



University of Tennessee, Knoxville  
**TRACE: Tennessee Research and Creative  
Exchange**

---

Chancellor's Honors Program Projects

Supervised Undergraduate Student Research  
and Creative Work

---

Spring 5-1999

## **TennCare and TennCare Partners- Success or Failure?**

Daniel Lewis Stanton  
*University of Tennessee - Knoxville*

Follow this and additional works at: [https://trace.tennessee.edu/utk\\_chanhonoproj](https://trace.tennessee.edu/utk_chanhonoproj)

---

### **Recommended Citation**

Stanton, Daniel Lewis, "TennCare and TennCare Partners- Success or Failure?" (1999). *Chancellor's Honors Program Projects*.  
[https://trace.tennessee.edu/utk\\_chanhonoproj/345](https://trace.tennessee.edu/utk_chanhonoproj/345)

This is brought to you for free and open access by the Supervised Undergraduate Student Research and Creative Work at TRACE: Tennessee Research and Creative Exchange. It has been accepted for inclusion in Chancellor's Honors Program Projects by an authorized administrator of TRACE: Tennessee Research and Creative Exchange. For more information, please contact [trace@utk.edu](mailto:trace@utk.edu).

# UNIVERSITY HONORS PROGRAM

## SENIOR PROJECT - APPROVAL

Name: Daniel Stanton

College: Arts and Sciences Department: College Scholars

Faculty Mentor: Dr. Glenn Graber

PROJECT TITLE: TennCare and TennCare Partners-  
Success or Failure?

I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

Signed: , Faculty Mentor

Date: 5/11/99

Comments (Optional):

Daniel Stanton

TennCare and TennCare Partners – Success or Failure?

Mentor – Dr. Glenn Graber

Honors/College Scholars Thesis

Spring 1999

## Table of Contents

Abstract	i
Introduction	1-3
TennCare Overview	4-10
TennCare Partners Program Overview	11-20
Cost Analysis of Health Care	
National Trends in Medicaid Spending	21-25
Tennessee's trends in Medicaid Spending	26-31
The Capitation Rate	32-39
Quality and Access of Care	40-48
TennCare and TennCare Partners Analysis	49-56
Appendix	57

## Abstract

Were the TennCare and TennCare Partners programs effective or fruitless in their attempts to transform the health care industry into both a more effective and more efficient mechanism of delivering health care?

This paper gives a brief synopsis of the drastically changing health care environment of our nation - the rapidly escalating costs of health care combined with the lack of universal coverage of all citizens. It explains the massive switch from traditional fee-for-service plans to current capitated managed care techniques by focusing on Tennessee's ambitious and innovative attempt to remedy this health care dilemma through two programs labeled TennCare and TennCare Partners. An overview of both the TennCare and TennCare Partners programs are delineated along with goals and objectives of each. The three major goals of each of the programs - 1)cost containment, 2)increased access, and 3)quality standards - are examined and evaluated in detail along with the author's conclusions of both of the programs accomplishments and inadequacies.

## TennCare - Success or Failure?

### **Introduction**

The economics of the entire health care industry has changed drastically since its inception long ago, but current changes have been rather intense and fairly sudden. With the recent annual increases in health care expenditures, as illustrated in table 1, widespread implementation of new payment system techniques has been necessary. The leading transformation of the health care industry has come in the form of managed care and the capitated care environment, and thus both a reevaluation as well as a restructuring of the industry's practice patterns and treatment standards has occurred. This has by no means been a simple process for anyone, but the widely varying degrees of adversity among plans has been quite startling to all. This is especially true for the massive state level Medicaid programs. National Medicaid growth, as shown in table 2, has been atrocious since its inception in 1966. These Medicaid programs are unique in that they commonly treat the uninsured or uninsurable population. This slender

fraction of the populace are often placed in distinctive dilemmas because they are either unaware of how to fully utilize the health care system or for some further reason are incapable of accessing the system at all.

With so many interwoven variables at play, the contrasting measures of achievement among the statewide programs should be of no great surprise. However, one may dare say that all of the states have been at least *partially successful* in their attempts to both control costs and improve access while maintaining at minimum a parallel quality status of health care for their inhabitants. In the mid 1970's not one state had a managed care Medicaid program in progress, by 1995 46 states had switched to this strategy along with nearly 13.3 million people across the nation (this is the most current year in which national data is available, see table 3 in appendix)<sup>1</sup>. Total enrollees in health maintenance organizations exclusive of the Medicaid program have also grown substantially during this period - from 6 million persons in 1976 to over 75 million in 1995, and growth has been even greater in the mental health and substance abuse market - nearing

---

<sup>1</sup> Thompson F, DiIulio J. Medicaid and Devolution - A View from the States. The Brookings Institution, Washington D.C., 1998.

50 percent of all Americans or approximately 130 million people<sup>2</sup>. As illustrated by these statistics, the growth of managed care across the nation has been both rapid and widespread. This document will attempt to restrict this seemingly infinite subject by focusing on just one state's outcome, Tennessee, and comparing its values to other states results and national trends.

---

<sup>2</sup>Shore M. Managed Care, the Private Sector, and Medicaid Mental Health and Substance Abuse Services...



### **TennCare Overview**

On January 1, 1994, Tennessee made history by beginning a program labeled TennCare, which was one of the first statewide health care reforms to replace the traditional Medicaid program already in existence. TennCare was an innovative and ambitious strategy to extend health care coverage for Tennesseans while simultaneously controlling costs and maintaining significant quality standards of medical care<sup>3</sup>. This switch from the traditional Medicaid program to the new managed care strategy essentially transformed the state's health care industry from a seller's market into a buyer's market, and by doing so would hopefully achieve the aforementioned goals of cost containment, expanded access, and analogous quality standards. Under prevailing federal law the program would have been unconstitutional because of the forbiddance of the managed care concept; however, the program was deemed constitutional under a Section 1115 waiver of the Social Security Act granted by the Health Care Financing Administration (HCFA) of the United States government.

---

<sup>3</sup> Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." *JAMA*. 1995;274:1235-1241.

One may wonder, "Why the sudden switch to managed care?" There are actually multiple justifications for this. As is the case in most governmental action, necessity simply became the 'Mother Of Invention' as stated by Gordon Bonnyman in the Journal of Health Affairs 1996. [Bonnyman is a managing attorney at the Tennessee Justice Center in Nashville, and was formerly on the staff of the Legal Aid Society of Middle Tennessee. He has played an integral role in the implementation and surveying of the TennCare program.] Years of rapidly escalating costs in the health care arena were creating an intense budget crisis that threatened the solvency of the entire state government. As was the case in most states, Medicaid had become the second fastest growing item (Education was first) in the Tennessee budget. Compounding this problem was the fact that Tennessee faced losing nearly \$500 million in funding from the federal government due to new federal laws trying to curb 'creative financing' techniques of which Tennessee was a profound user. [Creative financing techniques include disproportionate-share hospital (DSH) payments and other enhanced provider payment schemes to induce hospitals and other facilities such as nursing homes to partially fund the state's Medicaid costs.] Therefore, it was thought by both Tennessee Governor Ned McWherter and his staff

that the drastic change involved in TennCare was necessary for the stabilization of the state's budgetary crisis. The sudden implementation period was ingeniously used by Governor McWherter to assure the initiation of the program at all.

A rough proposal of the TennCare program was quickly passed through a closing legislative session with only hazy objectives and simplistically stated goals. The proposal was then refined by McWherter and his staff before the 1993 session ended on the belief that unless the state was decisively committed to TennCare's implementation when the legislature reconvened in late January for its 1994 session, lawmakers would face irresistible pressure to revoke their earlier authorization of the program<sup>3</sup>. In other words, once the simplistic program was hastened through the legislature it would be much more difficult for the program to be repealed than waiting and trying to pass the final product after opposition might (and probably would) have arisen - a simple political tactic used masterfully by the McWherter campaign. To further influence the implementation process, Governor

---

<sup>3</sup>Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." *JAMA*. 1995;274:1235-1241.

McWherter went to Washington to pressure the Clinton Administration to approve the waivers necessary to begin the plan. Less than two weeks after the Governor visited the White House, on November 18, 1993, the Health Care Financing Administration sanctioned the waivers necessary to execute the plan<sup>3</sup>. Due to these two vital circumstances - a budgetary crisis and crucial timing - TennCare was facilitated at a considerably accelerated pace toward a swift and sparsely debated beginning.

As Bonnyman delineates, aside from these above mentioned situations, three other favorable market conditions existed that enabled TennCare to be as successful as it has become. First, the state of Tennessee had a substantial excess capacity in the health care system. This fact was most significant in the hospital sector, where national averages of bed occupancy were a mere 47% for licensed beds<sup>4</sup>. Since much of a hospital's expenses are fixed costs that are incurred whether or not a bed is occupied, the marginal cost of treating an additional patient in what would

---

<sup>3</sup>Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." *JAMA*. 1995;274:1235-1241.

<sup>4</sup> Cleverley, *The 1994 Almanac of Hospital Indicators*, 233, 237.

have otherwise been an empty bed is only a small fraction of the rate paid by almost any insurance company - or in this case the state's old Medicaid program now labeled TennCare. Thus a large purchaser, such as the Medicaid population of the state of Tennessee, should easily be able to negotiate a contract with most vendors at well below the prevailing Medicaid rates, at prices only incrementally higher than the hospital's marginal costs<sup>5</sup>.

Second is the economics involved with the purchasing power generated by such a high volume of market share. With the centralization and concentration of the Medicaid market through TennCare's capitation and the state's purchasing of insurance for all state employees, several advantages immediately materialized. Of course, the sheer volume of customers allowed for the financially renowned 'purchasing power' and thus an overall ability to negotiate decreased prices. This 'purchasing power' was only magnified by the fact that physicians were told they would not be allowed to participate in the Tennessee Preferred Network (TPN) should they choose not to treat TennCare

---

<sup>5</sup> Gordon Bonnyman Jr. "Update - State Report - Stealth Reform: Market-Based Medicaid In Tennessee," Health Affairs (Summer 1996): 306-314.

patients<sup>5</sup>. This second point also relates to the vast transformation of the state (as well as the national) health care system into a capitated environment (capitation is explained in more detail in section labeled The Capitation Rate). The traditional fee-for-service plans of yesterday were quickly being devoured by not only individual providers who were merging into wholly integrated delivery systems but also managed care systems seeking out new business in this now extremely price-sensitive marketplace. There was also the significant notion that once bonds and relationships had been formed between provider and customers and the rules and regulations for service had been embedded into memory, change may have seemed both unwanted and unnecessary as well as costly to customers for such similar medical 'products'. Market shares would therefore need to be formed quickly for fear of never capturing any substantial portion at all. Because of these above listed circumstances, the ready made customer pool located in traditional Medicaid programs were highly valued and inordinately attractive

---

<sup>5</sup>Gordon Bonnyman Jr. "Update - State Report - Stealth Reform: Market-Based Medicaid In Tennessee," Health Affairs (Summer 1996): 306-314.

to the current groups and organizations collectively becoming known as managed care organizations<sup>5</sup>.

The third favorable market condition that Bonnyman asserts has led to the partial success of the program was the sensitivity of clinical practice patterns to follow financial incentives. After capitated payments became widespread, medical treatment patterns quickly shifted from high intensity/high cost methods to lower intensity/lower cost settings. Inpatient care has been shifted markedly to outpatient facilities such as surgicenters which provide comparable care at strikingly reduced prices. With the complicated combination of these several factors TennCare was expected to achieve its primary goals of increased access, cost containment, and comparable quality. Although the overall premise of the plan may have appeared infeasible and initial results may have been less than ideal, expectations for the future performance of the plan are still rather encouraging.

---

<sup>5</sup>Gordon Bonnyman Jr. "Update - State Report - Stealth Reform: Market-Based Medicaid In Tennessee," Health Affairs (Summer 1996): 306-314.

### **TennCare Partners Program Overview**

In July of 1996, Tennessee made history once again by initiating the TennCare Partners program, which was a managed mental health and substance abuse 'carve-out' of the larger TennCare program<sup>6</sup>. [There are generally two types of mental health and substance abuse (MH/SA) plans - 1)carve-outs, which consolidate all MH/SA services into a separate program and out-source the treatment from other treatment such as general medical care, and 2)an integrated health care system which combines all forms of health care into a single unified system of treatment. While both have their advantages and disadvantages, if run properly they should produce somewhat similar results.] The TennCare Partner's Program was merely regarded as a temporary solution from the beginning and was actually scheduled to join the TennCare program in early 1999, but this date has

---

<sup>6</sup> Chang C, Kiser L, Bailey J, Martins M, Gibson W, Schaberg K, Mirvis D, Applegate W. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services." JAMA. 1998;279:864-869.



been postponed for several months due to unforeseen administrative difficulties<sup>7</sup>.

Arons et al. stated in the journal of Health Affairs (1994), "Over time, the delivery of care and financing of mental health and substance abuse care have evolved into a complex patchwork of services. The result has been gaping holes in the public system for the poor and private insurance that runs out too quickly for many who could benefit from care." This statement delineates perfectly the status of the TennCare Partners program today.

TennCare Partners has been bombarded with severe criticism from the get-go. An enormous loss of continuity of care has been noted as well as a vast disintegration in the traditional 'safety net' of system care. It has undergone several design changes, and has also been heavily influenced from outside sources in its overall evolution and execution<sup>8</sup>. Other

---

<sup>7</sup> Tennessee Justice Center, Inc. "Medicaid Managed Behavioral Health Care: The TennCare Demonstration."

[http://www.chch.org/CHCS/gb\\_final.htm](http://www.chch.org/CHCS/gb_final.htm).

<sup>8</sup> Chang C, Kiser L, Bailey J, Martins M, Gibson W, Schaberg K, Mirvis D, Applegate W. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services." JAMA.

1998;279:864-869.

problems foreseen in the program but difficult to evaluate include 'adverse selection' and 'moral hazard', each of which is discussed below.

Adverse selection, also labeled 'cherry picking' in the industry, is characterized by the concept that health insurance plans have incentives to discourage high-cost enrollees from joining, thus undermining the entire principle of health insurance - to collectively pool a group of people such that statistical data can be used to average health care costs over the entire populace. Many mental health problems are persistent and therefore likely to be predictable to particular individuals. By promoting easy access and high quality to low intensity/low cost care while at the same time creating difficult access and low quality of high intensity/high cost care, health insurance plans can effectively produce a quality 'twist' to render this adverse selection dilemma<sup>9</sup>. If the health care industry is merely enrolling the healthy individuals to increase profits [or rather to decrease costs], the overall purpose of the industry is totally disregarded. There are multiple techniques to overcome this unwanted

---

<sup>9</sup> Frank R, McGuire T, Bae J, Rupp A. "Solutions for Adverse Selections in Behavioral Health Care." Health Care Financing Review/Spring 1997/Volume 18, Number 3: 109-122.

side-effect, however. A MH/SA carve-out is actually one method used to surmount this obstacle. Carve-outs abet this feat by budgeting out funds specifically for use on mental health and substance abuse treatment and services; thus ensuring a specific amount of care. The downside to carve-outs is that they add another layer of administrative costs onto the already thick bureaucratic pie. One other means used to curb adverse selection is known as risk adjustment. This philosophy tries to 'buffer' insurance companies from either exorbitant costs (losses) or excessive payment collection (profits) by adjusting the capitation payment based on certain demographic characteristics - e.g. age, sex, welfare status, and county of residence, and by doing so in effect protect both consumers and providers from financial catastrophes<sup>10</sup>. Although this technique appears promising and is gaining some acceptance, one unfortunate difficulty is that little attention has been paid toward MH/SA care or costs<sup>11</sup>

<sup>10</sup> Frank R, Huskamp H, McGuire T, Newhouse J. "Some Economics of Mental Health 'Carve-Outs'." Arch Gen Psychiatry/ Vol 53, Oct 1996:933-937.

<sup>11</sup> Frank R, McGuire T, Bae J, Rupp A. "Solutions for Adverse Selections in Behavioral Health Care." Health Care Financing Review/Spring 1997/Volume 18, Number 3: 109-122.

(explained in detail later). Also, the TennCare Partners program has not implemented any sort of risk adjusted premiums to the behavioral health organizations, which obviously indicates the lack of data on this subject for the state of Tennessee.

The additionally recognized potential problem of the TennCare Partners program labeled 'moral hazard' appears more easily remedied. This 'moral hazard' is the responsiveness of utilization to insurance coverage and payment. (The more co-payments and deductibles patients are required to pay the less likely they will be to utilize that particular aspect of care.) The RAND Health Insurance Experiment demonstrated that utilization of MH/SA treatment was twice as responsive to cost-sharing provisions as ordinary medical care<sup>12</sup>. By forming large networks of specialty providers who are willing to accept lower prices and by using particular techniques such as care management and utilization review, Tennessee managed care companies in the behavioral health field pledge to make more cost-effective choices while preserving access and maintaining quality of care. One such example of this

---

<sup>12</sup> Frank R, Huskamp H, McGuire T, Newhouse J. "Some Economics of Mental Health 'Carve-Outs'." Arch Gen Psychiatry/ Vol 53, Oct 1996:933-937.

'moral hazard' remedy involves the Massachusetts State government. After contracting with a carve-out firm to provide MH/SA benefits to almost 200,000 state and local employees, benefit payouts were reduced by 40%, and with no detectable decreases in the rate at which their enrollees entered treatment<sup>12</sup>. This case vividly illustrates the cost containment capabilities managed care may bring into the health care field. Of course, distinct results will occur in every experiment, but this demonstration explicitly displays the positive capabilities that managed care presents for patients and administrators alike. Unfortunately, as of yet, only inadequate data has been collected for the TennCare Partner's Program, but complete surveys of results are expected soon.

As briefly mentioned earlier, one further problem facing the behavioral health care industry has been the lack of routine sources of financing and expenditure information similar to that for health services generally even though MH/SA services are a significant component of all health care services. Policy makers

---

<sup>12</sup> Frank R, Huskamp H, McGuire T, Newhouse J. "Some Economics of Mental Health 'Carve-Outs'." Arch Gen Psychiatry/ Vol 53, Oct 1996:933-937.

must therefore deal with this lack of pertinent information which in turn has created numerous demanding obstacles to surmount. The first problem encountered is old spending estimates of mental health and substance abuse care. Even the most recent data is nearly fifteen years old. This creates assumptions based on past data that are probably inaccurate with present trends because of the massive shift in all of the health care arena. This problem is slowly being remedied as managed care organizations as well as other independent survey organizations have begun to collect and compare data on this understudied subject. The next difficulty deals with how the data was collected in many of these past studies. Each of the analyses usually only provides a snapshot of the mental health and substance abuse expenditures; none attempted to assess trends for future reference. This enigma is only compounded when combined with the last and possibly the most confusing predicament, the use of different definitions and methodologies in each of the surveys. These discrepancies make it nearly impossible to identify trends by comparing the separate surveys, and thus rendering the data almost completely inconsequential for current utilization<sup>13</sup>. Lags in

---

<sup>13</sup> McKusick D, Mark T, King E, Harwood R, Buck J, Dilonardo J,

research notwithstanding, the distinct impression in the financial community is that potential savings associated with managed care in the mental health and substance abuse environment are considerably larger than in overall health care<sup>14</sup>. When Massachusetts converted to a statewide Medicaid managed care program with a carve-out for MH/SA services for 375,000 enrollees in 1992, in the first year alone it showed cost savings of 22% below past expenditures based on future projections (taking into account the higher administrative costs of the managed benefit)<sup>14</sup>.

Although TennCare Partners has been marked as essentially a complete malfunction, much has actually been learned for future endeavors. One unfavorable lesson realized from the TennCare Partners program was that states contemplating similar reforms should consider beginning with a substantially more modest program to ensure a better transition between care. Also, for any MH/SA carve-out to be deemed even

---

Genuardi J. "Spending For Mental Health And Substance Abuse Treatment, 1996." *Health Affairs*, Vol. 17, Num 5, 1998:147-157.

<sup>14</sup> Frank R, McGuire T, Newhouse J. "Risk Contracts in Managed Mental Health Care." *Health Affairs*, Volume 14, Number 3, 1995:50-64.

partially successful it must promote accountability, decrease bureaucracy, and provide effective mechanisms for risk adjustments and moral hazard. Other problems encountered by the TennCare Partners program as well as other state carve-outs (such as the Massachusetts plan) include long delays in reaching the utilization review staff by telephone, excessive and time-consuming paperwork, conflicting responses from different utilization staff, differences between oral agreements and final written approvals, and slow or nonexistent transmission of paperwork to providers<sup>15</sup>. These obstacles could have been avoided had more time been available instead of political pressures for a quick implementation. However, under these particular circumstances this program's difficulties should be expected with any program this size, and in the end should work themselves out over time as the process becomes more refined and technologically capable. The state of Tennessee trusts that with the consolidation of the TennCare Partners program into the state's TennCare program, an improved health delivery system

---

<sup>15</sup> Callahan J, Shepard D, Beinecke R, Larson M, Cavanaugh D.

"Mental Health/Substance Abuse Treatment In Managed Care: The Massachusetts Medicaid Experience." *Health Affairs*, Volume 14, Number 3, 1995:173-184.



that is wholly integrated will result. To ensure this outcome, however, residents of Tennessee should exert significant political pressures to demand greater accountability of their health care system. Thus, an overall improvement will ensue in the welfare of the state's residents by both promoting accountability and decreasing bureaucracy as stated earlier to be crucial for success of the program.

## Cost Analysis of Health Care

### National Trends in Medicaid Spending

As Boyd comprehensively denotes, national trends in Medicaid spending have been explosive. The average annual rate of Medicaid growth has been more than 16 percent from 1966 to 1996, a rate far greater than the combined rate of growth in the population plus inflation, which was only 6.5 percent over this same period<sup>16</sup>. At this rate expenditures on Medicaid would double at approximately every four and a half years. Growth from Medicaid's first full year in 1966 through 1974 averaged 25.5 percent annually<sup>17</sup>. This astronomical growth was due to several factors

---

<sup>16</sup> Boyd D. Medicaid Devolution - A Fiscal Perspective.

Washington DC: Brookings Institution Press: 1998. For 1966 spending, see Congressional Research Service, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, Committee Print, House Committee on Energy and Commerce, 103 Cong., 1 sess. (Government Printing Office, January 1993), p. 83. 1996 total computable spending (including administration) obtained from <http://www.hcfa.gov>.

<sup>17</sup> Congressional Research Service, *Medicaid Source Book*, p.83.

including: 1) a great increase in the number of single-parent families receiving cash assistance under the welfare program entitled Aid to Families with Dependent Children (AFDC) who were categorically eligible for Medicaid, 2) a rapid growth in medical prices, and 3) the high cost of nursing home care<sup>18</sup>. Between 1975 and 1981 growth expenditures began to slow, averaging only 15.8 percent per year, but still was well above the combined growth in population and prices which was at 10.1 percent. This enormous growth in Medicaid spending was now beginning to place tremendous pressure on both federal and state budgets alike. Fortunately, growth between 1981 and 1988 slowed substantially to an average annual rate of only 9 percent. During this period growth in the number of new recipients of Medicaid coverage was a mere .6 percent per year, thus helping to keep the overall growth of the program under control. However, the cost per recipient was growing at an average annual rate of 8.2 percent a year, a

---

<sup>18</sup> Congressional Research Service, *Medicaid Source Book*, pp. 85-86, based on total computable expenditures including administration. See Teresa Coughlin, Leighton Ku, and John Holahan, *Medicaid since 1980: Costs, Coverage, and the Shifting Alliance between the Federal Government and the States* (Washington: Urban Institute Press, 1994), pp. 87-99.

number worthy of serious consideration and due in part to two important policy changes - 1) the federal government's enactment of the Omnibus Reconciliation Act of 1981 (OBRA81), which gave substantial incentive to slow program growth by reducing federal reimbursements to states whose spending growth exceeded targets tied to the medical care component of the consumer price index, and 2) a series of enactments that either mandated or allowed states to expand eligibility for pregnant woman and for children<sup>19</sup>. Medicaid expenditures again skyrocketed during the years 1988 to 1993, growing at a compound annual rate of 19.3 percent that resulted in a growth of 142 percent in only five years<sup>20</sup>. As shown in table 4, growth was particularly rapid in 1991 and 1992, averaging 27 percent per year<sup>21</sup>. The Kaiser Commission on the Future of Medicaid divided this explosive growth

---

<sup>19</sup> Thompson F, DiIulio J. Medicaid and Devolution - A View from the States. The Brookings Institution, Washington D.C., 1998.

<sup>20</sup> HCFA, *Health Care Financing Review*, table 109.

<sup>21</sup> 1991 and 1992 growth rates obtained from Health Care Financing Administration, *Health Care Financing Review, 1996 Statistical Supplement* (Baltimore, Md.: Department of Health and Human Services, Office of Research and Demonstrations, 1996), table 109. 1995 growth rate obtained from HCFA, *Medicaid Statistics: Program and Financial Statistics, Fiscal Year 1995*, table 1.

over the five year period into these four major components: 38 percent was due to an increase in recipients, 24 percent from medical price inflation, 22 percent from the ballooning growth of payments to hospitals serving disproportionate share of the indigent (DSH), and the remaining 16 percent from a combination of increased service use, growth in reimbursement rates above medical inflation, and increased premium payments for Medicare and HMOs<sup>22</sup>. Fortunately, there has been a recent slowdown in overall Medicaid spending. Increases in national Medicaid expenditures have slowed to about 10 percent annually from 1993 to 1995, and slowed even further in 1996 to just .1 percent. This essential slowdown in the past few years has been due to three dominant themes. One, the DSH payments have trailed off dramatically in recent years due to recent federal limitations on the program expenditures. DSH payments grew tremendously in two years from \$902 million in 1990 to a tremendous \$17.4 billion in 1992 (up nearly 2000 percent), and then steadied substantially. By 1995 DSH payments had grown only slightly more, to \$19 billion in 1995 (up only 9 percent), and then finally

---

<sup>22</sup> Thompson F, DiIulio J. Medicaid and Devolution - A View from the States. The Brookings Institution, Washington D.C., 1998.

DSH payments decreased to \$15 billion in 1996 (down nearly 22 percent)<sup>23</sup>. Two, the growth in costs for low-income children came to an almost complete halt, and costs for low-income adults actually declined. This complete turnaround is due to more stringent state welfare policies, and an improving economy which has led to a decrease in the total number of national Medicaid recipients. Third, there was some slowing in the growth of the elderly and disabled recipients and in their average costs, which had been one of the fastest growing categories in the preceding years. (For a brisk synopsis of these Medicaid growth periods see appendix, table 2.)

---

<sup>23</sup> The source for the 1995 DSH number is HCFA, Medicaid Statistics 1995 (1995), table 3, HCFA form 64; the source for 1996 is the computer-readable version of same, obtained from <http://www.hcfa.gov>.

### Tennessee's Trends in Medicaid Spending

Bonnyman reiterates that Medicaid has always been summarized by a high extent of interstate variation in eligibility, aid, and degree of federal funding. The percentage of Medicaid costs endured by the federal government deviates from 50 percent in the more prosperous states to 79 percent in the most impoverished states and averages 57 percent nationwide, with states making up the remainder. Tennessee's federal matching percentage was 67.7 percent in 1993<sup>24</sup>. Tennessee was among the top seven states in 1993 percentage of poverty population covered by Medicaid. Tennessee covered 63 percent of its poor, while Medicaid as a whole covered only 54 percent of the nation's poor<sup>25</sup>. Tennessee was one of only thirty-seven states that encompassed the medically needy and

---

<sup>24</sup> Congressional Research Service, *Medicaid Source Book:*

*Background Data and Analysis* (A 1993 Update) (Washington: U.S. Government Printing Office, 1993), 485-486.

<sup>25</sup> J. Holahan and D. Liska, *State Variations in Medicaid:*

*Implications for block Grants* (Washington: The Urban Institute, February 1994), Figure 4. Poverty figures are based on numbers of people below 150 percent of the federal poverty line.

was also relatively generous in its coverage of children and pregnant women.

Mark Daniels notes [in *Medicaid Reform and the American States*] that during the five year period from 1987 to 1992, Medicaid expenditures in Tennessee increased 500 percent, from \$500 million to \$2.5 billion. This escalation was credited, in part, to the rationale affiliated with the universal escalating price of health care in the United States. These reasons included the use of costly, sophisticated technology; ingenious but expensive treatment of illnesses such as heart disease and kidney failure; the increasing frequency of AIDS and cancer; the increasing amount and longevity of the elderly persons who have an exceptional necessity for health care; and the therapy of ailments and impairments caused by alcohol and drug abuse<sup>26</sup>. In addition, this increase was due to the spiraling numbers of individuals eligible for Medicaid. During this period [from 1987 to 1992], a report issued by the Tennessee Department of Finance and Administration (DFA) estimated that the number of

---

<sup>26</sup> James M. Hoefler and Khi V. Thai, "Introduction to the Politics and Economics of Health Care Finance: A Symposium," *Journal of Health and Human Resources Administration* 16, no. 2 (1993): 116, 117.



Medicaid-eligible individuals increased by 70 percent, from 507,934 to 878,981 individuals, close to 20 percent of all Tennesseans<sup>27</sup>.

Tennessee's Department of Finance and Administration also projected that Medicaid's five-year trend from 1987 to 1992 would result in a 220 percent increase in cost by 1997, or approximately \$5.5 billion, as illustrated in table 5 of appendix. Based on the assumption that the federal share of Medicaid would remain fixed at \$2.5 billion, this \$3 billion swelling would be handled with by a \$851 million tax increase and health care benefit cuts of \$2.6 billion<sup>28</sup>. The most profound consequence of these massive benefit cuts would be the loss of coverage for many thousands of Medicaid recipients, reductions in the rates of reimbursements for providers of health services, and further cost-shifts to insured patients<sup>28</sup>.

---

<sup>27</sup> Tennessee Department of Finance and Administration, *TennCare: A New Direction in Health Care* (Nashville: State of Tennessee, 1993):95.

<sup>28</sup> Daniels M. *Medicaid Reform and the American States*. Auburn House, Westport, 1998:251-259.

Bonnyman notices by contrast to the extravagant matching funds of Tennessee's Medicaid program, Tennessee dawdled behind most states in the benevolence of its Medicaid rates and benefits prior to TennCare. The state ranked only forty-second in the nation in total Medicaid expenditures per enrollee<sup>29</sup>. Tennessee's disproportionate-share hospital payments per uninsured person placed it thirteenth in interstate comparison and made Tennessee a "high DSH state"<sup>30</sup>. However, after adjusting for the offsetting effects of hospital taxes, aggregate hospital payments were only 84 percent of the hospital industry's reported costs, compared with a national Medicaid average of 93 percent<sup>31</sup>.

As indicated in table 5 of the appendix, TennCare has been projected to reduce annual health care expenditures in the state of Tennessee by \$2.8 billion by fiscal year 1997-1998, with a cumulative savings of

---

<sup>29</sup> GAO, *Medicaid: Spending Pressures*, 18-19.

<sup>30</sup> Holahan and Liska, *State Variations in Medicaid*, Figure 7; and CRS, *Medicaid Source Book*, 324.

<sup>31</sup> Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to Congress* (Washington: ProPAC, June 1995), 133.

\$7.2 billion by the end of the five year demonstration period<sup>32</sup>. Similarly, federal costs would decrease by \$1.9 billion in the fifth year of the plan, with a cumulative savings of \$4.8 billion. Thus, the program anticipated substantial cost savings for both the state and federal governments. An analysis by the United States Government Accounting Office indicated that of four states with broad waivers as of mid 1995, only TennCare could realistically be expected to reduce federal Medicaid expenditures over the life of the demonstration project<sup>33</sup>.

As shown by these astounding statistics, TennCare was expected to be relatively successful in its use of managed care to contain Medicaid spending costs. The results thus far have not completely met expectations but are nonetheless on the appropriate track. Significant cracks in the fiscal base of the program emerged immediately, however, and in the first year alone, TennCare incurred a deficit of \$99 million. Although, this was due in part to unanticipated billing

---

<sup>32</sup> Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." JAMA. 1995;274:1235-1241.

<sup>33</sup> Medicaid: Spending Pressures Drives States Toward Program Reinvention. Washington, DC: US GAO; 1995.

errors which attributed to the failure in collection of \$37 million in premiums from enrollees<sup>34</sup>. The state maintains, however, that this shortage is meager when contrasted with what the deficit would have been had the old Medicaid system remained in place. The state also claims that after just the first eighteen months of the program an estimated \$1.6 billion in state and federal funds had been conserved based on the projection of the expected growth rate in conventional Medicaid expenditures. The current annual budget of the TennCare program has reached a level of nearly \$3.7 billion in 1998, well below the projected annual budget of the traditional Medicaid program at \$7.7 billion<sup>34</sup>. This experiment's results are obviously no trivial feat thus far, and hopefully the outcome will proceed to travel in both the appropriate direction and continue to accelerate its beneficial momentum.

---

<sup>34</sup> Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." JAMA, 1995;274:1235-1241.

### The Capitation Rate

The essence of the TennCare program lies in its capitation rate. [The capitation rate is the fixed, predetermined payment made to a vendor of health care (managed care organizations in this case) in exchange for medical services for a designated period of time. This capitation rate is also known as the per-member, per-month (PMPM) fee.] After months of negotiations with HCFA over the projected annual budget, an initial annual budget for TennCare of \$2,192,950,800 was established. Based on this annual budget, the state installed an annual capitation rate of \$1641 per person. This capitation rate was then discounted by the anticipated continuing charity care, local government contributions, and average co-payments by beneficiaries, so that the average per capita rate actually paid to managed care organizations for each enrollee was initially set at \$1214 per year<sup>34</sup>. This rate was then 'risk adjusted' based on several demographic factors such as race, gender, age, et cetera. For example, the rate of children aged 1

---

<sup>34</sup>Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." JAMA, 1995;274:1235-1241.

through 13 years was \$607 per year while that for the blind and disabled was \$3789 annually. [All providers, ie, physicians, hospitals, and so forth, are paid by the MCOs based on negotiated rates; the state is not involved in establishing provider rates.]

The capitation rate is perhaps the most critical - and controversial - issue of the TennCare program. The state compared its proposed capitation rate to its prior experience with the state run plan for state employees as well as prior experience with Medicaid populations. The Insurance Administration of the Tennessee Department of Finance and Administration determined that the average health benefits paid by the state per state employee in fiscal year 1991-1992 was \$1194.40. After out-of-pocket expenses of \$268.86 are added and inflationary costs to 1994 dollars are also included, the total per capita cost for the state employee plan comes to \$1664 a year, almost exactly the same as the initial TennCare per capita rate of \$1641<sup>34</sup>. This TennCare figure of \$1641 per member also coincides extremely well to the national average for health maintenance organizations - \$1636 per enrollee

---

<sup>34</sup>Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." JAMA, 1995;274:1235-1241.

per year<sup>35</sup>. Thus, the state argued that the anticipated TennCare rates would be comparable to both reported Medicaid and state employee per capita rates in Tennessee (taking into account Tennessee's specific demographics), as well as to commercially managed care fees across the nation.

The managed care organizations involved with TennCare argued fervently that the initial capitation rate of \$1641 per member per year was substantially below expected costs of treating their patients. The managed care organizations questioned the validity and the value of the comparisons, stating only limited correlations were truly accurate. Mirvis rationalizes the seven crucial distinctions between the state comparison group and the actual TennCare population.

First, TennCare was going to provide a more extensive assortment of benefits than did the traditional Medicaid program. By logical deduction, one must assume that with additional services must come additional costs. Second, enhanced entry to assistance by the formerly uninsured might swell use of services over that under Medicaid. This theory, as the managed care organizations asserted, implied that the increase

---

<sup>35</sup> *Managed Care Digest*. Kansas City, Mo: Marion Merrell Dow; 1994.

in availability of medical services would also increase the usage of these services. Third, the TennCare population would presumably be more heavily ailing than either the state employee group or enrollees in commercial health maintenance organizations due to a lack of knowledge of the system as well as a generally substandard welfare status contrasted to the comparison group. Fourth, it has been asserted that the state profoundly miscalculated the former expenditures of Medicaid. The state had presumed that all preceding beneficiaries had received an entire year of coverage, when in actuality the average duration of coverage was only 8.7 months. Hence, true annual expenditures per person were notably larger than the state had originally calculated. Data from the United States Government Accounting Office, for example, list 1993 per capita spending on health care at \$2943 - considerably higher than the TennCare capitation rate. Fifth, whereas the base capitation rate of \$1641 may be around other similar benchmarks, the real rate reimbursed to managed care organizations was reduced by approximately 25 percent to \$1214 per enrollee. This in turn meant that MCOs would have to secure their provided services at a reduction of 25 percent over prevailing rates, a discount that is substantially higher than the cost savings reported by other managed



care systems at this time<sup>36,37</sup>. Sixth, the entire system of capitation did not contribute for the start-up costs of the managed care organizations. This alarmed the managed care organizations because start-up costs were postulated to be fairly significant. Finally, the inclusion of a 5 percent charity contribution entices cost shifting into the design and recognizes that some citizens will continue to be uninsured or underinsured despite TennCare<sup>38</sup>. [Cost shifting is when one agency reduces its own expenditures by inducing another agency to pay for similar services<sup>39</sup>.] However, Mirvis contends that the health conditions of the potential TennCare beneficiaries may not be sufficiently represented by

---

<sup>36</sup> *Assessing the Design and Implementation of TennCare.*

Washington, DC: National Association of Public Hospitals; 1993.

<sup>37</sup> Hurley RE, Freund DA, Pual JE. *Managed Care in Medicaid.* Ann Arbor, Mich: Health Administration Press; 1993.

<sup>38</sup> *Assessing the Design and Implementation of TennCare.*

Washington, DC: National Association of Public Hospitals; 1993.

<sup>39</sup> Norton E, Lindrooth R, Dickey B. *Cost Shifting in a Mental Health Carve-Out for the AFDC Population.* Health Care Financing Review/Spring 1997/ Volume 18, Number 3.

the current group of Medicaid recipients because many qualified enrollees join into Medicaid only after they become ill. Thus, enrollment of healthy eligible citizens may reduce the overall severity level, and cost, of the total eligible TennCare population. For instance, children and their parents from low-income single-parent families - a group that may parallel newly covered citizens - comprised 72 percent of Medicaid beneficiaries but only 32 percent of Medicaid payments<sup>40</sup>. Mirvis also remarks that other monetary concerns may also have a bearing on the accomplishments of the program. The suggested annual rate of development of the global TennCare budget is tied to the expansion of the state's economy. This justification, while delineating comprehensive outlays, is separate from future health system needs. Health care costs may run either below or above the general state growth, and therefore should not be linked directly to the state's health care budget as debated by the managed care organizations. Finally, not all health care costs are funded through TennCare. For example, long-term care is funded under traditional Medicaid reimbursement rules, so that MCOs do not have

---

<sup>40</sup> Blendon RJ, Donelan K, Hill C, et al. Medicaid beneficiaries and health reform. *Health Affairs (Millwood)*. 1993; 12:132-143.

full control over all resources to care for their enrollees<sup>41</sup>.

Arguments such as these are quite convincing for both sides, but a decision had to be made and in the end the government always seems to prevail. The initial capitation rate of \$1641 went into effect at the program's initiation, and considering that several of the original MCOs, shown in table 6, are still providing services for the TennCare program, one must surmise that the initial rate must have been somewhat accurate. To fully understand how competitive this market has become, one must also note that several of the managed care organizations have reported financial deficits in the millions of dollars. The 'Survival of the Fittest' will eventually weed out all but the strongest of these managed care organizations, and unfortunately this rule has already begun to take effect. One of the MCOs has already gone out of business and several others are in precarious financial situations. However, this is part of the business world, and events such as this must occur to ensure the most economically efficient and effective markets. As shown in table 7, national stock prices of HMOs have

---

<sup>41</sup>Mirvis D, Chang C, Hall C, Zaar G, Applegate W. "TennCare - Health System Reform for Tennessee." JAMA,1995;274:1235-1241.

consistently outperformed the overall markets index, at a level almost three times as high today. Moving back to Tennessee statistics, table 8 illustrates that although costs per patient per day have steadily increased at a pace of approximately 10 percent a year for the past years, they have begun to level off to rates near 3 percent today. Table 8 also shows a substantial decline in the average daily census of patients per day seen in Tennessee hospitals, which indicates the enormous financial savings of the TennCare program.

### Quality and Access of Care

By the end of its first year, TennCare enrollment had reached 1.27 million people, including 850,000 former Medicaid recipients and 419,000 persons formerly uninsured. This translates into slightly more than 25 percent of the state's almost 5 million residents. Also, the increase in the percentage of Tennesseans under the age of 65 with health insurance increased from 89 percent in 1993 to 95 percent in 1994 - *the highest of any state*. A telephone survey conducted by the University of Tennessee's Center for Business and Economic Research in August of 1994 indicated that between private insurance and TennCare, 94.6 percent of the state's total population were covered by some form of health care coverage - *once again the closest level any state had reached toward universal coverage of its population*<sup>42</sup>. Figures have since indicated a fluctuation in enrollment from 1.27 million persons in 1994 to 1.18 million in 1995, down nearly 80,000 enrollees. This was due in part to the newly elected Governor Don Sunquist, who has quietly attempted a

---

<sup>42</sup> W. Fox and W. Lyons, "A Survey to Determine Insurance Status of Tennessee Residents" (Knoxville: University of Tennessee Center for Business and Economic Research, August 1994).

number of tactics to reduce enrollment. These strategies include the following as expounded by Gordon Bonnyman: "higher premiums and more aggressive collection from waiver eligibles, more stringent eligibility verification, and closure of enrollment to new uninsureds"<sup>43</sup>. The enrollee population has since been expanded to nearly 1.29 million residents of which 818,00 are Medicaid eligibles and 470,000 are uninsured/uninsurable<sup>44</sup>.

On February 5, 1996, a little more than two years after the program was started, TennCare released the first reports compiled from patient data submitted by the MCOs. The plans were required to report all encounters not just samples, and this information was to provide the foundation for TennCare's quality assurance program. However, the state had formerly declined to distribute the figures to HCFA, state politicians or the populace stating that the data was unfinished or questionable, and demanded further

---

<sup>43</sup> Bonnyman G. Center For Health Care Strategies. TennCare: Where It Stands Today - - March 1996.

[http://www.chcs.org/CHCS/gb\\_march.htm](http://www.chcs.org/CHCS/gb_march.htm)

<sup>44</sup> TennCare Fact Sheet. TennCare Home Page.

<http://www.state.tn.us.health/tenncare>

development. The reports are suspected of declaring that primary care access under TennCare was superior to both that seen by former Medicaid recipients or comparable figures reported by a commercial managed care plans<sup>45</sup>. At the time of its release, however, the details supplied by the managed care organizations had not yet been substantiated, and the publicity spin of the state reports had brought abundant suspicion among the public.

Although no official reports were released at the program's inception, tremendous problems promptly surfaced. The managed care organization's ability to serve their enrollees were supposedly grossly inadequate when the program began. There were also critical marketing exploits, some amounting to fraud, in a number of communities. Access to particular medical services, or even hospital care, was troublesome in some areas. Serious disruptions arose for the continuity of care for the especially vulnerable populations, as were the revenues of essential providers who served them. The state encouraged hundreds of thousands of previously

---

<sup>45</sup> Bonnyman G. Center For Health Care Strategies. TennCare: Where It Stands Today - - March 1996.

[http://www.chcs.org/CHCS/gb\\_march.htm](http://www.chcs.org/CHCS/gb_march.htm)

uninsured residents to apply for the new coverage, but it was several months before computer systems and administrative procedures were developed to handle the situation and process the applications. In one particular example, a state contractor had failed to inform enrollees of their premium liability or even where to send their payments for several months. Patient encounter data, which was essential to the state's ability to monitor quality assurance and access statistics, were supposed to be submitted by managed care organizations' standard electronic format as stated above. However, the incomplete data received eventually led to the state's partially withholding capitation payments to further compel the collection and compilation of the information. Recently, however, TennCare has had reports released stating that primary care access under the new program is superior to that enjoyed by Medicaid beneficiaries before the plan was implemented as well as superior to comparable figures reported by commercial managed care plans<sup>45</sup>. These surveys, as shown in table 9 of appendix, show that the perceived quality of care for both heads of households as well as their children are rated at rates slightly

---

<sup>45</sup> Bonnyman G. Center For Health Care Strategies. TennCare: Where It Stands Today - - March 1996.

[http://www.chcs.org/CHCS/gb\\_march.htm](http://www.chcs.org/CHCS/gb_march.htm)



below former Medicaid proportions. It is not surprising that satisfaction with TennCare itself is lower than for the former Medicaid program, given the fact that TennCare places its patients in a managed care environment which obviously restricts patient autonomy somewhat. Although the satisfaction assessments for TennCare were somewhat below the previous Medicaid program levels of satisfaction in the first year of the programs existence, they are nonetheless on the rise. The survey results, table 9, show a definite positive trend toward patient satisfaction over not only the individual years observed, but also the life of the project as an entirety to rates which are comparable to former Medicaid satisfaction levels of the past.

Chang et al<sup>46</sup>. unfortunately acknowledge that although TennCare has become a potentially successful health reform program, the TennCare Partners program has all but deteriorated into a crisis. The 10 percent retention of capitation payments such as in the

---

<sup>46</sup> Chang C, Kiser L, Bailey J, Martins M, Gibson W, Schaberg K, Mirvis D, Applegate W. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services." JAMA. 1998;279:864-869.

TennCare program has unfavorably continued until today for the Premier behavioral health organization involved in the TennCare Partners program because of the plan's noncompliance with its contractual obligations to its enrollees. Premier, in turn, has withheld this 10 percent from its network providers, and has also given the state notice of intent to terminate its contract in June of 1999. State officials are dismissing the statement as mere posturing, however. This example ominously illustrates the dire state of affairs for the entire TennCare Partners program. The TennCare Partners plan has been marred with difficulties in quality since its inception. As described beforehand, many patients did not obtain care or lost continuity of care for quite some time, and the traditional 'safety net' for mental health nearly vaporized. Numerous added difficulties stemmed from the state's attempt to preserve the primary regulatory control, reducing the ability of the behavioral health organization managers to design and implement the state's plans effectively. For instance, the state permitted enrollees to appeal behavioral health organization denials of service and then overturned many of these denials. This clearly diminished the behavioral health organization's capability to competently perform any model of case management. The state also mandated that patients

could not be moved from their previous levels of care during the first three months of conversion. These and other state regulations undoubtedly hampered the behavioral health organization's ability to successfully manage behavioral health care and operate case management appropriately<sup>46</sup>.

TennCare Partners has been pronounced by Chang to be cursed by three serious blemishes<sup>46</sup>. First, the program lacks a single centralization point of accountability. TennCare Partners detaches responsibility for an individual's physical and mental health care between a paired BHO and MCO that are paid by a capitation basis separately by the state. These 'partners' in turn quarrel amongst themselves about service and payment responsibilities, irrevocably leading to cost shifting. As Mechanic states, "The dispersion of mental health care among so many different sectors and varying budget streams allows many opportunities to shift costs and responsibilities to others, which also gives the appearance of cost

---

<sup>46</sup> Chang C, Kiser L, Bailey J, Martins M, Gibson W, Schaberg K, Mirvis D, Applegate W. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services." JAMA. 1998;279:864-869.

savings<sup>47</sup>." Secondly, TennCare Partners spreads its global budget across the entire population covered by TennCare and links Behavioral Health Organizations (BHOs) capitation revenues to overall TennCare enrollment. This leads to a dire problem - should the TennCare enrollment level rise, the BHOs theoretically should benefit financially, and should the TennCare enrollment level fall, the opposite should ensue. The predicament that develops from this cycle is that there only appears to be a downside for the BHOs. The TennCare enrollment level is capped by budgetary constraints whereas enrollees are always able to drop out at their discretion. This leads to a vicious series that leaves the behavioral health organizations in an unfortunate and ill-fated situation. The third and final problem that has been expressed by Chang et al. with the TennCare Partners program is that it uses a single capitation rate with no risk adjustment to pay all of the behavioral health organizations. As discussed previously in the capitation section, an appropriate capitation rate is vital for the assurance of both quality care and company survival. With the simplistic capitation rate of the TennCare Partners

---

<sup>47</sup> Mechanic D. *Emerging Trends In Mental Health Policy and Practice*. Health Affairs - Volume 17, Number 6, 1998: 82-98.

program the differences of severity of illness are entirely ignored. This is a detriment to both the payor and the enrollee. Obviously the vendor loses dramatically in the financial aspects of business if only being paid a single rate to treat multiple levels of illness with most of the patients falling on the 'severely ill' end of the spectrum. This would inevitably lead to adverse selection, an entirely undesirable side effect. The enrollees who are severely ill, known as the 'priority population', lose in turn because of this adverse selection dilemma. Thus, with the disproportionate loss of healthier enrollees and the retention of the more ailing population, BHOs stand to further lose in their total capitation payments contrasted with their total expenses. These scatterings of design flaws, along with severe tight budgetary constraints that have made little provisions for reserve funds and start-up costs, have inescapably exposed the patients, providers, as well as the individual behavioral health organizations to unreasonable amounts of risks<sup>48</sup>.

---

<sup>48</sup> Chang C, Kiser L, Bailey J, Martins M, Gibson W, Schaberg K, Mirvis D, Applegate W. "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse Services." JAMA. 1998;279:864-869.

## TennCare and TennCare Partners Analysis

For one to completely understand the potential of these two programs it is first vital to review the most fundamental aspect, the political staying power. Mark Daniels states the first implication realized from Tennessee's experience was that the politics of health care is just as important as its content or structure<sup>49</sup>. TennCare and TennCare Partners have thus far weathered the transition from a Democratic to a Republican Administration, and advocates' adoration of market conditions agree favorably with this new political climate of cost containment and budgetary regulations. As Bonnyman so articulately states, "TennCare has been linked to *perestroika* in the former Soviet bloc: It is a reform process that, once initiated, is difficult to reverse. Indeed, like the 'shock therapy' being administered to East European economies, the very chaos and dislocations that TennCare has produced confound those who would turn

---

<sup>49</sup> Daniels M. Medicaid Reform and the American States. Auburn House, Westport, 1998:251-259.

back the clock<sup>50</sup>." Thompson reiterates this element with the following narration, "Governors and legislatures in such states as Tennessee and Minnesota have, for instance, served as catalysts for innovations that strive to achieve a better balance among access, quality, and cost in the Medicaid program. In shaping the program, state policy makers respond to multiple factors, including the policy legacy of their state as reflected in previous decisions of political leaders concerning Medicaid and the institutional configurations that have evolved over time from these choices<sup>51</sup>." This political power is not something to be taken lightly; without such influential governmental strength TennCare possibly might not have been implemented at all, let alone survived until today.

Added dimensions that should also be observed of the two plans involve the attainment of their goals and objectives as well as where the programs are going to be directed in the future. As shown above, the programs differ markedly in the attainment of their

---

<sup>50</sup> Bonnyman G. "Update -State Report-Stealth Reform:Market-Based Medicaid In Tennessee,"Health Affairs(Summer 1996): 306-314.

<sup>51</sup> Thompson F, DiIulio J. Medicaid and Devolution - A View from the States. The Brookings Institution, Washington D.C., 1998.

separate purposes. Whereas TennCare has achieved substantial cost containment, noticeably increased access for the uninsured/uninsurable, and preserved parallel quality standards; TennCare Partners has all but dissolved entirely. Fortuitously, TennCare Partners is scheduled to presently fuse with TennCare to fashion one, wholly integrated system of care for the entire state of Tennessee. A myriad of researchers believe the consolidation of the two programs to be a long overdue necessity. Although David Mechanic speaks of mental health and substance abuse programs in general and not specifically on the TennCare Partners program, his ensuing quote is nonetheless quite appropriate, "Hospital and community care are poorly coordinated, and hospital care needs to be integrated into a more balanced system of services<sup>52</sup>." Hopefully, this union will alleviate the somber difficulties associated with the unconsolidated program such as the lack of continuity of care [at least this problem should not occur again], shortage of care in catastrophic instances, or deficiency in either access to essential mental health/substance abuse care or MH/SA treatment centers.

---

<sup>52</sup> Mechanic D. *Emerging Trends In Mental Health Policy and Practice*. Health Affairs - Volume 17, Number 6, 1998: 82-98.



One final, and feasibly most pivotal element to survey is the public and physician response to the massive transformations that have transpired through these two unique programs. Although enrollee support of the TennCare program was truly disturbing at its inception, since then advocacy has flourished tremendously. In TennCares first year only 49 percent of TennCare clients claimed that the care provided under TennCare was either the same as or better than the care provided under the previous Medicaid system, whereas 51 percent stated that the care given through TennCare was worse than the care previously provided under Medicaid<sup>53</sup>. As of 1998, slightly more than 80 percent of the TennCare population affirmed they were satisfied with their health coverage<sup>54</sup>. It is of the utmost importance that the people for which these programs are meant to operate are pleased with the results, and judging by the these astounding statistics these same individuals seem to be content with the

---

<sup>53</sup> Pearson R. Health Care II: Status of TennCare. The Frank M. Norfleet Forum for the advancement of health. UTM, 1995: 14-23.

<sup>54</sup> Department of Health - Tennessee. More TennCare Enrollees Say Quality of Care Excellent. Nashville, March 11, 1998.

<http://www.state.tn.us/cgi-bin/hea...wwwroot/health/news/items/tc14.txt>

results that have occurred. One technicality that should be acknowledged, however, is that few patients actually utilize the care that it is afforded, and therefore patient satisfaction data may be skewed slightly. If a client is not seeking medical help, than he/she will probably reply in a positive fashion when surveyed of his/her health care coverage. Nonetheless, these feasible miscalculations should statistically occur in coinciding proportions from program to program, so overall trends of performance may be compared with reasonable accuracy.

While patients appear to be fairly appeased with the program as a whole, physicians differ noticeably in conviction. In 1994, a survey was taken of physicians across the state, and 86 percent of Tennessee doctors noted TennCare as either unsatisfactory or totally unacceptable<sup>55</sup>. This original disapproval by physicians was due to several significant factors, but it is likely that this was just an initial reaction to the possibility (and likelihood) of a decrease in salaries. First, while multitudinous suggestions were provided by the Tennessee Medical Association, not one single substantive physician recommendation was

---

<sup>55</sup> Pearson R. Health Care II: Status of TennCare. The Frank M. Norfleet Forum for the advancement of health. UTM, 1995: 14-23.

included in the TennCare program<sup>55</sup>. Secondly, physicians were troubled with not only administrative difficulties, but also enrollee problems. Many patients had a complete lack of understanding of the plan, and this unfortunately induced turbulent access dilemmas. Physicians' third distress over the program involved the sentiment of inadequate benefits coverage by the managed care organizations. This also blended in with the fourth distressing factor for physicians - restrictive drug formularies. The final tension among doctors engrossed the disruption/termination of physician/patient relationships<sup>55</sup>. These intricacies combined to fashion a tautly bound fabric of tension between Tennessee physicians and the administrative staff of TennCare. To demonstrate their displeasure with the plan, Tennessee physicians sent over 1200 faxes to HCFA officials in less than one week's time. The members of the Tennessee Medical Association also raised over \$1 million toward a lawsuit against the state<sup>56</sup>. A survey taken in 1994 also revealed that due

<sup>55</sup> Pearson R. Health Care II: Status of TennCare. The Frank M. Norfleet Forum for the advancement of health. UTM, 1995: 14-23.

<sup>56</sup> Daniels M. Medicaid Reform and the American States. Auburn House, Westport, 1998:251-259.

to continued problems with the TennCare plan, the program might incur a 15 to 20 percent reduction in the future supply of providers<sup>57</sup>. This viability proved correct and by just a few short months after the initiation of TennCare the Tennessee Preferred Network (TPN), a preferred provider program operated by Blue Cross/Blue Shield of Tennessee, roster of participating physicians had fallen dramatically from around 6,500 to 3,500. Nevertheless, with TPN's immense market share, nearly all original physicians had returned to the plan within just a year<sup>58</sup>. This 'cram-down' requirement, requiring any provider who participated in TPN to treat the network's TennCare enrollees, brought heavy assaults from the physicians. Due to the immense purchasing clout of the plan, however, physicians were essentially helpless against opposing it<sup>58</sup>.

With all of these elaborate pieces working both collectively and opposite each other, it is exceedingly perplexing to summarize the program as an entirety. It

---

<sup>57</sup> Pearson R. Health Care II: Status of TennCare. The Frank M. Norfleet Forum for the advancement of health. UTM, 1995: 14-23.

<sup>58</sup> Gordon Bonnyman Jr. "Update - State Report - Stealth Reform: Market-Based Medicaid In Tennessee," Health Affairs (Summer 1996): 306-314.

is in my opinion, however, to express my conclusion that the program, although incurring numerous misfortunes, has nonetheless been an enormous step in the proper direction. Costs have been contained, access has been increased, and quality has been held constant in this valiant effort to save the health care industry in the state of Tennessee. I believe that with the anticipated integration the two programs - TennCare and TennCare Partners - the health care of Tennesseans will vastly improve while stabilizing the budget of the state. This sentiment is also perceived by a majority of researchers studying this subject including Bonnyman as he writes, "the TennCare experience, for all of its problems, suggests that the savings from capitated managed care are substantial and that they can be applied to our most profound health policy challenge: protecting the millions of Americans now without health insurance<sup>58</sup>."

---

<sup>58</sup>Gordon Bonnyman Jr. "Update - State Report - Stealth Reform: Market-Based Medicaid In Tennessee," Health Affairs (Summer 1996): 306-314.

## Appendix

Annual Change in National Health Care Expenditures Annual Change in National Health Care Expenditures/Component	<b>Table 1</b>
Summary of National Medicaid Growth, 1966-1995	<b>Table 2</b>
National Enrollment in Medicaid Managed Care National Summary of Medicaid Managed Care Programs	<b>Table 3</b>
National Medicaid Spending Growth Rates Growth in Real Per Capita National Health Expenditures	<b>Table 4</b>
Projected Medicaid and TennCare Expenditures, 1993-1994 Total and per Capita Spending - TennCare Partners	<b>Table 5</b>
Statewide eligibles by Managed Care Organization	<b>Table 6</b>
HMO Mergers and Acquisitions, Number and Value 1987-1997 Stock Price Performance of HMOs, Health Services Companies, and Overall Stock Market 1987-1997	<b>Table 7</b>
Average Daily Census and Cost per Adjusted Patient Day in Tennessee Hospitals, 1991-1996	<b>Table 8</b>
Quality of Medical Care Received by Medicaid/TennCare Heads of Households, 1993-1995 TennCare Better or Worse: Former Medicaid Respondents, 1994-1995 Quality of Care Received by Children of Medicaid/TennCare Heads of Households, 1993-1995	<b>Table 9</b>
18 Principles of Managed Care Companies	

## Table 1

### **Annual Change in National Per Capita Health Care Expenditures, 1990-1997**

Year	National health expenditures(1)	Expanded health cost index(2)	Payroll, health services establishments(3)
1990	6.40%	5.50%	5.40%
1991	4.20%	3.10%	4.90%
1992	5.00%	4.40%	4.40%
1993	3.20%	3.10%	2.80%
1994	2.20%	0.70%	1.90%
1995	1.30%	1.20%	1.90%
1996	1.20%	0.90%	2.40%
1997	*	1.80%	3.60%

Sources:

Notes: Data presented here are adjusted for general inflation. Adjustment is based on the chain-type gross domestic product (GDP) price index developed by the U.S. Department of Commerce, Bureau of Economics Analysis.

1. From the National Health Accounts database at the Health Care Financing Administration, National Cost Estimates Unit.

2. Calculations by Ginsburg and Gabel using data from Milliman and Robertson's Health Cost Index database, expanded to include Medicare.

3. From U.S. Department of Labor Bureau of Labor Statistics, Employment, Hours, and Earnings database. Payroll calculated as the product of production workers, average hours per week, and average hourly wage.

\* Not Available.

### **Annual Change Per Capita In National Health Care Expenditures, By Component, 1990-1997**

Year	Total Health	Hospital	Physician	Drug
1990	10.10%	9.40%	9.60%	14.70%
1991	7.10%	7.10%	5.70%	12.40%
1992	7.30%	7.80%	5.00%	11.70%
1993	5.80%	6.50%	3.70%	7.10%
1994	3.20%	3.00%	2.50%	4.70%
1995	3.80%	3.10%	3.20%	10.90%
1996	3.20%	2.90%	1.40%	11.30%
1997	3.90%	2.40%	2.00%	11.50%

Source: Ginsburg and Gabel calculations using data from Milliman and Robertson's Health Cost Index database, expanded to include Medicare.

Note: Data presented here not adjusted for inflation.

Table 2

*Summary of National Medicaid Growth, 1966-1995*

<i>Years</i>	<i>Average annual growth (percent)</i>	<i>Driving Forces</i>
1966-1974	25.5	1)Recipients nearly doubled due in large part to AFDC growth (those categorically eligible for Medicaid) 2)Rapid medical price inflation, especially for nursing homes
1974-1981	16.8	1)Essentially no recipient growth, despite rise in poverty 2)Rapid general and Medicaid price inflation
1981-1988	8.9	1)OBRA81 allowed greater cost containment - especially affecting the early years of this period 2)Mandated and optional expansions began to take hold in later years
1988-1993	19.3	1)Increases in disabled and elderly recipients; disabled growth driven in part by Supreme Court decision and outreach efforts 2)Tenfold increase in DSH payments 3)Growth in AFDC caseloads due to increase in single-parent households and 1990-1991 recession
1993-1995	9.5	1)New federal limits on DSH payments reduce payments to some states 2)Improving economy and AFDC declines 3)Slowing medical price inflation 4)Elderly and disabled account for 85 percent of growth in payments

Source: Thompson F, Dilulio J. Medicaid and Devolution, 1998.



**Table 3**

**National Enrollment in Medicaid Managed Care as Percentage of Total Medicaid Enrollment, 1991-1996**

Year	Managed Care enrollment (millions)	Total Medicaid enrollment (millions)	Percent enrolled in managed care
1991	2.7	28.3	9.5
1992	3.6	30.9	11.8
1993	4.8	33.4	14.4
1994	7.8	33.6	23.2
1995	9.8	33.4	29.4
1996	13.3	33.2	40.1

Source: <http://www.hcfa.gov/medicaid/trends1.htm>.

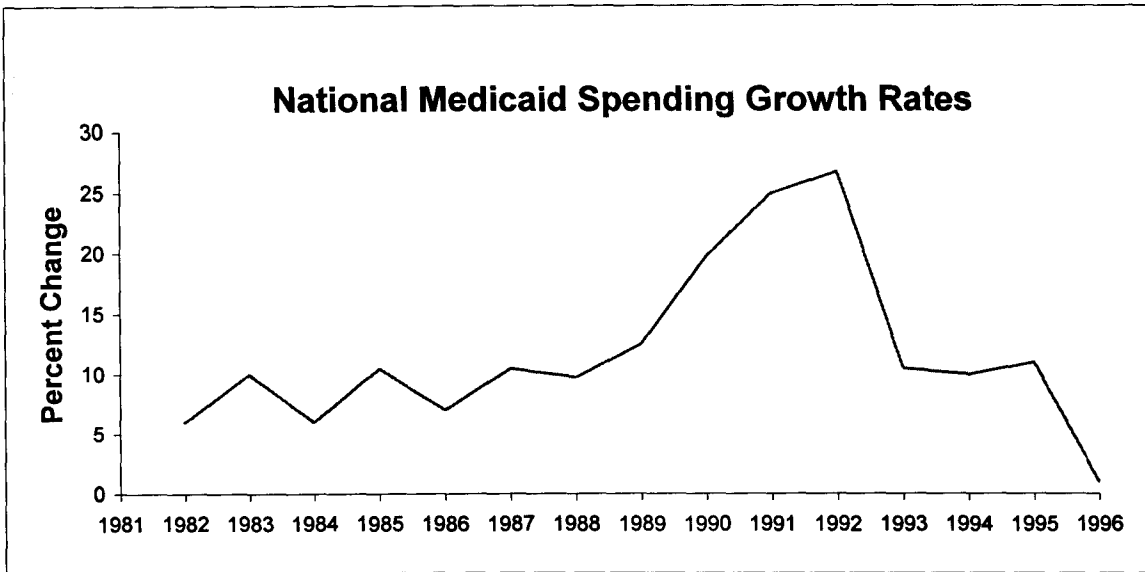
**National Summary of Medicaid Managed Care Programs and Enrollment**

30-Jun-97		
Plan Type	Number of Plans	Number of Enrollees
Health Insuring Organization	6	351,053
Health Maintenance Organization/ Federally Qualified	118	2,752,264
Health Maintenance Organization/ State Plan Defined	252	5,654,681
Primary Care Case Management	60	4,337,486
Prepaid Health Plan	113	3,850,589
Other	19	2,510,808
<b>Total</b>	<b>568</b>	<b>19,456,881*</b>

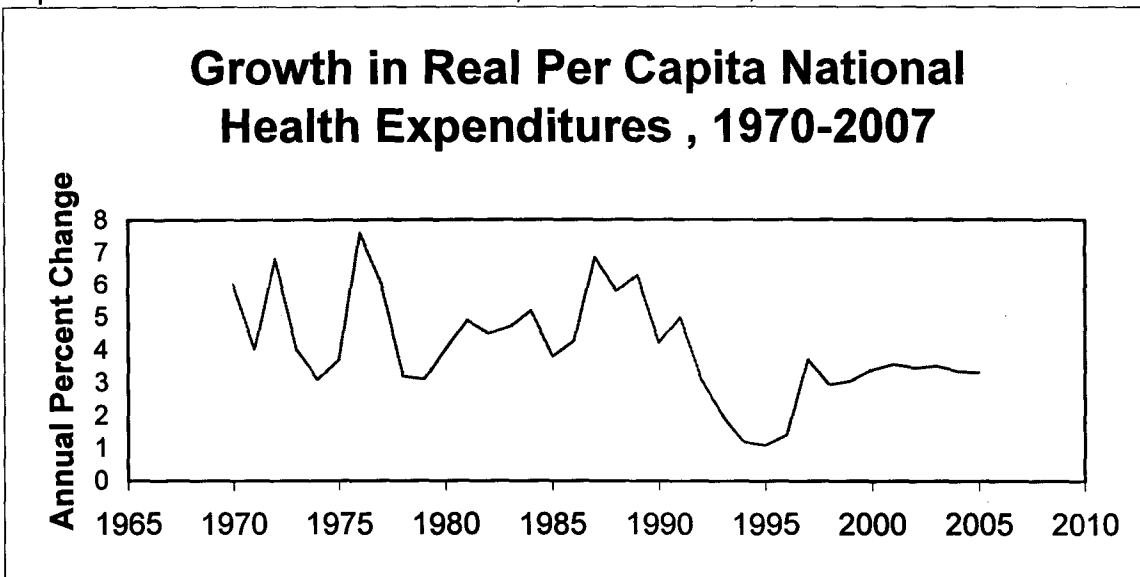
Source: <http://www.hcfa.gov/medicaid/plansum7.htm>

\*This total number of enrollees includes 4,111,379 individuals who were enrolled in more than one managed care plan. It also includes individuals enrolled in State health care reform programs that expanded eligibility beyond traditional eligibility standards.

**Table 4**



Sources: 1982-93 growth rates obtained from Health Care Financing Administration (HCFA), *Health Care Financing Review: 1996 Statistical Supplement* (Baltimore: HHS Office of Research and Demonstrations, 1996), table 109; 1994-95 growth rates obtained from HCFA, *Medicaid Statistics: Program and Financial Statistics Fiscal Year 1995*, table 1; 1996 growth rates based on growth in total computable expenditures for 1996 obtained from data file mfn96t01.xls, as compared with total expenditures for 1995 obtained from HCFA, *Medicaid Statistics*, table 1.



Source: Health Care Financing Administration, Office of the Actuary.

Notes: National health expenditures (NHE) are deflated by the gross domestic product (GDP) deflator. Much of the increase shown for 1998 reflects a sharp decline in the deflator rather than an increase in nominal NHE. Figures after 1996 are projections.

Table 5

**Projected Medicaid and TennCare Expenditures, Fiscal Years 1993-1994**

Health Care Program Expenses and Savings	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998
<b>TennCare expenses</b>					
Total	3131.6	3176.6	3331.8	3496.7	3669.7
Federal Title XIX	2107.8	2119.4	2223	2333.1	2448.5
<b>Medicaid expenses</b>					
Total	3384.9	3965.9	4662.7	5498.2	6500.3
Federal Title XIX	2267.1	2653.3	3120.6	3681.2	4353.5
<b>TennCare savings</b>					
Total	253.3	789.3	1330.9	2001.5	2830.6
Federal Title XIX	159.3	533.9	897.6	1348.1	1905

Source: Mirvis et al. JAMA, October 18, 1995 - Vol 274, No. 15.

Values are in millions of dollars.

**Total and Per Capita Spending - TennCare Partners\***

Total program costs	\$323,094,100
Minus state administration cost	\$6,818,000
Total Funds Available for Capitation	\$316,276,100
Numbers of Eligibles	
TennCare priority population	51,253
Non-TennCare priority population	6,608
TennCare nonpriority population	1,148,747
Total	1,206,608
Rates and per Capita costs	
Per Capita rate per 12 months	\$262.12
Per capita rate per month	\$21.84
Spending estimates if business as usual	\$335,268,522
Savings of TennCare Partners	\$12,174,422

\*Unpublished data from Tennessee Department of Mental Health and Mental Retardation, 1996.

Table 6

Bureau of TennCare

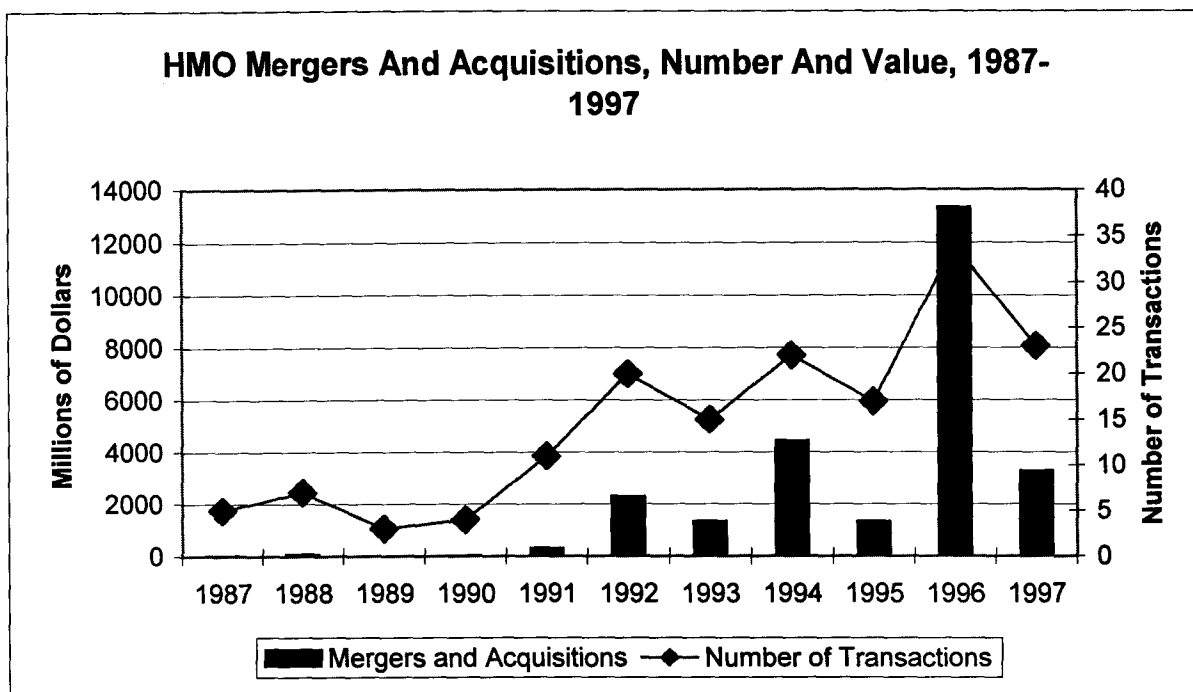
Statewide Eligibles by MCO

<b>MCO</b>	<b>Medicaid/TennCare</b>	<b>Uninsured/Uninsurable</b>	<b>Total</b>
OmniCare	28,614	16,558	45,172
Blue Cross	296,641	184,364	481,005
John Deere	16,887	11,794	28,681
TLC	39,940	16,332	56,272
Phoenix	103,475	64,233	167,708
PHP	45,130	32,690	77,820
Prudential	9,168	3,151	12,319
Access... Med Plus	204,550	92,261	296,811
BlueCare	67,856	39,271	107,127
Vanderbilt	8,359	2,971	11,330
<b>Total</b>	<b>820,620</b>	<b>463,625</b>	<b>1,284,245</b>

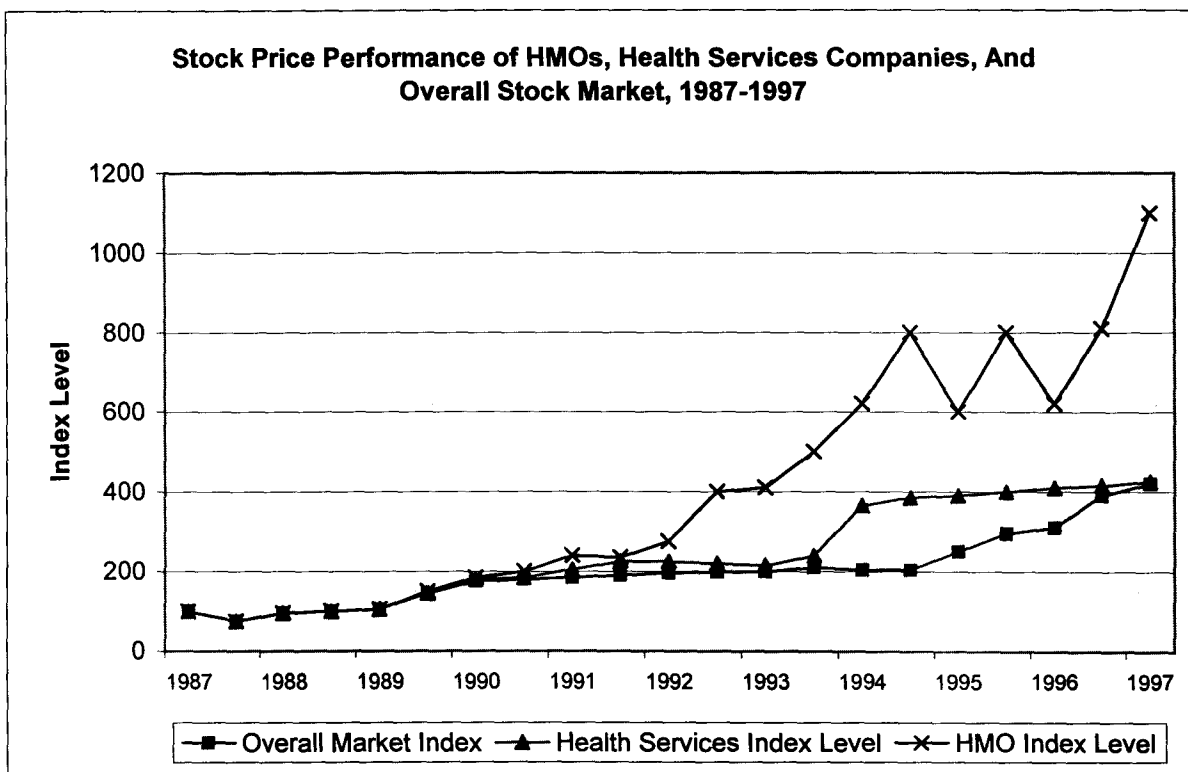
\*Eligibles by MCO as of 01/09/99

Source: Bureau of TennCare Web page.

Table 7



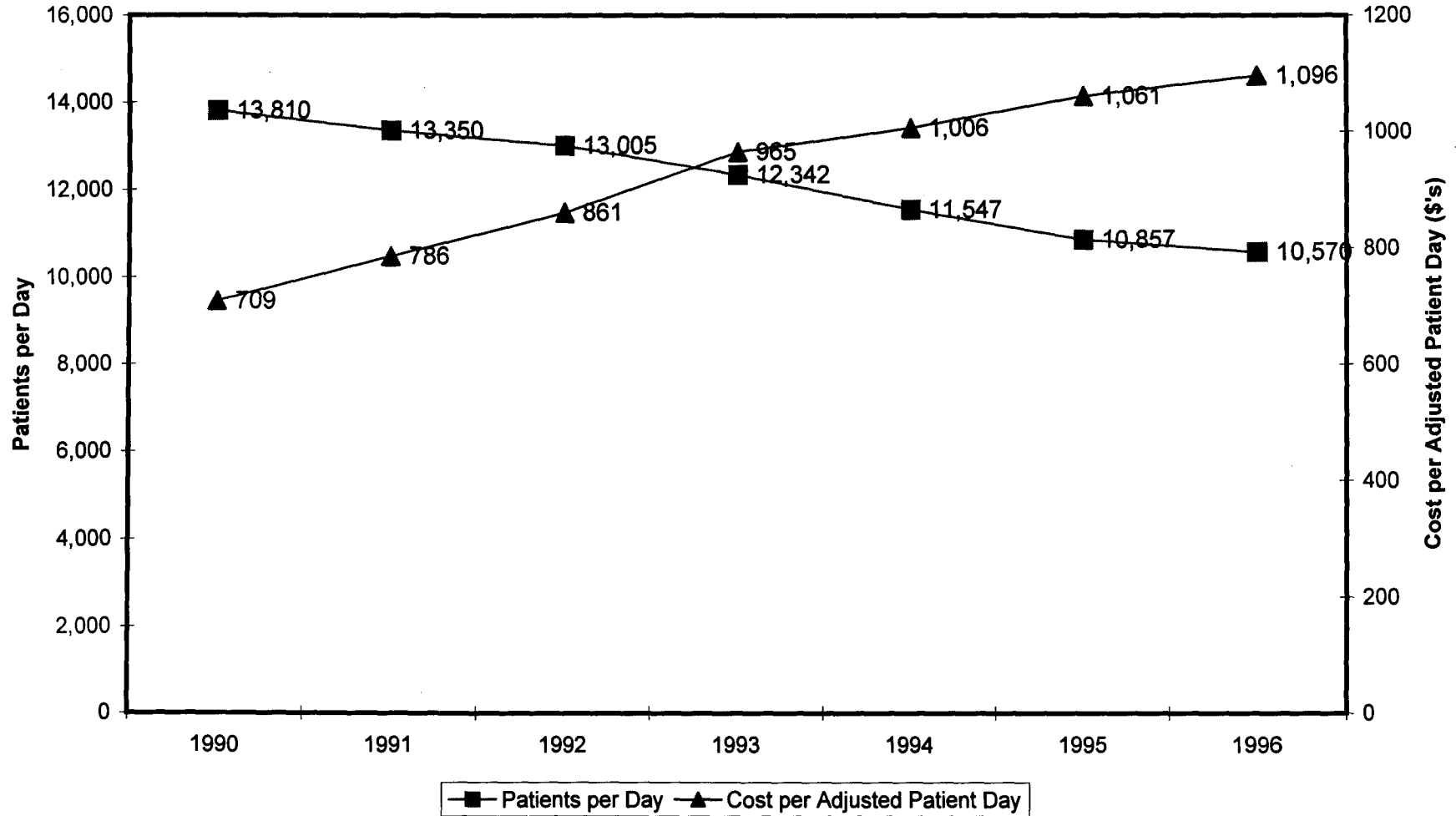
Source: Prepared for the Kaiser Family Foundation by Securities Data Company, 6 January 1998.



Source: Prepared for the Kaiser Foundation by the Center for Research in Security Prices (CRSP), University of Chicago, 14 January 1998.

**Table 8**

**Average Daily Census and Cost per Adjusted Patient Day in Tennessee Hospitals, 1991-1996.**



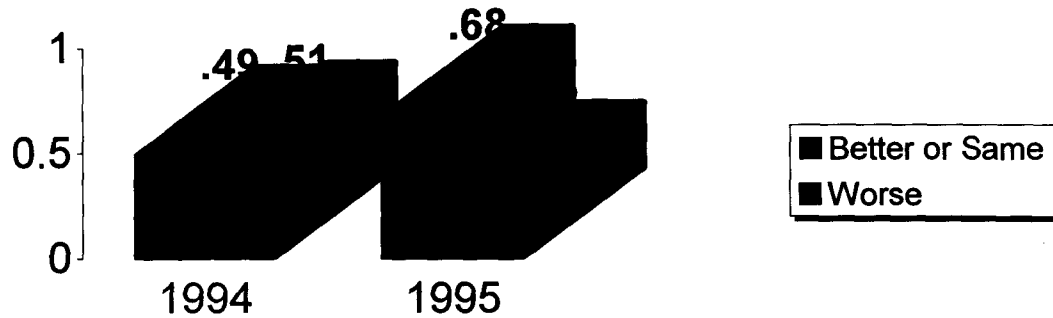
The Average number of patients in a facility on any day of the reporting year. Source: Tenn. Dep. of Health, Health Statistics and Information Health Access Update, 1994, 1995, and 1996.

Table 9

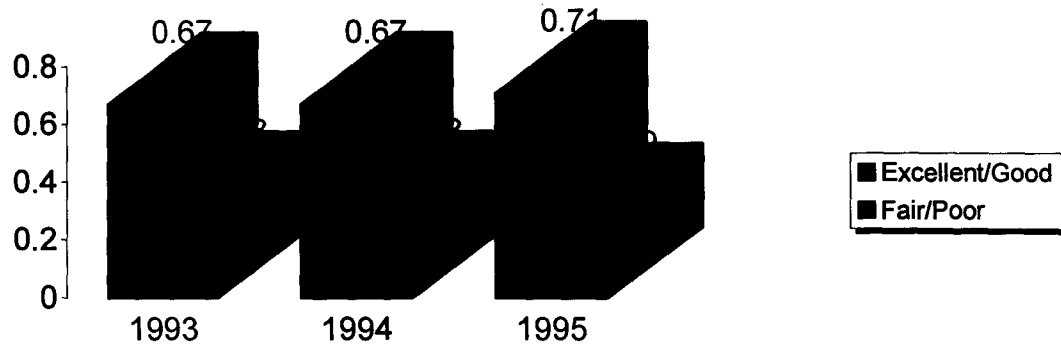
**Quality of Medical Care received by Medicaid/TennCare Heads of Households, 1993-1995**



**TennCare Better or Worse: Former Medicaid Respondents, 1994-1995**



**Quality of care Received by Children of Medicaid/TennCare Heads of Households, 1993-1995**



Source: Fox. Survey of Health Care Statistics. UTK: 1995.

## **18 Principles for Managed Care Companies**

- 1. Accessibility of services:** To ensure access to quality care, health plans should have enough physicians, specialists and other providers to provide timely, appropriate care 24 hours a day, seven days a week; provide women members with direct access to obstetricians and gynecologists; provide access to specialists and specialty care centers; provide out-of-network referrals at no cost to the member when the plan does not have a network physician with the appropriate training or experience; and provide health care materials and services in a culturally and linguistically sensitive manner.
- 2. Choice of health plans:** Individuals should be given a choice of health plans.
- 3. Confidentiality of health plan information:** Health plans should ensure that the confidentiality of member or patient information is protected. Information should not be disclosed except: if necessary for quality assurance, for purchasers or providers (to determine eligibility for coverage or to administer payments), or to conduct research (but these data should not contain patient identifiers); if the individual provides consent; or if required by law or court order.
- 4. Continuity of care:** Members should be allowed to choose their own PCP and change their PCP at any time. Members who are being treated for a serious illness or who are in the second trimester or pregnancy should be allowed to continue to receive treatment from their physician specialist for up to 60 days or through post-partum when their doctors' contracts are terminated by a plan.
- 5. Disclosure of information to consumers:** Information should be given to consumers, such as a description of the coverage provided and excluded, how to obtain service, select providers and obtain medically necessary referrals; members' cost-sharing methodologies used to compensate physicians; procedures for utilization management; a description of restrictive prescription drug formularies; procedures for receiving emergency care and out-of-network services; procedures for determining coverage for investigational or experimental treatments; use of arbitration; disenrollment data; and how to appeal decisions, file grievances and contact consumer organizations.
- 6. Coverage of emergency care:** Health plans should cover emergency services, including services provided when a layperson reasonably believes he or she is suffering from a medical emergency. Emergency departments should inform the health plan within 30 minutes after stabilization to obtain authorization for any medically necessary post-stabilization services.
- 7. Determinations of when coverage is excluded because care is experimental:** Health plans should have an objective process for reviewing new drugs, devices, procedures and therapies. Plans also should have an external, independent review process to examine the cases of seriously ill patients who are denied coverage for experimental treatments.
- 8. Development of drug formularies:** Health plans that cover prescription drugs and use restrictive formularies should allow physicians to participate in the development of the formularies and provide for an exception process when non-formulary alternatives are medically necessary.
- 9. Disclosure of loss ratios:** Health plans should uniformly calculate and disclose how much of premium dollars are going for health care delivery costs rather than for plan administration, profits, or other uses.
- 10. Prohibitions against discrimination:** Health plans should not discriminate in the provision of health care services on the basis of age, gender, race, national origin, language, religion, socio-economic status, sexual orientation, disability, genetic make-up, health status or source of payment.



11. **Ombudsman programs:** Consumers should have access to, and health plans should cooperate with, an independent external nonprofit ombudsman program that helps consumers understand plan marketing materials and coverage provisions, educate members about their rights within health plans, investigate members' complaints, help members file grievances and appeals and provide consumer education and information.

12. **Out-of-area coverage:** Health plans should cover unforeseen emergency and urgent medical care for members traveling outside a plan's service area.

13. **Performance measurement and data reporting:** National standards for measuring and reporting performance should be met in areas such as quality of care, access to care, patient satisfaction and financial stability.

14. **Provider communication with patients:** Health plans should not limit the exchange of information between health care providers and patients (regarding the patient's condition and treatment options). Health plans should not penalize providers who in good faith advocate for their patients with claims appeals, or report quality concerns to government authorities or health plan managers.

15. **Provider credentialing:** Health plans and provider groups should develop written standards similar to those used by the NCQA for hiring and contracting with physicians, other providers and health care facilities.

16. **Provider reimbursement incentives:** Neither health plans nor provider groups should use payment methodologies that directly encourage providers to over-treat patients or to limit medically necessary care. Full-risk capitation should not be used for an individual provider. Where capitation is used for an individual provider, it should only apply to services directly provided by that provider.

17. **Quality assurance:** All health plans should be subject to comparable comprehensive quality assurance requirements. National standards for quality assurance should be non-duplicative and should provide latitude in the specific methods and incentives employed to meet the standards to reflect differences in health plan organization.

18. **Utilization management:** Utilization management activities of health plans should be subject to appropriate regulation, including requirements to use appropriately licensed providers to evaluate the clinical appropriateness of adverse decisions. Health plans should make timely and, if necessary, expedited decisions, and give the principle reasons for adverse determinations and instructions for initiating an appeal. Health plans should be prohibited from having compensation arrangements for utilization management services that contain incentives to make adverse review decisions.

Source: The Managed Care Yearbook Fourth Edition. Melanie Matthews. 1998.