



CHIEF OF STAFF TO THE PRESIDENT
THE WHITE HOUSE

October 12, 1993

OCT 14 REC'D

The Honorable Ned Ray McWherter
Governor of Tennessee
State Capitol
Nashville, TN 37243-0001

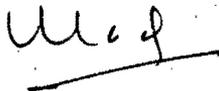
Dear Ned Ray:

Welcome back. I trust your trip was both enjoyable and positive.

As you know, we held our decision on your waivers until your return. I visited with Carol Rasco this morning, and she assured me that discussions were ongoing between your state officials and the proper people at HHS.

This situation is not an easy one, as you know, but hopefully we are making some progress toward a satisfactory resolution.

Personally,



cc: Carol Rasco

TO: Mack McLarty
Roy Neel
Nancy Hernreich

FROM: Carol H. Rasco

SUBJ: Tennessee

DATE: November 3, 1993

I have now spoken to the two people at HHS with whom the Governor AND his officials continue to speak just as there are three to four of us here called daily by the Governor. After piecing all parts together it appears fairly clear to me that :

1. Despite the calls here to us that have stated that HHS had not called Tenn. since the Friday submission of a revision, two officials of HCFA spoke both on Monday and Tuesday to Manning (financial person in Tenn. heading up this effort for the Governor and the person the Gov. has repeatedly told me with whom to work) with updates from the HCFA side and Manning working on the Tennessee side. Manning continues to tell Bruce at HCFA that he can't control the Governor and his calls up here.

2. John Monahan of Intergovernmental at HHS talked with the GOVERNOR on Monday evening, and they exchanged calls again yesterday. John will be calling the Governor as usual today.

3. Bottom line to date: We have games being played here from Tennessee, and the concern at HHS is that with the promise of an appointment with the President, Tenn. may be instructed by the Governor's office to hold on any final deal until the President tells them indeed they have to raise more money and phase in the program. However, HHS will continue to push on Tenn. as HHS knows we can't continue to refuse an appt. for the Gov.

4. Bottom line overall: I do believe we can't hold off the Governor much longer from the President, and I have told HHS to be prepared to see that meeting happen early next week and to start an iterative set of briefing notes for use with the President in preparation for the meeting so that we will have the most up to date information possible for him to use.

Finally, I FIRMLY believe Secretary Shalala MUST be in the meeting the President has with the Governor. I also should be there. Rationale? The President must be prepared to firmly back the department in their conditions for Tenn.'s waiver...more money in hard cash on the table and an elongated phase in. Without these two items as the plan currently stands, the harm to overall health care reform will be very serious. The press will be watching this waiver not only at the time of a decision but throughout its implementation which will parallel the Congressional debate.

TO: Mack McLarty
Roy Neel
Kathi Way
Nancy Hernreich

FROM: Carol H. Rasco

SUBJ: Tennessee

DATE: November 4, 1993

Attached is a very thorough memo on the Tennessee situation for those of you who want to read this much detail. In summary, HCFA has made what I consider based on my knowledge a very fair offer back to Tennessee. I say fair based on financial integrity, client protection, and the protection of our health care reform efforts. HCFA is waiting now on answers/questions from Tennessee.

I will continue to keep you posted and hope you will do the same should you hear from any of the parties. Many thanks!



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20001

November 4, 1993

NOTE TO CAROL RASCO

CONFIDENTIAL²

FROM: Bruce C. Vladeck
Administrator, Health Care Financing Administration

SUBJECT: TennCare Waiver Proposal -- Status

As you know, HCFA has been reviewing a proposal from the State of Tennessee that would waive Federal Medicaid requirements in order to provide coverage to Medicaid eligibles and uninsured in the State. While we are making every effort to provide maximum flexibility to states as they redesign their health care delivery systems, we have been concerned about the financing approach, beneficiary confusion, and the implementation schedule that the State has promoted. The State has provided responses to a number of our questions about TennCare, most recently on October 29. The Governor is pressing for a positive decision right away.

Last night we laid out for Tennessee the conditions under which we would approve a waiver. (Attached is the material we faxed to them.) The following are the key features of our offer, along with the reactions I expect from the State:

- o HCFA Offer: Our approach reflects significant movement on our part in three areas since the state's original proposal. We have agreed to (1) provide limited Federal matching funds for a new form of Certified Public Expenditures (CPE); (2) provide limited Federal matching funds for services provided to residents of institutions for mental diseases (IMDs), consistent with the Health Security Act, and (3) allow certain premium payments by patients who would not otherwise be eligible for Medicaid to count as the State's share of Medicaid costs. We have endeavored to limit the precedent these three developments might set in other states, although it is probably not possible to eliminate it.

Expected Reaction: The State should regard the first item as a positive development, and will perceive some improvement on the second item. On the third item, we had previously communicated our position to them, but they had argued against the very reasonable limitation we had placed on them. Our most recent response reiterates our position, which they will not regard as progress.

- o HCFA Offer: We clarified to the State that we will not provide Federal match for capitation payments for individuals who are eligible for TennCare but not enrolled in the program. However, I should note that we are prepared to match the costs of uncompensated care (similar to disproportionate share payments) to the extent that these are actual State cash expenditures that account for costs borne by participating providers.

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Expected Reaction: As we discussed in our meeting the other day, the State's latest proposal suggests that they may regard this a new and significant restriction, even though it should have been obvious to them based on all our previous statements. Tennessee may be interested in our alternative, but may have difficulty raising the State resources to support this approach.

- o HCFA Offer: Rather than dictating an implementation date to the State, we outlined for them the process we would require prior to implementation. In addition, we will require them to repeat the enrollment/plan selection process after contracts with providers have been signed and approved by HCFA.

Expected Reaction: We are mildly optimistic that the State will react positively to this approach.

- o HCFA Offer: We had previously argued that Tennessee must increase the capitation rate to providers because it is not adequate to ensure access and quality of care. (This is the core issue that has prompted 100-200 letters to us per day from Tennessee physicians.) In our new approach, we agree that HCFA should not be in the position of dictating Medicaid rates to states (a position with which we were never entirely comfortable), but we require that the State be able to assure access and monitor quality in the TennCare program.

Expected Reaction: Should be positive.

Finally, it is important to note that, even if Tennessee concurs with all of our conditions, the State still has a shortfall of funds for the program. Estimates of the magnitude of the shortfall can vary widely depending upon assumptions about the number of enrollees, treatment of CPE, capitation rates, and the need for any supplemental pools, but it is in the range of \$100-\$350 million per year.

The State will probably view the limitations that we have listed as significant. Nevertheless, these limitations are essential to assure that we maintain the current percentage shares of financing borne by the Federal and State governments and to protect beneficiaries during the transition.

We are preparing additional background documents and talking points on these issues for you to share with your colleagues.

CC: Kevin Thurm

HCEA POSITION ON TENNCARE ISSUES

The following provides details of our position on TennCare financing. These details reflect our longstanding view that we may only match allowable costs, rather than the originally-proposed block grant approach. We also provide further specification of our matching policy for certified public expenditures. In addition, we provide additional clarification on several non-financing issues.

Financing Issues

- o We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to the Managed Care Organizations (MCOs) for each TennCare enrollee.
- o We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing services to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.
- o These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.
- o We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 90 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- o We will provide FFP at the applicable matching rates (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.
- o We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.
- o Premium revenues must be offset on an individual by individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

~~CONFIDENTIAL~~ *rw*

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Non-financing Issues

- o We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.
- o Substantial changes have been made in the TennCare project, from agreements reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.
- o Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in Federal spending related to TennCare.
- o The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.
- o The State will repeat the enrollment/plan selection process after contracts with MCOs and providers have been signed.

TENNESSEE MEDICAID WAIVER MEETING

November 1, 1993
 OEOB Room 472

<u>NAME</u>	<u>AGENCY</u>	<u>PHONE #</u>
1. Kathi Way	DPC	456-7777
2. CHARLOTTE HAYES	OVP	456-6277/2872
3. Marcella Hale	Inter WH	456-7060
4. John Hunt	" "	456-2896
5. Debbie Fine	OPL	456-2566
6. David Cotter	NEC	395-3114
7. David Klingberg	OAS	395-4922
8. Darrel Grinstead	HHS-OGC	619-0300
9. JOE ANTOS	HCFA	690-7063
10. Diana Fortuna	HCFA	690-8502
11. Kathy Burt	HCFA	690-7063
12. Bruce Madock	HCFA	690-6726
13. John Monahan	HHS HHS-IGA	690-6060
14. G.H. Rasco	DPC	456-2216
15. JOAN BAGGETT	WH Political	456-1125
16. Todd Campbell	OVP	456-2022
17. ROY NEEL	WH DCOS	456-6797
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19.		
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21.		
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24.		



OCT 28 REC'D

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

DAVID L. MANNING
COMMISSIONER

October 26, 1993

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

Dear Mr. Vladeck:

Thank you for the time that you and your staff spent with us last Thursday to review the TennCare proposal. We felt that the meeting was productive, and that it brought us closer to resolving the financing issue that appears to be the impediment at this time to approval of the requested waiver.

We continue to believe that the capped grant approach (sometimes referred to as a block grant) would best meet the TennCare situation and serve the interests of both the State and the federal government, and we would prefer to go forward on that basis, as originally proposed by Tennessee. However, we understand that HCFA is not now willing to follow this course, and we are therefore attempting to develop an alternative approach that meets the match rate policies on which HCFA would prefer to predicate a waiver approval. In that connection, we have reviewed and refined our thinking on the certified public expenditure (CPE) issue in light of our meeting Thursday.

You indicated there that HCFA would be open to an approach that recognized CPE if there were an auditable basis for demonstrating the availability of state/local subsidies or surplus funds derived by public facilities from non-governmental business that was used to cover the cost of care for TennCare eligibles. The purpose of this letter is to set forth such an approach.

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There are two aspects to the CPE approach. The first is to identify the expenditure of funds for a TennCare eligible. The second is to identify the revenue source for the expenditure. We believe the expenditure can be determined without great difficulty from the Joint Annual Reports submitted by all hospitals in Tennessee. Those reports permit determination of the cost incurred in providing various categories of services, using Medicare cost-finding methods. We will require hospitals participating in TennCare to retain and report to their Managed Care Organizations (MCOs) the units of service provided to TennCare eligibles. This would permit a determination of the total cost incurred by each hospital in providing TennCare service. To the extent the service is provided to non-enrolled TennCare eligibles and is compensated by the supplementary TennCare pool, the State, as the source of compensation, will require reporting of units of service by the hospitals from which the cost determination can be made. While it would be possible to refine these determinations to obtain a case-by-case calculation of service cost, we see little purpose to be served by this and, as agreed at our meeting last week, the information will be aggregated by facility for all TennCare eligibles served by the facility.

We would then determine the revenue sources for the costs incurred in serving TennCare eligibles by these public hospitals. We would require the MCOs to report the method for compensating hospitals that are part of their networks and total amount paid for TennCare eligibles. The State would know the amounts paid by it from the supplementary TennCare pool. To the extent these payments were insufficient to cover the cost attributable to service for TennCare eligibles, there would be CPE on which we could rely in financing TennCare to the extent that the CPE came from two general sources: (1) public subsidies, and (2) surplus from other non-governmental business. We would identify the former by specific subsidies, and the latter by comparing revenues of each participating public hospital from non-governmental business to the costs attributable to that business using the same allocation method as was used in determining the cost of TennCare service (through the Joint Annual Reports and Medicare cost-finding principles). In connection with the public subsidies, we would offset any local government grant funds that had already been included in calculating the state share so as not to double count those funds.

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We have estimated the amount of CPE available for supporting TennCare taking into account the limitations set forth above. To make the estimate, we have examined the share of Medicaid and charity business that each public hospital has received based on the most recently available Joint Annual Reports and assumed that these hospitals would derive the same share of TennCare hospital business. We have also assumed that the hospital portion of TennCare (and the portion of the capitation fee attributed to hospitals) would equal the percentage of total Medicaid payments paid for hospital services (exclusive of Disproportionate Share payments). We further assumed that the appropriate part of the "discount" portion of the capitation fee was passed through by the MCOs to the participating hospitals. Finally, we determined from the Joint Annual Reports that hospital costs exceeded Medicaid reimbursement (exclusive of disproportionate share payments) by 5.45 percent. Based on these assumptions, we have calculated the amount of costs that public hospitals would incur in caring for TennCare eligibles that was not covered by the cash payments from the MCOs. The results of this calculation are set forth in the attached Table 1. We have assumed that in each case the public hospitals had revenues other than from governmental business that exceeded the cost of providing that care, or had public subsidies (other than the local grants), that together equalled the costs incurred for TennCare eligibles in excess of payments from MCOs. We understand that this would have to be demonstrated in the actual TennCare periods.

Attached Table 2 is a revised summary of the TennCare financing proposal that shows a substantially lower number for CPE than had been shown in our submission of September 30, 1993. This results from the limitations on use of CPE that are outlined above. You will note that we have added a new line under state funding called "Additional State Funds Required." That line represents the difference between the original CPE estimate and the CPE estimate in the attached table. We acknowledge that it will be the State's responsibility to develop additional revenue sources, which qualify as matching funds under current federal law and regulations, to replace the funds that would have been supplied as CPE under the prior proposal. These additional amounts could be a combination of additional CPE that meets the standards set forth above, or additional state appropriations. To the

Mr. Bruce C. Vladeck
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extent we are unable to produce state funds equal to the amount shown on the table, there would have to be a reduction in the scope of the program to stay within the reduced available funding. In no case would such a reduction reduce the number covered to less than 1,400,000.

We have also modified the previous proposal insofar as it had set aside a reserve fund to cover transition costs and to assure adequate reimbursement for providers. We have refined our thinking in this regard and now contemplate a primary care provider fund, to be used to assure adequate reimbursement for primary care physicians and others. These amounts would be over and above the capitation payments, and would be financed by the additional funds appropriated by the State to replace the CPE amounts that had been included in our earlier estimates. Needless to say, we would seek federal match on this fund only to the extent of expenditures made for TennCare eligibles.

You have also asked that we document the legal status of those facilities that we intend to treat as public providers for CPE purposes. Page 2 of Table 1 lists each of the hospitals we intend to treat as public. They fall into several categories: (1) state entities -- there are the University of Tennessee medical facilities; (2) county entities -- facilities owned and operated by county governmental agencies; (3) city entities -- facilities owned and operated by city governmental agencies; (4) government chartered entities -- facilities established by act of the legislature and that are governed by boards appointed by public officials. The latter are in the nature of special hospital districts and they possess the indicia of public entities, although in some cases they have been authorized to receive Section 501(c)(3) status in order to encourage contributions from private citizens. No facility sponsored by a private non-profit organization is included within this list.

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We would also like to respond to the two proposed conditions that were transmitted to us on Friday by Kathleen Buto.

Mr. Bruce C. Vladeck
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Premiums. This proposed condition is agreeable on the understanding that it is meant to be applied in the aggregate; that is, that where the aggregate premiums paid by TennCare enrollees exceed the State share of the capitation applicable to those enrollees, the amount of such excess will be deducted from the amount of FFP that HCFA pays to the State. It would be unfair and unreasonable to apply this condition on an individual basis, which would fail to take into account that while some enrollees pay more than the state share of the capitation, others will pay less, yet the State will be responsible for the full balance of the capitation in the latter cases. Also, the test should be predicated on the full amount of the capitation that is recognized for federal match purposes (the cash payment plus the CPE portion).

Raising the limit on premiums is not consistent with the understanding expressed in Governor McWherter's meeting with Secretary Shalala that the entire scope of the financial problem was the amount of CPE counted in the proposal of the State then under consideration. Nevertheless, we are willing to accept the proposed condition, construed as set forth above.

IMDs. It is the State's intent under TennCare to continue to implement our master plan for services to the seriously mentally ill. These services are primarily community based and utilize acute inpatient services only when necessary to stabilize the patient. The services are otherwise designed to support the needs of the seriously mentally ill in a much less restrictive and less expensive manner. While we do not object to a condition which excludes long-term hospitalization, we do request that TennCare support acute care needs of the seriously mentally ill, at least to the extent that the President's health reform proposals support acute inpatient mental health services. We understand that that proposal would permit 90 days of mental institution coverage in a single year.

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We are quite anxious to bring the financing issues to closure so that we can move forward with the TennCare program, and we are pleased that you have agreed to respond

Mr. Bruce C. Vladeck
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to our submission within three working days of receiving it. Should you have any questions about our submission, please feel free within the three-day period to contact us and we will attempt to respond as quickly as possible.

We understand that you have reserved final resolution of the question of implementation date, but that otherwise all of the issues that HCFA has to raise with respect to TennCare have now been placed on the table. We look forward to your response to this submission.

Sincerely,


David L. Manning
CAH

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

**TennCare
Fiscal Year 1993 - 1994**

October 26, 1993

Total Charity Estimate		\$595,500,000
Cost of Medicaid Hospitals - Fiscal Year 1992 - 1993	\$1,168,381,500	
Cost of all Medicaid Services - Fiscal Year 1992 - 1993 Excluding Nursing Home Cost and Medicare Cost Sharing	\$1,900,028,800	
Percentage of Hospital Expenditures to Total Medicaid Services	61.49%	
Hospital Charity (61.48% x \$595,500,000)		\$366,189,800
Certified Public Expenditure Projection - Hospitals		
Capitated Rate		\$1,641
Hospital Capitated Rate		\$816
Hospital Discount (\$366,189,800 / 1,300,000)		\$282
Charity	\$366,189,800	
TennCare Eligibles	1,300,000	
TennCare Cash Payment - Hospitals (\$816 - \$282)		\$534
Hospitals Cost Above Cap Rate (\$816 + 5.45%)		\$860
Difference Hospital Cost and Payment		\$328

OCT 27 '93 11:41 FROM 5TH FLOOR

TENNCARE
CERTIFIED PUBLIC EXPENDITURES BY HOSPITALS

October 26, 1993

PROVIDER NUMBER	PROVIDER NAME	5.34 AVG LOS CUTE HOSPITALS # OF RECIPIENTS	PERCENT AID RECIP. ^{1/}	TENNCARE ELIGIBLES ^{2/}	COST LESS PAYMENT ^{3/} CPE
044-0003	SUMNER	700.56	0.52%	6,746	\$2,200,135
044-0011	BLOUNT COUNTY	1,149.06	0.85%	11,064	\$3,608,669
044-0015	U.T. HOSPITAL-KNOXVILLE	8,422.85	6.24%	81,103	\$26,452,203
044-0023	RHEA COUNTY	114.04	0.08%	1,098	\$358,182
044-0024	BRADLEY MEMORIAL	1,075.28	0.80%	10,354	\$3,376,952
044-0031	HARRIMAN CITY	424.16	0.31%	4,084	\$1,332,079
044-0032	HAWKINS COUNTY	285.77	0.21%	2,752	\$897,482
044-0033	LAFOLLETTE COMMUNITY	248.13	0.18%	2,389	\$779,251
044-0051	MCNAIFY CO GEN	273.97	0.20%	2,638	\$860,411
044-0054	WOODS MEMORIAL	293.63	0.22%	2,827	\$922,163
044-0056	JEFFERSON MEMORIAL	85.21	0.06%	820	\$267,592
044-0057	CLAIBORNE COUNTY	346.82	0.26%	3,339	\$1,089,188
044-0059	COOKEVILLE	950.56	0.70%	9,153	\$2,985,288
044-0060	CITY OF MILAN	309.36	0.23%	2,979	\$971,565
044-0065	JESSE HOLMAN JONES	574.91	0.43%	5,536	\$1,805,511
044-0070	DECATUR CO. HOSP.	140.45	0.10%	1,352	\$441,086
044-0073	MAURY REGIONAL	1,511.24	1.12%	14,552	\$4,746,082
044-0102	LINCOLN REGIONAL	289.89	0.21%	2,791	\$910,401
044-0104	ERLANGER	7,371.91	5.46%	70,984	\$23,151,705
044-0109	HARDIN	251.12	0.19%	2,418	\$788,661
044-0111	NASH. METRO GENERAL	1,796.25	1.33%	17,296	\$5,641,182
044-0132	HENRY COUNTY	338.85	0.25%	3,284	\$1,064,487
044-0137	BEDFORD COUNTY HOSP	280.67	0.19%	2,510	\$818,655
044-0152	REG MED CTR-MEMPHIS	11,534.08	8.54%	111,061	\$36,223,133
044-0166	U.T.-BOWLD	628.59	0.46%	6,033	\$1,967,830
044-2006	NASH. METRO BORDEAUX	1,092.70	0.81%	10,521	\$3,431,847
TOTAL					\$127,091,490

^{1/} Represents listed hospitals' share of total Medicaid days.

^{2/} Medicaid percentage times 1,300,000.

^{3/} At \$326 per eligible.

TABLE 2

TennCare

October 26, 1993

	Fiscal Year 1993 - 1994	Fiscal Year 1994 - 1995	Fiscal Year 1995 - 1996	Fiscal Year 1996 - 1997	Fiscal Year 1997 - 1998	Five Year Total
Eligibles	1,300,000	1,500,000	1,500,000	1,500,000	1,500,000	
TennCare Cash Cost	\$1,067,300,000	\$2,584,500,000	\$2,713,500,000	\$2,648,500,000	\$2,991,000,000	\$12,204,800,000
Regular Program (7/93 - 12/93)	\$1,200,840,400	\$0	\$0	\$0	\$0	\$1,200,840,400
Primary Care Provider Fund	\$185,258,900	\$170,880,300	\$197,548,200	\$225,902,600	\$256,037,400	\$1,035,627,400
Long Term Care, Administration & Medicare	\$938,686,000	\$985,631,000	\$1,033,246,400	\$1,084,992,400	\$1,139,325,200	\$5,181,891,000
Grand Total Expenses	\$3,382,085,300	\$3,741,011,300	\$3,944,294,600	\$4,159,395,000	\$4,386,362,600	\$19,623,158,800
State Funding						
State Core	\$383,049,300	\$394,540,700	\$406,376,900	\$418,568,200	\$431,125,200	\$2,033,660,300
Patient Revenue	\$20,858,200	\$101,082,300	\$106,136,400	\$111,443,200	\$117,015,300	\$456,535,400
Broad Based Tax	\$202,178,000	\$0	\$0	\$0	\$0	\$202,178,000
Certified Public Expenditures	\$63,545,700	\$127,091,500	\$127,091,500	\$127,091,500	\$127,091,500	\$571,911,700
Local Government	\$25,000,000	\$52,500,000	\$55,125,000	\$57,881,000	\$60,775,000	\$251,281,000
Other State	\$77,969,700	\$159,871,000	\$164,091,000	\$168,301,000	\$172,602,000	\$742,834,700
Nursing Home Tax	\$60,300,000	\$84,000,000	\$88,200,000	\$92,610,000	\$97,241,000	\$442,351,000
Additional State Funds Required	\$185,258,900	\$170,880,300	\$197,548,200	\$225,902,600	\$256,037,400	\$1,035,627,400
Total State Funding	\$1,038,157,800	\$1,090,085,800	\$1,144,569,000	\$1,201,797,500	\$1,261,887,400	\$5,736,477,500
Federal Funding						
Title XIX	\$2,107,775,000	\$2,219,183,800	\$2,323,822,000	\$2,440,013,100	\$2,582,013,800	\$11,646,787,700
Other Funding						
Charity	\$246,182,500	\$437,781,700	\$475,903,600	\$517,584,400	\$562,461,400	\$2,239,893,600
Grand Total Funding	\$3,392,096,300	\$3,741,011,300	\$3,944,294,600	\$4,159,395,000	\$4,386,362,600	\$19,623,158,800

OCT 31 1993 11:33 FROM 5TH FLOOR

TENN CARE

ALL NUMBERS IN MILLIONS

	NEW PROPOSAL		OLD PROPOSAL	
	FY 93-94	FY 94-95	FY 93-9	FY 94-95
ELIGIBLES	1.3	1.5	1.8	1.8
TENNCARE COST	2,268.1	2,584.5	2,658.1	3,058.4
LONG TERM CARE, ADMIN, & MEDICARE	938.7	985.6	938.7	985.6
RESERVE FUND	89.1	66.6		
GRAND TOTAL EXPENSES	3,295.9	3,636.7	3,596.8	4,044.0
STATE FUNDING				
STATE CORE	383.0	394.5	383.0	394.5
PATIENT REVENUE	20.9	101.0	113.9	239.3
BROAD BASED TAX	202.2	0.0	303.3	0.0
CERTIFIED PUBLIC EXPENDITURES	248.8	298.0		
— LOCAL GOVERNMENT APPROPRIATIONS	25.0	62.5	25.0	52.5
— OTHER STATE APPROPRIATIONS	77.9	151.0	94.1	193.9
NURSING HOME TAX	80.3	84.0	80.3	84.0
OTHER FEDERAL FUNDING			32.3	67.9
TOTAL STATE FUNDING	1,038.1	1,091.0	1,031.9	1,032.1
FEDERAL FUNDING TITLE XIX	2,107.8	2,213.1	2,267.1	2,380.4
OTHER FUNDING				
CHARITY	150.0	333.5	297.8	631.5
GRAND TOTAL FUNDING	3,295.9	3,637.6	3,596.8	4,044.0

OTHER CHANGES:

Maximum number of enrollees reduced to 1.5 mil.
 Cap on growth rate will be lower of 8.3 percent or proposed Medicaid growth caps under health care reform.
 Certified public expenditures by public hospitals applicable to care of the uninsured* will be used as State source of funds for matching

Pub. Hoop. exp. - 3rd party payments (XIX, Medicare, uncomp. care) or diff. in what is earned & what chos are (way for pay chos) * cha to cost ratio (1.05%)

THE WHITE HOUSE

WASHINGTON

~~CONFIDENTIAL~~

October 29, 1993

DETERMINED TO BE AN ADMINISTRATIVE
MARKING Per E.O. 12958 as amended, Sec. 3.2 (c)

Initials: RW Date: 5/5/04

MEMORANDUM FOR DISTRIBUTION LIST

FROM: Carol H. Rasco *CHR*
SUBJECT: Tennessee Medicaid Waiver

It is absolutely critical that you attend if at all possible or otherwise send a designee to an informational meeting I have called on Monday, November 1 at 11 a.m. in the Roosevelt Room where we will be briefed by HHS officials and particularly by members from the Health Care Financing Administration within HHS on the Tennessee Medicaid Waiver which is currently pending in HHS. I have conveyed to HHS my concern that this meeting not be portrayed as anything other than what it is: and I stress to you (perhaps to cover myself should this particular inhouse memo be leaked): this is an informational meeting only...not a time for decision making; that task of a decision is one belonging to HHS.

Please do not hesitate to call me here at the office (2216) or at home over the weekend P6/(b)(6) should you have questions.

Please confirm your attendance or that of your designee to Rosalyn Miller of my staff (2216) as soon as possible. Thank you so much.

Distribution list:

Mack McLarty
Roy Neel
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Joan Baggett
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Bob Rubin
Alice Rivlin
Kathi Way

TennCare Managed Care Organizations

Access...Med Plus

Parent Company: Tennessee Managed Care Network
Location: Corporate office, 205 Reidhurst Avenue, Suite N-104, Nashville, Offices in Memphis.
Experience: Has coordinated services to Tennesseans on Medicaid since 1984.
Extras: \$10,000 life insurance policy, minimal fee dental and vision plans for adults over 21, free over-the-counter medications such as cough medicine, a Mom-2-B club which offers pregnant women free gifts such as car seats and disposable diapers for each prenatal visit they make.

Advantage Care

Parent Company: Phoenix Healthcare Corp.
Location: Corporate office, 3401 West End Avenue, Nashville. Opening offices in Memphis, Chattanooga.
Experience: MCO created in April, 1993.
Extras: Nurse-staffed, round-the-clock hot line; special fund to sponsor community projects to "Stop the Violence."

Affordable Healthcare Corp.

Parent Company: Managed, about one-third owned by United Management of Tennessee, a subsidiary of United American Healthcare Corp. in Detroit. Rest owned by Tennessee investors.
Location: State headquarters in Memphis; Nashville district office.
Experience: Manages HMOs, PPOs in Detroit and Cleveland, for a total of about 125,000 customers, about half covered by Medicaid.

Best Choice

Information not available at this time.

Better Health

Parent Company: PCA Health Plans of Tennessee, an affiliate of Physician Corporation of America.
Location: State corporate offices, Memphis; national corporate office, Miami.
Experience: Operates HMOs in Florida, Texas. Parent company in business since 1985; Tennessee arm established in March, 1993.

Blue Cross/Blue Shield of Tennessee

Location: District office in Nashville, home office Chattanooga.
Experience: More than 50 years in the health-care business.

Community Health Plan of Tennessee Inc.

Parent Company: Community Medical Plan of Miami. Tennessee company created several months ago.
Location: Corporate offices at 511 Union St., Nashville; moving to Briley Parkway.
Experience: Miami parent company, established in 1990, works strictly with Medicaid clients.
Extras: Life insurance for each participant, adult dental and vision care, free over-the-counter drugs, educational and support classes.

Community Health Systems

Information not available at this time.

Complete Care

Parent Company: Complete Health of Tennessee, subsidiary of Complete Health Services Inc. of Birmingham, Alabama.
Location: State corporate offices in Nashville.
Experience: Parent company created in 1985, Tennessee subsidiary in 1990. Offers HMOs and PPOs in Alabama, Georgia, Mississippi, Arkansas, Florida and Louisiana. About 290,000 customers total.

Erlanger Family Health Plan

Parent Company: Erlanger Medical Center
Location: Chattanooga, TN
Experience: Established over one-hundred years ago. Provides Level 1 Trauma and High Risk Maternity Care.

Health Net

Parent Company: Health Net
Location: 44 Vantage Way, Suite 300, Nashville, TN
Experience: Established 1984. Tennessee's first and largest Preferred Provider Organization. Network of 20 hospitals and over 1,400 physicians.

Heritage National Health Plan

Parent Company: John Deere Health Care
Location: 1515 Fifth Ave., Suite 200, Moline, IL
Experience: In operation in Tennessee since 1985. Seven years of experience with a full risk Medicaid program in Iowa. Experience operating HMO's since 1979.

My Health Care Network

Information not available at this time.

TennCare Managed Care Organizations

Preferred Health Partnership

Parent Company: Preferred Health Partnership
Location:
Experience: In the managed care business since 1985. Network of 1,200 physicians and 26 hospitals.

Prudential Community Care of Memphis

Parent Company: The Prudential Health Care System, Memphis Operations
Location: 2620 Thousand Oaks Blvd., Suite 4000, Memphis, TN
Experience: Eleven years experience in managed care in Memphis area.
Extras: Over the counter drugs. Special maternity program. Health education outreach. Studying feasibility of providing \$5,000 term life policy for all participants.

TennSource

Parent Company: Healthsource Tennessee, Inc.
Location: Two Centre Square, 625 S. Gay Street, Suite 300, Knoxville, TN
Experience: Managed care and HMO services in Knox County since 1986. Largest HMO in the region.
Extras: \$4.00 monthly allotment for medical supplies and drugs not covered by TennCare. Discounted adult dental services.

TLC Family Care Healthplan

Parent Company: Memphis Managed Care Corporation
Location: Memphis, TN
Experience: Joint effort of the Regional Medical Center at Memphis, and UT Medical Group, Inc.

Total Health Plus

Parent Company: The University of Tennessee Medical Center at Knoxville
Location: 600 Henry Street, Suite 100, Knoxville, TN
Experience: Providing services since 1956. Experience serving Medicaid and underserved populations. Regional prenatal and Level 1 Trauma Center.

VHP Community Care

Location: Nashville
Affiliation: Vanderbilt University Medical Center
Experience: Affiliation with a major medical research and treatment center.

+ 1091 33%
2213 67%

1501 cap rate

BFC → not forwards match

298.

IGT - transfer or

Mich ka SC Texas
certify act. expend.

~~Gen Strategy~~
we really want to make
this work
Real & must be put
on table



Tennessee Medical Association

2301 21ST AVENUE SOUTH, PO BOX 120909
NASHVILLE, TENNESSEE 37212-0909
PHONE (615) 385-2100 • FAX (615) 383-5918

FAX COVER SHEET

DATE: October 20, 1993

This fax is directed to: The Honorable Carol Rasco

PLEASE NOTIFY THIS PERSON THAT THEY HAVE BEEN SENT A FAX.

URGENT? XX YES NO

Office: _____

Number of pages including this cover sheet: 7 FAX Phone: (202) 456-2878

Special Instructions: _____

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| <input type="checkbox"/> First Class Mail | <input type="checkbox"/> Federal Express |
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| <input type="checkbox"/> Original will not be sent | |

This FAX was sent by: Mark D. Greene

Department: Government Affairs

IF THIS FAX IS UNCLEAR OR INCOMPLETE, PLEASE CONTACT MARK GREENE AT 615/385-2100.



Tennessee Medical Association

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Nashville

October 20, 1993

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

Dear Ms. Rasco:

Enclosed you will find copies of our most recent correspondence with you and Secretary Shalala regarding the TennCare waiver application. Under separate cover we have forwarded a cross-section of Tennessee press clippings which illustrate the chaotic situation which has been caused by the premature mailing of TennCare ballots to recipients and the likely shortage of participating providers.

We understand that you will meet with Governor McWherter today. Before any decision to grant the waiver is made, we respectfully ask that we be given an opportunity to address our side of the issue. We are willing to schedule a meeting at your convenience. Thank you for your consideration in this matter.

Sincerely,

Charles W. White MD.
Charles W. White, M.D.
President

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October 11, 1993

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

Dear Ms. Rasco:

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

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

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

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The Honorable Carol Hampton Rasco

Page 2

October 11, 1993

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

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

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

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

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

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

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

The Honorable Carol Hampton Rasco
Page 3
October 11, 1993

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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Nashville

October 19, 1993

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

Dear Secretary Shalala:

It is the understanding of the Tennessee Medical Association that you will soon be making the decision with regard to a waiver for the Medicaid program in Tennessee. We can't emphasize enough the importance of your decision and its effect on the health of one-third of our state's population.

The concerns that have been expressed over the past many weeks regarding the hurried implementation of TennCare have been born out by the state of Tennessee's recent actions. Rather than wait for your decision, the state has proceeded to create chaos and confusion about a program you have yet to sanction. The Governor specifically blames doctors for the flaws in his TennCare program and the clippings we have enclosed for your information indicate that non-acceptance in its present form is wide-spread throughout the state. It didn't take physicians to point out problems with TennCare, your capable staff at HCFA has been aware of all these problems from the day the waiver request was received. Under the current Medicaid laws states are required to provide sufficient funding that will encourage providers to participate. With the rate structure being proposed, the Governor is essentially requesting that you waive this requirement.

The Tennessee Medical Association wants very much to have a TennCare that will work. We feel TennCare can work if it is phased in, if competition among managed care organizations is put in place, and reasonable compensation to providers is part of the plan.

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The Honorable Donna Shalala
October 19, 1993
Page 2 of 2

This decision with which you are faced should be based solely on the welfare of the 1.7 million people who will come under the TennCare plan. We have confidence that you will rely on your staff's recommendations, and not be persuaded to yield to political pressure.

We thank you in advance for your careful consideration of this far reaching and critical decision.

Sincerely,

Charles W. White M.D.
Charles W. White M.D., President

CWW/as

Enclosures

c: The Honorable Ned McWherter, Governor, State of Tennessee
Carol Rasco

THE WHITE HOUSE
WASHINGTON

OCT 19 REC'D

Date Oct. 18, 1993

MEMO FROM: MAGGIE WILLIAMS

TO:

Milli Alston	_____	Evelyn Lieberman	_____
Pam Barnett	_____	Diane Limo	_____
Anne Bartley	_____	Capricia Marshall	_____
Lisa Caputo	_____	Ann McCoy	_____
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Neel Lattimore	_____	Melanne Verveer	_____
<i>Carol Rasio</i>	_____		_____
	_____		_____

The attached is for your:

Information _____

Advice _____

Action _____

COMMENTS:

FYI -
Carol
Ranco
from Maso

Pediatric Care Inc.

HELEN C. BURKS, M.D.
353 NEW SHACKLE ISLAND ROAD, SUITE 106
HENDERSONVILLE, TENNESSEE 37075

615-824-2323 (main number)
615-822-3217 (Cindy's line)

FAX TRANSMITTAL

Ms. Hillary Rodham Clinton 202/456-2878
Honorable Donna Shalala, Secretary Dept. of Health & Human Svces.
202/690-7203
To: Special Assistant Diana Fortuna - HCFA 202/690-6262
~~Ms. Faye Baggiano, Associate Administrator of Communications~~
~~Deputy Director Thomas Kickham, PhD~~ 202/401-2706
~~Director Mary Kennison, Office of Demos~~ 410/966-6511
FAX # _____

FROM: Cindy Aliff
615/264-4281

FAX # _____ (Hospital Administration)

Date: 10/12/93

URGENT please deliver
ASAP

Number of pages: 10

1. I have previously faxed information to all of you listing many concerns.
2. Putting unfair, deceptive, misleading, "bullying", and totally unprofessional marketing and public relations tactics by BCBST and the State Government of TN aside; the below must be addressed.
3. The majority of Medicaid/TennCare recipients in this state are individuals who are either (or several) elderly, disabled, illiterate, pregnant woman, and children. This state has not provided any assistance to these people and they are spoken to in very abrupt fashions by both state employees and BCBST employees. Upon calling the Human Services Dept. for information, the recipients are told they must contact the managed care plans - who the state knows are mandated to offer the very same plans and benefits. These companies are marketing themselves with deceptive remarks, adding to an already extremely confusing and fearful situation.
4. BCBST is spending hundreds of thousands of dollars in TV ads statewide assuring medicaid recipients they will have "the security card" shared by over 1.8 million residents. TennCare must issue ID cards because recipients go on and off state funds on a monthly basis. Recipients are not told the BCBST "security card" is useless for the provider and they will be carrying two cards, one of which will be of no special purpose except to get the BCBST ID number - one time. However, they will have to bring the TennCare ID card at each visit.

PAGE TWO

Hillary Rodham Clinton
Federal Officials

5. The State of Tenn. has not provided any time what so ever to allow pcps' or any organizations the means to educate the recipients (which actually is not our responsibility anyway). Our practice is fortunate but only because I have jeopardized cash flow with a back log of charges and insurance submissions due to spending over 200 hours "educating" myself. Other practices and physicians are requesting advice and assistance from me.

6. BCBST is a non-profit insurance company. Why have they not invested some tax-free dollars to assist in educating the residents of this state; as their charter states? Bob Harriman, manager of provider services for BCBST, has told the local community that BCBST "profits" are returned to the public welfare system. So..... I wonder, why is BCBST being allowed to "prey" on the unknowledgable of this state? Even very educated individuals come to me for advice and answers on their own employer sponsored plans.

7. The TN Commissioner of Human Svces, MR. Robert Grunow, is traveling the area holding public forums on THE HUMAN SVCE DEPTS: "answers, questions and comments" regarding the role, purpose and efficiency of Human Services. Why not TennCare?? Recipients call their case workers for advice and are told "we know nothing about TennCare, you must call the managed care plans."

8. Since September 1, 1993, I have communicated to all concerned that this has appeared to be an elaborate scheme for BCBST and TN Government to shovel money from the health care providers to BCBST "pockets". After all Mr. Harriman has said 6-8% administrative cost is "all" BCBST is retaining. And then there is the "public welfare system" contribution that is made by BCBST from "profits". BCBST manages the state employees health pland and TCHIP, The State program for high risk individuals.

9. TennCare could be a very innovative and progressive program. But until this State learns (educates themselves by past experiences or by investigating other states' plans) how to manage health care funds; I honestly doubt shifting federal funds from the providers into the pockets of insurance companies is going to accomplish a thing. Except, BCBST by "cornering the market" stands to earn from the TennCare program an annual income of \$130-300 million dollars- contingent of course on recipients signed up on January 1, 1993 and interest income on the capitated fees.

10. BCBST has demanded providers to make a decision if we are going to participate in the TPN (state employees and TCHIP PPO) by October 8, 1993, (originally)and has now moved the deadline to October 18,1993. As of today, BCBST has not provided the "withholds" they are going to access each region. And have refused to provide me the reimbursements for routine/wellbaby, hospital, and immunizations. I will ask again, "Who is protecting the pediatricians?"

11. State Officials have not commented on the community forum. I did receive a regretful denial from Mr. Manny Martins today (Oct. 11, 1993).

12. Reported in the Nashville Banner friday, Oct. 8, 1993: A HCFA official in Nashville last week "while expressing dismay over the TennCare ballot turmoil" clearly stated the TennCare waiver approval would not be affected by the confusion. The decision is based on the plan itself.

PAGE THREE
Blue Cross Blue Shield of Tennessee

Thank you for the past opportunities to participate. We wish ECBST the best of luck with TennCare.

Sincerely,

PEDIATRIC CARE, INC.
Cindy Aliff
Office Manager

Helen C. Burks, MD

cc: Bob Harriman, Manager Provider Relations - ECBST
Hendersonville Hospital Administration
Dr. Kenneth Wyatt, Director of Pediatrics
Director Mary Kennison, HCFA Office of Demos
Deputy Director Thomas Kickham, PHD, HCFA
Tennessee Insurance Commissioner
Mr. David Gregory, TennCare Legislative Liaison

4 It would be difficult for me to make a decision, being in the health care profession, with the information that's available at this time," said Groce.

Doctors deluged by TennCare calls

By Ed Overman and Bill Snyder
Special Services

1

At times this week doctors have had so many calls from Medicaid patients asking about TennCare that sick people couldn't get through.

In parts of the state, especially the Knoxville area, legislators also have been bombarded with phone calls.

In Columbia, officials of Maury Regional Hospital decided to take out an ad in the local newspaper telling Medicaid patients, in effect, wish we could help, but we don't know any more than you.

The confusion started when Tennessee's Medicaid recipients received packets of information

over the weekend about TennCare, including a "hallo" listing the managed-care organizations that are to serve a particular region. People on Medicaid must pick by Nov. 1 the organization from which they prefer to receive their health care services, or else the state will select one for them.

"They are scared. They don't know what to do," said state Sen. Jerry Cooper, D-Memphis, who has received several calls from worried constituents.

"In some places," said Mark Green, executive director of the Tennessee Medical Association, "the volume of calls to physicians' offices has just about ground business to a halt."

Please see TENNCARE, page A-13

3 A decision by the federal government originally had been promised by Sept. 17, but unresolved funding issues caused a delay. Slate Finance Commissioner David Manning and state Medicaid director Manny Martins met with officials of the federal Health Care Financing Administration, the agency that oversees the Medicaid and Medicare programs, for three days in Washington last week.

Feds in Nashville
And HCFA officials were in Nashville Tuesday and Wednesday this week to continue discussions. The decision, which ultimately rests with the White House, is not expected before next Tuesday.

One federal official, while expressing dismay at the "turmoil" through which Tennessee's Medicaid recipients are being put, told the *Banner* it would not affect the decision, which must be based on the plan itself.

That turmoil is most evident in Maury County.

"We are receiving your telephone calls seeking advice as to what your selection should be," Maury Regional Hospital told Medicaid recipients in a quarter-page advertisement that ran Wednesday in Columbia's *The Daily Herald*.

"TennCare has not been approved by the president. Therefore, Maury Regional Hospital cannot make any decision on TennCare until we know if TennCare will be approved in whole or in part. The hospital and other health care providers (such as your physician) will review the plan once approved, and then we will inform you of our decision on participation.

"We are concerned about your not having adequate information on TennCare, and we wish that we knew more so we could assist you."

Billy Groce, administrator of Lincoln Regional Hospital in Fayetteville, said his hospital may run a similar ad in the local paper next week. He expressed sympathy for the Medicaid recipients who are trying to make a major health care decision based on what he said is inadequate information.

5 FROM PAGE ONE

TennCare: Official decision not expected before Tuesday

Continued from page A-1

One of these places is Fayetteville.

"Monday, our switchboards were absolutely jammed," said Dr. Fred Ralston, one of eight physicians in the Fayetteville Medical Associates group. "It almost halted the medical business of this office. People with illnesses and medical emergencies could not get through to us because of the brochures mailed out prematurely by the state."

Medicaid is the government's health insurance program for the poor, funded 32 percent by the state and 68 percent by the federal government. The cost of the program — \$2.8 billion in the last fiscal year — has been increasing about 20 percent a year. TennCare is Gov. Ned McWherter's plan to control costs through a managed-care approach emphasizing preventive care.

The program, which would replace Medicaid if approved by the federal government, is scheduled to begin Jan. 1. Besides Medicaid patients, it would offer coverage to Tennesseans lacking health insurance, with those above the poverty level required to pay premiums on a sliding scale. The state is not yet trying to sign up the uninsured, though.

State officials have acknowledged that the mailing of ballots to Medicaid patients — before federal approval of the program and before organizations and providers have signed contracts — is creating confusion. But they argue it would have been even worse had they waited and still tried to implement the program by Jan. 1.

Wayne counties. Groce said Lincoln Regional Hospital officials have met face to face with representatives of only two of the organizations, Blue Cross and Health Net. They have an appointment with a third next week, he said.

"We're not as far along as the time frame would dictate," he added.

Complicating the matter, Groce said, is that Blue Cross has given providers an Oct. 15 deadline for making a decision. And Ralston, a general internist, said the proposed Blue Cross payment fees for physicians — especially those for pediatricians and obstetricians — are regarded by many doctors as too low, prompting them to look for other proposals.

Blue Cross already has two statewide preferred provider organizations in place, one of which covers state employees.

Manning has said that if the federal government requires the state to alter its financing scheme for TennCare, its implementation probably will have to be delayed.

The mailing of the ballots late last week caught off guard not only Medicaid patients but state legislators. Sen. Carl Koella, a Maryville area Republican, said he got 30 telephone calls early this week. Several Nashville legislators contacted by the *Banner* said they had received few calls, in contrast to a flood of inquiries in Knoxville.

"It looks like they would have at least informed the legislators," said Sen. Cooper, who said he would have liked to receive the same information sent Medicaid recipients. "They should have known what was going to happen."

Cooper said the matter will "definitely" be looked into by the Senate General Welfare Committee when the General Assembly reconvenes in January.

TennCare blitzed by confusion

An information hotline has been inundated with calls as Medicaid recipients try to sort through pamphlets and brochures on their health care options under the proposed TennCare program.

Sumner County residents have also been calling the offices of Sen. Don Wright and Reps. Randy Stamps and Mayo Wit with questions.

Medicaid recipients have until Nov. 1 to pick a health care network or the state will pick one for them.

Thousands of information packets were mailed last week by the Department of Health to Medicaid recipients about their TennCare options.

A special TennCare hotline — 1-800-669-1851 — has been flooded. Nearly 1,100 calls were received on Tuesday alone, agency spokeswoman Diane Denton said Wednesday.

Citizens can also call 615-741-4800.

Some people complain it's difficult to compare the various health care networks in their area.

Ron Specht, a Medicaid recipient from Morgan County, said the pamphlets were no more than advertisements from the various health maintenance organizations and preferred provider organizations.

He said he didn't get brochures on two of the eight health care providers in his area and the hotline didn't even have a phone number for one of them.

The department recommends recipients contact their primary care physician for advice on which plan to choose. But the health care networks haven't signed up the doctors yet.

"We have heard that is a problem from a lot of people — that their physician hasn't chosen a plan yet," Denton said.

So what does the state suggest? "Well, hopefully the physicians will go ahead and choose plans so that their patients can be signed up," she said.

TennCare is Gov. Ned McWherter's plan to provide health care for 500,000 uninsured Tennesseans and 1 million Medicaid recipients through networks of HMOs and PPOs.

Managed care, in which participants report to primary care physicians responsible for keeping them healthy, is TennCare's centerpiece.

McWherter reasons that healthier Tennesseans will have less need for health care services, and that will lower the program's cost from the \$2.6 billion spent on Medicaid in 1992-93.

Federal Medicaid officials have yet to grant a waiver to TennCare. But state officials expect it will come eventually and are proceeding to sign up recipients so a planned Jan. 1 TennCare startup isn't delayed.

State already enrolling for TennCare

By DUBEN CREEK Staff Writer

There was confusion among state Medicaid patients, doctors and hospital personnel yesterday from what critics said was the state jumping the gun and making TennCare to the state's poor too early.

The state Medicaid Bureau mailed packets of information and ballots last week to the state's 600,000 Medicaid recipients, asking them to select their first, second and third choices from competing health-care plans that would replace Medicaid. It gives them a Nov. 1 deadline or a plan will be chosen for them.

"Call the doctors you like to find out which TennCare plans they will be in," a memorandum in the packet advises. "Each TennCare plan has a list of doctors, hospitals and drugstores you can pick."

Under TennCare, the state would hire managed-care organizations, or MCOs, to deliver services to

Turn to PAGE 2A, Column 1

State already enrolling for TennCare coverage

FROM PAGE 2A

About 1 million Tennessee Medicaid and 500,000 working poor who have no insurance. These coverage would contract with doctors, hospitals and other health-care providers for treatment.

As Medicaid recipients started following the advice in the state packets this week, they discovered a not-so-pleasant industry offshoot: Few doctors, hospitals and drugstores know which plan they would be in.

Critics said the state acted too hastily because medical officials have not approved Gov. Ned McWherter's plan to replace Medicaid with a health plan. "We got a barrage of calls from doctors and physicians," said Russ Miller, spokesman for the Tennessee Medical Association. "The letter went out way too early."

"Doctors are not required to be signed up for TennCare yet. Patients are asking their doctors, 'What plan are you in?' and they are saying, 'I don't know.'"

Lamar Jackson, vice president of the Tennessee Hospital Association, said hospitals are receiving similar calls. Some of them not only don't have contracts with MCOs, they don't even know who these people are.

Mary Overlock, TMA's general counsel, said doctors are refusing to contract with the plans because they are unsure about what they would be signing.

There are several problems with the contracts. There are general terms left to be inserted later. It is kind of like starting up to buy a house and you don't have a price and you don't have a chance to check it out first to make sure the roof doesn't leak and things like that.

"One of the things left out is the amount of money these physicians are going to be paid in any given month."

Carolin Botwinna, an attorney with Legal Services of Nashville and a member of the Governor's Task Force on Medicaid Reform, said the state has no other bid to present.

Health-care options need more explaining

To the Editor:

I am an advocate for health insurance reform and have been favorably impressed by what I have read about TennCare. It is gratifying to see Tennessee taking a leadership role rather than simply waiting for reform on the national level.

Information packets have been sent to current Medicaid recipients informing them that they must select their "TennCare" health plan by November 1 or the state will make their selection for them. However, there is absolutely nothing in the mailing that describes what it means to select a "health plan" and no objective information comparing the 16 plans of-

Letters to the Editor

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tered. There are simply 30 slick publications to choose from. From the information provided, I would be unable to decide among the plans, and I consider myself to be better informed about this issue than most people. I have followed news accounts, have a master's degree in social work, and work in a health-care setting.)

I call upon the state of Tennessee, the media and advocates for health-care reform to make understandable and objective comparative information readily available so that TennCare recipients can make good choices for themselves.

Dorothy H. Gager
3315 Acklen Ave. 37112



How I feel about BCBS, TN, TENN CARE

30 LEISURE WEEKEND, D SECTION, OCTOBER 2, 1993

ANDY GAPP



WANT TO WORK WITH YOU.

Frank and Ernest

Pediatric Care Inc.

HELEN C. BURKS, M.D.
353 NEW SHACKLE ISLAND ROAD, SUITE 106
HENDERSONVILLE, TENNESSEE 37075

October 11, 1993

Blue Cross Blue Shield of Tennessee (BCBST)
Attention: Provider Service Division
801 Pine Street
Chattanooga, Tennessee 37402

"Certified"

Dear Provider Service Division:

After numerous lengthy discussions with BCBST representatives since receiving our TPN Amendment regarding TennCare on September 10, 1993; and after many hours of analysis and specifically due to BCBST inability as of this date to provide us with very important financial data (i.e., well-baby physicals, well-baby hospital admissions and immunizations) needed in order for this practice to make an informed decision; we have come to an unfortunate resolution.

Please accept this certified letter as our official notice that Pediatric Care, Inc., aka Helen C. Burks, MD, BCBST provider number 02004934, will no longer participate as a preferred provider under the BCBST TPN contract.

I would like to take a few moments to attempt to persuade BCBST to take a diligent and thoughtful look at the "treatment" of primary care physicians- especially pediatricians. I am enclosing a letter I submitted to the editors of local newspapers several weeks ago in order for the residents of Tennessee to understand a very real and legitimate concern for those individuals who have committed their lives to the care of our country's children ... future. As stated to me by several of BCBST's competitors "primary care is the vital ingredient in the formula for success to decrease health care costs."

Pediatricians are the PCP's who are called at all hours of the night; they are the individuals who ride in ambulances with extremely ill infants to medical centers; they are the physicians on call in community hospitals for the E.R. departments and nurseries for children whose parents have not chosen a doctor to care for their children. Pediatricians are the only private practitioners providing childhood immunizations. The records of immunizations and routine lab procedures are a very important and at times critical part of a child's medical history. Health departments have been unable to follow-up on preventive maintenance. Sure, the services are provided but the sheer volume of patients does not permit "follow-up" care or a recall system. Many lab procedures are duplicated because a high percentage of parents can not inform physicians if routine procedures have been performed. Two simple examples are hematocrits and lead screening. It is not a secret these two test can prevent severe and costly illnesses; as well as future learning difficulties and immune system deficiencies. My employer will not allow this practice to "disregard" or "take for granted" these test (as well as some others) have been performed.

BCBST's inability to provide the very important reimbursement schedule pertaining to routine physicals remains the number one incident which has discouraged us in participating with the TPN TennCare program.

ROUGH DRAFT -
Needed to pay today - Will mail.
COPY OF ORIGINAL

PAGE TWO

Blue Cross Blue Shield of Tennessee

This practice currently provides services to eight hundred (800) active medicaid patients. The cost of providing the routine services is the number one expense for this corporation. If BCBST does not understand or has not taken the time to consider this fact, then I feel BCBST "concerns" may be just a little indifferent to the philosophies of the TennCare program. This one simple fact, in comparison to the high and expensive marketing programs of BCBST to appeal to TennCare recipients the last few weeks, concerns many in the position of caring for a large number of TennCare patients.

Finally, after careful review of the TPN agreement I will share with you our conclusions. BCBST has solicited an unfair monopolized initiative by requiring physicians to make a decision to participate or not within a time limit without providing complete financial information. To challenge legally, this practice simply can not afford to do so.

Under III, 3.3 of the TPN agreement, BCBST requires a TPN physician "to maintain admitting privileges to at least one network provider (hospital)". Helen C. Burks, MD is on staff with Hendersonville Hospital only. Without the knowledge of Hendersonville Hospital's decision to definitely agree and participate to BCBST's offer for TennCare reimbursement, we can not in good sound consciousness and effective business management accept the terms of the TPN TennCare Amendment.

Pediatric Care, Inc. has extreme concerns on the following articles within the original TPN agreement: III 3.11, 3.12, IV 4.9, V 5.3 and 5.4 and whether these articles are relative to the TennCare amendment.

Also, it is Pediatric Care, Inc.'s opinion the following articles of the agreement were not conducted by BCBST; and others should be challenged by physicians' practices with the financial means to do so: IV 4.11, VII 7.1, 7.2, 7.3, VIII 8.3, X 10.2, XI 11.4, 11.5, and 11.11.

The association between Blue Cross Blue Shield of Tennessee and Pediatric Care, Inc. has been a good one. We regret the decision had to be made under such a mass amount of confusion and unpredictability. The uncertainty of TennCare and the events taking place at the moment has created an enormous amount of frustration for all parties concerned.

If any information or situation changes which may allow our future participation in BCBST Tenn. Preferred Provider Network (TPN); we hope BCBST will allow us the opportunity. Please recognize, if this practice had not been put under this thirty (30) day time period coinciding with the TennCare recipients thirty (30) day time period to choose an MCO; this practice would have postponed this distressing decision until a more appropriate time. Our inability to provide an informed decision to our medicaid residents in our county could create a "black hole" which would be filled up with our patients and later lost when they discover they are unable to obtain the concerned, quality primary care they are accustomed to by their preferred physician.

PAGE THREE

Hillary Rodham Clinton
Federal Officials

12. If federal officials have this little regard, if any, for the public, then how can we be expected to have confidence in Clinton's National Health Care?? Personally, I believe the individuals involved in making the decision on the TennCare waiver which has affected many, many Tennessee residents should commit someone from the Clinton Administration to be present. Atleast, to look into the eyes of Americans who are extremely **disillusioned**. How can you expect public confidence in a system which allows non-profit corporate America and State Government this type of dictatorship?????????

Thank you for your time and consideration.

*Fyi
Carol Rasco
also copy to
Christine
Heenan*

**THE CHILDREN'S DEFENSE FUND
25 E STREET, NW
WASHINGTON, D.C. 20001
202/628-8787**

TO: Maggie Williams
FAX #: 456-6244
FROM: Amanda Lehrer
DATE: October 12, 1993

NUMBER OF PAGES INCLUDING COVER: 4

IF ANY PROBLEM WITH TRANSMISSION, PLEASE CALL: 202-662-3506

COMMENTS:

Marian asked me to fax you the following "health examples".

Examples of likely scenarios on children and benefits

Speech and Physical Therapy: Currently, a child who is disabled and receiving Medicaid, even if not receiving cash benefits, is entitled to receive all the speech therapy and physical therapy that the child requires. This is true regardless of the cause of the child's impairments--whether it be from an accident or from congenital birth defects, all are covered. Under the Administration's bill, whether a child who is disabled will get the services needed will depend upon arbitrary line-drawing which is totally out of the control of the child and parents and which will undermine the ability of the child to grow to be a productive citizen:

- o If the child was born with the impairment, the child will not be eligible for services. Due to advances in medicine and technology, infants born very prematurely now survive, as do children with congenital defects. These children will not be eligible for the range of services they need under the package--including speech, physical and respiratory therapy.
- o If a child's impairments are the result of an "illness or injury," the child may be eligible for some speech and physical therapy, but only under rules which are not appropriate to children:
- o The plan provides for "rehabilitation" services. For most children in need of services, they are for "habilitation"---the child had not previously learned what therapy will teach him/her.
- o Any therapy must be reevaluated "at the end of each 60 day period...Additional periods of therapy are covered only if function is improving." The improvement requirement bars children from receiving services which assure that they do not deteriorate--this is a very significant part of therapy for children with disabilities. And, the 60 day review limit is far too short to establish improvement in children.

Prosthetic Devices: Poor children who need prosthetic devices will not receive them. The proposed plan includes a long list of items which are covered under "durable medical equipment, prosthetic and orthotic services." However, the two limitations mean that virtually all children can not benefit from this service. First, the "items must improve functional abilities or prevent further deterioration in function." Second, this "does not include custom devices." Most children need custom devices. Because it is so easy to visualize, the latter is likely to be of the greatest interest to the press. And, because these benefits will continue to be available to people who are elderly or disabled through Medicare and the veteran's health system, the inequities will be just that much more striking.

For example:

o A child, age 6, is riding her bike and slips off the driveway into the street. An oncoming car is unable to stop and hits the child. Her left leg is so badly damaged--and becomes infected--that doctors decide to amputate it. After recuperation, she will generally be fine, except for her leg. Doctors and therapists agree that once she is fitted with an artificial leg, she will eventually be able to walk again. At the age of 6, she still has plenty of growing to do. As she grows, she will periodically need a new artificial limb. Her parents, while both working, have combined incomes at just above poverty. Currently, she is eligible for Medicaid even though they do not receive any cash assistance. Under the proposed plan, the family will have to pay the cost for her customized leg. This is because the plan does not cover customized artificial limbs. They can not afford it. Doctors and therapists are worried that the child will be stuck in a wheel chair (which, if not customized, would be covered under the plan).

o A child, age 9, is diagnosed as having a severe scoliosis (curvature of the spine). If the degree of curvature is not arrested, she will require very expensive--and painful--spinal surgery. She will need customized braces until she finishes growing (usually around age 15 or 16). Under the plan, she has two problems:

1. Because scoliosis is congenital, not the result of an illness or injury, she is not entitled to the preventive treatment--the brace--which would preclude the need for expensive surgery. (She will, however, be eligible to have the surgery covered by the plan.)

2. Even if she could somehow get past the first problem, because her brace (like virtually all braces for children) must be customized to her body shape, and could do more damage if it is not correctly fit, the plan will not cover it.

Examples of likely scenarios on children and co-payments

While co-payments may usefully deter unnecessary medical visits for those who can afford to pay them, they also will very effectively bar poor and near-poor children from receiving medically necessary care.

o A little girl, age 9 months, has been pulling at her ear for the last three days. She doesn't want her bottle and is generally cranky. Her mother suspects that she may have an ear infection because of her behavior and because she has had three previous infections. She wants to take her daughter to the doctor, but can't: she works part-time at minimum wage, earning about \$300 per month. She is paid on the 15th and last day of the month. Most of her earnings pay the rent, she feeds herself and her child on the food stamps she receives. It is five days until her next pay day. She does not have \$10 for the co-pay at the doctor's office. She gives her child some tylenol and hopes that she will get better.

This factual pattern--for both working parents and those receiving public assistance--will be so common that it will be hard for the public to believe that it did not occur to the Administration.

o A little boy, age 1, wanders into a pond on his grandmother's farm. When he is discovered, his body has been floating in the water for some time. After a long period, the rescue squad is able to revive the child, but there is no question that he has suffered permanent neurological disorders, including seizures. Doctors believe that, with time and intensive therapy, he will be able to care for himself and may someday be able to perform simple work skills. However, they also tell the parents that it's possible that he will be able to do far more than this. The child will need speech and physical therapy four times per week for the far foreseeable future. He will also need to take the prescribed anti-seizure medication. The parents' income is below poverty. Now, the child is eligible for Medicaid and there are no co-pays. Under the proposed plan, the family will be required to pay co-pays for every visit to a therapist or doctor and for every prescription or renewal of a prescription. **For just one month, with 4 visits to therapists/week, one visit to a doctor during the month, and one renewal of just one prescription, the family will be paying \$175 per month in co-pays just for this one child.** While this child may be eligible for SSI, even if on cash assistance, the family will still have these high co-pays.



NOV - 5 REC'D

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

DAVID L. MANNING
COMMISSIONER

November 4, 1993

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

Dear Mr. Vladeck:

We appreciate your prompt response to our submissions of last week. We believe that as a result of your efforts, most of the issues that have been raised concerning TennCare are resolved or are on the way to resolution.

Attached please find our responses to the list of points that you supplied to me yesterday. Concerning the financial issues, we have tried in our responses to clarify our understanding of the points in your document, so as to be sure there is a clear basis of agreement between us. The one point on which we cannot agree is the treatment of patient revenues. We have tried in our response to that point to explain why the proposed condition is not appropriate. I hope after considering these comments that you will agree with our position.

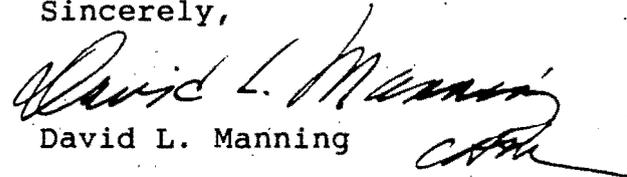
Concerning the non-financing issues, I am confident that we can proceed to successful implementation consistent with the points and conditions that you have raised. I do want to stress the importance of commencing TennCare implementation on January 1, 1994, for the consequences of not doing so are far more severe than any likely uncertainty or disruption that will attend implementation on that date. We are willing to do anything reasonable to ameliorate any such disruption, and will be pleased to work with HCFA officials to make the transition as smooth as possible.

I hope to be talking with you shortly about the HCFA points and our responses. I am hopeful that we can reach agreement on all outstanding issues by the end of this week,

Mr. Bruce C. Vladeck
November 4, 1993
Page Two

and I thank you again for your efforts to bring this matter to
a successful conclusion.

Sincerely,


David L. Manning

Attachment

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

TENNESSEE RESPONSES TO HCFA
POINTS OF NOVEMBER 3, 1993

Financing Issues

1. ● We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to Managed Care Organizations (MCOs) for each TennCare enrollee.

We understand this bullet to apply to the cash portion of the capitation payment to the MCOs. The cash portion includes the guaranteed premium applicable to those enrollees who are required to pay a premium for participation. (As to the treatment of premiums, see the seventh bullet below). The actual capitation payments made in cash should include the local grant funds paid directly to hospitals (\$25 million in FY 1994). These are cash payments from local tax sources made to cover hospital care to uninsureds who will be TennCare eligible. With this qualification, Tennessee accepts this condition.

2. ● We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing service to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.

This condition should be modified to cover TennCare eligibles, not just TennCare enrollees. We expect the hospitals to continue serving the uninsured even if they have not enrolled in TennCare, and to seek to recover whatever revenues they can from these patients, or to use local grant funds. To the extent hospitals are unable to recover their

full cost of serving these patients from these sources, they will be eligible to participate in the supplementary pool payments under TennCare. If those payments are insufficient to cover the uncovered costs, the difference in the case of public hospitals should be included in the certified public expenditure category in the same manner as in the case of enrollees. With this understanding, Tennessee accepts this condition.

3. ● These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.

This condition is acceptable to Tennessee. It does not address the separate question of how federal funds for TennCare will be disbursed to the State. We contemplate quarterly grants based on estimates that would include estimated certified public expenditures as well as capitation and supplementary payments.

4. ● We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.

This condition is acceptable to Tennessee. We understand that this proposal is intended to be consistent with the President's health reform plan.

5. ● We will provide FFP at the applicable matching rate (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.

Non TennCare costs should also include the accrued costs for services to Medicaid eligibles prior to implementation of TennCare for services that will thereafter be provided through TennCare. These payments are subject to reconciliation against actual payments made to providers. With this understanding, this condition is acceptable to Tennessee.

6. ● We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.

Provided that the second condition (relating to certified public expenditures) is understood to apply to services for TennCare eligibles, this condition is acceptable to Tennessee.

7. ● Premium revenues must be offset on an individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

This is the one condition concerning financing issues that we cannot accept. We have proposed that premiums be treated as state expenditures for matching purposes in light of the state's guarantee of those premiums to the MCOs. That guarantee is reflected in the inclusion of the premium in the capitation payments, with the state bearing all risk of

collection from the enrollees. Treating premiums in this setting as an appropriate form of state match acknowledges that they are similar in nature to state tax revenues. Given this nature, there is no basis for putting a limit on the amount of premiums that can be counted for each enrollee, and particularly for reducing FFP when premiums exceed a certain level (in this case the state's share of the capitation payment). This has the effect of penalizing the state for its success in achieving responsible participation by those uninsured who are able to pay a significant portion of the cost of their coverage. We are also concerned that pursuing this condition is not consistent with the statements of the Secretary to the Governor as to the scope of the outstanding financing issues. We proposed that any condition limiting the use of premiums as state match be expressed in terms of aggregate revenues, so that premiums recognized for state match in the aggregate cannot exceed the state share of the capitation payment.

Non-financing Issues.

1. • We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.

This condition is acceptable to Tennessee. It will be our intention to supply copies of the MCO contracts immediately upon approval of the waiver, and in fact, they will likely be available for review even before the approval process has been completed. We would anticipate that HCFA's review would take no longer than 30 days, and that if significant concerns are to be advanced that the State be informed as soon as possible. We believe this condition is consistent with our scheduled January 1, 1994, implementation date.

2. ● Substantial changes have been made in the TennCare project, from agreement reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.

We agree that an updated description of the program should be provided so that both federal and state governments have a clear understanding of what is covered by the waiver. While the revised plan will delineate the sources of state funding for TennCare, it must be recognized that funding is always subject to legislative action, including appropriations as well as authorization of particular methods of revenue generation. To the extent new funding sources will be utilized that require legislative action, our showing to HCFA will be based on the Governor's proposed sources. Certainly,

the state will be able to earn FFP only to the extent that it can produce the state share in accordance with the various financing conditions discussed above. We intend to provide the assurances sought by this condition in the manner described, which we believe will be sufficient for HCFA's purposes.

3. ● Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in federal spending related to TennCare.

The State understands that the waiver project will be subject to the budget neutrality principles as defined in the President's agreement with the National Governors Association. We believe that TennCare will actually result in cost increases that are much less than the increases that would have been experienced had the Medicaid program continued without the waiver. We anticipate no difficulty in working with you to work out the budget neutrality test, and assume that the limits of federal increases will in no event be lower than the limits contained in our proposal (8.3% of the rate of Medicaid cost increases predicted in the President's reform plan, whichever is lower).

4. ● The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.

This condition is acceptable to Tennessee. As you know, we are planning to commence TennCare operations on January 1,

1994 and believe that all of the necessary arrangements will be in place to permit start up on that date. We will work with HCFA representatives closely to assure their involvement in all phases of implementation preparation, so as to assure their concurrent review and to allow us the maximum opportunity to incorporate feedback and suggestions from them.

5. • The State will repeat the enrollment plan selection process after contracts with MCOs and providers have been signed.

This condition is acceptable to Tennessee. We presently contemplate providing a period of 45 days after waiver approval to permit enrollees to reconsider their enrollment decisions. We expect that all contracts with MCOs will be in place by that time and that the MCOs will have established their provider networks, so that the enrollees will be able to base their decisions on full knowledge of the available MCOs and their networks.

All
TennCare
8



OCT 25 REC'D

Tennessee Medical Association

2301 21ST AVENUE SOUTH, PO BOX 120909

NASHVILLE, TENNESSEE 37212-0909

PHONE (615) 385-2100 • FAX (615) 383-5918

October 20, 1993

The Honorable Carol Hampton Rasco
Asst. to the President for
Domestic Policy
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Dear Ms. Rasco:

Enclosed are the TennCare press clippings that we promised in
yesterday's correspondence.

Thank you for your consideration.

Charles W. White MD

Charles W. White
President



Tennessee Medical Association

2301 21ST AVENUE SOUTH, PO BOX 120909
NASHVILLE, TENNESSEE 37212-0909
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CHIEF EXECUTIVE OFFICER
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Nashville

EXECUTIVE DIRECTOR
Donald H. Alexander
Nashville

October 20, 1993

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

Dear Ms. Rasco:

Enclosed you will find copies of our most recent correspondence with you and Secretary Shalala regarding the TennCare waiver application. Under separate cover we have forwarded a cross-section of Tennessee press clippings which illustrate the chaotic situation which has been caused by the premature mailing of TennCare ballots to recipients and the likely shortage of participating providers.

We understand that you will meet with Governor McWherter today. Before any decision to grant the waiver is made, we respectfully ask that we be given an opportunity to address our side of the issue. We are willing to schedule a meeting at your convenience. Thank you for your consideration in this matter.

Sincerely,

Charles W. White M.D.
Charles W. White, M.D.
President

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Tennessee Medical Association

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October 11, 1993

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

Dear Ms. Rasco:

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

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

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

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The Honorable Carol Hampton Rasco

Page 2

October 11, 1993

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

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

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

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

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

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

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

The Honorable Carol Hampton Rasco
Page 3
October 11, 1993

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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October 19, 1993

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

Dear Secretary Shalala:

It is the understanding of the Tennessee Medical Association that you will soon be making the decision with regard to a waiver for the Medicaid program in Tennessee. We can't emphasize enough the importance of your decision and its effect on the health of one-third of our state's population.

The concerns that have been expressed over the past many weeks regarding the hurried implementation of TennCare have been born out by the state of Tennessee's recent actions. Rather than wait for your decision, the state has proceeded to create chaos and confusion about a program you have yet to sanction. The Governor specifically blames doctors for the flaws in his TennCare program and the clippings we have enclosed for your information indicate that non-acceptance in its present form is wide-spread throughout the state. It didn't take physicians to point out problems with TennCare, your capable staff at HCFA has been aware of all these problems from the day the waiver request was received. Under the current Medicaid laws states are required to provide sufficient funding that will encourage providers to participate. With the rate structure being proposed, the Governor is essentially requesting that you waive this requirement.

The Tennessee Medical Association wants very much to have a TennCare that will work. We feel TennCare can work if it is phased in, if competition among managed care organizations is put in place, and reasonable compensation to providers is part of the plan.

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The Honorable Donna Shalala
October 19, 1993
Page 2 of 2

This decision with which you are faced should be based solely on the welfare of the 1.7 million people who will come under the TennCare plan. We have confidence that you will rely on your staff's recommendations, and not be persuaded to yield to political pressure.

We thank you in advance for your careful consideration of this far reaching and critical decision.

Sincerely,

Charles W. White M.D.
Charles W. White M.D., President

CWW/as

Enclosures

c: The Honorable Ned McWherter, Governor, State of Tennessee
Carol Rasco

Many doctors cross about Blue Cross

By Mike Wilkinson
News-Scimitar staff writer

As the deadline to sign up for TennCare looms, health-care providers have objected to a requirement by the state's largest private health insurer to take on Medicaid patients.

A top Blue Cross/Blue Shield of Tennessee official, however, defended that decision Tuesday, saying the huge carrier wants to ensure that all its customers, including former Medicaid recipients, receive the same quality of care.

"We strongly believe the Med-

INSIDE

■ Gov. Ned McWherter says TennCare obstacles turning into a "land mine"/A7

icaid population should not be treated in a second-class fashion and have separate programs created for them," said Glen Watson, Blue Cross's senior vice president for marketing.

TennCare is Gov. Ned McWherter's attempt to control Medicaid costs. The program, still awaiting federal approval, also

would provide health-care coverage for the state's uninsured population.

Blue Cross has angered thousands of doctors and other health-care providers by stipulating that, in order to remain a part of their Tennessee Preferred Network, they must also accept TennCare patients who join TPN.

TPN has more than 7,000 doctors in the state, Watson said. There are 3,000 other providers in the network, he said. TPN covers nearly 2 million people, far and away the biggest carrier in the state. Last year, Blue Cross had revenues of nearly \$4 billion.

With that kind of buying power, Blue Cross's requirement for them to take TennCare patients is blackmail, providers say. Many doctors limit the number of Medicaid patients they take, and they feel Blue Cross is eliminating that choice.

Some have said they will stay out of TPN to show their displeasure. In the past several days, doctors around the state have been meeting to discuss their options.

Watson said about 40 doctors have opted out of TPN because of

Please see CARE, page A7

Care

Continued from page A1
the requirement. No hospitals have dropped out, he said.

Watson said many TPN doctors already accept Medicaid patients and that those patients won't "overrun" TPN doctors who would now be required to accept Medicaid patients.

"We expect physicians in our network to accept TennCare patients because they are TPN patients," Watson said. Doctors and providers would be reimbursed less, based on a fixed schedule of

fees, for taking care of TennCare patients, Watson said.

Medicaid patients have been asked to sign up for TennCare by Nov. 1 by selecting one of a handful of managed-care organizations (MCOs) that will deliver TennCare.

With that deadline around the corner, patients have been scrambling — like doctors — to figure out who'll cover them. Their participation is being solicited through a barrage of radio and television ads from the various MCOs.

Anger has not been limited to doctors. Joni Hirschhaut is a social worker for Dialysis Clinic

Inc., which operates clinics in South Knoxville and Maryville.

Although Hirschhaut's patients said they want to know in which plan the clinic will participate, she can't tell them — she doesn't know yet.

"They don't want to change doctors. They don't want to change clinics," Hirschhaut said.

If TennCare doesn't go through, McWherter has said the Medicaid program would have to cut \$750 million in spending during the 1993-94 fiscal year. Like TennCare, that option would have substantially reduced payout to doctors, hospitals and other health-care providers.

Local physicians reject TennCare

■ Dispute with Blue Cross may leave some area workers without their preferred physicians.

By TOM CORWIN
The Jackson Sun

Nearly all physicians in Madison County — including the area's largest health care providers — have rejected an insurance company's attempt to force them to take on patients of the proposed TennCare reforms, according to local physician groups.

The dispute between Blue



Cross/Blue Shield of Tennessee and area physicians may ultimately leave those area employers that depended on Blue Cross without the physicians their employees rely on.

Blue Cross/Blue Shield had hoped to coerce physicians and hospitals to take on TennCare patients by mandating that those in its Tennessee Preferred Network take on the

proposed TennCare patients or drop out of the TPN program.

Tennessee Preferred covers all state employees and 675,000 people statewide; as well as large area employers like Milan Army Ammunition Plant and Porter-Cable, according to physicians. Tennessee Preferred has contracts with nearly 200 physicians in Madison County alone and has contracts with the area's largest health care providers — Jackson-Madison County General Hospital and the Jackson Clinic.

But that strategy has apparently backfired because Jackson-Madison County has **Please see MOST, next page**

jected the TennCare amendment.

Jackson Clinic, representing 78 physicians in the region, has backed off the TennCare requirement.

Additionally, the Physicians' Health Care Network, an association of about 70 independent doctors has declined, member Jimmy Kee, a Jackson surgeon, said.

"They're saying, 'Take it or leave.' And we're saying, 'We're going to leave it,'" Key said. "I don't know of anybody I've talked to who is going to stay in. We're not resigning from TPN. Blue Cross is forcing us out."

Efforts to reach Blue Cross on Friday for comment were unsuccessful.

Jackson General has taken the position that its contract with Blue Cross for Tennessee Preferred is still valid despite refusing to be part of TennCare.

Jackson Clinic Administrator Carl Rudd said the clinic — which also operates clinics in Henderson, Alamo, Milan and Humboldt — is refusing the TennCare amendment to its contract, and the next move is up to Blue Cross.

TennCare is Gov. Ned McWherter's proposed reform of the Medicaid system, a joint federal-state program that covers primarily the poor and disabled.

TennCare proposes to take the state's 1 million Medicaid patients, along with up to 775,000 uninsured people, and contract with private insurance companies like Blue Cross to provide their health insurance. Those companies in turn would contract with hospitals, physicians and other health care providers to actually treat the patients.

McWherter recently called on doctors to support the program and both state and Blue Cross officials have said recently they believe the state's doctors will sign up.

TennCare is still awaiting approval from the federal government after questions were raised about how the program will be financed. McWherter has said he remains confident

it will still be approved. State officials have moved ahead with implementing the program anyway, sending out ballots to the state's Medicaid patients asking them to choose one of the health care companies.

Area physicians and hospitals say the reimbursement proposed by Blue Cross for TennCare was about 40 percent of their charges and would not even cover the costs of care.

"Many of us are having to say, 'I can't do this because it won't cover our overhead,'" said Dr. Mickey McAdoo, a Milan family practice doctor.

With large employers like Milan Army Plant providing McAdoo and his clinic a number of patients through the Blue Cross plan, the contract situation with Blue Cross is threatening to "drive a wedge between patient and doctor," McAdoo said. "Most of these people are sitting back saying TennCare doesn't affect. (But because of the dispute)... they're being dragged into the

middle of the situation."

That's how it felt to Sandra Fuller of Cedar Grove, who works at Milan Army and Mildred Lipscomb of Milan, who believes she is covered by Blue Cross at her job at Wilson Sporting Goods in Humboldt.

"It's going to hurt a lot of people, I think," Lipscomb said. Fuller said she doesn't know how it will affect her fellow employees.

Besides the payments, doctors complain that Blue Cross will not tell them how many additional patients they might get, a concern for small-town family practice doctors, McAdoo said.

"Not only is Blue Cross saying, 'You have to see everybody,' but 'there is no limit on the number of people we will send you,'" McAdoo said.

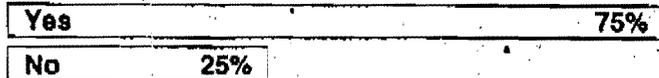


TENNESSEE POLL

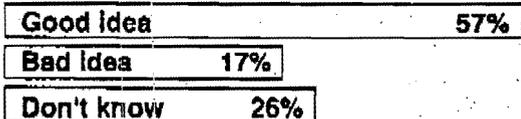
Staff graphic

Tennesseans on TennCare

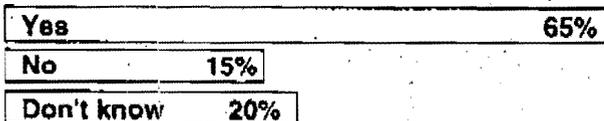
Have you heard of TennCare?



Is TennCare a good idea or a bad idea?



Will TennCare cost the state more money?



Source: University of Tennessee Social Science Research Institute, 1993

From Page B1

Poll

The survey questions about TennCare were included in the most recent Tennessee Poll, which is conducted regularly by the University of Tennessee for The Commercial Appeal and the Knoxville News-Sentinel. The poll has a margin of error of plus or minus 3.5 percentage points.

State and health care officials said they were unsurprised by the poll's results.

State finance commissioner David Manning said residents' support for the TennCare concept is "very encouraging," though expected.

"When you get outside the provider community, there is broad support," he said.

Manning attributes the pub-

lic's belief that TennCare will cost the state more to a lack of detailed information about the program and bad experiences with other government programs.

He said the state has proved its ability to contain costs by successfully doing so with the health plan serving state employees.

But Dr. Charles White, president of the Tennessee Medical Association, said Tennesseans are right to anticipate higher costs.

"It would require more funds to do it properly," he said.

The public's expectation that TennCare will cost the state more is predictable and on-target, said Lamar Jackson, a vice president of the Tennessee Hospital Association.

"A more interesting question," he said, "is, 'Where is the money going to come from?'"

CA - 10-17-93

TennCare would mean extra costs, say poll respondents

By Jon Hamilton
The Commercial Appeal

Tennesseans like TennCare, think it's going to cost them, according to a statewide poll. The poll of 800 state residents and that most (75%) had heard TennCare, Gov. Ned Wherter's plan to replace the state's \$3 billion Medicaid program on Jan. 1.

thought it was a bad idea (17 percent), the poll found. Support was strongest among people younger than 45 and those who earn less than \$25,000 a year.

But nearly two-thirds of respondents (65%) said they believe the TennCare plan, if implemented, would cost the state more money. About 15 percent of those polled said they believed the plan would not cost extra and 20 percent said they did not

know.

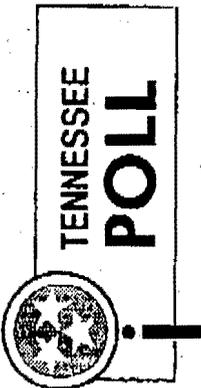
Such responses in the poll released Friday indicate skepticism about McWherter's contention that TennCare will cost slightly less than Medicaid, even though it will cover up to 1.8 million compared with Medicaid's 1 million.

TennCare is designed to hold down costs by enrolling recipients in private "managed care" plans, which would re-

ceive a fixed sum per patient from the state to provide care.

A federal waiver that would allow implementation of TennCare has been delayed because of questions about the program's funding. Many Tennessee doctors and hospitals have criticized the TennCare proposal as providing too little money to ensure good care.

Please see POLL, Page B3



TENNESSEE POLL

More than three times as many residents thought the plan was a good idea (57 percent) as

Doctors sting state director on TennCare

By Ed Cromer
Banner Chief Political Writer

Picture this: The state Medicaid director, accompanied by a bluegrass band, explaining to a roomful of skeptical, if not outright hostile, doctors why it is a good thing that their Medicaid patient fees will be squeezed by TennCare.

That was the scene, more or less, as Medicaid Director Manny Martins defended the state's proposed health care reform program Tuesday night to the medical staff of HCA Donelson Hospital in a question-and-answer session at the Marriott hotel.

Martins, at times difficult to hear above bluegrass music coming from an adjoining banquet room, acknowledged there has been a great deal of confusion as a result of the state's mailing Medicaid recipients a "ballot" for selecting managed-care organizations under Tenn-

'I understand the pressure it puts on the health care system. But, believe me, I don't think we have a choice.'



Manny Martins
State Medicaid director

Care — before the program has been approved by the federal government and before doctors and hospitals have decided in which organizations they will participate.

But he said if the state has to delay implementation of the cost-saving TennCare initiative, planned for Jan. 1, major cuts will have to be made in Medicaid.

"The confusion is nowhere near what it will be if we have to make cuts in this program," Martins said.

The state ran a legal notice in a Nashville newspaper in late September clearing the way for \$482.4 million in emergency Medicaid reductions, the bulk of which would come from the Medicaid Disproportionate Share Adjustment, a

program in which hospitals with heavy Medicaid caseloads receive funds supplementing the regular reimbursement rates of Medicaid.

A little more than 1 million Tennesseans are covered by Medicaid, the federal/state health insurance program for the poor. TennCare, the proposed reform, would cover not only the Medicaid recipients, but other Tennesseans lacking health insurance. The first-year cost of the program is \$2.9 billion.

But Dr. Martin Wagner, a neurologist, predicted the cost will jump to \$4.2 billion in 1994 and asked Martins where the money would come from.

Please see TENNCARE, page A-2

TennCare: 'It's easier to tax hospitals, doctors than tobacco'

■ Continued from page A-1

"I disagree with you," said Martins, contending that under TennCare, with a managed-care approach emphasizing prevention, the cost will rise nothing like Wagner's prediction.

"It will. You will see," the doctor replied.

Physicians at the meeting questioned whether TennCare's \$25 penalty for a non-emergency use of a hospital emergency room could be collected from much of the present Medicaid population.

Physicians also expressed resentment that health care providers are expected to contribute a substantial chunk of TennCare's funding — whether through the currently proposed "charity care" deduction in their fees, or through a tax on hospitals and doctors that Gov. Ned McWherter has said he will recommend if the federal government forces the state to put more hard cash into the program.

"You don't tax a product to reduce its cost," one physician called out.

Dr. Ben Birdwell, observing that a large portion of Medicaid patients smoke, asked why there was no anti-smoking element to TennCare. Martins said he hoped that TennCare, by assigning a "gatekeeper" physician to oversee services for each patient, would enhance opportunities for patient counseling on the subject. The director said a tax on tobacco was an option that could provide limited TennCare funding, but he noted

this is a tobacco-producing state.

In other words, responded Birdwell, "It's easier to tax hospitals and doctors than tobacco."

Dr. Alan Bachrach, a neurologist, told Martins he has a Ph.D. and an M.D. degree and asked the director what he "and Hillary Clinton" think the physician is worth per hour.

"The market place ought to determine what you're worth an hour, not me or any other government official," replied Martins. But the murmur that rippled through the crowd, and subsequent comments, made it clear many felt the government, in effect, is making a determination.

One of the biggest complaints health care providers have made about TennCare is the potentially dominant role to be played by Blue Cross/Blue Shield, which already has statewide preferred-provider organizations and is well-positioned to compete for TennCare patients. Physicians particularly are displeased with the fee schedules offered by Blue Cross; and many have complained bitterly about the health insurance giant's ultimatum that physicians in its Tennessee Provider Network must participate in TennCare or drop out.

State Rep. John Arriola, D-Nashville, has said he plans to introduce legislation next January aimed at blocking Blue Cross from linking other preferred-provider organizations to TennCare participation. Rep. Ben West, the Nashville Democrat who arranged the meeting with Martins, asked the director about the issue.

"I don't believe the state should step into the private sector and try to tell Blue Cross/Blue Shield or any other provider who they should have in their networks," Martins said.

Doctors, patients frustrated, upset by TennCare plan

By Mike Wilkinson

News-Sentinel staff writer

As Tennessee's leaders chase a solution to the state's hemorrhaging Medicaid program, the poor are scrambling to figure out just who will mend their ills if TennCare begins Jan. 1.

Maybe more frustrated with the proposed system, however, are the doctors who must provide that care.

Medicaid patients are filling phone lines trying to find out if their physicians will be part of the various managed care organizations (MCOs) that hope to be TennCare providers.

When they call, however, the patients are finding the doctors aren't signed up.

"The doctors are just inundated with calls," said Sonnie Bridgport, executive vice president of the Knoxville Academy of Medicine. "The patients are confused and the doctors are frustrated."

For physicians, the reason is simple: They're being asked to sign a contract that doesn't have all the necessary information.

"It means you can't sign a contract if you don't know what the contract says," said Knoxville allergy and immunology Dr. Robert

"The doctors are just inundated with calls. The patients are confused and the doctors are frustrated."

Sonnie Bridgport

Executive vice president of the Knoxville Academy of Medicine

Overholt. He is president-elect of the Knoxville Academy of Medicine. "You would never sign a note if you didn't have an amount in it."

Tennessee doctors have long complained about TennCare, saying its hasty implementation will cause too many problems. In fact, physicians' concerns brought to Washington are credited with helping to delay federal approval for TennCare.

Some of doctors' biggest questions about TennCare swirl around Blue Cross Blue Shield of Tennessee, the state's largest health insurance carrier. BCBST handles 40 percent of Tennessee's

Please see **TENNCARE**, page A10

TennCare

Continued from page A1

private insurance plans, with between 75 and 80 percent of the state's physicians belonging to BCBST's various programs.

To encourage physicians to join their TennCare package, BCBST has given them a hard-edged ultimatum: Either join TennCare or lose our commercial business, too.

Doctors, including Overholt, call the tactic blackmail.

The doctors, however, also know that the carrier hasn't — or

can't — answer their most pressing questions. If the TennCare plan runs out of money, the doctors — many of whom heavily rely on BCBST payments — may be responsible for providing care anyway.

Doctors are also worried how many TennCare patients they may be forced to accept. Doctors must decide within the month on whether they plan to join the Blues' TennCare plan. If they don't do anything, they'll be included in the BCBST provider list.

As an important backdrop to the doctor-health plan negotiations: The state hasn't secured the necessary approval to spend fed-

eral funds on TennCare. Doctors feel that is hurting the process, putting too much pressure on them.

"It's hard to have a contract when it's (TennCare) not even approved," Bridgport said.

Medicaid patients received packages from the state recently that asked them to pick which MCO they wanted. The MCO would be the conduit between the former Medicaid department, doctors and patients.

Gov. Ned McWherter proposed TennCare earlier this year as a much cheaper, more fair version of Medicaid.

What some area doctors are saying about TennCare

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

Dr. Joseph Zuckerman,
pediatrician

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

Dr. Michael Kosanovitch,
pathologist

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

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

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

Dr. Sharon Farber, neurologist

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

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

Dr. Lonnie Boaz III,
gastroenterologist

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

"It means a lot of doctor offices

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

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

Dr. Cassell Jordan, pediatrician

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

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

Dr. Henry Francis, obstetrician

Unprepared for TennCare

10,000 doctors, but who's where?

By **TAMMIE SMITH**
and **LARRY DAUGHTREY**

Staff Writers

Annette Easter mailed in her TennCare ballot two days after she got it, thinking the sooner she chose from among the 10 plans being offered, the better her chances of getting her first choice.

"I looked at the Blue Cross-Blue Shield brochure. It said there were 10,000 doctors, and you could have the doctor of your choice."

Easter figured the pediatrician who's been seeing her five children for the past five years, Dr. Helen Burks, would be among those 10,000 physicians.

She figured wrong, and she feels misled.

"They're not telling you your doctor might not be taking this," complained Easter, who called the state to try to change her ballot. "They told me to talk my doctor into trying to take the plan I took."

Easter is among thousands of Medicaid recipients thrown into confusion two weeks ago when



Rex Perry ● Staff

Carla Thomas, right, and son Trent watch as nurse Thea Murray gives a checkup to daughter Tajsza, 3 months.

the state mailed out TennCare packets that asked them to choose among the different managed-care organizations, or MCOs, under the state's new TennCare program.

Gov. Ned McWherter hopes to have TennCare in place Jan. 1 to replace Medicaid and slow the spiraling growth in Tennessee's health-care spending.

Under TennCare, managed-

◆ Turn to PAGE 12A, Column 3



◆ Managed-care organizations practicing sales pitches; features of some available plans detailed, on 12A.

TennCare question: How can I find my doctor?

FROM PAGE 1A

care companies will coordinate health services for the poor and disabled. Right now, patients are free to go to any doctor they choose as long as the physician accepts Medicaid.

Before TennCare can begin, however, federal approval is needed. The state wants the federal government to allocate to TennCare the \$2.2 billion that would ordinarily go to Medicaid. Questions about financing of the program have delayed that approval, but McWherter said this week he expects approval soon.

Meanwhile, the state is proceeding as if approval is a given. The packet mailed out to

Medicaid recipients included glossy brochures on the MCOs and ballots to be turned in by Nov. 1, but lacked the main information most folks wanted to know.

"People want to know which plan their doctor is in," said Thea Murray, whose 4-year-old daughter and 18-month-old son get Medicaid benefits. Murray has worked in a doctor's office for two years, but says that doesn't give her much of an edge in deciding which plan she should choose for her children.

Her boss' patients are confused, too.

"A lot of our patients are thinking they should choose Vanderbilt since Dr. [Barbara] Stephens sees patients at Vanderbilt. They're thinking she's under the Vandy plan, and she's not."

At least, not yet.

Stephens, a pediatrician who sees a lot of Medicaid patients, is like a lot of physicians dissatisfied with the reimbursement rates some of the plans are offering. She's devoted to her profession and her patients, she said, but can't work for free.

"I'm real concerned about whether I'll be in business Jan. 1 when TennCare comes," said Stephens during a recent conference on providing health-care services to the underprivileged.

"Under some of the contracts coming across my desk, I will be barely compensated. The rates they are talking about don't make it worthwhile." ■

Doctors deluged by TennCare calls

Nashville Banner, Friday, October 8, 1993

By Ed Cromer
and Bill Snyder
Banner Staff Writers

At times this week doctors have had so many calls from Medicaid patients asking about TennCare that sick people couldn't get through.

In parts of the state, especially the Knoxville area, legislators also have been bombarded with phone calls.

In Columbia, officials of Maury Regional Hospital decided to take out an ad in the local newspaper telling Medicaid patients, in effect: "Wish we could help, but we don't know any more than you."

The confusion started when Tennessee's Medicaid recipients received packets of information

over the weekend about TennCare, including a "ballot" listing the managed-care organizations that are to serve a particular region. People on Medicaid must pick by Nov. 1 the organization from which they prefer to receive their health care services, or else the state will elect one for them.

"They are scared. They don't know what to do," said state Sen. Jerry Cooper, D-McMinnville, who has received several calls from worried constituents.

"In some places," said Mark Green, executive director of the Tennessee Medical Association, "the volume of calls to physicians' offices has just about ground business to a halt."

One of those places is Fayetteville.

"Monday, our switchboards were absolutely jammed," said Dr. Fred Ralston, one of eight physicians in the Fayetteville Medical Associates group. "It almost halted the medical business of this office. People with illnesses and medical emergencies could not get through to us because of the brochures mailed out prematurely by the state."

Medicaid is the government's health insurance program for the poor, funded 32 percent by the state and 68 percent by the federal government. The cost of the program — \$2.8 billion in the last fiscal year — has been increasing about 20 percent a year. TennCare is Gov. Ned McWherter's plan to control costs through a managed-care approach emphasizing preventive care.

The program, which would replace Medicaid if approved by the federal government, is scheduled to begin Jan. 1. Besides Medicaid patients, it would offer coverage to Tennesseans lacking health insurance, with those above the poverty level required to pay premiums on a sliding scale. The state is not yet trying to sign up the uninsured, though.

State officials have acknowledged that the mailing of ballots to Medicaid patients — before federal approval of the program and before organizations and providers have signed contracts — is creating confusion. But they argue it would have been even worse had they waited and still tried to implement the program by Jan. 1.

A decision by the federal government originally had been promised by Sept. 17, but unresolved funding issues caused a delay. State Finance Commissioner David Manning and state Medicaid director Manny Martins met with officials of the federal Health Care Financing Administration, the agency that oversees the Medicaid and Medicare programs, for three days in Washington last week.

Feds in Nashville

And HCFA officials were in Nashville Tuesday and Wednesday this week to continue discussions. The decision, which ultimately rests with the White House, is not expected before next Tuesday.

One federal official, while expressing dismay at the "turmoil" through which Tennessee's Medicaid recipients are being put, told the *Banner* it would not affect the decision, which must be based on the plan itself.

That turmoil is most evident in Maury County.

"We are receiving your telephone calls seeking advice as to what your selection should be," Maury Regional Hospital told Medicaid recipients in a quarter-page advertisement that ran Wednesday in Columbia's *The Daily Herald*.

TennCare has not been approved by the president. Therefore, Maury Regional Hospital cannot make any decision on TennCare until we know if TennCare will be approved in whole or in part. The hospital and other

health care providers (such as your physician) will review the plan once approved, and then we will inform you of our decision on participation.

"We are concerned about your not having adequate information on TennCare, and we wish that we knew more so we could assist you."

Billy Groce, administrator of Lincoln Regional Hospital in Fayetteville, said his hospital may run a similar ad in the local paper next week. He expressed sympathy for the Medicaid recipients who are trying to make a major health care decision based on what he said is inadequate information.

"It would be difficult for me to make a decision, being in the health care profession, with the information that's available at this time," said Groce.

Managed-care organizations — either preferred provider organizations or health maintenance organizations set up to control costs — are to be paid a flat fee per patient by the state under TennCare to provide whatever health care is needed each year. These organizations, the largest of which is operated by Blue Cross/Blue Shield, must make their own financial arrangements with doctors, hospitals and other providers of health care services.

For the South Central Tennessee Region — one of 12 TennCare regions — the TennCare ballot lists seven managed-care organizations. Dr. Ralston said that, so far, only one of them — Blue Cross — has presented contract terms to doctors. South Central includes Bedford, Coffee, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry and Wayne counties.

Groce said Lincoln Regional Hospital officials have met face to face with representatives of only two of the organizations, Blue Cross and Health Net. They have an appointment with a third next week, he said.



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

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

By Pam Sohn
The Chattanooga Times

ATHENS, Tenn. — Pediatrician Iris Snider is now doctoring a second generation of children.

Some 18 years ago, when she began her practice in McMinn County's largest small town, she treated the father of twins Heather and Haley Hughes. Last week, the toddlers sniffled into her office for a cure.

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

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

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

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

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

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

Rather, says Dr. Snider, what

Please see **TennCare, A3**

TennCare

Continued from A1

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

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

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

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

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

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

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

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

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

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

Just how will payments under TennCare be split?

The Chattanooga Times

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

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

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

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

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

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

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

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

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

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

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

Their effort found that 55 percent to 80 percent of those doctors' patients are Medicaid patients.

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

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

LOCAL & STATE

B

Tennessee Scene/B-2

Obituaries/B-5

Weather/B-6

Medicaid patients get TennCare pick



Banner photo by Donn Jones

Tennessee Medical Association attorney Marc Overlock warns the Nashville Academy of Medicine about TennCare reimbursements.

Impatient officials mail out health plan 'ballot'

By Bill Snyder
Banner Senior Medical Writer

Tennessee Medicaid recipients will get something new in the mail this week — a "ballot" asking them to choose a TennCare health plan.

TennCare, Gov. Ned McWhert-er's health care-reform program, has not been approved by federal health officials.

But state officials say they can't wait.

Tennessee's burgeoning Medicaid program, which provides health services to 1 million low-income citizens, already is over budget by \$767 million this year, state officials say.

Unless TennCare is implemented as planned on Jan. 1, the state

will be forced to make major cuts in Medicaid services to balance the budget.

"Medicaid is due to die," Dr. John Gore, medical director of the state Medicaid Bureau, told members of the Nashville Academy of Medicine during their annual meeting Wednesday.

"Between now and January, we have to have something in place," he said. TennCare "has to push forward, and then we have to work through the problems."

TennCare would replace the state's Medicaid program with a statewide network of managed care plans covering Medicaid recipients and up to 775,000 Tennesseans who currently do not have health insurance.

The state would pool existing funds, most of them contributed by the federal government, to finance the program without raising taxes.

Federal health officials earlier this month delayed a decision on the program — reportedly because of concerns about the way it was being financed.

A decision could be made as early as Friday.

Doctors and hospital officials admit Medicaid is at a crossroads, and many of them applaud the TennCare concept.

But many of them also believe the state is trying to hold down costs by seriously underpaying physicians and hospitals.

Please see TENNCARE, page B-3



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TennCare: What if doctors won't participate in new program?

■ Continued from page B-1

"Our hospitals are being offered 30 to 50 percent of cost," Elliot Moore, president of the Hospital Alliance of Tennessee, a group of nonprofit hospitals, told the doctors' group.

"This is totally unacceptable

and serves as a disincentive for participation in the plan," she said.

TennCare is designed to help people get health insurance, said Marc Overlock, lawyer for the Tennessee Medical Association.

"The problem is it's all theoretical," he said.

Payment rates to physicians are so low, "it almost sounds like for every TennCare patient you take, you're going to owe somebody five bucks," Overlock said.

Gore said the state is not going to "squeeze" providers.

It will pay managed care plans a capitated, or per-person rate in

advance for every member the plans enroll. What portion of that money is distributed to doctors and hospitals is up to the plans, not the state.

"The business aspects of that are going to have to be worked out on your end," Gore told the doctors. "We're not going to do that anymore."

He said about 20 managed care plans have agreed to participate in TennCare — at least four in every area of the state.

They are "convinced there is enough money," Gore said.

One doctor asked what would happen if health care providers refused to participate in TennCare.

"The government will not allow this many people to go untreated," Gore responded. "You can't allow that many people to go untreated."

"You need to logically think about that."

Gore also said a tax on doctors was possible, especially if TennCare is not approved and Medicaid is continued in some way.

"There will be money to run the program," he said.

THE HEALTHY WOMAN



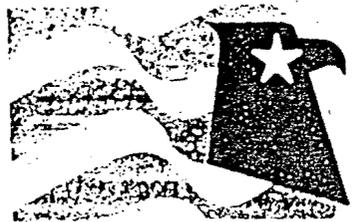
BREAST

Statistics show that one in nine women will develop breast cancer in her lifetime, yet if detected early, breast cancer can be treated when the chances for a cure are highest. Often women over 40, or who have a family history of cancer, are thought of as the only victims of breast cancer. But in reality, breast cancer is a risk to every woman.

Mammograms— Reduced Risk At A Reduced Cost
During October, "Breast Cancer Awareness Month," the Baptist Women's Pavilion Health Center is offering screening mammograms at a reduced cost of \$50. Since certain age and health

Durant's fever worries family — A-2

Fregosi finagles flaky Phillies — E-1



Nashville Banner

TUESDAY AFTERNOON, OCTOBER 19, 1993

Nashville, Tennessee □ 38 pages, 5 sections

TODAY'S NEWS TODAY

What's
INSIDE



How to top
fall's fashions?
You can leave
your hat on

Page C-1

NEWS

VU refuses TennCare contract

Medical center cites 'extraordinarily low' rates

By Bill Snyder
Banner Senior Medical Writer

Vanderbilt University Medical Center has rejected a TennCare contract offered by Blue Cross and Blue Shield of Tennessee.

Payment rates offered to the medical center by Blue Cross were "extraordinarily low," Dr. Roscoe Robinson, vice chancellor for health affairs at Vanderbilt, said Monday.

"We felt we had no recourse but to withhold our signature," he said.

Vanderbilt's decision is largely a symbolic gesture.

It will not affect patients on other Blue Cross plans who now go to Vanderbilt or to Vanderbilt doctors.

And Vanderbilt hopes to serve TennCare patients through other health plans, including its own health maintenance organization.

"We're trying to send a message to Blue Cross and the state," Robinson said. "TennCare is severely underfunded."

Next to the Regional Medical Center in Memphis, Vanderbilt treats more Medicaid patients than any other hospital in the state.

TennCare would replace the state's Medicaid program with a statewide network of managed-care plans covering about 1 mil-

lion Medicaid patients and up to 775,000 Tennesseans who now do not have health insurance.

The program, which has not yet been approved by the federal government, is scheduled to take effect Jan. 1.

State officials maintain they can control the cost of TennCare by pooling existing resources, including deductibles and premiums paid by people over the poverty line, and charity care that otherwise would have been given to people without health insurance.

The state would pay managed-care plans a capitated (per person) rate in advance based on the number of patients they enroll.

The plans, in turn, would negotiate payment rates with hospitals, doctors and other health providers.

But many doctors and hospitals say the TennCare rates offered by the plans, and especially those offered by Blue Cross, are too low to cover their expenses.

About 50 doctors statewide

Please see TENNCARE, page A-2

What's for supper, Grandpa? Birthday cake



Haiti army chief ignores embargo

U.S. Canadian ships refuse to

TennCare:

Vanderbilt willing to work with state, refine health plan

■ Continued from page A-1

have said they will not participate in the TennCare plan operated by Blue Cross, officials say.

That figure apparently does not include the 78-member Jackson Clinic in Jackson, the state's largest multispecialty group, which rejected the Blue Cross TennCare contract earlier this month, clinic administrator Carl Rudd said.

Glen Watson, Blue Cross' senior vice president for marketing and legislative affairs, said: "This is part of the shaking-out process.

"It happens every time you change health care reimbursement. The alternative is to do nothing," he added, and wait until the state is forced to cut Medicaid services to balance the budget.

Despite the defection of a few doctors, Watson maintains the 7,000 doctors in the Blue Cross network will be sufficient to serve its share of the TennCare population.

Doctors who refuse to sign the TennCare contract also will not be allowed to continue participating in the Tennessee Provider Network, a Blue Cross preferred provider organization that covers government workers, teachers and large employer groups.

But hospitals will not be kicked out of the network if they reject Blue Cross' TennCare plan, at least until their contract with the network expires, Watson says.

Vanderbilt's contract with the Tennessee Provider Network expires in March 1995, Robinson says.

In addition, Watson says Blue Cross will pay for services at hospitals not in its network that are not available elsewhere in the community.

Vanderbilt is a specialty hospital that provides unique services such as a burn center, organ transplantation and high-risk obstetrical and pediatric care.

"Overall we believe that in our network, recipients are going to have far more choices than they used to," Watson said.

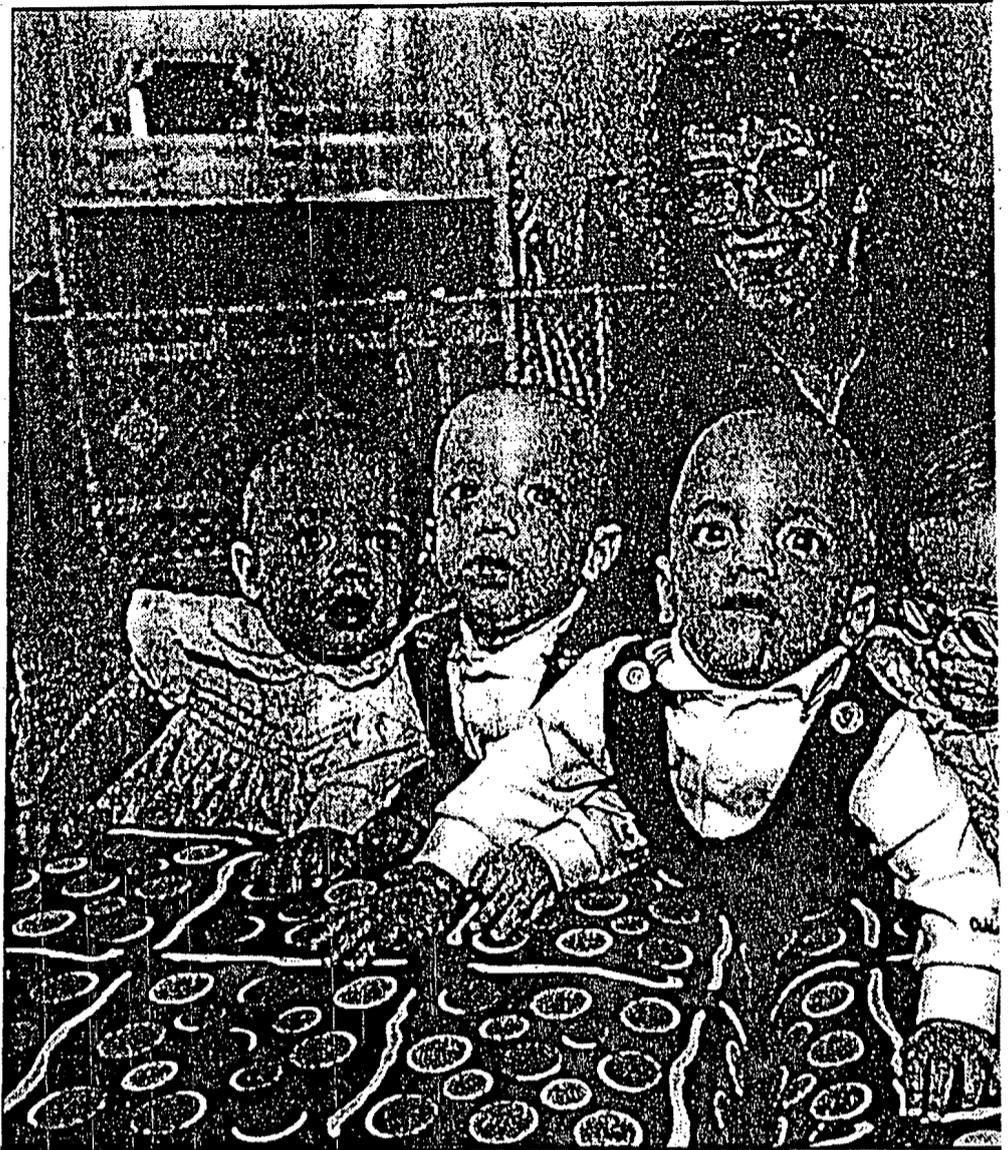
"But," he admitted, "there will be confusion."

Robinson said Vanderbilt is willing to work with Blue Cross and the state to make TennCare work.

"We're for the concept," he said. "But we've got to have some reasonable chance of (having) a financial outcome."

Robinson favors phasing in TennCare, rather than trying to cover a third of the state's population all at once.

"This crash program is too big, and much too fast," he said. "It's going to be absolute chaos for patients."



Quintuplets celebrate 1st birthday

Denise Aymond and her husband, Kirk, have had a busy year with quintuplets (from left) Alyssa, Harley, Garrett, Krysta and Connor. The couple said the quintuplets were b

2 teens face murder charges

By Leon Alligood
and Charlie Appleton
Banner Staff Writers

Two Midstate teen-agers are facing murder charges after they allegedly shot their mother and sister, respectively, in unrelated incidents.

District Attorney General Mike McCown said today he plans to petition the Lincoln County Juvenile Court to transfer a murder charge against Clint Robert Robertson, 16, to Circuit Court, where the youth would be tried as an adult. He is charged with gunning down his mother last Friday night.

In Warren County, the Public Defender's Office has been appointed to represent a 14-year-old boy charged with fatally shooting his sister and then taking their dad's car to flee the state.

The youth, who police refused to identify because of his age, appeared briefly in Juvenile Court at McMinnville Monday on murder charges.

The Lincoln County shooting occurred late Friday night and was allegedly precipitated by a domestic dispute between the youth's sister, their mother, Jerriellin Robertson, and the mother's boyfriend. According to police, the argument erupted after the teen-ager and his sister returned from a high school football game.

Authorities said the sister got into an argument with her mother and the older woman's boyfriend. The juvenile detainee allegedly told police that when the boyfriend pulled his sibling's hair, the teen-ager grabbed a gun and chased the man away.

However, police said the argument continued, ending with the mother being shot down outside the home.

After the shooting, the teen-ager allegedly took his sister in the family car and drove north. Alerted to a description of the car by Lincoln County authorities, Shelbyville police officers stopped the teen-agers

as they passed through McMinnville. No charges were filed against the girl.

"First we have to hear hearing before the Juvenile Court. Then we go to Circuit Court for another hearing. If approved, then we go to jury and get an verdict," McCown said.

"It's a rather lengthy process. It takes a while to transfer a juvenile to adult court and it takes a while to get a trial date.

Meanwhile, the girl was buried today. A grand jury will be held this week. Her son, Clint Robert Robertson, will not be allowed to testify. He remains in juvenile detention facility.

In McMinnville, police patched to the Park Apartments Saturday after the youth allegedly fired a rifle in the head with a rifle and then fled to a friend's house. At 14, the Warren

Retirees:

State employees don't contribute to pension system

■ Continued from page A-1

state Treasurer Steve Adams.

There are 166,000 workers participating in TCRS, including

gram costs more because teachers, on average, live longer and draw their benefits longer, said Steve Curry, director of TCRS.

Adams said the increase will move Tennessee's retirement benefits from eighth among 10 Southeastern states to sixth. With the change, a worker who retires after 30 years of service at age 65 with an average final compensation of \$30,000 will draw \$14,836 a year — which combined with \$12,204 in Social Security benefits will give

Denny:

Number, variety of charges perhaps confused jurors

■ Continued from page A-1

Robert Pugsley, a Southwestern University law

professor, said the prosecution's case was even if the defendant was directly involved in the crime, they were "aiders and abettors" did.

The charges relate to an assault and abetting, which included a deadly robbery, also require that Watson and Will be aware of the actual perpetrators.

PRESCRIPTION FOR REFORM

TennCare confusion was expected, McWherter says

By Phil West
The Associated Press

NASHVILLE — A state legislator says Gov. Ned McWherter should extend the sign-up deadline for the TennCare health-care plan because it's so confusing. But McWherter said Tuesday he expected the confusion.

State Sen. Jim Holcomb, R-Kingsport, asked McWherter in a letter Tuesday to give Medicaid recipients another two weeks to pick their health care provider under TennCare. The deadline is now

Nov. 1.

Nearly 1 million Medicaid recipients in the state must select a health-care network under the TennCare managed care plan or one will be picked for them.

TennCare is expected to cover Medicaid recipients and some 500,000 uninsured Tennesseans starting Jan. 1. It will rely upon networks of health maintenance organizations and preferred provider organizations.

The centerpiece is managed care, in which participants report

to primary care physicians responsible for keeping them healthy.

But Holcomb said Medicaid recipients are confused and frustrated by the ballot state officials sent.

"The problem seems to be that the managed care organizations have not completely identified their network of health-care providers," Holcomb wrote.

"The managed care organizations appear to be having difficulty in identifying specifics of contractual relationships with potential network providers."

Holcomb called that a "cart before the horse situation."

McWherter said his TennCare plan is radical health-care reform and some confusion was bound to follow.

"Health-care reform is coming. It's going to happen. We either phase it in now or wait for the debate in Congress," McWherter said.

"If you look at our request closely, it will fit in under nearly any plan they develop."

McWherter said his administration would work with Medicaid re-

cipients to ease their concerns.

State Finance Commissioner David Manning, TennCare's chief architect, said changing the Nov. 1 deadline would not ease confusion.

TennCare is modeled after the preferred provider organization that began providing health care for state employees beginning in 1989.

"In 1988-89 with the state PPO there was confusion. So this is 10 times more people involved," Manning said.

McWherter says that healthier Tennesseans will have less need for health care services, and that will lower the program's cost from the \$2.6 billion spent on Medicaid in 1992-93.

McWherter needs federal approval before he can use Medicaid money on TennCare. The federal government provides nearly \$7 out of every \$10 the state spends on Medicaid.

McWherter said he will go to Washington if necessary to speed up the waiver approval.



Tennessee Medical Association

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October 19, 1993

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

Dear Secretary Shalala:

It is the understanding of the Tennessee Medical Association that you will soon be making the decision with regard to a waiver for the Medicaid program in Tennessee. We can't emphasize enough the importance of your decision and its effect on the health of one-third of our state's population.

The concerns that have been expressed over the past many weeks regarding the hurried implementation of TennCare have been born out by the state of Tennessee's recent actions. Rather than wait for your decision, the state has proceeded to create chaos and confusion about a program you have yet to sanction. The Governor specifically blames doctors for the flaws in his TennCare program and the clippings we have enclosed for your information indicate that non-acceptance in its present form is wide-spread throughout the state. It didn't take physicians to point out problems with TennCare, your capable staff at HCFA has been aware of all these problems from the day the waiver request was received. Under the current Medicaid laws states are required to provide sufficient funding that will encourage providers to participate. With the rate structure being proposed, the Governor is essentially requesting that you waive this requirement.

The Tennessee Medical Association wants very much to have a TennCare that will work. We feel TennCare can work if it is phased in, if competition among managed care organizations is put in place, and reasonable compensation to providers is part of the plan.

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The Honorable Donna Shalala
October 19, 1993
Page 2 of 2

This decision with which you are faced should be based solely on the welfare of the 1.7 million people who will come under the TennCare plan. We have confidence that you will rely on your staff's recommendations, and not be persuaded to yield to political pressure.

We thank you in advance for your careful consideration of this far reaching and critical decision.

Sincerely,

Charles W. White M.D.
Charles W. White M.D., President

CWW/as

Enclosures

c: The Honorable Ned McWherter, Governor, State of Tennessee
Carol Rasco

OCT 22 REC'D

Pediatric Care Inc.

HELEN C. BURKS, M.D.
353 NEW SHACKLE ISLAND ROAD, SUITE 106
HENDERSONVILLE, TENNESSEE 37075

615-824-2323 (main number)
615-822-3217 (Cindy's line)

FAX TRANSMITTAL

To: Carol Baseo and Hillary Rodham Clinton

FAX # 202/456-2878

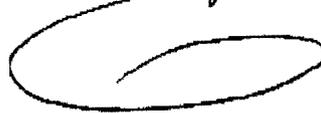
From: Cindy Sleib

Urgent

FAX # _____ (Hospital Administration)

Date: 10/22/93

Number of pages: 6

Urgent


TENNCARE

I

Fact

1993 Medicaid Budget 2.3 Bil 1994 TennCare Budget 2.9 Bil

*covered one million residents

*will cover one million
medicaid residents,
an additional 500-700k
uninsured residents
and TCHIP subscribers
(high risk individuals
with "pre-existing"
conditions)

State Officials claim there is strong reason to believe that TennCare is adequately funded due to an analysis of the State Employee Insurance Program with BCBST. Their claim is based on a 12% increase of the average cost per person under the State plan. (There are only approx. 180K state employees; the total enrollment for the BCBST TPN program is approx. 700K)

OPINION: 1. \$600K is not enough to cover almost as many residents; plus pay the 10% administrative fee to the insurance companies (MCO) participating in TennCare.

2. To compare the public assistance residents to the state employee plan is completely "off the wall". There are elderly, disabled, residents with pre-existing illnesses and alot of pregnant females under Medicaid; the state employee population is not the same.

Fact

The State Government of Tennessee has allowed BCBST to "strong arm" the physicians. The State is violating the civil rights of individuals who can not make a choice concerning the "MCO" without the knowledge needed to make such a decision. BCBST is preying on the unknowledgable, illiterate, and elderly citizens in this state with deceptive marketing practices.

OPINION: This is an elaborate scheme between the Governor and BCBST (a non profit insurance company who stands to earn approximately \$200-400 million dollars off of Federal Funds.) The Governors' last year in his final term is 1994. What does he have to lose if this program fails? What does he have to gain if this program is implemented?

continued

Fact

Most physicians are too busy taking care of their patients; the office staffs are trying to take care of business. I have spent 200 hours sacrificing cash flow to educate myself about TennCare. If I had depended on the State or BCBST to teach me Dr. Burks and I would be in the same situation as the medicaid patients- totally confused!!

Fact

We need your help, assistance or guidance.

Cindy Aliff
Home 615/264-1481
Work 615/824-2323
Pvt # 615/822-3217

I have just found out BCBST has told the State they can purchase childhood immunizations from the public health department and supply to the physicians. HA HA!!!! There is no way pediatricians in this state will remain with BCBST. Which will greatly jeopardize childhood immunizations in this state. I have also found out BCBST can not accomplish this ambitious program, per CDC in Atlanta, Ga., if the intention is to purchase the vaccine. However, due to an August 10, 1993 legislative bill signed by President Clinton; childhood immunizations will be purchased by the federal government and distributed to regional CDC centers and then re-distributed to the state health departments. Participating providers will be responsible for picking up the vaccine at their local health departments. My theory is BCBST may have intentions of utilizing this vaccine program to benefit their TennCare budget.

Questions

BCBST continues refusing to provide me with immunizations and well baby care. Is their resistance to answer due to a "hidden" agenda to force TennCare providers to participate in the program? If so, many, many children are at risk for sub-standard immunizations. Also, there are guidelines in the program which will restrain providers from receiving free immunizations and purchasing from vaccine manufacturers. Under programs such as the Aug 93 bill; providers are unable to choose the brand of vaccine they are more confident. At the present moment the State of Ohio is experiencing an epidemic of pertussis (whooping cough). It is being speculated (as well as currently researched) that this could have been avoided if it had not been for a buyers cooperative; where the physicians had to purchase the vaccine from the recipient of a buyers cooperative.

III

contract. Of course as all state and federal programs bids were submitted and the lowest bidder wins!! At what cost to our children and future are we willing to save money??

Do the state and federal employees, elected officials and their staff have knowledge of BCBST intentions?

Is BCBST aware their TPN members must participate in the free program if the TennCare physician is forced to participate?? Are the subscribers' monthly rates for premiums going to decrease due to less benefit pay out by BCBST??

And how about our State Officials and the 2.9 billion dollar budget?? Has immunization costs been deleted without public and medical community knowledge??

Opinion

I do not know how you feel about physicians. I do know you believe in America and the ability for all Americans to compete, earn a good living, and strive for excellence in all career fields. My employer is a wonderful lady and has taken care of children for 28 years. Her personal income is decreasing each year due to insurance company adjustments, state and federal public assistance programs. There are homeless citizens in this state. There are individuals with inadequate nutrition. Is the housing industry prepared to start losing money by funding programs to guarantee each individual in this country a warm, safe and comfortable place to live?? Is the grocery store industry prepared to supply each individual their right to have well-maintained and proper diets (which is a very real part of a "sound" health preventive-maintenance program)??

Fact

Under the BCBST contract the average office visit allowed charge for a primary care physician is \$16.15. BCBST will deduct from this charge 10% TPN discount and up to 20% "managed care" withhold. This makes the actual cash revenue to the office:

\$11.31

This practice must generate \$250,000 in cash just to pay the expenses: \$250,000 yearly equals \$5000 per week (50 weeks per year - physicians are required to attend conferences in order to receive CEU, continuing education credits). Even if this office closes there are expenses, i.e., vacation benefits, rent, utilities, etc. This practice can not even afford to offer full insurance, retirement benefits to the employees or the physician.

IV

\$5000 per week equals \$125.00 per hour. We absolutely must receive this guaranteed cash amount in order to continue the quality, concerned care Dr. Burks has provided for 28 years. Remember: physicians do not charge for telephone calls they receive all hours of the night or for spending the night with sick newborns in the hospital. They do not charge extra for coming to the office to see a sick child after office hours. What incentive will individuals have to enter the medical field if their personal income decreases after years of dedication?? Unfortunately, state/federal programs, government regulations and insurance company executives have made medical practices of yesterday extinct and forced physicians to worry, budget, and manage as all other businesses in this country.

Currently we are attempting to "charge" \$152.00 per hour; (\$27 over our needed revenue to pay bills) however, with insurance adjustments it is so difficult to determine how much each individual patient visit is worth. Many times we fall way short of our goal.

Considering: BCBST terms and 31% of our practice is medicaid. If we had accepted BCBST TPN agreement this is what would have happened:

53% decrease in medicaid/TennCare revenue
reducing hourly revenue to \$107
reducing weekly revenue by \$729
and reducing yearly revenue by \$36,425

In a practice where absolutely nothing within the budget can be cut; and additional expenses (benefits) are unheard of; there is no possible way to handle this type of drastic reduction.

Fact

Under Advantage Care, Phoenix Healthcare Corporation's, proposal the attached is a list of what they have proposed as capitated fees. This practice will receive a monthly payment of each category amount for each member we are assigned as primary care physician. Example:

case study

2 year old baby girl, started practice at birth.

Phoenix Healthcare will pay Dr. Burks 32.00 per month for 1 year = \$384.00. The second year Dr. Burks will receive \$174.00. The third through the fifth year = \$108.00.

The cost of the first full year of well-baby (no sick visits

v

included): $\$577.61 + 102.00$ (sick) = $\$679.61$

The cost of the second full year of well-baby (no sick visits included): $\$202.75 + 102.00$ (sick) = $\$304.75$

The average sick visits are:

age 0-1	3	\$102.00 (Cost only)
age 1-2	3	102.00
age 2-5	6	204.00

Actual loss to practice per child 0-2: $\$426.36$!! And this is contingent on if the child is with this plan for a full 24 months. Some children begin the practice at the 4 month physical or later.

We must receive $\$34.00$ in revenue per 30 patient visits per day for 250 days. Some days we treat 10 patients; some days we treat 40, all depending on time of year, outbreak of viruses, and office schedule (on call for other physicians, etc.).

Fact

Pediatricians are on call for the community hospital's E.R. department and nursery. We have confirmed from the various MCO's they will not reimburse an on-call physician if she is not on the patients' mco plan. Dr. Burks treated 22 medicaid babies as an on-call physician between January 1993 and July 1993.

OPINION: I am completely confused. Sixty percent (60%) of this practice is age 0-5. I have communicated to many "interested" individuals involved with TennCare that the $\$14.95$ capitated rate to the MCO's from the State has created a horrible disaster for pediatricians. The dilemma: to continue treating children whom they have dedicated their lives to or not.

*CDC Says Pertussis Outbreak Fits Natural Cycle; Ohio Doctors Differ

By SALLY KIRCH KUBITIS
Senior Writer

The outbreak of pertussis under way in Ohio represents a peak in the pertussis incidence cycle, which tends to erupt every 3-4 years, the CDC maintains.

However, Ohio physicians have their doubts.

Although a number of other states are also having pertussis outbreaks this year, with some reporting more total cases, the outbreak in Ohio is unusual in that three-quarters of the cases are concentrated in one county.

Other states experiencing outbreaks now are upstate New York, Vermont, Massachusetts, New Hampshire, Pennsylvania, and Minnesota. An outbreak is also under way in Chicago.

Among the concerns voiced by Ohio physicians are why the outbreak is limited to Hamilton county and why it shows no signs of slowing down as it should at this time of year if it is a normal cyclic pattern. Also puzzling is the observation that the infection is affecting significant numbers of fully immunized children as well as partially immunized and unimmunized youngsters.

"We don't consider [our outbreak] part of the cycling," said Cincinnati city epidemiologist Dr. Vicki Wells, who added that she thinks low immunization rates and reduced herd immunity play a part in the outbreak but do not explain it entirely.

The full answer to their concerns will not be available until sometime this

(Continued on page 26)

36 PEDIATRIC NEWS / October 1993

Ohio Physicians Puzzled by Pertussis Outbreak

(Continued from page 1)
month, when federal and state surveillance field offices complete their evaluation of the immune status and demographic details of the reported cases of pertussis.

Dr. Peter M. Strebel, a medical epidemiologist at the Centers for Disease Control and Prevention, Atlanta, said that pertussis cases generally peak between July and August, although some cases occur throughout the year.

Pertussis last peaked in this country in 1990. The national total may reach 4,000 cases this year, about the norm in an outbreak year, he said.

As of Sept. 15, a total of 2,800 pertussis cases had been reported nationwide. Of these, 267 cases had been reported in Ohio, with 240 cases in Cincinnati. Cases in the city began to peak in July and new cases are still being reported, with no signs of tapering off, according to figures from the Ohio health department.

In 1990, the last year of a significant pertussis outbreak in Ohio, there were 241 cases reported statewide.

Although exact numbers were unavailable at press time, estimates made earlier in the summer show that about 80% of the cases in Ohio have occurred in children under 12 years of age; young children ac-

count for all of the hospitalizations. The infection is particularly violent in young infants.

To date there have been no deaths attributable to the Ohio outbreak, although 5-10 people nationally die from complications of pertussis annually.

The Cincinnati public health department has declared an epidemic and has altered the immunization recommendations from shots at 2, 4, and 6 months of age to shots at 1, 2, and 3 months of age. This change was made after discussions with the CDC and the Ohio Department of Health. These two agencies question whether an accelerated immunization

INFECTIOUS DISEASES

schedule would prevent a significant proportion of the cases.

The rationale for giving the shots earlier and closer together is that maternally acquired antibodies to pertussis do not persist as long in newborns as do those from measles or other viral infections.

The half-life of maternally acquired antibodies to the bacterium *Bordetella pertussis* is 4-6 weeks, leaving 1- to 2-month-old babies susceptible to infection.

The goal of pertussis immunization is to prevent its transmission to young infants, who are most susceptible to complications.

The efficacy of the whole-cell pertussis vaccine is estimated at approximately 80% when three or more doses have been given. The acellular vaccine probably has a similar efficacy.

The CDC's Dr. Strebel said that natural loss of immunity is another factor that contributes to this or any other pertussis outbreak.

Immunity wanes in just 5-10 years even in fully immunized children, leaving them susceptible to infection, Dr. Strebel added.

Only very rarely can someone who has had pertussis once get it again.

Dr. Wells said that, unlike the measles epidemic that affected many poor urban,

The Cincinnati public health department has declared an epidemic and accelerated the immunization schedule.

minority children, an estimated 80% of the Cincinnati children diagnosed with pertussis are middle class or upper middle class, white suburbanites who have private health insurance.

All those interviewed for this article noted that reporting this may play a role in why most of the outbreak is being seen in more affluent children.

Dr. Strebel explained that, unlike measles, which presents with an obvious rash, pertussis is more subtle and the diagnosis may be difficult to make.

The child rarely coughs during the physical exam in the physician's office or clinic. The fastidious bacterium is difficult to grow and requires a special medium available only at public health clinics and teaching hospitals. In addition, antibody assays are poorly standardized.

Unless the mother is persistent and articulate enough to insist that the child's cough at night is severe, the physician may not consider the diagnosis. "A lot of other things cause a cough," Dr. Strebel noted.

An estimated 2-10% of pertussis cases are actually reported to the CDC, he said.

In response to the epidemic, the Cincinnati health department has dropped its requirement that a child have a physical examination before an immunization. Now a child can be immunized immediately at any of the six public health clinics, Dr. Wells said.

Although there is no effective treatment for pertussis, erythromycin is administered to prevent infection in case contacts.

Midwest Bureau Chief Peggy Park was attributed to this article.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Facsimile Cover Sheet

To: Carol Rasco

Organization: _____

From: John Morahan

Date: 10/22

Intergovernmental Affairs
200 Independence Ave., SW
Room 630 F
Washington, DC 20201
phone: (202)690-6060
fax: (202)690-5672

Recipient's Fax Number: 456-2878

Number of pages including this sheet: 2

Remarks:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

NOTE TO: Carol Rasco

RE: Negotiations on TennCare

Yesterday, we met with David Manning of Tennessee in order to clarify for the State what we believe is permissible as Certified Public Expenditures (CPE) under the TennCare waiver. We made it clear that we would not consider losses from the Medicare or Medicaid programs as CPE, and that any permissible CPE must be made on behalf of future TennCare patients. We did agree to consider the balance of their CPE proposal, although approving such a plan could be a major departure from our prior treatment of CPE.

*Fix to
Carol Rasco*

...Manning the additional information we
...for them to fully document their case
...and agreed to. We said we would
...within 72 hours after we receive it.
...them by close of business today our
...circumstances under which we would
...how we would limit our matching of
...In addition, we agreed that the
...secondary concerns are still open
...eting, Manning acknowledged that he
...ng with, HCFA's concerns with the

...you informed of our progress on this

Bruce C. Vladeck

cc: Kevin Thurm



OCT 25 REC'D

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Tennessee Medical Association

2301 21ST AVENUE SOUTH, PO BOX 120909
NASHVILLE, TENNESSEE 37212-0909
PHONE (615) 385-2100 • FAX (615) 383-5918

Fax: 202-456-2878

22 October 1993

The Honorable Carol H. Rasco
Assistant to the President for
Domestic Policy
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

Re: Tennessee's TennCare Proposal; Inadequate Funding; Lack of Physician Support; Statewide Confusion; and, Need for Delayed Implementation with Phase-In Period

Dear Ms. Rasco:

Early yesterday afternoon Tennessee Governor Ned McWherter held an impromptu press conference and blasted the Tennessee Medical Association and Tennessee Hospital Association for "causing" a delay in the Department of Health and Human Services (HHS) approval of a demonstration waiver for TennCare. He stated that there were seven issues that were raised at the federal level and that all but one had been resolved: the funding issue. He then blamed Tennessee's doctors and large hospitals for greedily holding out for more money, when the program as proposed is already "overfunded." In response, the TMA asks that you consider the following points.

1. TennCare as proposed is actuarially unsound and the funding will not provide for adequate, high quality patient care.

The TMA's member physicians believe that the Governor's claims, as described above, are outrageous. He has completely misrepresented the TMA's position on TennCare. It is true, however, that the TMA is concerned about TennCare being underfunded. We are sending along an actuary's report on TennCare that states in the strongest terms that TennCare is actuarially unsound. This opinion, by Jerry Winkelstein, comes from the same actuarial firm, Peat Marwick, that issued the earlier *TennCare formula analysis on the State's behalf*, which accompanies Tennessee's TennCare Demonstration Waiver document. (See Appendix VI, June 4, 1993 letter of Carlton Morris with KPMG Peat Marwick.) The TMA urges you to carefully

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The Honorable Carol Rasco
Special Assistant to the President
22 October 1993
Page 2

consider this second letter which is based on TennCare's *actual* numbers, not merely the "formula" which the State used to construct its waiver proposal. We believe that the funding issue cannot be glossed over by political gamesmanship since the health care of hundreds of thousands of Tennesseans is at stake.

2. Contrary to the McWherter Administration's claims, the TennCare proposal as currently constructed, does not enjoy broad physician support across Tennessee.

Despite the Governor's assurances to the TMA over the last several months that physicians would have input into his TennCare proposal, our meetings with him and advocacy letters to him have not borne fruit. Many physicians statewide are fearful of signing TennCare contracts because they contain so many blanks with terms and conditions to be filled in later *in the sole discretion of the managed care companies*. Such illusory contracts are completely unacceptable.

Even the fee schedules that companies have issued as exhibits to their contracts are meaningless because the contracts note that in any one month if there are too many TennCare enrollees or too many claims the fees will be substantially reduced, or the physicians and hospitals will be expected to provide the care at their sole expense. The TMA is adamant that for TennCare to succeed, physicians and hospitals cannot be at risk while the State washes its hands of any involvement in the health care of its citizens. Even Governor McWherter acknowledged in a late summer meeting with us that he would never sign a contract if half of his money would be withheld. No one can operate a business successfully if they cannot pay their regular overhead. This is but one more problem with the TennCare proposal.

In late August, HCFA officials explained to us that they had already raised the issues the TMA articulated *prior* to our meeting with them. Again, the Governor inappropriately blames the TMA for raising the issues we have articulated. HCFA officials noted that the Governor could have had his requested waiver if he simply had worked with providers *on the front end before* submitting his proposal to HHS and the Health Care Financing Administration (HCFA). Now, instead, he scapegoats the TMA and THA for the legitimate questions raised by these same federal officials.

3. There is mass patient and physician confusion statewide on how TennCare will begin and how it will administer health care services.

Since the State sent out its TennCare ballots to patients stating that they must choose from a short list of managed care companies before November 1st, *or the State would choose a company for them without their input*, physicians' offices and switchboards have been in utter gridlock. The State, without warning, placed physicians and hospitals in the position of having to explain how TennCare would administer health care. Patients fear that they will lose their

The Honorable Carol Rasco
Special Assistant to the President
22 October 1993
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physicians of longstanding, because the physicians cannot yet say which company they will sign up with given the veil of secrecy in the insurance contracts and the financial risks attendant with participation. If this confusion is an example of the State's promise to educate the Medicaid recipients, chaos will result on January 1st as TennCare starts.

The TMA urges you to delay TennCare's implementation so that an educational effort with some integrity can be used to teach patients about the reform effort. The TMA's physicians recognize the dire need for Medicaid reform in Tennessee. Indeed, the TMA applauds the Governor's reform effort. But how can the State expect patients or physicians to sign up with managed care companies that have yet to be licensed by Tennessee to issue insurance, or be certified as TennCare carriers? Many of these companies have only issued letters of intent to participate, giving them the option of exiting the program if they do not like the final terms of participation. Why would any physician stake his or her reputation or future patient care on such companies?

The TMA believes that, as currently proposed, TennCare will result in a melt down of Tennessee's former Medicaid system within two to three months of its January 1st start up date. This chaos will reflect poorly on President Clinton's evolving health care reform plan for the nation. In this environment, everyone must cooperate and work together to implement health care reform. The McWherter Administration, instead, has only paid lip service to allowing providers input into TennCare's creation, evolution, and ultimate administration. Physicians simply do not know what to tell their patients, even as they continue to provide them with high quality health care.

4. Governor McWherter has offended the state's physicians by threatening to tax them and falsely accusing them of "opposing TennCare", while simultaneously admitting that health care providers give away \$595 million of free care each year.

Physicians who have in the past conscientiously attempted to provide health care to the indigent have been so offended by the State's treatment of them that many have been rethinking the issue of whether they will accept Medicaid patients. With the viability of TennCare in question, Governor McWherter *now* asks physicians to "help with TennCare". Up until now, he has failed to obtain input from the medical community on TennCare, or even keep them advised of the status of the proposal. The TennCare waiver request was already filed before either the reimbursement rates or the provider contracts were completed.

Whether TennCare is approved for a demonstration waiver or not, with or without conditions, Governor McWherter has done irreparable damage to the State's relations with its physicians by the shoddy treatment he has given them. Time will tell whether this damage can be repaired. If Governor McWherter needs a scapegoat for the possibility of TennCare disapproval, he should look elsewhere.

The Honorable Carol Rasco
Special Assistant to the President
22 October 1993
Page 4

5. Another major problem with the TennCare funding shortfall is the addition of up to 750,000 uninsured persons to the current Medicaid recipient population of 1 million persons on January 1st. The State adds these individuals by "insuring" them at the financial risk of hospitals and physicians since only \$600,000 is added to the total Medicaid budget for fiscal year 1994.

Despite the Governor's attempt to scapegoat physicians for his TennCare waiver woes, physicians are not to blame for increasing Medicaid costs. Governor McWherter forgets to point out that a major factor in the increasing Medicaid budget is the *increased eligibility due to federal mandates*. Over the last ten years, the number of covered individuals has risen from 400,000 to 1,000,000 persons. That increase explains much of the budgetary crisis, not increasing provider fees. Managed care concepts will not alter increased expenditures from increased eligibility. The TMA supports increased eligibility, including the uninsured, because every Tennessean deserves high quality health care. But TennCare must begin realistically with the Medicaid population first. Then, as its success becomes apparent through joint governmental and provider efforts, the uninsured population can be phased in slowly.

Ironically, the McWherter Administration pins the future success of its TennCare campaign on the idea that managed care can reduce costs. However, as the TMA has repeatedly pointed out, the managed care organizations (MCOs) are not required to institute cost containment measures for the first three years. The TMA strongly urges you to require a gatekeeper system at the outset of the program. For the first three years, TennCare's success will be built on the premise of providers bearing all of the financial risks. The MCOs operate at a risk free, guaranteed profit! How does this risk pass through to providers comport with the Clinton Administration's managed care concepts? The TMA believes that it makes no sense to increase eligibility to include an additional 750,000 patients when the budget is inadequate to cover the present enrollees. The TMA has not opposed extending TennCare to the uninsured; it has, however, suggested that this be done *only after it is shown to be financially feasible to do so*. This is simply common sense.

6. If the State needs additional medicaid tax revenue, the State should tax goods and services that make people sick, not those that make them well.

Governor McWherter has repeatedly threatened to tax physicians to pay for the Medicaid program. Whether this is a threat to silence comments about the TennCare program, or whether it has other motivation, is irrelevant; either way, it is bad policy. It would make much more sense to levy a tax upon tobacco products and alcohol to fund health care for the poor, because the use of these products increases health care costs. The tax would either raise funds for health care costs, or would decrease consumption of these products and reduce resultant health care expenditures. Either way the State would come out a winner.

The Honorable Carol Rasco
Special Assistant to the President
22 October 1993
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A tax on health care providers, on the other hand, will simply be passed on to consumers, and will further increase health care costs. The TMA has long advocated such a tax to fund health care. A recent Harris poll showed that approximately seventy percent (70%) of the public also favors increased taxes on these products to fund health care. The obvious benefit of this kind of a tax is that it helps avoid the double financial risk the Governor now threatens to foist on providers: a tax and all financial risks of program underfunding.

* * * * *

In conclusion, we ask that you allow us to meet with you as soon as possible to discuss each of these points in detail. In the meantime, we hope that you will examine these remaining issues in light of the apparent effort by the McWherter Administration to bypass the review protocol administered by HCFA and HHS. We thank you in advance for your time and consideration, and look forward to hearing from you about a face to face meeting.

Sincerely yours,

Charles W. White MD

Charles W. White, M.D.
TMA President

R. Pearson MD

Richard M. Pearson, M.D.
Chairman
TMA Board of Trustees

Encls.

Peat Marwick

Management Consultants

303 Peachtree Street, N.E.
 Suite 2000
 Atlanta, GA 30308

Telephone 404 222 3000

Telefax 404 222 3050

September 7, 1993

Mr. Samuel H. Howard
 Chairman
 Phoenix Healthcare Corporation
 3401 West End Avenue
 Suite 185
 Nashville, TN 37203

Dear Mr. Howard:

At your request, we reviewed the proposed Tenn Care monthly capitation rates, effective January 1, 1994, contained in Manny Martins' September 2, 1993 letter to you.

As compared with Tennessee's "Medicaid Summary By Category", which reflected claims for the period October 1, 1991 through September 30, 1992, the rates compare as follows:

Category	Eligible Months	1091-92 Cost PMPM	TennCare Rate		Effective 2.25 Years Trend
			Gross	Net	
AFDC < 1	434,921	\$206.58	\$145.25	\$109.59	-47%
AFDC 1 - 13	2,821,280	59.98	50.60	14.94	-75%
AFDC 14 - 44	323,266	131.93	92.80	57.14	-57%
AFDC 14 - 44 P	1,486,204	189.71	153.32	117.66	-38%
AFDC 45 - 64	79,159	238.00	161.12	125.46	-47%
OAA	48,839	100.82	67.19	31.53	-69%
Blind/Disabled	1,295,330	284.93	315.74	280.08	-2%
Mcaid/Moore Dual		76.40	80.97	45.31	-41%

As can be seen from the chart above, although Manny's letter said that the "rates are based on Medicaid payment data for the 1992 calendar year trended to 1994", actually:

1. The rates were based on claims incurred 10/91 - 9/92 and paid through 3/93. Per the Tennessee Bureau of Medicaid, the claims should be further increased by approximately 1-1.5% for any liability for incurred but unpaid claims.

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2. While Tennessee was, at first, considering a positive annual trend of 5.5% (which in 2.25 years - the average length of time between 10/91 - 9/92 and calendar year 1994 - would amount to 12.8%), the actual trend used, per the chart on the prior page, varied between -2% and -75%. It averaged -35% overall, which amounts to a shortfall, versus +12.8% and +1.5% (for the liability mentioned in the first paragraph), of -43.2%.

Furthermore, it should be noted that no allowance for administration is included in the proposed rates.

Finally, again contrary to what was expressed in Manny's letter, in our work we have found that the Medicaid capitation rates in other states are considerably higher than these proposed TennCare rates.

In conclusion, we believe that, with the possible exception of the rates for the Aid to the Blind and Disabled, the proposed TennCare rates:

1. do not appear to be based upon trended 1992 Medicaid experience;
2. do not appear to be developed on an actuarially sound basis; and
3. would not produce an adequate revenue level for most HMOs to provide the desired TennCare benefits.

If you have any questions, please call me.

Very truly yours,

KPHG PEAT MARWICK

Jerry Winkelstein

Jerry Winkelstein, FSA, MAAA
Principal