Managed Care For Low-Income Populations with Special Needs: The Tennessee Experience

Kaiser/Commonwealth
Low-Income Coverage
and Access Project

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EXECUTIVE SUMMARY

FOCUS OF THIS REPORT

This paper provides a targeted review of Tennessee's experience providing health care to individuals with special needs under TennCare, its Medicaid managed care initiative. Our examination is organized in two parts that correspond to the structure of TennCare. The first part reviews the experience of TennCare Partners, the behavioral health carve-out program created in 1996. (The review is based on the system as it operated in early 1998 and does not reflect the redesign currently under way to address ongoing problems except where noted.) The second part reviews how TennCare's structure affects the disabled and chronically ill. This paper complements a paper providing a more general update of TennCare's experience using fully capitated managed care plans to expand coverage under a broadly based Medicaid Section 1115 waiver.

This work is part of an ongoing study of managed care for low-income populations in seven states that Mathematica Policy Research, Inc., (MPR) is conducting for the Henry J. Kaiser Family Foundation and The Commonwealth Fund. As part of that study, we conducted week-long site visits to Tennessee in December 1995 and January 1998. Through interviews at the state and community levels with public officials, health plan administrators, providers, advocacy groups, and other stakeholders, we examined how TennCare was structured and how it was operating, with a focus on the implications for health care access and safety net availability for low-income individuals in the state.

PART I: EXPERIENCE OF TENNCARE PARTNERS (THE BEHAVIORAL HEALTH CARVE-OUT)

BACKGROUND

Since it was first implemented in 1994, TennCare has included all those eligible for Medicaid regardless of the nature of their eligibility (i.e., through Aid for Families with Dependent Children(AFDC), supplemental security income [SSI], medically needy, or poverty-related expansion programs). Special provisions were made for those eligible for both Medicare and Medicaid.

Originally excluded from TennCare, however, were behavioral health care services for seriously and persistently mentally ill (SPMI) adults and children with severe emotional disturbances (SED). While these individuals were enrolled in TennCare managed care organizations (MCOs), the MCOs managed their acute physical health care but not their mental health care. This care was paid for on a fee-for-service (FFS) basis and provided largely through a network of state regional mental health institutes (RMHIs) and community mental health centers (CMHCs). However, mental health benefits for other users of mental health services under TennCare were managed by MCOs under the general capitated arrangements in place.

TennCare Partners evolved through a contentious process in which TennCare officials aimed to consolidate financing for all mental health/substance abuse (MH/SA) services into separate managed care plans specifically for behavioral health. The carve-out was to include the 52,000 SPMI/SED beneficiaries as well as others. The capitation funding pool for TennCare Partners included not only behavioral health expenditures currently in the TennCare and FFS Medicaid budgets, but also funding for state institutions providing these services. The state's goals were to test managed care's ability to deliver these services and to streamline the fragmented mental health system. Less-publicized motives included enhancing federal Medicaid matching funds, containing behavioral health care costs, and reducing the labor force in the state-owned institutional sector.

Originally, TennCare Partners was to contract with all five qualified behavioral health organizations (BHOs). But in April 1996 (three months before the start date), the state decided to require the five BHOs to align themselves into two large BHOs. The two emerging entities, Premier and Tennessee Behavioral Health(TBH), do not compete for patients, though each operates statewide. Rather, the state assigned the BHOs 60 and 40 percent of the TennCare population, respectively, and matched them with specific MCOs. (For this purpose, the large Blue Cross Blue Shield MCO was divided by region and is served by both BHOs.) All TennCare enrollees, except those receiving court-ordered mental health care services, are automatically enrolled in the TennCare Partners BHO that is affiliated with their MCO. The BHOs have two levels of benefits: (1) an enhanced level for SPMI/SED individuals, also known as the priority population; and (2) a basic level for all others. The 26 CMHCs are responsible for screening and certifying enrollees as SPMI/SED or priority by using classification assessment tools.

KEY FINDINGS

1. TennCare Partners has been controversial and problematic from the start.

TennCare Partners currently is being redesigned to address the structural problems that have confronted it from the start. These problems stem from several sources. First, the program required cooperation among diverse government agencies with distinct interests and agendas. Second, the carve-out structure established two sets of entities that, in addition to facing management coordination challenges, each had incentives to shift costs to the other. Third, the program's structure, as it evolved, required "forced marriages" between BHOs that had formerly been competitors and between BHOs and MCOs, which often had inconsistent systems. TennCare Partners also was hampered by already existing limitations in the state's behavioral health network. In addition, its performance was constrained by the conflicts between the state's cost containment goals and the limited existing scientific basis for developing practice guidelines and making coverage decisions under capitated arrangements.

2. TennCare Partners' capitation rate methodology results in unpredictable payments to BHOs.

BHOs are paid on a capitated basis that was modified after the first year. In the first year, BHOs received a single blended rate for all those enrolled in TennCare Partners (both priority members and others). In the second year, the state adopted a bifurcated variable rate under a monthly global budget of $27 million. BHOs receive a fixed monthly rate of $319 for each priority member, with a floating (variable) capitation rate for other members that is modified to reflect the number of priority members and the total state budget. While this gives TennCare budget predictability and limits spending, it passes on to providers the risk associated with the share of patients deemed eligible for the priority benefit package.

Capitation rates have been problematic for the BHOs. The changing percentage of priority and other enrollees makes it hard for providers to predict revenues. Other problems with the capitation rates include reportedly inaccurate actuarial projections for some services (e.g., prescription drug costs at $2.50 per member per month (pmpm) when they are said to be almost double that); requirements for additional services that BHOs believe (though state officials deny) were not included in the database used to establish the capitation rates (e.g., case management and discharge planning); and mandated per diem payment rates to RMHIs. One BHO recorded $160 million in net income in 1996 while the other reported a loss of over $9 million. The TennCare Bureau assumed financial responsibility for several specific drugs in May 1998 and for the

entire behavioral health pharmacy program in July 1998. Capitation rates were reduced $3 pmpm to help fund this. At the same time, BHOs received a 5 percent increase in their capitation rates.

3. Structures for care delivery in BHOs have weaknesses, some predating TennCare Partners.

BHOs are required to develop statewide provider networks so that outpatient services are available within a 30-mile radius of any enrollee and inpatient services are available within 60 miles. BHOs must contract with all 26 CMHCs and the five existing RMHIs and provide case management services to all SPMI/SED members on an ongoing basis and to all those discharged from inpatient facilities. A stipulated per diem payment for RMHIs is required. A number of care delivery issues have arisen. First, because some primary care providers who treat patients with mental health conditions in MCOs are not recognized as mental health providers, the BHOs have difficulty contracting with and receiving payment from MCOs. Second, while the BHO contracts have care management and coordination requirements, many of the systems have not yet been implemented. For example, an external quality review organization (EQRO) audit conducted after TennCare Partners' first year found that the BHOs had no quality management plans or activities in place.

4. Weaknesses in the BHO program are perceived to adversely affect care access and quality, although access to prescription drugs has improved.

Because providers are unable to access certain treatment modalities and do not understand BHO utilization management techniques, they perceive a loss in patient access to care under TennCare Partners. For example, inpatient hospitalization admissions and durations of stay have been limited without substituting what providers consider to be acceptable alternatives, such as well-functioning partial hospitalization programs. Care authorizations are viewed as troublesome. A fall 1997 EQRO audit showed that one BHO had not yet developed written criteria for various levels of CMHC services. On the plus side, access to prescription drugs appears to have improved, with few drugs requiring special approval. However, patients needing certain brand-name drugs were originally required to first undergo trials of less costly alternatives and to file appeals before gaining approval.

5. **BHO providers are financially stressed, though multiple factors contribute to this.**

CMHCs and other providers affiliated with the TennCare program have suffered financially under TennCare both because payment is risk-based and because of unpaid claims. Several lawsuits are pending regarding disputed claims.

CONCLUSIONS

While TennCare had start-up problems that have subsided over time, many key stakeholders view the program as having fundamental flaws that may prevent it from ever maturing. Stakeholders are also greatly concerned that access to mental health services for the seriously and persistently mentally ill has deteriorated under the TennCare Partners program. Recent actions by the state may provide some relief as state officials work now on major restructuring of TennCare.

To summarize, both TennCare and TennCare Partners were rapidly implemented, broadly conceived statewide initiatives with a major emphasis on making spending more predictable and improving coverage and benefits without increasing spending. Many now view the short-term disruption caused by TennCare's implementation as at least partially offset by expanded coverage and long-term systemwide restructuring (Aizer, Gold, and Schoen 1998). That optimism does not currently extend to TennCare Partners. It appears that Tennessee policy makers may not have recognized the enormous challenge they faced in integrating services for the seriously mentally ill into TennCare or how organizationally problematic the carve-out's ultimate structure would be.

PART II: TENNCARE AND DISABLED MEDICAID BENEFICIARIES

BACKGROUND

TennCare was implemented statewide for virtually all Medicaid and expansion populations beginning in January 1994, two months after the state received Health Care Financing Administration (HCFA) approval of its Section 1115 waiver application. By the end of 1994, 1.2 million people were enrolled in one of the 12 MCOs under contract to TennCare. All MCOs are fully capitated, and many were formed specifically for TennCare. TennCare's original design included few provisions specifically for special populations.

KEY FINDINGS

1. The structure of SSI eligibility makes informed choice harder to achieve for these beneficiaries.

TennCare has had relatively high rates of involuntary assignments to MCOs. Because SSI beneficiaries apply to the Social Security Administration (SSA) rather than the state for benefits, and the SSA then notifies the TennCare Bureau of applicants who qualify for TennCare, SSI enrollees in TennCare do not get the education about MCO selection that other enrollees get at the time of application. After this education, other enrollees are allowed to select a plan. SSI enrollees are automatically assigned to an MCO by the TennCare Bureau, though they can change their assignments within the first 45 days of enrollment. Consumer education has historically been limited, though TennCare has contracted with local health departments to provide outreach and beneficiary education generally as part of implementation of the Children's Health Insurance Program, an effort to expand coverage for low-income children under Title XXI of the Balanced Budget Act.

2. Tennessee's risk adjustment is limited for those with special needs.

TennCare uses two mechanisms to compensate plans for the higher costs associated with caring for special needs populations: (1) a higher monthly capitation rate for the non-Medicaid disabled; and (2) an adverse selection pool for a high-cost or a high-risk enrollees.

Capitation payments are set statewide using eight rates based mainly on age and eligibility category. One rate is for children and adults eligible for Medicaid (includes SSI, the non-SSI medically needy, and court-ordered Medicaid beneficiaries) who are disabled or blind as defined in the eligibility criteria (but not aged) and for the expansion population of uninsured and uninsurable individuals who report being disabled on the TennCare application. This rate ($287 pmpm for the 1997 and 1998 contract years) is twice that of the next highest rate. A separate rate is calculated for those eligible for both Medicare and Medicaid. Because long-term care and benefits jointly covered by Medicare and Medicaid are excluded from the capitation payments (and paid on an FFS basis by TennCare), this rate is set mainly to cover the cost of pharmaceuticals. It was $80 pmpm in 1997, with a 10 percent increase in 1998.

Plans also receive funds from an adverse selection pool to compensate for such factors as age, race, preexisting medical conditions, or episodic medical events that can make care disproportionately costly. However, plans find it difficult to project how much

funding to expect, and smaller plans complain that they are disadvantaged because of the way distributions are determined.

3. **TennCare's oversight processes are not specifically targeted to the disabled, though some monitoring has begun to focus on populations with special needs.**

The TennCare Bureau oversees the quality of care. Oversight and monitoring are not specifically targeted to the disabled, in part because they are hard to identify, relatively few in number, and their medical needs are so diverse. TennCare is beginning to expand its quality assurance activities to include conducting outcome studies using encounter data for subgroups of TennCare enrollees with special needs. These include children with asthma and adults with diabetes. Some MCOs, especially those with large enrollments, have begun to develop programs geared toward disabled members. While some access problems are still being reported, the problems appear less extensive than they were in the first year of the program.

4. **TennCare has had problems serving dually eligible individuals.**

As discussed, those jointly eligible for Medicare and Medicaid are enrolled in TennCare MCOs, but MCO risk-based payments primarily cover pharmaceuticals only. We found two specific problems. First, because Medicare is the primary payer and its rules apply, dually eligible TennCare enrollees are not required to use an MCO provider. Consequently, many dually eligible individuals have limited knowledge of how to access their TennCare pharmaceutical benefits, even though they receive a list of MCO network pharmacies and formularies. New members also may experience problems filling prescriptions written by non-network providers. Second, TennCare MCOs find it difficult to manage care for these members even though they are at risk for pharmaceutical services. MCOs' concern over the financial impact of this situation led to a recent increase in capitation rates for these members from $80 to $88 pmpm.

CONCLUSIONS

As it does for all other populations, TennCare requires disabled and special needs populations to enroll in MCOs. Operational constraints are accommodated by excluding certain services from the capitation rate (e.g., long-term care and Medicare-Medicaid crossover benefits) and paying for them on an FFS basis. In the four years since TennCare was implemented, care management processes have begun to be developed. However, efforts targeted at the disabled and many subgroups with special needs are still limited, with the diversity and small number of individuals involved complicating both targeted programming and oversight.

The impact of TennCare on access and health outcomes for disabled individuals and those with special needs remains an unknown, with some advocates citing continuing problems with access to specialty care while access to pharmaceuticals and case management have improved compared with traditional Medicaid. TennCare's experience teaches that states seeking to expand managed care to these populations need to establish some way of tracking care quality and access for these populations from the start. Another lesson is that unless program design accounts for the unique issues of coordinating Medicare and Medicaid benefits for those who are dually eligible, it will be difficult to develop a system that functions effectively either for patients or for the health plans and providers at risk for their care.

I. INTRODUCTION AND OBJECTIVES

This paper explores Tennessee's experience in providing health care for its acutely disabled and special needs populations (particularly those with behavioral health needs) under a Medicaid waiver program called TennCare. Because of the way its implementation was structured, TennCare provides an opportunity to examine how managed care affects vulnerable subgroups. Unlike some other states that have implemented managed care programs, Tennessee included special needs populations from the start, statewide, and with relatively little attention to the unique health care issues of these vulnerable subgroups. Under TennCare, all those eligible for Medicaid because they were eligible for Aid to Families with Dependent Children (AFDC) and supplemental security income (SSI) or for medically needy and poverty-related expansion programs were covered beginning in January 1994, with special provisions for those dually eligible for both Medicare and Medicaid.[1] In addition, the state expanded enrollment beyond traditional Medicaid populations to include the uninsured and the uninsurable with no income limitations.[2] The latter group consists of those who have been denied insurance because of a pre-existing condition and thus are likely to have a chronic condition but who either exceed Medicaid income requirements or do not meet stringent Medicaid standards to be classified as disabled.

Rather than exclude any specific eligible group from managed care (i.e., "carve" them out), TennCare addressed the constraints in program authority and service delivery by carving out specific benefits from the managed care program. At the start of TennCare, Medicaid-covered behavioral health benefits for adults with severe and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) were included in TennCare, while non-Medicaid-covered benefits continued to be

[1]While dual eligibles are enrolled in TennCare, benefits for jointly covered services continue to be reimbursed by Medicare in the traditional fee-for-service (FFS) manner unless the beneficiary is enrolled in a Medicare health management organization (HMO). Few Medicare beneficiaries are currently enrolled in Medicare HMOs in Tennessee. In effect, this means that for most dual eligibles, acute care services are paid for by Medicare on an FFS basis outside of TennCare. A major exception is the Medicaid pharmacy benefit, which is provided through TennCare managed care organizations (MCOs). TennCare MCOs, however, have no authority over the physician services benefit under which pharmacy services are authorized.

[2]TennCare subsidized premiums for enrollees with incomes up to 400 percent of the federal poverty level. Enrollees with higher incomes paid full premiums. In 1995, uninsured enrollment was closed to all except those losing Medicaid eligibility. In 1997, uninsured enrollment was partially reopened for uninsured children and displaced workers.

provided on an FFS basis for TennCare members. In July 1996, however, the state created the TennCare Partners program, under which behavioral health organizations (BHOs) assumed full risk for mental health and substance abuse treatment for all TennCare enrollees, including the SPMI and SED populations. Only long-term care services, home and community-based services, and Medicare premiums paid through Medicaid for the dually eligible continue to be provided on an FFS basis (Table 1).

TennCare's experience is significant because many other states are facing similar issues. Until recently, state efforts to expand managed care to low-income Medicaid-eligible populations have focused on families with children (those covered through AFDC and related programs). But while the aged and disabled make up less than one-third of the population in state Medicaid programs, they account for over two-thirds of spending (Liska et al. 1997). States are beginning to realize that to achieve meaningful health care savings, they have to include these populations in their managed care programs.

TABLE 1

COVERAGE OF MEDICAID BENEFITS BY TYPE OF BENEFIT AND ELIGIBILITY CATEGORY

	Coverage of Medicaid Benefits			
Medicaid/TennCare Population	Acute Medical Care	Pharmacy	Long-Term Care	Behavioral Health
AFDC	MCO	MCO	FFS	BHO
SSI	MCO	MCO	FFS	BHO
Dual Eligibles	FFS[a]	MCO	FFS	FFS[a]
Uninsured/Uninsurable	MCO	MCO	FFS	BHO

[a]Acute care benefits covered by Medicaid and Medicare are paid for by Medicare on an FFS basis, or for some beneficiaries by Medicare managed care plans; however, a few services that are covered by Medicaid but not Medicare, such as preventive care, are covered through the TennCare MCOs.

According to the National Academy for State Health Policy, 15 states had developed risk-based contracting programs for their SSI populations by 1994, and by 1996 the number had increased to 24. Because Tennessee has used risk-based contracting for its SSI population since January 1994, its experience provides useful insight regarding key issues and challenges. In addition to the potential cost savings for states, expanding managed care to the disabled, who tend to use more services than other Medicaid beneficiaries, may increase the quality of care for this group, given managed care's emphasis on care coordination. On the other hand, advocates warn that the disabled may be more vulnerable to managed care processes, which are designed to control service utilization. Further, state Medicaid programs and managed care plans have limited experience with managed care for the disabled.

The disabled and chronically ill populations covered under the Medicaid program are a diverse group. They include both children and working-age adults, and they present a range of disabling conditions. The care systems required by disabled persons with chronic medical conditions (e.g., HIV/AIDS, cardiac conditions, and chronic emphysema) may be very different from those needed by disabled persons with physical disabilities (e.g., partial paralysis and severe arthritis), developmental disorders (e.g., mental retardation), or other mental conditions (e.g., schizophrenia and bipolar disorders). Another complication is that almost all the aged and a significant portion of the disabled on Medicaid (usually from 30 to 40%) are dually eligible for both Medicaid and Medicare. For dual eligibles, Medicare is the primary payer for acute care services while Medicaid is responsible for the Medicare cost-sharing expenses (premiums, copayments, and deductibles) and services not covered by Medicare, such as prescription drugs, transportation, and nursing home and other institutional care.[3] As secondary payers for acute care benefits, state Medicaid programs are constrained by federal Medicare policy from using managed care to serve those eligible for both programs. And while such limitations apply less to long-term care services, the unique features of such services have meant that managed care models, if used at all, tend to be distinct from those used in acute care.

[3]Some dual eligibles with higher incomes or assets are eligible only for Medicare cost-sharing benefits under Medicaid, not the full Medicaid benefit package. The dual eligibles with limited Medicaid coverage include the qualified medicaid beneficiary (QMB) and specified low-income medicare beneficiary (SLMB) groups. These groups are not enrolled in TennCare.

Because the state has created a managed behavioral health component that is distinct from acute care, we discuss each separately. In Section II, we describe Tennessee's experience delivering behavioral health care under TennCare Partners, a carve-out program implemented in 1996. In Section III, we briefly describe the experience of the disabled under TennCare. Section IV draws general lessons from the Tennessee experience. Our research is based on two week-long site visits to the state, one in December 1995 and the second in January 1998. During both visits, we interviewed key stakeholders, including state officials, participating MCOs, providers, and beneficiary advocacy groups.

The issues surrounding the expansion of managed care to populations with special needs are complex. While we are not able to fully treat all issues here, TennCare's early experience should be illuminating as states move forward with managed care programs to provide care for diverse subgroups within their Medicaid and low-income populations, each of which has distinct and often special needs.

II. TENNCARE'S EXPERIENCE WITH BEHAVIORAL HEALTH AND MANAGED CARE

A. OBJECTIVES AND DEVELOPMENT OF THE BEHAVIORAL HEALTH INITIATIVE

As originally designed, TennCare enrolled eligibles with chronic mental illnesses in its MCOs, but non-Medicaid behavioral health benefits for these individuals were carved out of TennCare and paid for through a combination of FFS Medicaid payments and state funds.[4] In 1996, a new TennCare initiative brought all behavioral health benefits into managed care. The design and implementation of this initiative (called TennCare Partners because of the expectation that the MCOs and BHOs would work as partners) have been controversial from the start. TennCare Partners, a $323 million program, is widely viewed as problematic. While the experience with TennCare Partners has been similar in some dimensions to the initial experience with basic TennCare, concerned parties in the state fear that the problems with TennCare Partners are structural and therefore will not get better with time.

[4]The state initially excluded non-Medicaid benefit package enhancements for SPMI adults and children with SED under TennCare. MCOs managed their acute medical care and their Medicaid-covered behavioral health care, but more extensive mental health services continued to be funded on an FFS basis or through block grants. MCOs managed the Medicaid-covered mental health benefits of more casual users of mental health services.

The initial decision to carve out non-Medicaid benefits for the seriously mentally ill reflected opposition within the state to integrating such care. State regional mental health institutes (RMHIs) and community mental health centers (CMHCs), which had been providing most of the mental health/substance abuse (MH/SA) care for vulnerable populations, strongly opposed integrating the MH/SA benefit with acute medical care, as did other stakeholders in the behavioral health system. The CMHCs reportedly were concerned about the probable loss of influence of the Department of Mental Health and Mental Retardation and the shift in power to the TennCare Bureau, the program's central administrative office. State program administrators were also "uneasy" about the MCOs' lack of experience with behavioral health care delivery. Most MCOs subcontracted with BHOs to manage the nonchronic behavioral health care needs of TennCare enrollees. Thus, very few MCOs had developed any experience managing this care themselves. MCOs were likewise concerned, not about their ability to manage the behavioral health benefit but about the adequacy of capitation payments to compensate them for doing so.

After a few years, however, the state decided to consolidate financing for all MH/SA services. This financing included both Medicaid and non-Medicaid funds and all TennCare enrollees, including 52,000 SPMI/SED beneficiaries and those with less extensive mental health needs whose care was managed by the MCOs. The approach involved capitating BHOs for both acute and chronic behavioral health services. Because the BHOs had been providing many of the behavioral health services through subcontracts with the MCOs, one major implication of this shift was that it altered the relationship between the BHOs and MCOs and weakened their incentives to coordinate care.

The official goals of TennCare Partners were twofold: to test a managed care carve-out approach to delivering behavioral health services and to streamline the fragmented state mental health care system (Chang et al. 1998). Two additional, less publicized motives behind creation of the program were (1) generating federal matching funds under Medicaid by shifting state block grants from safety net providers to the Medicaid program and (2) constraining the growth in behavioral health care expenditures to an extent comparable to that accomplished for acute care under TennCare. The latter objective, in effect, required the state to exert more control over expenditures and to achieve reductions in the labor force in the state-owned institutional sector.

The way the Partners program was implemented magnified tensions between MCOs and BHOs and also within each BHO. A fundamental shift in TennCare Partners' design occurred midway through implementation. The original expectation was that the state would contract with all BHOs that met the established standards. Many mental health advocacy groups participated in the proposal review process, comparing the proposals with standards established by the TennCare Partners program. Five proposals met the standards for participation. All five are for-profit organizations, and four of the five are large national firms. None of the CMHCs or other consortiums of nonprofit providers qualified.[5] According to researchers from the University of Tennessee, by requiring statewide coverage and significant financial reserves, the state made it difficult, if not impossible, for community-based nonprofit providers to qualify (Chang et al. 1998).

In April 1996, three months before the program became operational, the state asked the five BHOs that met the standards to realign themselves into two large BHOs. The staff responsible for this decision have left state government, but it appears that the rationale behind it was to enhance operational efficiency by minimizing the number of BHOs with which the MCOs would have to contract and coordinate. The two entities that emerged from the realignment, Premier and Tennessee Behavioral Health or TBH (both of which are statewide), do not compete for patients. Rather, they are assigned 60 and 40 percent of the TennCare population, respectively, and work with separate MCOs.[6] The state then matched the BHOs with specific MCOs. MCOs report that they had only limited influence over the formation of these matches, with the state soliciting their preferences but then making linkages that did not necessarily correspond to those preferences. Some MCOs were teamed with a BHO that included one member that was owned by a competing MCO, leading to inherent conflicts over such things as sharing information considered proprietary.

Thus, only three months before the BHOs were to begin serving 1.2 million TennCare Partners enrollees, they faced the additional task of aligning with former

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[5]State officials say that while about 20 prospective parties submitted "letters of interest" and thus reserved application packets, only 5 organizations ultimately responded.

[6]Among the five plans — Premier, Greenspring/Advocare, Foundation, Merit, and TBH — the first three and the last two formed partnerships (Foundation was originally part of Premier, but soon dropped out). TBH is assigned members enrolled in Access MedPlus, TLC, Prudential, Physician's Health Plan, and two regions of Blue Cross Blue Shield (BCBS); Premier is assigned all members belonging to the remaining MCOs and BCBS regions.

competitors and integrating management systems into a cohesive structure. This situation created considerable confusion for the BHOs and others working with them. Within one BHO, individual members were assigned separate tasks (e.g., one was to create a claims payment system, another to work on provider network development), but, owing to their interdependent nature, poor coordination hindered the full development of any of the systems. For Premier, the withdrawal of Foundation after three months further complicated system development. As a result of the forced marriages between previously competing BHOs, provider contracting was also delayed. These internal conflicts created multiple stress points that affected the experience of beneficiaries accessing care under the partners program. These stress points exacerbated the already difficult task of coordinating health care for beneficiaries who require both medical and behavioral health services when these services are provided by two distinct and parallel organizations.

B. PROGRAM STRUCTURE

1. Program Benefits and Financing

All individuals enrolled in the TennCare program are automatically enrolled in the TennCare Partners program. Only those receiving court-ordered forensic mental health services (those related to criminal matters) are excluded and continue to receive care under an FFS model.[7] The Partners benefit package has two levels: (1) an enhanced level for the SPMI and SED populations and (2) a lower or base level for all other TennCare enrollees. The 19 CMHCs in the state are responsible for screening and certifying TennCare enrollees as SPMI/SED or "priority." The assessment tools employed are the Tennessee Clinically Related Groups (CRGs) for adults and the Target Population Group (TPG) system for children (Table 2). Adults classified as CRG 1, 2, or 3 and children classified as TPG2 are considered SPMI and SED, respectively, and classified as priority members. Priority members must receive services every 90 days in order to retain their priority classification.

Once certified, SPMI/SED or priority TennCare enrollees are eligible for an enhanced BHO benefit package that includes unlimited mental health benefits as medically necessary, mandatory case management services, 24-hour residential treatment, housing, and other specialized crisis services. Otherwise, MH/SA benefits

[7]These individuals were included in the first year and later excluded. Other court-ordered services remain covered by TennCare Partners.

are limited to 45 outpatient mental health visits per year and two outpatient substance abuse treatment programs in a member's lifetime, with a maximum fee per program of $3,000 (Table 3).[8]

[8]As of July 1, 1998, non-SPMI adults have an unlimited number of outpatient visits per year. (The limit never applied to children under early and periodic screening, diagnosis, and treatment or EPSDT.)

TABLE 2

THE TENNESSEE CLINICALLY RELATED GROUPS (CRG) AND TARGET POPULATION GROUPS (TPG) PATIENT CLASSIFICATION SYSTEMS

Clinically Related Groups for Adults	*Target Population Groups for Children*
CRG 1: Adults whose functioning has been severely impaired over a long period of time	TPG 1: Children in state custody
CRG 2: Adults whose functioning is currently severely impaired but for a shorter duration	TPG 2: Children with serious emotional disturbance defined as having a diagnosable mental, behavioral, or emotional disorder of sufficient duration
CRG 3: Adults whose functioning is not currently severely impaired but has been severely impaired in the past	TPG 3: Children at risk of severe emotional disturbance
CRG 4: Adults with mild or moderate mental disorders	

NOTE: Adults classified as CRG 1, 2, or 3 are considered seriously and persistently mentally ill (SPMI) and are eligible for enhanced mental health and substance abuse benefits.

Children classified as TPG 2 are considered severely emotionally disturbed (SED) and are likewise eligible for enhanced mental health and substance abuse benefits.

TABLE 3

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS UNDER THE PARTNERS PROGRAM

Mental Health and Substance Abuse Benefits	*Basic Benefit Package (all benefits must be medically necessary)*	*Enhanced Benefit Package (for those in the priority population)*
Psychiatric Inpatient Facility		
Under 21	As medically necessary	As medically necessary
Age 21-65	Limited to 30 days per occasion, 60 days per year per enrollee[a]	As medically necessary
Over 65	As medically necessary	As medically necessary
Physician Psychiatric Inpatient Services	As medically necessary	As medically necessary
Outpatient Mental Health Services	Limited to 45 visits per year per enrollee[b] (lifetime dollar limit of $100,000)[c]	As medically necessary (no lifetime dollar limit)
Inpatient and Outpatient Substance Abuse Treatment Services[(d)]	10 days detoxification Inpatient and outpatient substance abuse benefits have a maximum lifetime limitation of $30,000[c]	As medically necessary (no lifetime dollar limit)
Psychiatric Pharmacy Services and Pharmacy-Related Lab Services	As medically necessary	As medically necessary
Transportation to Covered Mental Health Services	As medically necessary for enrollees lacking accessible transportation	As medically necessary for enrollees lacking accessible transportation
Mental Health Case Management	-	Required
24-Hour Residential Treatment	-	As medically necessary
Housing/Residential Care	-	As medically necessary
Specialized Outpatient and Symptom Management	-	As medically necessary
Specialized Crisis Services	As medically necessary	As medically necessary
Psychiatric Rehabilitation Services	-	As medically necessary

[a]If medically appropriate for the patient, the BHO may authorize substitution of outpatient days, partial hospitalization days, or residential treatment days for covered psychiatric inpatient facility days. Two substitute days will count as one inpatient day. No substitute day may be counted toward any other benefit limit, such as the 45-visit outpatient limit or the substance abuse treatment limit.
[b]Does not apply to children under federal early periodic screening, diagnosis and treatment (EPSDT) requirements. Removed for adults July 1, 1998.
[c]In accordance with EPSDT requirements, the contractor is required to exceed service limits when medically necessary for children under the age of 21.
[d]When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.

Funding for BHO-covered benefits and services was derived from multiple sources and amounted to $323 million for the first year. The bulk of the funding ($186 million) came from existing Medicaid funds previously paid to state RMHIs and CMHCs for providing services to the TennCare priority population before the carve-out. An additional $86 million was derived from a reduction of $7 per member per month (pmpm) from the capitation payment to MCOs to cover treatment of nonpriority TennCare members. The remaining $72 million came from state direct subsidies to the RMHIs and the CMHCs for the non-TennCare priority population (Chang et al. 1998). This shift in funding eliminated direct care subsidies previously paid to providers, leaving safety net providers less secure in their funding and without a way to fund care for those outside TennCare's scope.

Two percent of the $323 million TennCare Partners budget is reserved for administration; the rest is disbursed to the BHOs through monthly capitation payments. In the first year of the program, the BHOs received a single blended capitation rate. The state reportedly chose this rate structure so as not to stigmatize the SPMI/SED population. After the first year, the state dramatically altered the structure of the capitation payments. In year two, the state adopted a bifurcated variable rate to target more resources for the SPMI population rather than spreading resources equally across the entire TennCare population.

A key feature of the new system is a $27 million cap on the amount of money the state will pay to the two BHOs in a given month. TennCare added this measure to accommodate a Health Care Financing Administration (HCFA) request for a differential rate aimed at achieving budget predictability and limiting spending.

The bifurcated rate under a monthly cap is unusual for a managed care program, particularly one operating within the context of Medicaid and its authorized entitlements. In effect, it imposes a total cap rather than a per capita fixed payment. The BHOs receive a fixed monthly rate of $319 for each priority member and a variable or floating rate for nonpriority members. The variable rate is adjusted to offset any changes in the number of priority members and state expenditures on them. This approach passes on to providers the risk associated with determining the share of patients eligible to receive the priority benefit package.

In response to concern about pharmacy services (discussed later in this paper) and funding for community services, the state announced plans since our last site visit to alter program financing.

2. Provider Contracting Requirements

To encourage continuity of care, protect essential providers, and foster management and coordination of care, the state established a number of requirements for provider contracting, case management services, and coordination with MCOs. The BHOs are required to develop statewide provider networks so that outpatient services are available to any enrollee within a 30-mile radius and inpatient services within 60 miles. BHOs must contract with all 19 CMHCs and the five existing RMHIs and provide case management services for all SPMI/SED members on an ongoing basis as well as for all members who have been discharged from inpatient facilities.[9] In addition, the BHOs must pay the RMHIs on a per diem basis and cannot negotiate any alternative payment arrangements. This last requirement, we were told, is an effort to appease those in the state interested in maintaining the RMHIs, which have become part of the fabric of the mental health community, providing both services and jobs.

C. IMPLEMENTATION EXPERIENCE

1. Network Development and Coordination with MCOs

The development of BHO networks has been problematic, as has coordination between MCO and BHO networks. Some stakeholders we interviewed trace the problems back to the underlying structure of mental health care delivery as it existed in the state before the establishment of TennCare Partners. According to these sources, Tennessee has always lacked the kind of broad-based system of mental health care delivery that generally exists on the acute care side. Instead, the SPMI population was treated by a publicly financed system with limited providers, capacity, and coordination mechanisms for both public and private providers. Nearly all outpatient care for the seriously mentally ill in Tennessee was provided by the 19 CMHCs that operated independently throughout the state. Most inpatient care was provided by the five state RHMIs.

Both the fragmented underlying structure of these providers and the state requirement that former competitors merge to participate in TennCare Partners hampered network development, as did the inherent difficulties of coordinating BHO and HMO provider networks and managed care systems.

[9]Since our visit, BHOs are no longer required to contract with the RHMIs.

Because a significant number of primary care providers (PCPs) who treat patients with mental health conditions in MCOs appear not to be recognized as mental health providers by BHOs, they have had difficulty contracting with the BHOs and procuring payment. Access MedPlus, for example, noted that its PCPs had been told they would be included in a BHO's network, but a year later they still had not been added, nor had they been told how to submit claims to the BHO for providing routine behavioral health treatment. In addition, after one full year of the program, one BHO had not yet entered into a behavioral health/medical joint protocol that dictates how services will be coordinated for members with problems that fall in both MCO and BHO areas of responsibility. The other BHO had developed a working protocol with its MCOs, but experience had been mixed. One MCO noted that the protocol was not always followed and was inadequate in some respects.[10] Not all MCOs encountered problems. One MCO, for example, had arranged with the BHO for capitated mental health payments to be made to its contracted PCPs to provide routine mental health care for its members. This arrangement had reportedly worked to the satisfaction of both the MCO and the BHO. However, the fact that both organizations shared ownership interests probably contributed to smoother linkages between them, and advocates question whether this relationship has benefited enrollees.

2. Care Management

Care management and coordination requirements included in BHO contracts with the state are limited and appear not to have been met 18 months after program initiation. Audits conducted by the external quality review organization (EQRO) found that for both BHOs, case managers were only sporadically involved in coordinating care for the priority population and in discharge planning. Providers we interviewed concurred, noting minimal, if any, interaction with case managers in the coordination of their patients' care.

3. Quality Management Infrastructure

The EQRO audit indicates an absence of quality management plans and activities at the BHO level after a full year of plan operation. In one BHO, the EQRO audit uncovered the absence of a working quality management plan and lack of a peer review committee to review appropriateness of care. In addition, though the BHOs'

[10]As an example, the MCO cited its inability to reach an agreement with the BHO as to which would take responsibility for a member hospitalized for a self-inflicted gunshot wound. While the MCO noted that the underlying diagnosis of depression was responsible for the wound, the BHO contended that the member required acute medical care.

contracts with the state require the development and dissemination of practice guidelines, the EQRO audit found that one BHO had developed only one guideline (for depression) and the other had adapted guidelines from the American Psychiatric Association but had no systems in place to monitor compliance with them. While troubling, this situation is not dissimilar to that after the first year of operation for the core TennCare Program, when the EQRO found it necessary to spend nearly 18 months helping many MCOs develop and refine appropriate quality management plans.

4. BHO Payment

The BHOs, as well as some of the providers we interviewed, find state capitation payments to the BHOs to be both unpredictable and insufficient. According to unaudited BHO financial statements for the first nine months of 1997, one recorded net income of $160,000 from TennCare and the other reported a loss of over $9 million on a $324 million program. BHO staff and providers point to the following factors as seriously undermining their financial viability:

- *The floating or variable nature of capitation payment rates for the nonpriority population.* If, for example, one BHO's SPMI/SED priority membership increases while the other BHO's membership remains steady, the latter will see a drop in its revenue because of a decline in the payment rate for its nonpriority membership.

- *Inaccurate actuarial projections for some services.* TBH reports that its prescription drug costs, for example, were underwritten at $2.50 pmpm when in fact they are closer to $4.80 pmpm, nearly twice as much. Studies conducted for the state confirm that the cost of drugs has generally increased at an unanticipated rate. As a result, even though TBH reportedly has been successful in lowering inpatient and residential treatment by 30 percent, all the savings have had to be reinvested in prescription drug coverage.

- *The use of historical experience to set rates that may not reflect the current risk profile of the covered population or services required under the contract.* Some contend that the recent elimination of relatively healthy uninsured adults from TennCare and TennCare Partner rolls has skewed previous estimates of the cost of caring for this population. In addition, according to BHO staff, services such as case management and discharge planning were not previously provided by Medicaid but funded through other sources such

as block grants. Thus, costs for these services were excluded from the development of capitation payments, which were based on Medicaid expenditure experience. State officials disagree with this assessment, arguing that the costs are included in the premiums because state-funded programs as well as Medicaid were used to set rates.

- *Mandated payment of RMHIs on a per diem basis.* By requiring the BHOs to contract with the RMHIs and pay them on a per diem basis, the state has hindered BHO efforts to explore alternative, less costly means of providing and managing inpatient care in the RMHI setting. BHOs are not prevented from seeking inpatient care elsewhere, but this option is not especially feasible in practice, given the limited availability of inpatient treatment for the severely mentally ill.

According to the BHOs, the resulting insufficiency of capitation payments has in turn affected their ability to pay providers. Audits conducted by the state comptroller's office after the Partners program's first six months of operation uncovered significant provider payment deficiencies in both BHOs. These deficiencies included the denial of claims for which authorization had been granted, denial of claims without cause, incorrect payment, and for one BHO (Premier), excessive rates paid to affiliated providers with ownership stake in the BHO compared with nonaffiliated providers.

Recognizing that the BHOs may not be adequately financed in light of escalating drug costs, the TennCare Bureau decided to assume financial responsibility for pharmacy coverage of four atypical antipsychotic drugs and three generic drugs beginning in May 1998 and to assume responsibility for the entire behavioral health pharmacy program beginning in July 1998. Capitation payments to the BHOs will be reduced by $3 pmpm to help fund the pharmacy program. TennCare officials believe the move will save the BHOs more than $35 million annually and allow them to "provide some financial relief to the CMHCs." In addition, the state announced in late May 1998 that the BHOs will receive a 5 percent increase in capitation payments effective January 1, 1998, adding more than $16 million to the program.

D. IMPACT OF TENNCARE PARTNERS ON ACCESS AND THE SAFETY NET

1. Access to Care

Providers complain that patients have less access to care under TennCare Partners because providers are unable to access certain treatment modalities and do not understand BHO utilization management techniques. BHOs report that they have stopped using some treatment modalities, such as day treatment programs and residential substance abuse treatment.[11] While providers and advocates admit that the previous use of these treatment modalities may have been excessive and not always appropriate, they are troubled that the BHOs would not offer them when they do not have alternatives. One mental health provider we interviewed said he was considering withdrawing from the Partners program because of the lack of appropriate services for referral. For example, this provider noted his willingness to consider shorter periods of inpatient hospitalization, as the BHOs have required, if an acceptable alternative, such as a well-functioning partial hospitalization program, were available. According to this provider, the only alternative is poorly staffed partial hospitalization programs that he considers insufficient substitutes for inpatient treatment.

Utilization management processes have also frustrated providers and beneficiaries who have had difficulty getting care approved or authorized by the BHOs. Given the medical necessity requirement of most utilization management techniques, the lack of evidence of the efficacy of much currently available MH/SA treatment further complicates management of the behavioral health benefit. An EQRO audit of the BHOs in fall 1997 found that one of the BHOs had not yet developed written criteria for utilization of the various levels of services provided by the CMHCs. The EQRO also found no process in place to communicate with providers about why services had been denied or to inform enrollees of their right to appeal such decisions.

On the other hand, access to prescription drug coverage has been adequate, according to most providers and BHO staff. Staff from TBH report that only five or six drugs require prior authorization, and 80 percent of the requests for those drugs are approved. When a beneficiary or provider appeals a denial, 95 percent of the appeals are eventually approved. Providers with whom we met agreed that access to prescription drugs is generally good and that the two BHOs' formularies (listings of drugs covered by the plan that physicians may prescribe without further authorization) are very similar, minimizing potential confusion. In addition, providers said they are able to get approval for most prescription drugs, though appeals are sometimes necessary.

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[11]Residential substance abuse treatment is not a covered benefit under TennCare Partners or traditional Medicaid. It is provided only at the option of the BHO as a cost-effective alternative to inpatient substance abuse treatment.

The approval process has been considerably more difficult if a physician prescribes a brand name drug for which a generic alternative is available, even if the use of a brand name drug is justified by greater efficacy in treatment. Both BHOs imposed a requirement that consumers need two failed trials of less costly alternatives before they will approve requests for the new atypical antipsychotics, such as Risedal or Zyprexa. In May 1998 (prior to taking over full responsibility for the pharmacy program in July 1998), the state lifted the requirement for two failed trials before dispensing these drugs. However, little else is known at this time about the type of management techniques, if any, the state will implement for the pharmacy program.

2. Impact on the Safety Net

The safety net for behavioral health appears to be suffering financially under TennCare Partners. One inner-city CMHC complained that its capitated arrangement with one BHO, intended to bring some stability and regularity to its revenue, is so erratic that the center is unable to properly plan the deployment of its resources. To maintain operations, this CMHC has exhausted all its reserves as well as $740,000 in borrowed money since the initiation of the Partners program.

CMHCs are not the only providers experiencing financial difficulty under the program. Representatives of an independent, private nonprofit Memphis provider with whom we met said their organization had been forced to stop caring for TennCare members because of the payment cuts it experienced after the implementation of the partners program. Before TennCare Partners, it received $10 pmpm from an MCO for the nonpriority population. After TennCare Partners began, payment dropped to $5 pmpm for all MH/SA treatment for the nonpriority population and outpatient and partial hospitalization for the priority population. This rate was further reduced to $3 pmpm, at which point the provider informed the BHO that it could no longer afford to provide services. Other providers are suing the BHOs over unpaid claims. The Council for Alcohol and Drug Abuse Services was planning at the time of our visit to sue the two BHOs for over half a million dollars (17% of its entire budget) in unreimbursed services for drug and alcohol abuse treatment.

E. DISCUSSION AND LESSONS

While the TennCare program has improved over time, managing and overseeing the provision of care to the severely mentally ill and others with behavioral health problems remains complicated by a host of continuing problems. Many key stakeholders view the TennCare Partners program as having a fundamentally flawed structure that may prevent it from maturing the way TennCare has. Some of the flaws are specific to the way Tennessee designed the program; others likely are generalizable to other states seeking to subject behavioral health to managed care processes.

The structure of the Partners program increases the complexity of coordinating care for those with behavioral health needs. First, the involvement of multiple government agencies, each with its own interests or agenda (such as the Department of Mental Health, which operates the RMHIs in Tennessee), complicates administration of the program. Second, the shift in the relationship between the MCOs and BHOs from an independent and voluntary contractual one to a noncompetitive match-up by the state appears to have diluted their incentives to manage and coordinate care. Instead, each now has an incentive to cost-shift to the other. In any case, having two separate administrative systems makes coordination of care for overlapping patient needs more complex. Third, the "forced marriage" between previous competitors and the short implementation period have hindered the development and integration of many BHO systems, such as provider networks, payment processes, and quality assurance mechanisms.

Other factors, independent of the Partners program itself, complicate the development and use of managed care processes for behavioral health in Tennessee. Foremost is the lack of a comprehensive network of mental health providers such as the one that generally exists on the acute care side. This factor hindered the provision and coordination of behavioral health services even before the Partners program. In addition, some behavioral health services are furnished by providers who may not be identified as mental health workers, such as primary care providers who offer mental health/substance abuse treatment. Last, the lack of evidence of the efficacy of many forms of mental health/substance abuse treatment hinders guideline development and compliance and makes medical necessity difficult to prove or justify. It also makes it difficult to determine the scope of services included in Tennessee's BHO carve-out. And reaching consensus on appropriate care is a particularly difficult issue in Tennessee, since an underlying if not always explicitly stated goal of the Partner's program has

been capitating spending on behavioral health services and gaining control of the state institutional service sector for the severely and persistently mental ill.

Many in the state expressed great concern that access to mental health services for the seriously and persistently mentally ill has deteriorated under the TennCare Partners program. Recent steps taken by the state to improve program financing will likely provide some relief. Whether the BHOs will be able to overcome the more general structural challenges associated with the program's design and implementation is less clear.

In summary, both TennCare and TennCare Partners were rapidly implemented, broadly conceived statewide initiatives with a major emphasis on regulating spending and improving coverage and benefits without added cost. With TennCare, many now view the initial short-term disruption as at least partially offset by expanded coverage and long-term systemwide restructuring. But, at least at present, this optimism does not extend to TennCare Partners. In hindsight, it appears that Tennessee policymakers may have failed to recognize the enormous challenge they faced in integrating services for the seriously mentally ill into TennCare and how organizationally problematic the structure they designed would be.

It is still far too early to tell how well Tennessee ultimately will confront these challenges. Clearly, the administrative challenge of addressing them is consuming much state energy, some of which undoubtedly would otherwise have been applied to strengthening the basic TennCare program.

The lessons for other states are clear, though applying them may be more problematic. First, managed care structures that split responsibility for the same individual between two organizations are inherently weak in that they make coordination more difficult. Second, moving beyond traditional acute care providers and services to apply managed care principles to the host of programs required by those with special needs, such as the chronically and persistently mentally ill, places a significant burden on the state that requires the cooperation of a host of entities and providers with distinct issues and mandates and limited experience with managed care. And third, setting up such programs without having developed the associated set of risk adjustment and administrative mechanisms to oversee and monitor care will make it harder for the state to monitor and reconcile conflicts of interest.

III. MANAGED CARE AND DISABLED MEDICAID BENEFICIARIES

A. TENNCARE DESIGN AND IMPLEMENTATION

Unlike the programs of other states, such as Oregon, TennCare's design did not differentiate included populations by eligibility category. Rather, TennCare aimed to apply one set of policies to the AFDC, SSI, uninsured, and uninsurable populations. Constraints, such as for those dually eligible for Medicare and Medicaid, were addressed by making necessary accommodations but limiting other policy differences. Therefore, examining managed care for those with special needs in Tennessee requires examining the general TennCare program from the perspective of a specific group that is not necessarily treated differently but whose experience may be different given its circumstances and special needs.

TennCare was implemented on a statewide basis for virtually all Medicaid and newly eligible populations beginning in January 1994, two months after the state received HCFA approval of its Section 1115 waiver application. By the end of 1994, 1.1 million people participating in the TennCare program were enrolled in one of 12 MCOs contracting with the state. Few provisions for special populations are included in the original design of the program. The disabled are not given any special consideration in the enrollment process. In fact, SSI beneficiaries may be at a disadvantage since the Social Security Administration (SSA) has no provision to allow beneficiaries a choice of MCOs when they initially enroll, as other enrollees have. SSI-eligible individuals can change MCOs, but only after their initial assignment. Plans are not required to provide them with any services not otherwise available to TennCare enrollees. However, the needs of disabled individuals are considered to an extent in the structure of the overall benefit package and in determining provider contracting requirements and plan payments.

As of January 1998, 1.2 million TennCare beneficiaries were enrolled in one of nine MCOs, of whom roughly 850,000 (69%) are Medicaid eligibles and the rest are uninsured or uninsurable. Among the 850,000 Medicaid eligibles, 172,000 (20%) are dual eligibles and another 180,000 (21%) qualify for aid to the blind and disabled but not for Medicare.

B. TENNCARE'S OPERATION FROM THE PERSPECTIVE OF THE NON-MEDICARE DISABLED

The "non-Medicare disabled" referred to here consist of those qualifying for SSI benefits through SSA, non-SSI Medicaid eligibles qualifying for Medicaid primarily

through a court-ordered process or medically needy program, and members of the uninsured and uninsurable populations who have disabling conditions.[12]

1. Benefits

TennCare's benefit package is an expanded version of the benefit package offered through the traditional Medicaid program. This situation was partly in response to advocate and safety net provider concerns that beneficiaries with special needs would be disproportionately harmed if the state were to reduce the scope of benefits. For example, TennCare removed the monthly limit of seven prescription drugs. It also increased payment for hospital inpatient services for stays longer than two weeks. Advocates note, however, that the benefits under managed care may not in fact be more generous. Prescription drugs, for example, while no longer limited to seven per month, are now constrained by the MCO formularies and approval process, which define the drugs that are available and how they may be obtained, including the processes for approving exceptions to the formulary test.

2. Initial Plan Selection and Enrollment

The way the disabled are enrolled in the TennCare program varies in terms of enrollee education and plan selection, depending on the enrollee's eligibility category. SSI beneficiaries apply to SSA for benefits. SSA informs the TennCare Bureau of all new and existing SSI beneficiaries, who are automatically eligible for Medicaid/TennCare. At the time of application, SSA does not educate the SSI applicant about the TennCare program or the MCO alternatives. As a result, the TennCare Bureau automatically assigns SSI beneficiaries to an MCO. The bureau attempts to assign the beneficiary to the same MCO as another family member, if applicable. In all cases, the TennCare Bureau assigns newborns to the same MCO as their mothers. SSI beneficiaries who do not have a family member already enrolled in a TennCare MCO are randomly assigned to one. SSI beneficiaries can change their assigned MCO within the first 45 days of enrollment, though we heard some reports that, due to delays in notifying beneficiaries of their MCO assignment, they may actually have fewer than 45 days in which to switch MCOs.

In contrast, non-SSI disabled Medicaid eligibles (those receiving court-ordered Medicaid benefits or qualifying through the medically needy program) and the uninsured

[12]As a result of a federal court ruling that predates TennCare, the state continues to enroll in Medicaid and TennCare those who may have been deemed eligible for SSI at some time by SSA but who no longer receive cash benefits. Roughly 20,000 Tennesseans are eligible for Medicaid under this court order.

and uninsurables who have disabling conditions are given the opportunity to select their MCOs at the time of application. The former enroll through the state's Department of Human Services. Staff there reportedly give beneficiaries information regarding MCO selection. The uninsured and uninsurables apply directly through the TennCare Bureau or local Department of Health offices. Neither the Department of Human Services nor the TennCare Bureau provide much in the way of consumer education. But recently, in response to implementation of the federal Child Health Insurance Program (CHIP), which provides enhanced federal funding to states to expand coverage for low-income children, the TennCare Bureau has contracted with local health departments to provide outreach and beneficiary education regarding the TennCare program generally.

3. Plan Payment for Populations with Special Needs

The state uses two mechanisms to compensate MCOs for serving populations with special needs: (1) a higher monthly capitation rate for the non-Medicare disabled and (2) an adverse selection pool for "high-cost or high- risk" enrollees.

a. Capitation Rates for the Non-Medicare Disabled

The state has created eight capitation rate categories, based primarily on age and sex, for paying MCOs for basic services. Of the eight rates, one is used to pay MCOs for TennCare enrollees not eligible for Medicare and another is to pay for enrollees with both Medicare and Medicaid benefits (dual eligibles). The former category includes children and adults eligible for Medicaid (SSI, the non-SSI medically needy, and court-ordered Medicaid beneficiaries) who are disabled or blind but not aged, and uninsured and uninsurables who report being disabled on their TennCare applications. This rate ($287 pmpm for the 1997 and 1998 contract years) is twice the next highest rate. Rates for dual eligibles are lower because Medicare is the primary payer and long-term care services are paid by TennCare on an FFS basis. TennCare MCOs basically are responsible for pharmaceuticals.[13] This fact accounts for their capitation rate of $80 pmpm in 1997, with a 10 percent increase for 1998. Uninsured and uninsurable TennCare enrollees who have disabling conditions qualify for the higher rate for the blind and disabled.

Inadequate capitation payments could disproportionately affect the chronically ill, disabled, and others with special needs, given the relatively high cost to the MCOs of treating them. The issue of the adequacy of capitation payments is contentious. We have not seen any actuarial analyses on the adequacy of capitation payments in Tennessee; while some believe payments may be inadequate, others believe they are sufficient.

[13]Tennessee officials have taken over the TennCare Partners pharmaceutical program but not the pharmaceuticals included in basic TennCare.

b. Adverse Selection Pool

The state established an adverse selection pool ($40 million in 1997 of a total TennCare budget of $2.72 billion) to compensate plans that have attracted large numbers of high-cost or high-risk enrollees. Adverse selection criteria established by the state consist of "health care factors such as age, race, sex, pre-existing medical condition, or episodic medical event which has been demonstrated statistically to increase both the utilization and the cost of services provided to a defined subpopulation of enrollees." Distributions from this pool vary each year, depending on TennCare's enrollment profile. As a result, plans are uncertain how much compensation to expect, and some reported difficulty interpreting the disbursements. In addition, the small size of the pool relative to the overall program means that it inevitably will fall short of addressing any inequities associated with the relatively crude form of risk adjustment used in setting TennCare's capitation rates.

One concern common to smaller plans is that the allocation distributes funds in proportion to the number of individuals enrolled. Because of fixed costs and economies of scale, smaller plans believe they are at a disadvantage compared with larger plans, which are able to offset their high-cost members with a large enrollment of relatively healthy members. This concern is not limited to TennCare. On the other hand, the two largest plans (Access MedPlus and BCBS), believe that because they are two of only four plans available in every part of the state, they are subject to greater adverse selection. BCBS believes the size and depth of its specialist network, the largest of the TennCare MCOs, further attracts a disproportionate number of members with special needs.

4. Oversight and Monitoring

The TennCare Bureau's oversight efforts focus on three areas: access to care, quality of care, and outcome studies. Quality oversight and monitoring activities do not specifically address the special needs of the disabled, in part because few such beneficiaries have the same needs, complicating identification and outcomes measurement.

The state examines access (through network adequacy) but, as in quality oversight, does not necessarily focus on measures for the special needs of the disabled. The state measures whether primary care providers, hospitals, and dentists are within the specified geographic proximity to MCO members and reviews population-to-provider ratios in each of the plans.

After a recent in-depth study by the state found that the obstetrical network was inadequate in 17 counties, the MCOs submitted corrective action plans. The state plans to conduct a similar study of pediatric access. Advocates question the accuracy of the state's assessments, however, and do not believe its methods fully account for the range of barriers beneficiaries face in seeking care. TennCare requires plans to contract with "essential community providers," defined as traditional Medicaid or safety net providers (e.g., federally qualified health centers or FQHCs). The purpose of this provision is to protect "vulnerable populations" who may rely on these providers. As part of this process, the state also reviews specialty networks, though not to the extent it reviews primary care networks.

Historically, the state has not focused on monitoring care for those with special needs, as its primary focus admittedly has been on defining its overall quality improvement program. However, the state is beginning to expand its quality assurance/quality improvement activities to consider specific issues relevant to populations with special needs. The TennCare Bureau contracts with an EQRO to perform annual audits of the contracted MCOs and conduct outcome studies based on encounter data supplied by the plans. Outcome studies have focused on issues primarily relevant to the non-disabled AFDC population, such as preventive care, prenatal care, and birth outcomes. Two recent outcome studies focused on the chronic conditions asthma and diabetes. The EQRO examined inpatient and emergency room use among children with asthma and adults with diabetes (chronic conditions that can be effectively managed on an ambulatory basis). Results indicate that emergency room and inpatient use have declined under TennCare. However, advocates question the methodology of the studies, believing them to be based on inaccurate or incomplete data.[14] The state is also active in the development of an AIDS center of excellence with support from the Robert Wood Johnson Foundation. The purpose of this program is to provide the state with up-to-date information on treatment options for AIDS patients. State staff believe that this model, though small in scope, can eventually be replicated for others in the TennCare program with special needs.

5. Care Coordination

Managed care's potential for improving care coordination has not yet been fully realized, but some progress has been made. Many plans have always used PCP gatekeepers to coordinate care for their TennCare members. Beginning in early 1997,

[14]Advocates believe the encounter data on which the studies are based may not capture all emergency department use, as hospitals may not be entitled to reimbursement if the care has not been authorized and therefore have little incentive to submit claims or encounter data.

the state required all remaining plans to use PCP gatekeepers.[15] After four years, plans have developed outreach and case management programs for easily identifiable and common conditions such as pregnancy, but are still in the process of developing such programs for members with special needs.

Some MCOs, particularly those with large enrollments, have already begun to develop programs geared toward disabled members with special needs. BCBS recently piloted a health risk appraisal project in northeastern Tennessee in which representatives administered health risk assessments to new members. When this program is implemented, the results will be provided to PCPs to facilitate early intervention for members with special needs. BCBS has also developed a catastrophic case management program that seeks to marshal all the community resources available for members with catastrophic illnesses, identify appropriate providers, and arrange for second opinions and any durable medical equipment (DME) required. Case managers also intervene in many instances when members appear to have "fallen through the cracks."

Phoenix Healthcare, the third-largest plan in the state, recently has developed a medical management program for members with chronic diseases. Case managers are assigned to all members in need of home health care or DME. Phoenix plans to designate case managers for most high-cost chronic disease states. Thus far, Phoenix has designated a case manager for oncology whose responsibilities include care coordination, ensuring that care is delivered in the most appropriate settings, investigating experimental drugs, and developing practice guidelines for chemotherapy. Phoenix hopes to designate case managers for other high-cost conditions such as diabetes and asthma.

6. Access to PCPs and Specialists

MCO provider networks have matured, and reports from providers and beneficiary advocates indicate sufficient numbers of PCPs and hospitals but a lack of certain kinds of specialists, such as orthopedic and ear nose and throat (ENT) specialists. Even before TennCare, specialist participation in Medicaid was problematic because of low payment rates and negative attitudes toward low-income populations. TennCare may have exacerbated the problem in some areas and for some specialties (e.g., orthopedics).

[15]The conversion in early 1997 of the few remaining plans that did not have PCPs was initially confusing, particularly for members of BCBS, which sought to assign gatekeepers to nearly 600,000 members in a relatively short time.

Providers cite poor payment from the MCOs and the "hassles" of contracting with them as the major reasons why some specialists have either refused to contract with or subsequently withdrawn from the TennCare program. This situation is troubling for patients with special needs, particularly for disabled individuals with chronic conditions, who often require specialized care. For example, certain specialists in Chattanooga (Hamilton County) have reportedly refused to contract with TennCare MCOs, citing difficulty procuring payment for services rendered. Primary care providers there note that they have had to send children with special needs as far as Knoxville or Nashville, 125 miles away, for ENT specialty care, for example. Some plans or providers can negotiate on a case-by-case basis for specialty care; however, this arrangement tends to be more expensive and administratively burdensome.

7. Access to Prescription Drugs

Problems with access to pharmacy benefits were widely reported during TennCare's first year (1994), with provider confusion over MCO formularies affecting all TennCare enrollees but particularly those with special needs, who tend to require prescription medication for chronic conditions. Reports of such problems have now subsided or at least become less pervasive. During the first year of the program, doctors reported that the plans did not inform them of the content of their formularies. Some plans also reportedly required beneficiaries to prepay the full purchase amount of drugs and file for reimbursement (though this practice was against TennCare regulations). The MCOs have refined and simplified the processes for prescribing and obtaining prescription drugs, we were told, and they are now largely uniform. (This has occurred through the marketplace rather than through any explicit state action.)

We did hear some reports of access problems related to new members' ability to fill prescriptions, as well as problems related to MCO disapproval of a prescribed medication. County Health Department officials in Hamilton County were surprised at the large number of children joining the TennCare program already on prescription medication who were unable to refill their prescriptions for up to six weeks after enrollment. Pharmacists reportedly refuse to fill prescriptions during the two- to six-week period between initial application and receipt of a TennCare card. Even after the member receives a TennCare card, pharmacists have reportedly refused to fill prescriptions obtained before TennCare enrollment written by doctors not in the plan provider network. Beneficiaries are also subject to delays when an MCO does not authorize a prescribed drug. A court decision that predates TennCare requires pharmacists to provide a 72-hour supply of medication if there is any disagreement over whether it is covered under Medicaid. According to advocates, this ruling is not being

honored under TennCare. Though enrollees may ultimately be able to fill their prescriptions in such situations, any delay is cause for concern, particularly for those reliant on maintenance drugs for chronic conditions.

C. SPECIAL CASE OF THE MEDICARE-MEDICAID DUAL ELIGIBLES

Under TennCare, dually eligible beneficiaries are required to enroll in a TennCare MCO, though the MCO is responsible for few services used by the dually eligible. Medicare beneficiaries in TennCare can access all Medicare-covered services on an FFS basis from any Medicare participating provider; the Medicaid program (not the MCO) is responsible only for coinsurance payments.[16] However, TennCare benefits that are not covered by the Medicare program can be accessed only through a TennCare MCO. These include pharmacy benefits, transportation, and some preventive care (such as more frequent Pap smears than Medicare allows). The pharmacy benefit is the one most often used and also the most costly.

In our discussions with state stakeholders about dual eligibles, two distinct but related issues surfaced. The first is the process by which the dually eligible become familiar with and access TennCare services without the benefit of a PCP. The second, which arises once beneficiaries have accessed their benefits, is conflict between holding MCOs at risk for managing the provision of pharmacy and other benefits and the Medicare protections that mean MCOs cannot require members to seek care from a PCP or other network provider. In effect, TennCare's design results in a capitated pharmacy benefit for the dually eligible but without providing an easy way for beneficiaries to understand this restriction or for plans to manage care consistent with their risk. It is not clear that TennCare considered this discrepancy in deciding to hold MCOs at risk for the pharmacy benefits for dual eligibles.

1. Education and Orientation to Managed Care

Dually eligible beneficiaries enroll in the TennCare program through the same process as other Medicaid eligibles; however, because they receive only some benefits through the MCO, their orientation to the plan and its managed care processes differs. Unlike Medicaid-only TennCare members — who receive a membership card, a member handbook that explains how to access services, and the name of the PCP to which they have been assigned — dually eligible members receive only a membership

[16]Tennessee's Section 1115 demonstration does not allow it to limit dually eligible beneficiaries to TennCare MCO providers for Medicare-covered services because it would restrict Medicare freedom of choice; nor does it allow the MCOs to assign dual eligibles to a PCP (unless requested by the member).

card and materials explaining how to access prescription drug benefits, including a list of MCO network pharmacies and the plan formulary. They do not receive a handbook or PCP assignment (Saucier and Mollica 1997).

No information or research exists on how successful dual eligibles are in accessing their TennCare benefits, such as prescription drugs and additional Pap smears, while using a non-network physician. Even though members are given the list of drugs in their MCO's formulary, it is not clear that non-network physicians would know about any formulary restrictions if they do not otherwise participate in TennCare. In addition, new members' difficulty with pharmacists refusing to fill prescriptions written by non-network doctors (discussed previously) would also likely affect dual eligibles whose use non-network providers.

2. Care Management and Coordination

The way TennCare structures MCO obligations for dual eligibles is cause for considerable concern for both beneficiaries, who may have difficulty accessing needed benefits, and MCOs. MCO executives were frustrated over their inability to subject the use of prescription drugs for the dually eligible to standard managed care processes, which rely on involving providers. Instead, MCOs can control the costs associated with prescription drug coverage mainly through their formularies. This structure also means that MCOs cannot offset managed care costs by any savings from reduced physician or hospital services as a result of effectively using prescription drugs.

This issue was explored in a November 11, 1997, article in the *Nashville Banner* entitled "TennCare Under Stress: Lack of Control Burdens MCOs" (Hallam 1997). The article quotes Sam Howard, Phoenix Healthcare's chief executive officer, reporting prescription drug costs as high as $40,000 a month for very sick or elderly dual eligibles. Some MCO executives argue that the financial impact of caring for the dually eligible is potentially devastating and threatens their ability to remain in the program. Others seriously question the validity of such claims. It may be that high-cost dual eligibles constitute a small number of unavoidable outliers and that the plans' ability to offset these costs though greater volume is the more important issue. In response to MCO concerns and after an actuarial analysis, the state increased the rate for dually eligible TennCare enrollees by 10 percent (from $80 pmpm to $88 pmpm) in its 1998 contract. However, raising the average rate will have relatively limited impact on any problems created by high-cost outliers.

D. CONCLUSIONS

It is difficult to say whether access to care for low-income populations with special needs has improved or deteriorated under TennCare. Since these individuals are difficult to identify through traditional tracking systems, few data exist on their needs, care, or outcomes. Surveys conducted by the University of Tennessee under contract to the TennCare Bureau have found the level of enrollee satisfaction with TennCare generally similar to that among Medicaid enrollees in 1993, the year before TennCare was implemented (Fox and Lyons 1998). In addition, TennCare enrollees more often rated the quality of medical care received as high than did Medicaid enrollees in 1993. However, survey results cannot be isolated to determine specific satisfaction levels of the disabled or those with special needs.

Advocates report both positive and negative experiences of the disabled and those with special needs under TennCare. Restricted access to specialty care still concerns some advocates, who believe it disproportionately affects those with disabling or chronic conditions. On the other hand, advocates believe that access to pharmacy benefits has improved since the first year of TennCare and is now better than under traditional Medicaid (because of the expanded benefit). In the four years since TennCare was initiated, plans have developed a number of care management processes for groups with special needs, such as pregnant women, a population that is both prevalent and easily identifiable. Plans are only now beginning to develop systemwide approaches for meeting the special needs of their disabled members whose conditions and health care needs are often highly individualized, but for whom the potential cost savings are great. The care management programs recently developed by the plans have reportedly benefited some enrollees with special needs and have the potential to benefit more as the programs evolve. But others maintain that case management programs only lower costs without improving patient care.

The most striking aspect of TennCare that is relevant here is how invisible the subgroups with special needs are in both the design and monitoring of TennCare. This is most obvious in the structure of TennCare for the dually eligible, where enrollment in MCOs appears to take little account of the role of Medicare coverage for this population. While to some extent the invisibility of individuals with specials needs is inevitable given their relatively small numbers and disparate nature, it is still striking that so little information appears to exist about the adequacy of MCO network structures to care for them. This makes it impossible to say with any certainty whether access to care for people with special needs has been improved or eroded by TennCare.

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