United States General Accounting Office

GAO

Report to the Ranking Minority Member, Committee on Commerce House of Representatives

September 1995

MEDICAID

Tennessee's Program Broadens Coverage but Faces Uncertain Future

GAO/HEHS-95-186

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-258562

September 1, 1995

The Honorable John Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

In early 1993, Tennessee projected that increases in state Medicaid expenditures and the loss of certain tax revenues used to help finance Medicaid costs would cause a financial crisis. Meanwhile, state officials believed that a portion of the medical costs for as many as three-quarters of a million uninsured persons were being shifted to the Medicaid program and other payers. To avert a financial crisis, control its Medicaid expenditures, and extend health insurance coverage to most state residents, Tennessee got federal permission to replace its fee-for-service Medicaid program with a capitated managed care program called TennCare.

Since then, Tennessee's Medicaid waiver program has generated both praise and criticism. TennCare has provided coverage to most of the uninsured persons in the state, while reducing Medicaid cost increases. However, concerns have been raised about TennCare's rapid approval and implementation, lack of provider buy-in to the program, and delays in implementing systems for monitoring TennCare's access and quality of care. In addition, the soundness of the methodology for determining and the resulting adequacy of the program's capitation rates have been questioned.

In response to your concerns about the controversy over TennCare, we examined the available information on (1) TennCare's basic design and objectives, (2) the degree to which the program is meeting these objectives, and (3) the experiences of TennCare insurers and medical providers and their implications for TennCare's future.

Results in Brief

In seeking its 5-year waiver approval from the Department of Health and Human Services (HHS), Tennessee had several objectives. Two of these were to expand health care coverage to the state's uninsured and to control total program and state costs. Specifically, Tennessee requested permission to mandate Medicaid enrollment in managed care and to cover

certain uninsured previously not determined eligible for Medicaid. In granting the waiver, HHS required that Tennessee implement measures to monitor and ensure access to quality care. In addition, HHS and Tennessee agreed that federal payments for the 5 years would be no more than $12.165 billion to ensure that federal costs not exceed what they would have been without the waiver.

In less than 2 months after receiving approval, Tennessee had contracted with 12 managed care organizations (MCO) to place its entire Medicaid population in its new capitated managed health care program, TennCare, and to open enrollment to uninsured persons in the state. By the end of the first year, Tennessee had enrolled approximately 800,000 Medicaid-eligible persons and over 400,000 uninsured persons who were not determined to be eligible for Medicaid in TennCare, with two of the MCOs accounting for nearly three-quarters of the over 1.2 million enrollees.

Despite this increase in the number of persons covered, federal and state reported expenditures for Tennessee's Medicaid program increased less than 1 percent in state fiscal year 1994, much below the national average. Excluding long-term care and administrative costs, which are not capitated, program costs actually declined. These reductions were realized largely from capitation rates paid to MCOs that were substantially below prior Medicaid per beneficiary costs. The rate-setting methodology understated historical Medicaid costs by approximately 25 percent, and, further, the state applied an additional discount of 22 percent on the assumption that more extensive insurance coverage would reduce charity care costs. Meanwhile, the state effectively reduced its share of Medicaid costs by claiming losses incurred by hospitals in caring for TennCare eligibles as federally reimbursable expenses without reimbursing the hospitals. In addition, the state recouped some federal dollars paid to MCOs through a state tax on capitation payments and retained a substantial share of premiums paid by TennCare enrollees.

Although TennCare essentially met its objectives to provide health care coverage to many uninsured individuals while controlling costs, concerns remain about TennCare. Primary among these concerns are enrollee access to quality care and MCO financial performance. Facts about access and quality of care are largely unknown due to delays in the MCOs' and state's implementation of adequate monitoring systems. One beneficiary survey, however, indicates that significant numbers of enrollees are less than satisfied with the program. Almost half of the beneficiaries surveyed felt that the care they received under TennCare was worse than under

Medicaid because their choice of doctors was limited and finding providers was difficult. In another survey, almost one-third of the physicians who were signed up with at least one MCO and said that their practices were accepting new patients also said that they did not accept new TennCare patients.

Concerns also have been raised about the MCOs' financial performance. Overall, MCOs lost money in 1994, even after receiving substantial supplementary payments in addition to their usual capitation payments. The largest MCO, with almost 50 percent of TennCare enrollees, lost almost $9 million in its first year in TennCare and is projecting a fourfold increase in losses for its second year primarily because some supplemental payments were discontinued on January 1, 1995, and utilization is expected to be higher. And although the second largest MCO reported a slight gain for 1994, concerns persist that its financial condition may be worse than reported.

So far, TennCare has met its initial objectives, but its long-range success is uncertain. Success will depend on the health care community's willingness to continue to participate. The largest MCO has stated that without a 10-percent increase in the capitation rate, it will have to reassess its participation in TennCare. To compensate for past losses and avoid future losses, some MCOs may act to contain costs that could reduce payments to providers. Institutional providers, already claiming large losses, face elimination of substantial state subsidies. Moreover, physicians have reported widespread dissatisfaction with the program, and a significant number of them have indicated that, overall, their practices are financially worse off under TennCare than under Medicaid. Further, many of the physicians in the largest MCO reportedly felt coerced to participate in TennCare because the MCO implemented a policy that required its network physicians to participate in TennCare. If providers decide to reduce their TennCare participation or leave the program in significant numbers, the viability of the MCOs and TennCare could be seriously threatened.

Background

Medicaid was established in 1965 as a jointly funded federal-state program providing medical assistance to qualified low-income persons. Each state designs and administers its own Medicaid program, subject to federal requirements for eligibility, services covered, and provider payments. States decide whether to cover optional services and how much to reimburse providers for a particular service. The federal government pays a portion of whatever qualifying expenditures a state Medicaid program

incurs. At the federal level, the program is administered by the Health Care Financing Administration (HCFA), an HHS agency.

In recent years, Medicaid costs have escalated. To control these costs, some states have sought to move some or most of their Medicaid population into a capitated managed care system. However, certain provisions of the Medicaid law—such as freedom of choice and the "75-25" beneficiary requirements[1]—inhibit states' use of managed care. States may obtain waivers of these provisions from HCFA under the authority of section 1115 of the Social Security Act.[2] Section 1115 of the act offers HCFA the authority to waive a broad range of Medicaid requirements for state demonstration projects.

In granting a waiver, HCFA requires the applying state to demonstrate that its proposal is budget neutral—that is, that federal expenditures for the entire demonstration project will not exceed costs projected for the existing Medicaid program. Until recently, budget neutrality was expected to be achieved in each year of the demonstration. However, HCFA now allows increased costs in some years as long as states achieve budget neutrality for the entire demonstration. HCFA may also require the state to implement improved quality assurance systems, which may include data collection on enrollee medical care utilization and an assessment of these data to determine the adequacy of enrollee access to and quality of medical care.

As of June 1995, 10 states had HHS-approved statewide waivers, 8 had applications pending, and 5 had inquired about submitting waiver applications. In November 1993, 5 months after Tennessee submitted its 1115 waiver application, HHS approved it. On January 1, 1994, Tennessee became the first state to move its Medicaid program enrollees to a statewide demonstration project.[3]

[1]The freedom-of-choice requirement allows Medicaid beneficiaries to choose any provider willing to accept Medicaid reimbursement. The 75-25 requirement specifies that the patient load of health maintenance organizations (HMO) serving Medicaid beneficiaries be more than 25 percent private patients.

[2]States may also obtain waivers of the freedom-of-choice requirement and establish managed care programs under section 1915(b) of the Social Security Act. However, significantly more flexibility is available under section 1115.

[3]Arizona has operated its Medicaid program under a statewide 1115 waiver since 1982; however, it did not have a Medicaid program before the waiver.

Scope and Methodology

To meet our reporting objectives, we interviewed officials and reviewed documents from the TennCare Bureau[4] and HCFA's Central Office in Baltimore and its Regional Office in Atlanta. In addition, we spoke with Tennessee officials from the Department of Finance and Administration and the Department of Commerce and Insurance, as well as officials from the Tennessee Medical Association (TMA), Tennessee Hospital Association, Tennessee Health Care Campaign, MCOs, federally qualified health centers, hospitals, physicians, and other advocacy groups. We also reviewed the results of provider and beneficiary surveys conducted by HCFA, the University of Tennessee, TMA, and the Tennessee Association of Legal Services and other available literature and studies. We also obtained financial data from MCOs and from financial reports filed with the Tennessee Department of Commerce and Insurance. Much of the MCO financial data were unaudited, and we did not attempt to verify them. Our work was performed between April 1994 and May 1995 in accordance with generally accepted government auditing standards.

TennCare Program Designed to Expand Coverage and Contain Costs

Tennessee's demonstration project was designed to use a capitated managed care system to expand coverage to the uninsured population and to control total program and state costs. TennCare's ceilings on total allowable federal funding are intended to be budget neutral—a requirement for HCFA approval of all demonstration projects. The state-federal sharing arrangements of the financing plan tend to favor the state since several waiver provisions allow it to effectively reduce its share of total spending. In addition, the waiver includes provisions to monitor and ensure enrollee access to quality care.

TennCare Designed to Expand Coverage

TennCare was designed to expand health coverage by allowing non-Medicaid eligible persons to enroll and by extending the period of coverage for Medicaid-eligible persons. It also increased the scope of coverage by lifting restrictions on many services and by allowing additional types of services to all enrollees.

In addition to including all Medicaid eligible persons, TennCare offered insurance to uninsured and uninsurable persons regardless of income who were not eligible for Medicaid. To qualify as an uninsured enrollee, a person must not have had access to health insurance on or after March 1,

[4]Until 1995, the TennCare Bureau was part of the Tennessee Department of Health. It is now under the Department of Finance and Administration.

1993.[5] Therefore, a person must have been uninsured at least 10 months to qualify for TennCare as an uninsured person on January 1, 1994.[6] To stay within budget ceilings, the state limited total enrollment to 1.3 million for the first year and 1.5 million in succeeding years. Tennessee expected enrollment of uninsured and uninsurables of 300,000 in the first year and 500,000 in succeeding years. The state expected that the 500,000 would include most of its uninsured.[7]

Under TennCare, enrollees who are not eligible for Medicaid and have incomes above the poverty level would be required to pay monthly premiums based on their income. At the MCO's option, these enrollees also may be required to pay a deductible and make copayments for costs that exceed the deductible as medical costs are incurred.[8] However, TennCare enrollees cannot be required to make deductible payments or copayments for preventive care, and copayments depend on the enrollee's gross income. TennCare limits the total enrollee out-of-pocket expense.

TennCare also extended the period of health coverage for many persons qualifying under Medicaid. Under TennCare, over 65 percent of Medicaid-eligible persons are effectively guaranteed 12 months of coverage at no cost to themselves because TennCare eligibility redeterminations are made only once every 12 months.[9] If, after that time, these enrollees no longer qualify for Medicaid, they can continue in TennCare, subject to the same requirements as the formerly uninsured. In addition, TennCare expanded services to include inpatient psychiatric facility services for persons between 21 and 65 years old and outpatient substance abuse treatment programs. TennCare also lifted many restrictions and limitations, such as the allowable number of inpatient physician services, outpatient visits, home health visits, and prescriptions.

[5]According to the TennCare Bureau this date was chosen to avoid employers' dropping their health plans in favor of TennCare, which was announced in April 1993.

[6]As of October 1994, the TennCare Bureau allowed people to enroll in the program as "uninsured" if they did not have health insurance available to them on or after July 1, 1994. However, enrollment of additional uninsureds was severely curtailed as of January 1, 1995.

[7]In its application, Tennessee stated that recent studies showed that it had approximately 392,000 to 775,000 uninsured residents.

[8]Capitation payments to MCOs for the uninsured are reduced on the assumption that the MCOs will collect the deductibles and copayments. However, at least two MCOs waived the requirement due to the difficulty of collecting the deductibles and copayments.

[9]As of December 31, 1994, over 500,000 Medicaid-eligible enrollees in particular eligibility categories had been guaranteed 12 months of TennCare eligibility due to this change.

TennCare Introduced Statewide Prepaid Managed Care to Medicaid

To implement its prepaid managed care system, the state contracted with 12 MCOs to provide delivery of all Medicaid acute and primary care services and to handle claims processing in exchange for a monthly payment per enrollee. In addition to these monthly payments, MCOs having enrollees with high-cost chronic conditions and higher than average utilization rates would receive additional payments.[10] Subject to the availability of unallocated TennCare funds,[11] MCOs could also receive payments for the cost of providing the first 30 days of care to uninsured and uninsurable enrollees and one-time payments for financial difficulties attributed to TennCare start-up. MCOs are not responsible for long-term care services or for special services to the severely and persistently mentally ill or to Children's Plan[12] enrollees.

TennCare contracts with health maintenance organizations (HMO) and preferred provider organizations (PPO) to operate as MCOs. The state requires HMOs to be licensed as such. The primary contractual distinctions between these types of organizations are that (1) administrative fees and operating profits are restricted for PPOs but not for HMOs and (2) the TennCare Bureau required on January 1, 1994, that HMOs assign each of their enrollees to a primary care physician responsible for managing and coordinating the enrollee's care; the contract with PPOs allows them until January 1, 1997, to assign enrollees to primary care physicians.[13]

Most enrollees have a choice of four MCOs, and enrollees in metropolitan areas have a choice of as many as seven. Figure 1 shows the geographic divisions of the state and the number of MCOs participating in each division.

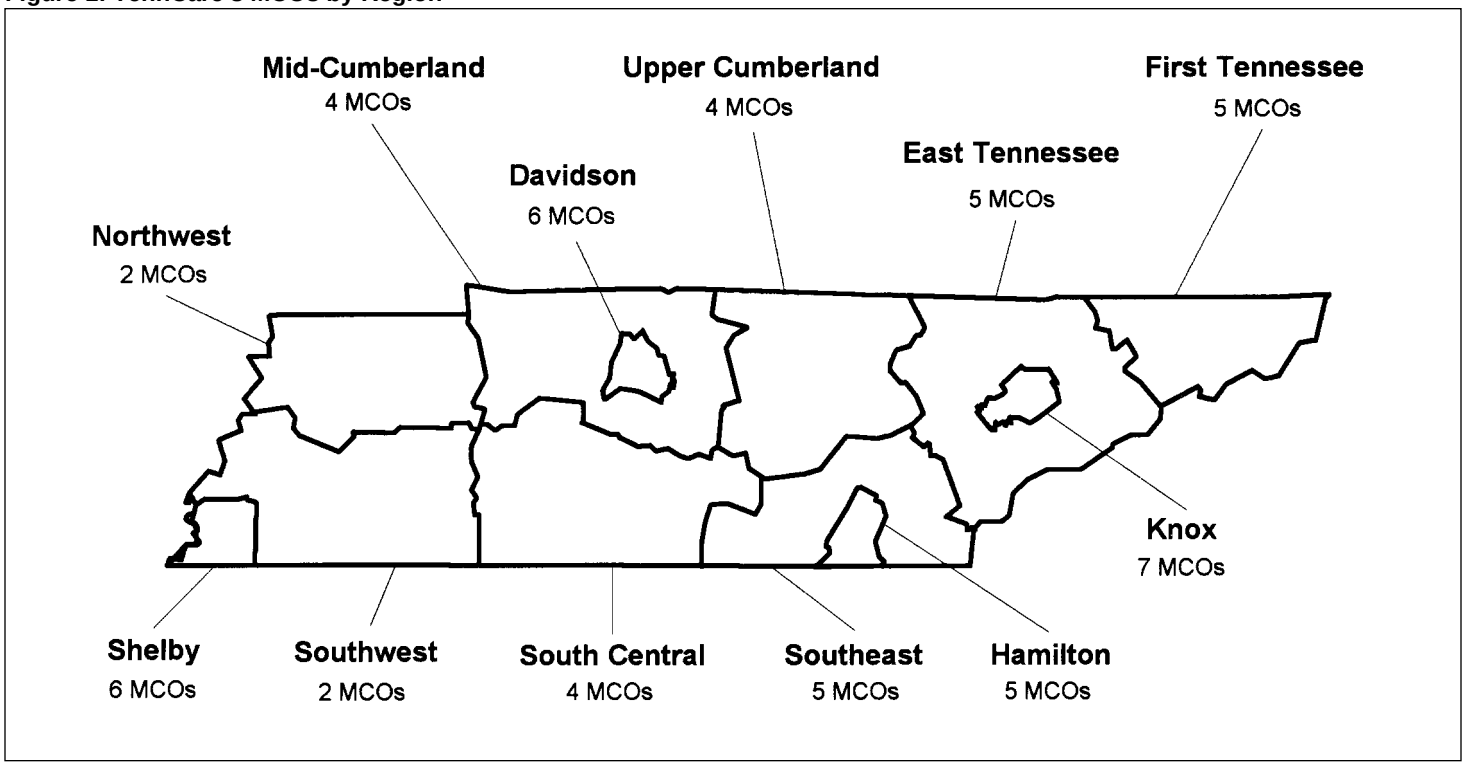
[10]On July 17, 1995, HCFA approved a Tennessee proposal to use only the high chronic condition payment methodology and not the higher than average utilization rates in determining adverse selection payments to MCOs.

[11]Tennessee has designated an unallocated fund pool equaling the difference between the capitation payments required if TennCare reached its total enrollment cap and the actual capitation payments made.

[12]The Children's Plan is a total care program that addresses the needs of children in state custody or at risk of being in state custody. The state covers special services for this population, such as case management and therapeutic intervention, and MCOs cover basic medical services. Special services to severely and persistently mentally ill enrollees include both inpatient and outpatient mental health services.

[13]PPOs' administrative fees cannot exceed 10 percent of their total TennCare revenues. The TennCare Bureau requires that any savings on overall PPO operations be shared: 5 percent with the PPO, 5 percent with the medical providers, and 90 percent with the TennCare Bureau. The TennCare Bureau does not share in MCO losses.

Figure 1: TennCare's MCOs by Region



The two largest MCOs, BlueCross BlueShield and Access MedPLUS, operate statewide and account for 73 percent of enrollees. Table 1 lists each MCO and shows the type of contract, number of enrollees, and percent of total enrollees. The table lists MCOs in descending order according to the percentage of total TennCare enrollees in the MCO.

Table 1: TennCare Enrollment by MCO

MCO	Type	Enrollment	Percent of total
BlueCross BlueShield of Tennessee	PPO	602,361	49.87
Access MedPLUS	HMO	286,639	23.73
Health Net	PPO	75,276	6.23
OmniCare Health Plan	PPO	64,006	5.30
Preferred Health Partnership	PPO	61,514	5.09
TLC Family Care Healthplan	HMO	35,421	2.93
Phoenix HealthCare	HMO	34,821	2.88
John Deere HealthCare/Heritage National Health Plan	HMO	17,155	1.42
VHP Community Care	HMO	12,558	1.04
Prudential Community Care	HMO	7,989	0.66
Total Health Plus	HMO	6,316	0.52
TennSource	PPO	3,834	0.32
Total		**1,207,890**	**100.00**

Source: TennCare Bureau,"Statewide Summary Eligibles by MCO," May 12, 1995.

In addition to making capitated payments to MCOs, TennCare seeks to encourage managed care in several ways. TennCare requires that by 1997, all MCOs assign their enrollees to primary care physicians responsible for managing and coordinating enrollee care. As of February 1995, MCOs had assigned approximately half of all enrollees to primary care physicians. TennCare promotes continuity of care by requiring enrollees to stay with the same MCO for a year, by providing extended enrollment periods to many Medicaid eligibles, and by allowing persons to continue in TennCare as "uninsured" if they lose their Medicaid eligibility. TennCare also encourages preventive care by not allowing deductibles and copayments for preventive care services.

Supplemental Payments Assist Participating Hospitals and Physicians

TennCare provides for incentive payments to physicians and allows several types of supplemental payments to hospitals based on the availability of unallocated funds. TennCare's design provides for two types of annual incentive payments to participating physicians: one to physicians that have a greater than average TennCare patient load and another to physicians whose practices are at least 10 percent TennCare to pay a portion of their malpractice insurance premiums.

Subject to the availability of unallocated funds, TennCare may also make supplemental payments to hospitals for graduate medical education and care provided to those eligible for, but not enrolled in, TennCare as well as payments to hospitals that provide care to large numbers of TennCare or indigent persons.

Savings From Capitation Discounts and Discontinued Disproportionate Share Hospital (DSH) Program Allow Expanded Coverage

To finance expanded coverage while keeping Medicaid expenditures within the budget limits set by the waiver agreement, Tennessee set capitation rates that are substantially below historical Medicaid costs. Further, it discontinued its DSH program and established a smaller Primary Care Provider Fund.

In setting capitation rates, the state began with the average annual cost per Medicaid-eligible person and then made "charity care" adjustments, which reduced the average capitation rate by 22 percent.[14] The state's rationale for making these adjustments was that the costs of charity care that had been built into the rates paid historically to providers would be significantly reduced by expanded insurance coverage.

To save additional funds, Tennessee also discontinued its DSH program and established a smaller Primary Care Provider Fund. Under its Medicaid DSH program in state fiscal year[15] 1993, the state provided $438 million in supplementary payments to hospitals that served large numbers of Medicaid enrollees or low-income persons. The Primary Care Provider Fund, budgeted for $185 million in state fiscal year 1994, was intended to provide essential provider payments, a reserve for MCO adverse selection of enrollees or other unforeseen circumstances, and payments to primary care physicians with large TennCare caseloads.[16]

Table 2 illustrates how savings from capitation discounts and the elimination of the DSH program offset the expected costs of expanded coverage and the new Primary Care Provider Fund.

[14]The state's methodology in setting capitation rates by using average annual cost per Medicaid eligible rather than average costs during participating months understates the historical cost of Medicaid. See appendix I for a complete discussion.

[15]Tennessee's state fiscal year runs from July 1 to June 30. For example, state fiscal year 1993 runs from July 1, 1992, through June 30, 1993.

[16]After TennCare enrollment began, the Primary Care Provider Fund terminology was no longer used. Supplemental payment components, methodology, and amounts have continued to change during the program.

Table 2: Estimated State Fiscal Year 1995 Costs for Expanded Coverage

Dollars in millions

Additional costs	
Capitation payments for 500,000[a] uninsured net of discounts	$519
Primary Care Provider Fund	171
Net additional costs	**$690**
Costs avoided	
Reduction in capitation rate for 1 million Medicaid eligibles for charity care, including local government contributions[b]	(382)
Discontinued DSH payments[c]	(438)
Net costs avoided	**$(820)**
Net cost of state fiscal year 1995 coverage expansion	**$(130)**

Note: The numbers used for Medicaid eligibles, uninsured, and the Primary Care Provider Fund are for the second year of the waiver.

[a]Based on the maximum enrollment of 500,000 allowed to enroll in years 2 to 5 of the waiver. Discounts are for charity care, local government, and enrollee cost-sharing deductions to the capitation payments.

[b]The average enrollee monthly charity care and local government deductions equal $31.83.

[c]Amount is the state fiscal year 1993 actual payments.

As shown in the table, savings from charity discounts and foregone DSH payments would more than offset the costs associated with the expanded coverage.

Waiver Imposes Limit on Federal Spending

In accordance with the requirement that demonstration waivers be budget neutral, the TennCare waiver agreement includes an overall available federal funding limit for the 5-year waiver period and sets interim limits on the availability of federal funding. The federal spending limits apply to the total TennCare program expenditures, including Medicaid expenditures for services not covered under capitated payments, such as long-term care.

For the 5-year TennCare waiver period, the federal government will provide no more than $12.165 billion. For every $1 in TennCare expenditures, the federal government pays approximately $.67 and the state pays approximately $.33. The overall federal funding limit for the waiver period was established by estimating what the federal funding for Tennessee's Medicaid program would have been during the first year

without TennCare[17] and increasing federal funding 8.3 percent or by the amount of the growth caps included in the President's 1993 health care reform proposal, whichever is lower, each subsequent year. For the first year, HCFA estimated that federal expenditures under Tennessee's existing Medicaid program would be slightly more than $2 billion, a 15.5-percent increase over the previous year's federal funding. Increases in federal funding for the subsequent years would range from 5.1 to 8.3 percent. Table 3 shows the annual spending limits calculated for each year.

Table 3: TennCare Federal Funding Spending Limits

Dollars in billions

State fiscal year	Spending limit
1994	$2.108
1995	2.283
1996	2.454
1997	2.594
1998	2.726
Total	**$12.165**

However, because HCFA allows budget neutrality to be achieved over the waiver's duration and not each year, the state has flexibility in annual spending. HCFA established cumulative federal funding targets that allow federal TennCare funding to exceed the spending limits as long as the cumulative annual spending limits are not exceeded by more than the set percentage. Table 4 shows the cumulative annual spending targets and the percentage by which they exceed the sum of the cumulative annual spending limits.

Table 4: TennCare Cumulative Federal Funding Targets

Dollars in billions

State fiscal year	Cumulative limit	Percent cumulative limit exceeds sum of federal spending limits
1994	$2.277	8
1995	4.654	6
1996	7.119	4
1997	9.628	2
1998	$12.165	none

[17]To determine the expenditure estimate, HCFA multiplied the prior year's expenditures by the average percentage expenditure growth over the prior 5 years, separately for the medical component and administrative component, then added in the prior year's DSH spending.

If TennCare exceeds the cumulative limit for the first year, it must downsize the program or otherwise reduce expenditures. In its waiver application, Tennessee stated that it would control TennCare spending to stay within the available resources. The waiver provides for cost containment by beginning to restrict new enrollment of uninsured persons when enrollment reaches 85 percent of the limit.

The federal spending limits apply to the entire TennCare program, which includes services that are not part of TennCare's capitated managed care program. Long-term care and special services to severely and persistently mentally ill and Children's Plan enrollees are not included in TennCare's capitated program. The year before TennCare's implementation, the increase in long-term care expenditures was over 18 percent.

Our analysis of federal spending ceilings in the waiver agreement shows that the amount of federal spending allowed in the first year of TennCare exceeds the federal funds estimated to be spent if the state's Medicaid program had continued. However, the amounts allowed in the second through fifth years are less than we estimate would be spent under Medicaid, and the federal spending limit of $12.165 billion for the entire waiver is less than would be spent if the state's current Medicaid program had continued.[18]

Financing Arrangements and Expansion of Coverage Favor the State

TennCare's financing mechanisms and program expansions have enabled Tennessee to reduce its revenue contributions while increasing the federal dollars it receives. The waiver agreement explicitly allows the state to claim losses incurred by some nonstate hospitals in caring for TennCare eligibles and to keep most of the premiums paid by TennCare participants. In addition, the waiver permits federal cost sharing for expenditures for services to enrollees in state mental hospitals that are not normally covered by Medicaid. The TennCare waiver provides other, indirect benefits to the state by expanding coverage for those not previously eligible under Medicaid but who received services through other state-funded programs, which allows the state to reduce its funding of such programs. In addition, since TennCare is a capitated program, the state obtains revenue from state taxes on capitation payments made to MCOs.

[18]We obtained these results by comparing the ceiling on expenditures under the demonstration with the administration's "current services" estimate for the year in which TennCare was approved. The current services estimate is the projected amount of federal and state spending necessary to maintain the current level of Medicaid services.

The state is allowed to claim hospital losses incurred in caring for TennCare eligibles at certain public and private hospitals[19] as TennCare expenses, which makes these claims eligible for federal cost sharing. However, the state is not required to forward any of the resulting federal payments to the hospitals. For the first 6 months of 1994, the state estimated that qualifying hospitals would incur total losses of approximately $64 million; however, these hospitals incurred only $34 million in such losses, according to a subsequent analysis by the Tennessee Office of the Comptroller of the Treasury. The federal government paid its share on the $34 million claim, which is approximately $23 million.[20]

The state is also allowed to keep most of the premiums paid by TennCare participants who are required to pay premiums—about half of the non-Medicaid TennCare enrollees. The state and HCFA agreed that for the first $75 million in premium revenues collected annually, the state gets $.90 of each dollar and shares the remaining $.10 with the federal government, according to the standard sharing rate. As revenue collections surpass $75 million, the percentage of premium revenue allowable as state share gradually decreases. The state initially estimated that it would collect $21 million for state fiscal year 1994 and an additional $101 million for state fiscal year 1995 but subsequently revised its state fiscal year 1995 estimate to $30 million. Actual collections to date have been less than estimated.[21]

The state benefits from federal funding provided to state mental hospitals for expanded TennCare coverage, some of which is not covered under Medicaid rules. Most significantly, Medicaid does not cover persons between the ages of 21 and 65 in state mental hospitals. TennCare allows short-term coverage[22] of this population and reimburses mental hospitals directly for the actual costs of such services. Federal TennCare cost sharing for this population reduces the amount of state subsidy needed for

[19]HCFA agreed that the state could claim unreimbursed TennCare expenditures for private hospitals in the Knoxville and Nashville areas, up to the amount of indigent care funds that the counties transfer to these hospitals for such expenditures.

[20]State officials have also claimed $22 million for the first 6 months of 1994 in local government funding of three hospitals as TennCare expenses, which would draw $15 million in federal cost-sharing funds. However, HCFA deferred federal funding for the claim, asserting that local government funding is not a TennCare expense because it would, in effect, be a duplicate claim. The state subsequently agreed to withdraw its claim.

[21]See appendix III for more detailed information on premium collections.

[22]Coverage is limited to the first 30 days of an inpatient episode, subject to an annual aggregate limit of 60 days.

state mental hospitals. As a result, Tennessee officials identified $69 million in annual state funding of state mental hospitals that could be used to fund TennCare.[23]

Indirect benefits to the state result from covering persons not previously included in Medicaid and making capitated payments to MCOs instead of fee-for-service reimbursements to individual providers. Covering the uninsured and uninsurable allows the state to reduce its funding for other state programs that had served these populations. Therefore, in addition to the state funding of mental hospitals, state officials identified $91 million in annual funding of other state programs that could be used to fund TennCare, which now provides such services to the uninsured. Most of this funding—$65 million—comes from reduced state funding of community mental health services. Also included is $5 million in reduced state funding for the Tennessee Comprehensive Health Insurance Program[24] and $21 million for public health services, such as communicable diseases and hemophilia services.

Making capitated payments to MCOs indirectly benefits the state because these payments are then subject to certain taxes; fee-for-service payments to providers generally were not. The state has a tax of 2 percent on payments made to HMOs and 1.75 percent on payments to PPOs. The tax on HMOs existed before TennCare, and a tax on accident and health insurers that existed before TennCare was extended to include PPOs.[25] Although the HMO tax existed before TennCare, only one HMO, which covered about 25,000 Medicaid-eligible persons, had been subject to the tax for Medicaid revenues. Total capitation tax payments for 1994 were approximately $24 million, $16 million of which are essentially federal dollars returned to the state treasury.[26]

[23]Although a Tennessee Department of Mental Health and Retardation official said that the majority of residents in state mental institutions are between the ages of 21 and 65, the funds transfer also accounts for savings resulting from federal cost sharing for state mental hospital services for uninsured and uninsurable TennCare enrollees aged 21 and younger and 65 and older.

[24]Tennessee Comprehensive Health Insurance Program is a state insurance program for the uninsurable, who are automatically eligible for TennCare.

[25]The state legislation that made TennCare MCOs subject to the requirements of accident and health insurers was effective on May 2, 1994. However, a state official told us that PPOs are liable for the tax for the entire calendar year 1994.

[26]According to the Deputy Commissioner, Tennessee Department of Commerce and Insurance, PPOs paid the taxes under protest and may file a suit against the state.

Waiver Includes Various Access and Quality Assurance Standards

Under the waiver agreement, HCFA permitted new requirements to address enrollee access to care and systems to evaluate the quality of care provided to substitute for the usual Medicaid quality assurance requirements and systems. HCFA waived the requirement that beneficiaries have the freedom to choose any participating provider and the requirement that participating HMOs have at least 25 percent private enrollment. Under TennCare, HCFA requires the TennCare Bureau to ensure adequate enrollee access to providers and quality of care. HCFA further requires the state to submit quarterly progress reports on quality of care, access, utilization of health services, financial results, benefits packages, and other operational issues.

HCFA's primary care access standards for TennCare MCO networks include a minimum primary care provider to patient ratio (1 to 2,500), maximum travel distances and times (30 miles or 30 minutes for rural areas and 20 miles or 30 minutes for urban areas), and maximum allowable delays for scheduling and waiting for appointments (3 weeks for nonemergency scheduling and 45 minutes for waiting). In addition, TennCare has standards for specialty care, hospitalization, and other services. TennCare's planned monitoring of these standards includes periodically evaluating the ratio of primary care providers to enrollees; surveying recipients, including measuring waiting periods for health care services; and measuring referral rates to specialist physicians.

HCFA's quality standards for TennCare include ensuring the implementation of quality monitoring programs and evaluating MCO data to assess quality of care. TennCare's quality monitoring program derives from the National Committee for Quality Assurance quality monitoring program requirements for its MCO quality assurance programs. These requirements include credentialing of providers, grievance procedures, and utilization review. In addition, the state has included a required minimum data set of quality indicators.

TennCare Has Initially Met Its Objectives, but Access and Quality Assurance Measures Have Been Delayed

For the first year, TennCare essentially met its objectives of expanding coverage and controlling costs. The state had expanded eligibility to include 300,000 of the state's uninsured, yet actual program costs for the state fiscal year ending June 30, 1994, were less than budgeted. However, the operation of a key monitoring system to determine the accessibility

and quality of medical care provided through TennCare has been delayed.[27]

Cost and Control Objectives Largely Met

In January 1995, more than 400,000 uninsured persons and almost 800,000 Medicaid-eligible persons were enrolled in TennCare. The state expanded eligibility as of October 1, 1994, by allowing persons to enroll who had (1) lost private coverage from March 1993 to July 1994 or (2) insurance that offered limited coverage. However, on January 1, 1995, TennCare stopped new enrollment for most uninsured. Only persons who (1) had applications pending before January 1, 1995, or they would lose Medicaid eligibility or (2) could not obtain commercial insurance because of serious medical conditions continued to be eligible. Because of this, enrollment may decrease as the formerly uninsured leave the program and the currently uninsured are not allowed to enroll.[28]

During state fiscal year 1994, the first year in which the waiver became effective, TennCare expenditures were $2.7 billion, less than 1 percent over the prior year's Medicaid expenditures and significantly less than the 10 percent increase in national Medicaid expenditures for federal fiscal year 1994.[29] The state achieved these savings even though (1) Tennessee's regular Medicaid program remained in effect for the first 6 months of the year, (2) enrollment increased by hundreds of thousands in the last 6 months of the year, and (3) long-term care costs increased 11 percent for the year. Our analysis shows that the overall increase in expenditures was attributable to lower than expected Medicaid expenditures during the first 6 months and the introduction of a capitated payment system[30] on January 1, 1994, that paid rates far below historical Medicaid payments.

Access and Quality of Care Uncertain

Delays in the MCOs' implementation of information systems have severely affected the state's ability to monitor enrollee utilization, patient access, physician practice patterns, and enrollee medical outcomes for TennCare.

[27]See appendix III for a discussion of start-up problems that affected the implementation of the monitoring system.

[28]Although the formerly uninsured may leave the program for many reasons, the TennCare Bureau reported that it had terminated TennCare coverage of approximately 62,000 people as of June 1995 for failure to pay premiums. See appendix III for more information on the state's collection of premiums.

[29]Tennessee's reported expenditures for federal fiscal year, October 1, 1993, to September 30, 1994, were also less than 1 percent greater than the previous federal fiscal year's.

[30]From January through June 1994, the TennCare Bureau paid or accrued about $620 million in basic capitated payments to MCOs and about $250 million for supplemental payments to MCOs, hospitals, and physicians.

The state has conducted other analyses that generally indicate that MCOs are in compliance with the required numbers of primary care physicians. Nonetheless, surveyed beneficiaries indicated access problems, and almost half of those surveyed with prior Medicaid said that the care they received was worse than under Medicaid. Advocacy groups also reported that access to care is a problem.

An important part of the state's quality assurance program is the analysis of encounter data (information on each enrollee's use of services). Using such data, the state can analyze utilization, access, physician practice patterns, and medical outcomes. However, the state has had difficulty obtaining data from the MCOs and has conducted only limited analyses of available data. According to HCFA's 1994 TennCare Monitoring Report, at the year's end, three MCOs were still submitting data in a format not usable to the state. Additionally, the state had identified problems with the data from the other nine MCOs. During the first year of the program, the state withheld 10 percent of capitation payments for a varying number of months to all but one MCO for failure to comply with reporting requirements. To help ensure that the MCOs gather accurate data, the state is reviewing the MCOs' data systems and providing technical assistance to them. The state estimates that data for the first year of TennCare's operation will not be available before summer 1995.[31]

The state also reviewed MCO provider networks and contracted with a state university to conduct a beneficiary survey to assess access and quality of care. Although the TennCare Bureau reported that the MCOs generally had met the required standards for primary care, the state has not provided the data on all the access standards to HCFA. As a result, HCFA has been unable to validate the TennCare Bureau's determination. Further, HCFA recommends that the state require the MCOs to provide data that ensure that provider networks have been validated as adequate and requests that the state submit provider lists whose accuracy has been validated.

A beneficiary survey conducted for the state by the University of Tennessee in September 1994[32] also raised concerns about access and quality of care. The survey indicated that 45 percent of TennCare enrollees who had previously been on Medicaid said that the care they received

[31]In the TennCare Bureau's response to a draft of this report, it said that, as of June 1995, the 1994 encounter data are now available to TennCare staff to perform quality assurance reviews. It noted that it has problems with some of the data.

[32]We used the responses for the head of household. The survey sometimes also asked the same questions for the youngest child and the child most in need of medical attention.

under TennCare was worse than under Medicaid, citing limited choice of doctors and difficulty in finding providers as the most significant reasons. The survey also provided information on MCO adherence to HCFA's access standards. Enrollees were able to schedule appointments generally within 3 weeks, the requirement for primary care; however, 12 percent responded that it took over 3 weeks for the first available appointment, and 21 percent said it took more than 3 weeks for a follow-up appointment. The survey results show that it took enrollees an average of 25 minutes to travel to their doctor's office, but the survey did not indicate how often travel time exceeded the 30-minute requirement for primary care.[33] In addition, average reported waiting time in physician offices was an hour longer than TennCare's maximum waiting time of 45 minutes.

Advocacy groups have also expressed concerns about the availability of medical care under TennCare. In October 1994, the Tennessee Association of Legal Services surveyed physicians who had been identified as participating in TennCare in an April 1994 survey. Of 461 physicians who said that their practices were accepting new patients, 144 or 31 percent said that they were not accepting new TennCare patients. In January 1995, a TennCare monitoring group—made up of patient advocates, health care providers, researchers, and others—expressed concerns about the inadequate numbers of both primary and specialty care physicians in some areas of the state.

Program Future Depends on Several Factors

Several factors could jeopardize TennCare's future. The capitation rates that have been set are questionable and may be insufficient to allow MCOs to operate profitably while paying reimbursement rates sufficient to enlist and sustain provider participation. Almost half of the MCOs, representing over 60 percent of TennCare enrollees, reported losses in the first year. Although the program's financial impact on providers is inconclusive at this writing, hospitals have indicated that TennCare payments did not cover their estimated costs of treating TennCare patients, and physicians report that their practices are financially worse off than they were under Medicaid. Expected reductions in future supplemental payments from the TennCare Bureau will also negatively affect MCOs and providers. And although access and quality of care have not yet been fully analyzed, access to care will likely be inadequate if large numbers of providers choose to discontinue or drastically reduce their participation.

[33]The 30-minute travel requirement was not met for the youngest child and the child most in need of medical attention; the survey reported 31 minutes and 35 minutes, respectively.

TennCare's Questionable Capitation Rates May Significantly Affect Program Success

TennCare's success in expanding coverage and controlling costs stems primarily from its average capitation rates being substantially below adjusted historical Medicaid per capita fee-for-services costs. In its November 16, 1993, report, Milliman and Robertson, Inc., consultants to the state legislature, concluded that in the aggregate, the capitation rates were about 25 percent below projected 1994 fee-for-service Medicaid costs, even before capitation discounts, and did not account for regional cost variations.[34] In addition, the report stated that the (1) capitation rates were not based on commonly accepted actuarial methods, (2) calculations had inconsistencies, and (3) bases for capitation rate reductions were not explicit or well documented. The report also estimated that since MCOs would incur administrative costs, which are not reflected in the capitation payment, they would have to significantly reduce medical costs to succeed financially.

Despite these criticisms, state officials maintain that the capitation rates were reasonable. For example, the former Assistant Commissioner in charge of the TennCare Bureau[35] indicated to us his belief that the health costs for the uninsured averaged less than those for Medicaid beneficiaries. He also stated that Medicaid had had a lot of overutilized services and that he believed the minimum savings from managed care was 15 percent. He further stated that historical cost was only one piece of information used in setting the capitation rates. The state used several factors and knowledge of the health care system to develop the rates.

While HCFA officials said that they believed that the capitation rates were low, they believed that the willingness of several MCOs to contract for the capitation rate indicated that the rates were adequate. (A detailed discussion of the TennCare capitation rates and their actuarial soundness appears in app. I.)

MCOs Report Losses

Financial data reported by MCOs for the first year of TennCare show that 5 of the 12 MCOs, which cover 60 percent of beneficiaries, experienced losses. BlueCross BlueShield, the largest MCO, reported an $8.8 million loss. And although Access MedPLUS, the second largest MCO, reported a

[34]According to Milliman and Robertson, Inc., the state reported regional cost variations ranging from 83 to 122 percent of statewide average costs.

[35]The former Tennessee Department of Health Assistant Commissioner in charge of the TennCare Bureau, who served from January 1994 to April 1995, was previously in charge of the Tennessee Bureau of Medicaid.

slight gain, its financial condition may be worse than reported.[36] In addition, the reported net income for some PPOs does not reflect the impact of capitation taxes or substantial deficits incurred for medical services costs. (A detailed discussion of MCOs' financial performances appears in app. II.)

The MCOs' reported financial conditions would have been worse except for supplemental payments, which are likely to be reduced in 1995. Without these payments, all of the HMOs would have incurred losses. The MCOs' 1994 financial statements included more than $100 million in both actual and anticipated supplemental payments[37] for (1) a supplement to capitation rates paid for 1994, (2) the first 30 days of care to formerly uninsured enrollees, and (3) adverse selection. As of May 1995, the TennCare Bureau had paid MCOs the capitation rate supplement and some payments for the first 30 days of care for the formerly uninsured. However, although one-half of the MCOs had included anticipated adverse selection payments in their 1994 financial results, the TennCare Bureau had made no such payments as of May 1995, almost 1 year and 6 months since the MCOs began participating in the program.

Only one PPO included the 1.75-percent capitation tax expense in its computation of net income, which, according to state officials, PPOs are required to pay. Officials from two of the five PPOs said that they were not aware that they were liable for the tax until they received a February 1995 notice. The additional cost of the capitation tax would reduce these PPOs' net income or the amount available to pay for medical services by approximately $4 million.

Two PPO financial reports included only the results from administrative operations and not the surplus or deficit for medical service expenses. One of these PPOs has a contractual arrangement with providers that puts them at risk for deficits resulting from excess medical costs. Officials from both PPOs indicated that their plans experienced a medical operating deficit of over $5 million representing about 7 percent of total capitation payments received by each plan. However, these medical deficits did not reduce these MCOs' net incomes. One plan established an accounts receivable of over $5 million due from providers, while the other PPO did

[36]We did not verify the financial condition of Access MedPLUS. The state required that we subpoena the information that would have enabled us to do so. We chose not to issue a subpoena because it would have delayed this report.

[37]Reported total supplemental payments received and expected for 1994 are as much as $26 million less than the $128 million the TennCare Bureau said is available for 1994. Thus, the Bureau could make some additional supplemental payments to MCOs, improving their financial position.

not reflect the excess medical costs on its financial statement because officials said it was the providers' liability.

TennCare's Financial Impact on Providers Uncertain

TennCare's financial impact on providers—hospitals, health centers, and physicians—is uncertain. Although available analyses suggest that TennCare has negatively affected providers, these analyses are not conclusive because they do not (1) compare TennCare reimbursements received with Medicaid reimbursement, (2) consider all TennCare reimbursement, or (3) provide actual financial data on which to base a conclusion. In addition, comparing physician reimbursement rates under BlueCross BlueShield, the largest TennCare MCO, and under the prior Medicaid system yields mixed results: the rates are generally lower under BlueCross BlueShield, except for office visits and consultations.

Hospitals and Health Centers Analyses Inconclusive

Analyses conducted by the Tennessee Office of the Comptroller of the Treasury and the Tennessee Hospital Association (THA) of hospitals' and federally qualified health centers' costs under TennCare are inconclusive. The two analyses of hospital finances indicate that hospitals incurred losses under TennCare, but neither analysis compared the TennCare experience with the hospitals' experience under Medicaid. A comparison of federally qualified health center finances under TennCare and under Medicaid showed that most of the centers' profits were reduced under TennCare, but the Comptroller's office expressed concerns about the reliability of the data submitted.

Tennessee's Comptroller's office analyzed whether TennCare payments to publicly funded, nonstate hospitals covered the cost of caring for TennCare enrollees from January 1, 1994, through June 30, 1994.[38] Even accounting for supplemental payments, 27 of 34 hospitals incurred $34 million in estimated losses by treating TennCare patients. All 34 hospitals would have reported losses, and total losses would have been much greater if the analysis had not accounted for supplemental TennCare payments.[39] THA claimed that TennCare payments did not cover hospitals'

[38]The purpose of the study was to calculate the allowable TennCare claim for federal reimbursement on the basis of losses at publicly funded, nonstate hospitals.

[39]The analysis included $30 million in medical education payments that had been paid to these hospitals; in addition, the Comptroller included $48 million in estimated high-volume payments that had not been received by the hospitals. The Comptroller did not include estimated TennCare payments made to the hospitals for care to TennCare eligible but not enrolled people. This was not included because the actual cost of providing services to such people had not been determined.

estimated costs of treating TennCare patients.[40] But this analysis did not compare TennCare hospital reimbursement with prior Medicaid reimbursement. In addition, the THA analysis did not include supplemental payments made to hospitals for caring for large numbers of TennCare and indigent persons because the payments had not been made at the time of the study. THA officials told us that hospitals subsequently received $50 million in such supplemental payments. However, this is only half of the $100 million that hospitals had expected to receive from the state.

As part of the state's waiver agreement with HCFA, the Comptroller's office reviewed cost reports from participating federally qualified health centers for the first 6 months of TennCare and concluded that, "it appears the clinics are not performing as well under TennCare compared to Medicaid." However, the Comptroller's office said that its analysis was not conclusive because it could not be sure that changes in costs were caused solely by TennCare nor that health centers accurately reported revenues, particularly pending payments. Our review of the Comptroller summary of the health centers' data shows that although 14 of 20 health centers had reduced total clinic profits during the TennCare period, only 3 reported an overall loss.

Physicians Report Their Practices Are Financially Worse Off Under TennCare

An opinion survey conducted by the TMA in October 1994 found that, compared with Medicaid, more than three-quarters of the physicians reported that their practices were somewhat or much worse off financially under TennCare.[41] Because the TMA survey was an opinion survey, it does not provide financial data on physicians' TennCare and Medicaid experiences. Further, a TMA official said that the physicians' financial situations may be worse than the survey reported because the physicians may have included in their assessments supplemental payments from the TennCare Bureau that had not been received as promised. In addition, physicians may have expected MCOs to return withheld reimbursements for 1994, but much of these have not been returned.

At the time of the survey, no supplemental TennCare payments had been made to the physicians, and withholds of physician reimbursement by the largest MCO had not been settled. The TennCare Bureau accrued $15 million in supplemental funds for payments to physicians for January to June 1994 but had not made any payments. As of March 1995, payments

[40]THA contracted with Ernst & Young LLP to compare TennCare payments for 35 hospitals with the estimated costs of providing care for the first 6 months of TennCare.

[41]TMA reported that the 1,221 responses it received from practices represented more than 4,631 physicians.

had still not been made. For state fiscal year 1995, $15 million has again been budgeted for supplemental physician payments.

At least six MCOs withhold part of their physician reimbursements, ranging from 5 to 25 percent. We talked to two MCOs that used such withholds to offset excess costs, as necessary. According to their physician contracts, these MCOs assess their plan's performance for the year and decide how much of the withhold to return, if any. BlueCross BlueShield had a 5-percent withhold on physician reimbursement and kept the entire amount for most of the providers. John Deere has a withhold of up to 25 percent of physician reimbursement and paid back approximately one-fourth of the withheld funds and may make further distributions.

Comparing BlueCross BlueShield TennCare Physician Reimbursement Rates With Medicaid Is Inconclusive

A TMA physician survey indicated that the reimbursement levels offered under TennCare had the most negative impact on physician practices. A comparison of BlueCross BlueShield TennCare reimbursements for selected services to Medicaid reimbursements shows that TennCare rates are generally lower than Medicaid rates, except for visits and consultations.

In comparing selected BlueCross BlueShield TennCare rates to Medicaid rates, BlueCross BlueShield pays at least slightly better for visits and consultations and significantly less for other services. For example, BlueCross BlueShield reimbursement rates for office, inpatient, and outpatient visits and consultations are higher than Medicaid rates; however, BlueCross BlueShield rates for other selected surgery and radiology services are significantly less than Medicaid rates, with differences for many services ranging from 20 to 50 percent less than Medicaid rates. The impact on a particular physician practice depends on the frequency and type of services provided.

TennCare's MCO and Provider Networks Threatened

The success of TennCare will also depend on the continued participation of the MCOs and providers for the duration of the 5-year demonstration. MCO officials are hesitant about continuing to participate in TennCare, given their financial performance in the first year; and providers—disconcerted about low reimbursement rates, heavy administrative burdens, payment delays, and lack of involvement in developing TennCare—could withdraw in large numbers.

Continued MCO Participation Uncertain

Although all participating MCOs have renewed their contracts for state fiscal year 1996, concerns remain. We talked to officials from three MCOs

about TennCare's future, and they expressed several concerns about operating without supplemental TennCare revenues, compensating for 1994 operations shortfalls, and maintaining an adequate provider network.

The TennCare Bureau budgeted less for MCO supplemental payments for 1995 than were paid and accrued for 1994. In 1994, TennCare supplemental payments designated for MCOs totaled $128 million. However, only $76 million had been paid as of May 1995, although the TennCare Bureau says it will make additional payments. For 1995, the TennCare Bureau has designated only $40 million in supplemental payments to MCOs and plans a 5-percent increase in capitation payments effective July 1, 1995.[42]

BlueCross BlueShield officials told us that they incurred a loss of $8.8 million in 1994, and they forecast a loss of $35 million for their 1995 TennCare operations, even though they plan to implement cost-control measures during the year. BlueCross BlueShield's projected deficit increase reflects expected reduced supplemental payments from the TennCare Bureau and higher utilization, which officials believe was low in 1994 due to the initial confusion over TennCare. To control costs, BlueCross BlueShield plans to (1) retain reimbursement rates at initial 1994 levels, (2) increase the percentage withheld from providers in some areas of the state, (3) control utilization by emphasizing outpatient visits over hospital admissions, and (4) aggressively address billing of unnecessary services.

BlueCross BlueShield officials have indicated that the company does not intend to continue to lose money. They have said that unless capitation rates are increased 10 percent retroactively to January 1, 1995, BlueCross BlueShield will face a decision about its participation. Since BlueCross BlueShield had enrolled nearly 50 percent of the beneficiaries and is one of only two statewide MCOs, changes in its participation could significantly affect TennCare.

Officials from two other MCOs that are holding providers responsible for their plans' 1994 medical services operating deficits expressed uncertainty about whether these deficits can be recouped. Officials said that efforts to reduce provider reimbursement would jeopardize their providers' continued participation. An official from one MCO said that if cost-containment efforts fail, the MCO will simply make payments until it can no longer do so.

[42]In the TennCare Bureau's response to our draft report, it said that for state fiscal year 1996 an additional 4.5 percent capitation supplement will be made available to MCOs that meet the performance standards specified in a contract amendment being sent to the MCOs.

Continued Provider Participation Also Uncertain

In early 1995, officials from THA, as well as from several major hospitals, expressed concern because the TennCare Bureau had announced that hospitals would not receive supplemental payments in 1995. Supplemental payments to hospitals for graduate medical education, care for TennCare eligible but not enrolled persons, and special payments to hospitals that cared for large numbers of TennCare and indigent persons totaled approximately $220 million for 1994. Subsequently, on the basis of a June 27, 1995, agreement with HCFA, the TennCare Bureau announced that it intends to make $55 million in one-time payments to two hospitals[43] and resume medical education payments to hospitals.

In addition to low reimbursement rates, other MCO actions may affect physician participation. For example, at least two other MCOs did not return all withholds to physicians on reimbursements for the first year of operation, and at least two MCOs held physicians liable for medical services deficits. As MCOs try to further control and contain costs, their network providers may assume additional administrative burdens as well as reduced reimbursement. These pressures will add to the dissatisfaction that providers already have with the program. An October 1994 TMA satisfaction survey of TennCare physicians reported that 86 percent of respondents felt dissatisfied with the program, and 77 percent felt that TennCare reimbursement was worse than under Medicaid.

Physician dissatisfaction was evident from TennCare's inception, when many doctors reported feeling coerced to participate. To guarantee a sufficient network, BlueCross BlueShield implemented a policy requiring physicians who participated in an existing network that operated for state employees and others to participate in TennCare. The policy, which became known as the "cram down" provision, prompted about a third of the 6,500 physicians in the existing network to drop out. Although most physicians returned to the network, their dissatisfaction with the cram down policy has persisted, and stakeholders and policymakers continually discuss eliminating it. If the policy were eliminated, BlueCross BlueShield officials believe many network providers might choose to stop treating TennCare patients.

Conclusions

Tennessee's capitated managed care program has enabled the state to control costs and provide health care coverage to hundreds of thousands of uninsured persons. In addition, it has established a system that enables

[43]HCFA requires that the hospitals be allowed to retain at least $18 million of these payments and allows the remainder of the payments to be transferred from the hospitals to the state.

persons who lose their Medicaid eligibility to keep health care coverage. But serious questions exist about the program's future. The quality and accessibility of medical care are largely unknown, but early indications are that quality and access could be improved.

Moreover, the rates paid to MCOs were substantially below prior Medicaid per beneficiary costs. Overall, MCOs lost money in the first year, even after receiving substantial one-time supplemental payments. In the absence of these supplements, MCOs may need to cut payment rates for providers and/or pressure providers to hold down costs to remain in the program.

Most providers have already indicated that their financial situations are worse off under TennCare than they were under Medicaid. MCO cost-control efforts and the termination of large supplemental payments to hospitals will only exacerbate their condition. If providers decide to reduce their TennCare participation or leave the program in significant numbers, the viability of the MCOs and TennCare could be threatened.

Agency Comments

Recent State Efforts

Both HCFA and the TennCare Bureau said that recent actions by the new state administration to address some of the problems we identified should be included in our report. We recognize that the organizational change regarding MCO financial oversight, forums for discussion and input provided by the TennCare Roundtable,[44] and the proposed plan to provide MCO performance-based incentive payments of up to 4.5 percent of the capitation payments are potentially significant. However, because of the recency of the changes, their impact on the problems we identify is uncertain at this time.

MCOs' Renewals

HCFA and the TennCare Bureau also pointed out that MCOs have renewed their contracts to participate in TennCare for at least the next 12 months. As a result, the TennCare Bureau said that our concern about the uncertainty of continued MCO participation is inconsistent with the MCOs' behavior. Our concern is that MCOs continue to participate for the duration of the 5-year demonstration project and that MCOs' financial difficulties not

[44]The TennCare Roundtable was a group of providers, MCOs, and beneficiary advocates appointed by Governor Sundquist to hold public hearings and make recommendations on how the program can be improved. It issued a report on June 29, 1995.

threaten TennCare enrollees' access to and quality of care. On the basis of our review of MCO financial information, discussions with MCO officials, and the uncertainty of supplemental funding from the TennCare Bureau, we remain concerned about the continued participation of MCOs and their ability to maintain adequate provider networks.

MCO Start-Up Costs

The TennCare Bureau also wanted our report to recognize that MCOs incurred start-up costs during the first year, writing that "the profits and losses in any business situation during the first year do not typically reflect what may result during ongoing operations." Although we recognize that start-up costs were incurred and that they do contribute to reduced profits or increased losses for the year, other factors should be considered. First, MCOs shared in an unexpected $54 million in additional capitation supplements for 1994 to address MCO financial difficulties, as well as additional payments of more than $20 million for the first 30 days of care provided to the uninsured. Similar payments are not planned in the future. Second, start-up costs were offset to some extent by lower utilization resulting from beneficiary and provider confusion during the first few months. Third, system development and start-up-like costs will continue to be incurred by some MCOs; for example,BlueCross BlueShield officials said that they will incur an additional cost in 1995 to purchase an HMO information system to operate as a gatekeeper. Fourth, MCO officials we talked to expected to experience financial difficulty in the second year, both because of the medical costs they expect to incur and reduced supplemental TennCare funding they expect to receive so they saw the need to act to mitigate future losses.

Federal Cost Sharing

On the issue of cost sharing, HCFA officials reiterated several times that HCFA has not changed the federal matching rate in the TennCare demonstration. We agree with HCFA that the federal matching rate applied to qualifying TennCare expenditures has not changed. However, a number of waiver provisions effectively increased the federal cost-sharing rate by reducing the net financial contribution required of the state. In particular, certain hospital losses are treated as qualifying TennCare expenditures, although the state does not pay the hospitals for those losses. The state can also recoup a share of both its and the federal government's contribution to MCO capitation payments through a tax on the capitation payment and by retaining 90 percent of premium collections. How such arrangements can effectively increase federal cost sharing is fully

described in Medicaid: States Use Illusory Approaches to Shift Program Costs to the Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

Quality Assurance Programs

HCFA officials described the difficulties of the state staff and MCOs due to their lack of experience and having to simultaneously address their financial and organizational problems. HCFA officials also said that the state is working with an external organization to help fully implement quality programs at the MCOs. HCFA indicated that the state's progress in implementing its quality assurance monitoring plan is slow and that HCFA is requiring the state to develop interim monitoring strategies to ensure access and quality. We agree with HCFA's assessment and attribute the magnitude of these problems to inadequate planning and TennCare's rapid implementation. (See apps. IV and V for comment letters from HCFA and the TennCare Bureau, respectively.)

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services, Tennessee officials, and the chairmen and ranking minority members of congressional committees with an interest in these matters. We will make copies available to others on request.

Please contact me on (202) 512-7123 if you or your staff have any questions. Major contributors to this report are listed in appendix VI.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Associate Director, Health Financing
and Public Health Issues

Contents

Tables

Figure

Abbreviations

DSH	Disproportionate Share Hospital
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MCO	managed care organization
NAPH	National Association of Public Hospitals
PPO	preferred provider organization
THA	Tennessee Hospital Association
TMA	Tennessee Medical Association

Tennessee's Methodology for Setting Capitation Rates and Concerns About the Methodology

To control its health care costs, TennCare makes monthly capitation payments to MCOs for each of their enrollees. The state's methodology for setting the capitation rates, however, has raised some concerns. For example, consultants to the state legislature reported that the aggregate capitation was understated by more than 25 percent.

The capitation rates are based on historical Medicaid costs and set by enrollee type; the rates are then reduced by charity care deductions and enrollee cost sharing. Before the capitation rates were established, consultants to Tennessee's Bureau of Medicaid reviewed the state's historical Medicaid cost information. Although the consultants found this information to be generally acceptable, they recommended that the capitation rates (1) reflect historical costs for eligible months and (2) account for regional cost variations. The TennCare Bureau did not follow either recommendation.

After the capitation rates were established, consultants to the state legislature reviewed the state's rate-setting methodology and found it actuarially unsound. As a result, the consultants recommended that capitation rates be increased 20 percent, even when allowing for cost savings from potential utilization reductions.

Establishment of Capitation Rates

To set monthly capitation rates, Tennessee used 1992 Medicaid costs projected to 1994 for each enrollee type. These rates were then reduced for charity care, local government funding, and enrollee cost-sharing adjustments. The state also calculated an overall average capitation rate used for budgeting purposes and not for paying MCOs. The overall average rate for 1994 was $136.75 a month. After a reduction of $35.65 for charity care, local government expenditures, and coinsurance and deductibles, the rate was $101.10. Effective July 1, 1994, the TennCare Bureau increased capitation rates 5 percent.

Tennessee set rates for eight categories of eligibles determined by factors such as age, gender, and whether the enrollee has a disability. Deductions to the capitation rates are based on various assumptions about charity care, local government funding, and medical costs incurred by the uninsured.

The charity care deduction—meant to capture approximately one-half of the estimated cost of charity care provided in the state—was estimated at

$595 million annually.[45] The state assumed that Medicaid and other payers had been paying for charity care when medical providers shifted charity care costs to others. Because coverage of the uninsured would reduce charity care, the state reduced the capitation rate accordingly. On average, a monthly charity care deduction of $27.96 was applied to each monthly capitation rate on the basis of the state's estimated upper limit of the total number of Medicaid and uninsured people.

The deduction for local government funding—meant to capture an amount equal to the local government funding that would be expected to be provided without TennCare—was estimated at $50 million annually. On average, a local government deduction of $2.35 was applied to each monthly capitation on the basis of the state's estimated upper limit of the total number of Medicaid and uninsured people.

The third deduction, for copayments and deductibles, applies only for non-Medicaid eligible TennCare enrollees with incomes above the federal poverty level and is computed on an individual basis. For budget purposes, the state computed an average deductible and copayment deduction equal to $5.35 monthly. In calculating these deductions, the state assumes that everyone will exhaust their deductible and make copayments. For example, the monthly capitation rate for a non-Medicaid TennCare enrollee with income above the federal poverty level would be reduced for one-twelfth of the annual deductible and up to an additional 10 percent of the reduced capitation to account for expected copayments. Enrollees subject to cost sharing are required to pay the deductible and copayments to MCOs or providers as they incur medical costs.

Validity of Capitation Rates Questioned

In May 1993, Peat Marwick, as consultants to the state's Bureau of Medicaid, reviewed the historical Medicaid cost information on which the Bureau planned to base its capitation rates. Peat Marwick found that the data underlying the state's cost projections were sound, except for an understatement of incurred claims.[46] However, it made several recommendations on factors to include in setting rates. Among the recommendations was that claims data should be used to set monthly

[45]The estimate is based on information from the University of Tennessee and estimates made by health care providers in meetings with state officials.

[46]Peat Marwick's analysis was based on the assumption that TennCare benefits would be the same as Medicaid, with the exception of eliminating prescription limitations, and that cost reductions due to managed care aspects of the new provider arrangements would offset this benefit expansion. A Peat Marwick letter stating that the methodology used in calculating the cost per eligible month was actuarially sound was attached to the TennCare waiver application.

rates on the basis of eligible months rather than the number of eligibles participating in Medicaid for some period during the year. Peat Marwick also recommended that regional capitation rates be established. The state did recompute the capitation rates, but it used total number of eligibles to establish an annual cost regardless of eligible months, and it did not establish regional rates.

When TennCare's capitation rates were announced about 3 months after the Peat Marwick review, concerns were raised. To address these concerns, the Legislative Oversight Committee on TennCare[47] contracted Milliman and Robertson, Inc. (in conjunction with Schubert & Associates) to review the TennCare Bureau's capitation rate-setting methodology.

In its November 1993 report, Milliman and Robertson stated that in the aggregate, the capitation rates were about 25 percent below projected 1994 fee-for-service Medicaid costs. Further, since MCOs would incur administrative costs not reflected in the capitation payment, Milliman and Robertson estimated that MCOs would have to significantly reduce medical costs to succeed financially. In addition, Milliman and Robertson agreed with Peat Marwick's recommendation that rates should address regional variation and said that the variations were too significant to be ignored. According to Milliman and Robertson, the state's analysis showed that costs by region were as low as 83 percent and as high as 122 percent of statewide average costs.

The report made several conclusions: (1) the gross capitation rates were not based on commonly accepted actuarial methods, (2) inconsistencies existed between the Bureau's reported methodology and the actual calculations, (3) no explicit assumptions existed on cost reductions in the gross capitation rate development, and (4) capitation rate reductions were not well documented.

Milliman and Robertson found that the gross capitation rates were not based on commonly accepted actuarial methods because the state used the total number of people who received Medicaid during the year regardless of length of time on the program to determine capitation rates and ignored Medicaid cost variations by area. The state's computation of capitation rates, in effect, assumed that every Medicaid recipient in 1992 was covered for the entire 12 months. Milliman and Robertson calculated that on average, Medicaid recipients were only enrolled for 8.72 months

[47]Formally established by Tennessee law on April 18, 1994, as the Select Oversight Committee on TennCare, the Committee is made up of seven members each from the State House and the Senate. The Committee has broad oversight responsibility and authority.

during 1992, which understated the aggregate capitation by 26.2 percent. Also, the state projected 1994 rates from 1992 data, on the basis of a 5.5 percent annual inflation rate.[48] However, the state may have understated actual inflation increases since it had provided information in its TennCare application that showed an average annual increase of 8.7 percent from fiscal years 1988-1989 to 1991-1992.

In addition, Milliman and Robertson said that the average gross capitation rate that TennCare used for budget purposes overstated the actual rates paid by eligibility category. This was due to an error in how Tennessee weighted the eligibility categories. In calculating each of the eight capitation rates, the state counted people equally regardless of how many months they had been in the program and whether they were in more than one capitation category. For example, a 9-month-old child qualifying for Medicaid halfway through the calendar year would be counted in determining the capitation rate for each of two categories—"less than one year of age" and "aged 1 to 13"—even though the child would have been in each category for only a few months. This understates the per capita costs because the child is treated, in effect, as having received services for an entire year in each capitation category. Milliman and Robertson calculated that the gross capitation rates by eligibility category were about 6.2 percent too low to achieve the TennCare Bureau's reported average gross capitation rate because of this error.

Milliman and Robertson also reported that no explicit assumptions existed about cost savings under TennCare. They said that the state's utilization data indicated the potential for significant utilization reductions. Given this and other states' experiences, Milliman and Robertson said that a 10-percent reduction assumption for 1994 would have been appropriate to apply to otherwise actuarially sound rates. Even when allowing for the utilization cost reduction, Milliman and Robertson said that an overall increase of 20 percent was still needed to address problems in the rate-setting methodology.

Further, Milliman and Robertson noted that the Bureau did not provide them with the necessary information to evaluate the capitation reductions for charity care, local government funding, and enrollee cost-sharing adjustments. They also said that the data available to them suggested that

[48]Although the state reported that it increased the 1992 costs by 5.5 percent for each of 2 years to arrive at the 1994 costs, we found that the actual average rate applied to Medicaid enrollees was about 6.4 percent. According to state officials, increases were originally calculated using a 5.5 percent rate. However, the amount budgeted for TennCare exceeded the expected capitation payments required for the number of people believed to be eligible for TennCare. The state consequently increased the individual capitation rates to reflect the higher amount budgeted.

the deductible reductions were too high because they are based on the assumption that all enrollees would incur costs exceeding the deductible.

Financial Performance of TennCare's MCOs

The overall financial performance of the five PPOs and seven HMOs that TennCare contracted with appears to have been weak for the first year of participation. According to its financial analysis,[49] BlueCross BlueShield, the largest TennCare MCO, with almost half of the state's TennCare enrollees, estimated that its losses on TennCare revenues total almost $9 million. These losses could be more than twice that amount if incurred claims expenses have been underestimated—even though the MCO withheld payments from providers and limited its administrative costs. The financial condition of Access MedPLUS, the second largest TennCare MCO, with nearly a quarter of the state's TennCare enrollees, is unknown, but examiners of the HMO's records have discovered weak controls in its financial reporting and have questioned its financial viability.

For our review, we used the annual financial reports that HMOs submitted to the Tennessee Department of Commerce and Insurance, and we obtained financial reports from participating PPOs. Four PPOs provided us with unaudited information, and one PPO, BlueCross BlueShield, provided us with an audited report, although it contained little specific information on its TennCare operations and additional financial analyses.

BlueCross BlueShield Reported Losses for the First Year of TennCare

BlueCross BlueShield, the state's largest PPO,[50] estimated that it lost about $8.8 million on TennCare revenues of about $610 million even though it (1) retained about $17 million that it had withheld from providers to cover losses and (2) limited administrative costs to 7 percent of premiums plus the $9 million in premium taxes it paid. According to BlueCross BlueShield officials, the loss could be as much as $18.8 million if incurred claims expenses have been underestimated. In calculating its loss, BlueCross BlueShield included received and anticipated supplements to the capitation rate of $45.9 million. These consisted of a retroactive premium increase payment of $23.8 million, anticipated adverse selection payments of $9 million, and anticipated payments of $3 million for the first 30 days of care for formerly uninsured enrollees, as well as $10.1 million that had already been received for the first 30 days of care.

[49]As part of their contract with TennCare, MCOs are required to file an audited annual report 9 months after the end of their corporate operating year. In addition, HMOs are required to file quarterly financial reports with the Tennessee Department of Commerce and Insurance.

[50]BlueCross BlueShield has about half of the state's TennCare enrollees and about three times as many enrollees as the combined total of the other four PPOs.

Other PPOs' Financial Reports Raise Concerns

Most of the data provided to us by the other four PPOs were unaudited or informally produced, and differences in their reporting methods preclude combining their results in a meaningful way.

One PPO's unaudited financial statements did not include income or expenses related to medical costs. Its income statement, which showed a net income of about $93,000, was limited to administrative costs because PPOs are not considered at risk for medical costs. The PPO's financial statements only record the liabilities for medical services equal to the amount of available funds. A PPO official told us that approximately $5 million in excess medical services liabilities is not recorded because this is the medical providers' liability. On the basis of discussions with a PPO official, the medical deficit could be reduced to less than $3 million if the PPO receives estimated adverse selection payments and additional payments for the first 30 days of care provided to uninsured enrollees. The PPO plans to recover the deficit through utilization reduction efforts during 1995; according to the official, providers would leave the network if the PPO reduced its fees.

Officials from another PPO provided us with unaudited financial statements that showed a $77,212 loss for 1994, which did not account for the 1.75 percent state tax on capitation payments. However, the PPO's deficit would have been $5.3 million higher had it not established a $5.3 million accounts receivable item for provider-shared risk. This item, which equals about 7 percent of the capitation payments received from the state, represents the amount of operating deficit to be recovered from future provider reimbursements. Officials from the first PPO gave several examples of plans to contain costs, but they were uncertain what impact their efforts would have. Officials from both PPOs expressed concern about maintaining their provider network.

A third PPO reported a loss of over $2 million. However, according to the PPO TennCare contract, PPOs must account for their administrative and medical operations separately. Using the PPO's unaudited financial statements, we computed that the PPO incurred about a $3 million loss, after taxes, even though it realized a gain of $1 million on its medical operations—of which 90 percent would have to be returned to the state and 5 percent distributed to providers, according to the contract provisions.

HMOs' Reported Earnings Mixed

Table II.1 shows the reported earnings for the first year of TennCare for the seven HMOs.

Table II.1: First-Year Earnings for Seven TennCare HMOs

HMO	Net income	Enrollees[a]
Access MedPLUS	$66,127	286,639
John Deere Health Care/Heritage National Health Plan	0[b]	17,155
TLC Family Care Health Plan	391,305	35,421
Phoenix Healthcare	794,433	34,821
Prudential Community Care	94,743[c]	7,989
Total Health Plus	(1,016,839)	6,316
VHP Community Care	($4,301,614)	12,558

[a]TennCare enrollment as reported by the state as of May 12, 1995.

[b]Both John Deere and Prudential reported for their overall health care organizations rather than only for their TennCare plans. An official of John Deere Health Care, which reported earnings of $3.8 million on its Heritage National Health Plan of Tennessee, told us that it broke even on its TennCare plan.

[c]The Prudential Health Care Plan reported a net income of $25,497,539 for all its health care plans. Information provided to us by a Prudential official showed that it earned $94,743 from its TennCare operations after receipt of a supplemental capitation payment.

Adequacy of Reserves Questioned for Three HMOs

Reports reviewed by the Department of Commerce and Insurance for the quarterly period ending June 30, 1994, indicated problems with the adequacy of reserves for three HMOs. The problem was eliminated for one HMO and largely eliminated for another when the Commissioner of Finance and Administration assured the Commissioner of Commerce and Insurance that the state would make adverse selection payments that would address the reserves question. However, financial problems of the third HMO—Access MedPLUS, which is one of the two statewide MCOs serving TennCare beneficiaries and about 2.3 times the size of all other HMOs combined—may not have been resolved.[51]

Examiners for the Department of Commerce and Insurance have raised questions about Access MedPLUS' financial viability.[52] They reported that a major asset—advance payments to medical providers—on the MCO's

[51]Access MedPLUS has been criticized for its nonpayment of claims and an inadequate provider network. A Tennessee Medical Association member survey ranked Access MedPLUS last among the MCOs in physician satisfaction with MCOs' fulfillment of their duties.

[52]The financial reports are filed by the Tennessee Managed Care Network, Inc. TennCare beneficiaries in Access MedPLUS constitute nearly all of the network's enrollment.

financial statements, representing about half of Access MedPLUS assets, was questionable. They also could not reconcile the data in the financial statements to the MCO's general ledger and noted that the MCO did not appear to have sufficient management and accounting controls to ensure that funds were available to pay claims. They recommended that the MCO be placed under the supervision of the Department of Commerce and Insurance.

Further efforts to determine the financial performance of Access MedPLUS have been problematic. According to Department of Commerce and Insurance records, a Deloitte & Touche LLP review of the MCO, contracted through the state, included determining (1) claims processing ability, (2) amounts owed to providers, and (3) solvency or the degree of insolvency. We sought the results of this review, but the State Attorney General's office would not release the report without a subpoena, maintaining that the documents are confidential in accordance with state law and that the report and its confidentiality were the subject of pending litigation. To avoid the delay and expense that could result from issuing and enforcing a subpoena, we decided not to use GAO's statutory authority to subpoena such records and to proceed without them.

State officials subsequently advised us that they were committed to ensuring that MCOs are in full compliance with all statutory and contractual requirements mandated by their participation in the TennCare program. They stated that if any MCO is found not in compliance, the state will either act to bring the MCO into compliance or pursue other remedies to protect TennCare. They noted that, at this point, the state has taken no action to place Access MedPLUS under supervision.

Start-Up Problems

Less than 7 months after submitting its waiver application to HCFA, Tennessee placed its entire Medicaid population in a statewide prepaid managed care program and opened enrollment to the uninsured. Before TennCare, the state Medicaid program had little capitated managed care experience nor a model to follow since Tennessee was the first state to place its Medicaid population into such a program. Rapid program implementation and lack of managed care experience led to several problems, such as confusion among enrollees, providers, and MCOs; provider resistance; and delays in enrollment, claims processing, and premium payments.

Although many of these problems have been addressed to some degree, the Assistant Commissioner in charge of the TennCare Bureau testified in March 1995 that TennCare continues to experience several problems as does any program in its "infancy."

Limited Managed Care Experience Led to Confusion Among MCOs, Beneficiaries, and Providers

TennCare introduced a prepaid, capitated system, in which the TennCare Bureau makes monthly payments to MCOs for enrollee care, and the Bureau assumes responsibility for MCO oversight. The state Medicaid program had primarily operated a fee-for-service reimbursement system. As a result, state staff were inexperienced with the characteristics and complexities of MCOs, and the state's relationship with physicians and hospitals changed dramatically under TennCare. Despite this lack of experience and the magnitude of these changes, Tennessee began operating its statewide program within 9 months of announcing it.

According to TennCare Bureau officials, they met with parties interested in contracting as TennCare MCOs beginning in the summer of 1993. However, interested parties did not enter into TennCare contracts until late November, little more than a month before actual enrollment was to begin. Of the 12 contracted MCOs, only 1 had experience serving the Medicaid population before TennCare, and most of the MCOs developed their TennCare products in response to TennCare. This inexperience caused confusion for the contracted MCOs as well as TennCare beneficiaries and participating providers. TennCare reported that after program start-up, the state's hotline averaged 50,000 calls a day, from beneficiaries, MCOs, and providers—compared with 9,000 calls a day in the following quarter. For all parties involved, the transition to TennCare was

"traumatic," according to a National Association of Public Hospitals (NAPH) report in April 1994.[53]

The state reported general start-up problems for MCOs, such as inability to handle the large volume of enrollee calls, adjusting to the increased enrollment, and claims processing problems. According to the NAPH report, the MCOs were unprepared to assume many of the contractual responsibilities for TennCare. One MCO's enrollment grew overnight from 35,000 to over 260,000, and officials from the MCO reported receiving 2,000 calls each hour in the first days of implementation. In addition, HCFA Region IV's 1994 Monitoring Report found that during the first months of TennCare, multiple changes to enrollment and eligibility—some retroactive—further burdened the MCOs. The president of one MCO said that enrollment changed by over a third in 1 week. Officials from the MCOs we visited found that verifying participant enrollment was nearly impossible in the first months of the program.

Providers Take Action Against TennCare

In December 1993, the Tennessee Medical Association (TMA) filed an injunction to stop TennCare's implementation. The court dismissed the case, but TMA appealed the ruling. TMA opposed TennCare in part because it had been implemented without opportunity for public comment on its development and payment rates for providers were inadequate. TMA also opposed BlueCross BlueShield's "cram down" provision, which required physicians who participated in a network that operated for state employees and others to participate in TennCare. The provision prompted about a third of the 6,500 providers in the network to drop out in the early months of TennCare and providers in some parts of the state, particularly rural Western Tennessee, to boycott the program. The state, however, characterized initial problems with provider participation as the providers' unwillingness to accept change.

Poor Communication and Outreach Led to Delays in Enrollment

Several start-up problems have been attributed to poor communication and outreach, which affected providers and TennCare beneficiaries alike. HCFA reported that (1) provider directories were not available to enrollees, (2) information on operational guidelines for the general Medicaid population was insufficient, and (3) notifications of MCO enrollment were delayed. As a result, beneficiaries were confused about the number and type of plans and the available providers, and some families signed up with

[53]National Association of Public Hospitals, Assessing the Design and Implementation of TennCare; A National Health Reform Briefing Paper (Washington, D.C.: 1942).

more than one MCO, exacerbating difficulties in managing enrollment. Some beneficiaries were further frustrated when they found that their primary care physicians were not participating in TennCare. A TMA satisfaction survey of physicians in October 1994 reported lack of patient understanding of TennCare as a major problem and recommended better efforts by MCOs to educate and manage patients. In its 1994 monitoring report, HCFA recommended expanding education and outreach efforts to raise awareness of the availability of services and the method of obtaining these services as well as frequent mailings to enrollees to explain benefits and services.

Delays in signing providers with MCO networks and assigning patients to primary care providers also presented several problems. To complicate matters, providers—like the MCOs—had difficulty in obtaining information on patient eligibility and identifying with which TennCare MCO a patient was enrolled. Providers we talked to reported problems getting through by phone to the state and MCOs to verify patient information. As a result, providers needed to hire additional staff to manage the increased administrative burden in dealing with more than one MCO.

Claims Processing and Premium Payments Delayed

Delays in claims processing and collecting premium payments have been a problem. According to the state, MCOs had difficulty fully developing their claims processing systems. For example, Access MedPLUS initially was processing claims manually, which delayed provider reimbursement. In addition, state external review organization reports from July to November 1994 reported that 5 of the 12 MCOs exceeded the state 30-day requirement to process claims. The largest discrepancy reported was a 76-day average from receipt of claim to the payment date.

The state initially estimated that it would collect premiums from qualifying uninsured people of about $21 million during the first 6 months of TennCare; however, it collected only $2.4 million. Over the next 12 months (state fiscal year 1995), TennCare initially estimated collections of $101 million and subsequently reduced this estimate to $30 million. However, as of March 1995, with less than 4 months left in the state fiscal year, only $10 million had been collected.

These collection shortfalls were due in part to the state's delay in establishing its premium billing process. Although enrollment of uninsured people began in January 1994, the initial billings were not mailed until June 1994. In addition, enrollees were given two alternatives to reduce the

burden of paying the full accumulated premiums for the prior months: (1) pay reduced premiums by retroactively changing from a low cost-sharing plan to a cost-sharing plan with a higher deductible and higher total out-of-pocket liability or (2) pay no premiums by changing their effective enrollment dates to June 1, 1994. Enrollees were to receive premium booklets and begin scheduled monthly payments in July 1994. However, the state contractor failed to mail some of the booklets, and this error was not discovered until November 1994. In February 1995, the TennCare Bureau sent letters to nearly 60,000 TennCare households notifying them of past due premiums totaling $31 million. As of June 1995, a TennCare Bureau official said it had terminated TennCare coverage of approximately 62,000 people for not paying premiums. In addition, 17,000 family units are now on a payment plan to pay past due premiums.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUL 21 1995

TO: William J. Scanlon
Associate Director
Health Financing and Policy Issues
General Accounting Office

FROM: Bruce C. Vladeck
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicaid: Tennessee's Program Broadens Coverage But Faces Uncertain Future"

As requested, I am attaching the Health Care Financing Administration's comments on the subject GAO draft report.

Thank you for the opportunity to comment on this report. If you have any questions, please feel free to contact me, or your staff may contact Ron Miller on (410) 966-5237.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, "Medicaid: Tennessee's Program Broadens Coverage But Faces Uncertain Future"

Overview

We have reviewed the draft GAO report which discusses Tennessee's capitated managed care program called TennCare. The report focuses on an examination of available information on (1) TennCare's basic design and objectives; (2) the degree to which the program is meeting these objectives; and (3) the experiences of TennCare insurers and medical providers and their implications for the future of TennCare. The report concludes that, so far, TennCare has met its initial objectives, but its long range success is uncertain.

The State has taken several steps to improve the TennCare program. The report does not recognize that there is a new State administration for TennCare that is attempting to be more responsive to provider concerns. The Governor of Tennessee has instituted a TennCare Roundtable composed of providers, managed care organizations (MCOs), consumer advocates, and others to address current TennCare problems. The State plans to increase the capitation rates above the expected new levels to address provider and MCO concerns. In addition, a new oversight position has been created in the State to oversee the financial stability of all types of MCOs in the State, rather than the limited oversight of health maintenance organizations (HMOs) that existed previously.

We recommend that GAO include a section that indicates the action the new State administration is taking to address some of the problems discussed in this report.

Specific Comments

Results in Brief

Certain conditions of the demonstration have allowed the State to use sources other than State appropriations as the State share of Medicaid eligible for Federal matching funds, under section 1115 authority. For example, on page 2, paragraph 2, the report indicates that the State "effectively reduced its share of Medicaid costs by claiming losses incurred by hospitals in caring for TennCare eligible costs. . . . " HCFA has not changed the Federal matching rate in the TennCare demonstration. HCFA did recognize certain hospital expenditures as certified public expenditures, as recognized under current regulations (the certified public expenditures for the two non-public hospitals required waivers) and allow the State to keep premiums paid by TenCare participants; but the Federal medical assistance percentage has not been altered.

Page 2

Page 2

We also think it is misleading to cite the State tax on capitation payment as an example of the State reducing its Medicaid costs, without noting that this is simply a provider tax permitted under current statute. Many States have used provider taxes as a source of State matching funds.

On page 2, paragraph 3, the report states, "Despite this increase in the number of persons covered, federal and State expenditures for Tennessee's Medicaid program increased less than 1 percent in state fiscal year 1994. . . ." While this may be a true statement at this time, we believe there is a possibility it could be misleading, since all expenditures applicable to Fiscal Year (FY) 1994 have not been claimed.

Background

On page 4, GAO mentions that States request demonstrations under section 1115 of the Social Security Act (the Act) to obtain waivers of Medicaid provisions that "inhibit States' use of managed care". We believe that the report should clarify that States may also use program waiver authority under section 1915(b) of the Act to waive freedom-of-choice requirements and establish managed care programs. In fact, at least 40 States either operate managed care programs under section 1915(b) waivers or have applied for waiver authority under that section.

On page 6, the report indicates that the "State-federal sharing arrangements of the financing plan tend to favor the State, since several of the waiver provisions allow the State to reduce its share of total spending." Again, this sentence seems to imply that the Federal matching rate was changed. This is misleading because the matching formula was not changed.

TennCare Program Designed to Expand Coverage and Contain Costs

On page 7, the report indicates that under TennCare, Medicaid-eligible persons are guaranteed 12 months of coverage. HCFA did not provide the State waivers that would guarantee eligibility. While the State may do redeterminations on a 12-month basis, eligibility is not guaranteed.

On page 11, the report should distinguish supplemental payments that the State planned to make, versus those actually made. For example, the State never implemented the incentive payment to physicians for greater-than-average TennCare patient load.

On page 17, we continue to disagree with GAO's methodology of determining budget neutrality by simply comparing the demonstration trend rates to the administration's "current services" estimates. This methodology does not recognize differences between individual State's trends.

Page 3

On page 18 and 19, the report often cites savings to the State from TennCare. However, when actual State savings are available, they have been substantially lower than the State's original estimate. We suggest GAO note that State estimates have generally been too high.

On page 20, the report indicates that HCFA waived some Medicaid quality assurance mechanisms. Besides the waiver of the 75/25 requirement (which can be waived under the regular program for three years if a plan is making progress toward meeting the requirement), HCFA did not waive any quality assurance requirements. HCFA actually required Tennessee to establish more stringent requirements, such as collecting encounter data, implementing a Health Care Quality Improvement System for Medicaid Managed Care (QARI), and conducting annual satisfaction surveys.

TennCare Has Largely Met Its Objectives, But Access and Quality Assurance Measures Have Been Delayed

The GAO report states (on page 21) that ". . . the operations of a key monitoring system to determine whether medical care through TennCare is accessible and of sufficient quality has been delayed." The report follows an incomplete discussion of the factors that affected the implementation of an effective quality monitoring system. In Appendix III, the report rightly cites the inexperience of the State, MCO and provider staffs with managed care, difficulties with providers, poor communication and outreach, and delays in claims processing and payment of premiums as affecting quality monitoring. The report, however, does not adequately describe how these problems affected quality and access monitoring.

For the State, the relative lack of experience with managed care meant that State staff and MCO staff were learning about quality assurance (QA) monitoring criteria at the same time. Many MCOs had difficulty acquiring and dedicating staff to QA activities due to financial and organizational problems. This hampered activities designed to effectively implement the quality monitoring studies and use the resulting information to make informed management decisions. The State has been working with the MCOs through its external quality review organization, First Health, to fully implement quality programs.

The State, however, has not provided a formal analysis plan for using the encounter and claims data, or a plan to validate the accuracy of the data. In addition to individual encounter data, TennCare receives aggregate utilization reports for each of the MCOs. Since the State is not monitoring providers directly, and no validation system is in place, it has little assurance that services are indeed being given as indicated in the aggregated reports it receives from MCOs, or from its encounter and claims data. Tennessee may eventually be able to use its MMIS to supply detailed information on service delivery on each individual enrollee.

Page 4

This could include the ability to link an individual enrollee to dates of services with a specific provider, and distinct services and prioritized medical diagnoses using uniform coding conventions. The State is currently working on this process.

We believe it is fair to say that the State is making slow progress in implementing its QA monitoring plan. Further, delays in validating encounter and claims data to track service delivery and slow implementation of quality assurance studies, will necessitate the State's development of interim monitoring strategies to ensure access and quality.

Update of TennCare Operations

The TennCare enrollment as of June 23, 1995, was 1,198,991. Of this total, there are 800,397 Medicaid enrollees and 398,594 uninsured/uninsurable enrollees. The original proposal for the TennCare project set the enrollment cap at 1.5 million enrollees. During 1994, the State reduced the enrollment cap to 1.4 million enrollees and effective January 1, 1995, the State reduced the enrollment cap to 1.3 million enrollees. (Enrollment at December 31, 1994 was 1,261,448, including 842,795 Medicaid eligible and 418,653 uninsurable or previously uninsured persons. The State has reached 90 percent of the enrollment cap of 1,400,000, and, as of January 1, 1995, has closed enrollment to new applicants from the uninsured population.)

All 12 of the original MCOs have signed contracts with the State to continue to participate in the program through July 1, 1996. (The two Statewide MCO contracts are for the full 5-year period of the waiver. However, HCFA is requiring that these two MCOs sign new contract amendments yearly at the same time as the other MCOs.)

The State has contracted with an external quality review organization (EQRO) who is a subsidiary of the State's fiscal agent, First Health. The EQRO has conducted an initial review of MCO quality efforts as well as a follow-up on the results of the reviews. Their assessment indicates that the MCOs are making uneven progress in their QA efforts, again due to lack of resources. Staff training efforts are planned in the second operational year of the project. Additionally, the HCFA Regional Office (RO) has began working intensively with the State's Medical Director and the EQRO in monitoring the MCO QA activities and developing corrective actions.

All of the MCOs are now submitting encounter data in the standardized format and using the data sets for reporting. The State is currently inserting edits and developing validation techniques to ensure the data submitted is clean and useable. First Health has subcontracted through the EQRO for installation of the PANDORA system, which will enable the State to use encounter data for monitoring of service delivery.

Page 5

The State established a new position within the Department of Commerce and Insurance with responsibility for oversight of the MCOs. This oversight will consist of monitoring the MCOs for financial solvency as well as compliance with contract provisions, State laws and rules. The MCO contract extensions effective July 1, 1995, now contain requirements for Preferred Provider Organizations to meet the same State financial reporting requirements as the HMOs. The Department of Commerce and Insurance will also be performing continual audits of financial records and operations of the MCOs. Thus, current information should be available relative to solvency and operational compliance at all times.

In an attempt to resolve enrollment issues, priority is being given to the enrollment process such as a redesign of the enrollment/application form. To provide better outreach and information to recipients, additional telephone lines and staff are being added to the hotlines. However, there still remain problems with the enrollment of newborns, plan changes and family enrollments.

The State provider listing reports of provider networks indicate that there are still problems with specialty provider participation. However, the State is closely monitoring the networks and is requiring the MCOs to ensure that services not available from practitioners within the respective MCO network are being reimbursed on a fee-for-service basis. Since specialty provider participation remains a concern, the RO is monitoring the networks closely and will review the documentation submitted by the State relative to the provider participation.

The State's grievance process has not been adequate. Beneficiaries and providers have complained that the grievance process is not accurately written and that the process is cumbersome. In order to resolve this and other operational issues, the State has agreed to provide HCFA with the following by August 15th:

1) A detailed description of the grievance procedures currently in place at the State level and at each of the MCOs, as well as planned modifications to those procedures, including a timetable for changes.

2) A detailed explanation of the circumstances and process for changes in individuals' plan enrollment.

3) A detailed explanation of the availability and sources of funding for TennCare for State FY 1996 and later (due August 1). Additionally, within 60 days after the funding plan submission, the State is required to submit a funding plan for the remainder of the 5-year term of the waiver.

4) A workplan for monitoring the provision of services by MCOs, documentation of actual participation by providers, and a separate action plan for detecting fraud.

Comments From the Bureau of TennCare

STATE OF TENNESSEE
BUREAU OF TENNCARE
729 CHURCH STREET
DEPARTMENT OF FINANCE AND ADMINISTRATION
NASHVILLE, TENNESSEE 37247-6501

July 24, 1995

Mr. Dan Meyer
Senior Evaluator
U. S. General Accounting Office
Chicago Regional Office
200 West Adams Street
Suite 700
Chicago, Illinois 60606

Dear Mr. Meyer:

I am writing this letter in response to the draft copy of the GAO report that was published based on the review of the TennCare [sm] program.

We have reviewed the report in detail and found it to generally reflect the program as it existed in the past and to reflect the opinions of the various groups that have had comments on TennCare. However, we question the validity of including the opinion poll results of professional associations in a report that should be based on facts. Finally, we found some specific errors in the report or items that require additional clarification.

Our specific comments on the report are listed below:

Throughout the report, it was declared and alluded to that the future of the program is uncertain because the MCOs are losing money and may not continue in the program. The report cited the losses of BlueCross, the largest MCO and a plan that operated under a fee-for-service system without managed care. The report failed to mention that none of the MCOs elected to opt out of the program during the time period they were given to do so and those with 18 month contracts have renewed their contracts for an additional 12 months. This does not seem to be consistent with the forecast of uncertainty portrayed by the report.

Page 6 - In the discussion of the March 1, 1993 date as it relates to eligibility determination for the uninsured, the author seemed to miss the intent of that date. The program was announced in April, 1993; March 1, 1993 was chosen as the date of being uninsured to prevent employers from dropping employer sponsored health plans. By choosing a date in the past, there was no incentive for an employer to do that, since their employees would not be eligible for TennCare [sm]. This date qualification did not apply to those applicants that were uninsurable.

Page 7 - Enrollment caps are considered in the aggregate and not by specific CPAs on enrollee categories.

Mr. Dan Meyer
July 24, 1995
Page 2

Page 7 - Deductibles and coinsurance can only be imposed on those uninsured enrollees above 100% of the poverty level. TennCare [sm] determines an enrollee's percentage of coinsurance based on income. This ranges from 2% to 10%.

Page 8 - Inpatient hospital days were unlimited prior to the implementation of TennCare [sm].

Page 8 - HCFA has recently approved that the entire $40 million set aside annually for adverse selection can be paid based on the high cost chronic condition methodology.

Page 9 - An additional difference in the PPO and HMO contract is the date on which the gatekeeper model must be implemented. HMOs were required to implement "gatekeeper" on January 1, 1994 while the PPOs have until January 1, 1997.

Page 11 - See comment above regarding implementation dates of gatekeeper models.

Page 12 - The $185 million primary care provider fund that was once discussed and submitted with budget information was later revised. The three components listed as part of this fund are really contained in three different line items. Essential provider payments were paid from the Unallocated Fund Pool; adverse selection is budgeted as a supplemental capitation payment; and primary care physician payments are part of the Reserve Fund Pool.

Page 16 - The 85 percent limit is imposed during times of open enrollment and only applies to the uninsured at certain poverty levels.

Page 21 - TennCare [sm] covered over 400,000 uninsured and uninsurables during the first year.

Page 21 - The External Quality Review Organization conducted reviews of all of the MCOs during the first year. Encounter reporting was defined and data began to be transmitted to the State in the spring of 1994. As of June 1995, the 1994 encounter data is now available in the Pandora System which is the system used by the EQRO staff and the TennCare [sm] staff to perform quality assurance reviews. As should be anticipated in a program of this magnitude at this stage of implementation, there are still problems in some of the data collected thus far. State and EQRO staff continue to work with the MCOs to identify and correct these problems.

Page 23 - The author should compare surveys conducted on TennCare [sm] beneficiaries to those conducted on other groups that have converted from a fee-for-service insurance plan to a managed care system.

Page 24 - The author did not provide any data to compare TennCare [sm] results in scheduling appointments or wait times with those encountered by Tennesseans with private insurance.

Page 25 - While it is obvious, the author did not mention, in the discussion of MCO losses, the fact that 1994 was a "start up" year for the program. Profits and losses in any business situation during the first year to not typically reflect what may result during ongoing operations. All twelve MCOs have renewed contracts to continue another year in TennCare [sm].

Mr. Dan Meyer
July 24, 1995
Page 3

Page 32 - An additional 4.5% increase in the capitation payments is available under certain conditions for FY 1995.

Page 50 - The report incorrectly states that Tennessee released its bid request for TennCare [sm] in November, 1993 giving interested organizations less than 2 months to submit a proposal and put together their programs. This statement is inaccurate. The state held numerous meetings with the interested parties beginning in the summer of 1993, shared several draft versions of the contract document with them for their comments and input and began testing their networks in the fall of 1993. The November, 1993 date apparently is in reference to the actual issuance and signing of contracts by the interested and qualified MCOs.

There was no mention of the Roundtable on TennCare [sm] established by Governor Sundquist. This Roundtable consisted of providers, MCO representatives and advocacy group representatives. The mission of the Roundtable was to solicit input from interested parties and recommend ways that the TennCare [sm] program could be improved. This group existed and held numerous meetings prior to publication of the GAO report.

The state has worked to correct many of the problems identified in the report and make additional improvements in operation of the program. These changes/improvements include:

1. Implementing a monthly billing for premium collections. This process validates the enrollee's location and provides a mechanism for enrollees to inform the state of changes in circumstances that could affect their ability to pay the premiums.

2. Effective July 1, 1995 the MCOs were given a five percent (5%) rate increase. An additional four and one-half percent (4.5%) will be made available to MCOs that meet the performance standards specified in a contract amendment being sent to the MCOs.

I appreciate the opportunity to comment on the draft report. If you have any questions about any of our comments, feel free to contact me.

Sincerely,

Rusty Siebert
TennCare [sm] Bureau Chief

Major Contributors to This Report

Robert Hughes, Assistant Director
Daniel S. Meyer, Evaluator-in-Charge, (312) 220-7683
Richard N. Jensen, (202) 512-7146
Karin A. Lennon
Betty J. Kirksey
Karen Sloan

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (301) 258-4097 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Mail
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested