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STATE REPORT

Stealth Reform: Market-Based Medicaid In Tennessee

by G. Gordon Bonnyman Jr.

Caught between a major loss of federal Medicaid funds and legislators' fear of enacting new taxes, Gov. Ned McWherter (D) declared in early 1993 that he would make Tennessee the first state in the nation to "withdraw from Medicaid." Within months Tennessee had obtained a federal Medicaid waiver under Section 1115 of the Social Security Act and had launched a managed care program that would affect the state's entire health care delivery system.[1] At the end of its first year the new program, known as TennCare, had expanded coverage to 300,000 previously uninsured Tennesseans, while bringing Medicaid spending under control. More fundamentally, TennCare transformed the provision of health care to Medicaid beneficiaries from a seller's market into a buyer's market.

Although TennCare remained dependent on federal Medicaid dollars, Tennessee did, in an important sense, "withdraw from Medicaid"—for the new program challenged fundamental tenets of Medicaid and Medicare policy regarding government pricing of health services. TennCare represents an unusual laboratory for assessing the capacity of capitated managed care systems to deliver both expanded public coverage and substantial savings.

Gordon Bonnyman is managing attorney at the Tennessee Justice Center in Nashville. He formerly was on the staff of the Legal Aid Society of Middle Tennessee. He received his law degree from the University of Tennessee.

Background: An Unlikely Suspect

Medicaid is characterized by a high degree of interstate variation in eligibility, benefits, payment rates, and level of federal funding. The percentage of Medicaid costs borne by the federal government varies from 50 percent in more affluent states to 79 percent in the poorest states and averages 57 percent nationwide, with states making up the balance. Tennessee's federal matching percentage was 67.6 percent in 1993.[2]

Tennessee was among the top seven states in 1993 in percentage of poverty population covered by Medicaid. Tennessee covered 63 percent of its poor, while Medicaid as a whole covered only 54 percent of the nation's poor.[3] Tennessee was one of thirty-seven states that covered the medically needy and was also relatively liberal in its coverage of children and pregnant women.

By contrast, Tennessee trailed most states in the generosity of its Medicaid rates and benefits prior to TennCare. The state ranked forty-second in the nation in total Medicaid expenditures per enrollee.[4] Tennessee's disproportionate-share hospital (DSH) payments per uninsured person placed it thirteenth in interstate comparisons and made Tennessee a "high DSH state."[5] However, after adjusting for the offsetting effects of hospital taxes, aggregate hospital payments were only 84 percent of the hospital industry's reported costs, compared with a national Medicaid average of 93 percent.[6]

Before TennCare, Tennessee had little experience with Medicaid managed care. In 1993 fewer than 30,000 of its 900,000 full-time-equivalent (FTE) beneficiaries were enrolled on an optional basis in the lone managed care plan then participating in

Medicaid.[7] For that matter, capitated managed care had little presence anywhere in Tennessee: only 7 percent in the private sector, and none at all in the Medicare market.[8] Apart from Medicaid, Tennessee had some of the highest health care costs in the country, as reflected in physician incomes and adjusted Medicare expenditures per beneficiary.[9] The state's health care system, like the nation's, also was characterized by substantial excess hospital capacity. The median hospital occupancy rate was only 46.7 percent of licensed beds, or 63.2 percent of staffed beds.[10]

In sum, with little managed care experience, already low Medicaid rates, and generally high health care costs, Tennessee seemed an unlikely candidate for the role of innovator in Medicaid managed care.

Necessity, The Mother Of Invention

By early 1993 several years of burgeoning growth in Tennessee Medicaid expenditures had created a budget crisis that affected the entire state government. Growing Medicaid rolls, combined with health care cost inflation, had nearly tripled expenditures in just five years. As in most states, Medicaid was now the second-largest (after education), fastest-growing item in Tennessee's budget.[11]

Governor McWherter, a conservative Democrat, had temporized since assuming office in 1987, by pioneering the use of "creative financing" techniques such as DSH subsidies and other enhanced provider payments to induce hospitals and nursing homes to fund part of the state's share of Medicaid costs.[12] Such legerdemain had increased the federal medical assistance percentage from an official rate of 67.6 percent to an effective rate closer to 83.1 percent. By this device, Tennessee held the increase in its general revenue fund appropriations for Medicaid to less than 25 percent during years when the program's budget grew nearly threefold.[13]

However, by 1993 new federal laws designed to curb such schemes began to take effect, and Tennessee faced the loss of $494 million in federal Medicaid funding. An aura of crisis pervaded the state's annual legislative session, as adjournment approached with no solution in sight. Then, in April, with perfect dramatic timing, McWherter unveiled his TennCare proposal. The proposal called for simultaneous repeal of the state's hospital tax, the broadening of Medicaid eligibility to cover most of the state's uninsured, and the mandatory enrollment of new eligibles as well as the entire existing Medicaid population in capitated managed care networks.[14] Within weeks the General Assembly enacted a two-page statute that effectively gave the governor *carte blanche* to seek a federal waiver and implement TennCare by executive fiat, by the beginning of the following year.[15] State Medicaid officials worked frantically to prepare for TennCare's implementation while McWherter, who had been an early and influential supporter of Bill Clinton's presidential candidacy, badgered the White House to grant the waiver. The Department of Health and Human Services gave its reluctant approval in November 1993.

By that time, provider groups, especially the Tennessee Medical Association, had concluded that TennCare would mean a loss of income and autonomy. They had reversed their earlier positions of tentative support and were actively attempting to block the new program. Media coverage, which was initially glowing, had turned heavily negative. Given these circumstances, the McWherter administration believed that unless the state were already irrevocably committed to TennCare's implementation when the legislature reconvened in late January for its 1994 session, lawmakers would face irresistible pressure to revoke their earlier authorization of the program. The state hastened to implement TennCare by 1 January 1994, ready or not.

If They Come, We Will Build It

At the stroke of midnight on 1 January, Tennessee moved all 800,000 Medicaid beneficiaries into managed care networks and began to accept applications from persons who were newly eligible. When this

occurred, the broad outlines of TennCare were in place, but months would pass before important details of its design would be implemented.

Details of the program. For an initial average rate of $101 per member per month, TennCare paid twelve managed care organizations to deliver care to the program's beneficiaries. Borrowing a contract enforcement tool common to commercial markets but novel in Medicaid, TennCare withholds from each organization 10 percent of its monthly capitation payment, contingent upon the plan's compliance with performance standards. Most of the health plans serve limited geographic areas; two operate statewide. In every region beneficiaries have a choice of at least two managed care plans, and each plan has to accept any beneficiary who selects it. All of the managed care organizations are at financial risk if their expenditures exceed the total amount of TennCare's capitated payments. The state lets each plan bargain with its network providers regarding the allocation of financial risk between managed care organization and provider. The state also leaves to the plans the negotiation of provider fees, although such fees are subject to the constraints of the overall capitation rate established by TennCare.

The managed care organizations are responsible for all covered services except long-term care, which continues to be reimbursed directly by the state agency on a fee-for-service basis. Tennessee provides the same benefit package to all enrollees. That package is slightly more generous under TennCare than it was under the former Medicaid program.

TennCare covers anyone who meets Medicaid eligibility requirements in effect in 1993. The waiver also extends eligibility to the uninsured. A second category of waiver eligibles are persons who are deemed uninsurable by commercial insurers because of poor health. There is no upper income eligibility limit for waiver eligibles. A sliding scale determines the financial liability of non-Medicaid enrollees with incomes above poverty; there is no cost sharing for the poor.

The budget for TennCare's first twelve months of operation was $2.4 billion, exclusive of the long-term care "carve-out," Medicare payments for dually eligible beneficiaries, and administration. The expansion of eligibility was partly funded by a negotiated 16 percent increase in total federal funding the first year.[16] Under the terms of the waiver, the growth of total federal payments for TennCare acute care services and Medicaid fee-for-service long-term care was capped at a declining rate. The federal share is allowed to grow by 8 percent between the program's first and second years; the growth rate is curtailed to 2 percent between the fourth and fifth years of the five-year demonstration.[17]

Although not described in the TennCare waiver documents, a key element of the program's design was the Tennessee Preferred Network (TPN), a preferred provider program operated by Blue Cross/Blue Shield of Tennessee. By far the largest provider network in the state, TPN covered one million persons, one-fifth of the state population. Enrollees included large private workforces, but the state and local government employee health plan represented TPN's single largest account. Using its control of that account for leverage, the state negotiated with Blue Cross to make TPN's providers, many of whom had never served Medicaid patients, available to the new program. The state's success in those negotiations also was attributable to the fact that TennCare offered Blue Cross the attractive prospect of dramatically swelling TPN's total enrollment.

Blue Cross requires any provider who participates in TPN to treat the network's TennCare enrollees. Physicians bitterly attacked the policy, characterizing it as a "cram-down" requirement. In the first few months of TennCare's existence the TPN roster of participating physicians dropped from around 6,500 to 3,500. But TPN's large market share was such that by the end of 1994 almost all had returned to the fold.[18] Even with the "cram-down," access to providers has sometimes been problematic for the half of TennCare beneficiaries who chose TPN. Without this use of its purchasing clout, the state would have had great

difficulty assuring federal officials that TennCare's beneficiaries would have adequate access to care.

Implementation. Given the magnitude of the changes wrought by TennCare, some confusion and dislocation were inevitable. The politically driven implementation timetable compounded the confusion. The managed care organizations' ability to serve their enrollees generally was inadequate when the program began. There were serious marketing abuses, some amounting to fraud, in a number of communities. Access to particular medical specialties, or even hospital care, was problematic in some areas and for enrollees in several managed care organizations. Care for vulnerable populations was disrupted, as were the revenues of essential providers who served them.[19]

The state encouraged hundreds of thousands of uninsured Tennesseans to apply for the new coverage, but it was months before computer systems and administrative procedures were developed to process those applications. For months a state contractor failed to inform new enrollees of their premium liability or where to send their payments. Patient encounter data, which were essential to the state's ability to monitor quality and access, were to be submitted by managed care organizations' standard electronic format. However, such data were initially incomplete, inaccurate, or nonexistent, which prompted the state to partially withhold capitation payments to compel the data's production.

The state used discretionary funds to mitigate the side effects of TennCare's implementation by making payments to essential providers and initially underwriting much of the care that was delivered out of plan. Even with TennCare's expanded coverage, hundreds of thousands of Tennesseans remain uninsured. The same market forces that TennCare exploits and reinforces make it increasingly difficult for the uninsured to obtain charity care in the private sector. TennCare thus makes them more dependent than ever on the state's beleaguered public hospitals and on community health centers. Nonetheless, TennCare has terminated subsidies, effective in 1996, for the major public hospitals of last resort in Memphis and Nashville and for such health centers.

TennCare's turbulent implementation caused stress and suffering for many beneficiaries. There were localized disruptions of maternal and infant care, and TennCare's overall impact on pregnancy outcomes remains unclear.[20] However, even as the state and its contractors struggled to build the program, health care continued to be delivered, and the health care delivery system remained intact. There was a great deal of social inertia; patients continued to see the same providers and providers continued to render care, whether or not such care would be covered by TennCare.

By the end of 1994 TennCare had achieved an enrollment of 1.2 million, including a net FTE of 300,000 previously uninsured Tennesseans, half of whom were poor.[21] A telephone survey conducted by the University of Tennessee indicated that between private insurance and TennCare, 94.6 percent of the state's residents enjoyed some form of health care coverage, as close as any state had yet come to establishing universal coverage.[22] Moreover, TennCare had resolved Tennessee's budget crisis by controlling Medicaid expenditures and capping their rate of future growth. Program revenues were less than projected because of premium collection shortfalls and continuing disagreements with the Health Care Financing Administration (HCFA) regarding the amount of state funds that qualified for federal matching. However, these revenue discrepancies, $99 million in a total budget of $3.1 billion, were manageable within the existing state resources and did not require, as Medicaid had threatened to do, a major realignment of the state's budget.

Impact on the state's health care system. TennCare is forcing major change on the state's entire health care system. It has catalyzed the movement to managed care and the related reorganization of health care delivery across the state. By increasing the demand for primary care providers, the program prompted the legislature to remove long-standing legal barriers to the use of physician assistants and advanced practice nurses. There are anecdotal reports that in-

comes of primary care physicians with substantial TennCare patient loads have increased. TennCare has triggered reform of Medicaid funding for graduate medical education, to encourage the training of primary care physicians.[23] Twenty-four-hour clinics, offering a primary care alternative to hospital emergency rooms, have proliferated. TennCare has meant the termination of DSH payments to rural hospitals that were neither clinically nor financially viable and that had been maintained on "life support" with infusions of DSH money. The program thus has accelerated the restructuring of rural health care delivery in the state, with results as yet unknown.

Fee-for-service nursing home costs are outstripping overall federal spending caps contained in the TennCare waiver. A study committee is likely to recommend that nursing facility services be capitated as an integral part of TennCare, with the expectation that this will shift long-term care from institutions to home and community-based settings. By mid-1996, after several false starts, the state is planning to integrate behavioral health services (which, although never the subject of a formal carve-out, had continued to enjoy a separate state funding stream) into TennCare. For good or ill, these changes are certain to have a profound effect on traditional methods and systems of care.

An important measure of TennCare's success will be its political staying power. At the state level, at least, TennCare thus far has weathered the transition from a Democratic to a Republican administration, and proponents' invocation of market rhetoric well suits the new political climate. TennCare has been likened to *perestroika* in the former Soviet bloc: It is a reform process that, once initiated, is difficult to reverse. Indeed, like the "shock therapy" being administered to East European economies, the very chaos and dislocations that TennCare has produced confound those who would turn back the clock.

New Paradigm, New Paradox

TennCare remains a work in progress. Empirical data crucial to its evaluation are lacking, and careful analyses of its performance are years away. However, since some already cite TennCare as a model for other states, it is worth a closer look at the market conditions in Tennessee that gave rise to the program and the extent to which those factors exist elsewhere in the United States.

TennCare has reversed the central paradox of American health care: continuous increases in health care spending accompanied by an equally steady decline in the number of insured Americans. By controlling inflation while expanding coverage, TennCare has provoked widespread skepticism. Across a broad ideological spectrum, from the Heritage Foundation to the National Association of Public Hospitals, a number of analyses agree that TennCare can be little more than a conjuring trick, an extension of the old "creative financing." Those of more kindly disposition have regarded TennCare as a "miracle," implying that it cannot be replicated by others.[24]

Skepticism is fueled by the fact that Tennessee came late to Medicaid managed care. The state seems to be pursuing policies already tried elsewhere over two decades but claims to produce markedly different results. Moreover, some explanations offered by Tennessee officials and by Medicaid managed care apologists generally cannot remotely account for savings of the magnitude that TennCare apparently has created. For example, the purported diversion of Medicaid primary care patients from emergency rooms, or the cost efficiencies realized by managed care organizations' promotion of prevention, would not generate sufficient savings to expand the beneficiary population by a third, as TennCare has done, even if managed care organizations were actually managing enrollees' care.

Leveraging Medicaid funding. TennCare's initial financial success was neither a scam nor a miracle. Tennessee was indeed adroit at leveraging federal Medicaid funds through creative financing and at negotiating to incorporate those federal funds into the TennCare budget base. Even with such machinations, Tennessee still ranked in the lower half of states in federal Medicaid

spending per poor person.[25] Tennessee's very success in holding down its own "real-dollar" commitments to Medicaid meant that the total dollars available to implement TennCare were that much lower than would be at most states' disposal.

Using market forces to set rates. In broad terms, the explanation for how TennCare expanded coverage while controlling costs is that it reduced provider fees—primarily for hospital and specialty physician care—and used the savings to finance the expansion. The program accomplished that result by employing market forces, rather than traditional reimbursement methodologies, to set rates.

That is not to say that Tennessee's health care economy operates like a perfect market, or that TennCare relied on classical free-market processes such as competitive bidding to establish prices.[26] (Managed care organizations do compete, but in the marketing of their networks to beneficiaries, not in the prices they offer the state.) When it came to establishing the capitation rate, Tennessee simply set a price and allowed any managed care organization to participate that it deemed qualified and that was willing to accept that price. In this regard, TennCare behaved much like traditional Medicaid.

The assumptions that informed the setting of TennCare's rates were quite different, however, from the principles that guide conventional Medicaid reimbursement. TennCare exploited a number of favorable market conditions that prevail generally throughout the country.

Substantial excess capacity in the health care system. This is especially significant in the hospital sector, where national median occupancy of licensed beds is 47.3 percent, and of staffed beds, 69.4 percent.[27] Most of a hospital's expenses are fixed costs that are incurred whether a bed is occupied or vacant. The marginal cost of treating an additional patient in an otherwise vacant bed is but a fraction of the rate paid by even the most parsimonious of Medicaid programs. A bulk purchaser should be able to find vendors of hospital care willing to sell their services well below prevailing Medicaid rates, at prices only incrementally higher than marginal cost.

Purchasing advantages related to market share. Because of the fragmented nature of fee-for-service Medicaid expenditures and the variability of state programs, it is easy to overlook the clout Medicaid can wield when revenue streams are centralized and controlled through capitation. Medicaid is the second-largest U.S. insurer after Medicare. It is the largest purchaser of prescription drugs and long-term care, the most important source of funding for certain high-cost specialized services such as neonatal care, and a major buyer of every other service it covers.

However, this advantage reflects more than just the ability of any large buyer to negotiate for discounts on the basis of volume. It relates to the transformation of health care that is now under way in the United States. The health care system is rapidly moving from fee-for-service to capitation; individual providers are merging into integrated delivery systems; and managed care systems are jockeying for business in a newly price-sensitive market. In such circumstances, Medicaid is attractive to managed care companies, because it delivers a large, ready-made pool of enrollees that otherwise would take years of costly and uncertain marketing efforts to develop. With the "instant market share" that a Medicaid contract can provide, such companies enjoy important advantages in the scramble to build provider networks and compete for the more lucrative business of private purchasers. As a result, Medicaid business has a value to managed care networks that transcends the profit that such networks can realize from the Medicaid contract itself.

Sensitivity of clinical practice patterns to financial incentives. When payment is capitated, treatment patterns developed under fee-for-service reimbursement quickly shift to lower intensity and from high-cost to low-cost settings. Inpatient utilization and specialty physician care, which together account for more than half of acute care expenditures, drop markedly.

In short, these economic forces contain the makings of a "buyer's market" for health

care, at least for those buyers, such as Medicaid and Medicare, that account for a significant share of the market. When TennCare's designers set the average TennCare capitation rate at $101, a third below the corresponding national Medicaid average, they were betting on those forces to induce participation from contractors willing to accept the state's terms.[28] In fact, the sharply discounted rate did prove sufficient to attract the participation of an adequate number of networks, including the respected Blue Cross plan, Tennessee's largest.

Contrast with Medicare and Medicaid rate-setting policy. In the exercise of its oligopsony power, TennCare deviated sharply from Medicare and Medicaid rate-setting orthodoxy. Law and regulation, heavily influenced by the health care industry, have superseded economic dynamics and prevented the government from becoming a prudent purchaser of care. Medicaid, and the Medicare financial standards that it generally applies, accepts the premises implicit in the term *provider reimbursement*: inherent worth, just deserts, and moral duty. Whether in the legislation governing physician rates, the Boren Amendment guiding reimbursement of institutional providers, or "reasonable cost" principles applicable to certain primary care centers, Medicaid policy assumes that health services have an inherent value that it is the government's duty to pay. Rules of enormous complexity purport to guide the government's discernment of those values. However, wide variation in rates among different programs purporting to apply similar rules, and even within a given program over time, betray the essentially political nature of these policies.[29]

The "reimbursement" approach lives on in Medicare and Medicaid, even when those programs convert from fee-for-service to capitation. A 1982 statute mandates that Medicare HMO capitation payments equal 95 percent of local fee-for-service costs, known as adjusted average per capita cost (AAPCC). Medicaid managed care programs generally have applied the same standard.[30] Obviously, if government programs contract with managed care plans for only a 5 percent discount, the savings to government cannot exceed 5 percent. That begs the question of how much savings are captured by the HMOs, savings that might accrue to government if, like TennCare, it abandoned the 95 percent rule in favor of more aggressive price negotiations with managed care contractors.

Others Can Do It, Too

Utilization data suggest that HMOs' savings are substantial and that TennCare's financial success is replicable by other government programs. Tennessee's Medicaid fee-for-service hospital utilization ran between 1,100 and 1,200 days of inpatient care per thousand beneficiaries per year. At the end of TennCare's first year, Blue Cross/Blue Shield of Tennessee, which covers half of the TennCare population, reported a TennCare utilization rate of 750 days per thousand enrollees per year and projected an eventual rate comparable to the private TPN enrollee figure of 350 days.[31] (This initial decrease attests to the power of capitation's incentives to influence practice patterns, since Blue Cross conceded that it had yet to actually manage enrollees' care in any meaningful way.) Medicaid capitation in other states has produced similar reductions in utilization.

Given widespread reports of underservice and compromised access to care in Medicaid managed care plans, these figures should be treated with caution. However, data suggest that marked reductions in utilization attend capitation, even in private-sector HMOs where there is greater confidence in the adequacy of care. The average utilization rate for private HMOs was 296.8 days of inpatient hospital care per thousand enrollees per year in 1993.[32] Medicaid HMO utilization should approach that figure as well, except to the extent that there are differences between the health status of Medicaid beneficiaries and that of private HMO enrollees.

Such differences do exist, of course. Medicaid covers a predominantly low-income population with poorer health status and elderly and disabled beneficiaries who typically are excluded from private HMOs

because of their poor health. But Medicaid utilization statistics already adjust for most such differences. They exclude any inpatient days that are wholly or partially covered by Medicare, thereby discounting most of the hospital care received by the elderly and disabled.[33] The largest segment of the Medicaid population, and those most often enrolled in capitated plans, consists of children receiving Aid to Families with Dependent Children (AFDC). A conservative estimate of fee-for-service utilization by this subgroup averages between 1,000 and 1,100 inpatient days per thousand Medicaid enrollees. That is more than three times the private HMO rate, far more than can be explained by disparities in health status.[34]

Substantial reductions in utilization also occur among the elderly and disabled, as reflected in Medicare statistics. The Medicare fee-for-service utilization rate is approximately 2,560 days per thousand enrollees per year, compared with an average Medicare HMO figure of 1,352.[35] HMOs are believed to benefit from positive selection by healthier-than-average Medicare beneficiaries, so these figures may not precisely reflect the experience of Medicaid's sicker group of aged and disabled enrollees. Still, it is unlikely that a twofold difference in utilization between fee-for-service and capitated plans can be explained simply by positive selection. It is more probable that the same incentives that are driving practice patterns for other capitated populations are at work in this group. Given the much greater use, in absolute terms, of hospital care among the elderly and chronically ill, lowering their consumption yields even greater dollar savings than does reducing a healthier population's use by the same percentage.

There are continuing questions about whether one can extrapolate savings from private-sector capitated managed care to Medicaid or Medicare.[36] Given the vastly greater purchasing clout that those programs wield compared with private payers, such doubts seem more than a little ironic. The question should not be whether government programs can match private savings but rather, how far beyond the private sector should those programs go in demanding the savings that market forces are prepared to deliver. Are there social concerns for, say, the impact on health-sector employment or on sensitive elements of the health care infrastructure that should constrain government's exploitation of market forces? The TennCare experience, for all of its problems, suggests that the savings from capitated managed care are substantial and that they can be applied to our most profound health policy challenge: protecting the millions of Americans now without health insurance.

NOTES

1. See generally J. Holahan et al., "Insuring the Poor through Medicaid 1115 Waivers," *Health Affairs* (Spring 1995): 200–217; Health Care Financing Administration, *Special Terms and Conditions: Tennessee TennCare Demonstration*, Pub. no. 11-C-99638/4-03 (Baltimore, Md.: HCFA, 18 November 1993); U.S. General Accounting Office, *Medicaid: Spending Pressures Drive States toward Program Reinvention* (Washington: GAO, 1995); T. Coughlin and D. Lipson, *Increasing Insurance Coverage through Medicaid Waiver Programs: TennCare Case Study* (Washington: The Urban Institute, 1994); General Accounting Office, *Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future* (Washington: GAO, 1995); and D. Mirvis et al., "TennCare: Health Care Reform for Tennessee," *Journal of the American Medical Association* 274, no. 15 (1995): 1235–1241.
2. Congressional Research Service, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)* (Washington: U.S. Government Printing Office, 1993), 485–486.
3. J. Holahan and D. Liska, *State Variations in Medicaid: Implications for Block Grants* (Washington: The Urban Institute, February 1994), Figure 4. Poverty figures are based on numbers of people below 150 percent of the federal poverty line.
4. GAO, *Medicaid: Spending Pressures*, 18–19.
5. Holahan and Liska, *State Variations in Medicaid*, Figure 7; and CRS, *Medicaid Source Book*, 324.
6. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington: ProPAC, June 1995), 133.
7. Marion Merrell Dow, *Managed Care Digest: HMO Edition* (Kansas City, Mo.: Marion Merrell Dow, 1994), 31.
8. ProPAC, *Medicare and the American Health Care System*, 135.
9. Ibid., 115; and American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 1993 ed. (Chicago: AMA, 1993).
10. W. Cleverley, *The 1994 Almanac of Hospital Financial and Operating Indicators* (Columbus, Oh.: Center for Healthcare Industry Performance Studies,

1994), 233, 237 (1993 data).

11. Governor's Medicaid Task Force, "A Study of Medicaid in Tennessee" (Unpublished report, Nashville, Tennessee, 1982); and R. Dabbs, *Medicaid in Tennessee: Trends and Prospects* (Knoxville: University of Tennessee Center for Business and Economic Research, 1993). The effect of "creative financing" was to overstate actual inflation. After offsetting $541 million in provider taxes against increases in Medicaid payments to providers, the 1993 budget in "real" terms was approximately $2.25 billion.
12. CRS, *Medicaid Source Book*, 498–514.
13. Dabbs, *Medicaid in Tennessee*, 18–19.
14. N. McWherter, *TennCare: A Proposal for Health Care Reform* (Nashville: Tennessee Governor's Office, April 1993).
15. Tennessee Public Acts of 1993, Sec. 358.
16. GAO, *Medicaid: Spending Pressures*, 46.
17. Ibid., 45–51; and HCFA, *Tennessee TennCare Demonstration*, para. 16. The GAO has suggested that Tennessee's is the only Medicaid demonstration project that is budget-neutral.
18. Presentation of Thomas Kinser, chief executive officer, Blue Cross/Blue Shield of Tennessee, before the Citizens' TennCare Review Commission, 10 January 1995.
19. TennCare Monitoring Group, "TennCare: Issues for Implementation" (Unpublished report, Nashville, Tennessee, January 1995).
20. Preliminary data indicate that Tennessee's infant mortality rate declined during 1994 by 19.1 percent to 7.6 deaths per thousand live births, then rose by 17.1 percent in the first half of 1995 to 8.9 per thousand. TennCare covers approximately 50 percent of births in Tennessee. Tennessee Department of Health, *Vital Signs* (May 1995 and October 1995).
21. In 1993 one million Tennesseans received Medicaid coverage for some part of the year. Tennessee's monthly Medicaid enrollment was 800,000. Partial-year enrollees brought the FTE enrollment to 900,000. In 1994 TennCare enrolled more than 400,000 waiver eligibles, some of whom would have qualified under traditional Medicaid rules.
22. W. Fox and W. Lyons, "A Survey to Determine Insurance Status of Tennessee Residents" (Knoxville: University of Tennessee Center for Business and Economic Research, August 1994).
23. M. Garg, *TennCare and Support of Graduate Medical Education* (Nashville: Citizens' TennCare Review Commission, June 1995).
24. The Heritage Foundation, "TennCare: Health Care Reform Dream or Disappointment?" *Heritage Foundation State Backgrounder* (28 February 1995); National Association of Public Hospitals, *Assessing the Design and Implementation of TennCare* (Washington: NAPH, 1994); Tennessee Medical Association, *TennCare: Good Intentions Gone Bad* (Nashville: TMA, 1994); and S. Schear, "A Medicaid Miracle?" *National Journal* (4 February 1995): 294–298.
25. GAO, *Medicaid: Spending Pressures*, 18–19, Table 1.1 (1993 data).
26. By contrast, managed care organizations in Arizona's Medicaid equivalent compete on price. See General Accounting Office, *Arizona Medicaid: Competition among Managed Care Plans Lowers Program Costs* (Washington: GAO, 1995).
27. Cleverley, *The 1994 Almanac of Hospital Indicators*, 233, 237 (1993 data).
28. J.K. Iglehart, "Health Policy Report: Medicaid and Managed Care," *The New England Journal of Medicine* (22 June 1995): 1728.
29. CRS, *Medicaid Source Book*, 319–359.
30. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), sec. 114(a); U.S. Code, vol. 42, sec. 1395mm(a)(1)(C); and CRS, *Medicaid Source Book*, 1034. At least one state, Oregon, is using a managed care waiver to increase provider fees, in an effort to improve access to care.
31. Presentation of Kinser.
32. Marion Merrell Dow, *Managed Care Digest*, 24.
33. HCFA, *Statistical Report of Medical Care: Eligibles, Recipients, Payments, and Services, FY 93* (Baltimore: HCFA, 1994), Tables 17, 34. Medicaid is secondary to Medicare as a payer for hospital care for those who are dually eligible for both coverages.
34. Ibid. In 1993 Medicaid's 30.3 million FTE beneficiaries reportedly received 31.1 million days of inpatient care nationwide, for a utilization rate of 1,026 days per thousand beneficiaries. These figures understate utilization because of deficiencies in state statistical reports (including Tennessee's). Understatement also results from inclusion in the beneficiary total of enrollees who, because of membership in Medicaid HMOs or Medicare eligibility, did not actually receive Medicaid fee-for-service inpatient care. On the other hand, comparison with private HMO figures also is inexact because the private rates exclude some inpatient days (most notably, neonatal), which account for significant Medicaid utilization. Marion Merrell Dow, *Managed Care Digest*, 24. One estimate is that AFDC beneficiaries are 23 percent more costly for HMOs to insure than are commercial enrollees. W.P. Welch and M. Wade, "The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs," *Health Affairs* (Summer 1995): 212–223.
35. ProPAC, *Medicare and the American Health Care System*, 73.
36. Congressional Budget Office, *The Effects of Managed Care and Managed Competition* (Washington: CBO, 1995). The CBO acknowledges that some HMO models reduce utilization by as much as 22 percent and suggests policy changes that might enhance the ability of Medicare and Medicaid to reap larger managed care savings. However, the CBO apparently does not consider the savings potential inherent in government's enormous market share.