

Growing An Industry: How Managed Is TennCare's Managed Care?

Tennessee's Medicaid managed care program now stands at a crossroads: expand coverage and continue to build infrastructure, or just contain costs.

by Marsha Gold and Anna Aizer

PROLOGUE: With the possible exception of the Oregon Health Plan, perhaps no other state Medicaid program has generated as much national interest or controversy as Tennessee's TennCare program, which moved all of the state's Medicaid beneficiaries into managed care at the stroke of midnight, 1 January 1994. The initial cost savings from this move were sufficient to expand TennCare's rolls by 50 percent immediately, while projected savings offered the prospect of near-universal coverage. Unfortunately, the projected savings never arrived, and optimistic early reports have given way more lately to growing concerns about poor management of risk and eligibility that is threatening the program's viability. These concerns have touched off an often unseemly debate within the state that has spilled onto the pages of the nation's major newspapers.

With interest in state-level innovations on the rise, this paper could not be more timely, nor could one hope to find authors better suited to the task of guiding readers through the complexities of Medicaid managed care. Marsha Gold has a long-standing interest in state health policy and managed care. She holds a doctoral degree from Harvard University's School of Public Health and is a senior fellow at Mathematica Policy Research in Washington, D.C. Anna Aizer was a health research analyst at Mathematica at the time the work was done on the current study. She holds a master of public health degree from Harvard and is now at work on a doctoral degree in economics from the University of California, Los Angeles.

ABSTRACT: In 1994 Tennessee moved virtually its entire Medicaid population and new eligibles into fully capitated managed care (TennCare). We analyze Tennessee's strategy, given limited existing managed care; and health plans' development of managed care infrastructure. We find signs of progress and developing infrastructure, but these are threatened by concerns over TennCare's financial viability and the state's commitment to TennCare's objectives. State policymakers seeking systems change need to recognize the substantial challenges and be committed to long-term investment.

IN JANUARY 1994, Tennessee enrolled 1.2 million persons into TennCare, an 1115 Medicaid waiver program covering virtually all Medicaid beneficiaries and a large newly covered group in fully capitated managed care plans. Most new managed care plans were created just for TennCare and served only TennCare enrollees. TennCare was developed as a means of achieving substantial, immediate control over the state budget while moving rapidly to a managed care model that state officials hoped would allow more people to be covered for the same amount of state money.¹ Today, the realism of TennCare's goals and the state's financial commitment to them is coming to a head as Tennessee debates the adequacy of its capitation payments and further limits on the enrollment of uninsurable adults.

While many have examined the politics of reform, few have focused on a key underlying assumption of TennCare: that the state would be able to jump-start a managed care industry with sufficient structure to control the growth of per capita costs and allow savings to be used to expand eligibility. This required sufficiently developed systems to avoid major issues with network adequacy or quality. This paper focuses on the development of managed care infrastructure, which is fundamental to history's ultimate judgment of TennCare.

We analyze whether and how TennCare secured managed care organizations (MCOs) and established provider capacity; and how the rapid growth affected health plans' ability to develop the structures to manage care effectively and efficiently. This paper is based on week-long visits to the state after both the first (1994) and fourth (1997) years of TennCare.² For the most part, it depicts TennCare after its first four years, although we also show current enrollment and take into account more recent major events.

TennCare's lessons are exceedingly relevant now. In 1997 twelve states had more than 75 percent of their Medicaid populations in managed care, and many more states were aggressively moving in that direction, including states with limited existing managed care, just as Tennessee had in 1994.³ Although TennCare's development may be unique, the issues faced by Tennessee are germane to all states that are considering whether to use managed care to reorganize care processes as a way to contain costs.

Developing Plan And Provider Participation

TennCare's developers had little managed care infrastructure on which to build in recruiting sufficient plans and provider capacity. In 1993 eleven small health maintenance organizations (HMOs) enrolled 216,000 Tennessee residents. Blue Cross and Blue Shield (BCBS) enrolled another million in loosely structured preferred provider organizations (PPOs).⁴ The only Medicaid managed care plan was a small, partly capitated HMO with 35,000 enrollees. Further, a third of Tennessee's population was in rural areas, where managed care tends to be harder to develop. By mid-1997 Tennessee had sixteen HMOs with more than 20 percent of the state's population.⁵ In hindsight, three decisions appear important to TennCare's growth: (1) leveraging of the BCBS state employee provider network; (2) focusing on local organizations; and (3) allowing plans to participate initially without being licensed as HMOs in the state.

■ **Leveraging BCBS.** Tennessee BCBS's participation was critical to building a credible statewide managed care network. BCBS, with statewide provider contracts and a PPO product for the state employees' program, could serve as the core for a TennCare MCO. BCBS's PPO and its contract to insure state employers was an important part of its business. The details of negotiation between TennCare and BCBS officials are closely held, involving generally private, off-the-record discussions. Through these negotiations TennCare officials were able to leverage the state's contract with BCBS to get BCBS to agree to participate in TennCare, and to require that all of their network physicians participate in TennCare if they want to maintain participation in the state employees program—a provision physicians later termed a “cram-down.”

Physicians who would not agree were dropped by BCBS from the network. Although this led to some (mostly temporary) erosion in provider participation, it got the provider capacity of BCBS as an anchor for TennCare. And although BCBS later lifted the “cram-down” requirement, the requirement arguably was essential for recruiting plans with sufficient provider capacity at the start of the TennCare program.

■ **Focus on local plans.** Tennessee's limited managed care base meant that the state could either solicit proposals from MCOs outside the state or encourage existing insurers and large provider systems in Tennessee to develop new systems. Out-of-state firms had the corporate experience and infrastructure that local plans lacked but had only limited Medicaid experience and were not familiar with Tennessee providers. Ultimately, the state chose to focus on contracting with local Tennessee organizations and plans (although

others were not precluded from applying).⁶ This meant that many of the plans were formed just for TennCare and had only TennCare enrollment when they began.

■ **Flexible standards.** TennCare allowed organizations to participate without an HMO license. These were designated as “PPOs.” PPOs were not required to employ a gatekeeper and were not initially subject to oversight by the state insurance department that regulated HMOs. In theory, TennCare’s strategy provided equivalent consumer protection for those enrolled in HMOs and PPOs because the contract requirements on fiscal solvency and quality were reportedly the same. In practice, oversight of PPOs was limited in the first year. Although the contract had detailed requirements, there was no process to monitor adherence to them. But the PPO option made TennCare more accessible to those who could not offer or were not interested in offering a licensed HMO product.

TennCare’s strategy seems to have been one of creating flexibility to encourage participation and then tightening requirements and oversight as problems arose and the program matured. After three years (in 1997) TennCare mandated that all MCOs contracting with the state be licensed by the Tennessee Department of Commerce and Insurance (DCI) as HMOs and also employ primary care gatekeepers. Oversight also was strengthened after the first year following widely publicized instances of alleged marketing abuses, network inadequacies, and financial weaknesses. The TennCare Division within the DCI (together with the comptroller’s office) was mandated to oversee and assure MCOs’ fiscal solvency. Audits conducted by the state’s contracted external quality review organization are more demanding than they were in the first year.

Plan Participation And Enrollment Over Time

■ **Initial year.** TennCare began with twelve participating plans (six HMOs and six PPOs), two of which were offered in every county, and the rest, within more limited service areas. Two applicant plans withdrew because they were required to participate for eighteen months. Reportedly, a few plans with uncertain reputations were quietly discouraged from applying. Four of the HMOs were formed in anticipation of TennCare: two by academic medical centers interested in retaining their patient base (Vanderbilt University and the University of Tennessee, or TLC) and one started by an entrepreneur (Phoenix Healthcare). The other two (Access MedPlus and John Deere) existed before the TennCare initiative was launched and served, respectively, Medicaid and commercial enrollees. Two licensed HMOs decided to participate in TennCare as PPOs (Prudential and Health Net). The remaining four TennCare PPOs were BCBS, Omni-

care, Preferred Health Partnership, and TennSource. The state continues to contract with all plans that meet contracting requirements, expecting that market forces eventually will result in a shakeout.

■ **1995–1998.** As of early 1998 most of the MCOs participating in 1994 remained in the program, and enrollment among plans shifted only slightly (Exhibit 1). The most recent data (June 1999) show that this continues to be the case. BCBS and Access MedPlus, the two largest plans in 1994, continue to serve the largest number of TennCare enrollees, although their total enrollment and market share have declined somewhat as program enrollment has fluctuated and plans have become more competitive. Only a few of the smaller plans have exited the program, contrary to state expectations. A shakeout is still expected, with some feeling that it is overdue.

Initially, only two plans (BCBS and Access MedPlus) were statewide. By 1998 two more plans operated statewide (Phoenix Healthcare and Preferred Health Partnership [PHP]), and at least five plans operated in most major urban areas (Exhibit 2).

While TennCare has maintained its plan base, three MCOs closed enrollment for all or part of 1997—Health Net, John Deere, and BCBS (except in Memphis-Shelby County).⁸ BCBS executives said that this happened because of a desire to limit the plan’s financial exposure, concerns about serving roughly half of TennCare’s

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**EXHIBIT 1
TennCare Plan Enrollment, 1995–1998**

Plan	January 1995	January 1996	January 1997	January 1998	4-year change	Most recent ^a
Access MedPlus	306,585	248,006	249,064	289,608	-5%	303,011
BCBS (includes BlueCare)	616,006	626,968	538,820	507,378	-18	611,670 ^b
Health Net	78,756	70,249	80,905	0 ^c	- ^d	- ^d
John Deere	18,454	17,073	22,741	22,189	20	30,752
Omnicare	68,974	51,650	39,150	44,250	-36	44,065
Phoenix/Xantus	36,379	36,467	53,043	171,707 ^c	372	160,339
PHP	63,947	54,391	61,007	91,121	42	80,323
Prudential	8,383	8,882	9,795	11,118	33	13,049
TennSource	4,263	3,490	4,004	0	- ^d	- ^d
TLC	37,953	32,472	32,706	47,774	26	57,950
Total Health Plus	6,944	4,530	0 ^e	0 ^e	- ^d	- ^d
Vanderbilt	14,033	10,150	9,611	11,362	-19	11,810
Total	1,260,577	1,164,328	1,133,101	1,219,512	-3	1,312,969

SOURCE: Authors’ analysis of TennCare data.

NOTES: BCBS is Blue Cross and Blue Shield. PHP is Preferred Health Partnership. TLC is affiliated with the University of Tennessee.

^a Reported 29 June 1999 enrollment.

^b Includes reports for two separate BlueCare plans with 501,548 and 110,122 enrollees, respectively.

^c Reflects Phoenix Healthcare’s purchase of Health Net in December 1997 and the absorption of Health Net’s 81,316 TennCare members. The plan is now known as Xantus Healthcare.

^d Not available.

^e Total HealthPlus was bought by Blue Cross Blue Shield in 1996.

EXHIBIT 2

Number Of TennCare Plans Available, By Geographic Area, 1995–1998

Geographic area	Proportion of TennCare enrollees in area	Number of plans serving area			
		January 1995	January 1996	January 1997	January 1998
First Tennessee	9%	5	5	5	5
East Tennessee	13	5	5	5	5
Southeast Tennessee	5	5	5	5	5
Upper Cumberland	6	4	4	4	5
Mid Cumberland	9	4	4	4	5
South Central	5	4	4	4	5
Northwest	4	2	3	3	5
Southwest	7	2	3	3	5
Davidson County	10	6	5	6	6
Hamilton County	5	5	5	5	5
Knox County	6	7	7	6	5
Shelby County	21	6	6	6	7
Out of state	<1	2	3	3	4

SOURCE: Authors' analysis of TennCare records.

enrollees, and a need to focus resources on shifting 500,000 TennCare members to a primary care provider (PCP) model. Competitors viewed the closure adversely because only Medicaid-eligible and uninsurable (a high-cost population) persons were enrolling in 1997. In early 1998, BCBS agreed to reopen enrollment statewide.

■ **Provider participation.** TennCare plans were able to contract with providers initially and have since expanded their networks, although some areas and specialities are reportedly still underrepresented. It is significant that plans were able to attract providers, given the initially high level of physician opposition.⁹ How provider availability compares with the situation before TennCare is difficult to assess, as plan networks may overlap considerably and available data to assess this issue are limited. For TennCare beneficiaries, gaps in the network can increase travel time and reduce convenience.

Trends In Health Plan Financial Performance

TennCare MCOs generally fared well financially in the first few years, but financial performance declined considerably in the fourth year (1997) (Exhibit 3). In 1995 TennCare MCOs reported, in aggregate, positive net income of nearly \$23 million, and only four plans reported negative net incomes. In 1996 aggregate net income dropped slightly to \$20 million, but only two plans reported a negative net income. For the first nine months of 1997, however, TennCare MCOs lost in aggregate more than \$23 million, and the number of plans reporting negative net income rose to six, which together serve 45 percent of the TennCare population. The exact



EXHIBIT 3
Financial Performance Of TennCare Managed Care Plans

Plan	CY 1995			CY 1996			January-September 1997		
	Profit	Net Income	MLR	Profit	Net Income	MLR	Profit	Net Income	MLR
Access MedPlus	2%	\$19,314,023	86	0%	\$13,280,934	83	-1%	\$ -405,485	89
BCBS	-3	-6,517,874	- ^a	-5	9,544,574	- ^a	-1	2,814,443	- ^a
Health Net	-2	0	92	-2	0	92	-5	-14,988,916	106
John Deere	15	3,989,470	71	8	2,786,044	76	-16	-9,114,678	120
Omnicare	8	7,864,526	75	-4	-7,846,726	82	2	1,320,084	78
Phoenix	-1	846,612	80	1	2,107,333	78	-5	-2,927,711	89
PHP	-2	126,849	91	-3	312,118	88	-2	564,896	90
Prudential	-12	-1,593,625	92	4	875,880	90	12	1,292,294	77
TLC	-3	-262,904	91	-7	-1,878,200	92	-4	-1,764,625	92
Vanderbilt	-8	-1,116,160	89	3	958,821	76	-5	-361,873	89
Total		22,650,917			20,140,778			-23,571,571	

SOURCE: Net income for TennCare for the ten plans contracting with the state for calendar years (CY) 1995 and 1996, and the first nine months of 1997 as reported in plans' unaudited financial statements submitted to the Tennessee Department of Commerce and Insurance.

NOTES: MLR is medical loss ratio, which represents the ratio between the cost to deliver medical care and the amount of money that was taken in by the plan. BCBS is Blue Cross and Blue Shield. PHP is Preferred Health Partnership. TLC is affiliated with the University of Tennessee.

^a Not available.

cause of this financial decline is not known. Some suggest that by closing enrollment to relatively healthy, uninsured adults while continuing to enroll Medicaid eligibles and less healthy uninsurables, the state may have contributed to adverse selection and financial strain. This overloaded plans that were small, had weaker economies of scale, and were undercapitalized or had weak management.

This financial deterioration, combined with the number of plans that requested no new enrollees in all or part of 1997, is troubling. Despite plans' agreements to open enrollment in 1998, many stakeholders in the state question TennCare's financial viability and the state's ability to maintain sufficient plan participation over time.

Creating Managed Care Infrastructure

We consider the development of managed care in TennCare by focusing on the three largest plans: BCBS, Access MedPlus, and Phoenix Healthcare. These plans are statewide, differ from one another, and together serve more than 80 percent of TennCare enrollees.

BCBS was the largest insurer in the state before TennCare, with the largest PPO but no HMO. BCBS participated in TennCare as a PPO until it converted to an HMO in January 1997. From the start BCBS was the dominant plan. At year-end 1994 BCBS enrolled 616,000 beneficiaries—almost half of all TennCare beneficiaries. Plan enrollment peaked at 623,000 by January 1996 and declined thereafter.

Access MedPlus is a minority-owned HMO that has always been closely aligned with Tennessee's low-income population. Before TennCare, it enrolled 35,000 Medicaid beneficiaries and relied heav-

ily on community health centers as its provider base. It assumed only partial risk for the care of its members. Under TennCare, Access MedPlus was fully at risk and expanded statewide from a much smaller base around Memphis and western Tennessee. Although it had a target enrollment of 100,000–150,000, enrollment surpassed 330,000 by the end of the first year, when TennCare officials assigned those who did not choose plans (as many did not) based on the pattern of voluntary selections. Since then, enrollment in Access MedPlus fell somewhat but is rising again.

Phoenix Healthcare was formed specifically for TennCare by two entrepreneurs, an executive with the national hospital chain HCA and the former chief financial officer of Access MedPlus. Phoenix Healthcare opted to seek a license as an HMO in 1993 rather than entering as a PPO. In contrast to the other two plans, Phoenix Healthcare's enrollment grew slowly, which seems to have limited the strain on developing systems. Enrollment was at 36,000 by year-end 1994, rising to 53,000 at the start of 1997. The latter reflects both internal growth and the absorption of TennCare enrollees from a smaller participating plan, Health Source. By the end of 1997 Phoenix Healthcare enrollment had reached 90,000, making it the third-largest TennCare plan. In December 1997 Phoenix Healthcare purchased and merged with Health Net, the fourth-largest plan in the state, with 81,000 enrollees, nearly doubling membership to 171,000.

■ **Management infrastructure.** Developing management infrastructure was the first order of business for each of the plans. All found that this took time, although BCBS had an existing structure that provided a temporary base on which to build operations.

BCBS. BCBS took initial advantage of its commercial PPO and indemnity experience by using the same systems to manage TennCare. Claims payment, for example, was not the issue for BCBS that it was for other TennCare MCOs. But building on established processes also delayed the development of managed care and clinical infrastructure, which were largely absent from existing BCBS products. BCBS is now building this infrastructure, hiring outside high-level managed care executives for needed expertise.

We were struck, in our interviews, with the contrast between the indemnity focus of BCBS officials in 1994 and the managed care emphasis in late 1997. But the shift came at a price. In 1994 BCBS's TennCare operations were integrated into its commercial business practices, making it more likely that TennCare enrollees would receive services similar to those received by other enrollees (although TennCare's provider payments were lower). While integration may occur again later, the price of moving to a managed care model is that BCBS's TennCare and commercial staffs are located in different fa-

cilities and operate relatively independently.

Access MedPlus. Access MedPlus had the most visible problems initially with developing management infrastructure. The plan started with a staff of fifty that functioned for its 35,000 member enrollment. There were no claims processing systems because the plan capitated PCPs and relied on state systems for contracting with and paying specialists. Even the systems that were in place, such as credentialing and quality assurance, were taxed by the demands of the massive influx of TennCare enrollees. The first two years were devoted almost exclusively to developing basic systems. Claims processing has been and continues to be the plan's greatest problem. In 1996 the state threatened to terminate its contract and reassign its 250,000 members after identifying nine deficiencies related to timely payment, claims processing, and grievances and solvency requirements. Ultimately, Access MedPlus secured a loan guarantee from Methodist Hospital and restructured and refinanced the plan to meet the state's standards. Its contract was never terminated, although some difficulties remain.

Phoenix Healthcare. Up until recently, Phoenix Healthcare appeared to have developed its management infrastructure smoothly. The state comptroller's audit of the plan for calendar year 1995 (TennCare's second year) found two minor deficiencies, neither of which involved claims payment. Slow enrollment growth in the first three years likely contributed to Phoenix Healthcare's ability to grow its infrastructure gradually and without major disruption. Also, plan executives believe that by seeking HMO licensure from the start and building on that base, the plan avoided many of PPOs' problems. Although we did not meet with Phoenix in 1994, plan executives told us in late 1997 that most of the growth in management and clinical infrastructure had occurred in the past six months. Unfortunately, the acquisition of Health Net appears to have undercut the plan's progress. In April 1999 Tennessee officials assumed control of Xantus Healthplan of Tennessee (as Phoenix Healthcare is now called) after it reported a negative net worth of \$24 million in 1998. Press reports suggest that the erosion in performance stemmed, at least in part, from the acquisition of Health Net and its outstanding debts.¹⁰

■ **Provider network development.** BCBS had an easier task than the other two plans had in building a provider network, since it could build on its large commercial network. Providers' resistance to TennCare was not trivial: Some refused to provide credentialing information or to accept TennCare; others reportedly did not live up to contractual obligations. However, the strategy of leveraging the state employees' PPO network for TennCare basically worked.

BCBS. Having established the plan, BCBS no longer requires par-

ticipation, and executives say that they are focusing more on developing strong cooperative relationships with network physicians as the plan shifts to a gatekeeper model. The model was new to many providers, and the transition was challenging and at times chaotic. To protect vulnerable populations during the transition, BCBS made special allowances for specialists to serve as PCPs for some members and moved the medically fragile to PCPs before moving the general population. BCBS officials believe that the model is attractive to providers because it effectively guarantees a certain volume of patients and revenue and conversely allows them to limit enrollment. The gatekeeper approach also is valuable to the plan because it means that enrollees are assigned to specific physicians, which makes it easier for the plan to assess network adequacy. To enhance provider communication, BCBS has regionalized its quality and service-delivery function, conducted provider workshops on the referral and authorization processes, and shared its utilization management guidelines (previously regarded as proprietary) with the goal of gaining providers' consensus and buy-in.

Access MedPlus. In contrast, provider capacity has been a continuing problem for Access MedPlus. During the first year complaints about insufficient specialty physician and hospital participation were particularly common. Primary care was less of a problem, as Access MedPlus intentionally set its primary care capitation payments relatively high compared with historical Medicaid fee-for-service rates and other plan experience. Despite considerable efforts, though, early problems with administration and prompt payment have reportedly discouraged provider participation and contributed to network inadequacies. Some providers with whom we met believe that Access MedPlus's ties to traditional safety-net providers, while initially helpful to network development, ultimately limited network growth beyond this core set of providers. Plan staff note that they continue to recruit new providers and work on improving relations with existing ones.

Phoenix Healthcare. Phoenix's experience reinforces the need for continued work on the network even as a plan matures. The opportunity to enhance its provider network was a primary motivator behind Phoenix Healthcare's merger with Health Net. Before the merger Phoenix had contracted for hospital services primarily with Columbia/HCA (with which it had strong ties through its chief executive officer). The extensive contracts with Columbia/HCA hospitals made it more difficult, we were told, to secure contracts with competing systems such as Baptist Health System. Because Baptist Health System is Health Net's major inpatient provider, the merger allows Phoenix Healthcare to include the Baptist system in

its provider network, thereby greatly enlarging its inpatient and specialty network.

Phoenix Healthcare also changed its provider payment and utilization management processes to improve provider satisfaction and retention. For example, the plan does not require providers who show efficient and appropriate utilization patterns to receive prior approval. These providers receive “automatic approvals” for most referrals (diagnostic imaging and rehabilitation are the main exceptions). Also, Phoenix offers a bonus of up to \$6 per member per month for PCPs with good utilization and quality measures.

■ **Prevention, care management, and coordination.** In all three plans the development of care management and delivery systems largely took a back seat to that of management infrastructure and provider capacity, without which the plans could not function. Plans then could turn to building care management systems, which was occurring four years after the start of TennCare.¹¹

BCBS. BCBS had furthest to go in developing managed care infrastructure. Initially, BCBS’s TennCare product more closely resembled a traditional indemnity product. Changes, for the most part, have been fairly recent after the transition to a gatekeeper model. BCBS used a three-prong approach to improving care management: (1) adopting a regional model in which plan staff are placed “in the field” and focused on diseases that are population specific; (2) shifting the focus of utilization management to include care management; and (3) developing a comprehensive member outreach program. To support these activities, the plan developed a new clinical effectiveness department. BCBS says that its regional medical management philosophy, based on claims data, has enabled the plan to look at comparable populations across the state, identify variations in care delivery and members’ needs, and concentrate resources accordingly.

BCBS uses a regional structure for care management, with teams identifying opportunities to improve clinical and delivery system processes in a given region. For example, goals in Region III (which includes Chattanooga) include implementing diabetes management and high-risk obstetrics programs, decreasing the number of prescriptions per member to reduce possible drug interactions, and increasing ambulatory management of patients with chronic diseases. In regions, two to three case managers work in teams with regional medical directors and utilization management nurses. The teams focus on managing catastrophic cases such as neurologic disorders, brain injuries, human immunodeficiency virus (HIV), and cerebral palsy; the development of clinical pathways; and education of providers and members. The latter includes an expanded member-outreach department with field representatives in each re-

gion, a twenty-four-hour nurse triage telephone line, and a health risk appraisal for all new members.

Access MedPlus. Like BCBS, Access MedPlus paid more attention to provider contracting and claims payment than to developing clinical management structures in the early years of TennCare. Since then the plan has made progress in these areas and has been able to focus on care management, devoting more resources to the development of prevention and outreach programs in particular.

Plan staff report that they have developed more than sixty outreach programs for prevention and care management. Most are for children and pregnant women, the largest and most easily identifiable subset of TennCare members. Key to the plan's strategy in this area has reportedly been recruiting former staff from the state Medicaid program, who bring knowledge of the Medicaid population and programs. Some outreach activities are fairly simple, such as presentations at health fairs and basic health risk assessments. Some are more intensive, such as a program to train plan members as nurse's aides to assist with asthma intervention, prenatal care, and other preventive activities. Roughly five to ten such nurse's aides are now assigned to 25,000 members in a geographic area.

Access MedPlus also is refining its prenatal care programs to reach more members. As part of its "Mom-to-Be" program (to decrease emergency room use and increase birthweight), 4,000–5,000 pregnant members receive gifts (such as a car seat) as an incentive to seek prenatal care. Access MedPlus has been pleased with the results for those who enroll and is now focusing on outreach to the 20 percent of pregnant women who do not use the program.

Phoenix. As with the other two plans, Phoenix Healthcare's care management programs were mostly just being developed in 1997. Like Access MedPlus, Phoenix was refining and enhancing the prenatal care programs developed early on under TennCare. There is now more emphasis on outreach, encouraging physicians to bring more women into the program and to actively coordinate their prenatal care. The plan similarly has revamped its basic case management program to increase continuity of care, with care management teams responsible for managing care in specific geographic areas. The intent is to have members and providers work regularly with the same case management team and to have the teams become familiar with local care management resources. Phoenix Healthcare also was beginning to focus on managing the care of those with costly chronic diseases (such as cancer, premature birth, diabetes, and asthma), although only the case management program for cancer was in place when we visited. A designated oncology case manager investigates the appropriateness of experimental drugs; devel-

ops and distributes practice guidelines for the use of chemotherapy; identifies indicators on which to gather data; and reviews treatment plans to ensure the use of the most appropriate mode of care. Whether these developments continue is uncertain, given the plan's adverse position.

Plans' Current Status

While their trajectories differed, all three plans found that developing managed care infrastructure took substantial time. Developing clinical infrastructure, which took the longest, is still under way and, arguably, may still be relatively invisible to the providers whose participation will ultimately be required to make it work.

BCBS's specialty network is still more comprehensive than are most of the other plans' networks, according to primary care providers with whom we spoke. Although it is still too soon to gauge the impact of BCBS's recent efforts to build an infrastructure to truly manage care (which is being phased in regionally), there are some positive early signs. Among advocates and providers we interviewed, some report good experience with BCBS's outreach or disease management programs, while others have had little or no interaction with these programs thus far. It will be important to learn whether these programs and support for them continue, how they come to be viewed by members and providers, and how they influence the development of BCBS's broader product line.

Access MedPlus's current market position has been affected by its history and start-up difficulties, which remain fresh in some participants' minds. One former state administrator, while acknowledging the progress made to date, refers to the plan's past troubles as "the biggest black eye on the TennCare program." Among the providers we interviewed, perceptions of the plan varied, with PCPs reporting more positive experiences than did specialists and hospitals. One safety-net provider told us that Access MedPlus is "the only plan really managing care." Yet other providers, particularly specialists and hospitals, continue to report serious problems receiving adequate and timely payments, and difficulty referring patients to specialists. The disparity in views is not surprising, given the plan's historical ties to the safety-net community and its philosophy of favoring primary care with relatively high capitation rates.

The future of Phoenix Healthcare (now Xantus Healthcare) is unclear. Initially, Phoenix faced less public scrutiny than the other two plans did, most likely because it was small. Providers we interviewed reported mixed experiences: Some had difficulty procuring payment; others were satisfied with payment speed and bonus payments. The plan's recent acquisition of Health Net represents the

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first merger of two relatively large TennCare plans. With the merger, Phoenix Healthcare doubled in size and faced the daunting task of integrating the systems of two plans with very different histories. At the time of our visit, we perceived that the tasks facing the plan were challenging. It now appears that they were underestimated, by state and plan officials alike.

Conclusions And Policy Implications

Starting with a limited base of managed care, TennCare shifted more than a million people to a totally capitated managed care environment within one year. Nearly 400,000 others gained eligibility. Beyond its effects on care for low-income Tennesseans, the move to Medicaid managed care in Tennessee effectively jump-started the entire managed care industry in the state. The state’s ability to gain BCBS’s participation by leveraging the state employees’ health insurance contract was critical to building start-up provider capacity.

This evolution was not without its costs, particularly for existing Medicaid beneficiaries. To offer two statewide plans (so the program could offer choice) meant allowing rapid growth in a second plan that was poorly equipped to absorb that growth. It also meant going with many new and relatively undeveloped plans that might have been regulated on paper but not very closely in fact during the initial year. The first year of TennCare was chaotic for beneficiaries, providers, plans, and the state. Many of the MCOs were little more than mechanisms to procure discounted rates from providers, and only recently have they developed some of the structures and processes to manage care. Not until the fourth year did plans truly focus extensively on managing care, and many systems are still “under development.” In addition, most systems focused initially on the “typical” TennCare beneficiary, turning only gradually to specific systems to care for the chronically ill—key subgroups in TennCare because of the inclusive approach to managed care.

The key question for policymakers is whether the costs are “worth it” and whether managed care can generate savings that will allow eligibility expansions as steps toward universal coverage. Based on our review of the TennCare experience, we conclude that policymakers choosing this route need to be prepared for limited savings, at least initially, and for a very long period of development. Managed care systems do not evolve “overnight” even if basic infra-

structure and contracting arrangements are put in place. This can be interpreted in two ways. The first is to discount managed care, based on the long lead time it takes to develop. The second, which we prefer, is to acknowledge the long lead time yet argue that fundamental systems change may be worth the investment. For example, many of TennCare's care management features are not typical of traditional fee-for-service systems and would not exist without TennCare. Such investments need to be justified on their own merits (better care), however, since their cost savings potential is limited, especially in the short run and in a Medicaid context where underfunding has always affected access.

Whether Tennessee is well positioned to support such investment is unclear. The TennCare structure was conceived by two state officials with the support of a governor who later left office. Since then, broadened eligibility has added support for the program, but the depth of support is uncertain, as is the political commitment to continuing to expand eligibility rather than just containing costs. There has been considerable turnover in key TennCare staff.¹² Turnover has eroded both the state's ability to administer the program and (arguably) the conceptual understanding and support for program strategies that never were very explicit anyway.

Tennessee is now debating whether to close TennCare to new uninsurables or to tighten eligibility and benefits as fiscal pressures grow.¹³ Medically uninsurable status is the main way in which non-Medicaid-eligible adults can gain access to TennCare. The need to prove this status has encouraged the program to support a needy and broad-based group of Tennesseans. But it also has added disproportionately to program costs while limiting access for those who could benefit and making inequities more likely across plans based on whom they attract. Covering uninsurables also has accentuated the tension between public and private coverage, with allegations of abuses by insurers and others and claims that TennCare is being asked to shoulder burdens that others should assume.

In sum, TennCare shows that states can leverage their resources to encourage fundamental systems change but also that such change is disruptive and requires an ongoing commitment. Arguably, what Tennessee officials do next will determine whether the early "costs" associated with TennCare are "worth" it. For the program to remain viable, officials must retain experienced state staff, maintain plans' financial stability so that they can continue to evolve, and secure support for funding levels adequate to TennCare objectives and to the authorized expansion of eligibility—not just to children but to low-income adults. For many Tennesseans, the latter remains the program's main selling point.

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This paper was developed through a project funded by the Henry J. Kaiser Family Foundation and the Commonwealth Fund. All views are those of the authors and do not necessarily reflect those of the funders or Mathematica Policy Research. The authors acknowledge especially Cathy Schoen of the Commonwealth Fund, who participated in the TennCare site visit and case study. She and Barbara Lyons of the Kaiser Family Foundation provided guidance on the overall project.

NOTES

1. See M. Gold, "Markets and Public Programs: Insights from Oregon and Tennessee," *Journal of Health Politics, Policy and Law* (April 1997): 633–666.
2. For additional information, see A. Aizer, M. Gold, and C. Schoen, "Managed Care and Low-Income Populations: Four Years' Experience with TennCare" (Washington: Kaiser/Commonwealth Low-Income Coverage and Access Project, May 1999).
3. Henry J. Kaiser Family Foundation, "Fact Sheet: Medicaid and Managed Care" (Washington: Kaiser Commission on the Future of Medicaid, November 1998).
4. See Group Health Association of America, *1994 National Directory of HMOs* (Washington: GHAA, 1994); and *InterStudy Competitive Edge 3.1* (Minneapolis: InterStudy, 1993).
5. *InterStudy Competitive Edge, Part II: HMO Industry Report 8.1* (Minneapolis: InterStudy, April 1998).
6. Whether soliciting national managed care firms would have been feasible, given TennCare's time frame, is unclear.
7. TennCare rules and regulations defined a PPO rather loosely as "a managed care organization other than an HMO which is approved by the Bureau of TennCare as capable of providing medical services in the TennCare program" (Tennessee Department of Health, 1994).
8. Phoenix Healthcare also asked to close its enrollment, but the state denied its request.
9. Opposition was widespread and resulted in an ultimately unsuccessful legal challenge to TennCare by the state medical association. Certain specialists, such as orthopedists, boycotted TennCare, refusing to participate.
10. "Managed Care Monitor: State Takes Reins of Largest TennCare HMO," *American Healthline* (1 April 1999); and "Managed Care Monitor: Misguided Acquisition Fueled Xantus Collapse," *American Healthline* (6 April 1999).
11. Our description of clinical systems, based on plan reports, is indicative of plan priorities, not audited performance. Studies show that satisfaction rates stabilized at pre-TennCare levels by 1997. See W.F. Fox and W. Lyons, "The Impact of TennCare: A Survey of Recipients" (www.state.tn.us/health/tenncare, March 1998).
12. "TennCare Faces Leadership Exodus," *American Healthline* (1 January 1997); "Health Commissioner Resigns Amidst TennCare Troubles," *American Healthline* (5 February 1999); and Aizer et al., "Managed Care and Low-Income Populations."
13. P.T. Kilborn, "Tennessee Talks of Rolling Back Health Plan for Uninsurables, Rising Costs Help Threaten Ambitious Program," *New York Times*, 1 May 1999, A1; Tennessee Department of Health, "Lapps Presents TennCare Reform Plan" (Press release, 10 May 1999); and "TennCare: Governor Unveils New Reform Plan," *American Healthline* (1 December 1999).

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