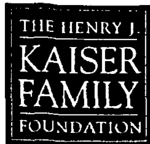

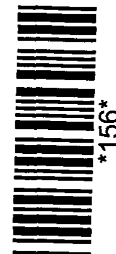

Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee

1996 Update

Prepared by
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For the
Kaiser/Commonwealth Low-Income Coverage and Access Project

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Kaiser/Commonwealth Low-Income Coverage and Access Project

To gather early insights and timely information for state and federal policymakers concerning how the restructuring of programs serving low-income people is affecting their insurance coverage and access to care, The Henry J. Kaiser Family Foundation and The Commonwealth Fund are jointly sponsoring the Low-Income Coverage and Access Project. This is a large scale effort to monitor changes in health care delivery and financing and the impact of managed care for low-income populations in seven states: California, Florida, 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.

This report is an update to the July 1995 case study on managed care in Tennessee released as part of the Kaiser/Commonwealth Low-Income Coverage and Access Project.

TENNCARE CASE BRIEF UPDATE

Core Case: Covers Year 1 of TennCare (ending December 1994); selective updates through April 1995

Current Update: August 1996

OVERALL STATUS OF PROGRAM

- Basic design remains intact with most emphasis on maturing the program and addressing acknowledged problems associated with the scope and rapidity of the first year start up.

- New enrollment continues to be closed to anyone not otherwise Medicaid eligible or uninsurable. At year end 1995 (the second program year), there were 1,181,425 enrollees, slightly below the previous year. Of these, 347,550 were said to be uninsured or uninsurable. The lack of program growth reflects to a large extent limitations placed by the state on new enrollments, and state efforts to purge enrollments of ineligibles and those not paying premiums.

- Enrollment has continued its decline. Total TennCare enrollment as of June 1996 is 1,166,377; total number of uninsured/uninsurables as of June 1996 is 332,546.

KEY CHANGES IN CORE FEATURES

- *Mental Health/Substance Abuse*. On July 1, 1996, the TennCare Partners Program was implemented. Under this program, state mental and health and substance abuse services for TennCare enrollees and several thousand others covered under state programs will be consolidated. Previously, TennCare managed care capitation rates included funding for selected mental health services but most services were excluded from the capitation payments and funded through the Tennessee Department of Mental Health and Mental Retardation (TDMHMR). The program is being administered jointly by the TennCare Bureau and TDMHMR. State officials cite extensive educational efforts associated with the transition.

  With the change, TennCare will contract with two Behavioral Healthcare Organizations (BHOs) (Premiere and Tennessee Behavioral Health) to provide mental health and substance abuse services on a capitated basis to TennCare enrollees and a limited number of others with chronic mental illness. The BHOs will be paid $21.84 per person per month. Each MCO will be affiliated with one BHO except for Blue Cross-Blue Shield's MCO, which will affiliate with both because of its large enrollment. BHOs will provide services

through contracted providers. MCO capitation rates will be reduced by $7.53 to reflect the carve-out of selected mental health benefits previously provided through the plans.

Press reports indicate substantial negotiations on the number of BHOs (originally set at 5), their relationship to MCOs, and potential anti-trust and other issues associated with providers like community mental health centers. The implementation date for the initiative was shifted backward three months from earlier in 1996 to allow more time to plan.

- ***Other Excluded Services.*** Special services for children (under the Children's Program for those in custody) continue to be provided independently of TennCare. Long term care benefits similarly continue to be carved out. TennCare expenditures for long term care services have been rising rapidly. After failing to reach agreement on more comprehensive TennCare integration, the state and industry agreed to a global spending cap on Level I and Level II beds with a 7 percent inflator for FY 1996-1997.

- ***Participating Plans.*** These have remained relatively the same as at the initiation of the program. The same plans still participate in TennCare; however, two of the plans have merged, with Blue Cross-Blue Shield acquiring one of the smallest plans. Another plan, Phoenix, has been awarded statewide status, bringing to three the number of statewide plans. Blue Cross-Blue Shield, which accounted for 55 percent of TennCare enrollment as of June 1996, including its recent plan acquisition, has expressed concern over any further growth in market share; TennCare officials are said to be working with the plan to address this concern.

  Access Med-Plus continues to participate as a statewide plan after the state threatened to cancel its contract and reassign its nearly 250,000 enrollees in early 1996 because of solvency concerns. The threatened action was the culmination of an original notification by the TennCare Bureau in July 1995 of lack of compliance with the contract. After examination by regulators, the state identified nine deficiencies that had to be met by February 23, 1996. Eight, including deficiencies related to prompt payments, claims processing, and grievances, were met. The ninth--capitalization requirements--was disputed by Access MedPlus. The NAACP intervened in negotiations on the side of the black-owned company. As resolved, Methodist Health systems guaranteed a $2.4 million loan; $1.5 million was provided by an undisclosed party; and $1 million was provided through a bank loan directly to the plan. The provider network will remain the same as will the plan's senior executives, but the plan will now be operated under a new management company. Methodist will have seats on the parent company board.

  Existing MCO contracts will be renewable through 1997. In fall 1996, TennCare officials plan to release a competitive RFP for awards effective January 1, 1998. In his transition document, outgoing Commissioner Corker indicated an interest in moving to 4-5 plans, each of which would be statewide, with integration of mental health and substance abuse services. Price would be one factor in selection.

- *Capitation Rates.* Payment rates for MCOs were increased 9.5 percent in two steps in 1995. A planned 5 percent increase was joined by an additional 4.5 percent increase in exchange for contract stipulations. Another 4 percent is due in July 1996. With the premium reduction because of the mental health carve out (see above), plans get an average of $109.82 per member per month in July 1996, according to Commissioner Corker's transition document.

- *Financial Status of TennCare.* Federal matching payments continue to lag behind projections because enrollment is below projections and because certain matching payments were denied by HCFA. Additionally, federal matching payments have been reduced because of Tennessee's recent economic upturn. Press reports indicate that the slowdown in TennCare enrollees made up for much of the $56 million shortfall in the state general fund. TennCare proposed adding copayments for enrollees below the poverty level, but HCFA denied that request.

  TennCare's initial special pools to assist in program transition have mostly been eliminated. In general, the TennCare Bureau's position has been to limit the use of supplemental pools that are regarded unfavorably from a policy perspective. The 1996-1997 budget eliminates funds for the reserve fund pool (to provide initiatives for primary care providers) and the malpractice pool (for those with a high volume of Medicaid patients). Twenty million dollars and $10 million, respectively, were paid for each of these pools in December 1995.

  TennCare has asked HCFA for help in developing a methodology for addressing adverse selection that can be piloted and substitute for the Adverse Selection pool. However, 1 percent of the MCO capitation rate is being withheld to offset adverse selection concerns associated with high cost drugs and federal mandates. After initial opposition, the Governor agreed to continued funding for GME of $45 million in 1996-1997, with a plan to enhance the focus on primary care training and gradually transition to funding residents rather than facilities. HCFA approved the state's new funding methodology for GME payments in June 1996.

  The financial experience of TennCare's MCOs is not clear from information readily available within the scope of this effort. Some plans appear to have experienced losses in Year One of the program. The effort at increased oversight led to state intervention to bolster finances for at least two plans. However, we are not aware of any imminent financial crises with plans, some of which probably remain shaky.

ADMINISTRATION

- *Leadership.* TennCare underwent an administrative shake-up early in 1995 when Governor Sundquist took office. Bob Corker replaced David Manning as Finance Commissioner, and Rusty Siebert replaced Manny Martins as Director of TennCare. Both new appointees indicated from the start an interest in remaining only for a short time. Corker left in July

1996 and Siebert in May 1996. Siebert has been replaced by career staffer Theresa Clarke; Corker has been replaced by John Ferguson from Memphis.

- ***State Oversight***. In early 1995, Sundquist created a Deputy Commissioner in the Department of Commerce and Insurance to help oversee the financial status of plans, with semi-annual audits and public release said to be involved (Transition Report 1996). A Governor's Roundtable was convened in early 1995 and generated recommendations that included restoring GME funding, introducing a formulary oversight system, moving to a gatekeeper system expeditiously, addressing adverse selection, increasing MCO accountability, and improving enrollee education, as well as ongoing advisory review.

- ***Administrative Actions***. TennCare introduced monthly premium reminders for participants in mid-1995 as a replacement for the previously used coupon book; close to 100,000 have been dropped from the TennCare rolls for nonpayment. Collections increased though they remain below projections. Press reports indicate concern over potential enrollments from bordering states seeking care for costly conditions. The perception is that non-resident individuals with costly illnesses are accessing TennCare because of the out-of-state proximity to Memphis, a situation potentially exacerbated by some state insurers dropping high cost individuals. Tennessee's waiver application requires applicants to be state residents. TennCare has contracted with a private firm, TRW, to identify out-of-state enrollees.

- ***Quality Oversight***. TennCare continues to address weaknesses in these components. All TennCare MCOs will have to be HMOs and have primary care gatekeeping by January 1, 1997. In spring 1995, TennCare reviewed problems with its original telephone hotline system, including long waits, poor staffing and communications, and high cost. A new system, adopted from California, has been introduced, which staffs the telephone hotline with selected inmates from the Tennessee Prison for Women and makes other changes. Telephone waits are said to be reduced from 20 minutes to 2 minutes under this new system.

- ***Physician Opposition***. The Tennessee Medical Association withdrew the lawsuit it was pursuing on TennCare, reflecting both the lack of legal success and a wary acceptance of the continued existence of managed care.

NEW INSIGHT ON OTHER ISSUES OF ORIGINAL CONCERN

- ***Eligibility and Enrollment Systems***. Though some progress has been made, there remain weaknesses in these areas. A number of measures have been taken with the stated goal of enhancing premium collections and, particularly, weeding out ineligibles. A face to face application/recertification process is being tested in one county and program-wide systems are being enhanced. A rule making hearing was held June 1996 on measures to enhance program integrity. It is unclear what effect these may have on enrollment levels, which already have been shrinking, and enrollment composition. Some education and outreach is said to be involved, but this does not appear to be the main emphasis.

- ***Plan Administrative Systems.*** Delays in provider payments continue to be reported. Most reports center on Access MedPlus, but the problem appears broader. For example, transportation providers are reported to have problems with prompt payments. In his transition document in 1996, Commissioner Corker cites the development of an information clearinghouse as a vehicle for assisting providers in gaining access to eligibility and MCO information.

- ***Access and the Maturity of the Managed Care Market.*** The Washington Post reports results of a 1995 University of Tennessee survey showing greater consumer acceptance of TennCare in Year 2. The proportion of former Medicaid patients reporting TennCare was better than Medicaid rose from a low 49 percent in 1994 to 68 percent in 1995. Sixty percent of formerly uninsured reported coverage under TennCare was better in both reported years. The waiting times for appointments decreased. Formularies continue to be a controversial issue. With the implementation of TennCare Partners, there is a particular concern for MCO approvals of pharmaceuticals prescribed by BHOs that may not be on MCO formularies.

- ***Safety Net Providers.*** There continue to be issues. The most visible problems are reported by the Med in Memphis. Reportedly, deliveries have dropped from 8,000 to 3,500, residents from 140 to 110, and beds from 530 to almost 200 less (*Washington Post* 1996). Press reports indicate an independent review of management at the Med and continuing financial problems despite an infusion of $25 million of additional funds from various sources, including local government and restored GME funding. Even with these funds, however, the Med still faces a potential shortfall of a reported $5 million annually. Of this, $3.5 to $4 million is said to be potentially retrievable with improved collections and cost reductions. The Med has filed suit against Access MedPlus alleging $2 million in late provider payments; Access MedPlus deposited $1 million with the court on February 16th as insurance on future payment. Washington law firm Powell, Goldstein, Frazer, and Murphy (through Larry Gage who also is executive director of the National Association of Public Hospitals) has been hired to spend up to $25,000 to develop a framework to guide negotiations between the Med and other health systems. This is consistent with a Shelby County committee recommendation that the Med explore partnerships with other health systems.

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4. "Tennessee Site Visit Report," in Harriet B. Fox and Margaret A. McManus, *Impacts of State Medicaid Demonstration Waiver Programs on Children: Results from Hawaii, Oregon, Rhode Island, and Tennessee*, March 1996.

5. Fredricks Schneider Research, "*Medicaid and Managed Care: Focus Group Studies of Low Income Medicaid Beneficiaries in Five States*." Prepared for the Kaiser Family Foundation, May 1996.

6. University of Tennessee 1995 survey cited in David Brown, "Deluged by Medicaid States Open Wider Umbrellas--A Three Part Report." *Washington Post*, June 9, 10, and 11, 1996.

7. Martin Gottlieb. "The Cutting Edge: Tennessee's Health Care Revolution: A Managed Care Cure-All with Flaws and Potential." *The New York Times*, October 1, 1995.

8. Martin Gottlieb. "A Free-For-All in Swapping Medicaid for Managed Care." *The New York Times*, October 2, 1995.

9. *Tennessee Managed Care: The Harkey Report.* vol. 7, no. 3; vol. 8, nos. 1, 2, 3. Harkey & Associates, Inc. Nashville, TN. 1995.