



VANDERBILT UNIVERSITY MEDICAL CENTER

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7853948

FAX TRANSMISSION

DATE:

5-18-99

TO:

Marilyn Geyer % Chris Jennings

FAX #:

202-456-5557

PAGES:

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SUBJECT:

COMMENTS:

SCHEDULE FOR MAY 26 AND 27 - BILL RICE

Wednesday, May 26	
11:39 am	Flight arrives at National Airport
12:30 pm	
1:30 pm	Meeting with Rep. John Tanner, Chief of Staff/Health LA Vickie Walling, 1127 LHOB, 225-4714 (Kathy)
2:00 pm	Meeting with Rep. Harold Ford, Jr., Health LA Gina Mahony, 325 CHOB, 225-3265 (Rebecca)
3:00 pm	Meeting with Rep. John Duncan, 2400 Rayburn HOB, 202/225-5435 (Victoria)
3:45 pm	Meeting with Rep. Bart Gordon, Health LA Dana Lichtenberg, 2201 Rayburn HOB, 202/225-4231 (Ellen)
4:30 pm	
5:00pm	
Thursdaay, May 27	
12:00 Noon	Meeting with Rep. Van Hilleary, Health LA Joby Fortson, 1127 LHOB, 225-4714 (Carli)
3:00 pm	
5:30 pm	Flight departs



Marilyn.Yager@mcm.vanderbilt.edu
05/13/99 04:17:31 PM

Record Type: Record

To: Jeanne Lambrew/OPD/EOP

cc:

Subject: TennCare



How are you, thank you for returning my call. I am forwarding to you a letter that we sent to the Tennessee Commission for Administration and Finance (oversees the TennCare department). If you feel a sense of panic in the letter, you are right. the crisis around TennCare is very acute, and with each day, more providers drop out of the program (resulting in even more TennCare patients coming to our institutions at a time when we can't afford more patients). In addition, as you may know one of the largest TennCare MCO went into receivership several weeks ago (state version of bankruptcy) and another two are about to. The state has stated that they cannot guarantee any past due payments from these MCOs, which sent the confidence of providers to an alltime low that the State would ever honor payments for care already given to TennCare patients. Vanderbilt is the largest TennCare provider in the state and we are seeing patients from all over the state coming to us for routine (not emergency) needs because no one in their communities or in the towns between their home and here will see TennCare patients.. However, Vanderbilt is about ready to cancel a significant number of TennCare contracts (except for emergency care) until we start to get paid (this is not about the low TennCare payment, this is about not getting paid AT ALL for care that was preapproved, and then the bills get denied after the care has been given). If we do this the program may go under.

My email to you is because the State folks are more and more blaming the Administration and HCFA for not approving some of the things they were to do to fix some of these problems, and I think they are setting up the Administration to take the fall if the program fails (by the way, none of us want the program to fail, we just want it fixed). A key area of misinformation is that the Governor's people keep saying that HCFA won't let them do the essential services fund (DSH) because it is not in the waiver and therefore can't get matching funds. I have talked with Rose Hatton at HCFA, who told me that it is true that the waiver parameters are fairly clear, but she also said that all the state needs to do is submit a waiver amendment on the essential services fund, and that HCFA would likely approve it since TN is so far below the budget neutrality cap.

We are doing all we can here to try to get the Governor to submit a waiver amendment to HCFA, and I really hope that if they do that HCFA gives it immediate approval. The state legislature is only in session for two more weeks (unless they do a special session because of a crisis), so there is little time to get the state legislature to approve the funding for the state portion of an essential services fund, which they won't do without a guarantee of federal matching. I think you folks might want to make sure that HCFA is being as creative as possible to help insure that TennCare does not go under, which it will if two more MCOs go bankrupt or if Vanderbilt pulls out of the program for all elective contracts.

Let me know if you have questions, sorry for the long email.

----- Forwarded by Marilyn Yager/VUMC/Vanderbilt on 05/13/99
03:01 PM -----

Margie Naylor
05/13/99 11:02 AM

To: Marilyn Yager/VUMC/Vanderbilt
cc:

Subject:

(See attached file: Ferguson.wpd)

 - Ferguson.wpd

May 7, 1999

The Honorable John Ferguson
Commissioner of Finance and Administration
Tennessee State Capitol
Nashville, Tennessee 37243

Dear John,

It is my understanding that the 1999 legislative session is quickly coming to an end without good prospects for significant improvements in TennCare. If there is not a turn around, TennCare patients in Middle Tennessee are likely to be faced with more restricted access to TennCare providers. Access will be limited, not because providers do not have deep concerns for these patients, but because hospitals and doctors are being forced to chose between opening their doors to unlimited TennCare patients and jeopardizing the fundamental soundness of their institutions.

Vanderbilt cannot continue to subsidize the TennCare Program at the level of approximately \$20 million a year and growing.

As it stands right now, for FY99, VUMC's GME payments are flat. We will not receive essential provider funds as we did in FY98. Because of the failure of the State to manage and monitor its contracts with TennCare MCO's, we are also expected to write off more than \$5 million in Xantus losses. To make matters worse, our Xantus losses are still mounting. The April 1999 prospective payments, which promised to cover net billings, fell woefully short. For the Vanderbilt Medical Group, the payment was \$192,000 for net billings of more than \$300,000. For the Vanderbilt Hospital and Clinic the payment was \$412,000 for net billings of more than \$1,000,000. Furthermore, because the payments come in the form of cash advances, they cannot be distributed to physicians in the Vanderbilt Medical Group or to appropriate accounts at the Vanderbilt University Hospital and Clinics when they are received. We must wait until claims have been processed by Xantus. As you are well aware, other TennCare MCO's are also experiencing financial difficulties.

For Vanderbilt to be in a position to continue to serve TennCare patients at the current level, we must receive additional direct payment from TennCare to the hospital and clinics to compensate for our high volumes of TennCare and charity care patients. These payments may be designed as essential access payments, 24 hour eligibility or some other form of direct compensation. We are certainly open to your suggestions.

What we know from experience does NOT work is to expect increases in the CAP rate to the MCO's to trickle down to providers. As you are aware, the 27 percent increases to the MCO's during the life of the program have had little impact on payments to providers. To add insult to injury, the State has failed to monitor those contracts responsibly, resulting in additional extraordinary losses to providers. It is my further understanding that the ONLY improvement for providers in the Governor's projected FY 2000 budget is a 3% increase in the CAP rate. While Betty Nixon, Norman Urmy, Anne Carr and I have had informal indications that the Administration understands the great burden being placed on safety net hospitals, we see no evidence of that understanding in the policy statements and budget proposals for FY 2000.

As of May 7, 1999, Vanderbilt University Medical Center has spent \$80 million in reserves to prop up the TennCare program. To continue to do so will jeopardize the integrity of the Center. That is not an option I am willing to entertain. Without relief from the current burdensome and unfair policies, we will have to proceed with consideration of closing our burn unit, which will impact all persons in Middle Tennessee regardless of their insurance status; to further limit non-emergency care for TennCare and Kentucky Medicaid patients; and to reconsider the TennCare contracts now in place. You should know that this means turning non-emergency patients away.

VUMC is extremely unhappy about being forced into this position by the State, and TennCare cannot deliver the promise of health care to its enrollees without an adequate network of providers.

As I have indicated to you and Governor, and to Members of the General Assembly in the past, we are ready and willing to roll up our sleeves and work on fixing TennCare, but we cannot continue on the present path.

I welcome the opportunity to discuss these matters with you at any time.

Sincerely,

Harry R. Jacobson, M.D.

cc: Senator Douglas Henry, Representative Matt Kisber



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

DATE: 5/19/99TO: Chris JenningsFAX#: 456-5557FROM: Mary Beth Donahue
Chief of StaffMarilyn Yeager

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

 Pages [including this cover]

05/14/99 FRI 11:07 FAX 61 5343 7 286

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FAX TRANSMISSION

DATE: 5-14

TO: Mary Beth Donahue

FAX #: 202-690-7755

PAGES: 10

SUBJECT:

COMMENTS: Sorry I missed your page last week. I heard that TennCare came up in the mtg with the Secretary, so I thought she might like to see these articles. The program is exploding -- and there is more I don't want to say in writing. Hope you are doing well.

05/14/99 FRI 11:08 FAX 615 343 7286
 ctors refusing new TennCare children - Friday, 5/14/99

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<http://www.tennessean.com/stl/99/05/14/doctors14.shtml>

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CENTENNIAL PEDIATRICS

Doctors refusing new TennCare children

By Bill Snyder / Tennessean Staff Writer

One of the area's largest pediatric practices will close its doors to new TennCare patients Monday, frustrated that the state is not doing more to revive the troubled health-care program.

The decision by Centennial Pediatrics, a seven-doctor practice with offices in Nashville and Brentwood, means that hundreds of newborn babies and children on TennCare soon may have a harder time finding a pediatrician close to home.

"This is devastating from the point of view of the children," said Dr. Mary Keown, who practices in another Nashville pediatrics group.

Centennial Pediatrics' owner, Dr. Eddie Hamilton, said his decision was forced by economics -- the practice is owed \$167,000 by Xantus, the third-largest TennCare health plan that was taken over by the state in March after losing nearly \$28 million.

Hamilton said the decision also was "clinched" by state Finance Commissioner John Ferguson's comment that if the legislature cannot adequately fund TennCare, "we've got to be thankful for the Hippocratic oath."

The Hippocratic oath taken by doctors, in which they promise to "do no harm," does not require doctors to work for free, Hamilton pointed out.

Ferguson was responding to a legislator's question

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Jura Publishing New TennCare children - Friday, 5/14/99

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<http://www.tennessean.com/sti/99/05/14/doctors14.shtml>

about what would happen if the General Assembly cut the state's funding request for TennCare improvements in half.

"Those comments let me know there are some people who aren't serious" about the problems of TennCare, Hamilton said. "We are."

TennCare Director Brian Lapps Sr. would not comment when contacted yesterday.

Ferguson said the state might be able to reimburse doctors for half of the \$50 million in unpaid claims Nashville-based Xantus incurred before March 31.

"That doesn't ensure that a year from now we won't be in the same position," Hamilton responded. "We just can't afford to be exposed that way."

Hamilton said his practice will accept newborn siblings of current TennCare patients. But the practice has to limit its TennCare exposure because the program covers more than half of its 12,000 patients.

Some rural pediatricians and pediatric dentists have had to borrow money to pay their bills because of underpayment by Xantus and other TennCare health plans.

State officials predict that large numbers of physicians will stop participating in the program, which serves nearly 1.3 million low-income, disabled and previously uninsured Tennesseans, unless funding is increased and other reforms are enacted.

Ferguson on Monday asked the legislature to approve \$190 million in additional state dollars for the \$3.7 billion TennCare program, two-thirds of which is funded by the federal government.

But with state government expenses outpacing revenue, he admitted he did not know where the money would come from.

Currently, pediatricians at Vanderbilt University Medical Center accept new TennCare patients, as

do pediatricians in the Children's Medical Group in Hermitage.

So does Dr. Barbara Stephens, medical director of the second-largest TennCare plan, Access MedPLUS, who said she will probably expand her private pediatrics practice when a new partner joins her in July.

But some of the largest pediatric practices in Nashville do not accept new TennCare patients, including Green Hills Pediatrics, Old Harding Pediatric Associates, Rivergate Pediatrics and the Terrace Pediatric Group.

Keown said she and her three partners accept only newborns, regardless of insurance coverage, because they are close to capacity.

With Centennial Pediatrics closed to new TennCare patients, Keown predicted that parents who cannot find a doctor may delay seeking treatment for their children until they end up in the emergency room.

But Keown and Stephens said they could not criticize Hamilton's decision.

Pediatricians aren't paid as much as other doctors, Stephens said.

"We do it because we love our patients. But love does not pay" the bills.

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Unpaid bills may force doctors out of program, business



Columbia pediatrician Rufus Clifford examines Derrick Ritch, 3. Underpayments by TennCare are a financial strain on Clifford's practice. (Bill Steber / Staff)

By Bill Snyder /
Tennessean Staff Writer

The state's takeover of the third-largest TennCare plan has left some health professionals, especially those who care for children in rural areas, on the brink of insolvency.

Some doctors and dentists, owed hundreds of thousands of dollars by Nashville-based Xantus Healthplan, are borrowing money to pay their bills, considering laying off staff or closing their offices.

And it's not just Xantus, which was taken over by the state in March after it racked up \$50 million in unpaid claims and lost almost \$27 million in 1998.

Some pediatricians, frustrated over chronic underpayments by other TennCare plans, said they may drop out of the program altogether unless, as Columbia pediatrician Dr. Rufus Clifford put it, "some new arrangement is made."

TennCare director Brian Lapps Sr. said he understands their pain. He said his plan for reforming the state's troubled health-care program, to be unveiled to the legislature today, will include recommendations for helping physicians.

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<http://www.tennessean.com/sti/99/05/10/doctors10.shtml>05/14/99 FRI 11:09 FAX 615 343 7288
program, business - Monday, 5/10/99

"We've got some tough decisions for the legislature," Lapps said. TennCare "does need additional funding."

"But if we don't fix this, we will see a large exodus of providers. It would certainly affect our enrollees severely."

Lapps, a former health-care consultant from Franklin who was appointed TennCare director 14 weeks ago, would not give details of his reform plan before today's meeting. But pediatricians who met with him Thursday said they were impressed by his knowledge, concern and ideas.

"If he pulls off what he says he'll pull off, he may just fix TennCare," said Dr. Iris Snider, a pediatrician from Athens.

Here are the cracks in the system:

- Fed up by poor payment and other hassles, pediatricians across the state are closing their practices to new TennCare patients. Some, like Dr. Craig Horton, have left Tennessee.

"It's almost like a breath of fresh air," said Horton, a former Winchester pediatrician, about his new practice in Vidalia, Ga.

- In 1993, the year before TennCare started, 1,100 dentists participated in the state's Medicaid program. Last year, according to a state Health Department survey cited by the Tennessee Dental Association, only 370 participated in TennCare.

David Snodgrass, a pediatric dentist in Hermitage, said he gets TennCare patients from as far away as Cookeville, Tullahoma and Jackson because there are so few dentists participating in the program.

- It's getting more difficult for children in some rural areas to find doctors willing to accept TennCare patients. In Greenville, Dr. Stanley Giles is the only pediatrician left who still routinely accepts normal newborn babies covered by TennCare.

"It's coming to a crisis stage," said his partner, Dr. Orville Swarner. "I don't think we can do it

05/14/99 FRI 11:09 FAX 615 343 7286

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anymore."

• TennCare is causing the state's pediatric care "safety net" to deteriorate.

Pediatricians say they are having trouble recruiting partners, particularly in rural areas. Hospitals are putting off buying new equipment and upgrading facilities.

In rural West Tennessee, for example, mental health services have been "decimated," said Tom Hamilton, executive director for the West Tennessee Community Development Foundation, which monitors TennCare.

"We've lost two pharmacies," he said. "The Methodist Hospital of McKenzie lost \$1 million last year. ... TennCare's problems are a threat to every rural Tennessean."

It wasn't supposed to be this way.

When TennCare replaced the state's financially ailing Medicaid program in 1994, it was designed to streamline health care for low-income and disabled people who traditionally qualify for Medicaid.

The new managed-care system also was supposed to save so much money that coverage could be expanded to other people, including the previously uninsured and the "uninsurable," those who had been denied private coverage because of pre-existing medical conditions.

From a coverage standpoint, the bold experiment was immensely successful. TennCare covers about a quarter of the state's population, 1.28 million people, including a third of all children under age 21 and nearly half of all births.

The state hired 12 private health plans, which have since dropped to nine, to provide a wide range of benefits to TennCare enrollees. The plans are paid a set, "capitated" amount each month for each of their enrollees, and they, in turn, pay health-care providers.

The price tag wasn't cheap. This year TennCare's

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<http://www.tennessean.com/staff/99/05/10/doctors10.shtml>

03/14/99

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budget totals \$3.7 billion, two thirds of which is provided by the federal government. And costs are expected to rise 12% next year.

But almost from the beginning, health-care providers complained they were not being paid enough to cover their costs, claims for reimbursement were constantly being lost or denied, and, in many cases, they weren't being paid anything at all.

Then some of the health plans got into financial trouble. When Xantus went into state receivership, doctors began to worry who might be next.

"It certainly puts a big case of doubt in your mind," Clifford said.

In February, Gov. Don Sundquist proposed closing enrollment temporarily to the uninsurable adults, to give state officials time to rein in costs, possibly by cutting benefits, raising premiums or restricting those who can enter the program.

Adults on TennCare, children and those who are Medicaid eligible because of low income or disability would not be affected. TennCare already had been closed to new enrollment by all but a few of the uninsured.

Advocates for TennCare enrollees and some doctors have protested the proposal to close enrollment to uninsurables, arguing that these are the people who need the program most.

And other doctors argue that unless something dramatic is done to reform TennCare and pay what Xantus owes, they may not stay in the program. "Something has to happen or, come Jan. 1, very likely there will not be any doctors in TennCare," predicted Dr. Ted Taylor, an Elizabethton pediatrician.

Here's why:

Several pediatricians interviewed by *The Tennessean* said the TennCare plans have been paying them only about 50% of their average \$50-\$60 charge for an office visit. It is an amount that doesn't even cover the cost of office staff,

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equipment, lab tests, rent and other expenses.

To make matters worse, commercial HMOs increasingly are refusing to pay doctors anything more than TennCare pays. "Our floor (for setting fees) has become TennCare," said Dr. Eddie Hamilton, a Nashville pediatrician.

In many cases, it is difficult to determine whether a patient is eligible for TennCare, or what health plan and what physician they've been assigned to see.

Pediatricians said they will go ahead and provide the care, especially if the child is sick, only to find out later they won't be paid because the child was in some other plan or somebody else's patient.

Lapps, the TennCare director, has said part of TennCare's financial woes have been caused by enrollees who should not be on the program because they have access to other insurance.

Pediatricians agreed. "A third of children on TennCare have another insurance," said Snider, the Athens pediatrician.

The commercial plan will pay part of the claim, but when doctors try to collect the balance from TennCare, the TennCare plans refuse, she said.

Even collecting payment from TennCare for routine care to well-established patients can be a nightmare.

Several doctors said they had to refile claims three or four times before they received payment, often months after the services were delivered.

"If I delayed paying my bills on my house or car note, I'd be paying a heck of a lot of penalties," said Dr. Mark Gaylord, associate professor of pediatrics at the University of Tennessee Medical Center in Knoxville. "But there are no penalties here" for the health plans.

Another frustration is the lack of specialists willing to accept TennCare patients. "That worries us the most," Swarner said.

Then the Xantus problem hit.

The Tennessee Medical Association surveyed 70 medical practices across the state. The average amount owed by Xantus is nearly \$95,000.

Some practices, like Clifford's in Columbia and Hamilton's in Nashville, with large numbers of Xantus patients are owed nearly \$200,000 by the company, and they have no guarantee of being paid.

Dr. David Florence, a family physician in Manchester, said he is owed nearly \$94,500 by Xantus. He said he is the only physician in Coffee County still seeing new Xantus patients, but even he may have to close his doors to them "if nothing is done."

The state has pledged to process claims for services delivered to Xantus patients after April 1, but it has not determined how much, if any, of previous claims will be reimbursed.

And solving the Xantus problem won't help providers like Steve Lynn, a pediatric dentist in Tullahoma who had to borrow money to pay his taxes this spring because of chronic underpayment by other TennCare plans.

"No business can stay afloat if people aren't going to send you the money," he said.

Taylor, the Elizabethton pediatrician, is in a similar situation. He and his two partners took a 25% cut in their take-home income Jan. 1 so they could pay their bills.

Nearly half of their patients are covered by TennCare. Unless payments improve, they'll have to cut their income another 25% in July.

One of Taylor's partners is planning to leave the practice, and Taylor is interviewing for a job in Idaho later this week.

"I've been in Elizabethton for 21 years. I don't want to leave," he said. "But I don't know if I want to stay working full time for half pay. I can't not make payments. I've got a kid in college."



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

DATE: 5/19/99TO: Chris JenningsFAX#: 456-5557FROM: Mary Beth Donahue
Chief of StaffMarilyn Yeager

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

 Pages [including this cover]

 VANDERBILT UNIVERSITY MEDICAL CENTER**MARILYN K. YAGER**

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DATE:

5-14

TO:

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FAX #:

202-690-7755

PAGES:

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CENTENNIAL PEDIATRICS

Doctors refusing new TennCare children

By Bill Snyder / Tennessean Staff Writer

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Unpaid bills may force doctors out of program, business

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Columbia pediatrician Rufus Clifford examines Derrick Ritch, 9. Underpayments by TennCare are a financial strain on Clifford's practice. (Bill Steber / Staff)

By Bill Snyder /
Tennessean Staff Writer

The state's takeover of the third-largest TennCare plan has left some health professionals, especially those who care for children in rural areas, on the brink of insolvency.

Some doctors and dentists, owed hundreds of thousands of dollars by Nashville-based Xantus Healthplan, are borrowing money to pay their bills, considering laying off staff or closing their offices.

And it's not just Xantus, which was taken over by the state in March after it racked up \$50 million in unpaid claims and lost almost \$27 million in 1998.

Some pediatricians, frustrated over chronic underpayments by other TennCare plans, said they may drop out of the program altogether unless, as Columbia pediatrician Dr. Rufus Clifford put it, "some new arrangement is made."

TennCare director Brian Lapps Sr. said he understands their pain. He said his plan for reforming the state's troubled health-care program, to be unveiled to the legislature today, will include recommendations for helping physicians.

"We've got some tough decisions for the legislature," Lapps said. TennCare "does need additional funding."

"But if we don't fix this, we will see a large exodus of providers. It would certainly affect our enrollees severely."

Lapps, a former health-care consultant from Franklin who was appointed TennCare director 14 weeks ago, would not give details of his reform plan before today's meeting. But pediatricians who met with him Thursday said they were impressed by his knowledge, concern and ideas.

"If he pulls off what he says he'll pull off, he may just fix TennCare," said Dr. Iris Snider, a pediatrician from Athens.

Here are the cracks in the system:

- Fed up by poor payment and other hassles, pediatricians across the state are closing their practices to new TennCare patients. Some, like Dr. Craig Horton, have left Tennessee.

"It's almost like a breath of fresh air," said Horton, a former Winchester pediatrician, about his new practice in Vidalia, Ga.

- In 1993, the year before TennCare started, 1,100 dentists participated in the state's Medicaid program. Last year, according to a state Health Department survey cited by the Tennessee Dental Association, only 370 participated in TennCare.

David Snodgrass, a pediatric dentist in Hermitage, said he gets TennCare patients from as far away as Cookeville, Tullahoma and Jackson because there are so few dentists participating in the program.

- It's getting more difficult for children in some rural areas to find doctors willing to accept TennCare patients. In Greenville, Dr. Stanley Giles is the only pediatrician left who still routinely accepts normal newborn babies covered by TennCare.

"It's coming to a crisis stage," said his partner, Dr. Orville Swanner. "I don't think we can do it

anymore."

- TennCare is causing the state's pediatric care "safety net" to deteriorate.

Pediatricians say they are having trouble recruiting partners, particularly in rural areas. Hospitals are putting off buying new equipment and upgrading facilities.

In rural West Tennessee, for example, mental health services have been "decimated," said Tom Hamilton, executive director for the West Tennessee Community Development Foundation, which monitors TennCare.

"We've lost two pharmacies," he said. "The Methodist Hospital of McKenzie lost \$1 million last year. ... TennCare's problems are a threat to every rural Tennessean."

It wasn't supposed to be this way.

When TennCare replaced the state's financially ailing Medicaid program in 1994, it was designed to streamline health care for low-income and disabled people who traditionally qualify for Medicaid.

The new managed-care system also was supposed to save so much money that coverage could be expanded to other people, including the previously uninsured and the "uninsurable," those who had been denied private coverage because of pre-existing medical conditions.

From a coverage standpoint, the bold experiment was immensely successful. TennCare covers about a quarter of the state's population, 1.28 million people, including a third of all children under age 21 and nearly half of all births.

The state hired 12 private health plans, which have since dropped to nine, to provide a wide range of benefits to TennCare enrollees. The plans are paid a set, "capitated" amount each month for each of their enrollees, and they, in turn, pay health-care providers.

The price tag wasn't cheap. This year TennCare's

budget totals \$3.7 billion, two thirds of which is provided by the federal government. And costs are expected to rise 12% next year.

But almost from the beginning, health-care providers complained they were not being paid enough to cover their costs, claims for reimbursement were constantly being lost or denied, and, in many cases, they weren't being paid anything at all.

Then some of the health plans got into financial trouble. When Xantus went into state receivership, doctors began to worry who might be next.

"It certainly puts a big case of doubt in your mind," Clifford said.

In February, Gov. Don Sundquist proposed closing enrollment temporarily to the uninsurable adults, to give state officials time to rein in costs, possibly by cutting benefits, raising premiums or restricting those who can enter the program.

Adults on TennCare, children and those who are Medicaid eligible because of low income or disability would not be affected. TennCare already had been closed to new enrollment by all but a few of the uninsured.

Advocates for TennCare enrollees and some doctors have protested the proposal to close enrollment to uninsurables, arguing that these are the people who need the program most.

And other doctors argue that unless something dramatic is done to reform TennCare and pay what Xantus owes, they may not stay in the program. "Something has to happen or, come Jan. 1, very likely there will not be any doctors in TennCare," predicted Dr. Ted Taylor, an Elizabethton pediatrician.

Here's why:

Several pediatricians interviewed by *The Tennessean* said the TennCare plans have been paying them only about 50% of their average \$50-\$60 charge for an office visit. It is an amount that doesn't even cover the cost of office staff,

equipment, lab tests, rent and other expenses.

To make matters worse, commercial HMOs increasingly are refusing to pay doctors anything more than TennCare pays. "Our floor (for setting fees) has become TennCare," said Dr. Eddie Hamilton, a Nashville pediatrician.

In many cases, it is difficult to determine whether a patient is eligible for TennCare, or what health plan and what physician they've been assigned to see.

Pediatricians said they will go ahead and provide the care, especially if the child is sick, only to find out later they won't be paid because the child was in some other plan or somebody else's patient.

Lapps, the TennCare director, has said part of TennCare's financial woes have been caused by enrollees who should not be on the program because they have access to other insurance.

Pediatricians agreed. "A third of children on TennCare have another insurance," said Snider, the Athens pediatrician.

The commercial plan will pay part of the claim, but when doctors try to collect the balance from TennCare, the TennCare plans refuse, she said.

Even collecting payment from TennCare for routine care to well-established patients can be a nightmare.

Several doctors said they had to refile claims three or four times before they received payment, often months after the services were delivered.

"If I delayed paying my bills on my house or car note, I'd be paying a heck of a lot of penalties," said Dr. Mark Gaylord, associate professor of pediatrics at the University of Tennessee Medical Center in Knoxville. "But there are no penalties here" for the health plans.

Another frustration is the lack of specialists willing to accept TennCare patients. "That worries us the most," Swarner said.

Then the Xantus problem hit.

The Tennessee Medical Association surveyed 70 medical practices across the state. The average amount owed by Xantus is nearly \$95,000.

Some practices, like Clifford's in Columbia and Hamilton's in Nashville, with large numbers of Xantus patients are owed nearly \$200,000 by the company, and they have no guarantee of being paid.

Dr. David Florence, a family physician in Manchester, said he is owed nearly \$94,500 by Xantus. He said he is the only physician in Coffee County still seeing new Xantus patients, but even he may have to close his doors to them "if nothing is done."

The state has pledged to process claims for services delivered to Xantus patients after April 1, but it has not determined how much, if any, of previous claims will be reimbursed.

And solving the Xantus problem won't help providers like Steve Lynn, a pediatric dentist in Tullahoma who had to borrow money to pay his taxes this spring because of chronic underpayment by other TennCare plans.

"No business can stay afloat if people aren't going to send you the money," he said.

Taylor, the Elizabethton pediatrician, is in a similar situation. He and his two partners took a 25% cut in their take-home income Jan. 1 so they could pay their bills.

Nearly half of their patients are covered by TennCare. Unless payments improve, they'll have to cut their income another 25% in July.

One of Taylor's partners is planning to leave the practice, and Taylor is interviewing for a job in Idaho later this week.

"I've been in Elizabethton for 21 years. I don't want to leave," he said. "But I don't know if I want to stay working full time for half pay. I can't not make payments. I've got a kid in college."

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CENTENNIAL PEDIATRICS

Doctors refusing new TennCare children

By Bill Snyder / Tennessean Staff Writer

One of the area's largest pediatric practices will close its doors to new TennCare patients Monday, frustrated that the state is not doing more to revive the troubled health-care program.

The decision by Centennial Pediatrics, a seven-doctor practice with offices in Nashville and Brentwood, means that hundreds of newborn babies and children on TennCare soon may have a harder time finding a pediatrician close to home.

"This is devastating from the point of view of the children," said Dr. Mary Keown, who practices in another Nashville pediatrics group.

Centennial Pediatrics' owner, Dr. Eddie Hamilton, said his decision was forced by economics -- the practice is owed \$167,000 by Xantus, the third-largest TennCare health plan that was taken over by the state in March after losing nearly \$28 million.

Hamilton said the decision also was "clinched" by state Finance Commissioner John Ferguson's comment that if the legislature cannot adequately fund TennCare, "we've got to be thankful for the Hippocratic oath."

The Hippocratic oath taken by doctors, in which they promise to "do no harm," does not require doctors to work for free, Hamilton pointed out.

Ferguson was responding to a legislator's question

about what would happen if the General Assembly cut the state's funding request for TennCare improvements in half.

"Those comments let me know there are some people who aren't serious" about the problems of TennCare, Hamilton said. "We are."

TennCare Director Brian Lapps Sr. would not comment when contacted yesterday.

Ferguson said the state might be able to reimburse doctors for half of the \$50 million in unpaid claims Nashville-based Xantus incurred before March 31.

"That doesn't ensure that a year from now we won't be in the same position," Hamilton responded. "We just can't afford to be exposed that way."

Hamilton said his practice will accept newborn siblings of current TennCare patients. But the practice has to limit its TennCare exposure because the program covers more than half of its 12,000 patients.

Some rural pediatricians and pediatric dentists have had to borrow money to pay their bills because of underpayment by Xantus and other TennCare health plans.

State officials predict that large numbers of physicians will stop participating in the program, which serves nearly 1.3 million low-income, disabled and previously uninsured Tennesseans, unless funding is increased and other reforms are enacted.

Ferguson on Monday asked the legislature to approve \$190 million in additional state dollars for the \$3.7 billion TennCare program, two-thirds of which is funded by the federal government.

But with state government expenses outpacing revenue, he admitted he did not know where the money would come from.

Currently, pediatricians at Vanderbilt University Medical Center accept new TennCare patients, as

do pediatricians in the Children's Medical Group in Hermitage.

So does Dr. Barbara Stephens, medical director of the second-largest TennCare plan, Access MedPLUS, who said she will probably expand her private pediatrics practice when a new partner joins her in July.

But some of the largest pediatric practices in Nashville do not accept new TennCare patients, including Green Hills Pediatrics, Old Harding Pediatric Associates, Rivergate Pediatrics and the Terrace Pediatric Group.

Keown said she and her three partners accept only newborns, regardless of insurance coverage, because they are close to capacity.

With Centennial Pediatrics closed to new TennCare patients, Keown predicted that parents who cannot find a doctor may delay seeking treatment for their children until they end up in the emergency room.

But Keown and Stephens said they could not criticize Hamilton's decision.

Pediatricians aren't paid as much as other doctors, Stephens said.

"We do it because we love our patients. But love does not pay" the bills.

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STATE HEALTH

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notes

TennCare at a Turning Point: In Search of a Long-Term Solution

“We are close to finding ourselves back where we were before TennCare, when the ruinously expensive Medicaid program threatened our state’s solvency.”
—Tennessee Gov. Don Sundquist, State of the State address, Feb. 8, 1999

With a little luck and a lot of money and hard work, TennCare—Tennessee’s daring experiment to replace Medicaid with a managed care program encompassing a broader pool of uninsured and uninsurable residents—will be pulled back from the brink of disaster. But without a reexamination of the program’s original mission and a recommitment to it, advocates for the poor and the sick admonish, TennCare’s ultimate ruin is only a matter of time.

At a May 10 briefing, TennCare director Brian Lapps told lawmakers that the program, which has 1.3 million enrollees—almost a quarter of the state’s population—and a \$3.8 billion price tag—almost a quarter of its \$16 billion budget—needs an immediate infusion of \$190 million in state funds to keep doctors from dropping out. With a \$365 million overall budget shortfall and with taxes off the table, the governor will have to find the money elsewhere—from road projects, perhaps—to salvage the program in the short term, Lapps said in an interview, and there are “rumblings” of a special session of the General Assembly on tax reform sometime in the fall. “Everyone recognizes that if we don’t fix this, it will implode around us,” he declared.

In addition to the cash, Lapps outlined a comprehensive package of reforms, including a temporary freeze on enrolling “uninsurables,” or people with preexisting medical conditions who can’t buy policies privately; raising premiums to reflect market levels and levying higher copays on wealthier recipients; modifying benefits “to correspond with those available under Medicaid” in the pre-TennCare days; and imposing a uniform prescription drug formulary. For future consideration, he also proposed taxing insurers that exclude coverage of “routine catastrophic conditions” or that have “many applicants going to TennCare” and offering a tax break to small companies that offer insurance (and conversely, financial disincentives for firms offering limited or no coverage.)

Gordon Bonnyman, managing attorney for the Tennessee Justice Center, commended officials for their effort but decried the lack of direction toward an overriding goal. “Yogi Berra used to say, ‘If you don’t know where you’re going, you’re likely to end up somewhere else,’” he said. While more money is needed, it is “not a significant solution.” Many of the proposed reforms work at cross-purposes, he said, and “clarity of the program’s core principles” is sadly absent.

Money Matters: Setting Accounts Straight

Proposed six years ago by then-Gov. Ned McWherter as a way of averting a \$764 million Medicaid shortfall, TennCare was put in place on Jan. 1, 1994 under a fast-track federal waiver. (The original five-year waiver was extended last July for three years, through Dec. 31, 2001.) The aim: to move Medicaid recipients into managed care networks (there was just one at the time the plan was hatched), using the savings generated by capitated payments to cover residents who don’t qualify for Medicaid and who can’t afford health insurance or are denied it because of a preexisting condition.

And indeed, enrollment has flourished. In addition to 768,000 [TennCare, p.2]

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TennCare needs an immediate infusion of \$190 million to stay in business and keep providers on board. But advocates for the poor say money isn’t enough and that what’s needed is a ‘recommitment’ to the program’s original mission.

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TennCare, from p. 1

Medicaid recipients, TennCare covers 108,000 "uninsurables" and 411,000 uninsured workers and their families. (Enrollment was closed to that last group on Jan. 1, 1995 but was reopened to children under 18 without family coverage as of April 1, 1997.)

The problem, providers in particular argued long and loud, is that payments for services don't come close to meeting costs. An actuarial study by Price Waterhouse Coopers released in March confirmed the criticisms: rates paid to health plans are \$11 per member per month lower than what is actuarially sound; physician payment levels are about 34 percent of billed charges; and hospital payments average 72 percent of costs. On balance, the study reported that plans broke even during the program's early years but more recently have shown "slight losses," and further that providers "appear to be under significant financial stress."

To right the wrongs, most of the \$190 million will be used to raise the capitation rates—which now average \$120 per member per month—by \$16; plans would then be required to pass \$12.60 of the increase directly along to providers.

Seeking to diffuse another crisis—the financial failure of Xantus HealthPlan, TennCare's third largest managed care plan—the state also agreed to dip into program reserves to pay 50 percent of up to \$60 million in claims filed before the plan went into state receivership in March. (When TennCare began, 12 plans were participating; over the years, three have dropped out; besides Xantus, two others are said to be in serious fiscal trouble.)

The Tennessee Medical Association (TMA) welcomed the "overture" and overall direction of the reforms, calling them "long overdue" but "a step in the right direction." The Tennessee Hospital Association's (THA) response was cooler, saying "it is significant the administration has acknowledged the financial deficiencies... inherent in the TennCare program from its inception."

In an interview before the rescue plan was unveiled, THA president Craig Becker said the problem is "more than money. It's also stricter oversight" of health plans and of commercial insurers, who, by refusing to

cover to all but the healthiest residents, "aren't pulling their weight." TennCare "isn't a safety net any more," Becker said. "It's a \$4 billion insurance program, but it's being run like a storm door company."

To address the oversight concerns, Lapps' reforms would prohibit plans from spending money on marketing, cap their administrative costs, institute county-by-county audits and establish "clear time frames for paying claims on a timely basis," perhaps within 30 days.

View from the Trenches

To Bonnyman, the focus of the reforms is misplaced. "If it were up to me, I'd target money to a few essential providers"—three or four urban hospitals and community health centers—and devise a strategy for dealing with financially troubled plans. "If they're not viable, I would find a way to foster consolidation. I would not [raise] capitation rates to prop them up."

Most troubling, he said, is the call to close enrollment to uninsurables, even temporarily, and to increase what the working poor pay. Barring people with preexisting conditions will simply lead to more cost-shifting, he said, and asking the poor to pay more may drive them out of the program, reducing the revenues they generate in the process. Instead, he suggested that officials reopen the rolls to the non-Medicaid uninsured to bring in even more money.

But with premium contributions averaging just \$72 per member per year, Lapps said adding "more people... will bury the program. I've said we'll reopen enrollment to uninsurables as soon as possible and to the uninsured as soon as it makes sense." But first, "we have to pay providers adequately" for those already in the program. (Closing enrollment to uninsurables requires federal approval—not likely at this point, observers say.)

Bonnyman also said some proposed reforms—the residency requirement, for example—"are hardly worth comment." Despite anecdotes about out-of-staters coming to Tennessee for insurance, "that's not a major problem," he said.

Taxing Issues

Even if the General Assembly comes through with the \$190 million, and even if some of the other reforms yield a quick payoff, some TennCare observers worry about the program's stability and financial viability over the longer haul.

To maintain it, the state's "low, unstable tax base" must be expanded, said TMA spokesman Russ Miller. "We need an income tax," agreed Keith Johnson, executive director of the TennCare Oversight Committee—an unlikely scenario in the short term, almost everyone involved agrees. The issue for now, Johnson said, is coming up with the \$190 million. "I don't know where we'll find it," though legislators have been "very good at pulling a rabbit out of the hat."

As for the overall package, "I didn't hear a magic bullet, but I liked what I heard," said Johnson, former director of operations for TennCare. The problem is, "they're trying to do too much, too fast. It's going to take a long time to fix this. There are things on the list that should have been started years ago."

Ginger Parra, Johnson's predecessor with the committee, suggested helping program staff by hiring someone with knowledge of TennCare history. Lapps has a solid background in the managed care field, but he's been on the job only since late January, she noted, and his medical director only since April 29. "We may need to open the windows to let in fresh air, but we also need someone who knows all the rules and agreements" built in the original waiver. For the next year, she suggested bringing in a transition "coordinator" to help with such details.

To Parra, program officials have become too involved in "micromanaging" health plans, losing sight of the mission along the way. "They need to go back to being a money transfer: issue the checks and put all your strength into managing quality." There is money for benefits—"you can't drive across Tennessee for all the highway construction," she observed, and the tobacco settlement is still up for grabs. "It's a matter of setting priorities and reappropriating," she said. • LD

PRIMARY CARE *news*

States See Success in Physician Retention & Recruitment Efforts



In the early 1990s, the television show *Northern Exposure* profiled Joel Fleischman, a young doctor who left his home town, New York City, to set up practice in a rural Alaska village as a way to pay off his medical school debts. Viewers tracked his struggle as he adjusted to the cultural and geographical differences of small-town life and, over time, bonded with community residents.

The situation no doubt rang true to state health planners, who regularly deal with the task of finding physicians who match a community's needs and then keeping them there—not an easy feat to accomplish, particularly if the community lacks the attractions of city or suburban life.

Over the years, states have tried a variety of recruitment and retention strategies: loan forgiveness and repayment programs or tax credits for physicians who agree to set up practice in underserved areas; *locum tenens* programs that bring in a replacement provider to give solo practitioners or those working in remote regions a break from the demands of daily doctoring; and continuing education programs to help isolated practitioners keep abreast of advances in their field. In the latest twist, a growing number of states have jumped on the virtual bandwagon of two Internet-based products that match up potential doctor candidates with searching communities. (See box, page 6.)

Despite those efforts, however, the number of health professional shortage areas hasn't changed significantly over the years. U.S. Bureau of Census figures for 1996 show that rural communities, which

are home to more than 20 percent of the U.S. population, and inner cities have the greatest need for physicians—primary care physicians in particular. According to a December 1998 report by the federal Bureau of Primary Health Care, the U.S. needs 5,465 practitioners simply to remove shortage area designations and 12,484 to meet target ratios in those areas.

A Look at Trends

To influence where medical school students practice and to steer them toward primary care, states have been moving away from traditional “no-strings-attached” scholarships and loans to loan repayment and incentive programs that carry an immediate service obligation of at least two years in a health professions shortage area and impose stricter financial penalties for defaulting.

According to Don Pathman, M.D., a senior research fellow at the University of North Carolina, the shift has taken place in part because too many doctors were defaulting on both their financial and practice obligations. (In the case of the former, state Attorneys General were often called in to help with the collection efforts, which proved to be both time- and resource-consuming.)

In addition, Pathman said, the move away from traditional scholarship and loan programs reflects states’ “fairness” concerns—that is, the belief that it’s not “right to hold someone who’s now approaching 30 to a commitment they made when they were 21,” he said.

In a March 1997 report, NCSL’s Primary Care Resource Center counted 111

scholarship and loan repayment programs in 47 states targeted not only to physicians but also to nurses, physician assistants and other providers needed in shortage areas.

A more recent variation on the loan repayment theme is the incentive program. Operational in several states—including Arkansas, South Carolina and Texas—the programs are run like loan repayment programs, but, Pathman noted, the money given to the resident can be used for any number of things: to buy a car, to repay loans or to use as a downpayment on a house. The Arkansas program, for example, provides \$55,000 over four years to primary care providers who agree to practice in a “priority medically underserved area.”

(Pathman and his colleagues are currently researching programs run by states or state medical societies that provide financial support to physicians and other providers. They plan to produce a series of publications on their findings, the first of which will come out next winter, for the federal Agency for Health Care Policy and Research.)

Something Old....

One “payback” program with a long track record is the University of Massachusetts’ Learning Contract. Founded in 1978, the program accepts only in-state residents—a decision the legislature made so that constituents would have an affordable option for medical school, said Michael Huppert, associate dean for community programs at the U-Mass Medical Center. (Other programs operating in the Commonwealth are based at Tufts University, Boston University and Harvard.)

To be accepted into the program, students must sign the contract, which requires a four-year service payback—a modification from the original one-year requirement—in a primary care setting, public or community service site or an underserved area within the Commonwealth. The two components—the requirement for in-state applicants and the contract—capture important characteristics
[Retention, p.6]

NEWSMAKERS *debate*

Interstate Nursing: Should States Adopt the Mutual Recognition Compact Model?

Like most Americans, health care professionals work in an increasingly mobile, technology-dependent society. Within the field, growth of multistate delivery systems and evidence of the benefits of "telehealth"—better access to care, quicker access to patient records, lower costs—give physicians, nurses and other professionals greater opportunities to practice across state lines. In addition, many health plans are setting up telephone "advice lines" to link nurses with enrollees—often located in different states—as a means of providing patient education and other triage services.

While most telehealth activity occurs within individual state boundaries, the spread of interstate practice threatens a state's exclusive prerogative to regulate nursing and other health professions by calling into question whether the federal government has jurisdiction over such matters under the U.S. Constitution's interstate commerce clause. To head off any potential challenge, the National Council of State Boards of Nursing (NCSBN) is calling on states to take the lead in regulating interstate nursing practice. Specifically, it has recommended the adoption of the Mutual Recognition Model on Nursing Regulation, under which states may enter into a legal agreement with each other to recognize their respective nursing licenses, regardless of differing standards. The net effect would be to let registered nurses practice—physically or electronically—in any state participating in the agreement under the license issued by their state of residence (with only one licensing record for interstate practice.) RNs would be held accountable for the practice laws in the state where they provide services, much as motor vehicle operators must obey the laws of the state where they drive.

Supporters of such agreements, called interstate compacts, say they see a way of ensuring that nurses have proper legal authority to practice across state lines, thereby safeguarding the public health and safety. According to NCSBN, states' power to enter into such reciprocal licensure agreements is well recognized. In Kansas and Nebraska, however, the Attorneys General have issued opinions on interstate compacts that, in general, declare them an unconstitutional delegation of legislative authority. California's Department of Consumer Affairs has raised constitutional concerns about the compact as well. And the American Nurses Association (ANA) and some state regulators also argue that the compact model has flaws that must be addressed before it is widely implemented.

Interstate compacts, which supercede state laws, generally must be adopted by the legislature of each participating state. Going into the 1999 sessions, Utah was the only state with a law adopting a compact to regulate interstate nursing practice, with an effective date of Jan. 1, 2000. This year, similar laws have been enacted in Arkansas and Maryland, with legislatures in at least four other states (Iowa, Nebraska, North Carolina and Texas) reporting some movement in that direction.

Carolyn Hutcherson of the NCSBN, Susan Whittaker of the ANA and Bruce Douglas of the Colorado Department of Regulatory Agencies offer their views on nurse licensure compacts and their impact on states. An edited transcript follows.

Q: Given the growth in interstate nurse practice and today's greater mobility, does it make sense to have greater uniformity among states on scope of practice laws and other regulation of the profession?

Whittaker: It does, and the ANA has committed to work with NCSBN to develop a single model nurse practice act that all states could adopt as the mechanism for increasing uniformity.

Hutcherson: NCSBN is committed to improving uniformity. One reason the interstate compact is possible is that two of the major nurse licensure requirements—graduation from an approved training program and passing the licensure exam—are uniform for registered nurses across all states. Even scope of practice [standards] for RNs are not too different across states.

Douglas: Certainly it makes sense. There is already pretty good uniformity in standards along with mobility among states. What's varied is the regulation of advanced practice nursing. Anything states can do to facilitate mobility of nurses should be done. For nurses who physically practice in more than one state, however, it is not an undue burden to get a license in all of the states.

Q: Should states facilitate or limit interstate practice of telenursing?

Hutcherson: Telenursing as a dimension of integrated health systems and managed care is a reality. From a practical point of view, limiting interstate telenursing is more market-driven than anything else. Every consumer satisfaction survey says that [patients] love having access to a toll-free, multistate phone number to get medical advice. Our objective is to make sure that our interstate telenursing model has a solid legal foundation and that there is a 'safety net' to capture providers who would potentially harm patients.

Whittaker: ANA has always supported consumer access to nursing services. But you have to balance that with the ability of nurses to provide services and the ability of states to ensure public safety.

Douglas: We have a large telenursing center in Colorado whose nurses, many of

whom live outside our state, provide advice to patients, and I don't believe that the states where the patients reside have jurisdiction over that activity. It is Colorado's regulatory responsibility to oversee the interstate telepractice of nurses at the center. If we don't deal with the associated problems, realistically the problems are not going to be resolved.

Q: *Under the compact, how will the quality of care provided by nurses practicing across state lines be monitored and enforced?*

Douglas: Picture yourself as a nurse delivering interstate teleconsulting services. You are trying to help a patient in another state decide whether to take two aspirin and go to bed or go to the hospital emergency room. Under the compact, the first thing you have to ask patients is not how they're feeling but what state they're calling from. You are somehow held responsible for knowing the specifics of the laws of the state the patient is calling from. That's crazy.

Hutcherson: The quality of nursing care will be monitored as it is currently. At the local practice level, quality oversight will actually be enhanced because of new mechanisms to communicate information about subquality care across states. Most of regulation is about patient safety rather than quality of care. We are convinced that improved communication will guarantee

“Anything states can do to facilitate mobility of nurses should be done.”

safe patient care or provide a safety net against “bad-apple” providers.

Q: *Should licensure under the interstate compact be based on the nurse's state of residence or the state of practice?*

Whittaker: ANA's House of Delegates has said that licensure should be based on nurses' state of predominant practice, not their state of residence.

Douglas: Nurses should be required to be licensed in any state where they physically practice. Under NCSBN's compact they can only have a license in their state of residence. The problem with telenursing, or what I call the “metaphysical model” of nursing, is that [the compact suggests that] the practice of telenursing occurs where the patient is. That means that a Colorado nurse providing telephone advice is magically transported to the other states every day, which is silly.

From a regulatory position, you're making the problem very complicated. You're assuming that remote states are in a realistic position to have remedies with which to correct problems by telepractice. But unless the state has a license to discipline, there isn't a remedy. Any other remedies are just “smoke and mirrors.” Plus, you're putting a huge regulatory burden on the remote states instead of on the states where the nurse practices. It is a nightmare.

Hutcherson: We've done a lot of legal analysis of this issue. At the outset, NCSBN felt that basing licensure on practice location would be preferable. But the reality is that government regulation has to be workable to be effective. We spent a year trying to come up with an enforceable mechanism based on practice location, and the consensus was that it cannot be done. There are precedents for regulation based on residence, like driver's licenses. Rather than confuse the issue and compromise patient safety, we chose to anchor licensure under the compact to the nurse's residence.

Q: *Why are nurse practitioners and other advanced practice nurses (APNs) not included in the model?*

Whittaker: While all states base an APN's authority to practice on having a registered nurse license, the interstate compact says the authority to practice as an APN would not be allowed for the nurse in the remote state. To ANA, nursing is a continuum of practice and we reject the idea that an advanced practice nurse must have an RN license. The idea of separating RNs and APNs into two compacts (NCSBN is working on a second compact for advanced practice nurses) is rigid and stifling for nursing practice in general.

Hutcherson: Advanced practice nurse licensure and credentialing are not nearly as standard across states as for RNs. Also,

Patients “love having access to a toll-free, multistate phone number to get medical advice.”

many issues related to advanced nurse practice, like prescriptive authority and physician collaboration, would not be addressed at all by the compact. Including APNs now would do more to confuse the issue than to clarify it.

Q: *How would the interstate compact be financed? And would participating states stand to lose their licensing revenues?*

Whittaker: NCSBN estimates that 10 percent to 12 percent of nurses hold multiple state licenses, so nursing boards in states participating in the compact would have a revenue loss of at least 10 percent to 12 percent. We are concerned about that and are waiting for more information about the financing and revenue implications of the compact.

We know that a number of state nursing boards recently increased their fees, and I'm guessing that may be in anticipation of participation in the interstate licensure compact. The nursing board in the District of Columbia, in particular, has great concerns about the proposed change because the majority of its practicing nurses don't live in the District.

Hutcherson: The interstate compact itself doesn't require financing. The database referenced in it has been under way as a separate project and is designed to be self-sustaining in the long-term. (NCSBN is underwriting the initial development costs.) What states must do is look at how revenue changes will affect them individually. • TH

Retention, from p. 3

ties in the profile of "what makes or drives applicants to stay" in the area once they're done with school, said Huppert. (Other variables in retaining students once they've completed their schooling include occupation of a spouse or partner and location of the doctor's residency.)

And it appears the contract concept has worked. For one thing, the number of students who sign has remained steady over the years. In a 1998 annual report to the legislature, program officials estimated that 97 percent of incoming medical students agreed to the commitment in

both 1997 and 1998, and of the more than 2,000 alumni, 860 still practice in state, 414 of them in primary care.

While primary care providers are still in short supply in some parts of the Commonwealth, "both in rural and core urban areas, we don't have the same shortages we had 25 years ago," said Huppert. Along with the learning contract, recruitment efforts by community health centers have had an impact, he added. While Massachusetts differs demographically from many other states, he said, the mechanism nonetheless "could begin to help" schools elsewhere in channeling med students into primary care.

... and Something New

Without a single medical school inside its borders—another variable in helping to retain students—Montana has faced special problems recruiting physicians. Altogether, ten of its counties have no primary care physicians, and 46 of 56 counties are designated health care professional shortage areas.

Hoping to overcome those obstacles, officials three years ago launched a "first-ever" family practice residency program, the first class of which is set to graduate next month. The program "does not have a 'learning contract' or other written agreement to stay in Montana," said Roxanne Fahrenwald, M.D., the program's director, because that type of arrangement "is difficult to enforce." Plus, she said, "we don't want to force people to stay here, because then they would leave in two years."

Instead, the family practice residency program aims to get medical residents to make a connection with the community, by screening applicants carefully and selecting those with an interest in rural practice and a clear desire to stay. "We try very hard to choose people with strong ties to" the state, said Fahrenwald.

How has the program worked? "So far it's great," she said. Four of the five doctors in the graduating class are staying in state and the one who's not "is going to a small community in Oregon, so in the larger picture, we're still on track."

The future looks promising as well. At least "40 percent of the medical students we interviewed are either from Montana or have family" in the state, she said. With only six open positions, the program received 277 applications, so "it seems to be something that people want to do," Fahrenwald noted. • MG

The Web: Make Me a Match

Two Internet-based products are helping to match states that are seeking to recruit primary care physicians with doctors who are scouting job prospects:

- Launched in August 1995, the National Rural Recruitment and Retention Network—3R Net, for short—now serves as a clearinghouse for 46 states and the U.S. Virgin Islands. Its website, which is being updated, will soon allow physicians access to interactive community profiles and a rundown of available jobs in specialty areas, according to director Fred Moskol. State agencies will also be able to link directly to 3R, giving potential candidates instant access to detailed information on a particular region in a state, for example. Supported in part by the Robert Wood Johnson Foundation under its Practice Sights Initiative, 3R Net currently costs a state \$1,200 a year. (Call Moskol at 608-265-3601 for details. To a look at the prototype site, go to <http://www.3Rnet.org/webproject>)
- Described by one user as capable of doing "everything but brush[ing] your teeth," the Medical Provider Placement software package is also funded under the Practice Sights Initiative. Developed by the North Carolina Foundation for Advanced Health Programs, Inc., the program, like 3R Net, maintains a listing of job opportunities and provides tracking of viable candidates. In addition, the software package goes a step further by generating correspondence to candidates and communities and alerts the in-state program director via an internal e-mail to take follow-up action. At least 17 states are either current or projected users.

The program "allows one person to do the work of three," Tom Tucker of North Carolina's Office of Research, Demonstrations and Rural Health said. The one-time charge to train four people is \$1,500, and states must also pay a \$2,000 annual fee for technical support. The package is now available in Macintosh format, but a PC version is in development as is accessibility via the Internet. (For additional information, call Barbara Comer at 919-821-0485 or send an e-mail to bcomer@worldnet.att.net) • MG

STATE HEALTH notes

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HIGHLIGHTS

HEALTH CARE PROVIDERS

Collective Bargaining

The move to increase physicians' clout in the managed care world through collective bargaining is picking up steam:

- A Senate bill in Texas that would allow physicians to negotiate contract terms collectively with health plans is on the move as the legislative session nears its close. Introduced on March 12, the measure (S 1468) passed the Senate by a 28-2 margin on April 28 and was reported favorably out of the House Committee on Insurance on May 11. As *Notes* goes to press, Darren Whitehurst, a spokesman for sponsor Sen. Chris Harris, predicted that the House will vote on the bill sometime during the third week of May. "I'm pretty confident [it] will pass" before the session's end on May 31, he added. (For background, see *SHN* #298, 4/12/99.)

- The Illinois Medical Society decided by voice vote at its annual House of Delegates meeting in late April to establish collective bargaining units to "regain control over patient care and protect the doctor-patient relationship." In a release, Clair Callan, M.D., the president of the 15,000-member society, said the "onerous conditions and regulations forced on us by insurance companies, hospital management and government are crippling our ability to give our patients the care they need." In addition to the vote on collective bargaining, the delegates fell just three votes short of a two-thirds majority—the final tally was 125-66—needed to deunify from the American Medical Association. (Deunification does not mean the society would abandon the AMA but rather that it would give members the right to decide on their own if they want to belong.)

HEALTH INSURANCE

Purchasing Institute

The Robert Wood Johnson Foundation has awarded a \$7.7 million, five-year grant to the Washington, D.C.-based Alpha Center to establish a National Health Care Purchasing Institute, the aim of which "is to improve health care for Americans through value-based, results-driven purchasing." According to a May 3 center release, the initiative will target executives and senior managers in the public and private sectors, including state Medicaid agencies, the federal Health Care Financing Administration, public employee health purchasing agencies, purchasing alliances and large corporations, which collectively buy \$600 billion in health services for 100 million Americans. Call the Alpha Center at (202) 296-1818 or visit <http://www.ac.org> for details.

BEHAVIORAL HEALTH

New Department

At an April 28 press briefing attended by members of Heroin Hurts, a support group for parents of children with drug problems, Delaware House Speaker Terry Spence proposed creation of a cabinet-level Department of Drug Control to take charge of education and prevention, treatment and oversight programs. Still on the drawing board, the bill would also put the new department in charge of producing a long-term strategy to combat drug use, deal with the consequences of drug abuse and develop guidelines for cooperation among local, state and federal anti-drug efforts. Finally, it stipulates that the person named as secretary have at least five years experience as a licensed pharmacist and two years in law enforcement and creates a

ten-member advisory committee to offer input. At the briefing, Spence also announced plans to establish a permanent House committee to deal with drug-related issues.

Welfare Drug Testing...

With his signature on HB 4090 on April 28, Gov. John Engler made Michigan the first state in the nation to require welfare applicants to take drug tests before receiving benefits. While citing the state's "great success" in "helping families move off welfare and into jobs," Engler declared that "substance abuse remains a barrier to independence" and that the testing program will provide abusers "with the incentive to change their lives." Under the new law, the Family Independence Agency will launch pilot programs in at least three counties to test for illegal drug abuse and offer treatment for the addiction. Individuals who test positive must comply with a required substance abuse treatment plan or risk penalties, from a reduction of benefits to the termination of assistance for the entire family. The agency is expected to expand the program statewide by April 1, 2003—six months after an evaluation of the pilots has been submitted to the Legislature.

...and a Reaction

Calling Michigan's policy insulting to "law-abiding citizens," the National Organization for the Reform of Marijuana Laws said in a release that it is "unprecedented for [legislators] to single out low-income citizens and compel them to prove they are 'drug free' as a requirement for financial aid." Along with NORML, the American Civil Liberties Union, the state affiliate of the National Organization for Women and the National Council on Alcoholism and Drug Dependence of Michigan are opposing the law. NORML is considering a legal challenge.

STATE HEALTH notes

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Foster Care Children: Expediting Enrollment

All but a handful of the 300,000 American children living in foster care arrangements qualify for Medicaid, generally through one of two routes: Title IV-E of the Social Security Act, which provides maintenance payments to families caring for kids no longer being cared for in their own homes, or the poverty pathway, which ties eligibility to the program's income standards. Even so, according to a recent National Academy for State Health Policy report, there are barriers to getting foster care children enrolled, the biggest of which is "the lag time between the child's placement in foster care and... receipt of a Medicaid card," despite the often "immediate need" for health services.

"There can be incredible delays with the paperwork," the academy's Neva Kaye noted—some related to Medicaid eligibility rules, some to the circumstances within a given state. Child welfare workers often don't understand Medicaid rules and *vice versa*, for example, hampering enrollment efforts. Even if a child is certified as eligible, "it can be months before a permanent ID card is issued," she said, and many providers "don't like temporary cards because they're not sure they'll get paid." In addition, Kaye said, there are often disruptions in eligibility when a child is returned to his or her biological family.

In Utah—one of five states involved in a long-term academy-led effort to improve the health of children in foster care (the others are Alaska, California, Massachusetts and Texas)—officials are moving to coordinate the Medicaid and IV-E eligibility processes.

In the past, said Cosette Mills, a IV-E specialist in the Department of Human Services (DHS), several agencies handled Medicaid applications for Utah's foster care kids. To replace that "fragmented" system, there's been a year-long transition to move all determinations on IV-E and Medicaid status under the aegis of DHS. Initially, Mills said, the Health Department wanted to take on the task but "we argued that because foster care children are such a small part of the overall Medicaid population, they wouldn't be given the priority or attention" needed to get them into the program. (At any point in time, an estimated 2,400 kids are in such placements across the state.) To facilitate the transition, DHS hired a full-time IV-E trainer to walk eligibility workers through the labyrinth of rules and regulations.

In Alaska, the Health and Social Services Department is also working to improve coordination. In Anchorage, where half of the state's 2,300 foster care kids reside, public assistance eligibility workers have been stationed in child welfare offices to facilitate enrollment, said Nancy Davis, a public health nurse overseeing the effort. In addition, the

department is working to educate IV-E workers about the importance of expediting eligibility packets, to ensure that kids living in more remote regions of the state receive their Medicaid cards as quickly as possible.

The fact that children have been removed from their home implies neglect of their health, Davis said. At the least they're not likely received basic preventive services and in many cases, they've been physically harmed as well. "No one's been watching out for them," she said.

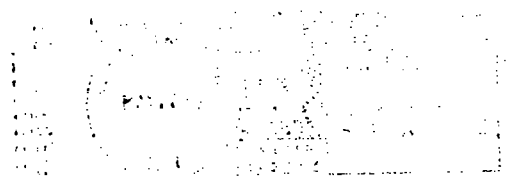
The report also looks at the small percentage of foster care kids who don't qualify for Medicaid by the traditional routes and at the special problems faced by children who are disenrolled from Medicaid when they leave a foster care home for a "kinship placement," until the relative who's agreed to take them in reenrolls them. The good news for states, it said, is that there's "more flexibility than is generally recognized to draw down federal Medicaid matching dollars" to provide coverage, including to kids in kinship care. States that want to create an eligibility category for children who fall through the cracks need only file a Medicaid plan amendment, approval of which "is generally a routine matter" if it is consistent with Medicaid law and rules.

• LD

Order "Medicaid Eligibility Policy for Children in Foster Care" by phone (207-874-6524) or at <http://www.nasbp.org>

STATE HEALTH *notes*

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