary Shalala:

This letter is in support of the letter written by Dara Howe, president of the Tennessee Health Care Campaign, asking you to approve the Medicaid waiver for the state of Tennessee.

The Tennessee Commission on Aging also respectfully requests that no delay or phase-in implementation of TennCare be required.

This may be the most crucial issue facing our state, and many, many families in Tennessee are depending upon a January 1, 1994, start-up in order to receive the medical care they need.

Thank you for your consideration.

Sincerely,

Emily M. Wiseman
Director

EMW/ps

STATE OF TENNESSEE
TENNESSEE COMMISSION ON CHILDREN AND YOUTH
Gateway Plaza Building, First Floor
710 James Robertson Parkway
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

September 27, 1993

Tony Garr, Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, Tennessee 37208

RE: Tennessee Health Care Campaign Letter of Support for TennCare

Dear Tony:

The purpose of this letter is to communicate the support of the Tennessee Commission on Children and Youth for the Tennessee Health Care Campaign letter to Secretary Donna Shalala, Department of Health and Human Services, encouraging implementation of TennCare without the imposition of unnecessary conditions or financial burdens on the waiver.

Please add the Tennessee Commission on Children and Youth to the list of signatory agencies for the letter. We believe that it is in the best interest of hundreds of thousands of Tennessee children and families for TennCare to be fully implemented January 1, 1994.

We strongly encourage Secretary Shalala to approve the TennCare waiver so Tennessee can proceed with meaningful health care reform.

Sincerely,

Linda O'Neal

Linda O'Neal
Executive Director

TENNESSEE HUNGER COALITION

P.O. Box 120961 Nashville, Tennessee 37212-0961 (615) 298-3888

September 27, 1993

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

RE: Tennessee Health Care Campaign

Dear Madam Secretary:

The Tennessee Hunger Coalition supports the position of the Tennessee Health Care Campaign regarding TENNCARE. We also endorse their letter to you dated September 27, 1993. As advocates for social justice, we strongly encourage you to put your weight behind TENNCARE.

Bread and Justice,

Jean Stone

Jean Stone
THC President

Bob Walker

Bob Walker
Vice-President

TNA
THE STRENGTH OF NURSING

TENNESSEE NURSES ASSOCIATION
545 Mainstream Drive, Suite 405
Nashville, TN 37228-1201
Telephone: 615/254-0350
Fax: 615/254-0303

September 27, 1993

Donna E. Shalala, Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

The Tennessee Nurses Association is in strong support of the position as stated in the September 27 letter to you from the Tennessee Health Care Campaign.

We have worked closely with the Administration in Tennessee to fine tune this proposal and believe TennCare deserves your approval.

Regards,

Frances M. Edwards

Frances Edwards, MSN, RN
President, Tennessee Nurses Association

cc: Mr. Bruce Vladeck
Ms. Carol H. Rasco

TENNESSEE
TASK FORCE
AGAINST
DOMESTIC VIOLENCE

September 27, 1993

Mr. Tony Garr
Executive Director
Tennessee Health Care Campaign
2020 Meharry Boulevard
Nashville, TN 37208

Dear Tony,

I am writing to you today to express the support of The Tennessee Task Force Against Domestic Violence (TTFADV) in your efforts to encourage Donna Shalala to approve TennCare and not impose on the waiver any conditions which would force the state to impose greater financial burden on consumers, or limit the program's coverage.

As you know, TTFADV is the state coalition of domestic violence programs and many of the 30,000 victims our programs serve annually have very few resources and are part of the staggering number of people dependant upon Medicaid or unable to afford health care or insurance of any kind. A delay in switching to TennCare could have a devastating impact on these families.

We appreciate your continued efforts in the struggle to establish affordable health care for all Tennesseans.

Sincerely,

Kathy England

Kathy England
Executive Director

P.O. Box 120972 • Nashville, Tennessee 37212 • (615) 327-0805