LEVEL 2 - 3 OF 10 STORIES

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HEADLINE: Turning Away Patients as a Way to Survive

SERIES: TENNESSEE'S ECONOMY OF CARE; A HOSPITAL SUFFERS; Pg. 3/3

BYLINE: David Brown, Washington Post Staff Writer

DATELINE: MEMPHIS

BODY:

For most of her 25 years at the Regional Medical Center at Memphis, nurse Josephine Blaylock has had to worry only about the people who come through the doors of the emergency room. For the last couple of years, however, she's also had another patient in mind -- the hospital itself.

This is clear when David Metcalf, a brick mason's helper in his forties, hobbles into her cubicle in the ER of this huge public hospital.

"I stepped in a ditch and twisted it all up across here," he says after taking off his unlaced white running shoes. He rubs the top of his foot.

"When did this happen?" Blaylock asks as she puts on a pair of rubber gloves.

"This happened two months ago, but it's getting worse," Metcalf says.

"Does it hurt when I mash on it?"

"Yes."

"Move your toes."

"It hurts when I move them, too."

The nurse asks a few more questions as she examines the foot. In a minute, though, she's seen enough. The toes move, the foot is not deformed, and there is no festering sore. She takes off her gloves and writes her findings on a one-page "triage sheet." It will be the sole record of the laborer's trip to the hospital.

"Mr. Metcalf, I know you know all about the new rules of the hospital," Blaylock says. She addresses him the way an older sister might remind a younger brother of the tragedy that's befallen the family. "I know this is an emergency for you, or you wouldn't have come out here today. But you've had this for more than a month and this is not an emergency."

She briefly inquires whether he goes to a clinic for his other medical care. He does. She advises him to make an appointment there so a doctor can look at his foot. She also gives him a printed list of clinics in town, in case it's hard to get an appointment at his usual one. He thanks her, folds the paper in half and leaves.

Shift in Policy

Turning some people away from emergency rooms (after a brief assessment of their condition) is a practice that was virtually unheard of in American medicine a decade ago. In the past two years, however, it has become established practice at Memphis's only public hospital.

The hospital is struggling to survive. It has laid off workers and closed wards in order to stay afloat. Today, it can't afford to treat people who come through its doors unless there's a good chance they're really sick. This is true whether or not they have insurance. (The man with the painful foot, in fact, had medical insurance.) The reason for this policy is simple.

TennCare, the state health insurance program for the poor, which started in 1994, is radically changing where, and to some extent, how, low-income Tennesseans get their medical care. In so doing, it has taken away millions of dollars that the Regional Medical Center -- barely a break-even concern in the best of years -- had always counted on for its survival.

TennCare replaced Medicaid, the traditional health insurance program for the poor whose costs are shared by federal and state governments. The new program covers 1.2 million people -- the 800,000 eligible for Medicaid and an additional 420,000 formerly uninsured Tennesseans -- but has a budget barely larger than the old program's.

It has accomplished this seemingly impossible task through the techniques of "managed care." It also has pared to the bone the amount of money doctors and hospitals can expect to get when they take care of poor people.

TennCare's strategy is based on a new world of hard-nosed number-crunching in medicine. The program seeks to make one corner of America's patchwork medical system more efficient, rational and fair. On the way to that goal, however, it is leaving some casualties. One of them is the Regional Medical Center at Memphis.

Known universally as "the Med," the hospital has one of the nation's five busiest trauma centers. In this part of the country, it's also the only trauma center within 150 miles. It has the city's most advanced intensive care unit for newborns. It has the region's only burn center. It's affiliated with the University of Tennessee's medical school, and many of its doctors are medical school professors and researchers.

For most Memphians, however, the Med has always had a far more pedestrian identity.

It's the city's only public hospital. It's the place where the poor and near-poor could see a doctor when they were injured, ill, pregnant or worried --

even if they didn't have medical insurance or a dollar in their pocket.

More than three-quarters of the hospital's patients live in the county that includes Memphis. Eighty percent are black, less than 60 percent have finished high school and 30 percent live below the poverty line. For many, the Med has always been the family doctor.

In the past, about 45 percent of the Med's patients had Medicaid. About 20 percent were "self-pay" -- the euphemistic term for the uninsured, who usually paid little or nothing for their care. The rest had other forms of insurance.

Poor people tend to need more health care than affluent people. One of the ironies of American medicine, however, is that the fees provided to hospitals and doctors for taking care of the poor are steeply discounted. Often they're barely enough -- or not enough -- to cover costs. This is true of Medicaid's fees, which are generally far below those paid by commercial insurance companies.

Nevertheless, the Medicaid program recognized that hospitals caring for large numbers of Medicaid patients -- and, because of their location, usually a large number of uninsured patients as well -- carried a particular burden. Medicaid partially compensated those institutions for their losses from something called the "disproportionate share" (DSH) fund.

A second Medicaid fund, the "graduate medical education" (GME) fund, served a similar purpose. It helped pay salaries of medical residents, young doctors undergoing training after medical school. Most residents worked in hospitals with many low-income patients, and GME payments in effect helped subsidize the care of those people.

TennCare eliminated both funds. Of the many changes the new program wrought, those two stabbed at the already vulnerable underbelly of the Med. The hospital, whose budget was about $ 210 million, lost $ 42 million.

In theory, however, elimination of DSH and GME made sense.

TennCare was supposed to provide insurance to virtually all poor people. Though TennCare's fees would be very low, hospitals at least would be getting them from more patients. Consequently, the theory went, there was little need for DSH and GME payments to help balance the accounts.

A Flawed Premise

But reality clashed with theory.

TennCare didn't eliminate as many nonpaying patients as it had hoped to. The program stopped enrolling uninsured, non-Medicaid eligible people in January 1995 because there wasn't enough money to cover them. The exception was people denied commercial insurance because of "preexisting" medical conditions.

Today, there are still about 304,000 uninsured people in Tennessee out of a population of 5.2 million. Many of them live in the Memphis area, the state's largest urban area.

The fraction of the Med's patients who have no insurance and little cash with which to pay for their care "hasn't fallen appreciably" since the arrival of TennCare, said Charlotte Collins, the Med's senior vice president. Their care still needs to be subsidized.

Many hospitals effectively overcharge patients with private insurance in order to make up the money lost on nonpaying patients, a practice known as "cost-shifting." But with only 35 percent of its patients carrying relatively high-paying insurance, the Med can't make up its losses that way.

"If you have 50 percent TennCare and 20 percent no-pay, it is hard to cost-shift," Collins said. "It is a recipe for bankruptcy to have more than 50 percent of your customers pay less than it costs to serve them. No business can sustain it."

Facing disaster -- and risking the possible loss of its blue-ribbon services such as the trauma center and the neonatal intensive care unit -- the Med performed radical surgery on itself.

In the past two years, it has closed almost 200 of its 530 beds. It has reduced the number of medical residents to 110 from 140. Doctors used to deliver 8,000 babies a year at the hospital. Now the number is 3,500.

The cardiac care unit closed in March 1995. Ambulances no longer bring heart attack victims to the Med. If such a patient walks in, an ambulance is called to take him elsewhere. Each month, about 25 percent of the people who come to the emergency room are carefully, thoughtfully and gently turned away.

The magnitude of the Med's transformation is evident when Kevin Merigian, chief of the hospital's department of emergency medicine, conducts a tour.

When he came to the Med in 1993, before the birth of TennCare, he undertook what seemed a sensible and long-needed reform. Patients were coming to the ER in tens of thousands every year for non-emergency medical care. They endured long, uncomfortable waits in a place whose ostensible purpose was to treat the far fewer people with illnesses requiring the speed, technology and expertise of a modern emergency department.

Merigian created an "ambulatory care area" physically -- and psychologically -- distinct from the low-privacy, high-stress part of the ER where life-threatening cases were treated. Seventeen examining rooms were built. Doctors saw people with sore throats, sexually transmitted diseases, minor injuries, asthma attacks and headaches. The new system could get patients in and out the door in 2 1/2 hours -- and it did so about 50,000 times a year.

Today, the entire ambulatory care area is empty, the victim of TennCare in two ways. The Med no longer has the money or people to run it. And many of the former Medicaid -- and now TennCare -- patients who used to frequent it now have doctors or clinics they must go to first when they have a non-life-threatening illness.

Merigian is proud of what he created but, perhaps curiously, not unhappy to see it gone. The Med's ER, even with its two distinct areas, "basically was a dysfunctional system, as all academic medical centers are," he said, wandering past the shuttered rooms.

"I am not one of the people who thinks an emergency room is the safety net for society. I know there are some very vocal community physicians who believe that. But that's not what emergency medicine is," he said. "People who have MIs [myocardial infarctions, or heart attacks] or strokes can't get good care because they are competing with patients that need less intensive service -- and there are many more of them."

Truly an 'Emergency Room'

TennCare has forced the Med to define "emergency room" with a literalness only a few other American hospitals can imagine.

Already in debt and with the $ 42 million cutback looming, the hospital decided in late 1994 that it would refer clearly non-emergency cases out of its ER. TennCare patients would be referred to their doctors, and uninsured patients would be referred to clinics that might treat them.

The new policy was advertised months before it took effect in March 1995 so that the public could be prepared and the hospital could blunt charges that it was being racist and unfair to the poor. The ER staff was trained in the new, potentially risky protocols governing who would be seen by a doctor and who wouldn't. Merigian sent one of his colleagues to the ER at the University of California at Davis Medical Center, which has had a similar policy in effect since 1988.

An article in the Annals of Emergency Medicine last year described the California hospital's experience. It's a testament to how much medical care can be cut -- or, more precisely, redirected -- with virtually no risk.

Of the 176,000 adults who came to the ER between 1988 and 1993, 31,000 (or about 18 percent) were referred elsewhere without seeing a physician. Review of the records identified 0.4 percent who had been turned away with potentially high-risk conditions, mostly chest and abdominal pain. A few hand fractures also were missed, and six patients had had symptoms requiring hospitalization within a week of their ER visit. Among the thousands of people turned away, none died within 72 hours.

When TennCare arrived, the Med adopted a system virtually identical to that at the University of California at Davis Medical Center. The consequences of the policy, though not as well studied, appear to be similar. Every patient who is referred out is called within 48 hours to see how he or she is doing. Although only 30 percent of people are reached, more than half of those say they have not sought care elsewhere, either because their symptoms have improved or because the visit reassured them that the problem was minor.

The hospital is quite sure it's not missing serious cases. The policy "is not cavalier," said Lynda Park, the medical director of the ER. Furthermore, most people aren't resentful when they're told the reason for it. "One thing our patients understand is being broke," she said.

Nevertheless, it's a new order of things that must be practiced and explained dozens of times a day.

The winnowing, or "triaging" of the patients begins even before a clerk gets the personal and financial information that usually precedes a medical evaluation. New arrivals, unless they're clearly emergencies, go first to a booth where they sign in and where their vital signs -- pulse rate, respiratory rate, blood pressure and temperature -- are measured. Though the purpose of the system is to identify problems that can be treated elsewhere, everything is tipped toward letting people in if there's any possibility they're seriously ill.

Everyone with chest or abdominal pain sees a doctor. Everyone younger than 16 sees a doctor. Anyone who can't walk and anyone claiming to have a high-risk condition such as human immunodeficiency virus -- HIV -- infection gets in. People whose blood pressure, temperature, pulse rate or respiratory rate fall outside prescribed limits must be examined by a doctor, regardless of how well they may appear. There's also room for judgment. The medical technician manning the booth can send someone straight into the ER even if they just look sick.

Most walk-in patients, however, are referred to the triage nurse, whose job requires both medical knowledge and skillful diplomacy.

On this particular morning, Blaylock has seen a 68-year-old woman with hypertension. Several days earlier, the woman had her blood pressure taken for free, and it was found to be elevated. She was told to see a doctor, but hasn't been able to get through to the one she usually sees at a clinic. Her blood pressure does not fall outside the limits.

"It's so very important for you to continue doing what you're doing," the nurse tells the woman. She pats the back of the patient's hand. "Maybe you could go by the clinic today." The woman agrees to do this and leaves seemingly without regret.

Other cases are less clear-cut.

A 21-year-old, part-time freight handler at a local airport arrives soon after the woman with high blood pressure. Three days earlier, he bruised his legs in a collision with a set of mobile stairs. Paramedics had told him to apply ice, which he had done. Now he wants to make sure there's no permanent damage.

Fractures or ligament tears -- which are the patient's worry -- are distinctly unlikely. But when Blaylock examines the man's legs, one feels warmer than the other. A blood clot or an infection could cause this, although it's probably just predictable inflammation from the injury. But the nurse is not going to take chances.

"I'm going to go ahead and check you in," she tells him.

When the man goes to see the check-in clerk, however, she tells him his "managed care organization" -- the company that provides his TennCare medical insurance -- requires approval from his doctor for a non-emergency ER visit. The clerk gets the physician on the phone and hands the receiver through the window. The freight handler describes his problem in a conversation lasting about five minutes. The doctor doubts he has a complication from the accident and schedules him for a clinic appointment in four days. Like the previous patient, this one

won't be seen by an emergency room doctor today.

"I don't mind," the man says, when asked about the resolution of his visit.

TennCare affected how these patients were treated. By such encounters, money is saved and TennCare pursues its difficult goal of providing broader and cheaper medical care to the poor and uninsured in Tennessee.

Many students of American medicine think this is how all hospitals will operate in a few decades.

Hospitals will no longer be places where the worried well, the slightly sick and the deathly ill all are seen and treated. Instead, hospitals will evolve into places where only the very ill will receive medical care. Everyone who can possibly treated outside a hospital will be.

The Med probably will end this year several million dollars in debt. It is no longer threatened with bankruptcy, however. About $ 5 million in GME funding has been restored, and the local government has also contributed money to help assure the hospital's survival. Most important, the Med is more efficient, and in some senses more "competitive" than it used to be.

"We've already done what most public hospitals will have to do in the next few years," said Collins, the senior vice president.

Keeping a Crucial Role

Almost certainly, however, hospitals in the United States will have to retain some of their roles as safety nets, places that won't turn away a sick and penniless person. The Med isn't willing to give up this responsibility, even though fulfilling it threatens its very existence.

This is clear when a 23-year-old man named Christopher Ruff arrives in the triage room. He's wearing a Harley-Davidson T-shirt and is sitting in a wheelchair doubled over in pain. He's from El Dorado, Ark., and has been in Memphis less than two months, working as a sheet metal worker for $ 6 an hour.

The young man explained that an hour earlier he'd been down on his hands and knees scrubbing a weld with a wire brush when he was struck with an excruciating pain in the groin. Several bosses came over and said they'd call an ambulance, but he told them not to because he didn't have the money to pay for it. One asked him if he had medical insurance, and he said no. So they told him to go to the Med. A fellow worker brought him over in a truck.

He could have a hernia. He could have a condition called torsion of the spermatic cord. There's no question that he'll be seen by a doctor. After a brief interview, Blaylock wheels him to the clerk's window where he gives his personal information.

"If it's going to cost me anything, I'm going to leave," Ruff says defiantly, as the clerk inquires whether he has insurance.

"It's $ 85 to be seen. We ask you to pay $ 20 minimum right now," she says. "However, if you can't pay, you will be seen."

"If they let me do it with payments, that's okay," he says, suddenly relieved. He hands the clerk a crinkled $ 20 bill. It may or may not be all that the Med, millions of dollars in debt, gets for this visit. After a few more questions, he's wheeled back into the emergency room.

GRAPHIC: Photo, steve jones for The Washington Post, Before people are treated, nurse Josephine Blaylock must determine whether their problems are serious, regardless of whether they have insurance. Blaylock checks David Metcalf's foot, which he twisted a month before coming to the hospital. Blaylock tells him the injury is not an emergency.

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HEADLINE: When Specialists Aren't the Norm

BYLINE: David Brown, Washington Post Staff Writer

BODY:

"Our plan gives you your choice of doctors. You keep your doctor. You make your decision."

Many attempts to reform medical care in the United States have come with declarations such as that one, made by President Clinton two years ago. A doctor for everyone -- it seems like such an obvious solution to the problem of people who don't get the medical treatment they need.

But if the problem is inadequate medical care, then getting every citizen his or her own doctor isn't the complete solution. The era when one doctor could treat all of a patient's problems ended about a hundred years ago. Today, it takes high-paid specialists, fancy tests, expensive drugs, complicated procedures -- and lots and lots of money.

J.O. Patterson III knows this. But he's not sure that TennCare -- his state's ambitious health care program for the poor and uninsured -- knows it.

"They are selling this [program] to the patients as the answer to their prayers," said Patterson, a 38-year-old internal medicine specialist, as he sat in his office across from the huge Methodist Hospital in Memphis. "The message is: If you were uninsured, now you will have full access to what you need for your medical care. The reality is not quite like that."

The reality is that it's hard to give people everything they need or want under TennCare, the program Tennessee created in 1993 as a better, cheaper substitute for Medicaid, the government-financed health insurance plan for the poor and disabled.

Nevertheless, Patterson and doctors like him are trying. They are replacing the blank-check, sky's-the-limit tradition of American medicine with a penny-pinching ethic that requires a do-it-yourself attitude, time-consuming cajolery and old-fashioned barter. In addition, of course, to everything you have to know to be a doctor.

"I'm aspirating and injecting joints now," Patterson said with a mixture of sheepishness and pride. "I've learned a lot of orthopedics in the last year. It's all self-taught. The first few patients -- I felt like I was experimenting on them."

When he was in medical school, injecting steroids and local anesthetics into painful joints was the province of orthopedic surgeons and rheumatologists. Now, it's his, too. He's boned up on X-ray reading and gotten better at diagnosing tendon, ligament and cartilage problems. He even does the tricky shoulder injections. He now takes care of all the cases of lupus he sees, as well as the severe cases of rheumatoid arthritis -- two diseases that in the past he often referred to specialists. And that's not all.

"I'm going to have to become more comfortable in prescribing psychiatric medicines," he added. "I clearly can't wait until the patients can get in to see a psychiatrist."

This crash course in self-improvement is an essential ingredient in the new world of cost-conscious medicine, of which TennCare is perhaps the nation's most extreme example. TennCare was created to slow the rapid growth of Tennessee's Medicaid budget, and it has done so by forcing economy into the medical treatment of low-income people. The place where that economy happens is in offices like Patterson's.

Slowing Spiraling Costs

TennCare insures 1.2 million Tennesseans -- including all 800,000 eligible for Medicaid, and 420,000 formerly uninsured people who can't afford or can't get commercial medical insurance -- through "managed care organizations." These insurance companies agree to provide all necessary health care for a fixed, per-person annual fee, which they receive from the state's Bureau of TennCare.

Private practitioners (and in some cases, public clinics) contract with the managed care organizations to treat the patients. Primary care doctors such as Patterson get a fixed fee to treat a patient for a year. Specialists, who see TennCare patients only when one is referred to them by a primary care doctor, get paid for each consultation or procedure.

As with all "capitated" insurance plans, the managed care organizations enrolling TennCare patients gamble that they can provide medical care for their members for less money than what they get from the state.

One of the managed care organizations' main strategies for making a profit is to shift care away from high-paid specialist physicians and toward lower-paid generalists, who function as "gatekeepers." No longer can a patient shop the medical supermarket on his own, seeing an orthopedic surgeon for a twisted ankle, a dermatologist for acne and a neurologist for a headache. Most of TennCare's managed care organizations have gatekeeping systems in place. By law, all must have them by the start of next year.

Gatekeeping saves money in two ways. It regulates and keeps track of the use of specific, high-cost services. Equally important, it creates a psychological (and, ultimately, economic) environment that encourages gatekeepers to provide more of a patient's care themselves.

Patterson is a gatekeeper. About 40 percent of the patients in his practice are covered by TennCare. Most belong to Access MedPlus, the second-largest managed care organization.

Patients get to choose which managed care organization will serve them and can change organizations once a year. They also get to choose their primary care doctor from a list of practitioners affiliated with their managed care organization. If they don't choose, they will be assigned one.

A Watchful Eye

As part of its managing function, Access MedPlus requires that a doctor get "pre-certification" from the company before ordering relatively high-cost or over-used procedures such as CAT scans, allergy testing, arthroscopy (using a fiber-optic viewing scope to examine a joint) and colonoscopy (using a similar instrument to look into the large intestine). However, the company permits a doctor to refer a patient to a specialist as long as the referral is "medically justified."

The system gives practitioners relative autonomy. But it doesn't mean they are not being watched. When a doctor refers a patient outside his office, he fills out a form. A copy goes to Access MedPlus's headquarters. Over time, reviewers there develop a profile of the gatekeepers. They see which ones are quick to refer or seem excessively cautious about treating patients on their own.

"You look for patterns of care, not just isolated instances," said Andrea Thaler, assistant vice president for contract compliance at the Tennessee Managed Care Network, Access MedPlus's parent company.

Access MedPlus has not dropped doctors from its rolls based on their referral practices, Thaler said. In fact, the company is only now developing a system for judging practitioners' habits and behavior. She said the system will be "more geared toward education and training than toward disciplining [providers]."

Many managed care health plans elsewhere in the country already are monitoring the behavior of their physicians. Few doctors who take care of TennCare patients doubt that managed care organizations eventually will try to winnow out practitioners they view as incompetent, timid, defensive or free-spending.

In TennCare's early days, however, there was a blunter instrument at work keeping down consultations with specialists. It was a simple shortage of specialists willing to see TennCare patients for the fees the program pays.

Government regulations stipulate that every TennCare patient have access to a full range of medical services. They have to be able to see specialists, just like patients covered by other insurance programs. Finding those physicians, however, isn't always easy. In a few specialties (such as orthopedic surgery and ear, nose and throat surgery), many practitioners have refused to see TennCare patients. Nevertheless, the gatekeeper's job is still to ensure the patient gets what he or she needs. Patterson has found that for some problems, it's easier just to do it yourself.

"In some ways it's like being back in residency, when everything is new and fun," he said of the last two years, when he greatly expanded his clinical skills.

In general, Patterson is happy and comfortable about this change. Nevertheless, he can't help feeling he is party to a deception. It may be a benign and necessary deception, but it still makes him uneasy.

"It's a sometimes daunting responsibility to be entrusted with the care of these patients and to know you are not going to be able to offer state-of-the-art care for their problems," he said. "They may not be able to see the subspecialists who are more skilled in treating their ailments."

In the early days of TennCare, this problem sometimes reached hazardous proportions. Patterson said he won't soon forget one brush with disaster.

Access MedPlus had assigned him to be the primary care doctor for a woman in her sixties. He had never seen her, however, until he got a call from the Methodist Hospital emergency room saying she was there with an acetabular fracture -- a kind of broken hip.

Hip fractures fall entirely outside internal medicine. They're not a problem Patterson would ever treat on his own. Consequently, when he heard about the woman, he asked the ER doctor to call the orthopedic surgeons' group practice that took care of Access MedPlus patients.

When he got to the hospital the next day, he was surprised to learn that the woman hadn't been seen by a surgeon. He asked his secretary to call the orthopedic group he had requested. She was told it no longer saw Access MedPlus patients because it had such a hard time getting paid for its services.

For the next five days, the woman lay in Methodist Hospital as Patterson and his staff frantically looked for a surgeon who would take the case. TennCare headquarters in Nashville provided a list of all the local orthopedists seeing Access MedPlus patients in the Memphis area. The problem was that every one that Patterson called had dropped out of the program.

Eventually, he found two still under contract to the managed care organization. One practiced out of town, the other at Baptist Hospital, Memphis's biggest hospital. Neither had privileges at Methodist. Transferring the woman out of town was impractical, and transferring her to Baptist was not allowed because Access MedPlus had an agreement to hospitalize all its patients at Methodist.

The days passed with the elderly patient lying in the hospital untreated and at risk for blood clots, pressure sores, lung infections and other hazards of immobility. It was becoming a weird and dangerous example of managed care gridlock. Finally, hospital administrators got involved and began negotiating with surgeons.

"Fortunately, there was one renegade orthopedist," Patterson recalled. "At first he said no. The administrator told him: 'Motley, Patterson [the name of Patterson and his partner's practice] admit a lot of patients. They may refer patients to you if you help them out.' "

The doctor agreed to examine the woman with the broken hip, who, it turned out, didn't need an operation. She has recovered uneventfully -- an outcome that pleases Patterson but doesn't reassure him.

"I've been waiting for more disasters like that to come along. It's a bomb ticking, and I hope it doesn't go off when I'm on call." He paused a moment, and then added: "You have to trust that true emergencies will be handled out of innate responsibility."

Many doctors who have been in on TennCare from the start tell stories similar to this one.

Emerging From Chaos

As the program enters its third year, many of its early problems have abated. It's still hard to find an orthopedic surgeon, but a larger number of other specialists are participating. In most cases, providers are paid for their services within 30 days, officials now say. Access MedPlus, the managed care organization on shakiest financial footing, averted bankruptcy this year with a loan from a large hospital.

For Patterson, however, the lean and chaotic early years of the program have permanently changed his practice.

In the last six months, he and his partners have taken on semiofficial specialties within the confines of their group practice. They've done this even though they could probably now find specialists to see most of the patients. Patterson got training in the interpretation of treadmill tests and now administers them and runs a clinic for patients with heart disease. One partner is developing an expertise in skin diseases. Another recently became certified in sigmoidoscopy, a screening procedure for colon cancer usually done by gastroenterologists. Three partners take the patients with gynecological problems.

Although the fees paid by TennCare are still unattractively low in the eyes of many specialists, Patterson and his partners are finding they can bargain to get TennCare patients the care they need. A team of cancer specialists recently offered to take all of the practice's TennCare referrals -- if it also got all the private insurance patients.

Patterson senses, however, that it's always going to be a struggle to make certain that his indigent patients don't get the slightly shorter end of the stick. Doing the right thing by them will take vigilance. This came to mind as he made rounds at Methodist Hospital one morning.

He visited Rosie Johnson, a 47-year-old woman with dilated cardiomyopathy, a condition that periodically makes her breathless with congestive heart failure. It's a bad disease, and hers is getting worse.

She used to be covered by her husband's medical insurance. He was a mechanic for a large paper company in Memphis. But now they're separated, and he has lost his job and the insurance that came with it. With two children younger than 15, Johnson is on public assistance. The last time she worked was two Christmases ago when she wrapped packages at a department store, an activity that even then wore her out.

Patterson took care of her in the hospital twice when she had no insurance. Methodist has an arrangement for indigent patients -- it won't charge them as

long as the doctors don't charge them, either. But now she's on TennCare.

"It helped me. I wasn't able to pay the doctor bill or the hospital bill. I'm all for it," she said of the program, sitting up in her hospital bed.

In some ways TennCare is even better than private insurance. She takes three medicines, and under her husband's plan she had to pay $ 10 for a prescription. Under TennCare, she pays nothing.

Johnson leaned forward, and Patterson listened to her heart and lungs. She was almost ready to leave the hospital. But she would be back.

"She's not long for this world if we don't get her a new heart," the doctor said after he left the room.

An Expensive Procedure

As a relatively young and otherwise healthy person, Johnson is a good candidate for a heart transplant. But Patterson said he doubted she'd ever get one through TennCare.

"She's clearly being helped by the program," he mused as he wrote notes in her chart at the nurses' station. "She doesn't have to worry about coming in as a charity case. On the other hand, we may have problems getting this incredibly expensive procedure done." Then, as if to justify this to himself, he added: "I know there is a limit to the money. I'm sure there has to be some rationing somewhere."

This was a while ago. It turns out that Johnson doesn't want to be considered for a transplant right now. She's worried about the surgery. Furthermore, Access MedPlus has paid for four heart transplants for TennCare patients. One of them cost $ 186,442. (Tellingly, the original bill, before negotiations between the company and the hospital reduced it, was about $ 391,000.)

Getting Johnson a transplant -- should she change her mind and should a match be found -- isn't out of the question.

Nevertheless, Patterson is hedging his bets. He has talked to Methodist Hospital's transplant coordinator, and to the transplant surgeon, about the case. He said they told him that being a TennCare patient wouldn't affect Johnson's chances of getting a new heart, all other things being equal.

"They assured me this should not deter me," he said recently. "They said that if necessary the hospital would eat the cost."

ABOUT THIS SERIES

Medicaid is America's largest welfare program, paying for the health care of 37 million people. Three years ago, alarmed by Medicaid's steadily rising cost and by the growing problem of people without health insurance, the Clinton administration proposed a system of government-regulated, universal health coverage. That effort failed, but a dozen states have received permission to create their own redesigned versions of Medicaid, both to save money and to insure more people. TennCare, Tennessee's new health insurance program for the poor, is the most daring of these experiments. It's also a portrait of the

"managed care" revolution that is changing American medicine.

NEXT: A hospital suffers

GRAPHIC: Photo, steve jones for The Washington Post, Physician J.O. Patterson III examines Lillie Gibson, who has TennCare coverage. J.O. Patterson examines Eddie Henderson at Methodist Hospital in Memphis. About 40 percent of patients in Patterson's practice are covered by TennCare. Rosie Johnson, 47, has a heart condition that periodically makes her breathless, and she may need a heart transplant. Johnson's managed care organization has paid for four heart transplants for TennCare patients.

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BODY:

The state of Tennessee has proved that you really can hammer a round peg through a square hole, as long as you don't mind an awful screeching sound and a fair number of splinters.

Three years ago, Tennessee forecast a huge budget deficit for Medicaid, the health care program for the poor that it, like all states, ran with help and money from the federal government.

The cost of Medicaid in Tennessee was predicted to go up $ 700 million in one year, more than the whole program had cost only eight years earlier. In 1993, the program consumed roughly one-quarter of Tennessee's budget. And things were going to get worse.

"No issue is more urgent, and without a solution, the entire state government in Tennessee remains in jeopardy," then-Gov. Ned McWherter told the Tennessee legislature.

So, in the spring of 1993, McWherter asked state lawmakers to allow his administration to design an alternative to Medicaid. A month later, and with little debate, the legislature granted McWherter's request.

By the beginning of 1994, Tennessee had "TennCare," the boldest health care reform any state has ever undertaken.

In less than three years, TennCare has stopped the hemorrhage of money in Tennessee's Medicaid program, saving state and federal taxpayers about $ 1 billion. It has cut the growth of state spending on health care for the poor to about 5 percent a year.

But the program has done more than that. It also has tried, with some success, to solve the problem of the "medically uninsured" -- those people who must pay cash, rely on charity or go without treatment when they become ill. The uninsured were about 12 percent of Tennessee's population in 1993 and about 13 percent in the country as a whole.

Today, TennCare pays for the health care of the state's 800,000 former Medicaid patients and heavily subsidizes the coverage of an additional 420,000 formerly uninsured people. Remarkably, this has been done for roughly the price

Tennessee and its federal partner would have paid for Medicaid alone.

It's impossible to tell how much illness and death has been avoided -- or how much has been hastened -- as a result of TennCare. But some indicators suggest that health care for the poor has not suffered and may have improved. In the program's first year, compared with the 1993 figures under Medicaid, emergency room visits and hospitalizations declined. Among elderly participants, the annual number of prescriptions per person increased. Preventive services for children, such as immunizations, rose fourfold. Infant mortality fell.

It's not coincidence that TennCare has pursued the twin goals of cheaper medical care and expanded coverage. In the minds of many experts, the two are inextricably linked.

According to this view, the permanent existence of nonpaying "customers" in the medical economy creates a tangled system in which some patients are overcharged and others aren't charged enough. The result is neither socially just nor economically efficient -- and perhaps not medically optimal, either.

Medicaid serves 37 million people at a cost of about $ 156 billion a year. It is the country's biggest welfare program -- about twice the size of those that dole out cash to the poor. State and federal governments split the tab. Medicaid consumes 19 percent of the average state's budget, a portion that has been growing steadily.

To slow this trend, many states have sought "waivers" from the federal government that allow them (with certain restrictions) to refashion Medicaid as they see fit. Since January 1993, 12 such requests have been granted. Like Tennessee, many states have sought to expand insurance coverage while simultaneously placing patients in cost-conscious, highly regulated programs of "managed care." Such programs seek to control health care costs by limiting which specialists, treatments and drugs they will pay for.

Of the 37 million Americans on Medicaid, about 8 million now are in some sort of managed care program, up from 280,000 15 years ago. This trend is likely to continue. In its last session, the Maryland General Assembly enacted a law that requires all Medicaid patients to be in managed care programs by Jan. 1.

The new state programs do not address all the reasons for Medicaid's explosive growth. TennCare, for example, does not include people in nursing homes whose bills are paid by Medicaid -- a growing and expensive portion of the Medicaid population.

Nevertheless, in strategy if not in detail, TennCare is where Medicaid is headed. In rough sketch, it's also a picture of where much of American medicine is headed. The managed care revolution happened without warning in Tennessee. The changes it wrought in the lives and habits of patients and doctors are occurring, in subtler form, across the United States.

An Elastic Commodity

Health care is an elastic commodity. The amount and type of care a person "consumes" depends greatly on what is available. Many people go long periods without seeing a doctor, getting a prescription, having a diagnostic test or undergoing a therapeutic procedure. When those opportunities are available,

however, people tend to use them.

Furthermore, the menu of health care services is constantly growing as research gives birth to new therapies, drugs and procedures. It's not always clear that these innovations are better than the old way of doing things, or better than doing nothing at all. Nevertheless, things in medicine have a way of becoming "essential" very soon after they become possible.

Managed care plans such as TennCare, however, challenge these habits and assumptions. They view frequent consultations with specialists, many non-generic drugs and long hospital stays as relatively expendable -- and a good place to cut costs. At the same time, managed care plans seek to assure a person's access to drugs, consultations and procedures of known worth.

TennCare hoped that by using such a strategy it could offer no-frills coverage to as many as 1.7 million people -- double the number of people on Medicaid -- for the previous cost of covering Medicaid patients alone. The federal government, however, was doubtful and lowered the ceiling to 1.3 million. Even that was too ambitious. TennCare virtually stopped enrolling uninsured Tennesseans at the end of its first year because if it had signed up everyone who wanted to get into the program it would have gone bankrupt.

Today, there are still about 304,000 uninsured people in Tennessee -- about 6 percent of the population. The program's failure to reach its goal of universal health coverage has had serious, if unintended, consequences. Memphis's public hospital, for example, is trying to survive on TennCare fees that are even lower than those Medicaid paid but must still carry a large burden of "charity cases," whom it treats for free.

The Bureau of TennCare is a state agency in Tennessee's Department of Finance and Administration. It employs no doctors and treats no patients. Instead, it distributes money to "managed care organizations," which are private companies that contract with doctors, nurses and hospitals to treat patients. Unlike health maintenance organizations in some states, none of the 12 managed care organizations employs physicians on its staff or owns clinics and hospitals.

Every managed care organization gets a fixed amount of money per patient -- a "capitation" -- from the TennCare bureau each year, which it uses to pay for all the care a person will need. Not surprisingly, the size of the capitation is crucial. On it depends the solvency of the system, the profitability of the managed care organization and the earnings of participating doctors, nurses and hospitals who agree to take care of TennCare patients.

Based on what the Medicaid program had been paying out each year for each patient, TennCare's designers initially came up with a "gross capitation" of $ 1,641 per person. This was comparable to the $ 1,636 average annual premium for people in health maintenance organizations nationwide in 1993.

But the $ 1,641 was whittled down for various reasons.

One was the "automatic" savings expected to come from a managed care system. Next, some local governments were expected to provide money to hospitals treating large numbers of low-paying TennCare patients -- so the capitation was further reduced. Similarly, uninsured people would pay small premiums and co-payments once they were on TennCare. (Medicaid patients would continue to get

the coverage free.)

Also cut from the $ 1,641 was part of the value of "charity care," the subsidy that had been built into Medicaid rates to help cover the community's cost of caring for uninsured people. The rationale was that, under TennCare, there would be few or no charity cases because the uninsured would become insured.

What was left was an average capitation of $ 1,214 per TennCare patient per year, an amount that many people argued was simply not enough to do the job.

Low-income people -- which describes nearly all TennCare patients -- tend to have more illness than higher-income people. In addition to welfare mothers and their children, the Medicaid population includes large numbers of disabled and chronically ill adults. TennCare's patients looked to be a population that was more expensive than average, but doctors and hospitals would be getting below-average fees to take care of them.

Furthermore, there was no guarantee that premiums and co-payments could actually be collected from TennCare's formerly uninsured patients, who were close to the poverty level. And hospitals and doctors would still have "charity cases" at their doors because there were still going to be uninsured people in Tennessee.

Though Medicaid's rates were indefensibly low in the minds of many, TennCare's were going to be even lower. In pursuit of doing more without spending more, TennCare used several tools. The most important one was very simple: It would simply pay less to doctors, nurses, clinics and hospitals.

"What TennCare in effect did was reallocate money from a large, politically influential health care industry to a poor or near-poor population that did not have a lot of political influence," recalled Gordon Bonnyman, a lawyer who at the time worked for the Legal Aid Society of Middle Tennessee and functioned as one of the main spokesmen for the people who would become TennCare's patients.

The boldness of this move explains, in part, why it was formulated and put into effect in just a few months.

"We understood that as we grew closer to implementation, and various interest groups grew more and more restive, there would be an effort to undo the plan or radically change it," said David Manning, who was Tennessee's commissioner of finance and administration in 1993 and one of TennCare's two main architects. (Today, he is vice president of Columbia/HCA Health Care Corporation.) "The only way we could ensure the integrity of the plan was to be certain it was well on its way to implementation before the legislature could act [to amend it]," he said.

Unprepared for Arrival

Unveiled in late 1993, this brave new world of medicine hardly could have landed in a place less prepared for it.

Most of Tennessee's doctors were in private practice and had little experience with cost-conscious, rule-heavy insurance plans. Only 6 percent of the state's population was in some sort of managed care health plan.

Many doctors vowed not to participate in TennCare because its fees would be so low. The state had little leverage to convince them otherwise. But the biggest medical insurer in Tennessee did.

Blue Cross and Blue Shield wanted a piece of the TennCare market (and now has about 50 percent of it). The inducement it used to persuade physicians to treat the TennCare patients is now universally, if indelicately, referred to as the "cram-down provision."

The insurer had a plan, called the Tennessee Preferred Network, in which patients paid a smaller portion of their bills if they chose doctors from the network list. The network enrolls 554,000 people, of whom working and retired state employees -- about 113,000 -- are the largest single group. Blue Cross said that if a doctor wanted to be in the network, he or she had to agree to take TennCare patients, too.

Soon after TennCare began, nearly one-third of the 6,842 doctors in Blue Cross's network dropped out of it -- simultaneously refusing to see TennCare patients and protesting what they viewed as blackmail on the part of the insurer. This led to acute shortages of some specialists, particularly orthopedic surgeons. The Blue Cross managed care organization was not alone in facing this problem. More than six months into TennCare, the second largest managed care organization -- a company called Access MedPlus -- had enticed only eight of the 291 orthopedists practicing in the state's seven urban counties to sign up for TennCare patients.

Over time, however, the leverage worked. Blue Cross's network now has 6,664 physicians on the rolls -- 97 percent of the pre-TennCare number.

Nevertheless, the first-year walkout by many of Tennessee's doctors had an effect. The Bureau of TennCare acknowledged that its capitation rates were unsustainably low. Since the program's inception there have been two increases, raising the average capitation to $ 1,416.

In this battle over fees, specialist physicians have lost the most. The managed care organizations pay them per patient visit or per procedure, and the reimbursement is about 35 percent of the amount that the average doctor bills. Primary care doctors, in contrast, are paid a flat fee -- essentially a capitation -- to care for a person for a year. So far, the capitation has been high enough to attract enough primary care physicians to make the system work.

Low fees, however, are not the only mechanism for keeping TennCare within its budget. The program also puts a brake on prescription drugs, which are a huge expense. (As an example, the Blue Cross managed care organization spends more on drugs -- about 24 percent of its budget -- than it does on doctor bills -- about 19 percent.)

The mechanism is the "formulary" -- a list of drugs compiled by each managed care organization from which a physician must prescribe unless permission is granted to use an unlisted medication.

Formularies favor generic medicines, which are almost always cheaper than those covered by patents and sold by a single company. In most (but not all)

categories of drugs, there are generics available. As a rule, a physician must prove that a formulary drug has failed, or is inappropriate, in order to prescribe a pricier, off-formulary alternative.

To stay within its budgetary constraints, TennCare also counts on taking in money, not just paying it out as parsimoniously as possible.

People who qualify for Medicaid pay no premiums, deductibles or co-payments for their medical insurance. The uninsured whose incomes are above federally established poverty levels pay monthly premiums ranging from $ 3 for an individual just over the poverty line, to about $ 275 for a family of four whose income is three times the poverty level. Deductibles range from $ 250 to $ 500. At incomes above four times the poverty level, subscribers pay the full "market value" of TennCare policies.

In TennCare's chaotic first year, only $ 18 million was collected of $ 45 million due from clients. Officials say collections are improving. Though TennCare is subsidized insurance for the needy, the program is not beyond acting like its brethren in the commercial world. To date, it has canceled the policies of about 45,000 people for nonpayment.

Rough Beginnings

TennCare essentially was created overnight. So were all but two of its 12 managed care organizations. Stories of inconvenience and confusion in the program's first year are legion. Neither patients nor doctors fully understood the rules of the game when the starting whistle blew.

The 24-hour telephone line of one managed care organization saw its number of calls rise from 2,000 per day before TennCare to 60,000 per day in the program's first month. Doctors came and went from the program as they waited months to receive even small payments owed. Abuses in the early days, when managed care organizations furiously recruited patients, included the fraudulent enrollment of 10,000 people, including 2,500 nonexistent homeless persons and numerous prisoners.

"Do you want happy stories or unhappy stories? Because I have file drawers of both," said Bonnyman, the former Legal Aid lawyer.

He recalled the experiences of two women in his office. One woman, who had no insurance even though both she and her husband worked, signed up with a managed care organization. She got her enrollment card in three days. She subsequently gave birth to a child who had a serious lung disease and was hospitalized three times in the first year. The child got first-rate care.

Just down the hall, a second woman "went through the trials of Job" trying to get her grandchild, whom she cared for, enrolled in the program, Bonnyman said. In one week, the woman received 19 TennCare enrollment cards, none of which was valid.

"The first year of TennCare was something like a tornado going through a subdivision," he said. "One house is flattened and blown into the next county, while at the one across the street the big plastic toys are still lying around unmoved in the front yard."

Every managed care organization lost money the first year. The second largest one, Access MedPlus, only escaped bankruptcy this year because Memphis's Methodist Hospital stepped in and bailed it out.

At the same time, TennCare offered some clear benefits over Medicaid even apart from the fact that a lot more people were being covered.

The old program limited the number of outpatient hospital services, doctor visits and prescriptions a person could have. TennCare had no such limits. Unlike Medicaid, TennCare covered inpatient psychiatric care for adults. The "benefit package" has continued to expand. This year, TennCare added high-dose chemotherapy and autologous bone marrow transplant as a covered treatment for certain women with advanced breast cancer. Many health care plans -- including many far richer than TennCare -- still view this as an experimental procedure and don't pay for it. TennCare is convinced of its usefulness, and does.

Statistics from TennCare's first year of operation suggest there was no dramatic worsening of health care for Tennessee's poor, and there are indications that the situation is getting better. A subjective, though important, assessment of TennCare comes from surveys of people in the program.

A telephone survey, published last November by two professors at the University of Tennessee in Knoxville, showed less than wild enthusiasm for TennCare, especially among former clients of Medicaid. However, it also showed that TennCare had measurably improved since its early days.

For example, the proportion of former Medicaid patients who said TennCare was better than or equal to Medicaid rose from 49 percent in 1994 to 68 percent. In both years, 60 percent of the formerly uninsured said TennCare was an improvement compared to their previous status.

In 1994, 46 percent of people reported they could get an appointment with their primary care doctor either the day they called or the next day. This rose to 52 percent last year. Over the same period, the length of time a person had to wait beyond the scheduled appointment time to see the doctor (or nurse) fell from 105 minutes to 63 minutes.

In 1995, 71 percent of Tennesseans rated their medical care "excellent or good." That opinion was held by 62 percent of TennCare members.

Nevertheless, TennCare's overall reputation -- both inside and outside Tennessee -- has been that of a low-budget semi-disaster cobbled together on the fly.

"When the people who are benefiting are the poor and disenfranchised -- and the people who are losing are physicians and health-care interest groups with all their cultural authority to speak on these matters -- it's not surprising that the overall prism that people have looked through is negative, and remains so," Bonnyman said recently.

Even TennCare's staunchest advocates agree there have been a lot of problems. But every trend, they argue, is heading in the right direction.

"It's a work in progress. It's a picture half painted," said Rusty Siebert, a former venture capitalist who served as the program's second director until resigning last month. "It will get better and better."

ABOUT THIS SERIES

Medicaid is America's largest welfare program, paying for the health care of 37 million people. Three years ago, alarmed by Medicaid's steadily rising cost and by the growing problem of people without health insurance, the Clinton administration proposed a system of government-regulated, universal health coverage. That effort failed, but a dozen states have received permission to create their own redesigned versions of Medicaid, both to save money and to insure more people. Tenncare, Tennessee's new health insurance program for the poor, is the most daring of these experiments. It's also a portrait of the "managed care" revolution that is changing American medicine.

NEXT: The physicians adapt

GRAPHIC: Photo, steve jones for The Washington Post, SHIFTS IN TREATMENT Although it's difficult to assess TennCare's impact on health care for poor people in Tennessee, the program's arrival had some measurable effects. They include: ER VISITS: In one year, the rate at which Medicaid patients under age 21 visited hospital emergency rooms was cut nearly in half. (It dropped from 900 visits per 1,000 Medicaid patients in 1993 to about 500 visits per 1,000 TennCare patients in 1994.) For people between age 21 and 64, ER visits dropped more than one-third. PRESCRIPTIONS: The annual number of prescriptions per person below age 64 decreased under TennCare. For people over 64, however, it increased -- a change that perhaps reflected a TennCare policy that did not limit the number of prescriptions a patient could receive, as Medicaid had. HOSPITAL STAYS: For everyone under 64, the rate of hospital admission, and the number of days in the hospital, fell by roughly one-third in TennCare's first year, compared with the last year of Medicaid. For people under 21, the average number of "physician services" (such as office visits and diagnostic procedures) fell from nine per year under Medicaid to six per year under TennCare. For people age 21 to 64, the decrease was even more dramatic -- 16 to nine. PREVENTIVE CARE: The rate of "preventive services" (such as immunizations) for people under 21 increased more than fourfold. PRENATAL CARE: Manuel Martins, a principal architect of TennCare and the program's first director, recently compiled the rates of infant deaths and low-birth-weight babies in 1993, Medicaid's last year, and 1994, TennCare's first. Infant mortality fell from 9.4 per 1,000 live births to 8.9 per 1,000 births. The number of low-birth-weight infants stayed the same, at 8.8 per 100 live births. RECIPIENTS RATE THEIR CARE Previously uninsured Tennesseans give TennCare favorable reviews, according to polling data. Opinions are mixed among former Medicaid recipients. TennCare compared

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