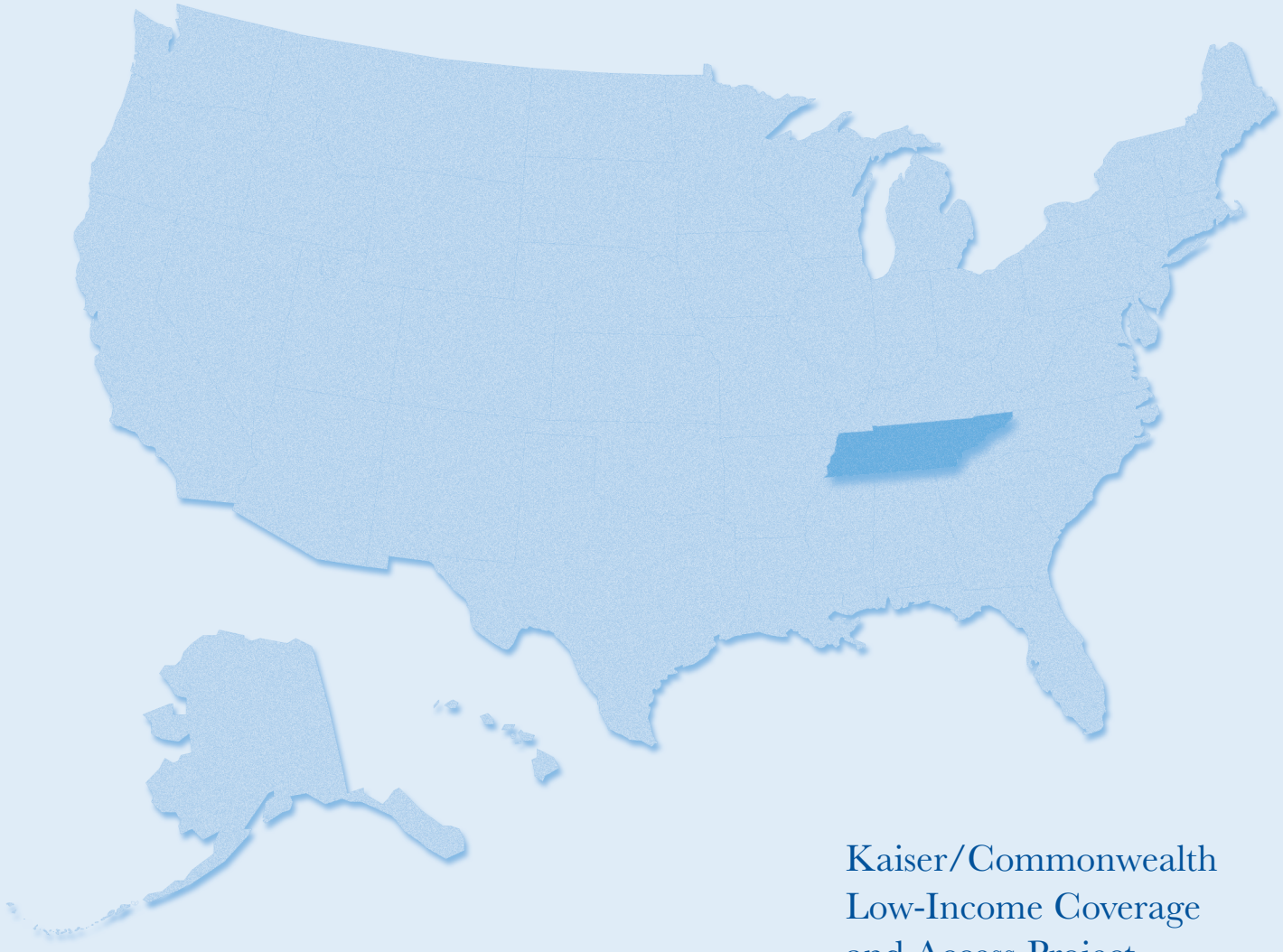
Managed Care and Low-Income Populations: Four Years' Experience with Tenncare



Kaiser/Commonwealth Low-Income Coverage and Access Project

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Henry J. Kaiser Family Foundation and The Commonwealth Fund are jointly sponsoring *The Low-Income Coverage and Access Project* to examine how changes in the Medicaid program and the movement toward managed care are affecting health insurance coverage and access to care for the low-income population. This large-scale project, initiated in 1994, has examined the impact of changes in eight states: California, Florida, Maryland, Minnesota, New York, Oregon, Tennessee, and Texas. Information is being collected through case studies, surveys and focus groups to assess changes in health insurance coverage and access to care from the perspectives of numerous key stakeholders — consumers, state officials, managed care plans, and providers.

MANAGED CARE AND LOW-INCOME POPULATIONS: FOUR YEARS' EXPERIENCE WITH TENNCARE

May 1999

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ACKNOWLEDGMENTS

Many people helped make this update possible. Among them are the numerous individuals in Tennessee—including state officials, plan representatives, providers, advocates, and analysts—who generously contributed their time, granting interviews, furnishing written materials, and reviewing drafts. We are deeply grateful for their efforts. We want to especially acknowledge Gordon Bonnyman for his help in setting up the site visit.

Barbara Lyons of the Henry J. Kaiser Family Foundation and Cathy Schoen of the Commonwealth Fund developed this follow-up study to our earlier case studies. We are grateful for their guidance and that of Diane Rowland, Executive vice president of the Kaiser Family Foundation, who developed the concept for the original study. We also appreciate the contributions of Alina Salganicoff and Julie Hudman of the Kaiser Family Foundation and Brian Biles of the Commonwealth Fund.

We greatly appreciate the contributions of Marilyn Ellwood, Margo Rosenbach, and Jessica Mittler of Mathematica Policy Research for comments on an earlier draft. We also are grateful to Pat McCall, who provided secretarial support, and Anne Kelleher, who provided editorial assistance.

ACRONYMS

AFDC	Aid to Families with Dependent Children
BCBS	Blue Cross Blue Shield
BHO	Behavioral Health Organization
CHIP	Children's Health Insurance Program
DCI	Department of Commerce and Insurance
DOH	Department of Health
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FPL	Federal Poverty Level
GME	Graduate Medical Education
HMO	Health Maintenance Organization
MCO	Managed Care Organization
MPR	Mathematica Policy Research, Inc.
PCP	Preferred Care Provider
PPO	Preferred Provider Organization
QI	Quality Improvement
SED	Severe Emotional Disturbance
SPMI	Severely and Persistently Mentally Ill
TANF	Temporary Assistance for Needy Families

EXECUTIVE SUMMARY

This update of a 1994 case study on Tennessee's TennCare Medicaid managed care program—one of a series of updates Mathematica Policy Research, Inc. (MPR) is developing for seven earlier case studies—examines the program's effect on low-income populations in the state. In focusing on how the program has matured and what impact it has had on access to care and the safety net, the report revisits issues identified earlier in the series. It is based largely on interviews conducted during a weeklong site visit to Tennessee in January 1998; other sources include MPR's earlier work on TennCare (Gold, Frazer, and Schoen 1995).

Two separate MPR reports focus on special aspects of Tennessee's experience with Medicaid managed care. One reviews in more detail the process of expanding TennCare to special needs populations, including aged, blind, and disabled individuals and those needing behavioral health care. The other describes the transition to managed care, with a focus on health plans.

BACKGROUND

The TennCare program was implemented in 1994 to rapidly revamp Tennessee's Medicaid program by shifting virtually all Medicaid beneficiaries statewide into capitated managed care arrangements. At the same time, the program sought to substantially expand eligibility—an effort that resulted in health insurance for an additional 330,000 uninsured persons by the end of 1994. TennCare's design incorporates substantial patient cost-sharing, on a sliding scale, both in premium contributions and at point of service in copayments.

In our original review of TennCare's first operational year in 1994, we concluded that Tennessee's rapid movement to managed care created confusion for patients, providers, and health plans that was exacerbated by weaknesses in the state's oversight infrastructure. The speed with which TennCare was developed and implemented, with limited stakeholder involvement, and the state's limited experience with managed care both in Medicaid and in the commercial market were important factors contributing to the program's tumultuous first year.

The key questions that resulted from our 1994 study were:

- Can the program mature administratively and function more effectively?
- Can it evolve an effective managed care structure from its very rudimentary beginnings in year 1?
- Can the state develop a system of oversight that will promote access to quality care?

There were also fundamental questions concerning the long-term financial viability of TennCare and how successful TennCare would be in meeting its goals for expanded coverage.

KEY FINDINGS

1. TennCare's basic structure is essentially the same as it was in 1994, with the important exception of the behavioral health care carve-out.

There have been a few changes: eligibility requirements for managed care organizations have been strengthened, with the state requiring state health management organization (HMO) licensure for all plans; eligibility criteria for new TennCare enrollees have been tightened; and most transitional funding has been phased out, including additional funding for essential safety net providers and uncompensated care. TennCare's enrollment, however, continues to be concentrated in two statewide plans, Blue Cross Blue Shield and Access MedPlus, which together serve nearly three-quarters of the TennCare population. Two additional plans have also gained statewide status, but otherwise there have been few changes in the plans participating in the program.

The key change from 1994 is the implementation of TennCare Partners, the mental health and substance abuse carve-out. Launching TennCare Partners involved contracting separately with capitated behavioral health organizations for all behavioral health services, including care for seriously and persistently mentally ill adults and children with severe emotional disturbance. The controversial program has been beset with problems from its inception, and there are potentially major structural weaknesses. Efforts to address these limitations by diverting scarce administrative resources have helped to color the perception of TennCare within the state.

2. **Enrollment of eligible residents has been very limited since 1994. While the state recently relaxed restrictions for children, additional cutbacks have been proposed**.

Total TennCare enrollment in January 1998 was 1.2 million, about the same as at year-end 1994 and up from some slight declines during the intervening years. Since January 1995, TennCare has been closed for new enrollment to those who are not otherwise uninsurable because of health problems or eligible for Medicaid. In April 1997, enrollment was opened to uninsured children whose parents do not have access to workplace insurance. In May 1997, it was opened to dislocated workers. Since 1998, enrollment has been open to 18-year-olds and all uninsured children in families with incomes below 200 percent of the federal poverty level, regardless of their access to workplace insurance. This change, originally intended to be temporary but subsequently extended, was made partially in response to the 1997 federal legislation establishing the Children's Health Insurance Program (CHIP). Future growth is uncertain. In early 1999, Governor Sundquist proposed closing new enrollment for uninsurables.

3. **Although participation by managed care plans remains strong, signs of potential future problems exist.**

All the plans participating in TennCare in 1994 remain in the program, although there has been some merger and consolidation of plans.[1] Three plans voluntarily closed enrollment to new eligibles for all or part of 1997, including the largest plan, Blue Cross Blue Shield (BCBS). Though BCBS has now agreed to reopen enrollment, the state comptroller reports that plans are currently experiencing greater financial difficulty than previously. In comparison to the net positive gains realized in the program's first three years, plans lost more than $20 million on TennCare in the first nine months of 1997.

Factoring out the effect of the behavioral health carve-out, TennCare's capitation rates increased, in aggregate, by the equivalent of about 20 percent over the three-and-a-half-year period to mid-1997. Plans, however, believe that the rate increases have been inadequate given the scope of the benefit package and the state's failure to effectively adjust for adverse risk selection. The latter has been a more prominent concern because some plans were closed to new enrollees for all or part of 1997, when new enrollment was limited to the relatively unhealthy, uninsurable population. An additional 4 percent increase retroactive to July 1, 1997, has been approved, and as of

[1] In April 1999 however, Tennessee assumed control of Xantus Health plan of Tennessee (as Phoenix is now called) after it reported a negative net worth of $24 million in 1998. Press reports suggest the erosion in Xantus' performance stemmed at least in part, from the acquisition of Health Net and its outstanding debts.

January 1998, all participating TennCare plans had agreed to reopen to new enrollment. In addition, TennCare has suffered as program leadership has changed, including the exodus of many experienced leaders in early 1999.

4. The state has strengthened its administrative structure and oversight activities.

Since TennCare's initial year, TennCare's administrative structure and monitoring activities have evolved considerably. Three state departments—the TennCare Bureau, the TennCare Division within the Department of Commerce and Industry, and the Office of the Comptroller of the Treasury—now share oversight responsibility, and their roles appear to be clearly articulated and well coordinated. Both financial and quality oversight have been strengthened as well. Plan requirements have also been standardized, with all plans now required to be licensed as HMOs. Preferred provider organization (PPO) status is no longer acceptable.

Although administrative systems have matured over time, plan staff still report considerable frustration with what they perceive to be a lack of understanding of managed care principles among bureau staff. Most contentious is TennCare's interpretation of the benefits for which plans are held financially responsible.

5. Stakeholders all agree that TennCare has improved access to health insurance, largely because it has expanded coverage to those who were previously uninsured.

An analysis by the University of Tennessee suggests that the proportion of the state population that is uninsured declined from 8.9 percent in 1993 to 5.9 percent in 1997, which translates into an additional 130,000 insured people. The major concern we heard about coverage was the state's policy of closing enrollment to adults who are not otherwise uninsurable or eligible for Medicaid.

With regard to access to services for TennCare enrollees, the reports are mixed. Plans and providers generally believe that more providers are available to serve TennCare enrollees than were available under Medicaid. After initial declines in provider participation at the start of TennCare, participation is now back up. However, some shortages persist, particularly in selected specialties like orthopedics, where physicians appear to be boycotting the program. Studies within the state show improvements in selected access and satisfaction measures since the implementation

of TennCare. Nevertheless, a relatively high proportion of covered individuals appear to never use services or to continue to rely on emergency rooms. In addition, Tenncare has suffered as program leadership has changed, including the exodus of many experienced leaders in early 1999.

6. In general, safety net providers appear stressed by TennCare.

TennCare's safety net providers are diverse and vary across the state. While traditional safety net providers are contracting with TennCare plans, most do not receive special consideration and are expected to compete with other providers on an equal footing. Some have been more successful than others. A particular focus of concern has been the Regional Medical Center in Memphis, a large public teaching hospital serving TennCare beneficiaries and uninsured residents: given a choice, many TennCare enrollees have chosen to seek care elsewhere. Combined with the transfer of graduate medical education funding to the University of Tennessee and not the hospital, this reduced patient base has left the Med without a stable source of funding for indigent care.

CONCLUSIONS

The TennCare program has evolved considerably over its four years of operation. Managed care plans continue to participate in the program, and administrative systems for quality and financial oversight have been strengthened. While the rapid pace and nonparticipatory nature of the program's implementation initially caused severe problems, TennCare now appears to have broad-based support. Expanding coverage was critical to this outcome.

Nonetheless, some cause for concern remains. The financial status of participating plans has deteriorated, raising questions about the long-term viability of the program, which are only reinforced by recent events. In addition, the state has not devoted the funding necessary to enable TennCare to achieve its coverage objectives; whether a lack of financial resources or a lack of political will is responsible is an issue for debate. TennCare's experience also illustrates the long lead times needed to develop efficient and effective administrative and managed care systems to ensure a smooth transition. The future of TennCare will depend on the way in which the program evolves in response to these and other issues detailed in this case. Thus, TennCare, as it has in the past, promises to continue providing valuable lessons for other states.

A. INTRODUCTION

This paper reviews the experience of TennCare after four years of operation, building on the detailed case study of the first year's experience prepared by Mathematica Policy Research, Inc. (MPR). TennCare is an ambitious undertaking by the state of Tennessee to revamp the state's Medicaid program substantially and rapidly. Key features include a rapid shift to capitated managed care along with a broad expansion in eligibility. The program's impetus was primarily though not exclusively cost-related. The objectives were to constrain spending by quickly shifting from a traditional system of care delivery to managed care, to expand coverage for the uninsured with only a small infusion of new state funding, and to provide better access and health care to beneficiaries. The TennCare program draws on the flexibility provided by Section 1115 waiver authority granted by the Social Security Act to the secretary of the Department of Health and Human Services.

The speed of TennCare implementation created considerable disruption. While TennCare succeeded in enrolling virtually all Medicaid beneficiaries in managed care and in expanding coverage to an additional 330,000 uninsured persons by the end of 1994, the rapid pace of the change created confusion for patients, providers, and health plans. The fact that Tennessee lacked a well-defined managed care infrastructure prior to TennCare exacerbated the strain on the system. Weaknesses and transitional problems existed in state administration and managed care organization (MCO) oversight in the first year. Because of the speed of implementation and the lack of experience with managed care, the state focused on urgent administrative needs, with only limited attention to developing larger, standardized, prospective systems of managed care monitoring and oversight.

The first year of the TennCare program raised key questions about whether and how fast the program could mature administratively and function more effectively; about its ability to evolve managed care from very rudimentary beginnings in year one, and about the ability to develop an oversight structure that would promote organized access to quality care. The first year's experience also raised more fundamental questions about the long-term financial viability of the TennCare approach.

This paper provides an overview of the changes in TennCare over its four-year history, focusing on some of the concerns identified in the first site visit in late 1994. The purpose is to understand what the TennCare experience can teach federal policy makers and other states. This general overview is complemented by separate analyses that provide more detail on specific questions raised in year one about TennCare's ability to evolve managed care quickly, as it aimed to do, and to greatly expand

coverage with little new state funding.[2] A third paper covers the issue of special populations, particularly regarding the behavioral health initiative, a major recent managed care expansion that has been problematic and controversial. Because it is dealt with separately, the behavioral health initiative is referred to here only as it highlights the general TennCare experience.

This and other current papers on TennCare are based largely on a week-long site visit to Tennessee made by MPR in early January 1998, along with document review and earlier work on TennCare (Gold, Frazer, Schoen 1995).

The Tennessee study is one of a number of studies MPR is conducting for the Henry J. Kaiser Family Foundation and The Commonwealth Fund's Low Income Coverage and Access project. Other states being studied include California, Florida, Maryland, Minnesota, New York, and Oregon, each of which is restructuring its health care system for its low-income populations. By focusing on understanding how the movement to managed care is affecting low-income populations and their access to health care services, these analyses will be useful to other states in efforts to shape the rapidly evolving development of managed care systems and health reforms for these populations.

B. OVERVIEW OF THE TENNCARE STRUCTURE AND INITIATIVE

The design of the TennCare program has remained largely as it was when the program was implemented in 1994, with a few notable exceptions.[3] These exceptions include tightened eligibility requirements that closed TennCare to all but Medicaid eligibles and the uninsurable until recently; standardized MCO participation requirements; the phase-out of most transitional financing pools; and the carve-out of the entire behavioral health benefit for all TennCare enrollees. Perhaps the most important change since the first year of the program is that the TennCare Bureau and the MCOs have gained three additional years of experience developing managed care systems.

This section reviews the basic design of TennCare along with what seem to be the most important changes made to the program's design and structure between 1994 and

[2]See Aizer, Anna, and Marsha Gold, *Growing an Industry: How Managed is Tennessee's Managed Care?* Washington, DC: Mathematica Policy Research, Inc., 1999; and Aizer, Anna, and Marsha Gold, *Managed Care for Low-Income Populations with Special Needs: The Tennessee Experience.* Washington DC: Mathematica Policy Research, Inc., 1999.

[3]For detailed background information, see Gold, Frazer, Schoen 1995, and Gold 1997.

1998. Also highlighted are other concurrent changes at the federal and state levels that have affected the program. Readers already familiar with the TennCare structure and first-year experience may want to skip or skim Section 1 below.

1. Review of TennCare's Basic Structure

TennCare, implemented in January 1994, aimed to revamp Tennessee's Medicaid program substantially and rapidly by using federal and state funds to expand eligibility and reconfigure services. Prior to TennCare, Tennessee had a traditional fee-for-service (FFS) Medicaid program. Use of managed care as a delivery and financing vehicle was limited to one MCO serving 35,000 Medicaid beneficiaries on a partially capitated basis.

TennCare substantially expanded eligibility based on enrollment in managed care. In its first 12 months, TennCare added 350,000 uninsured persons to the 770,000 already on its Medicaid rolls, enrolling all 1.1 million beneficiaries in one of 12 fully capitated MCOs.

a. Eligibility and Enrollment

When the program was originally implemented, TennCare's eligibility criteria were broader than those of virtually all other state Medicaid initiatives approved under Section 1115 waivers. TennCare removed categorical and asset restrictions and expanded eligibility to include those previously eligible for Medicaid as well as the uninsurable and those who were uninsured but not eligible for employer- or government-sponsored health care. The program requires premium contributions and cost sharing for services received on a sliding scale for all non-Medicaid enrollees above the poverty level. For low-income families using extensive services, cost-sharing requirements may result in considerable financial contributions.

Enrollees are required to select one of 12 qualified TennCare MCOs or be assigned to one. Enrollees have 45 days after initial plan selection or assignment to switch plans. The process of entry differs for various groups of eligibles. The Tennessee Department of Human Services determines eligibility for most Medicaid categories, for whom enrollment in TennCare is automatic. The uninsured and uninsurable are approved directly by the TennCare Bureau.

Despite efforts by TennCare officials and advocates to develop an effective enrollment process with appropriate enrollment materials, the enrollment process in year one created considerable confusion. Contributing factors included the speed of the change, limited enrollee and provider education, and difficulty in handling the

substantial volume of telephone calls. Further, because provider lists were not readily available and networks were not fully formed at the time, it was hard for enrollees to determine how their care patterns would be influenced by the plan selected.

b. Plan Participation

When TennCare was originally implemented, any state-licensed health maintenance organization (HMO) or plan meeting the state's definition of a preferred provider organization (PPO). (The state defined a PPO as "a managed care organization other than an HMO which is approved by the Bureau of TennCare as capable of providing medical services in the TennCare program.") PPOs reportedly faced the same fiscal solvency and quality requirements as HMOs, but enforcement and oversight mechanisms were limited.

TennCare pays each plan a monthly capitated rate. Rates are adjusted for age, sex, blind and disabled status, and Medicaid/Medicare dual eligibility. The rate structure does not distinguish those persons eligible for TennCare because of prior uninsurability. It does not vary by geographic area or by other type of Medicaid eligibility (e.g., the medically needy versus recipients of Aid to Families with Dependent Children). The rates were based on historical Medicaid experience. Rates are reduced 22 percent to account for charity care contributions (since TennCare expanded coverage to the previously uninsured), 3 to 4 percent to account for plan and provider revenues from enrollee copayments and deductibles, and another 2 percent because of the availability of local government funding for care for the uninsured. An additional 10 percent is withheld from all capitation rates and paid the following month if the plan meets TennCare's quality assurance standards (Health Systems Research 1997). Thus, the rates include less than three-quarters of the estimated costs, not including the additional 10 percent withheld, which, when included, lowers the amount to less than two-thirds.

A total of 12 MCOs participated in TennCare in 1994, including two statewide plans, Blue Cross Blue Shield (BCBS) and Access MedPlus. The other 10 served diverse areas of the state. At the end of year one, more than two-thirds of the total enrollees were in one of the two statewide plans and half of the total were in BCBS, causing some concern about that plan's ultimate role in the market.

The team's discussions with the two largest plans suggested that the ability to implement, refine, and operate a managed care system was severely constrained in the first year by the speed of implementation and enrollment. Thus, starting from a base of limited managed care, TennCare predictably did not shift in year one to a system of

fully functioning and well-developed MCOs. Many of those the team interviewed after the first year believed that, at that point, TennCare was more about managed costs than managed care, with limited change in the delivery system.

c. State Administration and Oversight

TennCare was based on a complex financing arrangement. An important objective was to maintain federal Medicaid funds despite policy changes limiting the use of disproportionate share payments and provider taxes to generate federal matching payments. Maintaining state funding at traditional Medicaid spending levels was another important objective of the program. State funds for TennCare were drawn from funds for indigent care and public hospital charity care as well as from other state, local, and private sources.

Financing pools were a key component of the first year. The pools, financed through a combination of explicit funds and anticipated savings, were designed to smooth the transition to TennCare by providing flexible funds to protect essential safety net providers, compensate for adverse selection, support graduate medical education (GME), and cover uncompensated care. As originally designed, the pools were to be phased out after the first one to two years.

Initial responsibility for MCO oversight was shared among the Tennessee Department of Commerce and Insurance (DCI), the TennCare Bureau within the Department of Health (DOH), and the Comptroller of the Treasury. Although DCI licensed all new TennCare participating HMOs and was responsible for ongoing oversight, it was not heavily involved in the program's design and implementation. DCI and the comptroller monitored the financial status of HMOs, oversaw marketing, handled complaints, and required plans to comply with DOH health care delivery requirements. The TennCare Bureau had primary oversight of the PPOs.

Weaknesses and transitional problems plagued state administration and MCO oversight in the first year. The speed of implementation required a primary focus on urgent administrative needs, with only limited work on more generic systems. As a result, procedures for implementing and overseeing many MCO provisions were poorly developed after the first year. The extent to which the state, PPO, or individual provider would ultimately be accountable for any revenue and expense shortfalls was unclear. TennCare's administrative structure in 1994 also raised issues of public process and procedures. Many key policies and procedures were not reported or at least not widely available and known in the first year.

2. Summary of the Most Important Structural Changes 1994–1998

Since the first year, a number of important structural changes have taken place. They include strengthening MCO eligibility requirements; tightening eligibility criteria for new TennCare enrollment; phasing out most of the transitional financing pools; and implementing TennCare Partners, the behavioral health carve-out.

a. Stronger MCO Requirements

After the first three years, during which both HMOs and PPOs participated in the TennCare program, the TennCare Bureau standardized the requirements for participating MCOs. As of January 1, 1997, all TennCare MCOs were required to be licensed as HMOs and use primary care gatekeepers for their TennCare membership. All four PPOs (BCBS, HealthNet, OmniCare, and Preferred Health Partnership) participating in TennCare at that time converted to HMOs. The change was most difficult for BCBS because of its size—BCBS covered nearly half the state's 1.2 million TennCare beneficiaries at the time. The state has no plans at this point to shift to a competitive bidding process as other states have, but will continue to contract with all plans that meet its HMO contracting requirements.

b. Tighter Enrollment Criteria and Children's Health Insurance Program (CHIP) Expansion

In January 1995, the state closed TennCare enrollment to the uninsured who were not otherwise eligible for Medicaid or who were uninsurable by virtue of extensive prior health problems. At the time, it intended to reopen enrollment to the uninsured periodically. However, reportedly because of financial problems, the state has not reopened enrollment to uninsured adults who are insurable. Enrollment has remained continually open for the Medicaid-eligible and the uninsurable.

Recently, the state opened enrollment to uninsured children and dislocated workers on a limited basis. In April 1997, the state opened enrollment to uninsured children (without income restrictions) age 17 and younger whose parents do not have access to workplace insurance, and in May 1997, it opened enrollment to dislocated workers. In January 1998, partly in response to 1997 federal legislation establishing the Children's Health Insurance Program (CHIP), the state opened enrollment to 18-year-olds and all uninsured children with family income below 200 percent of the federal poverty level (FPL) regardless of their access to private insurance. Though the period of enrollment was supposed to last just three months, the state is likely to keep it open for the year. Further, the state reduced some of the cost-sharing requirements (eliminating the $250 annual deductible previously payable by the enrollee and reducing co-insurance) for all children below 200 percent of FPL, but maintained the premium payments (Table 1).

TennCare premiums for both groups of newly eligibles (uninsured children and dislocated workers) are based on family income, as they are for all other non-Medicaid-eligible TennCare beneficiaries (Table A-2).

c. Phase-Out of Most Transitional Financing Pools

The special financing pools set up to assist in the transition to TennCare have been mostly eliminated, including pools for essential service providers and malpractice. The GME pool was eliminated but then reinstated in July 1995 to enhance primary care training by directing money to universities rather than medical facilities. The impact of these changes on safety net providers is discussed later. A medical technology pool and a $40 million adverse selection pool are the only pools currently operating. Plans report receiving payments from the latter, but they have found distribution of funds unpredictable.

d. Implementation of TennCare Partners, the Mental Health and Substance Abuse Carve-Out

The TennCare program originally stipulated that both mental health and acute care be provided and managed by the MCOs. However, state program administrators were reportedly “uneasy” about the MCOs’ lack of experience and knowledge of mental health services. Consequently, they excluded from TennCare non-Medicaid-covered, more extensive mental health benefits for seriously and persistently mentally ill (SPMI) adults and for children with severe emotional disturbance (SED) and continued to provide them on an FFS basis. However, Medicaid-covered mental health benefits for the SPMI, SED, and more casual users of mental health services were included. Ultimately, to contain costs and subject all behavioral health services to managed care processes, the state decided to carve out the entire behavioral health benefit in July 1996, creating the TennCare Partners program through which it began contracting directly with separate, capitated behavioral health organizations (BHOs) to provide all behavioral health services. In creating Partners, the state also redirected non-Medicaid block grant funding into the capitation payment to the BHOs for the first time. Prior to that, only Medicaid funding had been included in capitation payments to the MCOs, leaving block grant funding for community mental health centers and other community providers intact. State administrators hope that MCOs will eventually assume management of both acute care and mental health benefits.

The TennCare Partners program was implemented July 1, 1996. Two BHOs were awarded state contracts to serve all TennCare members, including the SPMI and SED population. Each MCO except for BCBS is affiliated with one of the BHOs. Because of its large size, BCBS has members in both BHOs. Individuals receiving court-ordered

mental health services were originally included in the BHO carve-out but have since been excluded.

The TennCare Partners program has been problematic from its inception. Commonly heard complaints include inadequate networks, poor payments, and lack of care coordination. Although some of the problems are similar to those initially encountered by TennCare and eventually overcome, other problems appear to be structural and therefore may be more difficult to resolve. A separate paper on the experience of special populations under TennCare focuses specifically on the behavioral health carve-out. For this reason, and because the structure of the TennCare Partners program is largely parallel to and separate from TennCare, experiences of the carve-out are not discussed in detail in this paper. However, this related experience is important to keep in mind when considering the lessons from TennCare.

3. Concurrent Contextual Changes

Along with changes made or planned by TennCare itself, important external changes have had a considerable effect on the program. These changes include the enactment of CHIP, new federal legislation concerning health insurance for children, and welfare reform. The latter resulted in the elimination of the Aid to Families with Dependent Children (AFDC) program and the creation of a new welfare program. Changes in the political composition of the executive and legislative branches of the Tennessee state government also affected TennCare. Each of these external changes is discussed below.

a. Children's Health Insurance Program (CHIP)

CHIP essentially enables all states to expand insurance coverage to low-income uninsured children not previously covered under their Medicaid programs by offering the states an enhanced federal matching rate for doing so. Even before the creation of CHIP, Tennessee had planned to reopen enrollment to uninsured children under age 18 regardless of income and without access to insurance in the workplace. CHIP simply allowed the state to receive a higher federal match rate (75 percent) to cover low-income children.[4] The additional federal money made available through CHIP also enabled Tennessee to expand enrollment and decrease cost-sharing for certain groups.

[4]TennCare expanded enrollment two weeks before the official enactment of CHIP. However, an amendment passed in November 1997 changed the effective date to include the TennCare start date of April 1 so that Tennessee would be eligible for the enhanced federal match.

TABLE 1

TIMELINE OF SELECTED MONTHS IN WHICH CHANGES WERE MADE IN TENNCARE ENROLLMENT, BY GROUP[5]

	January 1994	*January 1995*	*April 1997*	*May 1997*	*January 1998*
Adults:					
Medicaid	Open	Open	Open	Open	Open
Uninsured	Open	Closed	Closed	Open to dislocated workers only	Open to dislocated workers only
Uninsurable	Open	Open	Open	Open	Open
Children:					
Medicaid	Open	Open	Open	Open	Open
Uninsured <200% FPL*	Open	Closed	Open only if no access to work-place insurance	Open only if no access to work-place insurance	Open regardless of access to work-place insurance
Uninsured > 200% FPL	Open	Closed	Open only if no access to work-place insurance	Open only if no access to work-place insurance	Open only if no access to work-place insurance
Uninsurable	Open	Open	Open	Open	Open

*For all children living at less than 200 percent of the federal poverty level (FPL), deductibles have been eliminated and coinsurance reduced to 2 percent as of January 1, 1998.

[5] In early 1999, Governor Sundquist proposed closing enrollment to new uninsurable applicants for 6 to 12 months.

b. Temporary Assistance for Needy Families (TANF)

The replacement of the AFDC program with the TANF program, created under federal law in 1996, effectively decoupled welfare and Medicaid at the state level.[6] In 1996, Tennessee already had an AFDC waiver that preceded federal enactment of TANF which it elected to continue. Like TANF, Tennessee's welfare program, Families First, decoupled welfare and Medicaid. Families First, implemented in 1996, is administered by the same state department (Department of Human Services) that administered Tennessee's AFDC program.

According to TennCare Bureau staff, replacing the AFDC program with Families First has had little or no impact on the TennCare enrollment processes. As with the AFDC program, one year of automatic enrollment in the TennCare program is assured for Families First participants. Once a Families First recipient finds employment, and his or her income exceeds Medicaid eligibility requirements and transitional Medicaid benefits (extended to 18 months under Tennessee's AFDC waiver) are no longer available, he or she has only one month to apply for TennCare (unless he or she is uninsurable, in which case enrollment is continually open).[7]

c. Changing Policy Context

The political climate in Tennessee has shifted somewhat over the past four years. When TennCare was first developed and implemented in late 1993 and early 1994, the state had both a Democratic governor and legislature, which had developed a strong and trusting working relationship. The strength of this relationship, which was viewed as critical to the successful implementation of TennCare, seems to have eroded over time. Consequently, the legislature's TennCare Oversight Committee has assumed a more active role in program policy. The joint committee does not have authority to pass or veto legislation, but it meets weekly when the legislature is in session and serves as a public forum for shareholders, consumers, providers, and plans to present their concerns or air any grievances regarding the program. However, since the site visit, the

[6]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) replaced the AFDC program with the TANF program, a new federal block grant to states. Before TANF, anyone who received cash assistance through AFDC was automatically entitled to Medicaid. The new law requires states to use the AFDC eligibility criteria of July 1996 (just before enactment of the TANF program) to determine Medicaid eligibility for families with children, regardless of TANF eligibility requirements. Tennessee uses 1993 Medicaid eligibility criteria.

[7]By federal law, states are required to provide six months of extended Medicaid coverage to each working family that received AFDC in at least three of the past six months but lost such assistance because of increased income from work. Further, families that are covered for the six-month period qualify for a second six-month extension if they have incomes below 185 percent of the FPL. However, Tennessee's AFDC waiver extended transitional benefits to 18 months.

TennCare Oversight Committee has lapsed. Although the legislature intends to renew it, partisan politics have effectively prevented it from doing so. As a result, future legislature oversight of the program is uncertain.

The strong executive branch leadership of TennCare has likewise changed over time. Two well-seasoned and experienced members of the executive branch, Commissioner of Finance and Administration David Manning and TennCare Bureau Chief Manny Martins, were responsible for much of the design and implementation of the program. But in 1995, Republican Don Sundquist was elected governor. Shortly thereafter, David Manning and Manny Martins left the administration and were replaced with less-experienced appointees who from the start indicated an interest in remaining only for a short time and have likewise left. Since their departure, the TennCare Bureau has been headed by a career staffer with many years' experience administering the TennCare program. Since the site visit, she too has left, moving to the Commissioner of Health's office, calling into question the future administration of the program.

Contrary to the positive trend in many other states, the fiscal situation in Tennessee has not improved considerably since 1994. With the economy strong throughout the country, many state budgets are flush with additional revenue. Tennessee, however, does not have a state income tax. As a result, its revenue base is not significantly stronger than it was the first year of TennCare. Maintaining state spending on TennCare at no more than historical levels is still an important objective. Although the additional funding available through CHIP has enabled the state to expand eligibility for uninsured children, the state has not dedicated the necessary funding to reopen enrollment for adults who are not otherwise eligible for Medicaid or are uninsurable. Whether the state lacks the financial resources or the political will to do so is a question debated in Tennessee.

C. PROGRAM EXPERIENCE IN KEY OPERATIONAL AREAS

This section analyzes program experience from 1994 through the end of 1997 in key operational areas, focusing on the critical areas defined in MPR's 1995 case study. These include issues related to enrollment, managed care participation, payment rates, provider participation, and state administration and oversight.

1. Enrollment Trends Over Time

Total TennCare enrollment in early 1998 was up to the year-end 1994 level of 1.2 million after a few years of slight declines (Table 2). The declines resulted primarily from decreases in the number of uninsured and uninsurable participating in the program. The participation of these subgroups most likely declined because of a combination of

four factors: natural attrition, the state's closing of enrollment to the uninsured until very recently (and then only for children), faulty administrative systems and data that erroneously terminated some from TennCare rolls, and implementation of a system to collect premiums that was absent in the first year. With the development of the latter, a significant number of enrollees unable to pay their premiums were dropped from TennCare rolls. Unfortunately, little information exists about these individuals and their current insurance status and access to care.

Medicaid enrollment has not declined as much as many believed it would with the implementation of Tennessee's welfare reform program, Families First. Although the number of Tennessee residents qualifying for welfare benefits declined 45 percent from January 1994 (when TennCare was implemented) to June 1997, from 303,000 to 167,000, enrollment in Medicaid decreased only slightly during this period.[8]

One possible explanation for stability in Medicaid enrollment despite the effects of welfare reform is TennCare's separate identity. Because of the large size of the TennCare program and its inclusion of non-Medicaid-eligible residents, it is less likely to be identified with state welfare programs. Thus, the decision to apply to the TennCare program may be independent of the receipt of welfare benefits. Furthermore, the effect of welfare reform on Medicaid may not be felt until later, as the 18-month transitional Medicaid benefit is still available to former AFDC recipients.

2. Structure and Administration of the Enrollment Process

The structure of the enrollment process remains largely intact from the first year of the program; only the enrollment process for the new group of eligible children differs significantly. The administration of the enrollment process appears considerably smoother after four years for all but two groups of eligibles: prospective eligibles (pregnant women and their newborns) and retrospective eligibles (members whose effective date of enrollment precedes the date the MCO is informed it has been assigned a new member). Enrollment for these two groups still appears to create considerable confusion. However, because enrollment has not increased significantly

[8]Further examination of those qualifying for Medicaid indicates that the number of beneficiaries (adults and children) receiving cash assistance in 1996 is similar to that in 1993 (320,000) with slight increases in 1994 and 1995.

TABLE 2

TENNCARE ENROLLMENT OVER TIME

Year*	Total Enrollment	Medicaid		Uninsured/Uninsurable	
		Number	*Percent of total*	*Number*	*Percent of total*
1994	1,251,008	836,647	67	414,361	33
1995	1,193,506	845,501	71	348,005	29
1996	1,152,666	850,334	74	302,332	26
1997	1,231,220	848,566	69	382,654	31

*All figures represent enrollment in December of the year indicated

SOURCE: TennCare Bureau, Tennessee Department of Health.

since the first year, the state's enrollment system has not been stressed. As the state moves to expand eligibility and enrollment to children, the enrollment process may face a more serious test.

For uninsured children for whom enrollment has been open since April 1997, the state contracts with local health departments to perform most of the enrollment activities, including verification of application information, confirmation of eligibility, submission of completed applications to the TennCare Bureau, and collection of applicable premiums, if any. The local health departments also assist in outreach activities geared toward potential eligibles, including helping residents complete applications, distributing provider network information, and educating members about the TennCare benefit package.[9] To assist the local health departments in performing outreach activities, the TennCare Bureau provides them with monthly updates by county of new TennCare enrollees added and those whose coverage was terminated.

According to Nancy Menke, Tennessee's commissioner of health, the bureau decided to contract through the local health departments for enrollment assistance for two reasons: first, to put a public face on the TennCare program, and second, to include outreach and benefits education as part of the enrollment process. The local health departments that the team visited in Memphis and Chattanooga were developing outreach programs to reach potential eligibles that consisted of public service announcements, community health fairs, and communication with community leaders. However, the two differed in their approach, with the Chattanooga health department taking a more active approach, placing outreach workers in clinics and conducting eligibility verification in children's homes when necessary. The Memphis health department, in contrast, maintains a single, central site where all enrollment and education activities are conducted.

At the time of the site visit in January 1998, the number of eligible children enrolling was lower than projected. Slightly fewer than half the estimated 50,000 newly eligible children have enrolled in the year since enrollment has been open to them. Officials from local health departments suggested that either the monthly premiums or the fact that only the children and not the entire families were eligible may have deterred some from enrolling. They were hopeful that elimination of the deductibles for those under 200 percent of the FPL would encourage more to enroll.

[9]The contract between TennCare and the local health departments in effect at the time of the site visit was for one year, beginning July 1997, during which time TennCare was to pay the health departments, collectively, over $21 million to perform these functions.

In addition to the disappointing enrollment rates for this new group of eligibles, enrollment of two traditional groups of TennCare eligibles (prospective and retrospective eligibles) remains problematic, though for different reasons. Prospective or presumptive eligibility was created to help assure pregnant women immediate access to prenatal care. Rather than having to wait the two to six weeks it takes to process an application before enrolling in the program, a pregnant woman can enroll immediately on a presumptive eligibility basis through a local health department. However, data indicate that more than 20 percent of women granted presumptive eligibility in 1996 either did not enroll in TennCare on a more permanent basis or experienced a gap in enrollment after presumptive eligibility expired (Phillippi 1997). This figure has decreased only slightly since 1993.

Although providers reported that they had been told to assume all newborns belong to the same plan as the mother, the state appears to have assigned some newborns to different plans. This situation created confusion when providers and plans were informed only after the fact that a newborn had been assigned to them. Plans balked at being told they were financially responsible for covering all costs incurred, even though they had not been involved in any care management decisions. According to staff in one local health department, however, the state has since reverted to its policy of assigning all newborns to their mothers' MCO.

Retrospective eligibility is primarily an issue for plans and occurs when a member's effective date of enrollment precedes the date the MCO is informed that it has been assigned a new TennCare member. This may happen because applicants are eligible for TennCare benefits on the date the application is received by the bureau even though a lag may exist between the date of application and receipt of supporting materials (and assignment to an MCO). During this period, a TennCare beneficiary may use services that an MCO did not approve or have any knowledge of, but for which the MCO is still financially responsible. MCOs believe this requirement is unfair because they are effectively unable to manage the care. Phoenix Healthcare estimates that retrospective eligibility cost the plan more than $2 million last year, causing considerable financial hardship. The state is reportedly examining the frequency and seriousness of this problem.[10]

[10]The subject of retroactive eligibility and its impact in terms of care management and financial stability was explored in "TennCare Under Stress: Lack of Control Burdens MCOs," *Nashville Banner,* November 9, 1997.

3. Trends in MCO Participation

The number of plans participating in the program has remained fairly stable, with limited merger activity. BCBS bought the University of Tennessee Health Plan in 1995, and Phoenix Healthcare bought the right to serve TennCare enrollees through Health Source (another small plan) in 1996 and bought and merged with HealthNet (an 80,000-member plan with ties to the Baptist Health System based in middle Tennessee) in late 1997. The state's requirement that all PPOs convert to HMOs and assign primary care gatekeepers to all members by January 1997 did not discourage any PPOs from continuing to participate. That so many plans (including relatively small ones) have remained in the program and not withdrawn or merged has surprised many in the state.

TennCare enrollees continue to be concentrated in two statewide plans, BCBS and Access MedPlus, which together serve nearly three-quarters of the TennCare population (Table 3). After the first year, these two plans served 616,000 (49 percent) and 307,000 (24 percent), respectively, of the TennCare population. However, the plans drew most of their members from different parts of the state. BCBS drew members from eastern Tennessee and throughout the state but relatively few from Memphis/Shelby County. Nearly one-third of the membership of Access MedPlus comes from Memphis/Shelby County. Three years later, both the proportion and geographic distribution of the TennCare population served by BCBS and Access MedPlus remain virtually unchanged.

A third plan, Phoenix Healthcare, expanded statewide in 1995. Phoenix's purchase of Health Net in late 1997 nearly doubled its TennCare enrollment and solidified its position as the third largest TennCare plan in the state, serving 14 percent of all TennCare enrollees. Other plans have also expanded their service areas, so that TennCare enrollees now have between four and seven plans to choose from in a given area (up from two to six after the first year of the program). The fourth and last plan to expand statewide was PHP in 1997. Many plans still serve small geographic areas and enroll fewer than 50,000 TennCare enrollees each. TLC and Vanderbilt, for example, are hospital-sponsored plans that mainly serve the area surrounding their sponsoring hospitals.

In what many in the state interpreted as a sign of future difficulty maintaining MCO participation, three plans were voluntarily closed to enrollment for all or part of 1997—HealthNet, John Deere, and BCBS (except in Memphis). BCBS officials cited their concern that BCBS not serve more than half the TennCare population as well as their desire to limit their financial exposure as the main reasons for their decision to close

enrollment for 1997. Information from the state comptroller's office suggests that TennCare plans are currently experiencing greater financial difficulty than they have at any other point during their TennCare participation. According to the comptroller, for the first three years of the program, the MCOs reported positive financial experiences under the TennCare program. However, for the first nine months of 1997, plans lost in aggregate more than $20 million on TennCare. The factors responsible for these losses are unclear. However, if financial difficulties continue, many fear that temporary plan closures (though now reversed) will escalate to permanent closures and plan withdrawals. Since the site visit to the state in early 1998, BCBS has agreed to reopen enrollment throughout the state, a move many hope signals a permanent return to full participation in the program.

However, recent events have led the issue of the adequacy of program funding to resurface. In late March 1999, Tennessee officials assumed control of Phoenix health plan (doing business as Xantus Healthplan as a result of the Health Net merger) after the plan reportedly showed a negative net worth of $28 million for 1998 (American Healthline, April 1, 1999).[11]

4. Trends in Payment Rates and Methods

As originally envisioned, the capitation rates were to be increased as necessary and as funding was available. As of June 1997, MCO rates had increased 13 percent across all categories since the inception of the program. However, this increase includes a behavioral health carve-out of $7.53 per member per month. Without the carve-out, MCO rates would have increased nearly 20 percent across all categories during this three-and-a-half-year period.[12] Providers note that MCOs do not necessarily pass rate increases on to providers. With the discontinuation of the essential community provider pool, some safety net providers are actually receiving lower payments today than they were in year one. The state legislature has approved an additional 3 percent rate increase retroactive to July 1, 1997. This increase is added to a 1 percent increase (also effective July 1, 1997) that is distributed from the new medical technology pool.

[11] The rehabilitators are former TennCare officials Manny Martins and David Manning (American Healthline April 6, 1999). Advocates argue that the erosion of performance was due to acquisition of HealthNet which had unanticipated debts, though industry believes that state's capitation rates also contribute.

[12] From July 1995 through June 1996, the rates were increased by 9.5 percent. From July 1996 through June 1997, the rates were increased by 4 percent (including the behavioral health carve-out), with an additional 1 percent increase set aside in a $40 million adverse selection pool.

TABLE 3

ENROLLMENT BY PLAN OVER TIME

	1995		1996		1997		1998	
	Enrollees	*Percent Total Enrollment*	*Enrollees*	*Percent Total Enrollment*	*Enrollees*	*Percent Total Enrollment*	*Enrollees*	*Percent Total Enrollment*
Access MedPlus	306,585	24	248,006	21	249,064	22	289,608	24
Blue Care[1]					113,160	10	104,321	9
Blue Cross	616,006	49	626,968	54	457,915	40	426,062	35
HealthNet[2]	78,756	6	70,249	6	80,905	7		
John Deere	18,454	1	17,073	1	22,741	2	22,189	2
Omnicare	68,974	5	51,650	4	39,150	3	44,250	4
Phoenix Healthcare	36,379	3	36,467	3	53,043	5	171,707	14
PHP	63,947	5	54,391	5	61,007	5	91,121	7
Prudential	8,283	1	8,882	1	9,795	1	11,118	1
TennSource	4,263	0.3	3,490	0.3	4,004	0.4		
TLC	37,953	3	32,472	3	32,706	3	47,774	4
Total Health Plus	6,944	1	4,530	0.4				
Vanderbilt	14,033	1	10,150	1	9,611	1	11,362	1
Total	**1,260,577**		**1,164,328**		**1,133,101**		**1,219,512**	

[1]Blue Care is a wholly owned subsidiary of Blue Cross.
[2]Phoenix Healthcare purchased Health Net in December 1997, absorbing 81,316 of Health Net's TennCare members.
NOTE: All figures represent enrollment in January of the year indicated.
SOURCE: TennCare Bureau, Tennessee Department of Health.

However, plans and providers believe this 4 percent rate increase will prove inadequate given the scope of the benefit package and the fact that the state has not effectively adjusted rates to account for adverse selection. Having commissioned an independent accounting firm (William Mercer) to compare encounter data with expenditure data, the state plans to increase some but not all rate categories, so that, on aggregate, rates will increase 4 percent. Two rate categories that were overfunded, according to the state, were the blind/disabled and nondisabled adult male rates. The rate for the dual eligibles, on the other hand, was reportedly too low. Although the forthcoming rate increase and adjustment will attempt to correct these deficiencies among rate cells, they do not address the issue of the adequacy of overall plan payments or risk adjustment beyond the established rate cells.

The formula for distributing funds from the state's adverse selection pool, established to compensate plans for the care of high-cost or high-risk enrollees, leaves some uncertainty as to the amount plans can expect to receive, because payments depend not only on the number of high-risk plan members but also on the risk profile of the entire TennCare population.[13] Plan staff indicated that although they received the payments from the state for 1996 and the first half of 1997, they are still waiting for documentation from the state as to how the payments were calculated and until then have no basis for determining whether the adverse selection payments are adequate. Smaller plans have objected to the method of distribution, which stipulates equal payments for each high-risk enrollee, arguing that they are subject to a disproportionate amount of adverse selection that larger plans can offset. Nationally, risk adjustment methods remain relatively inexact and are subject to considerable debate.

The issue of adverse selection is further exacerbated by the state's closing of enrollment to the uninsured while enrollment of the relatively less healthy uninsurables has remained open. Many plans perceive that enrolling relatively unhealthy uninsurables without enrolling healthier uninsured beneficiaries has led to adverse selection and corresponding poor financial outcomes. The closing of enrollment in three plans for all or part of 1997 has further concentrated the uninsurable population in a subset of plans. Although the state has opened enrollment to uninsured children, plan staff note that the number of children meeting the criteria and enrolling in the program is too small to offset the high cost of caring for uninsurables. However, none had data to

[13]Distribution from the fund is based on the number of plan enrollees who meet adverse selection criteria, defined by TennCare as "a health care factor such as age, race, sex, pre-existing medical condition, or episodic medical event which has been demonstrated statistically to increase both the utilization and cost of services provided to a defined subpopulation of enrollees" (Health Systems Research 1997). Equal payments are to be made for each high-risk enrollee.

support their assertions about the number of uninsurables and their financial impact on plans and the program.

5. Trends in Provider Participation and Network Development

When the TennCare program was first initiated, providers were extremely resistant and many refused to participate, as documented in the first case study. However, BCBS, the largest plan in the state, instituted a "cram-down" policy during the first year that required physicians to participate in TennCare PPO in order to participate in BCBS's commercial PPO. Although many providers resented this provision, others credit it with enhancing capacity in TennCare and possibly eroding provider resistance to the program. In fact, after the first year of the program, the large initial drop in physician participation was almost fully reversed.

Provider networks have grown significantly since the first year of the program. Pockets of inadequacy are said to exist in some rural areas and for some specialties, but they are largely undocumented. Pharmacy networks have likewise reportedly matured since the confusion of the first year, and formularies have been standardized across the plans. Most plans report that their primary care networks are adequate, and the state confirmed relatively few instances of noncompliance with state geo-access standards (which stipulate that a contracted primary care provider and hospital be within 30 miles/minutes of a plan member). The geo-access standard does not apply to specialists, however.

Specialties that are still said to be under-represented in MCO provider panels include ear, nose, and throat; neurosurgery; and orthopedics. The latter have "boycotted" participation in the TennCare program since the program's inception. These providers reportedly refuse to join plan networks because they do not wish to subject themselves to the "hassles" of contracting with MCOs and because of difficulties procuring plan payment for services rendered. Some specialists treat TennCare members as out-of-network providers on an individual basis, which provides greater flexibility and allows higher payments. However, primary care providers (PCPs) report that out-of-network care is often difficult to arrange and the resulting uncertainty and delay are stressful to the provider and patient.

The introduction of the gatekeeper requirement, according to BCBS, the largest PPO at the time, actually enhanced PCP participation in its plan and increased satisfaction levels among its specialists. By assigning members to a single PCP, the plan was able to guarantee a certain volume of plan members to participating providers, a feature with considerable appeal to providers seeking to maintain or expand their

market share. The PCP gatekeeper also relieved specialists of the burden of referring patients back to generalists to care for routine problems. Advocates contend, however, that elimination of the cram-down, while encouraging greater PCP involvement, may have adversely affected specialist participation and created access problems.

6. Evolution of State Administration and Oversight

a. Administration

After the first year, oversight and administration of the TennCare program were still relatively immature and fragmented. PPOs and HMOs were regulated by different agencies (the TennCare Bureau and DCI, respectively), with DCI only minimally involved in the design and ongoing operation of the TennCare program. In addition, after the first year, few monitoring activities had been implemented on an ongoing basis. Instead, the short implementation time frame required a focus on urgent administrative needs, with only limited work on more generic administrative and oversight systems. Instead of preventing problems before they arose, TennCare systems in the first year dealt with them after they arose, addressing most problems on a case-by-case basis.

Since then, TennCare's administrative structure and monitoring activities have evolved considerably and are now uniform throughout the program. Three departments (TennCare Bureau, the TennCare Division within DCI, and the Comptroller of the Treasury) now share responsibility for monitoring the TennCare program. The roles and responsibilities of the three departments are more clearly articulated than they had been previously. The TennCare Bureau is responsible for administering the TennCare program and ensuring that the MCOs and BHOs deliver quality health services to TennCare enrollees. Financial oversight of the program is largely delegated to DCI and the comptroller's office.

Activities among the three appear to be well coordinated. DCI, through an interdepartmental agreement with the bureau, and the state comptroller's office, on contract to the bureau, conduct regular audits of all MCOs and BHOs. The audits involve site visits every 18 months to review plans' compliance with specific aspects of their contracts. DCI and the comptroller's office report regularly on the results of the audits and have developed a system to track plan deficiencies until adequate resolution has occurred. The TennCare Bureau retains responsibility for monitoring quality of care and access, contracting with an external quality review organization (EQRO), First Health, to monitor both the MCOs and the BHOs. First Health administers a standard annual audit of every MCO and a follow-up focused study on those areas identified during the annual audit as requiring additional attention.

As the administrative structure has evolved over time, so too have the staff involved in monitoring and oversight. When the program was first implemented, TennCare staff had no direct knowledge of or experience with managed care programs and systems. Rather than hire new staff with managed care expertise, the bureau decided to develop the capabilities of existing staff. The bureau chief told us she is pleased with the staff's progress in adapting to a managed care system. Until recently, TennCare had been headed by a career staffer with considerable experience, who assumed control after several turnovers in top administrative staff. The interim bureau director has indicated that she will not stay permanently and it is not clear who will replace her.

Although administrative systems have matured over time, plan staff still report considerable frustration with what they feel is the bureau's lack of understanding of managed care. MCOs perceive that the state, by including additional benefits in the capitation rate, repeatedly attempts to hold them financially responsible for care they had no knowledge of or way to manage. Plans also are concerned that TennCare staff alter standard operating procedures without negotiation or adequate preparation. According to some plans, such alterations have hindered their development of managed care processes and systems.

The ability of TennCare oversight to evolve also has been hampered by the turnover in key program staff. In early 1999, after our visit, press reports highlighted the departure of several key officials, including Nancy Menke and other senior TennCare officials and Bill Young who oversaw TennCare in the Insurance Department (American Healthline 1/7/99 and 2/5/99). While a search firm reportedly is seeking to fill the Directorship position, the instability of leadership has raised concern for the stewardship of the program.

Problems with the implementation and oversight of the TennCare Partners program (the behavioral health carve-out) also have diverted essential department resources. Staff are repeatedly called upon to address issues and problems that arise within the carve-out, leaving them less time to devote to monitor the basic program.

b. Quality Monitoring

A new TennCare director of quality assumed responsibility in May 1997. She noted that a comprehensive quality improvement (QI) program at the bureau had taken nearly three years to develop. The QI program's staff of 18 together with the EQRO monitor the following three areas: access to care, quality of care, and outcome measurement. Some plan staff have suggested that outsourcing quality monitoring audits (to an EQRO) has hindered staff development within the TennCare Bureau.

The bureau's current method of access monitoring is an example of how the quality assurance program has evolved. In addition to monitoring plan networks with respect to geo-access standards, in May 1997 the bureau began to contact providers directly regarding their availability and accessibility. The bureau's first survey focused on access to prenatal care for pregnant women. TennCare staff called 600 obstetric providers to confirm their participation in MCO networks and their willingness to accept new members, and to ask about other access issues such as waiting time for appointments. Four of the ten plans had no deficiencies. Among the remaining six plans, deficiencies were identified in a total of 17 counties. Discrepancies between MCO networks and provider reports in these areas were brought to the plans' attention and a corrective action plan was developed. TennCare staff are planning a follow-up telephone survey of 1,500 pediatric providers.

The role of the EQRO, which conducts the plan audits and special studies, has also evolved over time, according to MCOs and the state. The EQRO now reportedly conducts more sophisticated analyses and audits, considering, for example, not only the type of quality-of-care studies the plans have conducted but the methodology behind them. In addition, TennCare staff note that the recent development and refinement of an adequate encounter data collection system has, for the first time, enabled the EQRO to conduct more detailed reviews of clinical access and quality indicators. Examples of studies and reports that the EQRO has conducted include "Inpatient Admissions Due to Diabetes," "Pediatric Asthma Admissions," "ER Visits," "Delivery of Preventive Services," and "Ambulatory Care, Infant Death and Prenatal Care."[14]

D. TENNCARE'S EFFECT ON ACCESS TO CARE AND THE SAFETY NET

1. Expansion of Coverage, Satisfaction, and Choice of Providers

All agree that the TennCare program has expanded access to insurance coverage among the previously uninsured. According to a survey conducted by the University of Tennessee under contract to the TennCare Bureau, the proportion of Tennessee residents without insurance has declined from 8.9 percent in 1993, the year before the TennCare startup, to 5.9 percent in 1997, translating to an additional 130,000 insured persons (Fox and Lyons 1998). Reports on the accessibility of services for TennCare enrollees are somewhat mixed. Plans and providers generally believe that a wider variety of providers are available to serve TennCare enrollees than were available under traditional Medicaid. This greater variety likely results from a combination of

[14]Staff from some of the plans, however, question the validity and completeness of the encounter data on which these studies are based.

factors, including the deliberate strategy among some plans to increase reimbursement levels for primary care under TennCare and the more competitive nature of health care in Tennessee (as in the nation generally), which has increased the relative value of TennCare as a payor (compared with commercial payors and Medicare). The shift to a PCP gatekeeper appears to have increased provider participation by guaranteeing PCPs a certain patient volume. Hospitals that have not traditionally served the Medicaid population are likewise serving an increasing number of TennCare members as part of a stated goal to attract and maintain greater market share. The extent to which the provider pool has expanded under TennCare, however, is difficult to assess. Although individual plan networks are expanding, they may be including the same core sets of providers.

TennCare beneficiaries appear to appreciate the new, expanded choice of hospitals available to them and no longer rely on traditional safety net hospitals as they have in the past. In Memphis, for example, the Regional Medical Center (the Med), which had been the traditional safety net provider and main provider of inpatient care for Medicaid beneficiaries prior to TennCare, has been replaced by another, more mainstream provider of inpatient care, Methodist Health System. According to some observers, this shift is a direct outcome of the greater choice TennCare enrollees now have compared with traditional Medicaid in terms of the number and types of providers willing to treat them. Although PCPs and hospitals appear increasingly available, some specialties are still under-represented in MCO provider panels, most likely as a result of poor MCO payment for specialty care as well as the greater potential for specialists to treat patients on an “as needed” basis, without formal plan interaction.

Studies of service use and satisfaction under TennCare conducted by the EQRO and the University of Tennessee show improvements over previous Medicaid experience. Studies by the EQRO regarding enrollee access to preventive services (defined as mammographies, Pap smears, and routine dental care) indicate a slight improvement over pre-TennCare experience. In addition, results of the survey conducted by the University of Tennessee indicate that after declines in 1994 and 1995, the satisfaction levels among TennCare enrollees in 1996 and 1997 (81 percent) were roughly the same as those recorded for Medicaid beneficiaries surveyed in 1993 (the year before TennCare was implemented) (Fox and Lyons 1998). The survey also

indicates that access to care on an ambulatory basis may have improved under TennCare. According to the 1997 survey, the proportion of those seeking medical care from doctor's offices has increased from 66 percent in 1993 to 74 percent in 1997, while the proportion seeking care from hospitals has declined from 14 percent in 1993 to 7 percent in 1997.[15] In addition, advocates laud improvements in the grievance/appeals procedures established by the TennCare Bureau and believe they compare favorably with the procedures of any other program elsewhere in the nation.[16]

On the other hand, some plans report a disturbing number of enrollees who do not appear to have accessed primary care services (this finding could, however, simply reflect encounter data deficiencies) and a high percentage who continue to rely on the emergency room. This pattern is the primary reason why plans that currently capitate primary care providers are considering a return to FFS payments in order to provide financial incentives for their PCPs to see their patients more often rather than refer them to emergency departments after hours or on weekends. However, providers the team met with opposed the reversion to FFS, noting that they have adapted their systems (both financial and care management) to capitated payments, which ensure steady cash flow and enable better resource planning. A return to FFS, some providers say, would disrupt their operations significantly, with potential adverse impacts on access to care.

Access to some specialty care remains poor. A provider in Chattanooga reported having to send some children as far as Nashville, 125 miles away, for some specialty services. While Medicaid access to some specialists has always been problematic, even before TennCare, some specialty groups (such as orthopedics) became more resistant to serving Medicaid with the implementation of TennCare, and their resistance has not abated.

[15]These figures represent rates for heads of households surveyed but are similar to those reported for children.

[16]The TennCare Bureau periodically reviews and tabulates all appeals received, comparing the number of appeals by region and by plan. For the first six months of 1997, 514 appeals (0.89 appeals/1000) were received, of which more than 60 percent were pharmacy related. Of those appeals that have been resolved, 54 percent were reversed by the MCO, 29 percent were withdrawn by the enrollee, and 14 percent were reversed by the Appeals Unit.

2. The Safety Net and Access to Care for Those Remaining Uninsured

Tennessee's safety net system is diverse and varied. In Nashville, for example, community health centers and public hospitals care for TennCare and uninsured residents. In Memphis, the health department is still a major provider of care for both TennCare and uninsured residents, and the public hospital serves considerably fewer Medicaid beneficiaries than it did before TennCare. Just as the composition of the safety net varies throughout the state, so too has the effect of TennCare on safety net providers.

The safety net does not receive any special consideration under the TennCare program. Tennessee initially maintained an "essential provider" pool for traditional Medicaid providers, but the pool has since been eliminated as it was intended only to provide transitional funding. In addition, the GME pool, which was eliminated but reinstated, no longer directs payment to the teaching hospitals, but instead pays universities directly. State and county health departments receive one special consideration: They receive FFS payments from the MCOs for traditional public health services provided to any TennCare enrollee, regardless of PCP assignment. The state's current attitude toward the safety net is that it does not deserve special consideration and should compete in the market on an equal footing with other TennCare providers.

After the first year, traditional safety net providers were contracting with multiple TennCare MCOs but were concerned about their ability to maintain their market share, procure adequate MCO payments, and survive financially with the elimination of transitional funding. While some have been successful on these counts, others have been less so. Safety net alignment with particular MCOs (such as Access MedPlus) that occurred after the first year remains, but most safety net providers contract with multiple MCOs to maintain their market share. With the elimination of many of the state funds for charity care and the essential provider pool after TennCare's first year, safety net providers have lost access to considerable subsidies. Some providers have been successful in developing the appropriate systems to contract with MCOs (e.g., claims payment, specialty referral, and authorization systems) and have maintained their patient and revenue base. Others have been less successful, losing their patients to private physicians (particularly African-American physicians with whom they had been previously aligned) and relying on financial reserves. Still others have not had the luxury of relying on reserves. For example, the Med, the largest safety net provider in Memphis, witnessed a significant loss of revenue as a result of a decrease in Medicaid admissions and a reduction of GME funding. To make up the loss, the Med lobbied

extensively for additional funding, relying on its history and strong community ties. It received nearly $11 million to cover some of its operational losses. However, this "emergency funding" was a stopgap measure, leaving the Med without a stable source of funding to continue to care for the indigent in Memphis.

Because of a general tightening of funds throughout the health care system and the elimination of funding for otherwise uncompensated or charity care, providers (particularly safety net providers) have found it increasingly difficult to care for the uninsured. Some providers report deploying scarce resources to accommodate managed care systems (i.e., referrals, authorizations, and claims payment), which effectively saps resources available to serve uninsured patients. As a result, access to care for those without insurance reportedly has declined.

For example, some safety net providers are seeing increasing numbers of uninsured patients, stressing their own systems considerably. One community health center in Nashville noted that roughly 20 percent of its patients were uninsured until another local safety net provider ceased serving the uninsured, when the proportion increased to 60 percent. At the same time, fewer resources are available to serve the uninsured because of competing demands from the TennCare program. If a large safety net provider such as the Med, whose weakened financial position and declining market share threaten its long-term viability, were to close, it is not clear that other providers would be able to absorb the indigent. Capacity is sufficient, but without a financing mechanism, providers under TennCare lack the necessary resources to care for the indigent.

E. CONCLUSIONS

The TennCare program, one of the first statewide comprehensive Medicaid managed care initiatives exercised under Section 1115 waiver authority, has evolved over its four years of operation. In this section, conclusions are drawn regarding TennCare's operational experience and important lessons from the state's experience, including key issues to continue to monitor over time.

Quick Implementation of Such an Expansive Program has Short-Term Costs, but Does Enhance the Potential to Put in Place Concrete Change.

Most of those in the state believe that quiet, "behind-the-scenes" development and quick statewide implementation of the TennCare program was the best, if not the only, way to achieve such broad-based reform. Given the variety of stakeholders and the public scrutiny that a program like TennCare would generate even during the planning phases, the program might otherwise never have been implemented. In addition, the underlying belief that a program as comprehensive as TennCare would be difficult to dismantle once it was established proved largely correct. Although the original architects of the program concede that the short-term costs were significant, they believe they were justified by the results: expanded coverage and financial stability of the state Medicaid budget. However, plans' poor financial performance in 1997, if not adequately addressed, could threaten the current stability. Whether TennCare will prove viable in the long term is a somewhat distinct question, and the answer could vary depending on how success is defined. A separate but key question now appears to be the state's ability to ensure adequate financing and further develop the organizational structure for its behavioral health program.

Expanding Eligibility Strengthens Support for the TennCare Program.

The TennCare program now has a broad-based supportive constituency. TennCare is supported not only by advocates for the poor and underserved who appreciate that the program both stabilized the budget and expanded access to the working poor, but also by many middle-class constituents who were previously uninsurable but now have coverage through the TennCare program. Expanding coverage to the latter group has contributed significantly to the program's broad base of political support. As one state official put it, "It's a program all Tennessee politicians are proud of."

The size and broad reach of the TennCare program may also have contributed to the state's steady levels of Medicaid enrollment over the past four years. TennCare's size may have helped shape an identity for the program that is separate from the state's welfare program (unlike the previous Medicaid program). As a result, Tennessee did not witness as sharp a decline in Medicaid enrollment as many other states did after the decline in welfare rolls. It will be important to monitor TennCare enrollment levels in the future as beneficiaries lose their automatic transitional benefits.

Lack of Sufficient Funding Prevents TennCare from Achieving its Goal of Broad Coverage.

Fiscal constraints reportedly have prevented the state from reaching its goal of expanding coverage to all Tennesseans, as the number of uninsured persons in the state continues to increase. Advocates, however, question whether fiscal constraints or a lack of political will is primarily responsible for the state's closing enrollment to uninsured adults.[17] The state's continued closure of enrollment to uninsured adults while enrolling Medicaid beneficiaries and the uninsurable has also contributed to adverse selection among those enrolled in the program. Though CHIP funds have enabled the state to reopen to some extent, incoming money from the children enrolling through CHIP will not be sufficient to offset the costs of the uninsurables. The fiscal stability of TennCare is further at issue given the reported erosion in the program's fiscal base and its proposed closing of new enrollment by uninsurables.

Administrative Systems Mature Slowly.

The state has continued to develop TennCare's administrative structure and processes. For the basic TennCare program, the past three years have been relatively tranquil compared with the first year, facilitating the development of oversight systems. Oversight of the financial health of the MCOs has improved considerably as a result of the creation of the TennCare division within DCI, the development of a comprehensive examination plan, and the continued development of a strong working relationship between DCI and the comptroller's office. This relationship has allowed the two offices to pool resources and work more efficiently.

However, while program administration is stronger, issues still outstanding are likely to take many years to address. The challenge inherent in a shift of this magnitude is manifest in both the quality assurance activities of the state, which, after four years, still resemble an FFS Medicaid surveillance system, though they are changing. Also, the plans perceive that the state views the TennCare benefit package more as a "block grant" than a capitation system for a defined benefit structure that encourages the development of efficient and effective care management. Such a perception highlights the challenge for bureaucracies that seek to shift their financing and delivery mechanisms, partcularly when their ability to retain top staff and stable leadership is limited.

[17]As evidence, advocates point to the state's recent allotment of $34 million in additional funding for nursing home care.

Tennessee Grew a Managed Care Industry from a Very Limited Base.

Starting from a limited base of managed care, the state was able to attract multiple plans to participate in TennCare. However, TennCare's first year raised key questions about the state's ability to evolve managed care from the ground up. Four years after implementation, TennCare appears to have effectively jump-started a growing managed care industry in Tennessee. Managed care enrollment in the commercial and Medicare sectors, though lagging that of Medicaid, is increasing. However, developing the systems to truly manage care is challenging and time-consuming. Initially, plans simply managed costs through primary care capitation and discounted FFS. Only recently, after four years, have plans begun to develop care management programs and has the state started to move beyond a traditional FFS surveillance system in its monitoring efforts. In addition, commercial and Medicare managed care, while growing, continue to lag growth in the TennCare program.

This issue is explored more fully in a separate MPR paper, "Growing an Industry: How Managed is Tennessee's Managed Care?," based on site visits in 1994 and 1998.

Key Issues to Monitor in the Future.

Given the past experience of the TennCare program, the following issues should be examined in future monitoring efforts:

- Whether the recent financial problems reported by plans indicate a general lack of adequate funding or not, in light of their recent decision to remain in the program.

- The continued impact of closing enrollment to all but uninsured children and the uninsurables on plans' financial viability and how the state addresses adverse selection through the distribution of funds from the dedicated pool.

- The extent to which the new enrollment process involving the local health department successfully facilitates TennCare enrollment among uninsured children.

- If payment issues continue to plague MCOs, whether providers will cease contracting with some or all plans (as some are reportedly considering) and how the state might better track how much the provider base is expanding or contracting given the reported high degree of overlap among MCO provider networks.

- The status of the safety net and implications for the uninsured.

- Whether the TennCare Partners program will evolve over time, improving coordination with the MCOs, enhancing program's networks, and developing alternative treatment modalities to replace those no longer used.

- The extent to which the state's monitoring and oversight systems evolve to accommodate managed care processes.

TennCare has been a highly visible program nationwide, leading to continuing efforts to monitor its performance. Although the program has now matured, continuing analysis of its experience remains as valuable as ever.

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TABLE A-1

TENNCARE COVERED BENEFITS

SERVICE	BENEFIT
Inpatient Hospital Days (including days at a designated perinatal center)	As medically necessary. Preadmission approval and concurrent reviews allowed.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services	As medically necessary.
Lab and X-Ray Services	As medically necessary.
Newborn Services	As medically necessary including circumcisions performed by a physician.
Hospice Care (organization certified pursuant to Medicare hospice requirements)	As medically necessary.
Dental Services	Preventive, diagnostic, and treatment services (including orthodontics) for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life-threatening infection, accidental injury to natural teeth including their replacement, and the removal of impacted wisdom teeth.
Vision Services	Preventive, diagnostic, and treatment services for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults as well as enrollees under age 21.
Home Health Care	As medically necessary.
Pharmacy	As medically necessary. Selected exclusions.
Durable Medical Equipment	As medically necessary.
Medical Supplies	As medically necessary.
Emergency Ambulance Transportation	As medically necessary.
Nonemergency Ambulance Transportation	As medically necessary.
Nonemergency Transportation	As necessary for enrollees lacking accessible transportation for covered services.
Community Health Services	As medically necessary.
Renal Dialysis Services	As medically necessary.

SERVICE	BENEFIT
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	Screening and follow-up treatment services as medically necessary for enrollees under age 21.
Rehabilitation Services	As medically necessary when determined cost effective by the MCO.
Chiropractic Services	When determined cost effective by the MCO.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative.
Speech Therapy	As medically necessary, by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder.
Sitter	As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that an R.N. or L.P.N. is needed and neither is available.
Convalescent Care	As medically necessary, up to and including the one-hundredth day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care.
Donor Organ Procurement	As medically necessary for a covered organ transplant.

TABLE A-2

MONTHLY PREMIUMS, DEDUCTIBLES, AND CO-INSURANCE FOR TENNCARE ENROLLEES: INDIVIDUAL AND FAMILY OF FOUR

	Percent of Poverty Level	*Monthly Income ($)*	*Monthly Premium ($)*	*Annual Deductible ($)*	*Coinsurance (%)*
Individual (Adult and Child)	Up to 100	0–650	0	0	0
	101–199	651–1,289	14–33	250	2–8
	200–299	1,290–1,934	73–110	250	10
	300–399	1,935–2,579	128–147	250	10
	400–749	2,580–4,837	185	250	10
	750+	4,838+	190	250	10
Family	Up to 100	0–1,312	0	0	0
	101–199	1,313–2,599	35–71	500	2–8
	200–299	2,600–3,899	184–274	500	10
	300–399	3,900–5,199	320–366	500	10
	400–749	5,200–9,749	NA	NA	NA
	750+	9,750+	NA	NA	NA

NOTES: There is no limit on out-of-pocket expenditures.

For the uninsurables, eligibility is open only to individuals, not families.

NA=not applicable

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