



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

Actuarial Review of Capitation Rates in the TennCare Program

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PRICEWATERHOUSECOOPERS 

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EXECUTIVE SUMMARY

PricewaterhouseCoopers LLP was retained by the Tennessee Office of the Comptroller to perform an evaluation of the actuarial soundness of the rates paid under the TennCare program. Our analysis was designed to answer several specific questions and to investigate certain issues:

- Are the rates paid to health plans actuarially sound from the perspective of payments to managed care organizations, including behavioral health organizations?
- Are the amounts retained by health plans for administrative expenses reasonable?
- Are payments to providers resulting from the TennCare capitation rates reasonable in comparison to other payers both within Tennessee and other state Medicaid programs?
- Are there areas where the methods used to determine the rates and the distribution of rates to health plans could be improved?
- How do TennCare's benefits, eligibility rules, and premium requirements compare to those for other payers and other state Medicaid programs?
- What has been the impact on the program of closure to the uninsured?
- What has been the impact on the program of inclusion of the uninsurable?

To assess the actuarial soundness of the capitation rates, we approached the question from several perspectives:

- Are the methods used for calculating the rates consistent with generally accepted standards?
- If the methods are not consistent with generally accepted standards, what is the likely effect of these deviations on the capitation rates?
- Regardless of the methods used for developing the rates, are health plans under financial stress as a result of participating in TennCare?

- Are providers under financial stress as a result of participating in TennCare?
- How do provider payment levels under TennCare compare to amounts paid by other purchasers in Tennessee?
- Because TennCare was designed in part to reduce the amount of charity care provided by hospitals, what is the level of charity care today compared to 1993 (the year before TennCare began)?
- Are there structural issues regarding the operation of TennCare that result in additional costs to MCOs and providers that are different from costs for other programs?

Our Approach

We structured our analysis to examine issues related both to the rate setting methods and the effect of the rates on health plans and providers. We also compared TennCare to other Medicaid programs. Specific methods we used included the following:

1. We reviewed the methods used by TennCare administrators to develop the capitation rates both at the start of the program and over the ensuing five years.
2. We reviewed financial statements filed by participating health plans with the Department of Commerce and Insurance to measure the financial effect of TennCare's payments on health plan financial viability.
3. We collected data from the TennCare Bureau and health plans regarding use of services and program costs.
4. We reviewed data from providers on payment levels and amounts of uncompensated care.
5. We surveyed other state Medicaid programs to provide a comparison to TennCare.

Conclusions

Our analysis was designed to assess whether the rates paid to health plans under TennCare are actuarially sound, and to identify areas for adjustment. It was also designed to determine whether health plans or providers appear to be under financial stress as a result of participation in TennCare. In addition, we investigated a number of operational issues and provided a comparison to other state Medicaid programs. We laid out a series of specific questions above that formed the framework of our analysis. Our conclusions related to each of those questions are provided below.

1. Are the methods used for calculating the rates consistent with generally accepted standards?

The methods used to develop capitation rates for TennCare are not consistent with generally accepted standards. We identified several methodological issues relating to the rate development process. Taken together, the items we identified would tend to increase the payment rates if the State did not make adjustments to the traditional fee-for-service program in the face of rising costs. However, we believe it is important to note that the methods used were explicitly chosen to assure that TennCare operates within its state budget limit. Changes in the methods will result either in increased costs to the State or reductions in the number of covered individuals. This reduction would, most likely, result in an increase in the number of uninsured and a commensurate increase in the amount of uncompensated care.

Items we identified include the following:

- Rates are based on an expectation of 12 months of enrollment, but derived from annual costs for shorter lengths of time.
- Adjustments have not been made to the rates to reflect changes in program rules imposed at the state or federal level.
- Changes in responsibility for behavioral health services have resulted in average adjustments to capitation rates across rate cells that do not reflect differences in use of these services.
- Capitation rates were reduced based on an expectation that uninsured individuals would enroll in TennCare; this reduction was not adjusted when the program was closed to the uninsured.

From the data available for this analysis, it is not possible to assess whether the initial capitation rate setting methodology for behavioral health organizations followed traditional actuarial guidelines.

2. If the methods are not consistent with generally accepted standards, what is their likely effect on the capitation rates?

We have identified several specific concerns with the methods used to develop the capitation rates. Our most substantive concerns relate to the population mix included in the primary rate setting categories and changes in eligibility rules over the years. The initial capitation rates for this group were developed strictly based on an Aid to Families with Dependent Children (AFDC) population. There are significant differences in costs between AFDC, uninsured and uninsurable individuals. While we understand the desire of TennCare administrators to pay a single rate for AFDC, uninsured, and uninsurable enrollees, this payment approach does not preclude a more precise calculation of the capitation rates.

We have not been able to quantify the likely effect of paying a single rate with no adjustments for changes in eligibility rules because data have not been available that separately report enrollment of individuals who are uninsured versus those who are uninsurable.

Two other areas with significant effects on the capitation rates are: 1) the use of average annual costs based on less than 12 months of eligibility spread over a full 12 month period, and 2) the reduction in rates to reflect expected decreases in the level of charity care that have not been subsequently increased.

We estimate that corrections to the rate methodology would result in increases in capitation rates ranging from 5% to 35%, with a best estimate of 20%. This wide variation results largely from two factors: 1) the effect of changing the method to calculate the number of months of eligibility for the program, and 2) assumptions regarding changes in trend rates and managed care savings.

Trend rate increases over the life of TennCare have been larger than those for other payers in Tennessee, most likely to accommodate the additional service requirements of the program. Most Medicaid managed care programs begin with an expectation of savings resulting from the use of managed care compared to fee-for-service delivery. No such savings expectations were explicitly built into the TennCare capitation rates. The effect of the mix of uninsured/uninsurable and charity care varied over time. In this table we show the estimated effect in 1998.

The following table provides a summary of these results.

Effect of changes in methodology on capitation rates in 1998				
	Adjustments	Low Estimate	High Estimate	Best Estimate
1.	Eligibility (exposure)	13%	26%	18.5%
2.	Incomplete claims	1%	2%	1.5%
3.	Benefit changes	5%	6.5%	5.8%
4.	Trend	(6.5%)	(5%)	(5.8%)
5.	Uninsured/Uninsurable & Charity Care	(1%)	5%	3%
6.	Managed Care Savings (after administrative costs)	(5%)	(1%)	(3%)
7.	TOTAL	5%	35%	20%
8.	TOTAL w/o Uninsured & Charity care effect	6%	30%	16.5%

In order to develop the above Best Estimate surplus/(deficit) of MCO capitation rates over the history of the TennCare program, we began with the methodology used in 1994 and analyzed the capitation rates going forward. The uninsured/uninsurable and charity care impact, shown above, represents a 1998 estimate; this amount will be adjusted in the analysis shown later in this section to show this impact over time. The Best Estimate of the deficit in 1998 due to the capitation rate methodology is 16.5%, or \$16 per member per month.

A separate analysis of the TennCare Partners program indicates that capitation rates paid to behavioral health organizations are currently between 6.7% and 13%, or \$1 to \$2 per member per month, below what would be considered the minimum rate acceptable for the plans to provide adequate service.

3. Regardless of the methods used for developing the rates, are health plans under financial stress as a result of participating in TennCare?

Our analysis of health plan financial statements shows that health plans are operating on a break-even basis on TennCare business when administrative costs are constrained to 13% of capitation payments. There has, however, been an apparent down-turn in recent financial results. Results for 1997 and year-to-date 1998 show that plans have moved from making a slight profit to a slight loss. We would expect that plan financial positions will continue to

deteriorate based on current capitation rates and the need to increase payments to providers.

Behavioral health plans are fairing slightly worse, with losses of 1% to 6% of capitation payments. Recent changes in the Partners program can be expected to improve the financial condition of these plans.

Our analysis did not investigate the actual health care delivery processes used by MCOs and BHOs to determine whether those processes are efficient or consistent with generally accepted standards of medical necessity.

4. Are providers under financial stress as a result of participating in TennCare?

Hospital payments under TennCare are significantly lower than those from other payers. The State has made large supplemental payments to hospitals every year since TennCare began. These payments cover some portion of the short-fall in provider payments.

Some specific types of providers are under significant financial stress. The rural acute care hospitals have shown increasing negative margins in their operations over the course of the program. These hospitals have few alternatives for enhancing revenue from other sources.

Physician payment levels under TennCare are approximately 34% of billed charges. While few health care purchasers pay billed charges, providers typically require 40% to 50% of charges to cover the cost of delivering care. Payments below the cost to deliver care result in cost shifting to other purchasers.

- Our analysis shows that on average hospitals are receiving payments that are approximately 72% of costs, when supplemental provider payments are considered.
- Physicians receive payments that are approximately 34% of charges. Physician costs of delivering care typically represent 40% to 50% of billed charges.
- Federally Qualified Health Centers receive payments that are 85% of costs.
- Mental health safety net providers have experienced significant losses under TennCare; the TennCare Bureau is in the process of implementing changes to the payment methodology to address these concerns.

5. How do provider payment levels under TennCare compare to amounts paid by other purchasers in Tennessee?

Hospitals in Tennessee receive payments for inpatient care from TennCare plans that are significantly below those from other payers. This is true even after adjusting for expected contributions by hospitals through reductions in charity care. As shown in the following tables for the Safety Net providers and general hospitals, TennCare per diem average reimbursement for inpatient care was approximately 40% of the commercial average. Even after adjusting for the 22% reduction for charity care and local government payments, these reimbursement rates are approximately 50% to 55% of the corresponding commercial levels.

Safety Net Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 936	\$ 1,200	\$ 2,238	\$ 2,304
1997	\$ 949	\$ 1,217	\$ 2,520	\$ 2,873
1998	\$ 971	\$ 1,245	\$ 2,426	\$ 2,941

All General Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 470	\$ 602	\$ 1,258	\$ 964
1997	\$ 479	\$ 614	\$ 1,312	\$ 1,109
1998	\$ 415	\$ 532	\$ 1,043	\$ 993

For general hospital outpatient services, TennCare reimbursements are closer in level to those of commercial and Medicare payments. For outpatient care, comparisons are measured in terms of reimbursement per claim. As seen in the following table, TennCare payments are approximately 50% – 55% of commercial levels; after adjusting for charity care, these payments are 65% – 70% of commercial average payments.

All General Hospitals – Outpatient Care

Year	TennCare Per Claim Reimbursement	TennCare Per Claim (Adj. For Charity Care)	Commercial Per Claim Reimbursement	Medicare Per Claim Reimbursement
1996	\$ 462	\$ 592	\$ 849	\$ 498
1997	\$ 434	\$ 556	\$ 847	\$ 472
1998	\$ 455	\$ 583	\$ 823	\$ 483

Comparable detailed information was not available regarding commercial payment levels for other services.

6. Because TennCare was designed in part to reduce the amount of charity care provided by hospitals, what is the level of charity care today compared to 1993 (the year before TennCare began)?

In developing the capitation rates for TennCare, the State assumed that charity care provided by hospitals would be reduced by approximately 46%. While charity care decreased in the early years of the program, the amount of charity care has returned to pre-TennCare levels. Two important questions must be addressed in evaluating the effect of charity care on provider payments under TennCare:

1. what is the most likely amount of charity care in 1999 in the absence of TennCare, and
2. have the costs of providing services to low-income populations been spread more broadly under TennCare.

We cannot estimate the likely level of charity care in the absence of TennCare. Estimates of the number of uninsured/uninsurable in Tennessee vary widely and a precise estimate was not available within the time provided for this analysis. We believe that the number of Tennesseans without insurance would have been higher had TennCare not expanded coverage to 400,000 uninsured and uninsurable individuals.

Our analysis shows that charity care decreased significantly at the time that TennCare started. More recently, charity care has returned to the levels seen in 1993. No adjustment was made to the capitation rates to reflect the decrease in available funding resulting from the change in the level of charity care. Reductions to the capitation rates to reflect expected decreases in the level of charity care implicitly spread the cost of providing that care across the entire state.

The specific payment amounts to hospitals appear to reflect a reduced payment amount per admission consistent with an expectation that total hospital payments would include both costs associated with traditional Medicaid enrollees and individuals who had previously been uninsured or uninsurable. Supplemental payments to hospitals provide extra revenue to cover costs. However, hospitals cannot be assured of receiving those payments on a year-to-year basis under the current funding approach.

7. Are there structural issues regarding the operation of TennCare that result in additional costs to MCOs and providers that are different from costs for other programs?

Medicaid managed care programs impose requirements on health plans that are different from those of other purchasers. Medicaid programs offer a broader range of benefits with fewer barriers to obtaining services. Health plans that are most familiar with serving commercial populations may need to make significant adjustments to their processes, data reporting and utilization review. These changes can require significant investments, but are typical of the needs of plans participating in Medicaid programs.

The results of our state survey show substantially similar benefits covered in all states. For items that comprise the majority of health plan costs (inpatient and outpatient hospital, physician and prescription drugs), all states provided full coverage without restrictions. Dental services did show some variation across states, as some programs have significant restrictions on services for adults, similar to TennCare.

A significant concern among TennCare MCOs is the EPSDT “consent decree”. Our survey shows that all states cover EPSDT services as required by law, but the degree to which the operation of the program results in an expansion of what is considered a covered service can not be determined from the information available. EPSDT expansions are a concern among health plans in all states.

The grievance and appeals procedure used in the TennCare program also causes additional administrative and medical costs to be incurred by health plans by requiring the coverage of services not included in health plan contracts. Our survey of other states shows similar grievance processes in those programs. Typically members must appeal their coverage decision through the health plan’s internal review procedures. If care is denied at that level, recipients can appeal their decisions either to the state or to some other external review organization. Information was not available for survey states, or for Tennessee, to determine the extent to which appeals are raised up to the state level and the extent to which additional services result from the appeals process.

Summary of results

TennCare health plans have generally broken even financially during the early years of the program. More recently, health plans in total show slight financial losses. TennCare capitation rates are low when compared to Medicaid programs in other states. Our analysis shows that reductions in charity care occurred in the early years of the program, but that those reductions have not been sustained.

Providers operating under TennCare appear to be under significant financial stress, and we would expect those providers to force higher payments from MCOs over time or withdraw from the TennCare program. We do not believe the current funding level can be sustained while ensuring adequate access to care.

In the following tables we summarize our results showing the net deficit in funding under three scenarios, including low, high and best estimates. The best estimate generally falls at the midpoint between the low and high estimates, with minor variations.

In these tables we begin with the capitation rates paid to the MCOs in row 1. We then estimate the funding deficit as calculated above, excluding the effect of the uninsured/uninsurable mix and changes in charity care levels (row 2). MCO and provider supplemental payments (rows 3 and 4) are added to the capitation payments to recognize total funding amounts. Row 5 shows our best estimate of the effect of the changing distribution of uninsured and uninsurables over time as the program has been closed to the uninsured. Because the uninsurable population is significantly more costly than the uninsured, this changing population mix has a negative financial impact on health plans. Finally, we estimate the effect of the changing charity care burden on providers (row 6). TennCare capitation rates were calculated based on an expectation of reductions in the amount of charity care that would be provided by hospitals concurrent with the enrollment of the uninsured in TennCare. Charity care decreased in the early years of TennCare, but has begun to approach pre-TennCare levels. This charity care is partially funded by provider supplemental payments. The total deficit is shown in the last row.

TennCare Summary of Surplus/(Deficit) – Low Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$6)	(\$6)	(\$6)	(\$6)	(\$6)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	\$0	(\$1)	(\$1)	\$0
6.	Estimated deficit due to charity care	N/A	\$0	(\$1)	(\$1)	(\$1)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	\$15	\$5	\$0	\$1	\$1

TennCare Summary of Surplus/(Deficit) – High Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$29)	(\$29)	(\$29)	(\$29)	(\$29)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	(\$2)	(\$3)	(\$4)	(\$4)
6.	Estimated deficit due to charity care	N/A	\$0	(\$3)	(\$3)	(\$3)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	(\$8)	(\$20)	(\$27)	(\$27)	(\$28)

TennCare Summary of Surplus/(Deficit) – Best Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$16)	(\$16)	(\$16)	(\$16)	(\$16)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	(\$1)	(\$2)	(\$2)	(\$1)
6.	Estimated deficit due to charity care	N/A	\$0	(\$2)	(\$2)	(\$2)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	\$5	(\$6)	(\$12)	(\$11)	(\$11)

Recommendations

We believe that the rates currently paid to MCOs are approximately \$11 per person per month lower than the amount that would be considered actuarially sound, and that an increase is required to keep the program viable. Alternatively, program rules should be changed to decrease the cost to providers and health plans of serving TennCare enrollees. A significant reduction was made in the capitation rates based on an assumption that charity care would be reduced. While a portion of this reduction was realized in the early years of the program, charity care levels appear to have returned to prior levels, and no adjustment has been made to the capitation rates to recognize this change. Adjustments have also not been made to reflect the changing population mix covered by the program, as TennCare was closed to uninsured adults, but uninsurable individuals remained eligible.

If a payment rate increase is implemented, it should be done in a manner that assures most of the additional funds will flow to providers. Our analysis shows that providers are being paid at rates that are significantly below their costs, and it is important that payment increases flow to those institutions and individuals. This can be accomplished by enforcing the minimum percentage of the capitation rate that is allocated for health care expenses, as compared to health plan administration. Average health plan results for the most recent two years also show net losses on TennCare business, and plans may need to retain a portion of any rate increase to cover those losses.

Based on TennCare Partners performance through 1998, we further believe that the capitation rates currently paid to BHOs are approximately \$2 per person per month lower than the amount that would be considered actuarially sound. Program modifications to be implemented this year should be considered in recommendations for capitation rates going forward in 1999.

We believe any increase in rates should be allocated to health plans and providers with the greatest responsibility for serving high cost TennCare members. This can be accomplished by adjusting capitation rates to more clearly reflect the population enrolled. Several methods are available: structuring rate categories to more accurately reflect expected costs, adjusting broad rate categories as the enrolled population changes, and health status-based payment. With more explicit capitation rate methods, the High Cost Condition (Adverse Selection) Pool could be incorporated directly into the capitation rates while assuring the funds are targeted to health plans and providers with a disproportionate share of high cost cases. The special payments should be included in the capitation rate methodology to assure on-going funding to health plans and providers.

The expectations of the TennCare program as they relate to charity care should be explicitly stated, and any adjustments to the capitation rates related to expected levels of charity care should be monitored and adjusted as appropriate. If an adjustment is made to the capitation rates to reflect an explicit level of charity care, it is critical that adjustment change if charity care levels change.

Significant changes have been recently implemented in the Partners program, and it is not yet possible to assess the effect of those changes. BHOs now have a reduced level of responsibility, and those changes can be expected to significantly improve the position of BHOs and community mental health providers.

We do not believe that changes in the benefit design of TennCare would have a significant effect on the costs of the program. The benefits offered under TennCare are standard for a Medicaid program. Improved communication between the TennCare Bureau, MCOs, and BHOs may decrease the number of problems that appear to exist currently in the relations between those entities.

The grievance and appeal process used by TennCare is not significantly different from the process used by Medicaid programs in other states we surveyed, and we do not believe changes are warranted in that general process.

Future monitoring

Going forward, the State may wish to develop processes for monitoring the appropriateness of the capitation rates paid to health plans and payments to providers. We believe the methods used in this report could provide a framework for monitoring the program. Evaluation of health plan financial statements, with appropriate adjustments, can provide an early indicator of health plan stress under the program.

Payments to providers could be monitored through an analysis of payment levels and review of charity care obligations. These analyses require significantly more resources, as data are not as readily available.

Specific analysis appears warranted in the following two areas:

- Cost estimates for uninsured and uninsurable should be developed separately. The capitation rates should be adjusted to reflect the actual population mix from year to year.
- Given the changes in place for the TennCare Partners program, the experience of that program should be monitored to ensure the program is actuarially sound going forward.

Finally, program participation levels provide the ultimate indicator of the adequacy of capitation rates. Decreases in the willingness of providers to serve TennCare members in the absence of any requirement to do so to participate in other programs should be seen as an indication of significant stress in the system. Our analysis showed stress among particular types of providers, and indications of cost shifting from TennCare to other purchasers through the use of below-market payment rates to providers. Those providers with limited ability to shift costs to other purchasers are under significant financial stress and may have a limited ability to continue to participate in the program.

Acknowledgements

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1. BACKGROUND

Intent of the TennCare program

Effective January 1, 1994 the State of Tennessee replaced its Medicaid Program with a new health care reform plan called TennCare. The TennCare program was created for two primary reasons: to slow the large growth in cost of the Medicaid program and to extend coverage to the working poor and other uninsured Tennesseans. Other goals at the program's creation included encouraging preventive care, providing continuity of coverage, and removing disincentives for Aid to Families with Dependent Children (AFDC) recipients to return to work.

TennCare extended health coverage to approximately 400,000 uninsured or uninsurable persons in addition to the 800,000 Tennesseans already in the Medicaid population. Coincident with the transition to TennCare, the scope of services covered by the program was expanded.

Funding for the additional populations and services comes from reduced costs through managed care arrangements as well as the recognition of funds spent by local governments and through charity care. In other words, the State pays the managed care organizations (MCOs) monthly rates that are lower than prior payments under the fee-for-service Medicaid program. Other funding for the TennCare program comes from cost-sharing and premium payments made by higher-income members on a sliding-scale basis.

The TennCare program was originally based around an overall enrollment cap of 1.3 million members; this cap was later increased to its current level of 1.5 million members. While there is no limit on the number of Medicaid or uninsurable eligibles that can be covered under the program, enrollment is closed to the uninsured population when total enrollment approaches the ceiling. Expenditure limits are also used to control costs. TennCare was seen as a means of providing health insurance to all individuals under the poverty level, but with strict budget limits.

In order to implement TennCare, the State of Tennessee was granted approval by the Health Care Financing Administration (HCFA) for a five-year demonstration project under Section 1115 of the Social Security Act. The initial five year demonstration project ended December 31, 1998; HCFA approved a waiver extension for three years, from January 1, 1999 through December 31, 2001.

TennCare services are currently offered through nine MCOs and two behavioral health organizations (BHOs) under contract with the State. The MCOs and BHOs negotiate payment rates with individual providers.

Enrollees have a choice of MCOs from those available in their geographic area; BHOs are partnered with the MCOs to serve all members choosing that MCO.

History of coverage

The TennCare program began on January 1, 1994, operating under an 1115 waiver. At its inception, the program contracted with MCOs for all physical health and certain behavioral health services. Other behavioral health services were carved out of the managed care program and were funded on a fee-for-service basis by the Medicaid program and by the Department of Mental Health and Mental Retardation. TennCare recipients were enrolled in managed care plans on a mandatory basis at that time.

The TennCare Partners program began on July 1, 1996, and covered all behavioral health services, including mental health related prescription drugs. The program contracts with Behavioral Health Organizations to provide necessary services. On July 1, 1997, a two-tiered structure was implemented in the Partners program. An enhanced benefit structure was created for “Priority” members, including those who are Severely and Persistently Mentally Ill (SPMI) and those who are Seriously Emotionally Disturbed (SED). This enhanced benefit includes case management services. The remaining “Non-Priority” population receives a reduced benefit package.

Also in the Partners program, the State resumed payment responsibility for seven types of behavioral health drugs on May 16, 1998 due to financial concerns surrounding the TennCare Partners program. On July 1, 1998 total responsibility for behavioral health drugs returned to the State; all other mental health services remained the responsibility of the BHOs.

The intent of the program is that MCOs and BHOs work collaboratively to provide all necessary physical and behavioral health services for each member.

Eligibility for TennCare

The TennCare program, due to its budget-based nature, opens or closes eligibility depending on the funds available to cover additional uninsured members. When enrollment approaches the pre-determined enrollment cap, eligibility is closed to new uninsured members. At initial program creation in 1994, demand for the program exceeded capacity in the State’s budget, and restrictions were implemented during the first year. Subsequent to that date, eligibility has been slowly expanded to several groups of uninsured children; coverage to uninsured adults has remained limited. Uninsurable adults are not subject to enrollment limits. A description of enrollment restrictions by eligibility group is as follows:

- **Traditional Medicaid eligibles and Medicaid eligibles losing eligibility without access to insurance.** Continuously eligible and not affected by enrollment caps.
- **Uninsurables.** Includes members who have a prior or existing health condition causing them to be uninsurable. Continuously eligible and not affected by enrollment caps or income restrictions.
- **Uninsured.** Includes members who are not eligible, either directly or as a dependent, for an employer-sponsored or government-sponsored health plan. Coverage was open at the start of TennCare if uninsured as of April 1, 1993. In October 1994, eligibility was reduced to members uninsured as of July 1, 1994 with incomes less than 200% of the Federal Poverty Level (FPL). In January 1995, enrollment was closed to new uninsured members.
- **Uninsured children without access to insurance.** Became eligible in April 1997 if under age 18; the age limit for this group was raised to age 19 in January 1998.
- **Uninsured children with access to insurance.** Became eligible in January 1998 if under age 19 and with family income under 200% FPL.
- **Individuals with limited coverage.** Became eligible in October 1994.
- **Individuals losing COBRA coverage.** Continuously eligible and not affected by enrollment caps.
- **Dislocated workers.** In May 1997 additional eligibility rules were added to allow uninsured workers to enroll in the event of plant or business closings. Members can maintain eligibility until insurance is available from other sources. Approximately 5,600 members have enrolled under this group since June 1997.

TennCare payments to plans and providers

As with most Medicaid managed care programs, TennCare pays participating health plans capitation rates equal to a pre-determined per member per month (PMPM) amount. Physical health capitation rates are paid separately for the following groups of members:

- Age 0 – 1,
- Age 1 – 13,
- Age 14 – 44 Female,
- Age 14 – 44 Male,
- Age 45 – 64,
- Age 65 and Over (without Medicare),
- Aid to Blind/Disabled, and
- Medicare/Medicaid Dual Eligibles.

Behavioral health capitation rates are currently split into two rate cells: those who are seriously mentally ill, and all other members. In 1999, the program expects to move to one comprehensive capitation rate for all members for behavioral health services.

In addition to these capitation payments, the State makes other “off-line” payments to health plans and providers. Some of these external payments are systematic, occurring every year in roughly the same amount; other payments are of a special, one-time nature.

2. OUR ASSIGNMENT

PricewaterhouseCoopers was retained by the Tennessee Office of the Comptroller to perform an evaluation of the actuarial soundness of the rates paid under the TennCare program. Our analysis was designed to answer several specific questions and to investigate certain issues:

- Are the rates paid to health plans actuarially sound from the perspective of payments to managed care organizations, including behavioral health organizations?
- Are the amounts retained by health plans for administrative expenses reasonable?
- Are payments to providers resulting from the TennCare capitation rates reasonable in comparison to other payers both within Tennessee and other state Medicaid programs?
- Are there areas where the methods used to determine the rates and the distribution of rates paid to health plans could be improved?
- How do TennCare's benefits, eligibility rules, and premium requirements compare to those for other payers and other state Medicaid programs?
- What has been the impact on the program of closure to the uninsured?
- What has been the impact on the program of inclusion of the uninsurable?

To assess the actuarial soundness of the capitation rates, we approached the question from several perspectives:

- Are the methods used for calculating the rates consistent with generally accepted standards?
- If the methods are not consistent with generally accepted standards, what is the likely effect of these deviations on the capitation rates?
- Regardless of the methods used for developing the rates, are health plans under financial stress as a result of participating in TennCare?

- Are providers under financial stress as a result of participating in TennCare?
- How do provider payment levels under TennCare compare to amounts paid by other purchasers in Tennessee?
- Because TennCare was designed in part to reduce the amount of charity care provided by hospitals, what is the level of charity care today compared to 1993 (the year before TennCare began)?
- Are there structural issues regarding the operation of TennCare that result in additional costs to MCOs and providers that are different from costs for other programs?

Overview

In assessing whether the capitation rates are actuarially sound, we believe it is useful to provide a framework for comparison. Standard methods exist for calculating capitation rates both for Medicaid and other insurance programs. These methods suggest the types of data that should be used for developing the rates and adjustments to the data that should be considered. In all cases, standard methods require a clear understanding of the program rules and population covered, and the resulting capitation rates should be sensitive to issues that could change the expected per person cost of program participants. Using these standard methods will yield an average cost per person per month, which should be interpreted as a point estimate within an acceptable range of variation. It is not correct to state that there is a single “right” payment level for a population, particularly for a group as complex as that covered by TennCare.

An important consideration in evaluating whether a Medicaid program is actuarially sound is whether health plans and providers are willing to participate in the program. Turnover among health plans or other actions that limit enrollment, such as a freeze on new enrollment, may indicate that payment rates are unacceptable, or that other aspects of the program are problematic. At the same time, the fact that plans and providers have participated to date is not in itself proof that there are no concerns with the payment levels. Both plans and providers may be willing to accept lower payments in the short run to gain market share for the longer run, or because they believe participation in programs for low-income populations is part of their mission.

The financial viability of health plans and providers is another indication of whether the rates paid are actuarially sound. Regardless of the methods used for developing the rates, health plan financial reports may show that payments for TennCare members fully cover program costs. Health plan financial

viability, however, may come at the expense of providers. If health plans are financially viable under the current payment structure this may be a result of paying below-market rates to providers. Methods for controlling utilization imposed by health plans may also affect health plan and provider financial viability. A health plan that tightly controls utilization may be able to operate with lower levels of funding than a plan that does not control utilization. A correct evaluation of utilization statistics requires that the health status of health plan enrollees be evaluated.

For a Medicaid program, it is important to note that the correct point of comparison for rates generally is not to commercial payment rates, but to Medicaid fee-for-service payments. Medicaid programs typically use a fee schedule for the fee-for-service program that results in payments that are significantly below those of commercial health plans. It is also important to consider the most likely scenario for providing services to Medicaid enrollees in the absence of TennCare. We believe Tennessee would have moved to a managed care program for Medicaid enrollees, consistent with national trends. The specific form of the program may, however, have been different.

Issues such as grievance procedures, benefit structure, and eligibility rules all enter into an evaluation of whether the rates are actuarially sound because they can affect the cost of providing care. More importantly, these issues provide a point of comparison to other programs and a means to assess the TennCare program in context. Medicaid programs typically provide a broader scope of benefits than do commercial health plans. In certain areas, coverage under Medicaid is significantly more extensive than is coverage for other population groups. For example, federal regulations mandate comprehensive coverage for rehabilitation services under the Early, Periodic Screening, Diagnosis and Treatment program. This program can result in virtually unlimited treatment for conditions that, under a commercial health plan, would be much more limited. Processes for reaching agreement between a health plan and a participant may also be different under a Medicaid managed care program compared to a commercial plan. These issues are relevant to assessing whether rates are actuarially sound, as payments to plans should specifically reflect expected use of services.

The unique structure of TennCare, which covers both traditional Medicaid eligibles as well as those who are previously uninsured or uninsurable, is also important to an evaluation of the capitation rates. Because TennCare has been open to the uninsured on only a sporadic basis, it is important to consider how these changes in eligibility for the program affect likely costs. A corollary to this issue is how inclusion of individuals who are uninsurable affects program costs. A portion of TennCare's funding was derived from an expectation of a reduction in the level of uncompensated care. Consequently, the effect of TennCare on providers should include an evaluation of the level of charity care both before and after implementation of the program.

Our Approach

We structured our analysis to examine issues related both to the rate setting methods and the effect of the rates on health plans and providers. We also compared TennCare to other Medicaid programs. Specific methods we used include the following:

1. We reviewed the methods used by TennCare administrators to develop the capitation rates both at the start of the program and over the ensuing five years.
2. We reviewed financial statements filed by participating health plans with the Department of Commerce and Insurance to measure the financial effect of TennCare's payments on health plan financial viability.
3. We collected data from the TennCare Bureau and health plans regarding use of services and program costs. Our evaluation did not include a detailed review of the utilization statistics and finding of medical necessity of health plans, as that evaluation was outside the scope of this report.
4. We reviewed data from providers on payment levels and amounts of uncompensated care.
5. We surveyed other state Medicaid programs to provide a comparison to TennCare.

Our analysis began with meetings between our staff and staff from the State of Tennessee, Comptroller of the Treasury, and the TennCare Bureau. We requested data from these individuals related to historical costs of the TennCare program, including data on health plan costs where available. Additionally, we held meetings with the managed care organizations, behavioral health organizations, provider associations and individual providers. A list of these organizations and groups is included as Exhibit 1. The purpose of the meetings was to gain an understanding of the TennCare program from a health plan and provider perspective as well as to discuss health plan and provider data available for our analysis.

We surveyed eight states to provide a comparison to the TennCare program. The states were selected either due to their geographic proximity to Tennessee or due to their common program features with TennCare such as mandatory managed care enrollment or the expansion of coverage to non-traditional Medicaid populations.

Finally, we reviewed MCO and BHO financial statement data for calendar year 1997 and the first three quarters of 1998. To gain a complete picture throughout TennCare's timeframe, we supplemented this data with State of

Tennessee audit reports and Department of Commerce and Insurance exhibits, as well as information contained in the 1998 Harkey Report.

Data collected from the State

Claims Data

Under the TennCare program, participating plans are required to submit encounter data to the State. In the development of this report, summary reports based on this information were requested from the TennCare bureau for the time period January 1, 1994 through June 30, 1998 or the most recent period available.

Due to constraints on data processing, the TennCare Bureau was able to provide historical data only for the 9-month time period of January 1, 1997 through September 30, 1997. Data was provided for MCO and BHO contractors. However, since plans do not uniformly report services that are covered by subcapitation, the State estimates that the data provided may be under-reported.

Financial Statements

The State also provided financial information on 11 MCOs. This information included calendar year 1997 financial statements as well as consistent information on the first nine months of 1998. The 1997 statements included 5 years of historical information.

Four of the TennCare MCOs changed their corporate reporting over the period studied. UT (University of Tennessee) Health Plan in Knox County was purchased by Blue Cross and Blue Shield of Tennessee. The two Volunteer Health Plans (Blue Cross Blue Shield of Tennessee) merged in 1998. Phoenix Healthcare purchased Tennesource on December 21, 1996. On November 30, 1997, Phoenix purchased Health Net TNCare HMO.

Financial statements were received from the Department of Commerce for the following 11 organizations:

- Volunteer State Health Plan (a subsidiary of Blue Cross and Blue Shield of Tennessee),
- Volunteer State Health Plan East (a subsidiary of Blue Cross and Blue Shield of Tennessee),
- Tennessee Managed Care Network d/b/a Access...Med Plus,
- Phoenix Healthcare of Tennessee,
- Health Net TNCare HMO (purchased by Phoenix Healthcare of Tennessee effective 11/30/97),
- Preferred Health Partnership,

- Memphis Managed Care Corp. d/b/a TLC Family Care,
- OmniCare Health Plan,
- Heritage National HealthPlan d/b/a John Deere Health Plan,
- Vanderbilt Health Plans, and
- Prudential Health Care Plan.

The Comptroller’s office also provided the following supplemental reports for MCOs that had missing financial statement information:

- State of Tennessee audit reports, and
- Department of Commerce & Insurance, Exhibits on Adjusted MCO Results.

An additional report, the 1998 Tennessee Managed Care Report (The Harkey Report), produced by Harkey & Associates, was also used in this analysis. (This report was procured directly from Harkey & Associates, not through the State.)

Data collected from MCOs — physical health

A request was sent to all TennCare health plans asking for summarized claims data similar to that requested from the State. As shown in the table below, seven plans submitted data, although most plans only had information for the most recent two fiscal years. One plan submitted data for the entire period requested.

HEALTH PLAN	FY94	FY95	FY96	FY97	FY98
BC/BS of Tennessee				✓	✓
Heritage/John Deere				✓	✓
Memphis Managed Care/TLC				✓	✓
Phoenix Healthcare of Tennessee	✓	✓	✓	✓	✓
PHP of Tennessee				✓	✓
Prudential Healthcare				✓	✓
Vanderbilt Health Plan				✓	✓

Data regarding Behavioral Health Organizations

The Tennessee Department of Health has engaged William M. Mercer, Incorporated to investigate the actuarial soundness of the proposed funding for behavioral health organizations for the period January 1, 1999 through June 30, 2000.

Our analysis used the results of that study as a starting point. Because we relied on a secondary report for this portion of our work, we carefully reviewed that report to determine whether the conclusions drawn appear to be consistent with other available information. We obtained data similar to that used in the Mercer report. Separately, we assessed the assumptions made and tested some revisions to the assumptions based on our experience with other state Medicaid programs. Our analysis focused on the following issues:

- Do we agree with the methodology employed?
- Do we agree with the findings of the report?
- Does the report agree with other data findings of our study?
- How are the key issues addressed-such as pharmacy costs and SPMI care versus the care of the remainder of those needing behavioral care services?

Data collected from providers

Hospitals

Individual hospitals submitted statistics on charity care and TennCare reimbursement levels. Hospital associations also provided extracts of their data regarding:

- Levels of charity care, and
- Hospital reimbursements versus cost.

The following supplemental survey information was collected from safety net and general hospitals for high-volume services:

- Reimbursement from MCOs over time, and
- Reimbursement levels under TennCare versus other payers.

Physicians

The following information was collected from physician practices:

- Amount of TennCare billings and TennCare percent of business,
- Amount and percent of TennCare billings collected,
- Amount and percent of billings written off as charity care,
- Administrative costs, and
- TennCare services average days in account receivables.

Survey of other states

We surveyed eight states regarding specific aspects of their Medicaid managed care programs. Seven of the states agreed to participate in a survey for this report. The states that agreed to participate are:

- Georgia,
- Illinois,
- Kentucky,
- Minnesota,
- Oregon,
- Virginia, and
- Washington.

Information was gathered from these other programs regarding eligibility criteria for Medicaid benefits, the extent of managed care enrollment, market share of the Medicaid managed care organizations, payment rates to managed care plans and providers, covered benefits and administrative procedures. A copy of the survey and the results are included as Exhibits 2a, 2b and 11.

3. ANALYSIS OF CAPITATION RATES AND ISSUES AFFECTING HEALTH PLANS

Description of standard rate setting methods

Capitation rates in Medicaid managed care programs are usually constrained by the Health Care Financing Administration (HCFA) “Upper Payment Limit,” which is described as the fee-for-service equivalent cost of providing services to an actuarially equivalent population. In other words, the capitation rates can be no higher than what would have been paid had the State maintained a fee-for-service delivery system.

The general approach for calculating capitation rates and Upper Payment Limits involves summarizing relevant historical Medicaid fee-for-service data by service category for each capitation rate cell. Rate cells usually include eligibility category, region and/or age. Corresponding months of historical eligibility are also summarized by rate cell, and preliminary per member per month costs are calculated by dividing these claims by eligible months in each rate cell.

To these preliminary per capita costs would be applied several adjustments, including trend, incurred but not reported (IBNR) claims, prescription drug rebates, benefit changes between the data and contract periods, and other adjustments required by the specifics of the state program, to arrive at a final set of capitation rates.

- **Trend and IBNR.** Since the historical data used for rate setting is typically at least one year old, trend adjustments must be applied to project the claims forward into the contract period. Trend rates are typically calculated separately for several broad service groupings, such as: inpatient, outpatient, professional, pharmacy, and miscellaneous. Trend rates can also be calculated separately for members with and without Medicare coverage due to the differing nature of claims covered by Medicaid for the two population groups. The calculated trend rates are typically compared to other state information regarding program changes during the data period to evaluate any anomalies.

IBNR adjustments are applied to “gross up” historical data to cover claims incurred during the historical data period but that have not been processed through the state Medicaid Management Information System (MMIS).

- **Drug Rebates.** Historical paid claims are reduced to account for the amount that the state recoups in the form of prescription

drug rebates. Once rebates are applied, the capitation rates reflect the state's net cost for pharmacy services.

- **Benefit Changes.** There is often a difference between the benefit package in place during the historical data period and covered benefits during the contract period. Adjustments are made to the capitation rates to most accurately translate the historical data to the updated benefit package. These adjustments are frequently specific to certain rate cells, such as the addition of prostate screening exams, which would affect older male members, or recent regulations requiring 48-hour maternity stay coverage, which would affect women of child bearing age and their newborns.
- **Other Adjustments.** Each state has unique adjustments that must also be applied in the rate development process. Examples of these other adjustments include claims that are not paid through the state MMIS that must be added into the cost structure, or changes in the population served by the program resulting from external state actions such as a reduction or expansion in eligibility rules.

The above process results in capitation rates that are equal to the HCFA Upper Payment Limit (UPL), also known as the fee-for-service equivalent cost (FFSE). Many states also opt to apply managed care savings adjustments to set capitation rates at a level below the UPL. Managed care savings can be developed at the aggregate level (e.g., 95%) or can be estimated by service category due to managed care shifts from institutional to ambulatory settings.

Calculation of initial TennCare rates

1115 Waiver

Costs for the TennCare program were initially set by the TennCare Bureau in 1993 using historical Tennessee Medicaid claims that were incurred during federal fiscal year 1992 (October, 1991 – September, 1992). These initial calculations, as presented in the waiver documents, were segregated among 576 rate cells (12 regions and 48 age/sex/aid category groups). Non-covered services were removed from the historical claims data. The resulting claims costs were divided by the corresponding months of eligibility to arrive at the initial per member per month (PMPM) cost estimates used in the TennCare 1115 waiver.

These cost estimates were averaged across all rate cells and multiplied by 12 to arrive at the final annual costs per member used in the waiver. This annual cost was then aggregated across the projected 1,775,000 TennCare enrollees to arrive at the total TennCare budget. [The original 1115 waiver included

total enrollment of 1,775,000 members. Subsequent State budget limits reduced this figure to 1.3 million at the start of the program; the enrollment cap was later raised to its current level of 1.5 million members.]

Included in the waiver is a projection that TennCare per member per year costs would increase at a rate of 5%.

These estimated TennCare medical costs were balanced in the waiver by funding from several sources, including the Federal government, state Medicaid funds, amounts already spent in the medical community on charity care, local government funds and cost sharing by higher income participants.

A fundamental component of the design of TennCare is the “budgetary” nature of the program. When enrollment reaches the pre-determined limit, eligibility is closed to new uninsured members to limit program spending.

Capitation rates – MCOs

To develop the capitation rates to be paid to health plans, separate calculations were undertaken in late 1993. The calculations included in the 1115 waiver show the total per capita costs under the program; funding sources, including charity care and local government funds, are listed as balancing factors against the projected medical costs to show budget neutrality. Capitation rates, however, are calculated as the projected medical cost minus offsetting funds from charity care and local governments. In other words, capitation rates reflect the projected spending by traditional Medicaid sources (State and Federal government), spread out over the entire TennCare membership.

These capitation rates were calculated using updated claims data that were incurred during calendar year 1992 (waiver calculations had used federal fiscal year 1992 information). At this time the number of rate cells was compressed into the following eight statewide age/sex/aid category groups:

Less than One Year of Age	Age 45-64
Age 1-13	Age 65 and Over
Age 14-44 Male	Aid to Blind and Disabled
Age 14-44 Female	Medicare/Medicaid Duals

These updated capitation rates were calculated by first summarizing calendar year 1992 data into the above rate cells. To these paid claims were added capital expenditures, as well as direct and indirect medical education costs. These total costs were trended forward to 1994 at a rate of 5.5% per year. An increase of 1.7% was also applied to the Medicaid-Only population based on the TennCare Bureau’s global budget estimates.

These trended claims were then divided by the number of eligible members to arrive at a cost per eligible per year; this rate was then divided by 12 to arrive at the preliminary cost per eligible per month. This calculation methodology represents a departure from the methods used in developing costs for the 1115 waiver.

The charity care and local government contributions included in the waiver as funding sources were included in the capitation rate calculation as reductions to the monthly costs. In the TennCare waiver these funds were estimated at the aggregate level. Total charity funds were estimated as 5% of total annual health care costs in Tennessee, both public and private. This amount is equivalent to 46% of recorded charity care amounts or \$595.5 million per year. Local government contributions were estimated at \$50 million per year. Historically, these local government funds were expended in certain geographic areas; the TennCare program spreads these funds across the state by making a single uniform adjustment to all rates.

Each of these offsets was translated into per member per month amounts by dividing by the total projected TennCare eligibles (1,775,000 people in the initial waiver estimates) and dividing by 12. The resulting charity care and local government offsets were \$27.96 PMPM and \$2.35 PMPM, respectively. Taken together, these offsets total \$30.31 PMPM, or 22% of the average monthly cost for all eligibles projected in the waiver. To translate this reduction to the individual capitation rate cells, this 22% reduction was applied to each cell to arrive at the final, or “net” capitation rates for the program.

For higher-income uninsured/uninsurable members that must pay a deductible and coinsurance under TennCare, an additional reduction is made to the capitation rate otherwise payable to recognize the offset resulting from the cost-sharing requirements. The capitation rate paid to health plans is calculated as follows:

$$\text{Capitation Paid to Plans} = [\text{Capitation Rate} - (\$250 / 12)] * 98\%.$$

In other words, the monthly capitation rate is reduced by one-twelfth of the \$250 deductible; the resulting value is multiplied by 98% to recognize the 2% coinsurance to be paid by the participant.

Capitation rates – BHOs

In July 1996 the TennCare Partners program was created to serve the behavioral health needs of the TennCare population. Initially, one capitation rate was calculated for all members, regardless of age or eligibility category. This capitation rate was calculated as \$21.84 PMPM, and it was comprised of three funding sources:

1. \$7.53 to be removed from the MCO capitation rate for services no longer provided by the health plans,
2. additional funds previously paid by the State on a fee-for-service basis for inpatient hospital and community mental health centers, and
3. funds for services that had been provided by the Department of Mental Health and Mental Retardation.

In July 1997, this rate structure was changed to include one fixed rate for Priority (SPMI/SED) members and a “floating” capitation rate for all other Non-Priority members. The floating capitation rate was calculated as the monthly TennCare behavioral health budget, minus amounts paid for Priority members, divided by the number of Non-Priority members.

Analysis of actuarial soundness – TennCare capitation rates

The methods used to calculate the initial capitation rates as described above contain certain calculations and features that do not follow standard actuarial practice. These items are discussed in detail below.

Historical claims data used

Waiver cost estimates and the capitation rates for the TennCare program were based on one year of historical claims data. Standard capitation rate setting methodologies use two years of claims data to reduce the impact of any anomalies that could have occurred during the data period. The size of the Tennessee Medicaid program negates in part the concern over using one year of data.

Typically, states recalculate capitation rates each year using updated fee-for-service data in order to ensure that the rates most closely reflect the underlying fee-for-service experience. Fee-for-service costs change over time due to inflation, changes in medical technology and changes in provider practice patterns.

In Tennessee, the capitation rates were developed once, using calendar year 1992 data. Once members are fully enrolled in managed care plans, recalculating rates using fee-for-service data is not possible. However, since TennCare members were enrolled in managed care plans starting in 1994, the rates could have been recalculated for the program’s second year using updated information from calendar year 1993. Some states have also begun to use health plan encounter data as a substitute for fee-for-service data in the rate setting process.

Costs per member per month

The TennCare capitation rates were calculated as the cost per eligible per year divided by 12. The division by 12 was explicitly chosen by the Bureau because it was assumed that members under TennCare would be enrolled in the program for 12 months, instead of the 5 – 10 months on average experienced during the historical data period under traditional Medicaid. However, this change implicitly assumes that members would incur no additional claims in the extended eligibility period. In other words, the division by 12 spreads the same historical fee-for-service cost over a longer period of eligibility.

Standard actuarial practice would dictate calculating the PMPM costs by dividing appropriate historical claims by member months of eligibility. A member enrolled for the full year would be counted as having 12 member months; a member enrolled for only half of the year would have 6 member months. Once accurate monthly costs are calculated, the estimates of aggregate costs or budget requirements would then account for the anticipated 12 months of enrollment by multiplying the PMPM cost by 12.

More refined calculations regarding the cost of longer lengths of eligibility can also be performed. For example, members who are eligible as a result of pregnancy have a large portion of their costs included in a measurable event, namely the cost of prenatal, delivery and postnatal care. When eligibility is lengthened for these members, their total costs over the course of the year do not increase proportionately, but rather their high level of fixed costs are spread out over a longer time period. The resulting PMPM cost for these members could decrease depending on the length of additional eligibility. Certain other service costs also tend to be spread over long periods of time, such as costs associated with surgery and some high-cost dental services. For most members, however, one would expect to see an increase in annual costs that is roughly proportionate to the increase in eligibility.

Based on the information presented in the TennCare 1115 waiver, the traditional Medicaid eligibles, upon whom the monthly costs are based, had average lengths of eligibility in fiscal year 1992 as shown in the following table. Because the per capita cost for these eligibility groups varies, the effect of this assumption on the capitation rates is less than the average 31% shown in the table. We have calculated a weighted average value to estimate the true effect of the method used for developing the capitation rates.

Eligibility Category	FY1992 Average Length of Eligibility (months)	Impact on Capitation Rates of 12-month Assumption
Blind/Disabled	9.8	-18%
Dual Eligibles	10.3	-15%
AFDC & Related, non-Medicare Aged	7.6	-37%
Average	8.3	-31%
Weighted Average	8.3	-26%

Trend and IBNR

The initial capitation rates were developed assuming a 5.5% annual trend rate, even though the TennCare waiver states that historical trends in the Medicaid program were 8.3%. While it appears that this 5.5% rate was selected as an aggregate value, there is insufficient documentation to determine the exact methods used. The estimated increase in annual costs put forth in the waiver was 5.0%.

A common actuarial method used in the calculation of capitation rates involves an examination of 24 months of historical per member per month costs to estimate trends. A regression analysis is performed on the 24-month data set to determine the actual trend experienced during the historical data period. Frequently these trend rates would be analyzed for several major service categories, as decreases in one area (e.g., inpatient) can lead to increases in another (e.g., outpatient). The historical trends would be evaluated against known past events and anticipated future events to determine their applicability to future rate periods. An evaluation of market changes in commercial premiums can also be added to anticipate future trends.

In the development of capitation rates, the 5.5% trend rate was applied to historical cost data from calendar year 1992 as well as Capital, Direct Medical Education and Indirect Medical Education. This calculation assumes that funding for these additional amounts would also increase at 5.5% over time.

No explicit incurred but not reported (IBNR) adjustment was made to the calendar year 1992 data to gross up the reported amounts to their estimated full level. Given that there was approximately 6 months of claims payment runout, the IBNR amount would likely have been 1% – 2% of reported claims.

Benefit changes

It does not appear that adjustments were made in the capitation rate calculation to reflect benefit expansions that occurred coincident with or since the implementation of TennCare. For example, the Medicaid program in place in 1992 (the historical data period) had limits on the use of certain services, such as:

- 30 outpatient hospital visits/year,
- 24 physician office visits/year,
- 30 radiology visits/year,
- 7 prescriptions/month, and
- 60 home health care visits/year.

Under the TennCare program, these and other benefit restrictions were removed; participating health plans were required to provide full coverage for the above services. However, the capitation rates were not modified to account for the additional cost of providing these services.

Other changes in benefits, payment arrangements and interpretation of coverage, such as 48-hour maternity coverage, the EPSDT “consent decree” and the pre-TennCare payment reductions on inpatient stays over 20 days, have been implemented or changed in the course of the TennCare program. Typically, when significant state or federal legislative changes are enacted, the fee-for-service equivalent cost of the services is estimated, and capitation rates are increased (or decreased) accordingly.

In addition to benefit expansions, certain services covered by MCOs were not reported in the State’s Medicaid Management Information System (MMIS), and were not included in the capitation rate calculation. These services include speech and hearing services, which were covered by another state agency in 1992, and non-emergency transportation.

The impact of these benefit expansions is approximately a 5% to 6.5% increase in expected costs.

Deductible reduction

For the new uninsured/uninsurable groups, members with incomes over 100% of the Federal Poverty Level (FPL) are required to pay monthly premiums as well as a \$250 annual deductible and coinsurance that ranges from 2% to 10% based on family size. For these members, capitation rates are reduced to reflect the amounts that the MCOs will collect directly from participants.

According to conversations with TennCare staff, this deductible and coinsurance offset was calculated in the following manner (2% coinsurance is used in this example):

$$\text{Capitation Paid to Plans} = [\text{Capitation Rate} - (\$250 / 12)] * 98\%.$$

The treatment of the deductible in this calculation makes two assumptions that overstate the level of the reduction. First, the deductible offset should account for the likelihood of each member using services in excess of \$250 during the year. The starting capitation rate is calculated as the average claims cost over a large number of members. The members covered by the historical data have a broad profile of claims use; some members' monthly costs are well in excess of the calculated average, while other members use little or no services. Hence, the capitation rate is inherently lowered by these non-utilizing members. Therefore, the deductible offset must take into account the likelihood of exceeding the \$250 limit so that impact of the low-cost members is not "double counted" in the overall rate methodology.

Second, in dividing the deductible by 12, the calculation assumes that all members are eligible for 12 months. This may not be true in cases where a family member becomes employed and obtains insurance from another source, or in the case where a member is disenrolled due to non-payment of premiums. A more accurate calculation would account for actual or predicted average lengths of enrollment for the new eligible groups. If the average length of eligibility is less than 12 months for members subject to cost sharing, the probability of their exceeding the \$250 deductible is further reduced.

If the average length of eligibility for these members is in fact less than 12 months, the formula above should be further modified to divide the deductible by the actual average length of eligibility for members with cost sharing. This change would increase the deductible reduction, partially offsetting the modifications for the probability of exceeding the deductible. The correct formula for the cost-sharing offset would then be:

$$\text{Capitation Paid to Plans} = [\text{Capitation Rate} - (\$250 * P / L)] * 98\%.$$

P = probability of exceeding the \$250 deductible during period of enrollment

L = average length of enrollment for members with cost sharing.

Behavioral health carve-out

In July 1996, MCOs were no longer responsible for providing the behavioral health services that were previously covered under their contracts. The State estimated that the portion of the MCO capitation rate covering behavioral

health services was, on average, \$7.53. However, in reducing MCO capitation rates for the reduction in services, this \$7.53 was uniformly deducted from each capitation rate cell without adjustment.

Examining specific behavioral health costs in other states shows that these costs are not distributed evenly by age or eligibility status. For example, children under age 1 rarely use these services. Costs in Oregon for full mental health and chemical dependency services (excluding behavioral health drugs) average \$0.06 PMPM for children under age 1. At the other end of the spectrum, Blind/Disabled members in Oregon (both with and without Medicare) have MH/CD costs that are approximately \$110 PMPM. Costs for TANF and uninsured/uninsurable adults range from \$10 to \$40 PMPM.

TennCare MCOs with disproportionately high enrollment of children at the time of this adjustment received rate reductions that were too large, resulting in significant underpayments; MCOs with large Blind/Disabled or Medicaid-Only adult populations received a windfall due to the insufficient funds removed from their rates. The following table shows that the distribution of members is not consistent among plans, and hence this uniform behavioral health carve-out did cause “winners” and “losers” among the health plans.

As an example, for Blind/Disabled, Prudential has the lowest proportion of these members with only 2% of their population in this group. Vanderbilt, on the other hand, has the highest proportion of Blind/Disabled members at 19%. For a plan such as Prudential with a low proportion of disabled members, the \$7.53 reduction resulted in a deduction that was too high, on average. For a plan such as Vanderbilt with nearly 20% of its members in the disabled group, the uniform \$7.53 reduction was probably too low overall.

TennCare FY97 Distribution of Members by Plan and Rate Cell						
	BC/BS	Heritage	PHP	Phoenix	Prudential	Vanderbilt
Age 0 – 1	2%	4%	3%	7%	3%	8%
Age 1 – 13	28%	26%	26%	27%	35%	30%
Age 14 – 44 Female	20%	22%	21%	24%	30%	21%
Age 14 – 44 Male	11%	11%	11%	10%	12%	6%
Age 45 – 64	8%	8%	8%	7%	11%	3%
Age 65+ Non- Medicare	1%	2%	1%	1%	5%	1%
Blind/Disabled	15%	12%	15%	12%	2%	19%
Dual Eligibles	16%	14%	16%	12%	2%	12%
Total	100%	100%	100%	100%	100%	100%

* FY97 eligibility data contained the largest representation of TennCare members from the data reported by health plans for this study.

While the \$7.53 cost may have been the correct average amount to deduct for the behavioral health carve-out, its uniform application does not reflect the underlying service use of the population groups affected, and health plans are not equally affected.

New eligibles

A fundamental goal of the State’s 1115 waiver was to provide health insurance coverage to a larger portion of the State’s residents, beyond what was covered by the traditional Medicaid program. Specifically, the program was expanded to cover two groups of new members: the uninsured and the uninsurable.

When the capitation rates for the TennCare program were developed in 1993, specific data for these new population groups were not readily available since the new members, by definition, lacked insurance. In using historical Medicaid data to set the capitation rates for these members, an assumption was made that these members would have similar cost structures and overall

costs as the members previously covered by Medicaid. While this assumption may be acceptable for the uninsured members, it is highly probable that the uninsurable, even those who are not classified as Disabled, will have a higher average cost than the AFDC-type members that largely comprised the historical database from which rates were developed.

In fact, an analysis of data from a participating TennCare MCO shows that while the uninsured group has average costs that are 19% lower than the traditional Medicaid-Only (non-disabled) population, the uninsurable group incurs costs that are 55% higher, as shown in the following table. [Only one participating plan submitted data in a format amenable to this analysis of uninsured and uninsurable costs. Information from other health plans may produce different results. Our experience in other states indicates that these figures are reasonable; we have seen costs for the uninsurable in other programs that are twice as high as the TANF population.]

Eligible Group	FY97/FY98 PMPM	Ratio to Medicaid Only
Medicaid Only*	\$69.73	1.00
Uninsured	\$56.56	0.81
Uninsurable	\$108.13	1.55

* Includes non-disabled, non-dual eligible members.

An actuarially sound calculation of capitation rates would have used other available data sources to estimate the cost profile for the new members. For the uninsured, commercial rates could be examined in combination with historical AFDC data to estimate costs. For the uninsurable, the experience of the Tennessee Comprehensive Health Insurance Pool (TCHIP), the State’s high risk pool could have been used to estimate costs.

In using AFDC or other traditional Medicaid data, adjustments could also be made on a service-category specific basis to more closely model the costs of the new population groups. For example, the Medicaid population in 1992 is likely to have had a higher proportion of maternity cases than the new uninsured/uninsurable groups to be added. Costs for these services could be reduced in the projection; costs for other services could have been adjusted upward based on external data or to account for “pent-up demand” for services such as dental or vision.

The TennCare program made a policy decision to pay a single capitation rate for all members, regardless of uninsured/uninsurable status. A theoretically correct calculation would have estimated the underlying cost of each identifiable subgroup of members based on the best available data for each group. Once baseline costs are estimated, a blending of rates could be performed to meet policy objectives regarding the specific capitation rate cells

used. This approach would facilitate making changes in the average capitation rate when significant changes in eligibility and enrollment occur.

Managed care savings

Many state Medicaid programs make explicit reductions of 5% – 10% to the per member per month costs developed from historical data under the assumption that managed care plans are expected to reduce costs compared to the fee-for-service program. Plans achieve these savings through utilization controls that direct patients to primary care physicians and other outpatient providers and away from emergency rooms and inpatient hospital settings.

The managed care savings adjustment serves two purposes. Some states use this adjustment as a means to control or reduce program costs. This adjustment also provides a “buffer” so that in total, program expenditures will not exceed the fee-for-service equivalent cost or Upper Payment Limit.

The TennCare program did not make these explicit managed care adjustments when calculating capitation rates.

Analysis of actuarial soundness – TennCare Partners capitation rates

Coincident with this analysis, the TennCare Bureau has engaged William M. Mercer, Inc. to evaluate the actuarial soundness of capitation rates paid to Behavioral Health Organizations (BHOs) under the TennCare Partners program. The Mercer analysis forms the basis for our evaluation of the current level of BHO rates.

As a supplement to the Mercer report, additional data was evaluated, including TennCare BHO rate calculations, financial statements, behavioral health data from other states, literature describing the Partners program, and an assessment produced by a provider organization regarding estimated costs.

BHO Priority/Non-Priority capitation rate split

From July 1996 through July 1997 the TennCare program paid one aggregate capitation rate for all BHO members; the payment rate covered all behavioral health and chemical dependency services. In July 1997, the program developed a two-tiered capitation rate and benefit structure for Priority and Non-Priority members. Priority members include the Severely and Persistently Mentally Ill (SPMI) and the Seriously Emotionally Disturbed (SED). Non-priority members comprise the remaining TennCare population.

The capitation rate for Priority members was set at \$319.41. The total payments for Priority members in a given month are subtracted from the monthly statewide budgeted amount; the remaining funds are divided by the

number of Non-Priority members eligible in the month to arrive at the Non-Priority capitation rate.

Thus, the capitation rate for Non-Priority members fluctuates each month depending on the number of Priority members. Non-Priority capitation rates have varied between \$6 and \$10 PMPM. A capitation rate that can fluctuate up to 67% from month to month cannot be considered actuarially sound, and does not permit health plans and providers to anticipate monthly cash flows with any certainty.

The dual rate structure of the Partners program will be eliminated at some point during 1999.

William M. Mercer report

The Mercer review analyzes a “comparison state” relative to the TennCare program. In evaluating the appropriateness of the rates, Mercer analyzed costs both with and without behavioral health prescription drugs.

Their review follows appropriate actuarial methodology in its analysis of TennCare versus the comparison state. Adjustments are made for regional differences, administrative differences, the Tennessee prescription drug carve-out, benefit differences, and trend. When pharmacy costs are excluded, results of this analysis indicate that the capitation rates are approximately 6.7% below the “minimum actuarially sound rate”.

The report cites results both with and without pharmacy costs. In order to relate the comparison state analysis to Tennessee BHO capitation rates, analysis of actuarial soundness should be restricted only to the services included in the capitation rates.¹ Since mid-1998, the State has been responsible for the payment of pharmacy costs on a fee-for-service basis; the actuarial analysis should therefore be restricted to non-pharmacy services.

Additional modifications could be made to the Mercer report to increase the accuracy of the “comparison state” evaluation. First, the comparison state included services that are provided in Tennessee by the Department of Children’s Services (DCS). To make a direct comparison between the two states, Mercer added these DCS costs into the TennCare portion of the analysis. However, as with prescription drugs, these services are not part of the BHO covered services and should be excluded from the analysis.

Rate index factors from a comparison state are then used to develop a relative behavioral health cost for the Tennessee uninsured/uninsurable population.

¹ In an HMO savings analysis, in which the state is measuring total managed care program costs against what would have been spent in a fee-for-service environment, including total costs is appropriate, but that was not the goal of the analysis.

The analysis as presented provides one estimate of potential costs. However, the adjustment factors for the SSI Non-Medicare membership appear too low to properly account for the very high costs of the SPMI/SED population. In order to provide a range of potential estimated costs for the uninsured/uninsurable population, rather than the 4.48 factor (relative to TANF/AFDC) used in the study, another plausible index is 7.6. This factor is supported by both another comparison state for which the SSI Non-Medicare population incurs costs relative to TANF close to this ratio, as well as an estimate based on the relative cost differences of the Priority versus Non-Priority population in Tennessee. Modifying the Mercer analysis to incorporate this range of results indicates that BHO rates are 6.7% to 13% below the minimum actuarially sound rate.

Provider cost estimates

As an alternate measure of rate adequacy, projected cost estimates were provided for this analysis by representatives of the community mental health centers and the Tennessee Association of Mental Health Organizations. These data are based on estimated utilization rates under the current benefit package, combined with estimated unit costs. This analysis projects an overall 7.5% deficiency in current capitation rates².

Impact of eligibility rules on program costs

Mix of eligibles

TennCare program administrators specifically chose to pay a single capitation rate for traditional AFDC recipients, new uninsured enrollees and new uninsurable enrollees. This policy decision was made with a goal of ensuring that all members be treated equitably under the plan. However, due to the disparate average costs of these groups, changes in the distribution of these members over time will impact the costs to health plans of serving these members. These changes could be accommodated within the structure of a single capitation rate by modifying the rate to reflect shifts in enrollment distribution.

The TennCare program has had several “windows” in which eligibility was closed or opened to certain population groups. These eligibility rules have the direct effect of changing the mix of eligibles covered by the capitation rates. When these changes increase or decrease the number of uninsurable members as a percentage of the total, the capitation rates become under- or over-funded. A summary of who has been eligible for the program over time is as follows:

² These estimates do not constitute an actuarial analysis of the capitation rate development; they represent provider projections of total costs using estimated units of service and projected unit costs.

TennCare Eligibility History						
Eligible Group	January 1994	October 1994	January 1995	April 1997	May 1997	January 1998
Medicaid Eligibles	✓	✓	✓	✓	✓	✓
Medicaid Eligibles losing coverage w/o access to insurance	✓	✓	✓	✓	✓	✓
Uninsurables	✓	✓	✓	✓	✓	✓
Uninsured	Covered if uninsured at 4/1/93	Covered if uninsured at 7/1/94 and <200% FPL				
Uninsured children w/o access to insurance				Covered if under age 18	Covered if under age 18	Covered if under age 19
Uninsured children w/access to insurance						Covered if under age 19 and <200% FPL
Individuals w/limited coverage		✓	✓	✓	✓	✓
Individuals losing COBRA	✓	✓	✓	✓	✓	✓
Dislocated workers					✓	✓

While the number of uninsurable members over time is not available, it is known that these program closures and subsequent openings have changed the mix of uninsured/uninsurable members from a low of 26.8% in January 1997 to a high of 36% in January 1999. Additionally, the enrollment of the uninsured/uninsurable group is not consistent across health plans. Prudential currently has the lowest enrollment of these members with 25.6%; PHP has the highest proportion at 41.8%. This difference by health plan may also be related to regional differences in the number of uninsured/uninsurable members. Memphis has the lowest concentration at 25.2%; Upper Cumberland has the highest proportion at 43.1%. To the extent that health plans are geographically oriented, they can expect to see lower or higher percentages of these members in their population base. Detailed enrollment information can be found in Exhibits 3a through 3c.

Data from one of the TennCare plans shows that uninsured members have an average cost that is 19% lower than the Medicaid Only average; uninsurable members have costs that are 55% higher than average. Clearly, the split of

this group between uninsured and uninsurable is critical to an analysis of the adequacy of capitation rates. The enrollment data available at the time of this analysis did not separately identify uninsured and uninsurable members. This distribution is important and should be included in the development of capitation rates and their modification over time.

Charity care/local government funds and mix of eligibles

The TennCare capitation rates were calculated to include an offset to the starting per capita costs to reflect the local government and charity care funds that have traditionally provided some services to residents without insurance. Since these new members were not placed in a separate capitation rate cell, the charity care funds associated with these members were spread over all TennCare enrollees.

When the number of new uninsured/uninsurable eligibles is decreased due to program closures, the charity care offset is not commensurately decreased, resulting in an under-funding of capitation rates for the remaining population group.

Starting rate in 1994 and adjustments through 1999

MCOs

The table below shows a history of the initial capitation rates calculated for the program and the rates that have been paid to participating MCOs since the inception of the program.

Capitation rates were initially calculated by the TennCare Bureau as described in the previous section; these rates are shown in the first column of the table below, labelled “Initially Calculated Rates”. As an incentive for health plans to participate in the program, a retroactive 5% rate increase was provided, resulting in the rates paid for January 1994 – June 1994.

These rates were continued for the following Fiscal Year 1995. An initial 5% rate increase was allocated for Fiscal Year 1996; an additional incentive increase of 4.5% was provided to encourage plan participation and cover additional administrative requirements for the MCOs, resulting in a total increase of 9.7% for FY96.

The TennCare Partners Program was initiated on July 1, 1996. Behavioral health services were no longer the responsibility of the MCOs, and their capitation rates were reduced by \$7.53 in each rate cell. After this deduction, the remaining capitation rates were increased by 4% to arrive at the final FY97 MCO capitation rates.

For FY98, TennCare administrators and their consulting actuaries determined that a rebalancing of capitation rates was required, with particular need for increases seen in the Age Over 65, Dual Eligibles and Age 0 – 1 rate cells. The budgeted 4% increase in rates was thus applied in the following manner:

- **Age 0 – 1.** 7.5% increase.
- **Age 1 – 13.** 0.6% increase.
- **Age 14 – 44 Male.** No increase.
- **Age 14 – 44 Female.** 0.9% increase.
- **Age 45 – 64.** 1.3% increase.
- **Age Over 65 (without Medicare).** 196.9% increase.
- **Blind/Disabled.** No increase.
- **Dual Eligibles.** 29.8% increase.

The need for this rate re-balancing can be seen in Exhibit 4, which shows health plan reported costs by eligibility category. In FY97, plans were reporting costs of approximately \$104 per member per month for the Age 65 and Over (non-Medicare) group, measured against a capitation rate of \$54.83. In FY98 this rate was increased to \$162.78.

Rate increases for FY99 included a 5% increase for Dual Eligibles and a 3% increase for all other groups.

TennCare Rate History							
Eligibility Category	Initial Rates CY94	January – June, 1994	FY 1995	FY 1996	FY 1997 *	FY 1998	FY 1999
Age 0-1	\$113.09	\$118.74	\$118.74	\$130.26	\$127.64	\$137.17	\$141.29
Age 1-13	\$39.40	\$41.37	\$41.37	\$45.37	\$39.35	\$39.61	\$40.80
Age 14-44 Male	\$72.25	\$75.86	\$75.86	\$83.21	\$78.71	\$78.71	\$81.07
Age 14-44 Female	\$119.37	\$125.34	\$125.34	\$137.50	\$135.17	\$136.45	\$140.54
Age 45-64	\$125.44	\$131.71	\$131.71	\$144.48	\$142.43	\$144.35	\$148.68
Age 65+	\$52.31	\$54.93	\$54.93	\$60.25	\$54.83	\$162.78	\$167.66
Blind/ Disabled	\$245.82	\$258.11	\$258.11	\$283.14	\$286.63	\$286.63	\$295.23
Dual Eligibles	\$63.04	\$66.19	\$66.19	\$72.62	\$67.69	\$87.86	\$92.25
% Increase	N/A	5.0%	0.0%	9.7%	4.0%	4.0% Average	5% Dual 3% Other
Weighted Average §	\$101.59	\$106.67	\$106.67	\$117.01	\$113.86	\$118.30	\$122.11
Average Paid	N/A	\$97.59	\$103.40	\$114.10	\$113.66	\$116.55	N/A

* Includes \$7.53 PMPM reduction for carved-out behavioral health services.

§ Weighted average based on FY97 distribution of members, not including deductible and coinsurance offsets.

Average paid based on actual distribution of members in each fiscal year.

BHOs

The capitation rate for BHOs was originally calculated as \$21.84 per member per month, effective July 1, 1996. A 5% rate increase was applied in November, 1996, resulting in a capitation rate of \$22.93.

In July, 1997, this capitation rate was transformed into a two-tiered structure for Priority (SPMI/SED) and Non-Priority members. The capitation rate for Priority members, who receive an enhanced benefit package including case

management services, was set at \$319.41. The capitation rate for Non-Priority members was calculated as the monthly TennCare behavioral health budget, minus amounts paid for Priority members, divided by the number of Non-Priority members. As a result of this budget-based methodology, the capitation rate for Non-Priority members varies each month, depending on the number of Priority members, and has ranged from \$6 to \$10 PMPM.

On May 16, 1998, the State resumed responsibility for certain specified behavioral health drugs. In exchange for this reduction in responsibility, the BHOs were required to provide financial relief to community mental health centers; no reduction in BHO capitation was made.

On July 1, 1998, the State resumed full responsibility for behavioral health drugs. The TennCare Bureau estimated that the monthly cost for behavioral health drugs was \$7.00. In this program change, the BHO capitation rate was reduced by \$3 per member per month, and the BHOs were additionally required to spend \$2.50 PMPM on improving community-based services. This \$3 capitation rate reduction impacted the monthly budget for behavioral health services; since the Priority rate remains at \$319.41, the full impact of this reduction is applied to the Non-Priority population.

Based on information received to date, TennCare anticipates that in 1999 the two-tiered rate and benefit structure for Priority/Non-Priority members will be removed, and that all members will have access to the same scope of services based on medical necessity. A single capitation rate will be paid for all members.

TennCare Partners Rate History		
Effective Date	Capitation Rate	Comments
January 1, 1996	\$21.84	
November 1, 1996	\$22.93	5% Increase
July 1, 1997	\$319.41 Priority \$6 - \$10 Non-Priority	"Floating" Non-Priority rate is remaining monthly funds after total Priority capitation paid.
May 16, 1998	No Change	State resumed responsibility for 7 behavioral health drugs; BHOs required to provide financial relief to CMHCs.
July 1, 1998	\$319.41 Priority Remaining Non-Priority	State resumed responsibility for all behavioral health drugs; overall cap rate reduced \$3.00. BHOs required to spend \$2.50 on community MH services.
1999 (projected)		Return to payment of one composite capitation rate for all members.

Capitation rate levels in other states

While the discussion above has highlighted a number of issues related to the development of the initial and ongoing capitation rates for the TennCare program, it is also useful to compare the payment levels in Tennessee to those in other state Medicaid managed care programs³. TennCare capitation rates are included twice in the following table: once showing actual capitation rates, and once showing what capitation rates would be in the absence of the 22% charity care adjustment.

Composite Capitation Rates *			
State	TANF & Related	Aged, Blind & Disabled	Capitation Rate Year
Tennessee	\$92.25	\$192.98	FY99
Tennessee Adj. for Charity Care	\$118.28	\$247.41	FY99 Adjusted
Georgia	\$118.28	\$238.38	FY99
Illinois	\$123.72	N/A	FY99
Kentucky	\$135.79	\$285.29	FY99
Minnesota	\$146.44	\$521.86	FY99
Oregon**	\$145.13	\$331.23	FY00/01
Virginia	\$137.33	\$437.02	FY99

* Composite rates calculated using FY97 Tennessee eligibility distribution.

** Oregon operates under an 1115 waiver and uses significantly different methods for developing capitation rates.

The following caveats should be noted when examining these comparison capitation rates regarding covered services and populations:

³ The capitation rates in the above table have been modified to reflect a benefit package similar to that provided under TennCare.

- The cost of dental services was added to the Georgia rates, using estimates derived from Virginia source data.
- Rates for Illinois have been modified to remove mental health services, using information from the IDPA rate development.
- The Kentucky capitation rates did not require modification.
- Rates for Oregon have been modified to remove the impact of dental services for adults, using actual Oregon Health Plan rate development data.
- Rates for Minnesota were adjusted using data from a supplemental report on Medicaid to remove the cost of dental and mental health services.
- Virginia source data was used to remove the mental health services normally covered by that managed care program.

➤ **Covered members.**

- The Virginia managed care program does not cover members with third party insurance, including those with Medicare. The resulting Aged/Blind/Disabled capitation rate for Virginia is higher due to the exclusion of lower-cost Aged members with Medicare. Aged, Blind and Disabled rates for all other states listed in the table above include dual eligibles.
- Oregon's expansion groups, OHP Families and OHP Adults/Couples are included in the TANF & Related capitation rates shown above. These groups are largely similar to Tennessee's expansion groups of the uninsured and uninsurable, but include only those individuals in families with income under 100% of the federal poverty level.

➤ **Cost Sharing.** Minnesota requires cost-sharing for its higher-income expansion population. Major cost sharing is as follows:

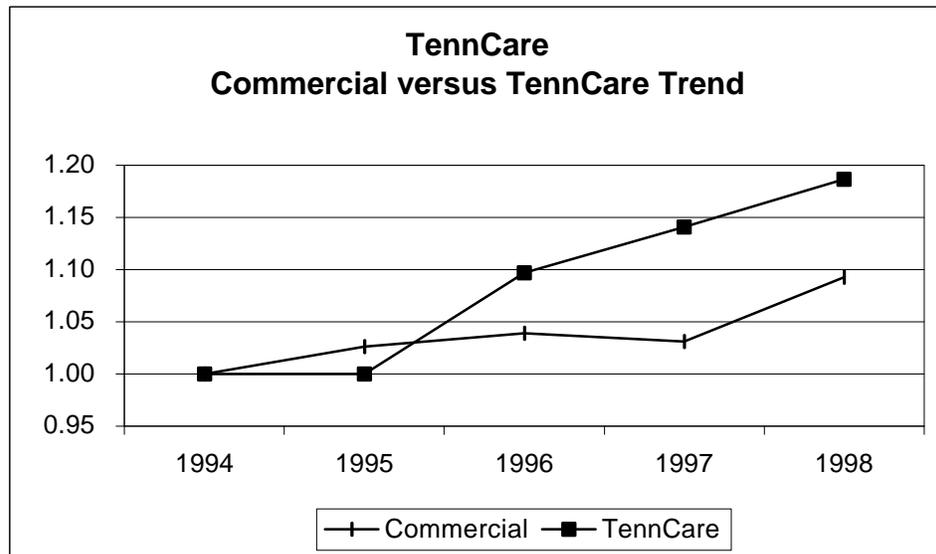
- 10% coinsurance for inpatient hospital,
- \$3 copay on prescription drugs, and
- 50% coinsurance for dental.

Tennessee's capitation rates are lower than those for other states when similar benefit packages are compared. When the TennCare rates are adjusted for the expectation of contributions to funding through charity care and local governments, the rates continue to lag behind those of several other states.

Growth rate of TennCare rates versus commercial plans

Aside from the overall level of capitation rates in the TennCare program, one can examine the rate of increase in capitation rates over time compared to other payers in the Tennessee health insurance market.

An analysis of managed care health plan rate filings and market surveys for commercial plans in Tennessee reveals an increase of 9% in total over the period 1994 – 1997. TennCare capitation rates have increased at an average of 4.4% per year, or approximately 19% in total over the four-year period.



As a caveat to this information, commercial plans tend to have fixed or decreasing benefit structures, whereas TennCare (and Medicaid in general) rarely decreases benefits. TennCare has specifically increased some benefits during the course of the data studied, notably with regards to EPSDT services. In addition, TennCare MCOs are restricted in their ability to impose cost sharing requirements in order to reduce cost and utilization.

Reported health plan costs as a measure of adequacy

MCO costs

Managed Care Organizations submitted detailed claims data for analysis in this report. Claims data was requested for each year of the TennCare program, though most plans were only able to supply data for the most recent two years (FY97 and FY98). Summarized results are presented in the following tables and information by rate cell is included in Exhibit 4.

The “Average Capitation Received” shown in the table below and in Exhibit 4 was calculated by multiplying reported member months of eligibility in each rate cell by the corresponding capitation rates. No adjustment was made to reflect cost sharing reductions for members over the poverty level who are required to pay a deductible and coinsurance. The resulting estimate of capitation received is slightly overstated, and the resulting loss ratio, calculated as Average Medical Cost divided by Average Capitation Received, is slightly understated.

FY97 results show plans spending an average of 89% of capitation on medical services. The two largest plans to submit information, BC/BS and Phoenix, averaged medical costs of 85 – 89% of capitation. Prudential Health Plan experienced the most adverse financial results, with a loss ratio of 117%.

TennCare MCO FY97 Medical Costs versus Capitation			
MCO	Average Medical Cost	Average Capitation Received	Medical Loss Ratio
BC/BS of Tennessee	\$101.24	\$113.56	89.1%
Heritage/John Deere	\$84.99	\$111.42	76.3%
Phoenix Healthcare	\$95.66	\$112.79	84.8%
Preferred Health Partnership (PHP)	\$111.28	\$115.88	96.0%
Prudential Health Plan	\$108.63	\$93.27	116.5%
Vanderbilt Health Plan	\$90.93	\$122.80	74.0%
FY97 Average	\$101.11	\$113.54	89.1%

FY98 MCO data show lower costs resulting in an 80% average loss ratio, with individual plan results varying from 73% to 103%. However, we do not expect that medical costs would drop so significantly from FY97 to FY98; it is possible that the claims data we received did not include sufficient run-out of claims payment. Blue Cross/Blue Shield and Memphis Managed Care, in particular, show vastly lower cost in FY98.

TennCare MCO FY98 Medical Costs versus Capitation			
MCO *	Average Medical Cost	Average Capitation Received	Medical Loss Ratio
BC/BS of Tennessee	\$92.69	\$113.21	81.9%
Heritage/John Deere	\$102.14	\$120.96	84.4%
Memphis Managed Care	\$86.34	\$117.75	73.3%
Phoenix Healthcare	\$95.07	\$113.72	83.6%
Preferred Health Partnership (PHP)	\$121.89	\$118.77	102.6%
Vanderbilt Health Plan	\$112.19	\$125.11	89.7%
FY98 Average	\$92.23	\$114.45	80.6%

* Prudential also submitted claims data for FY98, but data appeared to be incomplete.
 Memphis Managed Care data was provided for FY97 and FY98 combined.
 Member months for the first 6 months of FY97 were estimated based on 1997 data.

BHO costs

Behavioral Health Organizations were not able to provide detailed claims data for this analysis. However, financial statement information for calendar year 1997 and the first nine months of 1998 can be used to produce similar information as is shown above for MCOs.

TennCare BHO CY97 & CY98 Medical Costs versus Premium Revenue			
BHO	Average Medical Cost	Average Premium Received	Medical Loss Ratio
1997			
Premier Behavioral Health	\$21.45	\$23.04	93.1%
Tennessee Behavioral Health	\$19.12	\$21.66	88.3%
FY97 Average	\$20.46	\$22.45	91.1%
1998 (1st 9 months)			
Premier Behavioral Health	\$19.86	\$23.40	84.9%
Tennessee Behavioral Health	\$20.06	\$20.98	95.6%
FY98 Average	\$19.95	\$22.33	89.3%

BHO results show average medical loss ratios of 89% – 91%, with a wide fluctuation in results between the two plans in 1998. Information on the distribution of payments and members between Priority and Non-Priority recipients was not available; examination of this split may provide additional insight into the financial results by plan.

Total payments to MCOs

In addition to paying capitation amounts to MCOs, the State has made additional payments to MCOs through the following two mechanisms.

High-Cost Chronic Conditions Pool

This fund makes payments to health plans to compensate them for treating patients with high cost medical conditions. High cost condition patients are determined by patient diagnosis.

This pool has been funded annually at \$40 million since the beginning of the program; additional funds were added to this pool in FY97 as a substitute for

an additional 1% increase in capitation rates. These additional funds were distributed according to the use of AIDS drugs and stem cell treatments.

First 30 Days payments

These payments were made in the first calendar year of the program to recognize the cost of “pent-up demand” for uninsured and uninsurable enrollees. These payments were made in FY94 and FY95 only.

Total payments

The impact of the above two pools has been to increase the average capitation rates paid to health plans. In FY94, when the First 30 Days payments were highest, these pools paid plans an average of \$6.94 PMPM. From FY96 forward, these additional payments have included only the High Cost Chronic Conditions Pool, which equaled \$2.67 per member per month in FY98. Total payments to MCOs are shown in detail in Exhibit 5.

TennCare Payments to MCOs				
Fiscal Year	Average Capitation	1st 30 Days Payments	High Cost Chronic Conditions Payments	Total PMPM
FY94	\$97.59	\$3.51	\$3.43	\$104.52
FY95	\$103.40	\$0.21	\$2.72	\$106.32
FY96	\$114.10	\$0.00	\$2.77	\$116.87
FY97	\$113.66	\$0.00	\$3.87	\$117.53
FY98	\$116.55	\$0.00	\$2.67	\$119.22

While these payments have and continue to provide some relief to health plans, some of these payments are not guaranteed and must be funded annually by the program.

Evaluation of health plan financial statements as a measure of adequacy

The analysis above has focused on the actuarial soundness of the capitation rates and their development. A number of issues have been highlighted in that discussion. An additional measure of rate adequacy involves overall health plan financial results for the TennCare population.

Framework for financial data analysis

Financial statements were provided by the Comptroller's office for MCOs and BHOs for calendar year 1997 and the first nine months of 1998. 1997 statements include five years of historical information, allowing an analysis of financial results back to the beginning of the TennCare program. The TennCare Bureau provided supplemental financial reports to augment this analysis when financial statement data were missing. Additional information was also gained from the Harkey Report.

The following adjustments were made in analyzing these financial statements in order to make consistent comparisons across plans:

- OmniCare apparently omitted an initial claims reserve and recorded it as an expense. This claim reserve was adjusted to remove its impact.
- Two plans, Prudential and Heritage/John Deere, did not report TennCare information separately from other business. Supplemental TennCare financial reports were used to develop financial reports analogous to those submitted by other plans.
- Vanderbilt Health Plan reported extremely adverse financial results in its non-TennCare subsidiary operations. Financial statement footnotes provided information sufficient to remove this other experience.

In reviewing these financial statements, information has been grouped into the following time periods for analysis:

1. **1994 through 1996:** The first three years of the program include coverage of behavioral health care under the MCOs. This time period also covers any "ramp-up" required for plans to adapt to the new program.
2. **1997:** This is the most recent full year of data for the program, and includes segregated BHO experience.
3. **Nine months of 1998:** This time period reflects the most recent experience available. For two plans, Prudential and Heritage/John Deere, data was only available through the first three months of 1998. Both plans have relatively small market share.

Our summary of these detailed financial statements by plan and year are included in Exhibits 6, 7 and 8.

Reported financial experience of MCOs

TennCare MCO profits/(losses) are shown in the following table based on financial statement and other TennCare reported data, adjusted as described above.

TennCare MCO Profit/(Loss) as Percent of Revenue			
MCO Name	1994 – 1996	1997	1998 (1st 9 Months)
BC/BS of Tennessee	(0.09%)	2.18%	3.75%
Heritage/John Deere *	7.59%	(22.43%)	22.17%
Memphis Managed Care/TLC	(0.48%)	(2.58%)	(4.71%)
OmniCare	(5.61%)	(0.32%)	(1.17%)
Phoenix Healthcare	2.30%	(13.30%)	(2.67%)
Preferred Health Partnership (PHP)	0.32%	(4.60%)	(21.35%)
Prudential Health Plans *	(7.64%)	7.02%	4.65%
Tennessee Managed Care Network	2.63%	1.86%	(1.75%)
Vanderbilt Health Plans	(8.83%)	6.51%	(2.03%)
Total TennCare MCOs	0.62%	(1.02%)	(0.84%)

* 1998 data includes only the first 3 months.

The MCOs' pre-tax experience has been mixed over the periods analyzed. For the period 1994 – 1996, MCO results ranged from a loss of 8.83% for Vanderbilt to a profit of 7.59% for Heritage/John Deere. On average, MCOs broke even over the period 1994 – 1996. These results are reasonably consistent with the claims information supplied by health plans, discussed in the previous section, showing medical loss ratios of approximately 90%, combined with average administrative expenses of 12%.

In 1997, TennCare MCOs reported an overall 1% loss, including significant losses from the merger of Phoenix Health Plan with Health Net TNCare HMO on November 30, 1997. During the first nine months of 1998, TennCare MCOs again reported an aggregate 1% loss, with PHP reporting a significant loss.

The TennCare Bureau has noted that some MCOs waive cost sharing requirements for members who are required to pay a deductible and coinsurance, even though their capitation rates are reduced to account for these patient payments. If all plans were to collect these patient payments, reported revenues would be slightly higher; reported administrative costs would also likely be higher, although the extent to which these revenues and costs offset each other is unknown.

On an individual basis, certain plans are experiencing varied degrees of stress related to their financial operations.

- Tennessee Managed Care Network has had approximately the same size membership for the four-and-a-half years studied. After four years of profits, they experienced a 2% loss during the first nine months of 1998.
- Phoenix Healthcare of Tennessee purchased Health Net TNCare HMO in 1997 and experienced severe financial stress as a combined organization during 1997. During the first nine months of 1998 they recorded a loss of 3% of revenue.
- Preferred Health Partnership recorded small profits up through 1996. 1997 recorded a 5% loss, which grew to a 21% loss in the first nine months of 1998.

The financial stress of the past two years has also begun to create net worth difficulties for several health plans.

- Phoenix Healthcare and Memphis Managed Care each have negative net worth as of September 30, 1998.
- Omnicare and Preferred Health Partnership have small positive net worth values after significant supplemental funding in 1997 and 1998.

Adjusted financial experience of MCOs

Health plans with large market share in the TennCare program have been incurring administrative expenses of approximately 13%; this level of expense is consistent with previous levels allowed for PPOs⁴. For a consistent comparison across plans, all reported administrative expenses have been adjusted to a maximum of 13% in each year. These restated administrative expenses flow through to the pre-tax profits reported in the following table.

TennCare MCO Adjusted Profit/(Loss) as Percent of Revenue			
MCO Name	1994 – 1996	1997	1998 (1st Nine Months)
BC/BS of Tennessee	(0.09%)	2.18%	3.75%
Heritage/John Deere *	10.40%	(20.19%)	24.13%
Memphis Managed Care/TLC	(0.12%)	(1.40%)	(4.71%)
OmniCare	13.71%	6.35%	3.09%
Phoenix Healthcare	6.57%	(11.35%)	(2.67%)
Preferred Health Partnership (PHP)	0.32%	(4.60%)	(19.54%)
Prudential Health Plans *	(4.15%)	7.39%	6.59%
Tennessee Managed Care Network	3.06%	1.86%	(1.75%)
Vanderbilt Health Plans	(3.77%)	9.05%	1.02%
Total TennCare MCOs – Adjusted	1.70%	(0.42%)	(0.51%)

* 1998 data includes only the first 3 months.

Using these restated results with a maximum 13% administrative component, in aggregate health plans made small profits in the first three years of the program. These profits have eroded to small losses in aggregate during 1997 and 1998. When viewed on an individual basis, there is still significant variation among plans for each time period, including half of participating MCOs losing money during 1998.

Although the health plan with the largest market share, Blue Cross Blue Shield of Tennessee, has posted gains in 1997 and 1998, the next four largest TennCare plans have posted deteriorating results in 1997 and 1998 when compared to the 1994 – 1996 period. In order of market share, these plans include Tennessee Managed Care Network, Phoenix Healthcare, Preferred Health Partnership, and Memphis Managed Care.

⁴ At the introduction of TennCare, PPO organizations were allowed 10% for administrative expenses plus a premium tax allowance of 1.75%. This 11.75% allowance was no longer enforced when organizations became HMOs.

Financial experience of BHOs

Financial results in 1996, the first half-year of the Partners program, show a break-even position for Tennessee Behavioral Health and a significant loss for Premier Behavioral. In 1997, both plans reported results close to the break-even level, with Premier showing a 2% loss and Tennessee Behavioral showing a very small gain. In the first nine months of 1998, however, Tennessee Behavioral Health reported a large loss of over 6%; Premier Behavioral reported a profit of 6%.

The BHO financial results provide an indication of performance under the program. However, the time period studied included significant program changes, including the Priority/Non-Priority split in mid-1997 and a portion of the prescription drug carve-out in mid-1998. On average, 1997 and 1998 results show near break-even aggregate results, but variations between the two plans in the most recent period are significant.

TennCare BHO Profit/(Loss) as a Percent of Revenue			
BHO Name	1996	1997	1998 (1st Nine Months)
Premier Behavioral	(10.95%)	(1.92%)	5.70%
Tennessee Behavioral Health	0.66%	0.17%	(6.46%)
Total TennCare BHOs	(6.13%)	(1.07%)	0.63%

BHO administrative costs have been within acceptable levels in each of the financial statements examined and were not modified for this analysis.

Summary of effect of methods on rates

We have identified a number of areas where the methods used for calculating the capitation rates are imprecise or deviate from accepted standards. In nearly all cases, the choice of methods was explicit on the part of TennCare administrators and was designed to spread the available funding to additional enrollees. A summary of issues related to the rate-setting methods is provided below:

- A single rate is used to pay for a broad mix of population without taking into account changes in enrollment over time or differences in enrollment among health plans.

- Rates are based on an expectation of 12 months of enrollment, but derived from annual costs for shorter lengths of time.
- Adjustments have not been made to the rates to reflect changes in program rules imposed at the state or federal level.
- Changes in responsibility for behavioral health services have resulted in average adjustments to capitation rates across rate cells that do not reflect differences in use of these services.
- Capitation rates were reduced based on an expectation that uninsured individuals would enroll in TennCare; this reduction was not adjusted when the program was closed to the uninsured.

Conclusions regarding capitation payments

We estimate that corrections to the rate methodology would result in increases in capitation rates ranging from 5% to 35%, with a best estimate of 20%. This wide variation results largely from two factors: 1) the effect of changing the method to calculate the number of months of eligibility for the program, and 2) assumptions regarding changes in trend rates and managed care savings.

Trend rate increases over the life of TennCare have been larger than those for other payers in Tennessee, most likely to accommodate the additional service requirements of the program. Most Medicaid managed care programs begin with an expectation of savings resulting from the use of managed care compared to fee-for-service delivery. No such savings expectations were explicitly built into the TennCare capitation rates. The estimated deficit resulting from the rate development methods assumes that the State would not have made adjustments to the fee-for-service Medicaid program to remain within a fixed budget limit. The effect of the mix of uninsured/uninsurable and charity care varied over time. In this table we show the estimated effect in 1998.

The following table provides a summary of these results.

Effect of changes in methodology on capitation rates in 1998				
	Adjustments	Low Estimate	High Estimate	Best Estimate
1.	Eligibility (exposure)	13%	26%	18.5%
2.	Incomplete claims	1%	2%	1.5%
3.	Benefit changes	5%	6.5%	5.8%
4.	Trend	(6.5%)	(5%)	(5.8%)
5.	Uninsured/Uninsurable & Charity Care	(1%)	5%	3%
6.	Managed Care Savings (after administrative costs)	(5%)	(1%)	(3%)
7.	TOTAL	5%	35%	20%
8.	TOTAL w/o Uninsured & Charity care effect	6%	30%	16.5%

In order to best summarize results, the above estimate began with the 1994 capitation rate methodologies used and measured the impact of certain changes over time. The uninsured/uninsurable and charity care impact shown above represents a 1998 estimate. The best estimate of the deficit due to capitation rate methodology is 16.5%. This value does not include the effect of the changing mix of uninsured and uninsurable on the capitation rates.

The effect of this estimate on individual health plans would vary based on the population mix in each. An important caveat to this estimate is that the data used for calculating the capitation rates is more than five years old. Issues such as benefit mandates from the state and federal government may have been offset in the fee-for-service Medicaid program by other adjustments to the program to remain within a budgeted funding level.

Tennessee's capitation rates are lower than those for other state Medicaid programs. Health plans have operated at a break-even level under TennCare through 1996, although their financial position has worsened in 1997 and 1998.

We estimate that TennCare Partners capitation rates paid to Behavioral Health Organizations are 6.7% to 13% below the minimum actuarially sound level. This result is reinforced by the financial condition of BHOs. However, the improving BHO financial experience over the two years measured may have come at the expense of behavioral health providers.

4. ANALYSIS OF UNCOMPENSATED CARE AND PROVIDER PAYMENTS

Generally speaking, MCOs and BHOs receive capitation from the State and in turn contract with hospitals and other providers at negotiated rates. Most plans contract with providers on a fee-for-service basis. That is, providers are reimbursed as services are rendered based on a pre-determined fee schedule. A small number of providers (most commonly primary care physicians) are reimbursed on a capitated basis, in which a set amount is paid to the provider per member per month to cover all services for which the physician is contractually responsible.

In addition to these fee-for-service payments from the health plans, the TennCare program has made other payments directly to providers from time to time. Funding for these extra payments have come from various sources, including the recurring “Unallocated Pool” which is funded from budgetary enrollment savings (calculated as the difference between budgeted and actual enrollment). This pool was intended to help transition providers from fee-for-service Medicaid to the capitated program.

Payments to hospitals

Hospitals have received the majority of supplemental payments made by the State to TennCare providers. These payments have included:

- **Graduate Medical Education.** These payments have been funded by various TennCare pools, and are now focused towards teaching universities; in the past, payments had been made directly to teaching hospitals.
- **Uncompensated Care.** These payments are analogous to the Disproportionate Share Hospital payments made under the Medicaid program prior to TennCare.
- **Eligible But Not Enrolled (EBNE).** These payments were made to hospitals in the beginning of the program to cover uncompensated care related to patients served by the hospitals who were eligible for TennCare but not enrolled in the program. These payments were made during FY94 and FY95 only.
- **Other Special Payments.** Other payments have been made specifically for indigent care hospitals.

Payments to other providers

Certain supplemental payments have been made to non-hospital providers over the course of the program, including:

- **Primary Care Assistance Fund.** This fund made payments directly to primary care physicians to encourage participation in the TennCare program and transition providers from the fee-for-service to managed care environment. Payments from this fund were discontinued in FY97 after a total of \$26.9 million was paid.
- **Malpractice Assistance Fund.** These funds were also paid directly to physicians from the start of the program through the end of FY96, and totaled \$14.8 million over that time.
- **Transition Payments to Community Mental Health Centers.** These payments were made in FY97 and FY98 to Community Mental Health Centers to provide additional direct funding to operate the TennCare Partners program.

Total supplemental provider payments

The following table provides a detailed accounting of these supplemental payments by year. Total capitation payments made to MCOs and BHOs over time are shown at the bottom of the table to provide a benchmark comparison of the level of payments.

TennCare Supplemental Payments to Providers (in millions)					
	FY94 (6 months)	FY95	FY96	FY97	FY98
Hospital Payments					
Unallocated Fund Pool – Uncompensated Care *	\$50.0	\$0	\$12.0	\$0	\$60.0
Unallocated Fund Pool – EBNE	\$66.9	\$46.9	\$0	\$0	\$0
Special Pool – Medical Education+	\$26.6	\$24.3	\$48.0	\$48.1	\$48.0
Special Pool	\$0	\$54.5	\$0	\$0	\$0
Total Hospital	\$143.5	\$125.7	\$60.0	\$48.1	\$108.0
Other Provider Payments					
Primary Care Assistance Fund	\$6.8	\$8.9	\$11.2	\$0	\$0
Malpractice Assistance Fund	\$3.0	\$4.8	\$7.0	\$0	\$0
CMHC Distress Payments	\$0	\$0	\$0	\$8.3	\$7.8
Total Other Providers	\$9.9	\$13.7	\$18.2	\$8.3	\$7.8
Total Supplemental Payments	\$153.4	\$139.4	\$78.2	\$56.4	\$115.8
Total Capitation Payments	\$569.7	\$1,522.0	\$1,647.7	\$1,926.6	\$2,087.2

* The \$12 million and \$60 million payments made in FY96 and FY98, respectively, were not reported to HCFA as TennCare payments and federal financial participation was not accessed.
+ Paid directly to universities.

Understanding the issue of uncompensated care

TennCare capitation rates were calculated to recognize the amount of funds spent in the community for charity care. A 22% reduction was made to the capitation rates paid to health plans to account for these funds as well as payments made by local government entities. The assumption going forward from 1994 was that while the payments made to providers per unit of service would be reduced, the providers would be, in total, no worse off than if they

were receiving full reimbursement for Medicaid members and no reimbursement for the uninsured now covered by TennCare.

The expansion of the program to those without insurance has been variously characterized as planning to “do away with” uncompensated care. However, in the initial rate setting for TennCare, only 46% of estimated charity care funds in the state were included in the calculation. That is, an assumption was made that charity care would be reduced by approximately half through the coverage of new members who were previously uninsured. The future course of charity care would depend on continued eligibility for the program of the uninsured and uninsurable.

The analysis of hospital reimbursement under TennCare is somewhat complex. The issue of charity care and its measurement and the changes to Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) need to be considered in order to properly assess the changes since 1993 and the current position going forward.

While MCOs and BHOs file quarterly financial updates, providers report results on a year-by-year basis; hence the most recent provider data to analyze is for 1997. Recent surveys are indicative of current provider contracts through 1998.

In order to file for federal matching funds, the State needs to report certified public expenditures. One component of the calculation is the volume of uncompensated care delivered. The hospital associations that serve the hospitals in the State of Tennessee maintain a fairly extensive database of information. The hospital associations, on behalf of their member hospitals, supplied data for analysis. One issue to address was the volume of uncompensated care before TennCare began (the 1992/1993 period) and a similar measure following the maturation of TennCare experience.

As shown in the above chart, there were a number of supplemental payments to providers from 1994 through 1997. A separate comparison of TennCare payments to plans and providers (Exhibit 4) shows fiscal year 1994 payments per member per month exceeded those for fiscal years 1995 and 1996. It is important to ensure that the comparisons are appropriate given the changing nature of the coverage of behavioral health over the course of the program. This exhibit shows that most of the supplemental payments to providers were paid to hospitals as replacements for DSH and GME.

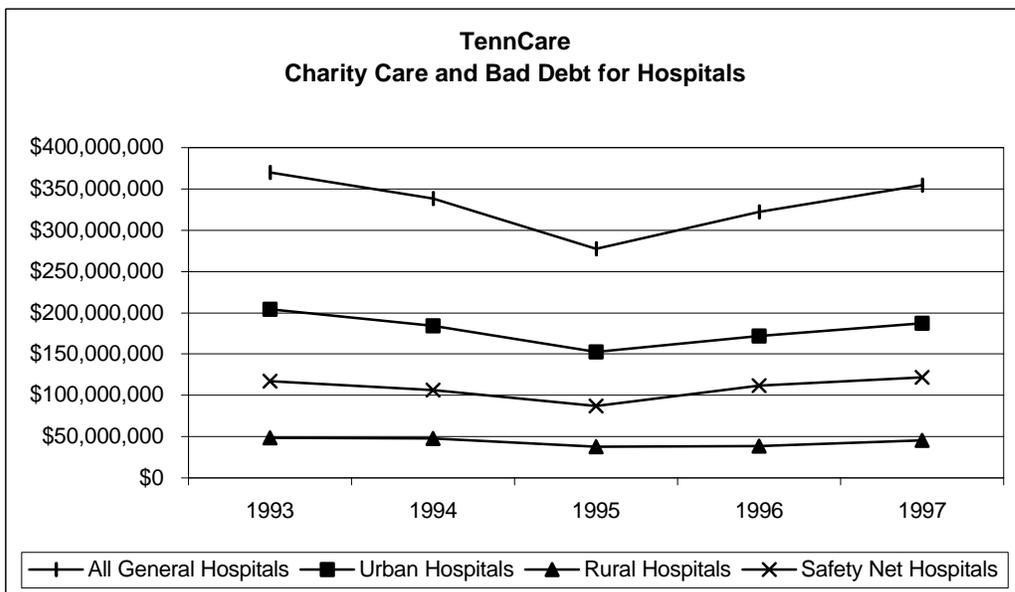
Payments to hospitals

Charity care

Within the above framework, hospital data can be analyzed. The table and chart below indicate the estimated dollar value of charity care, as calculated

by the hospitals in Tennessee, and provided to the hospital association. (See Exhibit 9a for detailed information.) Information on charity care has been grouped by type of hospital: urban, rural and safety net hospitals. (Long term care, psychiatric, chronic disease and rehab hospitals are not included in this or subsequent exhibits.)

Tennessee Hospital Charity Care (in millions)					
	1993 Medicaid	1994 Medicaid	1995 TennCare	1996 TennCare	1997 TennCare
All General Hospitals	\$369.7	\$338.3	\$277.2	\$321.9	\$354.2
Urban Hospitals	\$204.1	\$184.5	\$152.8	\$171.6	\$187.4
Rural Hospitals	\$48.4	\$47.4	\$37.6	\$38.4	\$45.3
Safety Net Hospitals	\$117.3	\$106.4	\$86.8	\$112.0	\$121.5



This chart indicates that although charity care dropped by 25% through 1995, it increased since that time, back to pre-TennCare levels. Another way to view this information involves looking at the number of uninsured Tennesseans as a “marker” for the corresponding experience of

uncompensated care. While these measures also appear to decrease in 1995, there are a number of conflicting reports.⁵

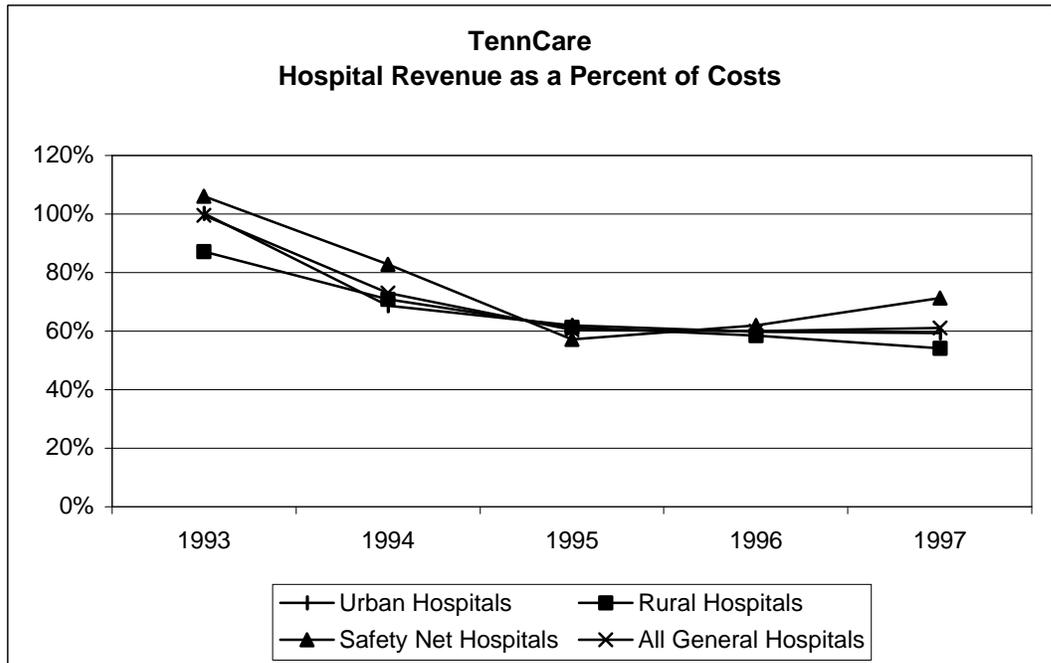
Hospital reimbursement levels

Data were also provided by the hospital association covering hospital revenues and costs for TennCare. Revenues as a percentage of costs are shown in the following chart for a comparison of hospital reimbursement over the course of the program. The detailed revenue and cost information leading to these percentages is included in Exhibits 9b – 9d. These reimbursement percentages do not include Disproportionate Share and Graduate Medical Education (GME) payments in the pre-TennCare period, and similarly do not include supplemental payments from TennCare to hospital providers.

⁵ Effects of Medicaid Managed Care Demonstrations on Safety Net Providers in Hawaii, Rhode Island, Oklahoma and Tennessee, a report recently issued by Mathematica Policy Research, Inc., and The Urban Institute, cites Employee Benefit Research Institute (EBRI) estimates of the uninsured using current population survey data (EBRI 1997a and 1997b). The report indicates that although the uninsured population post-TennCare initially declined by 25%, it has increased to a level beyond the original estimates. In a footnote to its chart however, the Mathematica report did acknowledge that other surveys indicate a significantly lower level of uninsured people in Tennessee. They reference a 1996 survey done by researchers at the University of Tennessee which indicates the 1996 uninsurance rate in the state to be near 6.3%. The Mathematica researchers attempted to adjust these rates to be comparable to EBRI's under 65 population estimate, but even after adjustment the figure only rose to 7.8%, almost a ten percentage point difference from EBRI's 17.2% non-elderly uninsured estimate for 1996. The Harkey & Associates, Inc., survey of Tennessee Managed Care issued in 1998, supports the lower estimates of uninsured; this survey uses the University of Tennessee 1996 data.

TennCare Hospital Revenue as a Percent of Cost ⁶					
	1993 Medicaid *	1994 TennCare	1995 TennCare	1996 TennCare	1997 TennCare
All General Hospitals	100%	73%	61%	60%	61%
Urban Hospitals	100%	69%	62%	60%	59%
Rural Hospitals	87%	71%	61%	58%	54%
Safety Net Hospitals	106%	83%	57%	62%	71%

* Not all starting payment rates equal 100% because the Medicaid reimbursement of "cost" in 1993 was based on a 1989 base rate indexed forward.



These data show that hospitals are receiving reimbursement that has largely decreased over the course of the TennCare program relative to their operational costs. The rural acute care hospitals have shown increasing negative margins in their operations over the course of the program.

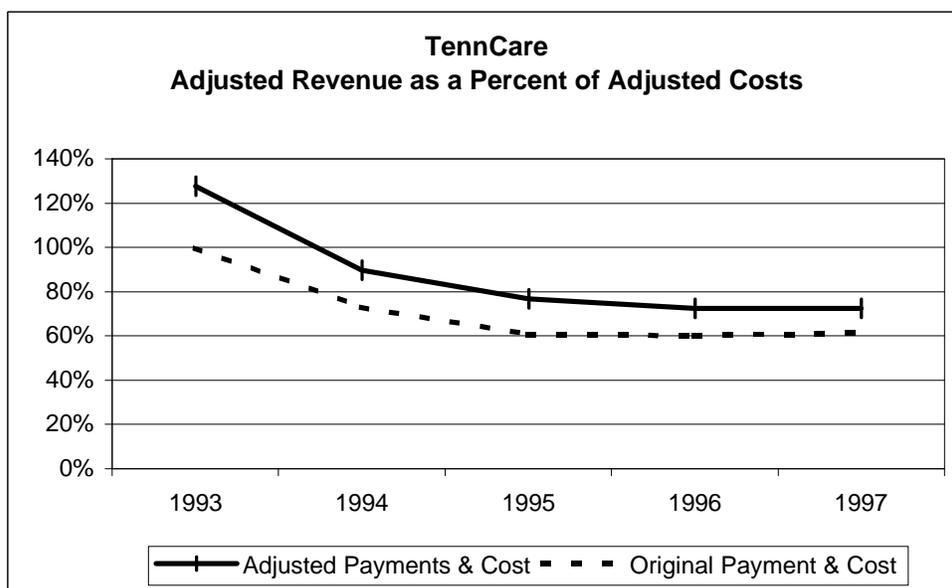
⁶ These hospital costs have not been adjusted for the repeal of the hospital services tax on December 31, 1993. Although the relative differences pre- and post-TennCare may be minor, the hospitals would have improved financial results on their non-TennCare business after this date.

According to the hospital organizations, in 1996 21 rural hospitals had negative margins. In 1997, the number increased to 27.

The above analysis reflects unadjusted revenues and costs as reported by hospitals. However, it is also possible to adjust cost and revenue for a more complete analysis of hospital costs. First, hospital payments can be adjusted to include supplemental payments made outside of reimbursement for direct services. In this adjusted analysis, disproportionate share, GME and Indirect Medical Education (IME) payments are added to revenue for 1993; supplemental pool payments are added for TennCare years.

On the cost side, adjustments were made to more closely reflect market conditions. From the data provided for this analysis, hospitals appear to have received relatively constant payment rates from MCOs over the period 1996 to 1998; this trend is consistent with anecdotal reports that reimbursements from MCOs have remained essentially level over the entire history of TennCare. The same trend can also be seen in commercial premiums, which have increased only 2.2% per year over the 4-year period studied. However, reported hospital costs for TennCare members over this time period reflect increases significantly in excess of these underlying market conditions. To establish a more consistent year-to-year comparison of revenue to cost for 1995 through 1997, reported costs were reduced by 5% in each year.

As seen in the chart below, after supplemental payments are included and hospital costs are restated for 1995 – 1997, the same decreasing trend in percentage reimbursement for hospitals is evident as was seen in the unadjusted figures. These restated costs and revenues result in average reimbursements to hospitals of approximately 72% of costs.



It is important to note that this level of reimbursement includes supplemental payments to hospitals that are not guaranteed. The level of these supplemental payments declined over the period 1994 to 1997, partially due to the stoppage of Eligible But Not Enrolled (EBNE) payments in fiscal year 1995. Supplemental payments increased in FY98 due to a special \$60 million payment made through the Department of Health. Also, the continuing payments for Medical Education, although eventually being paid directly to universities for medical residents, are not direct hospital compensation. [These payments for Medical Education were previously included in fee-for-service payment rates to teaching hospitals.]

It is also important to note that the structure of the TennCare program hinges on the inclusion of charity care funds in the evaluation of the program. It is therefore expected that per-unit reimbursement to hospitals and other providers would decrease by 22% on average when comparing to pre-TennCare levels. The program also fundamentally assumes that charity care will decrease so that when viewed in total, TennCare providers receive reimbursement that is comparable to what would have been paid in the absence of TennCare. While it is evident that reimbursements have decreased over time, it is equally clear that charity care has not seen a permanent decrease commensurate with these payment changes.

As stated, MCO payments and supplemental payments combined currently represent approximately 72% of hospital costs. If this 72% level of reimbursement is considered appropriate, it would require both a continuation of these supplemental payments and no further increase in uncompensated care.

Affect on safety net and rural hospitals

There have also been some shifts in hospital usage by sub-category of hospital. The Mathematica study Effects of Medicaid Managed Care Demonstrations on Safety Net Providers in Hawaii, Rhode Island, Oklahoma and Tennessee, referenced in the previous section and in the bibliography, indicates a shift away from traditional Safety Net providers when examining average annual Medicaid days per hospital. However, in conjunction with this shift, the study also documented a shift towards Sole safety net providers. The study defines Sole safety net hospitals as those that provide the most care to the Medicaid population in counties where significant portions of the population live in poverty. These hospitals are most likely to be rural hospitals. As noted in the chart above, rural hospitals receive the lowest reimbursement relative to cost of any of the noted hospital groups.

With declining reimbursements and/or lost patient days, the rural hospitals and the Safety Net providers have been relatively disadvantaged over the last five years.

Comparison to other payers

The last measure of hospital reimbursement involves examining reimbursements under TennCare as compared to those of other payers, including commercial health plans and Medicare. The data provided by the Tennessee Hospital Association included average reimbursements for a selection of the most common hospital admissions, identified using DRG codes. This data was separately collected for four Safety Net hospitals, as well as from the full complement of all general hospitals. Safety Net providers are examined separately from general acute care hospitals due to the different distribution of DRGs commonly provided .

As shown in the following tables for the Safety Net providers and general hospitals, TennCare per diem average reimbursement for inpatient care was approximately 40% of the commercial average. Even after adjusting for the 22% reduction for charity care and local government payments, these reimbursement rates are approximately 50% to 55% of the corresponding commercial levels. Exhibits 10a and 10b provide detailed information regarding these payments.

Safety Net Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 936	\$ 1,200	\$ 2,238	\$ 2,304
1997	\$ 949	\$ 1,217	\$ 2,520	\$ 2,873
1998	\$ 971	\$ 1,245	\$ 2,426	\$ 2,941

All General Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 470	\$ 602	\$ 1,258	\$ 964
1997	\$ 479	\$ 614	\$ 1,312	\$ 1,109
1998	\$ 415	\$ 532	\$ 1,043	\$ 993

For general hospital outpatient services, TennCare reimbursements are closer in level to those of commercial and Medicare payments. For outpatient care, comparisons are measured in terms of reimbursement per claim. As seen in the following table, TennCare payments are approximately 50% – 55% of commercial levels; after adjusting for charity care, these payments are 65% – 70% of commercial average payments.

All General Hospitals – Outpatient Care

Year	TennCare Per Claim Reimbursement	TennCare Per Claim (Adj. For Charity Care)	Commercial Per Claim Reimbursement	Medicare Per Claim Reimbursement
1996	\$ 462	\$ 592	\$ 849	\$ 498
1997	\$ 434	\$ 556	\$ 847	\$ 472
1998	\$ 455	\$ 583	\$ 823	\$ 483

Charges, payments, costs and charity care amounts were also provided by individual hospitals. Data for these individual hospitals generally supports the above analysis.

Payments to physicians

The Tennessee Medical Association assisted in structuring a survey of member physicians to gather data on TennCare reimbursements, similar to the data collected for hospitals. In addition, data presented in the Mathematica report allowed some analysis of issues related to Federally Qualified Health Centers (FQHCs).

While the hospital data analyzed represents virtually all hospital services provided, the physician data represents approximately 20% of amounts paid to physicians. The survey produced the following information:

Survey of Physician Practices	
Total Billings	\$ 2,057,791,323
TennCare Billings	\$ 236,635,584
TennCare as % of Total Billings	11.5%
TennCare Revenue	\$ 80,016,315
Revenue as % TennCare Billings	33.8%
Charitable Care	\$ 20,526,828
Charity Care as % Total Billings	1.0%

This survey indicates that TennCare reimbursement averages 33.8% of billed charges, a figure that is consistent with anecdotal information provided. This reimbursement level is below the marginal cost needs of most physician practices. Comparable data on payments by commercial plans and Medicare was not available.

FQHC reimbursement

The Mathematica report previously referenced also cited statistics regarding reimbursement for Federally Qualified Health Centers (FQHCs). This report presents summarized statistics on the use of FQHCs in Section 1115 waiver states, including Tennessee. The State of Tennessee, Office of the Comptroller confirms that in 1993, under Medicaid, FQHCs were being paid at a level equivalent to 100% of costs. An analysis of the data on FQHCs indicates that in 1996, this level had decreased to 85%. The generally accepted target for FQHC reimbursement is 100% of reasonable cost, based on the mission of FQHCs and the fact that very few other patients are available to pay subsidy cost for TennCare patients.⁷

Payments to other physical health providers

The remainder of the data collected on payments to providers was in relation to reimbursements available in the commercial market. Most other providers indicated the TennCare payments were 30% to 50% of that available in the commercial market. While this reimbursement appears consistent with or slightly lower than that of the hospitals, the economics driving provider behavior are different than that for hospitals due to the “mission” followed by many community hospitals. The level of reimbursement versus the marginal cost of delivering care is causing some of the providers with small volumes of TennCare services to consider dropping from the program (for example, DME providers).

The last large expenditure area under TennCare involves pharmacy benefits. A survey of reimbursement levels across participating MCOs was submitted by the Tennessee Pharmacists Association. The survey’s average payment rate is Average Wholesale Price (AWP) minus 13% plus a \$2.50 dispensing fee. The payment under Medicaid prior to TennCare was AWP minus 10% plus a \$3.91 dispensing fee. The level of reimbursement has declined and is lower than rates paid by other Medicaid programs, as evidenced by state surveys conducted for this analysis. Information comparing TennCare pharmacy payments to commercial payers in Tennessee was not available.

⁷ MCOs are not required to contract with FQHCs if their provider network is adequate without the centers.

State	Pharmacy Payment Level
Tennessee	AWP – 13% + \$2.50
Georgia	AWP – 10% + \$4.63
Illinois	AWP – 12% + \$5.00
Kentucky	AWP – 10% + \$4.75
Minnesota	AWP – 9% + \$3.65
Oregon	AWP – 11% + \$4.10
Virginia	AWP – 9% + \$3.36
Washington	AWP – 11% + \$4.25

Payments to behavioral health providers

Specific data relating to unit payments to behavioral health providers was not available for this study. Available information included literature describing the TennCare Partners program and projected BHO costs as estimated by provider groups.

The two-tiered rate program involving Priority (SPMI/SED) participants versus Non-Priority participants, combined with the Partners program’s global budget has necessitated new strategies by the BHOs. Contracts with Community Mental Health Centers (CMHCs) have been structured to reduce payments per unit of service as utilization increases, in effect a global budget, without regard to increasing or decreasing participant load. When the number of SPMI/SED members increases, funds available for remaining Non-Priority members decreases.

Citing similar concerns, the Journal of the American Medical Association stated in an article entitled “Tennessee’s Failed Managed Care Program for Mental Health and Substance Abuse Services”, March 18, 1998:

Shortly after TennCare Partners began, many “safety net” providers previously supported directly by state contracts and grants suffered a precipitous drop in revenue after becoming subcontractors of the BHOs.

The State intends to change its payments to BHOs in 1999 to revert to a flat per capita amount for all TennCare enrollees. This payment approach will likely return many of the traditional providers to a budget-based payment, which matches the historical method of paying for mental health services. It is important to note that the change in capitation rate methodology will not, in itself, change total payments to BHOs or providers.

The State has also recognized the financial stress placed on these Community Mental Health Centers by making supplemental payments to these providers totaling \$16 million in FY97 and FY98. In addition, in mid-1998 when the responsibility for prescription drugs was returned to the State, BHOs were required to spend an additional \$2.50 PMPM from their remaining capitation on community-based services. The CMHC supplemental payments are not expected to continue into the future.

Conclusions regarding uncompensated care and level of provider payments

Although the uninsured have been continuously eligible for TennCare, the program was closed to the uninsured in 1995, and opened later only to uninsured children and a small number of dislocated workers. The continued growth in the estimates of hospitals' and physicians' uncompensated care burden indicates that these original estimates of charity care reduction while initially reasonable, require adjustment as uncompensated care has returned to pre-TennCare levels.

An assessment of the adequacy of payments to providers under TennCare must be segregated by provider type and must be considered in the context of most likely payment levels under a fee-for-service Medicaid program. Medicaid payment levels are nearly always lower than payment levels for other purchasers.

- Our analysis shows that on average hospitals are receiving payments that are approximately 72% of costs, when supplemental provider payments are considered.
- Physicians receive payments that are approximately 34% of charges. Physician costs of delivering care typically represent 40% to 50% of billed charges.
- Federally Qualified Health Centers receive payments that are 85% of costs.
- Mental health safety net providers have experienced significant losses under TennCare; the TennCare Bureau is in the process of implementing changes to the payment methodology to address these concerns.

Some providers have received significant supplemental payments to cover costs not included in their TennCare reimbursement. These supplemental payments are important to achieving the payment levels described here. These payments must be renewed each year and are not guaranteed in the payment methodology.

5. ANALYSIS OF OTHER ISSUES AFFECTING PLAN COSTS

In addition to the payment issues discussed above for health plans and providers, there are a number of other issues that affect the overall cost of the program that are not readily measured, but should be considered in terms of the financial soundness of the system.

Health plan administrative costs and care management

In order to qualify for a federal waiver, the State has to ensure budget neutrality. State Medicaid programs typically pay health plans an amount that is less than or equal to the fee-for-service equivalent cost of providing services. This FFS cost usually includes only health care costs; some states include a small amount for the state's projected administrative cost savings, but most do not. Health plans must therefore manage the cost of providing services down to 10-15% below the fee-for-service equivalent level in order to provide sufficient funds for health plan administration and profit.

To the extent that the new program develops administrative burdens and additional layers of compliance, an already difficult financial environment will become more stressed. Health plans surveyed for this analysis cited several factors adding to their administrative and medical costs:

- **Retroactive eligibles.** Some members have long delays between their application and approval for TennCare. Under TennCare rules, members are made eligible retroactively to the date of their application.⁸ Health plans receive retroactive capitation for these members as well as responsibility for their claims incurred between application and approval. Plans cite the difficulty of managing care and cost for these members since they were not enrolled in the plan during the retroactive period.
- **Eligibility interface.** Health plans cited problems with the State's practice of over-writing the eligibility files provided to the plans, requiring additional work by plan staff to identify new and retroactively eligible members. In addition, plans are not well informed regarding each member's spend-down requirements or third party coverage, resulting in plans paying a greater share of costs for these members than necessary.

⁸ The effective date for uninsured children and dislocated workers who are enrolled through local health departments is the date on which the application is verified and the first premium payment (if any) is received.

- **Out-of-state care.** Plans are responsible for children who are placed in the custody of a parent living out of state. This arrangement does not allow plans to manage the care of these members, since they do not live in the plan’s service area.
- **Dual Eligibles.** The interface with Medicare coverage causes additional administrative burdens for health plans due to their inability to direct members to health plan providers. Plans believe that they function mainly as prescription drug payers for these members.

Covered benefits

In meetings held with health plans, representatives were concerned that the TennCare program covers benefits that are richer than those covered in other states. To respond to these concerns, we received survey information from seven other states that were either geographically close to Tennessee (Virginia, Kentucky, Georgia, Illinois) or had similar Medicaid managed care covering expansion populations (Minnesota, Oregon, Washington). Complete managed care benefit descriptions for the survey states are included as Exhibit 11.

The results of the survey show substantially similar benefits covered in all states. For items that comprise the majority of health plan costs (inpatient and outpatient hospital, physician and prescription drugs), all states provided full coverage without restrictions. Dental services did show some variation across states, as some programs have significant restrictions on services for adults.

A significant concern among TennCare MCOs is the EPSDT “consent decree”. Our survey shows that all states cover EPSDT services as required by law, but the degree to which the administration of this coverage results in an expansion of what is considered a covered service can not be determined from the information available. Increases in EPSDT costs are a concern among health plans in all states. While EPSDT services are federally mandated, growth in this area has been significant in Tennessee and other states.

Plans also expressed concern over coverage by specific types of special providers that are considered “add-ons” to the standard benefit package. From our survey most states responded that they are also required to provide coverage for these types of special providers.

Finally, on the issue of organ transplants, our survey shows that most states explicitly cover organ transplant services. Some restrictions by age do apply. TennCare plans were concerned that patients from other states may be establishing residency in Tennessee to obtain TennCare coverage of costly organ transplants. To address this issue, our request for data from TennCare

MCOs included a request for counts of transplants delivered to TennCare recipients. None of the responding plans provided this information.

Grievance and appeals process

The grievance and appeals procedure used in the TennCare program also causes administrative and medical costs to be incurred by health plans in excess of levels expected by MCOs. The plans have come to see this process as having the effect of expanding the scope of covered services beyond what was accounted for in the initial rate setting calculations. The plans also believe that the appeals board considers only questions of medical necessity, regardless of what services are included in, or explicitly excluded from, health plan contracts.

When patients file a grievance, their current level of coverage is maintained until the grievance is resolved. While this feature protects patients from unnecessary interruptions in care, it is likely to increase health plan costs, as the plan's normal utilization management controls are circumvented until the grievance completes health plan- and State-level review.

Finally, health plans perceive that the EPSDT consent decree results in more appeals being decided in favor of patients, regardless of health plan contractual services.

Our survey of other states reveals similar grievance processes in those programs. Typically members must appeal their coverage decision through the health plan's internal review procedures. If care is denied at that level, recipients can appeal their decisions either to the state or to some other external review organization. Information was not available for survey states, or for Tennessee, to determine the extent to which appeals are raised up to the state level and the extent to which additional services result from the appeals process.

BHO liquidated damages

Behavioral health plans cited concerns regarding proposed new requirements of liquidated damages as a feature that would likely increase plan costs. Under current rules, the plans face a withhold of 10% of capitation until contractual requirements are met concerning the timely and accurate payment of claims. The BHOs consider this feature to be a cash-flow problem, in which funds were received at a later date after the administrative issues were corrected.

However, the new proposal would include a 5% withhold of capitation (3% if the plan has been compliant for 2 months), and a liquidated damages clause. If the plan is out of compliance, the State would assess the plan an amount ranging from \$100,000 for one month, moving up to \$250,000 for four

months of non-compliance. These assessments would not be returned when the plan returns to compliance.

While this clause certainly provides incentives for BHOs to pay claims in a timely and accurate manner, the State should monitor the frequency of assessments and the reasons behind their application to ensure that BHOs are not dangerously financially impacted.

MCO/BHO coordination

Both MCOs and BHOs surveyed for this analysis acknowledge that the coordination between plans is not perfect and causes additional administrative burdens. Part of this tension stems from the discrete capitation payments made for physical health versus behavioral health services. A natural result is for the MCOs and BHOs to push “borderline” services, those that could be provided by a physical health or behavioral health provider, to the other system.

Additionally, MCOs were concerned about the need to cover the physical health consequences of adverse reactions resulting from the use of powerful antipsychotic medications.

Plans surveyed for this analysis agreed that an improvement in the coordination of services and a reduction in plan administrative burden could be achieved if the State took a greater role in mediating disputes between MCOs and BHOs. It would also be helpful if the State promulgated more distinct guidelines as to the division of responsibilities between the two systems.

Administration for providers

The providers who supplied information for this analysis indicated that the administrative burden under TennCare was large and that it exacerbated problems with the perceived low payment rates. Problems include:

- **Accounts Receivable.** Based on a survey by the Tennessee Hospital Association, providers are not paid promptly by TennCare MCOs. Contracts require payment of claims within 60 days of submission; survey reports show that 50% of claims are not paid within this time period and 30% are still not paid after 120 days. At the same time, providers report that the timing of claims payment has improved since the beginning of the program. For comparison purposes, hospitals indicate that 20 – 25% of Medicare claims are over 60 days old, and 10% are not paid after 120 days.

- **Pre-authorization.** Providers report numerous problems with pre-authorization of services. Issues include receiving

authorization and later being denied payment due to questions of medical necessity or ineligible members, as well as problems receiving pre-authorization for services that are routinely approved.

- **Eligibility interface.** Providers report not receiving information on beneficiaries who change MCOs, and later being denied payment for services rendered.
- **Administration.** Non-standard administrative requirements among the various MCOs cause additional hassles to providers.

Provider access

Information provided by the Tennessee Dental Association indicates that participation by dentists in TennCare has decreased. The Association cites statistics that prior to TennCare, 1,700 out of 2,800 dentists served Medicaid patients, with 824 of those dentists receiving payments of \$1,000 or more. Today, the number of dentists in the state has increased to 3,000, but the number participating in TennCare has dropped to less than 500.

Weekend trauma

Retroactive eligibility is a significant concern for providers, particularly trauma centers. The TennCare office determines and processes enrollment Monday through Friday from 8:00 a.m. to 4:30 p.m. Individuals who come into the trauma centers during the weekend are not enrolled in TennCare until the following Monday morning. The program does not make retroactive payments for these members, although significant funds have been spent stabilizing the patients. Under the Medicaid program prior to TennCare, providers were reimbursed for this care.

Enforcement of eligibility rules

Some providers perceive that eligibility rules are not enforced in a strict enough manner. They cite instances where patients have eligibility cards for TennCare and another insurance plan. The extent of this phenomenon is not documented.

It is conceivable that if the eligibility rolls were “pruned” of these ineligible members that the program would have space to cover bona-fide uninsured residents. Some providers believe uncompensated care would be reduced if more care were taken in assuring that only those individuals who are uninsured are allowed to participate in TennCare. We note, however, that Medicaid is always the payer of last resort, and that it is not uncommon for some individuals to have dual coverage. This phenomenon occurs most frequently with children, when a divorced parent is ordered to cover the health insurance costs of his or her dependents. Because the concern was cited anecdotally, we do not have information available to quantify the number of

individuals who may appear to have dual coverage. In developing the initial capitation rates, the availability of other insurance would have been taken into account, since actual Medicaid paid claims served as the basis of the calculation.

6. CONCLUSIONS

Our analysis was designed to assess whether the rates paid to health plans under TennCare are actuarially sound, and to identify areas for adjustment. It was also designed to determine whether health plans or providers appear to be under financial stress as a result of participation in TennCare. In addition, we investigated a number of operational issues and provided a comparison to other state Medicaid programs. At the beginning of this report we laid out a series of specific questions. Our conclusions related to each of those questions are provided below.

1. Are the methods used for calculating the rates consistent with generally accepted standards?

The methods used to develop capitation rates for TennCare are not consistent with generally accepted standards. We identified several methodological issues relating to the rate development process. Taken together, the items we identified would tend to increase the payment rates if the State did not make adjustments to the traditional fee-for-service program in the face of rising costs. However, we believe it is important to note that the methods used were explicitly chosen to assure that TennCare operates within its state budget limit. Changes in the methods will result either in increased costs to the State or reductions in the number of covered individuals. This reduction would, most likely, result in an increase in the number of uninsured and a commensurate increase in the amount of uncompensated care.

Items we identified include the following:

- Rates are based on an expectation of 12 months of enrollment, but derived from annual costs for shorter lengths of time.
- Adjustments have not been made to the rates to reflect changes in program rules imposed at the state or federal level.
- Changes in responsibility for behavioral health services have resulted in average adjustments to capitation rates across rate cells that do not reflect differences in use of these services.
- Capitation rates were reduced based on an expectation that uninsured individuals would enroll in TennCare; this reduction was not adjusted when the program was closed to the uninsured.

From the data available for this analysis, it is not possible to assess whether the initial capitation rate setting methodology for behavioral health organizations followed traditional actuarial guidelines.

2. If the methods are not consistent with generally accepted standards, what is their likely effect on the capitation rates?

We have identified several specific concerns with the methods used to develop the capitation rates. Our most substantive concerns relate to the population mix included in the primary rate setting categories and changes in eligibility rules over the years. The initial capitation rates for this group were developed strictly based on an Aid to Families with Dependent Children (AFDC) population. There are significant differences in costs between AFDC, uninsured and uninsurable individuals. While we understand the desire of TennCare administrators to pay a single rate for AFDC, uninsured, and uninsurable enrollees, this payment approach does not preclude a more precise calculation of the capitation rates.

We have not been able to quantify the likely effect of paying a single rate with no adjustments for changes in eligibility rules because data have not been available that separately report enrollment of individuals who are uninsured versus those who are uninsurable.

Two other areas with significant effects on the capitation rates are: 1) the use of average annual costs based on less than 12 months of eligibility spread over a full 12 month period, and 2) the reduction in rates to reflect expected decreases in the level of charity care that have not been subsequently increased.

We estimate that corrections to the rate methodology would result in increases in capitation rates ranging from 5% to 35%, with a best estimate of 20%. This wide variation results largely from two factors: 1) the effect of changing the method to calculate the number of months of eligibility for the program, and 2) assumptions regarding changes in trend rates and managed care savings.

Trend rate increases over the life of TennCare have been larger than those for other payers in Tennessee, most likely to accommodate the additional service requirements of the program. Most Medicaid managed care programs begin with an expectation of savings resulting from the use of managed care compared to fee-for-service delivery. No such savings expectations were explicitly built into the TennCare capitation rates. The effect of the mix of uninsured/uninsurable and charity care varied over time. In this table we show the estimated effect in 1998.

The following table provides a summary of these results.

Effect of changes in methodology on capitation rates in 1998				
	Adjustments	Low Estimate	High Estimate	Best Estimate
1.	Eligibility (exposure)	13%	26%	18.5%
2.	Incomplete claims	1%	2%	1.5%
3.	Benefit changes	5%	6.5%	5.8%
4.	Trend	(6.5%)	(5%)	(5.8%)
5.	Uninsured/Uninsurable & Charity Care	(1%)	5%	3%
6.	Managed Care Savings (after administrative costs)	(5%)	(1%)	(3%)
7.	TOTAL	5%	35%	20%
8.	TOTAL w/o Uninsured & Charity care effect	6%	30%	16.5%

In order to develop the above Best Estimate surplus/(deficit) of MCO capitation rates over the history of the TennCare program, we began with the methodology used in 1994 and analyzed the capitation rates going forward. The uninsured/uninsurable and charity care impact, shown above, represents a 1998 estimate; this amount will be adjusted in the analysis shown later in this section to show this impact over time. The Best Estimate of the deficit in 1998 due to the capitation rate methodology is 16.5%, or \$16 per member per month.

Our analysis did not investigate the actual health care delivery processes used by MCOs and BHOs to determine whether those processes are efficient or consistent with generally accepted standards of medical necessity.

3. Regardless of the methods used for developing the rates, are health plans under financial stress as a result of participating in TennCare?

Our analysis of health plan financial statements shows that health plans are operating on a break-even basis on TennCare business when administrative costs are constrained to 13% of capitation payments. There has, however, been an apparent down-turn in recent financial results. Results for 1997 and year-to-date 1998 show that plans have moved from making a slight profit to a slight loss. We would expect that plan financial positions will continue to deteriorate based on current capitation rates and the need to increase payments to providers.

Behavioral health plans are fairing slightly worse, with losses of 1% to 6% of capitation payments. Recent changes in the Partners program can be expected to improve the financial condition of these plans.

4. Are providers under financial stress as a result of participating in TennCare?

Hospital payments under TennCare are significantly lower than those from other payers. The State has made large supplemental payments to hospitals every year since TennCare began. These payments cover some portion of the short-fall in provider payments.

Some specific types of providers are under significant financial stress. The rural acute care hospitals have shown increasing negative margins in their operations over the course of the program. These hospitals have few alternatives for enhancing revenue from other sources.

Physician payment levels under TennCare are approximately 34% of billed charges. While few health care purchasers pay billed charges, providers typically require 40% to 50% of charges to cover the cost of delivering care. Payments below the cost to deliver care result in cost shifting to other purchasers.

- Our analysis shows that on average hospitals are receiving payments that are approximately 72% of costs, when supplemental provider payments are considered.
- Physicians receive payments that are approximately 34% of charges. Physician costs of delivering care typically represent 40% to 50% of billed charges.
- Federally Qualified Health Centers receive payments that are 85% of costs.
- Mental health safety net providers have experienced significant losses under TennCare; the TennCare Bureau is in the process of implementing changes to the payment methodology to address these concerns.

5. How do provider payment levels under TennCare compare to amounts paid by other purchasers in Tennessee?

Hospitals in Tennessee receive payments for inpatient care from TennCare plans that are significantly below those from other payers. This is true even after adjusting for expected contributions by hospitals through reductions in charity care. As shown in the following tables for the Safety Net providers and general hospitals, TennCare per diem average reimbursement for inpatient care was approximately 40% of the commercial average. Even after adjusting

for the 22% reduction for charity care and local government payments, these reimbursement rates are approximately 50% to 55% of the corresponding commercial levels.

Safety Net Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 936	\$ 1,200	\$ 2,238	\$ 2,304
1997	\$ 949	\$ 1,217	\$ 2,520	\$ 2,873
1998	\$ 971	\$ 1,245	\$ 2,426	\$ 2,941

All General Hospitals – Inpatient Care

Year	TennCare Per Diem Reimbursement	TennCare Per Diem (Adj. For Charity Care)	Commercial Per Diem Reimbursement	Medicare Per Diem Reimbursement
1996	\$ 470	\$ 602	\$ 1,258	\$ 964
1997	\$ 479	\$ 614	\$ 1,312	\$ 1,109
1998	\$ 415	\$ 532	\$ 1,043	\$ 993

For general hospital outpatient services, TennCare reimbursements are closer in level to those of commercial and Medicare payments. For outpatient care, comparisons are measured in terms of reimbursement per claim. As seen in the following table, TennCare payments are approximately 50% – 55% of commercial levels; after adjusting for charity care, these payments are 65% – 70% of commercial average payments.

All General Hospitals – Outpatient Care

Year	TennCare Per Claim Reimbursement	TennCare Per Claim (Adj. For Charity Care)	Commercial Per Claim Reimbursement	Medicare Per Claim Reimbursement
1996	\$ 462	\$ 592	\$ 849	\$ 498
1997	\$ 434	\$ 556	\$ 847	\$ 472
1998	\$ 455	\$ 583	\$ 823	\$ 483

Comparable detailed information was not available regarding commercial payment levels for other services.

6. Because TennCare was designed in part to reduce the amount of charity care provided by hospitals, what is the level of charity care today compared to 1993 (the year before TennCare began)?

In developing the capitation rates for TennCare, the State assumed that charity care provided by hospitals would be reduced by approximately 46%. While charity care decreased in the early years of the program, the amount of charity care has returned to pre-TennCare levels. Two important questions must be addressed in evaluating the effect of charity care on provider payments under TennCare:

1. what is the most likely amount of charity care in 1999 in the absence of TennCare, and
2. have the costs of providing services to low-income populations been spread more broadly under TennCare.

We cannot estimate the likely level of charity care in the absence of TennCare. Estimates of the number of uninsured/uninsurable in Tennessee vary widely and a precise estimate was not available within the time provided for this analysis. We believe that the number of Tennesseans without insurance would have been higher had TennCare not expanded coverage to 400,000 uninsured and uninsurable individuals.

Our analysis shows that charity care decreased significantly at the time that TennCare started. More recently, charity care has returned to the levels seen in 1993. No adjustment was made to the capitation rates to reflect the decrease in available funding resulting from the change in the level of charity care. Reductions to the capitation rates to reflect expected decreases in the level of charity care implicitly spread the cost of providing that care across the entire state.

The specific payment amounts to hospitals appear to reflect a reduced payment amount per admission consistent with an expectation that total hospital payments would include both costs associated with traditional Medicaid enrollees and individuals who had previously been uninsured or uninsurable. Supplemental payments to hospitals provide extra revenue to cover costs. However, hospitals cannot be assured of receiving those payments on a year-to-year basis under the current funding approach.

7. Are there structural issues regarding the operation of TennCare that result in additional costs to MCOs and providers that are different from costs for other programs?

Medicaid managed care programs impose requirements on health plans that are different from those of other purchasers. Medicaid programs offer a broader range of benefits with fewer barriers to obtaining services. Health plans that are most familiar with serving commercial populations may need to make significant adjustments to their processes, data reporting and utilization review. These changes can require significant investments, but are typical of the needs of plans participating in Medicaid programs.

The results of our state survey show substantially similar benefits covered in all states. For items that comprise the majority of health plan costs (inpatient and outpatient hospital, physician and prescription drugs), all states provided full coverage without restrictions. Dental services did show some variation across states, as some programs have significant restrictions on services for adults, similar to TennCare.

A significant concern among TennCare MCOs is the EPSDT “consent decree”. Our survey shows that all states cover EPSDT services as required by law, but the degree to which the operation of the program results in an expansion of what is considered a covered service can not be determined from the information available. EPSDT expansions are a concern among health plans in all states.

The grievance and appeals procedure used in the TennCare program also causes additional administrative and medical costs to be incurred by health plans by requiring the coverage of services not included in health plan contracts. Our survey of other states shows similar grievance processes in those programs. Typically members must appeal their coverage decision through the health plan’s internal review procedures. If care is denied at that level, recipients can appeal their decisions either to the state or to some other external review organization. Information was not available for survey states, or for Tennessee, to determine the extent to which appeals are raised up to the state level and the extent to which additional services result from the appeals process.

Summary of results

TennCare health plans have generally broken even financially during the early years of the program. More recently, health plans in total show slight financial losses. TennCare capitation rates are low when compared to Medicaid programs in other states. Our analysis shows that reductions in charity care occurred in the early years of the program, but that those reductions have not been sustained.

Providers operating under TennCare appear to be under significant financial stress, and we would expect those providers to force higher payments from MCOs over time or withdraw from the TennCare program. We do not believe the current funding level can be sustained while ensuring adequate access to care.

In the following tables we summarize our results showing the net deficit in funding under three scenarios, including low, high and best estimates. The best estimate generally falls at the midpoint between the low and high estimates, with minor variations.

In these tables we begin with the capitation rates paid to the MCOs in row 1. We then estimate the funding deficit as calculated above, excluding the effect of the uninsured/uninsurable mix and changes in charity care levels (row 2). MCO and provider supplemental payments (rows 3 and 4) are added to the capitation payments to recognize total funding amounts. Row 5 shows our best estimate of the effect of the changing distribution of uninsured and uninsurables over time as the program has been closed to the uninsured. Because the uninsurable population is significantly more costly than the uninsured, this changing population mix has a negative financial impact on health plans. Finally, we estimate the effect of the changing charity care burden on providers (row 6). TennCare capitation rates were calculated based on an expectation of reductions in the amount of charity care that would be provided by hospitals concurrent with the enrollment of the uninsured in TennCare. Charity care decreased in the early years of TennCare, but has begun to approach pre-TennCare levels. This charity care is partially funded by provider supplemental payments. The total deficit is shown in the last row.

TennCare Summary of Surplus/(Deficit) – Low Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$6)	(\$6)	(\$6)	(\$6)	(\$6)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	\$0	(\$1)	(\$1)	\$0
6.	Estimated deficit due to charity care	N/A	\$0	(\$1)	(\$1)	(\$1)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	\$15	\$5	\$0	\$1	\$1

TennCare Summary of Surplus/(Deficit) – High Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$29)	(\$29)	(\$29)	(\$29)	(\$29)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	(\$2)	(\$3)	(\$4)	(\$4)
6.	Estimated deficit due to charity care	N/A	\$0	(\$3)	(\$3)	(\$3)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	(\$8)	(\$20)	(\$27)	(\$27)	(\$28)

TennCare Summary of Surplus/(Deficit) – Best Estimate						
		FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
1.	MCO capitation rate	\$98	\$103	\$114	\$114	\$116
2.	Estimated deficit due to rate setting methods	(\$16)	(\$16)	(\$16)	(\$16)	(\$16)
3.	MCO supplemental payments	\$7	\$3	\$3	\$4	\$3
4.	Provider supplemental payments	\$14	\$8	\$5	\$5	\$5
5.	Estimated deficit due to uninsured/uninsurable mix	N/A	(\$1)	(\$2)	(\$2)	(\$1)
6.	Estimated deficit due to charity care	N/A	\$0	(\$2)	(\$2)	(\$2)
7.	Total estimated surplus/ (deficit) = 2. + 3. + 4. + 5. + 6.	\$5	(\$6)	(\$12)	(\$11)	(\$11)

Recommendations

We believe that the rates currently paid to MCOs are approximately \$11 per person per month lower than the amount that would be considered actuarially sound, and that an increase is required to keep the program viable. Alternatively, program rules should be changed to decrease the cost to providers and health plans of serving TennCare enrollees. A significant reduction was made in the capitation rates based on an assumption that charity care would be reduced. While a portion of this reduction was realized in the early years of the program, charity care levels appear to have returned to prior levels, and no adjustment has been made to the capitation rates to recognize this change. Adjustments have also not been made to reflect the changing population mix covered by the program, as TennCare was closed to uninsured adults, but uninsurable individuals remained eligible.

If a payment rate increase is implemented, it should be done in a manner that assures most of the additional funds will flow to providers. Our analysis shows that providers are being paid at rates that are significantly below their costs, and it is important that payment increases flow to those institutions and individuals. This can be accomplished by enforcing the minimum percentage of the capitation rate that is allocated for health care expenses, as compared to health plan administration. Average health plan results for the most recent two years also show net losses on TennCare business, and plans may need to retain a portion of any rate increase to cover those losses.

Based on TennCare Partners performance through 1998, we further believe that the capitation rates currently paid to BHOs are approximately \$2 per person per month lower than the amount that would be considered actuarially sound. Program modifications to be implemented this year should be considered in recommendations for capitation rates going forward in 1999.

We believe any increase in rates should be allocated to health plans and providers with the greatest responsibility for serving high cost TennCare members. This can be accomplished by adjusting capitation rates to more clearly reflect the population enrolled. Several methods are available: structuring rate categories to more accurately reflect expected costs, adjusting broad rate categories as the enrolled population changes, and health status-based payment. With more explicit capitation rate methods, the High Cost Condition (Adverse Selection) Pool could be incorporated directly into the capitation rates while assuring the funds are targeted to health plans and providers with a disproportionate share of high cost cases. The special payments should be included in the capitation rate methodology to assure on-going funding to health plans and providers.

The expectations of the TennCare program as they relate to charity care should be explicitly stated, and any adjustments to the capitation rates related to expected levels of charity care should be monitored and adjusted as appropriate. If an adjustment is made to the capitation rates to reflect an explicit level of charity care, it is critical that that adjustment change if charity care levels change.

Significant changes have been recently implemented in the Partners program, and it is not yet possible to assess the effect of those changes. BHOs now have a reduced level of responsibility, and those changes can be expected to significantly improve the position of BHOs and community mental health providers.

We do not believe that changes in the benefit design of TennCare would have a significant effect on the costs of the program. The benefits offered under TennCare are standard for a Medicaid program. Improved communication between the TennCare Bureau, MCOs, and BHOs may decrease the number of problems that appear to exist currently in the relations between those entities.

The grievance and appeal process used by TennCare is not significantly different from the process used by Medicaid programs in other states we surveyed, and we do not believe changes are warranted in that general process.

Future monitoring

Going forward, the State may wish to develop processes for monitoring the appropriateness of the capitation rates paid to health plans and payments to providers. We believe the methods used in this report could provide a framework for monitoring the program. Evaluation of health plan financial statements, with appropriate adjustments, can provide an early indicator of health plan stress under the program.

Payments to providers could be monitored through an analysis of payment levels and review of charity care obligations. These analyses require significantly more resources, as data are not as readily available.

Specific analysis appears warranted in the following two areas:

- Cost estimates for uninsured and uninsurable should be developed separately. The capitation rates should be adjusted to reflect the actual population mix from year to year.
- Given the changes in place for the TennCare Partners program, the experience of that program should be monitored to ensure the program is actuarially sound going forward.

Finally, program participation levels provide the ultimate indicator of the adequacy of capitation rates. Decreases in the willingness of providers to serve TennCare members in the absence of any requirement to do so to participate in other programs should be seen as an indication of significant stress in the system. Our analysis showed stress among particular types of providers, and indications of cost shifting from TennCare to other purchasers through the use of below-market payment rates to providers. Those providers with limited ability to shift costs to other purchasers are under significant financial stress and may have a limited ability to continue to participate in the program.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
ENROLLMENT				
1 Q	What are the eligibility categories in your Medicaid managed care program?			
A	Medicaid eligibles, Uninsurables, Individuals with limited coverage, Individuals losing COBRA coverage, Medicaid eligibles losing Medicaid eligibility who do not have access to insurance, Uninsured children under age 19 with no access to insurance, Certain dislocated workers, and Uninsured children under age 19 with access to insurance in families below 200% of poverty.	TANF; SOBRA eligible children; SSI w/o Medicare; SSI w/Medicare.	TANF MAG (Medical Assistance with Grant), MANG (Medical Assistance No Grant) and KidCare participants are eligible to enroll in Illinois' managed care program.	TANF, SOBRA, Social Service Kids, SSI w/Medicare, SSI w/o Medicare.
2 Q	Do the managed care enrollees include non-Medicaid "eligibility groups" such as the uninsurable or children under the new federal Children's Health Insurance Program (Title XXI)?			
A	All eligibility categories are participants in the managed care program.	Children's Health Insurance Program participants will be eligible to enroll in HMOs and similar entities. However, none are currently enrolled. The program becomes operational state-wide as of January 1, 1999. There are no other non-Medicaid categories.	Participants in Illinois' KidCare program, established pursuant to Title XXI, have been eligible to enroll in managed care since October 1998. As of November 1998, there were 934 KidCare participants enrolled in an MCO.	The program includes 14-18 year olds under CHIP. As of July 1, 1998 there were 20,000 eligibles in this category.
MANAGED CARE ENROLLMENT				
3 Q	What is the current (or most recently available) total Medicaid enrollment? How many of these enrollees are in managed care organizations (MCOs), primary care case management, or fee-for-service programs?			
A	The total enrollment in the program as of January, 1999 is 1,294,900. All enrollees are in MCOs.	Most recent Medicaid enrollment is approximately 900,000. Approximately 650,000 are enrolled in managed care. Approximately 21,000 are in one HMO, leaving about 629,000 in primary care case management and the balance of the 900,000 in fee-for-service.	As of November 1998, there were 1,296,285 Medicaid recipients in Illinois. A total of 167,781 people were enrolled in MCOs with the remaining 1,128,504 recipients in fee-for-service. Illinois does not offer a primary care case management option at this time. MCOs are comprised of ten traditional HMOs and 5 prepaid health plans (PHPs). One of the HMOs and one of the PHPs do not have enrollment as of November 1998. The HMOs and PHPs deliver the same comprehensive set of services.	Total Medicaid: 517,330; 152,000 enrolled with MCOs, 166,034 enrolled with PCCM.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
ENROLLMENT				
1 Q	What are the eligibility categories in your Medicaid managed care program?			
A	TANF; Disabled; Elderly	TANF; AB/AD (w/ and w/o Medicare); Old Age Assistance (w/o Med, w/Med-B only, w/Med Regular); General Assistance (receive state GA funds - generally indigent single men); Poverty Level Medical Adults <100% FPL (Pregnant women); Poverty Level Medical Adults 100-170% FPL (pregnant women); PLM Child 0-1, and 1-5 (<133% FPL); PLM Child 6-18 (<100% FPL); Foster Care; OHP Adults & Couples (not otherwise eligible adults <FPL); OHP Families (not otherwise eligible families <FPL - includes adults only; their children are classified as PLM Child); CHIP Children 0-1, 1-5 and 6-18 (<170% FPL)	TANF, Aged and Blind/Disabled. Excluded are those in long-term care or with other insurance (Medicare or other 3rd Party insurance).	TANF, TANF Related, pregnant women up to 185% of the poverty level, and children up to 200% of the poverty level.
2 Q	Do the managed care enrollees include non-Medicaid "eligibility groups," such as the uninsurable, children under the new federal Children's Health Insurance Program (Title XXI) or other non-traditional Medicaid groups? How many enrollees are in each category? How long have these eligibility categories been in place?			
A	MinnesotaCare is a program for the uninsured. There is also a general assistance program that does not have federal funding and the traditional medical assistance program. (Note: the 3 plans have separate rates but fall under one contract with MCOs.) 185,000 out of 400,000 eligible are in managed care. MinnesotaCare adds 105,000. Categories have been in place for 10 years.	CHIP - new 1998 - approx. 16,850 members; OHP A&C/OHP Families - effective w/OHP start 1994 - approx. 90,000 members; GA - effective pre-OHP - approx. 3,000 members.	Yes, Child Health Title XXI. Enrollment in CHIP was 1,811 as of October 1998.	No
MANAGED CARE ENROLLMENT				
3 Q	What is the current (or most recently available) total Medicaid enrollment? How many of these enrollees are in managed care organizations (MCOs), primary care case management, or fee-for-service programs?			
A	MinnesotaCare enrollment is approximately 105,000. Approximately 185,000 Medical Assistance and General Assistance are enrolled in managed care.	Total Eligibility: 369,500; In MCOs: 307,260; PCCM: 4,100; FFS: 58,140.	Total Medicaid: 492,000; MCO: 99,000; PCCM:188,000; FFS: 205,000.	As of June 1998, 444,336 clients were enrolled in mandatory managed care and 4,484 in the PCCM program. Total Medicaid population served in FY 98 is 732,802 average monthly eligible clients. The difference between the total population of 732,802 and the combination of managed care and PCCM enrollees (448,820) are cared for under the fee for service program (283,982).

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
4 Q	Of the total number in managed care how many are in each category of eligibility?			
A	Enrollment of the Medicaid eligibles is 829,000. Enrollment of the "non-traditional" Medicaid categories, the uninsured/uninsurable is 430,000.	The exact number of MCO enrollees as of Dec. 1, 1998 is 21,008, distributed 12,013 TANF, 5,348 SOBRA Eligible Children; 1,133 SSI w/Medicare; and 2,478 SSI w/o Medicare	Of the total 167,781 people enrolled in MCOs, 149,284 are TANF MAG clients and 18,497 are MANG clients.	TANF: 55,200; SOBRA: 41,600; Social Service Kids: 10; SSI with Med w/ABD: 22,300; SSI without w/ABD: 33,600
5 Q	What type of waiver does the state have (e.g., 1115, 1915(b), etc.)?			
A	1115	Georgia has a 1915(b) waiver to support its primary care case management program. The HMOs are a voluntary option to the PCCM, and are not included in the waiver.	Illinois was granted an 1115 waiver in July 1996 in order to implement the Illinois MediPlan Plus program. Implementation of the program has been put on hold to allow Illinois' newly elected governor to decide upon implementation of the mandatory program	1115
6 Q	When did managed care become an option for recipients? When did it become mandatory (if applicable)? Is managed care optional for some categories of aid but mandatory for others?			
A	Managed care became mandatory for all eligibility categories on January 1, 1994.	The PCCM program, which began October 1, 1993 in seven of Georgia's 159 counties is mandatory. The HMO program began February 1, 1996. It began as a voluntary program and has not become mandatory for any category of eligible.	Illinois' managed care program is completely voluntary. Clients may enroll and disenroll from MCOs at any time. Voluntary managed care first became an option for Medicaid clients in 1974.	Managed care became an option and mandatory in Nov. 1997. Managed care is not optional for some categories of aid.
7 Q	Are there any categories of eligibility that may not enroll in managed care?			
A	All categories of Medicaid eligibles that may enroll in managed care.	Recipients who are Medically Needy or who have short term eligibility, including SOBRA eligible pregnant women, or who are institutionalized, are ineligible.	Aid to the Aged, Blind and Disabled (AABD) clients, Refugee Assistance clients, wards of the state and clients with high-level Third Party Liability may not enroll in managed care.	Technically there are no categories of eligibility that are not covered, but there are services received which do not have managed care structures/controls (BH, AIS-MR, HCBW), those in extended care nursing facilities or psychiatric facilities, persons served under home and community based waivers, "spend down" individuals, Qualified Medicare Only Benefits, Qualified Disabled working, Specified Low-Income Medicare Benefits.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
4 Q	Of the total number in MCOs, how many are in each category of eligibility and/or capitation rate cell?			
A	Not available.	TANF: 20%; AFDC: 0.8%; Pregnant Women: 2.5%; CHIP 31.4%; ABD: 12%; SCF Kids 3%; SSI w/Medicare 6.7%; SSI w/o Medicare: 0.3%	ABD: 15,878; TANF: 83,362	TANF: 231,655; Pregnant Women: 10,090; Kids: 202,591
5 Q	What type of waiver does the state have (e.g., 1115, 1915(b), etc.)?			
A	1115	1115	1915(b): Medallion II (mandatory program). Also have Options (HMO program) and Medallion (PCCM) programs which do not require a waiver because they are not mandatory.	1915(b)
6 Q	When did managed care become an option for recipients? When did it become mandatory (if applicable)? Is managed care optional for some categories of aid but mandatory for others?			
A	Managed care has been around since the 70s. Did not become mandatory until 1984. Spend down and foster care are optional. SSI disabled and terminally ill (i.e., HIV positive) are excluded.	Before 1115, had 1915(b) in 1987 for AFDC only; OHP started February 1994 when it became mandatory for AFDC, new eligibles; Disabled started January 1995 when it became mandatory for aged, blind, foster children; Two small counties and Native Americans do not have mandatory.	PCCM became optional in 1993 and became mandatory state-wide in 1995. HMOs became optional in 1995 and became mandatory in 1996 in certain areas.	Mandatory enrollment under the current waiver began on October 1993 and was phased in by county throughout the state, with all counties covered by the end of CY 94. Kids to 200% of the poverty level and pregnant women to 185% of the poverty level were added in CY 1995. The managed care program is only available for the eligibility groups listed in #4.
7 Q	Are there any categories of eligibility that may not enroll in managed care?			
A	Spend down and foster care are optional. SSI disabled and terminally ill (i.e., HIV positive) are excluded.	Non-OHP: qualified Medicare and spend-down.	Members with TPL, including Medicare Foster Children	Managed care was only available for the eligibility groups listed in answer to question 4. Aged and Disabled, Medically Needy, State Program and Refugee clients may not enroll in managed care plans.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
8 Q	How do enrollees choose a managed care option?			
A	Enrollees have a choice of MCOs (and their corresponding BHO Partner plan) from those available in their geographic area. Enrollees can change their plan within the first 45 days of enrollment in the program and then once a year thereafter.	Georgia Medicaid has used an enrollment broker to facilitate the process. Effective 1/1/99 the enrollment broker contract will be terminated and not replaced at this time. Recipients are directly enrolled by participating MCOs.	At the Department of Human Services local office, Medicaid applicants are seen by a Health Benefits Representative (HBR). The HBR explains the differences between receiving medical care through the traditional fee-for-service system and through the managed care program and the importance of making a choice of how they wish to receive services. An applicant may enroll in the managed care program with the HBR at that time. Clients already receiving Medicaid who are eligible to enroll in managed care can see an HBR at any time to enroll in managed care. The MCO marketing staff can also assist clients in completing an enrollment form, which is then sent to the Department for processing.	Only one per region, so no choice of plan. Provider panel broader than just physicians. Thus enrollees able to choose hospitals, clinics as well as physicians within their plan.
BENEFITS				
9 Q	How many MCOs serve the program? Please provide the names of the MCOs and their estimated share of the Medicaid market.			
A	There are currently nine MCOs that serve the program. They are: Phoenix Healthcare of Tennessee 6.5% Heritage National Healthplan 4.1% Memphis Managed Care 3.2% OmniCare 3.4% Preferred Health Partnership 6.5% Prudential 6.6% Tennessee Managed Care Network 22.3% Vanderbilt Healthplans 1.0% Blue Cross Blue Shield Tennessee 46.4%	Currently only one MCO contracts to serve Medicaid, Grady Healthcare, Inc.	Current, there are 13 MCOs enrolling clients in managed care. Their names and % of enrolled beneficiaries are as follows: Accord Health Plan - 2.0% Americaid Community Care - 5.7% American Health Care Providers - 11.2% Community Health Choice - 2.6% County Care Total Health Plan (PHP) - 4.0% Family Health Network (PHP) - 2.3% Harmony Health Plan of Illinois - 15.9% Humana Health Plan - 8.2% Illinois Masonic Community Health Plan - 0.4% Neighborly Care Plan (PHP) - 2.5% UIHMO, Inc. - 2.9% United HealthCare of Illinois - 42.0% Your Health Network (PHP) - 0.2%	Region 3 and Region 5 are the only regions under managed care. 61,000 Kentucky Health Select Region 5 91,700 Passport Region 3

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
8 Q	How do enrollees choose a managed care option?			
A	There is either face-to-face enrollment with agency staff or mail in enrollment.	Open enrollment depending on aid category, and if don't choose may remain FFS if aged, blind disabled; Every 6 months can switch plans; New eligibles don't get eligibility to choose managed care plan; Aged, blind disabled not forced to choose.	Freedom of Choice, Letter using comparison chart, 60 day choice, otherwise preassigned, use PCP as part selector. 12 month enrollment period.	The state provides each client with an enrollment booklet with general program information and informs them of the plans and PCCM choices in their area. The enrollee has approximately thirty days to make a choice of plan. The client remains fee for service for determination of eligibility until enrolled in a plan. If the enrollee does not choose a plan, the client is auto-assigned to a plan. The client has an additional small period of time to choose another plan other than the assigned plan.
MANAGED CARE PENETRATION				
9 Q	How many MCOs serve the program? Please provide the names of the MCOs and their estimated share of the Medicaid market.			
A	Nine MCO contracts serve Medicaid: Altru, Blue Plus, Central Minnesota, First Plan, Health Partners/ Ramsey Care, Itasca Medical Care, Medica, Metropolitan Health Plan, UCare Minnesota.	13 MCOs CareOregon: 25,092 (10%) Cascade Comp. Care: 5,846 (2.3%) Central OR Indepen. Hlth Sys: 17,940 (7.2%) Douglas County IPA: 10,359 (4.1%) FamilyCare: 16,826 (6.3%) InterCommunity: 9,786 (3.9%) Kaiser: 19,732 (7.9%) Mid-Rogue IPA: 4,346 (1.7%) ODS Health Plan: 28,652 (11.4%) OR Health Mgmt Sys (Grants Pass Clinic): 9,587 (3.8%) Providence Health Plan: 33,969 (13.5%) Regence HMO OR: 68,028 (27.1%) Tuality Healthcare: 1,710 (0.7%)	As of April 1 there were 7 HMOs (or 5 with 1 in 3 regions) Health Keepers (Trigon Richmond, Peninsula, Priority) Southern Health-Care Net Optima - Centara Family Care MAMSI - Optimum Choice, Inc. VA Charter Health Plan (Medicaid Only)	10 Plans have contracted for CY 99. Plan Market Share Premera Blue Cross 14.26% Clark United 3.59% Community Health Plan of Washington 16.17% Group Health Cooperative 13.24% Kaiser Permanente 2.80% Kitsap Physicians Service 5.41% Aetna Health Plans 14.52% Qual Med

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
10 Q	Are any of the MCOs state-wide? If not, how are the plans' service areas defined?			
A	Blue Cross Blue Shield, Phoenix Healthcare of Tennessee, and Tennessee Managed Care Network are state-wide. The service areas for the other plans are defined by county.	The one MCO is not state-wide, but operates only in the metro Atlanta area. Service areas are defined by county.	None of the MCOs are state-wide. Their service areas are defined by contracting areas. The state is broken down into five different regional contracting areas.	None of the MCOs are state-wide. Department defines regions by county, based on practice and referral patterns.
11 Q	How many of the MCOs that serve Medicaid also have commercial business in the state?			
A	All TennCare plans have commercial business in the state. Tennessee Managed Care Network began as a pre-TennCare Medicaid-only HMO and now has a small commercial population.	The one MCO serving Medicaid does not currently have any commercial business.	The PHPs, by definition, exist to serve Medicaid clients only. Of the ten HMOs, six have commercial enrollment along with Medicaid enrollment.	Of the two MCOs, one also serves Commercial.
CAPITATION RATES				
12 Q	How are the MCO rate cells defined (e.g., category of aid, geography, age/gender, other factors), and what are the capitation rates?			
A	Rate cells are defined as follows: Less than one year of age Age 1-13 Age 14-44 Male Age 14-44 Female Age 45-64 Age 65 and Over Aid to Blind and Disabled Medicare/Medicaid Duals.	Capitation rates are age, sex, aid category and geographic area specific.	The rates are determined by category of assistance, geography and age/gender.	Age, geography, eligibility category.
13 Q	What is the basis for the managed care rates? Does the state perform an analysis of fee-for-service equivalency?			
A	Rates were developed using 1992 fee-for-service claims data.	The three prior years of Medicaid fee-for-service experience, ending 6 months prior to beginning of the new rate year, are examined and form the basis for the rates.	HMO rates are negotiated. The state performs an analysis of fee-for-service equivalency (FFSE) and rates are negotiated at an amount less than FFSE.	FFS calculation using historical FFS data.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
10 Q	Are any of the MCOs state-wide? If not, how are the plans' service areas defined?			
A	Blue Cross is state-wide. Others are regional; regions are defined by county.	5 regions define the entire state (regions include 1 or more counties). 3 plans serve all regions; remaining 10 plans serve one or more other regions.	No Medicaid carriers are state-wide.	No plan is contracted in all 39 counties. One is contracted in 30 counties, one in 28 counties and one in 27 counties.
11 Q	How many of the MCOs that serve Medicaid also have commercial business in the state?			
A	8 of the 9 have business other than Medicaid, but 2 of the 8 are Govt. only (Medicare and county workers).	6 serve commercial.	All but 1.	All of the MCOs that serve Medicaid also have commercial business in the state. The State will only do business with HMOs and MCHCS (Managed Care Health Care Service contractors) that are registered with the Insurance
CAPITATION RATES				
12 Q	How are the MCO rate cells defined (e.g., category of aid, geography, age/gender, other factors), and what are the capitation rates?			
A	Rate cells are age, gender, geography, category of aid, other factors.	Rate cells are by eligibility category (as listed in Q 1) and region. Blind and Disabled members are risk adjusted using the Disability Payment System. TANF and related rates are risk adjusted according to maternity and newborn prevalence.	Elig. Cat: TANF, Aged, Blind/Disabled Region: 5 regions in state Age: 0-1, 1-5, 6-14, 15-20 F/M, 21-44 F/M, 45+	The only rate cells used are the age/gender factors applied to the base per plan non-maternity negotiated rate. A Delivery Case Rate (DCR) is paid for each delivery and includes the hospital and professional components. The DCR rates are negotiated in conjunction with the non-maternity rate.
13 Q	What is the basis for the managed care rates? Does the state perform an analysis of fee-for-service equivalency?			
A	Rates are based off of FFS data and plans' experiences. The base rates are adjusted for DISPRO for some MCOs.	Historical MCO data used to set physical health rates, historical FFS data used for mental health rates. Since 1115 waiver, rates not based on FFSE; rates are set "to cover the cost of providing services".	FFS calculation performed using 3 years of historical FFS data.	The managed care rates are negotiated by plan by comparing the target rates projected year to year using budgetary limits. Fee for Service equivalency analysis is made only for demonstrating cost effectiveness for waiver continuation.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
14 Q	Does the state use an external actuary to set MCO rates or evaluate MCO bids?			
A	The state has not used an actuary to set rates. However, the state has, from time to time, brought in an external actuary for various rate studies.	Yes	The state used an external actuary to review the FFSE rates calculated by the state.	Yes
15 Q	Does the state provide stop-loss or any other type of risk-sharing for the managed care plans? Is there a mechanism to compensate plans that enroll a disproportionate share of high-risk people (e.g., AIDS patients)?			
A	The state does not provide stop-loss. There is a mechanism to compensate MCOs with a disproportionate enrollment of high-risk people through the High Cost Chronic Conditions Pool.	Not at this time.	No	In theory, state provides stop loss, but the state encourages plans to purchase stop loss through carriers. Also use lookback, but need to demonstrate offset. Thus, if a plan can prove that they had a disproportionate share of high risk enrollees AND they suffered measurable losses because of its, then the state may compensate.
16 Q	Are Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments included in capitation rates? If not, how do providers receive these funds? Are there any other payments made by the state to providers outside of the capitation rates? If so, what has been the approximate value of these payments over the past three years?			
A	Graduate Medical Education payments are paid to teaching hospitals and medical schools. There is a phase-in program in place which will ultimately pay GME only to the medical schools. DSH was discontinued under the TennCare program, however similar type payments are made to hospitals through a pool for uncompensated care and through special discretionary payments to hospitals.	GME and DSH are not included in the capitation rates. GME payments are an add-on to hospitals' inpatient DRG rates and outpatient payments also include the appropriate GME amounts. DSH payments are paid to hospitals outside of the claims payment system, i.e., they are lump-sum payments to hospitals.	The state includes disproportionate share payments in the capitation rates. The state does not pay for GME to HMOs or providers. The state does pay for services not covered by the HMO which were not included in the FFSE calculation.	GME in capitation rates. DSH not included in capitation rates, DSH payments received directly from department/state; this year's estimate is \$126M. Services that are carved out of managed care are made on a FFS basis; otherwise cap is full risk.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
14 Q	Does the state use an external actuary to set MCO rates or evaluate MCO bids?			
A	Yes	Yes	Yes	An outside actuary is used to review methodology and calculations to verify actuarial soundness and to provide services in establishing expected trends and bid evaluations.
15 Q	Does the state provide stop-loss or any other type of risk-sharing for the managed care plans? Is there a mechanism to compensate plans that enroll a disproportionate share of high-risk people (e.g., AIDS patients)?			
A	The state offers stop-loss but none of the plans have taken it. Starting in the year 2000 (1999 is a test year), payments will be risk-adjusted based on ACGs.		No	No stop-loss is provided by State. There is not any mechanism to compensate plans that enroll a disproportionate share of high-risk people.
16 Q	Are Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments included in capitation rates? If not, how do providers receive these funds? Are there any other payments made by the state to providers outside of the capitation rates? If so, what has been the approximate value of these payments over the past three years?			
A	GME: Carved out in 1999; still part of MinnesotaCare rates DSH: Paid on a plan specific basis for 2 counties; part of the rates for the rest of the counties. It is up to the health plans to pass on to providers.	GME and DSH payments are not included in capitation rates. Funds are calculated separately and based on FFS payments. There are no other payments made by the state to providers outside of the capitation rates.	VA - Direct to hospitals, not included in cap, dollar amounts not available.	Disproportionate Share Hospital (DSH) payments are not included in the capitation rates. Graduate Medical Education (GME) payments for only two teaching hospitals in the state (University of Washington and Harborview) have been removed from the capitation rate. The main Children's hospital and other small teaching hospitals' GME payments are still incorporated in the rate. Separate GME capitation amounts are paid to University of Washington and Harborview each month based on the number of capitation payments made.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
17 Q	In your opinion, how do Medicaid's capitation rates compare to capitation rates paid by commercial payers?			
A	N/A	Medicaid capitation rates are lower than rates paid by commercial payers.	The MAG rates are lower; however, the MANG rates are somewhat comparable to commercial payers. (PwC note: although the risk characteristics of these groups is very different).	Medicaid capitation rates are lower.
18 Q	In your opinion, how well are Medicaid providers paid, relative to the payments providers receive for commercial services? Are providers in your state anxious to sign up as Medicaid providers?			
A	N/A	Commercial payments are generally higher. Providers are not anxious to sign up with Medicaid MCOs. MCOs have generally had to pay a premium to develop a network.	Medicaid FFS rates are usually lower than commercial payers, so it can be assumed that Medicaid HMO payments are lower than commercial MCOs. We have no direct knowledge, however, the MCOs have informed us the recent rate increases in the FFSE rates have made providers hesitant to join the MCO plans.	Don't know how well Medicaid MCOs pay their providers. Providers are anxious to sign up, but minimal.
19 Q	Does Medicaid mandate the portion or percentage of MCO capitation rates that plans can use for non-medical expenses (including administration and profit)?			
A	At the inception of the program there were a few participating PPOs. PPOs' administrative fees and profit were not allowed to exceed 10% of TennCare revenue. There are not restrictions on the HMO administrative fees. At the current time, all organizations delivering care to TennCare participants are HMOs. BHOs' administration and profit are not	No	No	Yes, 10%
20 Q	What are the benefits covered under managed care? See Exhibit 11 for a comparison of covered services.			
21 Q	Are any benefits carved out of the MCO package (e.g., mental health, prescription drugs, dental)? If so, are these benefits purchased under a capitated arrangement with another vendor?			
A	Long-term care, Medicare cost sharing, certain services for children in state custody and behavioral health prescription days are carved out of the MCO/BHO package.	Please see benefits chart for exclusions.	Please see benefits chart for exclusions.	Please see benefits chart for exclusions. Behavioral health is separately capitated.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
17 Q	In your opinion, how do Medicaid's capitation rates compare to capitation rates paid by commercial payers?			
A	They are much lower. Commercial pays a 20% discount off charges. The state pays 60% of charges on a FFS basis.	5-10% lower than Commercial.	Lower	Unknown. Because of the carveouts, the extreme youthfulness of the population, and the high proportion of pregnant women covered, the population being served by the managed care plans is not representative of the commercial population.
18 Q	In your opinion, how well do Medicaid MCOs pay their providers, relative to the payments providers receive from commercial MCOs? Are providers in your state anxious to sign up with Medicaid MCOs?			
A	MCOs pay 10% over what the State pays.	MCOs pay Medicaid significantly less than Commercial. Providers are not anxious to sign up with Medicaid MCOs.	Don't know how well MCOs pay their providers. Think lower than what providers receive from commercial MCOs. No, except in Richmond.	Unknown how well the Medicaid MCOs pay their providers, but many of the providers in the state are available to serve Medicaid customers under the managed care plans.
19 Q	Does Medicaid mandate the portion or percentage of MCO capitation rates that plans can use for non-medical expenses (including administration and profit)?			
A	No, but there are requirements set forth to be a licensed HMO (not governed by the Medicaid agency).	No	No	No, but the administration portion is taken into consideration during negotiations.
20 Q	What are the benefits covered under managed care? See Exhibit 11 for a comparison of covered services.			
21 Q	Are any benefits carved out of the MCO package (e.g., mental health, prescription drugs, dental)? If so, are these benefits purchased under a capitated arrangement with another vendor?			
A	Please see benefits chart for exclusions.	Mental Health and dental are purchased via separate contracts with MHOs & DCOs. There is one stand-alone chemical dependency plan.	Case Management and Mental Rehabilitation are purchased under FFS.	Mental health, dental, and alcohol and substance abuse are major carveouts. Mental Health is covered under a separate 1915(b) waiver.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
22 Q	Does the state maintain any responsibility for FFS pharmacy claims (perhaps prior to managed care enrollment begins, or as a carve-out)? If so, does the state have a benchmark for pharmacy reimbursement stated in terms of a relationship to Average Wholesale Price (e.g., AWP – 15%)?			
A	The state pays for behavioral health prescription drugs FFS. Payment is AWP less 13% plus a \$2.50 dispensing fee.	Pharmacy, as with all other services, remains FFS until the actual effective date of enrollment (always the first of the month). The State pays AWP - 10%. One category of pharmacy claims are paid in FFS for HMO enrollees - those filled by community mental health center pharmacies, which are few in number and specifically identified in the claims processing programming. The capitation rates reflect that exception.	The MCO contracts require that the MCO pharmacy formulary be no more restrictive than the Department's formulary for Medical Assistance clients. There are no pharmacy carve-outs.	Prior to managed care, but not carved out. AWP - 10%
ADMINISTRATIVE PROCEDURES				
23 Q	Does the state collect encounter data? If so, how often are the data collected? What does the state do with the encounter data?			
A	Yes, encounter data is collected monthly and used for various purposes including quality improvement, outcomes studies, and management reporting.	Yes, encounters are required to be submitted within 60 days following the date of service.	Encounter data is collected monthly, within 120 days of the last day of the service month. For contracting HMOs, which are capitated full-risk plans, encounter data is used to assist in quality assurance activities. For contracting PHPs, which are capitated but not at-risk, the encounter data is used for quality assurance purposes, but is also used to reconcile the capitation payments to the fee-for-service equivalent for the services provided. If the fee-for-service equivalent is less than the capitation payments made, the PHP owes the state the difference and, if the fee-for-service equivalent is greater than payments made, the state owes the PHP the difference.	Yes, encounter data is collected monthly and analyzed for integrity. The data is used in setting future rates.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
22 Q	Does the state maintain any responsibility for FFS pharmacy claims (perhaps prior to managed care enrollment begins, or as a carve-out)? If so, does the state have a benchmark for pharmacy reimbursement stated in terms of a relationship to Average Wholesale Price (e.g., AWP – 15%)?			
A	Rx is not carved out of the managed care program. FFS Pharmacy payment rate is \$3.65 plus (AWP - 9%).	Yes, prior to enrollment in plan and for ALL Mental Health drugs regardless of enrollment in plan. 89% of AWP + dispensing fee (varies by pharmacy volume of Medicaid prescriptions).	FFS in preassignment. Pharmacy reimbursement is paid open formulary (AWP - 9% + Dispensing Fee). The dispensing fee is \$4.25, but is only paid once per person/per product/per person/per month. In other words, the dispensing fee is not paid for refills at the same pharmacy in the same month. About 80% of prescriptions are paid the dispensing fee; this averages out to a \$3.36 per prescription dispensing fee.	The state only covers pharmacy with the Healthy Options population until the client becomes enrolled. The state reimburses pharmacies for ingredient costs at 89% of AWP, I.e., AWP - 11%. Some pharmacy benefits have been carved out.
ADMINISTRATIVE PROCEDURES				
23 Q	Does the state collect encounter data from plans? If so, how often are the data collected? What does the state do with the encounter data?			
A	Yes, it is collected on a quarterly basis with a 3 month lag. The State is running reports to ensure that access to services has increased under managed care. Right now they are looking at dental and are finding that access has increased. They will also use the data for HEDIS measures, rate setting and measuring performance standards in MCO contracts.	Yes. Collected monthly and compiled in state data base. This data forms the basis of capitation rates.	Just starting Dec. 1, frequency open to plans, same edits as FFS and price claims under FFS. Not enough now, but for rate analysis.	The State collects encounter data from the plans on a quarterly basis. The State has several plans for the encounter data such as quality monitoring, risk adjusting/rate setting, utilization trends, etc.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
24 Q	Do other purchasers in the market collect encounter data?			
A	N/A	We are led to understand that the requirement for encounter data based on the HCFA 1500 is common practice for commercial HMOs in Georgia.	We are not aware of any other purchasers requiring this data.	Don't know.
25 Q	What kind of reporting and auditing requirements are placed on plans?			
A	Quarterly service utilization reports, weekly claims processing reports, and encounter data reporting. Quarterly NAIC HMO reports.	Plans provide quarterly unaudited financial reports and annual audited financial reports. These standard NAIC HMO report forms also provide some utilization information. Most utilization information is determined from the encounter data. The federal Physician Incentive Plan reporting is required. HEDIS reporting is required after the first year of operation. A detail of claims related to out of plan utilization is reported, as well as a number of quality of care elements including: low birth weight babies, inpatient mortality, education participation rate. An external quality of care review is performed annual, including a medical records review. Quarterly on-site monitoring is performed by Department staff to supplement the routine operational documentation approvals required.	Several reports are required on either a monthly, quarterly or annual basis. Reports include Quality Assurance plans, Utilization Review and Peer Review plan. Marketing materials, complaints, grievances and resolutions, financial statements and annual reports.	HEDIS, financial and quality reporting, member and provider services, network, utilization data, health education.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
24 Q	Do other purchasers in the market collect encounter data?			
A	Not specified in material provided.	Don't know.	Don't know if other purchasers in the market collect encounter data; State does and large groups.	No, some commercial purchasers require HEDIS.
25 Q	What kind of reporting and auditing requirements are placed on plans?			
A	There are numerous requirements through state licensure. Annual reports on spending are broken out by commercial and public programs. Apparently there are no guidelines on data collection or development so not all numbers are apples to apples.	Annual and quality utilization and financial information. Additionally, contractors are required to hold restricted reserves.	Extensive: monthly, quarterly, annual plus onsite, no HEDIS reporting at this time, but NCQA accredited required.	The reporting requirements include HEDIS measures, encounter data, provider network changes and health care experience data. Also, plans are required to file quarterly financial reports with the insurance commissioner who monitors solvency. In addition, the plans must file all their contracts with the State's Insurance Commissioner's Office.

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	TENNESSEE	GEORGIA	ILLINOIS	KENTUCKY
26 Q	What happens after a plan denies care because it is not "medically necessary," and the enrollee wants to appeal? What is the appeals process for disputes about medical necessity?			
A	Enrollees may fill out a form and send to the MCO. The MCO makes the initial decision. The enrollee may appeal the MCO decision to the TennCare appeals and grievances unit within the Department of Health. If the decision is adverse, the enrollee may hold a hearing.	Enrollees are encouraged to utilize the health plan's grievance process, required by Georgia law and the Medicaid contract. Enrollees retain the right to appeal through the State's fair hearing process.	The Department first requires MCO enrollees to appeal any coverage decisions to the MCO. The grievance process of the MCO is prior-approved by the Department. If the enrollee is not satisfied with the decision of the MCO, they can appeal to the Department. The Department is currently in the process of finalizing its appeals process. This information can be forwarded to you upon completion. It should be noted, however, that since Illinois' managed care program is voluntary, clients usually disenroll from the plan rather than go through the grievance process. In addition, the Department operates the Client HealthCare Hotline, where clients may file complaints. These complaints are usually worked out immediately by the Department contacting the MCO, therefore, formal grievances are rarely filed.	All plan denials reviewed by EQRO (External Quality Review Org). Enrollee can ask for a hearing for any reason.
27 Q	What is the appeals process for other disputes, including disputes between providers and MCOs?			
A	Contracts with MCOS specify that there must be arbitration and dispute resolution procedures established. These procedures are subject to approval by the Tennessee Department of commerce and Insurance.	N/A	As a general rule, the Department tries not to get involved in disputes between providers and MCOs especially network providers. The Department does take payment disputes over the hotline and facilitates resolution when possible, usually by contacting the MCO to ensure they are addressing the issue.	Contractual, providers can come to state (informal).

**COMPARISON STATES -
SURVEY QUESTIONS AND ANSWERS**

Exhibit 2a

Q/A	MINNESOTA	OREGON	VIRGINIA	WASHINGTON
26 Q	What happens after a plan denies care because it is not "medically necessary," and the enrollee wants to appeal? What is the appeals process for disputes about medical necessity?			
A	There is an extensive appeals process. There are advocates and ombudsmen available. Contracts with MCOs state that appeals are binding.	Plan level, then to state with hearing.	Enrollee appeals to state or plan. If plan cannot review within 7 days, must forward to state.	Plans must have a process which is consistent with the Quality Improvement Program Standards as set forth by the State.
27 Q	What is the appeals process for other disputes, including disputes between providers and MCOs?			
A	There is no appeals process for providers on decisions regarding medical necessity – only for recipients. The State Medicaid program does not get involved in this.	Model contract - not a lot of recourse for providers. Contractual for the state and plan; can withdraw with 30 days notice.	Do not intercede, unless quality of care an issue.	Included in the contract between the plans and their providers. Dispute resolution language is required to be included in the contract by the State's Insurance Commissioner's office.

TennCare
Enrollment by Status Over Time

Exhibit 3a

	Uninsured/ Uninsurable	Medicaid	Total	% Uninsured/ Uninsurable
January, 1995	418,636	841,259	1,259,895	33.2%
June, 1995	396,701	794,441	1,191,142	33.3%
March, 1996	351,723	822,138	1,173,861	30.0%
September, 1996	326,316	840,517	1,166,833	28.0%
January, 1997	306,585	836,741	1,143,326	26.8%
July, 1997	348,475	833,012	1,181,487	29.5%
January, 1998	390,637	833,575	1,224,212	31.9%
April, 1998	413,550	840,333	1,253,883	33.0%
July, 1998	429,612	829,808	1,259,420	34.1%
January, 1999	466,015	828,897	1,294,912	36.0%

from <http://www.state.tn.us/health/tenncare/enrol-co.htm>

TennCare
Enrollment by Status by MCO
As of January 1999

Exhibit 3b

	Uninsured/ Uninsurable	Medicaid	Total	% Uninsured/ Uninsurable
OMNI	16,595	28,808	45,403	36.6%
Blue Cross	185,444	300,539	485,983	38.2%
John Deere	11,847	17,222	29,069	40.8%
TLC	16,495	40,178	56,673	29.1%
Phoenix	64,553	103,888	168,441	38.3%
PHP	32,840	45,725	78,565	41.8%
Prudential	3,198	9,315	12,513	25.6%
Access MedPlus	92,688	206,174	298,862	31.0%
Blue Care	39,367	68,572	107,939	36.5%
Vanderbilt	2,988	8,476	11,464	26.1%
Total	466,015	828,897	1,294,912	36.0%

Data from <http://www.state.tn.us/health/tenncare/enrolmco.htm>

TennCare
Enrollment by Region
As of January 1999

Exhibit 3c

	Uninsured/ Uninsurable	Medicaid	Total	% Uninsured/ Uninsurable
Davidson	38,279	78,245	116,524	32.9%
East TN	84,642	124,394	209,036	40.5%
First TN	32,717	47,341	80,058	40.9%
Hamilton	21,328	42,089	63,417	33.6%
Knox	24,151	44,288	68,439	35.3%
Memphis/Shelby	60,864	180,591	241,455	25.2%
Mid-Cumberland	52,291	69,404	121,695	43.0%
Northwest	22,505	40,826	63,331	35.5%
South Central	29,485	46,812	76,297	38.6%
Southeast	30,415	42,563	72,978	41.7%
Southwest	33,777	61,184	94,961	35.6%
Upper Cumberland	35,483	46,813	82,296	43.1%
Out of State	-	4,614	4,614	0.0%
Total	465,937	829,164	1,295,101	36.0%

from <http://www.state.tn.us/health/tenncare/enrol-co.htm>

TennCare Actuarial Analysis
Health Plan Reported PMPM Costs

Exhibit 4

	Age 0 - 1	Age 1 - 13	Age 14 - 44 Female	Age 14 - 44 Male	Age 45 - 64	Age 65+ Non- Medicare	Blind/ Disabled	Dual Eligibles	Weighted Average Cost	Weighted Average Capitation Rates	Loss Ratio
FY97											
BCBS of Tennessee	\$149.74	\$36.15	\$110.34	\$52.56	\$143.78	\$89.07	\$237.29	\$83.70	\$101.24	\$113.56	89.1%
John Deere	\$58.46	\$18.52	\$82.83	\$38.12	\$106.03	\$56.82	\$226.73	\$124.24	\$84.99	\$111.42	76.3%
Phoenix Healthcare	\$74.59	\$25.99	\$129.60	\$70.70	\$193.11	\$137.77	\$196.43	\$53.38	\$95.66	\$112.79	84.8%
PHP of Tennessee	\$202.90	\$60.98	\$119.44	\$66.42	\$193.76	\$204.09	\$197.53	\$70.62	\$111.28	\$115.88	96.0%
Prudential Health Plan	\$548.85	\$31.58	\$129.40	\$59.69	\$187.15	\$88.17	\$419.95	\$93.39	\$108.63	\$93.27	116.5%
Vanderbilt Health Plan	\$109.54	\$27.49	\$89.82	\$85.60	\$148.08	\$172.26	\$180.46	\$80.22	\$90.93	\$122.80	74.0%
Average Cost	\$141.08	\$36.62	\$111.87	\$54.91	\$151.37	\$103.96	\$230.15	\$81.93	\$101.11		
Capitation Rates	\$127.64	\$39.35	\$135.17	\$78.71	\$142.43	\$54.83	\$286.63	\$67.69		\$113.54	89.1%
FY98											
BCBS of Tennessee	\$108.13	\$32.48	\$185.15	\$25.83	\$141.17	\$81.85	\$214.68	\$81.94	\$92.69	\$113.21	81.9%
John Deere	\$79.79	\$23.79	\$92.92	\$87.74	\$111.64	\$67.67	\$249.31	\$122.83	\$102.14	\$120.96	84.4%
Memphis Managed Care*									\$86.34	\$117.75	73.3%
Phoenix Healthcare	\$58.70	\$29.00	\$128.26	\$71.70	\$186.73	\$144.15	\$199.60	\$68.12	\$95.07	\$113.72	83.6%
PHP of Tennessee	\$176.52	\$84.78	\$147.31	\$91.13	\$192.22	\$149.44	\$195.04	\$49.57	\$121.89	\$118.77	102.6%
Vanderbilt Health Plan	\$95.77	\$66.93	\$103.10	\$89.00	\$196.76	\$162.99	\$199.30	\$108.30	\$112.19	\$125.11	89.7%
Average Cost	\$86.91	\$35.42	\$145.77	\$36.32	\$151.05	\$104.94	\$200.64	\$75.62	\$92.23		
Capitation Rates	\$137.17	\$39.61	\$136.45	\$78.71	\$144.35	\$162.78	\$286.63	\$87.86		\$114.45	80.6%

* Memphis Managed Care data was submitted in total for FY97 and FY98, and was not easily translated into the above rate cells. Total data is presented here for this plan.

TennCare Actuarial Analysis
Total Payments to Plans and Providers

Exhibit 5a

	FY 1994*	FY 1995	FY 1996	FY 1997	FY 1998
Average Monthly Eligibles (10/1/98 Data)	972,903	1,226,699	1,203,420	1,183,991	1,249,008
Capitation Payments					
MCOs	\$569,651,291	\$1,522,036,377	\$1,647,680,262	\$1,614,849,340	\$1,746,858,185
BHOs	N/A	N/A	N/A	\$311,703,786	\$340,328,258
Total	\$569,651,291	\$1,522,036,377	\$1,647,680,262	\$1,926,553,126	\$2,087,186,443
Additional Payments to MCOs					
High Cost Chronic Conditions	\$20,000,000	\$40,000,000	\$40,000,000	\$55,000,000	\$40,000,000
Unallocated Fund Pool - 1st 30 Days	\$20,493,622	\$3,068,814	\$0	\$0	\$0
Total	\$40,493,622	\$43,068,814	\$40,000,000	\$55,000,000	\$40,000,000
Total Payments to MCOs	\$610,144,913	\$1,565,105,191	\$1,687,680,262	\$1,669,849,340	\$1,786,858,185
Total Payments to BHO's	N/A	N/A	N/A	\$311,703,786	\$340,328,258
Additional Payments to Physical Health Providers					
Primary Care Assistance Fund	\$6,847,428	\$8,867,264	\$11,190,093	\$0	\$0
Malpractice Assistance Fund	\$3,021,480	\$4,836,478	\$6,982,773	\$0	\$0
Unallocated Fund Pool - Uncompensated Care	\$50,000,000	\$0	\$12,000,000	\$0	\$60,000,000
Unallocated Fund Pool - EBNE	\$66,856,021	\$46,876,823	\$0	\$0	\$0
Special Pool - Medical Education	\$26,640,060	\$24,276,607	\$48,000,000	\$48,085,490	\$48,000,000
Special Pool - Hospitals	\$0	\$54,499,069	\$0	\$0	\$0
Total	\$153,364,989	\$139,356,241	\$78,172,866	\$48,085,490	\$108,000,000
Additional Payments to Behavioral Health Providers					
SPMI through 6-30-96	\$51,097,207	\$106,836,707	\$105,277,535	\$0	\$0
Mental Health Clinic Pool Payments	\$0	\$0	\$0	\$8,300,000	\$7,750,000
Total	\$51,097,207	\$106,836,707	\$105,277,535	\$8,300,000	\$7,750,000
Total Payments to Physical Health Providers	\$763,509,902	\$1,704,461,432	\$1,765,853,128	\$1,717,934,830	\$1,894,858,185
Total Payments to Behavioral Health Providers	\$51,097,207	\$106,836,707	\$105,277,535	\$320,003,786	\$348,078,258
Total Payments	\$814,607,109	\$1,811,298,139.00	\$1,871,130,663.00	\$2,037,938,616.00	\$2,242,936,443.00

* Six months of data

TennCare Actuarial Analysis
PMPM Payments to Plans and Providers

Exhibit 5b

	FY 1994*	FY 1995	FY 1996	FY 1997	FY 1998
Average Monthly Eligibles (10/1/98 Data)	972,903	1,226,699	1,203,420	1,183,991	1,249,008
Capitation Payments					
MCOs	\$97.59	\$103.40	\$114.10	\$113.66	\$116.55
BHOs	\$0.00	\$0.00	\$0.00	\$21.94	\$22.71
Total	\$97.59	\$103.40	\$114.10	\$135.60	\$139.26
Additional Payments to MCOs					
High Cost Chronic Conditions	\$3.43	\$2.72	\$2.77	\$3.87	\$2.67
Unallocated Fund Pool - 1st 30 Days	\$3.51	\$0.21	\$0.00	\$0.00	\$0.00
Total	\$6.94	\$2.93	\$2.77	\$3.87	\$2.67
Total Payments to MCOs	\$104.52	\$106.32	\$116.87	\$117.53	\$119.22
Total Payments to BHO's	\$0.00	\$0.00	\$0.00	\$21.94	\$22.71
Additional Payments to Physical Health Providers					
Primary Care Assistance Fund	\$1.17	\$0.60	\$0.77	\$0.00	\$0.00
Malpractice Assistance Fund	\$0.52	\$0.33	\$0.48	\$0.00	\$0.00
Unallocated Fund Pool - Uncompensated Care	\$8.57	\$0.00	\$0.83	\$0.00	\$4.00
Unallocated Fund Pool - EBNE	\$11.45	\$3.18	\$0.00	\$0.00	\$0.00
Special Pool - Medical Education	\$4.56	\$1.65	\$3.32	\$3.38	\$3.20
Special Pool - Hospitals	\$0.00	\$3.70	\$0.00	\$0.00	\$0.00
Total	\$26.27	\$9.47	\$5.41	\$3.38	\$7.21
Additional Payments to Behavioral Health Providers					
SPMI through 6-30-96	\$8.75	\$7.26	\$7.29	\$0.00	\$0.00
Mental Health Clinic Pool Payments	\$0.00	\$0.00	\$0.00	\$0.58	\$0.52
Total	\$8.75	\$7.26	\$7.29	\$0.58	\$0.52
Total Payments to Physical Health Providers	\$130.80	\$115.79	\$122.28	\$120.91	\$126.42
Total Payments to Behavioral Health Providers	\$8.75	\$7.26	\$7.29	\$22.52	\$23.22
Total Payments	\$139.55	\$123.05	\$129.57	\$143.44	\$149.65

* Six months of data

TennCare
Summary of Unadjusted Financial Results
1994-1996 Data

Exhibit 6a

MCO	1994 - 1996				
	Average Members	Total Revenue	Unadjusted Admin	Unadjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee	592,574	\$2,321,046,637	\$208,563,454	\$2,060,694	0.09%
Heritage/John Deere	21,869	\$87,583,795	\$13,781,564	\$6,648,844	7.59%
Memphis Managed Care	37,665	\$155,991,438	\$16,337,219	(\$744,622)	-0.48%
OmniCare	57,659	\$144,143,379	\$53,933,618	(\$8,088,166)	-5.61%
Phoenix Healthcare	43,088	\$156,471,729	\$21,153,736	\$3,593,919	2.30%
Preferred Health Partnership	60,722	\$235,084,634	\$24,705,016	\$741,075	0.32%
Prudential Community Care	9,214	\$37,538,751	\$6,188,218	(\$2,867,755)	-7.64%
TN Managed Care Network	290,326	\$1,172,435,599	\$124,767,598	\$30,797,411	2.63%
Vanderbilt Health Plans	12,809	\$55,875,552	\$10,208,503	(\$4,934,862)	-8.83%
Total TennCare MCO*	1,125,926	\$4,366,171,514	\$479,638,926	\$27,206,538	0.62%

MCO Notes:

* Experience from the following were not reflected in the above financial results. Their amounts do not significantly alter the indicated trends.

1. **The University of Tennessee Health Plan, Inc** - Effective January 1, 1996, the University of Tennessee Health Plan, Inc. was acquired by Volunteer State Health Plan, Inc., a subsidiary of Blue Cross/Blue Shield of Tennessee.
2. **Healthsource Tennessee Preferred, Inc. d/b/a Tennesource** - TennCare enrollment of Healthsource Tennessee Preferred, Inc., d/b/a Tennesource, was sold to Phoenix Health Care of Tennessee, Inc., for \$1,829,500. The contract between Healthsource Tennessee Preferred, Inc., d/b/a Tennesource, and TennCare terminated on December 31, 1996. The TennCare enrollees in Healthsource Tennessee Preferred, Inc., d/b/a Tennesource, became members of Phoenix Health Care of Tennessee, Inc., effective January 1, 1997.
3. **Health Net** - Effective January 1, 1994, Health Net, Inc. contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. Effective January 1 1997, the TennCare contract was assigned to a related party, Health Net TNCARE HMO, Inc. TennCare HMO ceased providing services for TennCare participants when it was purchased by Phoenix Healthcare on November 30, 1997.

BHO	1994 - 1996				
	Average Members	Total Revenue	Administrative Expenses	Pretax Profit	Profit as % of Revenue
Tennessee Behavioral Health	544,080	\$64,731,150	\$6,636,241	\$429,189	0.66%
Premier Behavioral Health	700,072	\$91,379,880	\$10,069,179	(\$10,002,695)	-10.95%
Total TennCare BHO	1,244,152	\$156,111,030	\$16,705,420	(\$9,573,506)	-6.13%

TennCare
Summary of Unadjusted Financial Results
1997

Exhibit 6b

MCO	1997				
	Average Members	Total Revenue	Unadjusted Admin	Unadjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee	548,523	\$804,254,228	\$101,162,102	\$17,517,292	2.18%
Heritage/John Deere	24,565	\$37,917,611	\$5,652,281	(\$8,503,907)	-22.43%
Memphis Managed Care	43,191	\$60,062,927	\$7,747,022	(\$1,548,536)	-2.58%
OmniCare	43,021	\$59,893,844	\$11,696,844	(\$189,286)	-0.32%
Phoenix Healthcare	173,430	\$221,452,588	\$32,949,109	(\$29,460,137)	-13.30%
Preferred Health Partnership	91,269	\$112,614,439	\$13,121,164	(\$5,182,987)	-4.60%
Prudential Community Care	11,014	\$15,992,046	\$2,137,943	\$1,122,758	7.02%
TN Managed Care Network	291,710	\$400,841,595	\$50,612,855	\$7,467,501	1.86%
Vanderbilt Health Plans	11,887	\$17,848,886	\$2,734,552	\$1,162,613	6.51%
Total TennCare MCO	1,238,610	\$1,730,878,164	\$227,813,872	(\$17,614,689)	-1.02%

BHO	1997				
	Average Members	Total Revenue	Administrative Expenses	Pretax Profit	Profit as % of Revenue
Tennessee Behavioral Health	480,801	\$133,731,512	\$16,364,050	\$224,322	0.17%
Premier Behavioral Health	688,504	\$192,407,954	\$17,997,433	(\$3,702,795)	-1.92%
Total TennCare BHO	1,169,305	\$326,139,466	\$34,361,483	(\$3,478,473)	-1.07%

TennCare
Summary of Unadjusted Financial Results
First nine months 1998 Data

Exhibit 6c

MCO	9 Months of 1998				
	Average Members	Total Revenue	Unadjusted Admin	Unadjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee	569,271	\$600,342,902	\$72,564,731	\$22,503,388	3.75%
Heritage/John Deere*	23,187	\$9,142,000	\$1,341,000	\$2,027,000	22.17%
Memphis Managed Care	54,029	\$58,612,903	\$6,881,199	(\$2,758,953)	-4.71%
OmniCare	45,776	\$49,390,741	\$8,450,269	(\$579,641)	-1.17%
Phoenix Healthcare	180,207	\$200,494,192	\$25,790,919	(\$5,362,733)	-2.67%
Preferred Health Partnership	95,268	\$100,790,420	\$14,604,441	(\$21,520,764)	-21.35%
Prudential Community Care*	11,848	\$5,116,000	\$764,000	\$238,000	4.65%
TN Managed Care Network	304,900	\$331,944,185	\$41,443,930	(\$5,811,054)	-1.75%
Vanderbilt Health Plans	11,872	\$13,782,676	\$2,181,539	(\$280,059)	-2.03%
Total TennCare MCO	1,296,358	\$1,369,616,019	\$174,022,028	(\$11,544,816)	-0.84%

* Data is for the first 3 months of 1998

BHO	9 Months of 1998				
	Average Members	Total Revenue	Administrative Expenses	Pretax Profit	Profit as % of Revenue
Tennessee Behavioral Health	555,282	\$104,889,751	\$11,873,587	(\$6,781,063)	-6.46%
Premier Behavioral Health	707,734	\$147,158,331	\$14,876,345	\$8,381,502	5.70%
Total TennCare BHO	1,263,016	\$252,048,082	\$26,749,932	\$1,600,439	0.63%

TennCare
Summary of Adjusted Financial Results
1994-1996 Data

Exhibit 7a

MCO	1994 - 1996				
	Average Members	Total Revenue	Adjusted Admin*	Adjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee**	592,574	\$2,321,046,637	\$208,563,454	\$2,060,694	0.09%
Heritage/John Deere	21,869	\$87,583,795	\$11,319,674	\$9,110,734	10.40%
Memphis Managed Care	37,665	\$155,991,438	\$15,779,644	(\$187,047)	-0.12%
OmniCare	57,659	\$144,143,379	\$26,090,441	\$19,755,011	13.71%
Phoenix Healthcare	43,088	\$156,471,729	\$14,463,312	\$10,284,343	6.57%
Preferred Health Partnership	60,722	\$235,084,634	\$24,705,016	\$741,075	0.32%
Prudential Community Care	9,214	\$37,538,751	\$4,880,038	(\$1,559,575)	-4.15%
TN Managed Care Network	290,326	\$1,172,435,599	\$119,653,440	\$35,911,569	3.06%
Vanderbilt Health Plans	12,809	\$55,875,552	\$7,379,486	(\$2,105,845)	-3.77%
Total TennCare MCO***	1,125,926	\$4,366,171,514	\$432,834,504	\$74,010,960	1.70%

MCO Notes:

* Administrative expenses are adjusted to be a maximum of 13% of premium and related revenue.

** Administrative expenses not adjusted.

*** Experience from the following were not reflected in the above financial results. Their amounts do not significantly alter the indicated trends.

1. **The University of Tennessee Health Plan, Inc** - Effective January 1, 1996, the University of Tennessee Health Plan, Inc. was acquired by Volunteer State Health Plan, Inc., a subsidiary of Blue Cross/Blue Shield of Tennessee.
2. **Healthsource Tennessee Preferred, Inc. d/b/a Tennsource** - TennCare enrollment of Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, was sold to Phoenix Health Care of Tennessee, Inc., for \$1,829,500. The contract between Healthsource Tennessee Preferred, Inc., and TennCare terminated on December 31, 1996. The TennCare enrollees in Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, became members of Phoenix Health Care of Tennessee, Inc., effective January 1, 1997.
3. **Health Net** - Effective January 1, 1994, Health Net, Inc. contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. Effective January 1 1997, the TennCare contract was assigned to a related party, Health Net TNCARE HMO, Inc. TennCare HMO ceased providing services for TennCare participants when it was purchased by Phoenix Healthcare on November 30, 1997.

TennCare
Summary of Adjusted Financial Results
1997 Data

Exhibit 7b

MCO	1997				
	Average Members	Total Revenue	Adjusted Admin*	Adjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee**	548,523	\$804,254,228	\$101,162,102	\$17,517,292	2.18%
Heritage/John Deere	24,565	\$37,917,611	\$4,805,043	(\$7,656,669)	-20.19%
Memphis Managed Care	43,191	\$60,062,927	\$7,038,451	(\$839,965)	-1.40%
OmniCare	43,021	\$59,893,844	\$7,702,905	\$3,804,653	6.35%
Phoenix Healthcare	173,430	\$221,452,588	\$28,614,894	(\$25,125,922)	-11.35%
Preferred Health Partnership	91,269	\$112,614,439	\$13,121,164	(\$5,182,987)	-4.60%
Prudential Community Care	11,014	\$15,992,046	\$2,078,966	\$1,181,735	7.39%
TN Managed Care Network	291,710	\$400,841,595	\$50,612,855	\$7,467,501	1.86%
Vanderbilt Health Plans	11,887	\$17,848,886	\$2,281,371	\$1,615,794	9.05%
Total TennCare MCO	1,238,610	\$1,730,878,164	\$217,417,751	(\$7,218,568)	-0.42%

MCO Notes:

* Administrative expenses are adjusted to be a maximum of 13% of premium and related revenue.

** Administrative expenses not adjusted.

TennCare
Summary of Adjusted Financial Results
First nine months 1998 Data

Exhibit 7c

MCO	9 Months of 1998				
	Average Members	Total Revenue	Adjusted Admin*	Adjusted Pretax Profit	Profit as % of Revenue
BC/BS of Tennessee**	569,271	\$600,342,902	\$72,564,731	\$22,503,388	3.75%
Heritage/John Deere***	23,187	\$9,142,000	\$1,161,940	\$2,206,060	24.13%
Memphis Managed Care	54,029	\$58,612,903	\$6,881,199	(\$2,758,953)	-4.71%
OmniCare	45,776	\$49,390,741	\$6,345,505	\$1,525,123	3.09%
Phoenix Healthcare	180,207	\$200,494,192	\$25,790,919	(\$5,362,733)	-2.67%
Preferred Health Partnership	95,268	\$100,790,420	\$12,782,514	(\$19,698,837)	-19.54%
Prudential Community Care***	11,848	\$5,116,000	\$665,080	\$336,920	6.59%
TN Managed Care Network	304,900	\$331,944,185	\$41,443,930	(\$5,811,054)	-1.75%
Vanderbilt Health Plans	11,872	\$13,782,676	\$1,760,614	\$140,866	1.02%
Total TennCare MCO	1,296,358	\$1,369,616,019	\$169,396,432	(\$6,919,220)	-0.51%

MCO Notes:

* Administrative expenses are adjusted to be a maximum of 13% of premium and related revenue.

** Administrative expenses not adjusted.

*** Data is for the first 3 months of 1998

**Profitability Under TennCare
Blue Cross of Tennessee
The Volunteer State Health Plan**

Exhibit 8a

	1994**	1995**	1996**	1997	1998*
Total Members at End of Period	574,000	598,000	605,721	548,523	569,271
Total Member Months	6,888,000	7,176,000	7,766,772	6,809,831	4,988,306
Premium and Related Revenue	\$612,697,000	\$822,376,507	\$870,506,918	\$797,996,167	\$593,333,043
PMPM	\$88.95	\$114.60	\$112.08	\$117.18	\$118.94
Total Revenues	\$614,809,000	\$827,189,437	\$879,048,200	\$804,254,228	\$600,342,902
PMPM	\$89.26	\$115.27	\$113.18	\$118.10	\$120.35
Total Administration Expenses	\$51,706,000	\$66,769,276	\$90,088,178	\$101,162,102	\$72,564,731
PMPM	\$7.51	\$9.30	\$11.60	\$14.86	\$14.55
Pretax Income/(Loss)	(\$8,826,000)	(\$5,401,714)	\$16,288,408	\$17,517,292	\$22,503,388
PMPM	(\$1.28)	(\$0.75)	\$2.10	\$2.57	\$4.51
Total Net Worth	N/A	N/A	N/A	\$48,839,037	\$65,950,390
PMPM	N/A	N/A	N/A	\$7.17	\$13.22
Note: Administrative expenses as a % of premium:	8.44%	8.12%	10.35%	12.68%	12.23%

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** From TennCare Audit Reports.

Sources: The Volunteer State Health Plan Financial Statements as of December 31, 1997 and September 30, 1998

Profitability Under TennCare
Phoenix Healthcare of Tennessee, Inc.
Includes Health Net TNCare HMO, Inc. - Total

Exhibit 8b

	1994	1995	1996	1997	1998*
Total Members at End of Period	44,000	37,287	47,977	173,430	180,207
Total Member Months	433,559	457,093	495,080	1,899,755	1,634,304
Premium and Related Revenue	\$44,223,947	\$51,940,417	\$59,265,207	\$220,114,567	\$199,490,948
PMPM	\$102.00	\$113.63	\$119.71	\$115.86	\$122.06
Total Revenues	\$44,459,021	\$52,375,721	\$59,636,987	\$221,452,588	\$200,494,192
PMPM	\$102.54	\$114.58	\$120.46	\$116.57	\$122.68
Total Administration Expenses	\$6,581	\$9,877,734	\$11,269,421	\$32,949,109	\$25,790,919
PMPM	\$0.02	\$21.61	\$22.76	\$17.34	\$15.78
Pretax Income/(Loss)	\$1,022,317	\$392,178	\$2,179,424	(\$29,460,137)	(\$5,362,733)
PMPM	\$2.36	\$0.86	\$4.40	(\$15.51)	(\$3.28)
Total Net Worth	\$758,917	\$1,530,237	\$2,932,302	\$3,128,823	(\$14,583,105)
PMPM	\$1.75	\$3.35	\$5.92	\$1.65	(\$8.92)

Note: 1997 Admin, (Loss), and Net Worth were restated on 6/30/98 financial statement. The values on the 12/31/97 statement were \$20,327,822, \$(15,537,455), and \$2,934,279 respectively.

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	0.01%	19.02%	19.02%	14.97%	12.93%
Adjusted Administrative Expenses**	\$6,581	\$6,752,254	\$7,704,477	\$28,614,894	\$25,790,919
Adjusted Pretax Income/(Loss)	\$1,022,317	\$3,517,658	\$5,744,368	(\$25,125,922)	(\$5,362,733)
Adjusted Total Net Worth	\$758,917	\$4,655,717	\$6,497,246	\$7,463,038	(\$14,583,105)

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

Sources: Phoenix Healthcare of Tennessee, Inc. Financial Statements as of December 31, 1997 and September 30, 1998

Profitability Under TennCare
Heritage National Healthplan of Tennessee, Inc.
John Deere Health Care, Inc.

Exhibit 8c

	1994	1995	1996	1997	1998****
Total Members at End of Period	29,083	17,778	18,747	24,565	23,187
Total Member Months	337,409	220,754	214,445	315,164	69,560
Premium and Related Revenue	\$34,557,783	\$25,641,601	\$26,875,029	\$36,961,873	\$8,938,000
PMPM	\$102.42	\$116.15	\$125.32	\$117.28	\$128.49
Total Revenues	\$34,557,783	\$25,762,630	\$27,263,382	\$37,917,611	\$9,142,000
PMPM	\$102.42	\$116.70	\$127.13	\$120.31	\$131.43
Total Administration Expenses	\$5,986,973	\$3,763,336	\$4,031,255	\$5,652,281	\$1,341,000
PMPM	\$17.74	\$17.05	\$18.80	\$17.93	\$19.28
Pretax Income/(Loss)	(\$35,670)	\$3,898,470	\$2,786,044	(\$8,503,907)	\$2,027,000
PMPM	(\$0.11)	\$17.66	\$12.99	(\$26.98)	\$29.14
Total Net Worth	\$7,495,062	\$14,716,559	\$18,988,000	N/A	N/A
PMPM	\$22.21	\$66.66	\$88.54	N/A	N/A

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	17.32%	14.68%	15.00%	15.29%	15.00%
Adjusted Administrative Expenses**	\$4,492,512	\$3,333,408	\$3,493,754	\$4,805,043	\$1,161,940
Adjusted Pretax Income/(Loss)	\$1,458,791	\$4,328,398	\$3,323,545	(\$7,656,669)	\$2,206,060
Adjusted Total Net Worth	\$8,989,523	\$15,146,487	\$19,525,501	N/A	N/A

* Data for 1998 is for three months only.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

*** Harkey Report

Sources: TennCare Audit Reports

**Profitability Under TennCare
Memphis Managed Care Corporation
TLC Family Care**

Exhibit 8d

	1994	1995	1996	1997	1998*
Total Members at End of Period	41,380	37,690	33,926	43,191	54,029
Total Member Months	448,200	458,646	403,132	469,660	474,654
Premium and Related Revenue	\$45,667,325	\$47,720,711	\$45,281,609	\$54,141,927	\$54,108,412
PMPM	\$101.89	\$104.05	\$112.32	\$115.28	\$114.00
Total Revenues	\$51,157,251	\$53,801,661	\$51,032,526	\$60,062,927	\$58,612,903
PMPM	\$114.14	\$117.31	\$126.59	\$127.89	\$123.49
Total Administration Expenses	\$4,303,304	\$5,589,731	\$6,444,184	\$7,747,022	\$6,881,199
PMPM	\$9.60	\$12.19	\$15.99	\$16.49	\$14.50
Pretax Income/(Loss)	\$391,305	(\$262,905)	(\$873,022)	(\$1,548,536)	(\$2,758,953)
PMPM	\$0.87	(\$0.57)	(\$2.17)	(\$3.30)	(\$5.81)
Total Net Worth	\$2,152,460	\$2,296,297	\$781,817	\$791,621	(\$1,583,018)
PMPM	\$4.80	\$5.01	\$1.94	\$1.69	(\$3.34)

Note: 1997 Total Revenues was restated on 6/30/98 financial statement. The value on the 12/31/97 statement was \$60,208,194.

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	9.42%	11.71%	14.23%	14.31%	12.72%
Adjusted Administrative Expenses**	\$4,303,304	\$5,589,731	\$5,886,609	\$7,038,451	\$6,881,199
Adjusted Pretax Income/(Loss)	\$391,305	(\$262,905)	(\$315,447)	(\$839,965)	(\$2,758,953)
Adjusted Total Net Worth	\$2,152,460	\$2,296,297	\$1,339,392	\$1,500,192	(\$1,583,018)

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

Sources: TLC FamilyCare Financial Statements as of December 31, 1997 and September 30, 1998

**Profitability Under TennCare
OmniCare Health Plan, Inc.**

Exhibit 8e

	1994	1995	1996	1997	1998*
Total Members at End of Period	78,414	52,498	42,065	43,021	45,776
Total Member Months	701,245	758,615	582,948	501,855	404,430
Premium and Related Revenue	\$64,055,089	\$73,997,347	\$62,643,261	\$59,253,118	\$48,811,578
PMPM	\$91.34	\$97.54	\$107.46	\$118.07	\$120.69
Total Revenues	\$4,584,504	\$75,717,289	\$63,841,586	\$59,893,844	\$49,390,741
PMPM	\$6.54	\$99.81	\$109.52	\$119.34	\$122.12
Total Administration Expenses	\$21,524,819	\$12,297,154	\$20,111,645	\$11,696,844	\$8,450,269
PMPM	\$30.70	\$16.21	\$34.50	\$23.31	\$20.89
Pretax Income/(Loss)	(\$8,105,966)	\$7,864,526	(\$7,846,726)	(\$189,286)	(\$579,641)
PMPM	(\$11.56)	\$10.37	(\$13.46)	(\$0.38)	(\$1.43)
Total Net Worth	(\$8,258,860)	\$2,638,000	\$2,758,839	\$2,264,619	\$2,677,468
PMPM	(\$11.78)	\$3.48	\$4.73	\$4.51	\$6.62

Note: Administrative expenses of \$34,745,174 for 1994 were reduced by \$13,220,355 for reserves.

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	33.60%	16.62%	32.11%	19.74%	17.31%
Adjusted Administrative Expenses**	\$8,327,162	\$9,619,655	\$8,143,624	\$7,702,905	\$6,345,505
Adjusted Pretax Income/(Loss)	\$5,091,691	\$10,542,025	\$4,121,295	\$3,804,653	\$1,525,123
Adjusted Total Net Worth	\$4,938,797	\$5,315,499	\$14,726,860	\$6,258,558	\$4,782,232

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

Sources: OmniCare Health Plan, Inc. Financial Statements as of December 31, 1997 and September 30, 1998

**Profitability Under TennCare
Preferred Health Partnership of Tennessee**

Exhibit 8f

	1994	1995	1996	1997	1998*
Total Members at End of Period	65,000	58,666	58,501	91,269	95,268
Total Member Months	694,105	738,756	664,713	946,196	845,248
Premium and Related Revenue	\$70,798,710	\$83,389,620	\$79,610,952	\$109,099,360	\$98,327,029
PMPM	\$102.00	\$112.88	\$119.77	\$115.30	\$116.33
Total Revenues	\$70,798,710	\$84,013,131	\$80,272,793	\$112,614,439	\$100,790,420
PMPM	\$102.00	\$113.72	\$120.76	\$119.02	\$119.24
Total Administration Expenses	\$7,240,741	\$7,871,398	\$9,592,877	\$13,121,164	\$14,604,441
PMPM	\$10.43	\$10.65	\$14.43	\$13.87	\$17.28
Pretax Income/(Loss)	\$13,296	\$275,409	\$452,370	(\$5,182,987)	(\$21,520,764)
PMPM	\$0.02	\$0.37	\$0.68	(\$5.48)	(\$25.46)
Total Net Worth	(\$169,736)	(\$9,413)	\$3,019,330	(\$2,172,257)	\$4,738,493
PMPM	(\$0.24)	(\$0.01)	\$4.54	(\$2.30)	\$5.61

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	10.23%	9.44%	12.05%	12.03%	14.85%
Adjusted Administrative Expenses**	\$7,240,741	\$7,871,398	\$9,592,877	\$13,121,164	\$12,782,514
Adjusted Pretax Income/(Loss)	\$13,296	\$275,409	\$452,370	(\$5,182,987)	(\$19,698,837)
Adjusted Total Net Worth	(\$169,736)	(\$9,413)	\$3,019,330	(\$2,172,257)	\$6,560,420

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

Sources: Preferred Health Partnership of Tennessee, Inc. Financial Statements as of December 31, 1997 and September 30, 1998.

**Profitability Under TennCare
Prudential Health Plans**

Exhibit 8g

	1994	1995	1996	1997	1998****
Total Members at End of Period	9,000	8,911	9,730	11,014	11,848
Total Member Months	108,000	105,758	118,117	130,898	35,545
Premium and Related Revenue	\$9,280,306	\$13,313,720	\$14,944,725	\$15,992,046	\$5,116,000
PMPM	\$85.93	\$125.89	\$126.52	\$122.17	\$143.93
Total Revenues	\$9,280,306	\$13,313,720	\$14,944,725	\$15,992,046	\$5,116,000
PMPM	\$85.93	\$125.89	\$126.52	\$122.17	\$143.93
Total Administration Expenses	\$1,459,418	\$2,643,774	\$2,085,026	\$2,137,943	\$764,000
PMPM	\$13.51	\$25.00	\$17.65	\$16.33	\$21.49
Pretax Income/(Loss)	(\$2,150,010)	(\$1,593,625)	\$875,880	\$1,122,758	\$238,000
PMPM	(\$19.91)	(\$15.07)	\$7.42	\$8.58	\$6.70
Total Net Worth	N/A	\$178,110	\$99,146,000	N/A	N/A
PMPM	N/A	\$1.68	\$839.39	N/A	N/A

Note: 1994 administrative expenses are assumed to have the average percentage of the 1995-1998 administrative percentages.
1994 - 1998 total revenues are assumed to be equal to premium and related revenue for each year.

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	15.73%	19.86%	13.95%	13.37%	14.93%
Adjusted Administrative Expenses**	\$1,206,440	\$1,730,784	\$1,942,814	\$2,078,966	\$665,080
Adjusted Pretax Income/(Loss)	(\$1,897,032)	(\$680,635)	\$1,018,092	\$1,181,735	\$336,920
Adjusted Total Net Worth	N/A	\$1,091,100	\$99,288,212	N/A	N/A

* Data for 1998 is for three months only.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

*** Harkey Report

Sources: TennCare Audit Reports

**Profitability Under TennCare
Tennessee Managed Care Network
Access Med Plus**

Exhibit 8h

	1994	1995	1996	1997	1998*
Total Members at End of Period	335,259	281,299	254,421	291,710	304,900
Total Member Months	3,663,586	3,479,099	3,053,052	3,278,341	2,715,436
Premium and Related Revenue	\$397,739,650	\$401,374,231	\$358,567,197	\$396,057,566	\$329,373,633
PMPM	\$108.57	\$115.37	\$117.45	\$120.81	\$121.30
Total Revenues	\$404,797,990	\$403,806,199	\$363,831,410	\$400,841,595	\$331,944,185
PMPM	\$110.49	\$116.07	\$119.17	\$122.27	\$122.24
Total Administration Expenses	\$31,480,345	\$41,559,359	\$51,727,894	\$50,612,855	\$41,443,930
PMPM	\$8.59	\$11.95	\$16.94	\$15.44	\$15.26
Pretax Income/(Loss)	\$66,127	\$17,905,200	\$12,826,084	\$7,467,501	(\$5,811,054)
PMPM	\$0.02	\$5.15	\$4.20	\$2.28	(\$2.14)
Total Net Worth	\$2,865,070	\$3,997,754	\$19,267,513	\$21,690,155	\$15,198,311
PMPM	\$0.78	\$1.15	\$6.31	\$6.62	\$5.60

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	7.91%	10.35%	14.43%	12.78%	12.58%
Adjusted Administrative Expenses**	\$31,480,345	\$41,559,359	\$46,613,736	\$50,612,855	\$41,443,930
Adjusted Pretax Income/(Loss)	\$66,127	\$17,905,200	\$17,940,242	\$7,467,501	(\$5,811,054)
Adjusted Total Net Worth	\$2,865,070	\$3,997,754	\$24,381,671	\$21,690,155	\$15,198,311

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

Sources: Tennessee Managed Care Network Financial Statements as of December 31, 1997 and September 30, 1998

**Profitability Under TennCare
Vanderbilt Health Plans, Inc.**

Exhibit 8i

	1994	1995	1996	1997	1998*
Total Members at End of Period	15,712	12,373	10,341	11,887	11,872
Total Member Months	187,383	158,966	124,685	134,397	108,222
Premium and Related Revenue	\$20,301,038	\$20,917,860	\$15,546,377	\$17,549,007	\$13,543,188
PMPM	\$108.34	\$131.59	\$124.69	\$130.58	\$125.14
Total Revenues***	\$18,834,117	\$21,244,260	\$15,797,175	\$17,848,886	\$13,782,676
PMPM	\$100.51	\$133.64	\$126.70	\$132.81	\$127.36
Total Administration Expenses	\$3,506,054	\$3,815,290	\$2,887,159	\$2,734,552	\$2,181,539
PMPM	\$18.71	\$24.00	\$23.16	\$20.35	\$20.16
Pretax Income/(Loss)	(\$5,463,589)	(\$1,116,160)	\$1,644,887	\$1,162,613	(\$280,059)
PMPM	(\$29.16)	(\$7.02)	\$13.19	\$8.65	(\$2.59)
Total Net Worth	\$1,327,058	\$669,183	\$2,874,374	\$2,684,825	\$3,795,031
PMPM	\$7.08	\$4.21	\$23.05	\$19.98	\$35.07

Restated Financial Statements					
	1994	1995	1996	1997	1998*
Administrative Expenses as % of Premium	17.27%	18.24%	18.57%	15.58%	16.11%
Adjusted Administrative Expenses**	\$2,639,135	\$2,719,322	\$2,021,029	\$2,281,371	\$1,760,614
Adjusted Pretax Income/(Loss)	(\$4,596,670)	(\$20,192)	\$2,511,017	\$1,615,794	\$140,866
Adjusted Total Net Worth	\$2,193,977	\$1,765,151	\$3,740,504	\$3,138,006	\$4,215,956

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

** Administrative expenses are adjusted to a maximum of 13% of premium and related revenue.

*** There were losses from subsidiaries of \$3,174,815, \$5,753,792, \$9,465,028, and \$6,029,927 for 1995, 1996, 1997 and 1998 respectively.

These losses reflect losses from the commercial population and therefore are excluded from the Total Revenues and Income/(Loss).

Sources: Vanderbilt Health Plans Inc. Financial Statements as of December 31, 1997 and September 30, 1998, and TennCare Audit Reports.

**Profitability Under TennCare
Tennessee Behavioral Health, Inc.**

Exhibit 8j

	1994	1995	1996	1997	1998*
Total Members at End of Period	N/A	N/A	544,080	480,801	555,282
Total Member Months	N/A	N/A	2,877,386	6,126,705	4,975,874
Premium and Related Revenue	N/A	N/A	\$64,139,087	\$132,676,666	\$104,417,724
PMPM	N/A	N/A	\$22.29	\$21.66	\$20.98
Total Revenues	N/A	N/A	\$64,731,150	\$133,731,512	\$104,889,751
PMPM	N/A	N/A	\$22.50	\$21.83	\$21.08
Total Administration Expenses	N/A	N/A	\$6,636,241	\$16,364,050	\$11,873,587
PMPM	N/A	N/A	\$2.31	\$2.67	\$2.39
Pretax Income/(Loss)	N/A	N/A	\$429,189	\$224,322	(\$6,781,063)
PMPM	N/A	N/A	\$0.15	\$0.04	(\$1.36)
Total Net Worth	N/A	N/A	\$631,612	\$8,630,291	\$7,669,625
PMPM	N/A	N/A	\$0.22	\$1.41	\$1.54
Note: Administrative expenses as a % of premium are:			10.35%	12.33%	11.37%

* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

Sources: Tennessee Behavioral Health, Inc. Financial Statements as of December 31, 1997 and September 30, 1998.

**Profitability Under TennCare
Premier Behavioral Systems of Tennessee, LLC**

Exhibit 8k

	1994	1995	1996	1997	1998*
Total Members at End of Period	N/A	N/A	700,072	688,504	707,734
Total Member Months	N/A	N/A	4,198,715	8,303,919	6,239,383
Premium and Related Revenue	N/A	N/A	\$91,276,628	\$191,281,564	\$145,991,236
PMPM	N/A	N/A	\$21.74	\$23.04	\$23.40
Total Revenues	N/A	N/A	\$91,379,880	\$192,407,954	\$147,158,331
PMPM	N/A	N/A	\$21.76	\$23.17	\$23.59
Total Administration Expenses	N/A	N/A	\$10,069,179	\$17,997,433	\$14,876,345
PMPM	N/A	N/A	\$2.40	\$2.17	\$2.38
Pretax Income/(Loss)	N/A	N/A	(\$10,002,695)	(\$3,702,795)	\$8,381,502
PMPM	N/A	N/A	(\$2.38)	(\$0.45)	\$1.34
Total Net Worth	N/A	N/A	(\$2,170,269)	\$5,361,967	\$13,777,279
PMPM	N/A	N/A	(\$0.52)	\$0.65	\$2.21

Note: Administrative expenses as a percent of premium are:	11.03%	9.41%	10.19%
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* Data for 1998 is for nine months only. Total members at the end of the period 1998 are based on 3rd quarter 1998 member months.

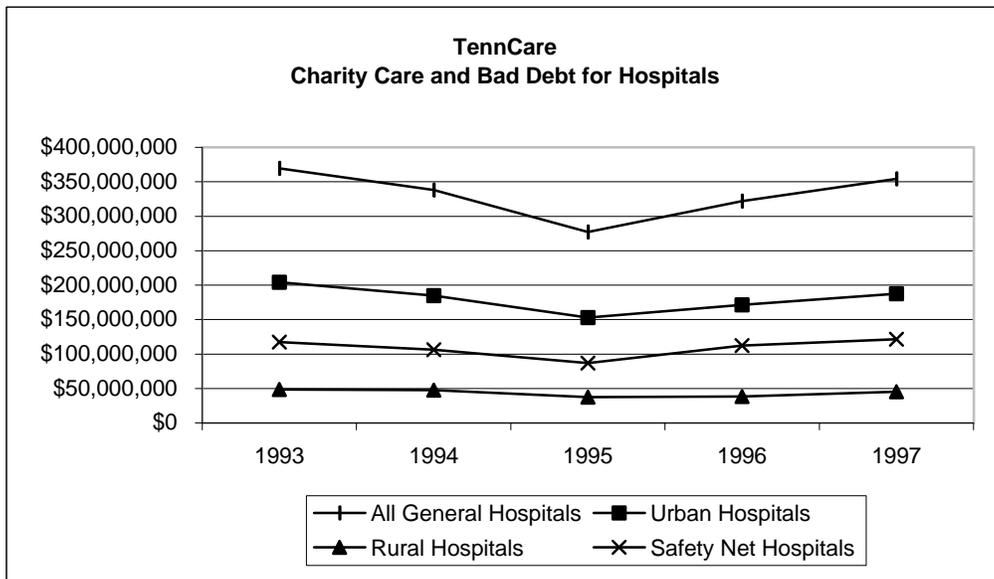
Sources: Premier Behavioral Systems of Tennessee, LLC Financial Statements as of December 31, 1997 and September 30, 1998.

TennCare Actuarial Analysis

Estimated Costs for Charity, Medically Indigent and Bad Debt- All Hospitals

Exhibit 9a

	Medicaid	TennCare			
	1993	1994	1995	1996	1997
Urban Hospitals	\$204,096,529	\$184,545,841	\$152,804,450	\$171,561,202	\$187,386,602
Rural Hospitals	\$48,367,235	\$47,416,737	\$37,594,406	\$38,350,215	\$45,254,099
Safety Net Hospitals	\$117,252,635	\$106,370,976	\$86,776,121	\$112,037,177	\$121,509,952
All General Hospitals	\$369,716,399	\$338,333,554	\$277,174,976	\$321,948,594	\$354,150,653

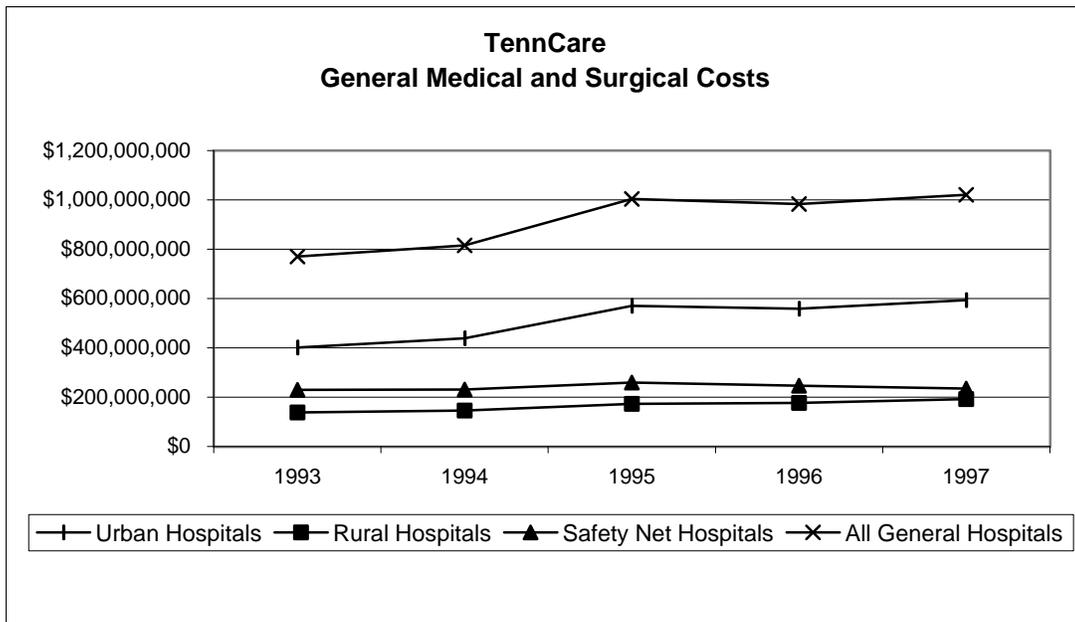


TennCare Actuarial Analysis

Costs by Hospital Type

Exhibit 9b

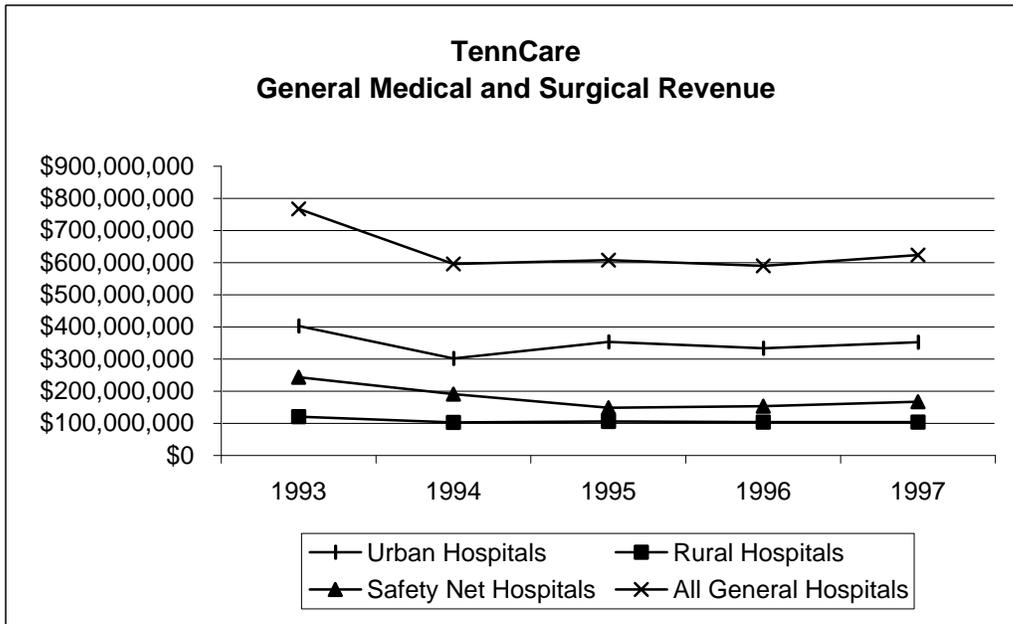
Hospital Type	Medicaid	TennCare			
	1993	1994	1995	1996	1997
Urban Hospitals	\$401,489,771	\$439,060,897	\$570,967,163	\$558,670,053	\$593,431,111
Rural Hospitals	\$138,640,025	\$145,882,304	\$173,476,036	\$177,143,712	\$192,705,676
Safety Net Hospitals	\$229,833,175	\$230,580,965	\$259,516,005	\$247,089,746	\$234,689,532
All General Hospitals	\$769,962,971	\$815,524,166	\$1,003,959,204	\$982,903,512	\$1,020,826,319



TennCare Actuarial Analysis
Revenue by Hospital Type

Exhibit 9c

Hospital Type	Medicaid	TennCare			
	1993	1994	1995	1996	1997
Urban Hospitals	\$402,535,583	\$302,028,644	\$353,170,658	\$333,455,604	\$352,476,521
Rural Hospitals	\$120,901,655	\$103,348,984	\$106,180,527	\$103,539,811	\$104,430,947
Safety Net Hospitals	\$243,704,075	\$190,794,654	\$148,393,784	\$153,231,247	\$167,167,470
All General Hospitals	\$767,141,313	\$596,172,282	\$607,744,969	\$590,226,662	\$624,074,938

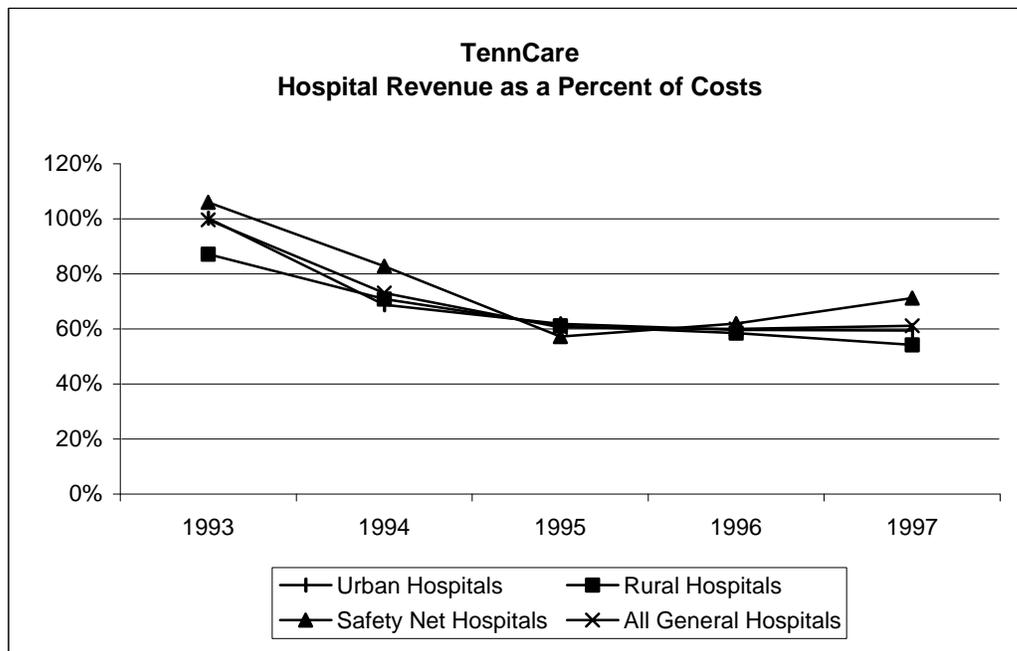


TennCare Actuarial Analysis

Revenue as a Percentage of Costs

Exhibit 9d

Hospital Type	Medicaid	TennCare				
	1993	1994	1995	1996	1997	
Urban Hospitals	100%	69%	62%	60%	59%	
Rural Hospitals	87%	71%	61%	58%	54%	
Safety Net Hospitals	106%	83%	57%	62%	71%	
All General Hospitals	100%	73%	61%	60%	61%	



TennCare Actuarial Analysis
Reimbursement of General Hospitals
TennCare versus Other Payors

Exhibit 10a

	TennCare		Commercial		Medicare	
	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
1996						
Total Reimbursement	\$19,088,257	\$4,386,532	\$56,791,619	\$17,701,043	\$33,379,451	\$3,970,452
Number of Days (Admissions for OP)	40,599	9,487	45,133	20,856	34,632	7,978
Per Diem Reimbursement	\$470	\$462	\$1,258	\$849	\$964	\$498
Adjusted Per Diem Reimbursement*	\$603	\$593				
1997						
Total Reimbursement	\$24,268,981	\$5,084,316	\$67,609,982	\$20,515,906	\$45,960,680	\$4,568,962
Number of Days (Admissions for OP)	50,648	11,704	51,541	24,233	41,437	9,681
Per Diem Reimbursement	\$479	\$434	\$1,312	\$847	\$1,109	\$472
Adjusted Per Diem Reimbursement*	\$614	\$557				
1998						
Total Reimbursement	\$22,665,731	\$5,398,152	\$57,714,590	\$25,345,222	\$37,386,398	\$5,661,647
Number of Days (Admissions for OP)	54,671	11,855	55,310	30,792	37,638	11,711
Per Diem Reimbursement	\$415	\$455	\$1,043	\$823	\$993	\$483
Adjusted Per Diem Reimbursement*	\$532	\$584				

* Adjusted to reflect TennCare 22% charity care/local government reduction for comparison to other payors.

TennCare Actuarial Analysis
Reimbursement of Safety Net Hospitals
TennCare versus Other Payors

Exhibit 10b

	TennCare	Commercial	Medicare
1996			
Total Reimbursement	\$27,705,611	\$58,309,591	\$33,809,187
Number of Days	29,589	26,060	14,675
Per Diem Reimbursement	\$936	\$2,238	\$2,304
Adjusted Per Diem Reimbursement*	\$1,200		
1997			
Total Reimbursement	\$29,023,226	\$68,504,292	\$41,753,923
Number of Days	30,586	27,183	14,532
Per Diem Reimbursement	\$949	\$2,520	\$2,873
Adjusted Per Diem Reimbursement*	\$1,217		
1998			
Total Reimbursement	\$37,584,891	\$100,335,954	\$70,410,320
Number of Days	38,722	41,353	23,945
Per Diem Reimbursement	\$971	\$2,426	\$2,941
Adjusted Per Diem Reimbursement*	\$1,244		

* Adjusted to reflect TennCare 22% charity care/local government reduction for comparison to other payors.

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	TENNCARE	ILLINOIS	KENTUCKY	MINNESOTA
REQUIRED FOR CATEGORICALLY NEEDY				
Inpatient Hospital Services	Yes. Preadmission approval and concurrent reviews allowed.	Yes	Yes	10% copay and \$10,000 limit for some eligibility categories
Outpatient Hospital Services	Yes	Yes	Yes	Yes
Physician Services	Yes, this shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure	Yes	Yes	Yes
Medical and Surgical Dental Services	Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered	Medical procedures performed by a dentist	Dental services, including oral surgery and orthodontics	Yes
Nursing Facility (NF) services for individuals aged 21 or older	Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1.) a Physician recommends confinement for convalescence; (2.) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.	Yes, services for the first ninety (90) days	Excluded	Not specified in material provided
Home health care for persons eligible for nursing facility services	Yes	Yes	Yes	Yes
Family planning services and supplies	Yes	Yes	Yes	Yes
Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan	As medically necessary	Not specified in material provided	Yes	Not specified in material provided
Laboratory and X-ray Services	Yes	Yes	Yes	Yes
Pediatric and Family Nurse Practitioner Services	As medically necessary including circumcisions performed by a physician.	Not specified in material provided	Yes	Yes

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	GEORGIA	VIRGINIA	WASHINGTON	OREGON *
REQUIRED FOR CATEGORICALLY NEEDY				
Inpatient Hospital Services	Yes, acute	Yes	Yes	
Outpatient Hospital Services	Yes	Yes	Yes	
Physician Services	Yes	Yes	Yes	
Medical and Surgical Dental Services	Not specified in material provided	Yes	Not specified in material provided	
Nursing Facility (NF) services for individuals aged 21 or older	Not specified in material provided	No	Yes; except those covered through the Aging and Adult Services Administration	
Home health care for persons eligible for nursing facility services	Yes	Yes	Yes	
Family planning services and supplies	Yes	Yes	Yes	
Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan	Yes	Yes	Yes	
Laboratory and X-ray Services	Yes	Yes	Yes	
Pediatric and Family Nurse Practitioner Services	Yes	Not specified in material provided	Yes	

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	TENNCARE	ILLINOIS	KENTUCKY	MINNESOTA
REQUIRED FOR CATEGORICALLY NEEDY				
Federally-Qualified Health Center services and any other ambulatory services offered by a Federally-Qualified Health Center that are otherwise covered under the State plan	Yes	Not specified in material provided	Yes	Not specified in material provided
Nurse-Midwife Services (to the extent authorized under State law)	Yes	Yes	Alternative Birthing Center Services	Yes
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for individuals under age 21	Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations for enrollees under 21.	Yes	Yes	Child and teen check-ups (C&TC) is a special health exam for members under 21.
REQUIRED FOR MEDICALLY NEEDY				
Prenatal care and delivery services for pregnant women	Yes	Yes	Yes, including alternative birthing services	Yes
Ambulatory services to individuals under age 18 and individuals entitled to institutional services	Yes	Yes	Yes	Yes
Home health services to individuals entitled to nursing facility services	Yes	Yes	Yes	Yes
If the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded, it must offer specified services	Yes (limited to 30 days per occasion, 60 days per year per enrollee ages 21-65)	Inpatient psychiatric care; psychiatric physician services.	Mental hospitals, psychiatrics, psychiatric beds, non-emergency transportation for mental health, behavioral health care management, EPSDT behavioral health services are excluded	Yes, inpatient has 10% copay and \$10,000 annual max for some eligibility categories
OPTIONAL				
Clinic Services	Yes	Yes	Yes	Yes
Nursing facility services for the under age 21	Yes	Yes, services for the first ninety (90) days	Excluded	Not specified in material provided
Optometrist Services and Eyeglasses	Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.	Optical supplies other than eyeglasses	Yes, including vision examination, eyeglasses (under age 21) and services of opticians, optometrists and ophthalmologists	Yes, \$25 copay on glasses for some eligibility categories
Prescribed Drugs	As medically necessary. Some therapeutic classes excluded. (Behavioral health prescription drugs carved-out and paid for by the state.)	Yes	Pharmacy and limited over-the-counter drugs	Yes, \$3 copay for some eligibility categories
Prosthetic Devices	Yes	Orthodontics/prosthetics/including reconstructive surgery incident to a mastectomy	DME	Yes

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	GEORGIA	VIRGINIA	WASHINGTON	OREGON *
REQUIRED FOR CATEGORICALLY NEEDY				
Federally-Qualified Health Center services and any other ambulatory services offered by a Federally-Qualified Health Center that are otherwise covered under the State plan	Not specified in material provided	Yes	Yes	
Nurse-Midwife Services (to the extent authorized under State law)	Yes	Yes	Yes	
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for individuals under age 21	Yes, Health Check Services	Yes	Yes	
REQUIRED FOR MEDICALLY NEEDY				
Prenatal care and delivery services for pregnant women	Yes, pregnancy related services including birthing center, childbirth education	Yes	Yes	
Ambulatory services to individuals under age 18 and individuals entitled to institutional services	Yes	Yes	Yes	
Home health services to individuals entitled to nursing facility services	Yes	Yes - inpatient services rendered at freestanding mental hospital, general acute care hospital; outpatient services	Yes	
If the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded, it must offer specified services	Mental health service excluded	Yes	Inpatient services provided by state mental hospitals and psychiatric hospitals are excluded	
OPTIONAL				
Clinic Services	Yes	Yes	Yes	
Nursing facility services for the under age 21	Not specified in material provided	No	Not specified in material provided	
Optometrist Services and Eyeglasses	Yes	Yes	Exams every 24 months for adults; every 12 months for children under 21	
Prescribed Drugs	Yes	Yes	Yes, according to a Department approved formulary	Some therapeutic classes excluded. (Behavioral health prescription drugs carved-out and paid for by the state.)
Prosthetic Devices	Yes	Yes	Yes	

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	TENNCARE	ILLINOIS	KENTUCKY	MINNESOTA
OPTIONAL				
Dental Services	Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20-1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered	Medical procedures performed by a dentist. Dental hospitalization in case of trauma, prescription drugs	Yes, including oral surgery, orthodontics, and prosthodontics	Yes, 50% coinsurance on specified procedures for some eligibility categories
Behavioral Health/Substance Abuse	Substance Abuse Treatment Services	-Inpatient medical detoxification -Psychological testing -Subacute alcohol and substance abuse services, benefits may be limited	-Behavioral health (limited visits to a primary care provider) -Medical detoxification	Chemical dependency care
Case Management Services			Specialized case management services for children and adults with complex chronic conditions	
Chiropractic Services	When determined cost-effective by the MCO.	Chiropractic services for enrollees age 20 and under if determined necessary by EPSDT screens		Yes
Organ Transplant	As medically necessary for a covered organ transplant.		Yes	Yes
DME	-Durable Medical Equipment -As medically necessary -Medical Supplies	Durable and nondurable medical equipment and supplies		Medical equipment and supplies
Emergency Care	Emergency/Non-Emergency Ambulance Transportation - As medically necessary	Emergency Care services	Urgent Emergency Services	-Urgent Care -Emergency medical services/Post-stabilization care

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	GEORGIA	VIRGINIA	WASHINGTON	OREGON *
OPTIONAL				
Dental Services	Excluded	Yes	No	
Behavioral Health/Substance Abuse				
Case Management Services	Perinatal Case Management services			
Chiropractic Services			Yes	
Organ Transplant		Yes	Tissue and Organ transplants	
DME	Durable Medical Equipment (DME)	Medical supplies and equipment		
Emergency Care	Emergency Ambulance services	-Emergency Services -Post Stabilization Care		

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	TENNCARE	ILLINOIS	KENTUCKY	MINNESOTA
OPTIONAL				
Transportation	-Emergency/Non-Emergency Ambulance Transportation - As medically necessary -Non-Emergency Transportation - As necessary for enrollees lacking accessible transportation for covered services. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to	Transportation to secure medical services	Medical transportation, emergency and non-emergency	Yes
Hospice	Must be provided by an organization certified pursuant to Medicare Hospice requirements - As medically necessary	Yes	Yes	Yes
Podiatry		Podiatric services for enrollees age 20 and under if determined necessary by EPDT screens	Yes	Yes
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by register nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.	Yes		
Preventative Services		Preventive Medicine Schedule for 21 years of age or older	Preventive health services including those currently provided by Public Health Departments Federally Qualified Health Centers and Rural Health Clinics	Prostate Specific Antigen (PSA) and digital rectal exams
Renal Dialysis	As medically necessary		Yes	
Rehabilitation Services	As medically necessary and when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989	-Physical, occupational and speech therapies -Assistive/augmentative communication devices	-Therapeutic evaluation and treatment including physical, speech and occupational therapies (provided in limited settings) -Hearing services including hearing aids (under age 21)	Yes
Hearing, Speech, and Vision	Speech Therapy - As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPST			-Contact lenses when necessary to treat disease or injury (other than corrective vision) -Hearing services -Language and hearing impaired interpreter services

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

Exhibit 11

MEDICAID	GEORGIA	VIRGINIA	WASHINGTON	OREGON *
OPTIONAL				
Transportation		Yes		
Hospice	Yes		Yes	
Podiatry	Yes	Yes		
Private Duty Nursing			As medically necessary and when prescribed by an attending physician for treatment and services rendered by registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.	
Preventative Services	Children's Intervention services	-Immunizations -Pap Smears -Prostate Specific Antigen (PSA) and digital rectal exams		
Renal Dialysis	Dialysis services			
Rehabilitation Services		Physical and Occupational Therapies, Speech Pathology and Audiology Services	Occupational, speech and physical therapy	
Hearing, Speech, and Vision			Vision	

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

MEDICAID	TENNCARE	ILLINOIS	KENTUCKY	MINNESOTA
Other	-Sitter - As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is need and neither is available.	-Blood, blood component and the administration thereof -Limited Covered Services: Termination of pregnancy; Sterilization services; Hysterectomy -Telephone Access - 24 hour toll-free number	-Appropriate escort meals and lodging	-Cosmetic surgery if for reconstruction following injury or surgery and treatment of birth defects -Gender reassignment if enrollee began services before 7/1/98 and was on MinnesotaCare or Medical Assistance at the time -Orthodontia for children if necessary to treat medical problems only -Private room if ordered by doctor -Special nutritional product if order by doctor -Surgery for being overweight if medically necessary
EXCLUDED				
	-Adult Day Care -Experimental Procedures/Treatment -Homemaker -Personal Care Services	-Audiology services, physical, occupational and speech therapies provided to under 21 years of age -Dental services -Early intervention services, including case management -Intermediate Care facilities for the Mentally Retarded -Nursing facility services beginning on the 91st day -Optometry services -Services provided through local education agencies that participate in the special Education Medicaid Matching Fund Program -Services provided through school-based clinics -Services provided under home and community-based waivers	-AIS/MR services -Certain Medicare only services (CORF services, chiropractor, physician assistant, physical and occupational therapy, psychologist, and clinical social worker) -Early intervention services for infants and toddlers with disabilities -EPSDT special services (behavioral health) -Home and Community Adult Day Care services -Home and Community-based waiver services, including model waivers -ICF/MR services -Mental hospitals -Non-Emergency Transportation (mental health) -Nursing Facility services -Psychiatric beds (Inpatient hospital) -Psychiatrists -School based services for students with disabilities specified in an individual education plan -Targeted Case Management (behavioral health)	-Abortion services (may be covered by the State) -Artificial ways to get pregnant, including fertility drugs -Autopsies -Case management for persons with severe emotional disturbance or serious and persistent mental illness (SED/SPMI) (may be covered by the State) -Child welfare targeted case management (may be covered by the State) -Contact lens supplies -Day training and habilitation -Ear piercing -Health care services or supplies -Intermediate care facility for people who are mentally retarded (ICF/MR) (may be covered by the State) -Job training and educational services -Personal groom items -Reimbursement for transportation to medical appointments for members who get the Expanded benefit set. Members who do not have Expanded benefit set are not eligible (may not be covered by the State) -Reverse voluntary sterilization -Skilled nursing facility care (may be covered by the State)

**TENNCARE
SUMMARY OF COVERED BENEFITS IN SURVEY STATES**

MEDICAID	GEORGIA	VIRGINIA	WASHINGTON	OREGON *
Other	<ul style="list-style-type: none"> -Birthing Center -Medicare Crossover payments 	<ul style="list-style-type: none"> -Court Ordered Services -HIV Testing and Treatment Counseling -Mammograms -Prostheses, breast -Reconstructive breast surgery -Temporary Detention Orders (TDOs) 		
EXCLUDED				
	<ul style="list-style-type: none"> -Mental Health/Substance Abuse Services -Non-Emergency Transportation (NET) Program -Traditional Medicaid Case Management (as a reimbursable service) Programs -Traditional Medicaid Community Care Services (CCSP) Program -Traditional Medicaid Dental Services -Traditional Medicaid Diagnostic Screening and Preventive Services (DSPS) Program 	<ul style="list-style-type: none"> -Case Management Services for Recipients of Auxiliary Grants -Case Management Services for Elderly-Induced Abortion -Chiropractic Services -Christian Sciences Nurses and Christian Science Sanatoria -Experimental and Investigational procedures -Hospice services -Lead investigation -Inpatient mental health services rendered in a State Psychiatric hospital -Personal care services -Private Duty Nursing services -Regular assisted living services provided to residents of adult care residences -School-based services -Substance abuse services 	<ul style="list-style-type: none"> -Dental -Eyeglasses -Hearing aid devices -Inpatient detox -Inpatient psychiatric care -Maternity care management -Some outpatient mental health (covered through Mental Health Division) -Substance abuse -Voluntary termination of pregnancy 	<p>*Oregon covers all services up to line 574 of the Prioritized List of services. The Prioritized List includes approximately 750 Treatment/ Condition pairs, defined by CPT and ICD-9 codes.</p>

Bibliography

Mathematica Policy Research, Inc. February, 1999. “Effects of Medicaid Managed Care Demonstrations on Safety Net Providers in Hawaii, Rhode Island, Oklahoma and Tennessee”.

William M. Mercer, Inc. February 1999. “TennCare Partners Program Study” (Draft).

Harkey & Associates. 1998. “Tennessee Managed Care (The Harkey Report)”.

**Meeting Attendees:
Managed Care Organizations, Behavioral Health Organizations
and Provider Organizations**

Access Med Plus
AdvoCare
Baptist Memorial Health Care System
Blue Cross Blue Shield of Tennessee
Vanderbilt Health Plan
Copper Basin Medical Center
East Tennessee Children's Hospital
Erlanger Health System
The Guidance Center
Heritage National Health Plan
Hospital Alliance of Tennessee
John Deere Health Care
Maury Regional Hospital
Memphis Managed Care/TLC
Metro Nashville General Hospital
National Association of Social Workers
OmniCare
Tennessee AHC
Tennessee Association for Home Care
Tennessee Association of Mental Health Organizations
Tennessee Dental Association
Tennessee Dietetic Association
Tennessee Hospice Association
Tennessee Hospital Association
Tennessee Medical Association
Tennessee Pharmacists Association
Tennessee Psychiatric Association
Tennessee Public & Teaching Hospital Association
Tennessee Public and Teaching Hospital Association
University of Tennessee of Social Work
Vanderbilt Medical Center

Exhibit 2

Comparison States – Capitation Rate Development

STATE	Capitation Rate Cells					Capitation Rate Basis
	Age	Gender	Aid Category	Geography	Other	
TENNESSEE	✓	✓	✓			FFS equivalent cost, minus charity care and local government payments. FFS calculation completed once for entire length of program.
GEORGIA	✓	✓	✓	✓		FFS equivalent cost calculation.
ILLINOIS	✓	✓	✓	✓		HMO rates negotiated to be less than FFSE.
KENTUCKY	✓		✓	✓		HMO rates negotiated to be less than FFSE.
MINNESOTA	✓	✓	✓	✓	Other factors also used	FFS equivalent cost calculation; plan data also included.
OREGON	✓		✓	✓	Risk Adjustment: - DPS for disabled groups - maternity/newborn prevalence for TANF & related groups	Historical MCO data for physical health rates, historical FFS data for mental health rates. Rates are set "to cover the cost of providing services".
VIRGINIA	✓	✓	✓	✓		FFS equivalent cost calculation.
WASHINGTON	✓	✓			Delivery Case Rate	Negotiated by plan by comparing the target rates projected year-to-year using budgetary limits.

Exhibit 2

Comparison States – Treatment of GME and DSH

STATE	GME	DSH
TENNESSEE	Paid directly to medical schools	Paid through supplemental payments: (uncompensated care). Let's double check after Ron gets back to us.
GEORGIA	GME payments are an add-on to hospitals' inpatient DRG rates, outpatient payments also include the appropriate GME amounts.	DSH payments are paid to hospitals outside of the claims payment system; i.e. lump sum payments to hospitals
ILLINOIS	Does not pay for GME to HMO's or providers. The State does pay for services not covered by the HMO which were not included in the FFSE calculation.	Includes disproportionate share payments in the capitation rates.
KENTUCKY	Included in capitation rates.	DSH payments paid directly from department/State; not in capitation rates.
MINNESOTA	Carved out in 1999; still part of MinnesotaCare rates.	Paid on a plan specific basis for 2 counties; part of the rates for the rest of the counties.
OREGON	Funds are calculated separately and based on FFS payments. There are no other payments made by the State to providers outside of the capitation rates.	Funds are calculated separately and based on FFS payments. There are no other payments made by the State to providers outside of the capitation rates.
VIRGINIA	Direct to hospitals, not included in capitation rates, dollar amounts not available.	Direct to hospitals, not included in capitation rates, dollar amounts not available.
WASHINGTON	GME payments for only two teaching hospitals in the state (University of Washington and Harborview) have been removed from the capitation rate. The main Children's hospital and other small teaching hospitals' GME payments are still incorporated in the rate. Separate GME capitation amounts are paid to University of Washington and Harborview each month based on the number of capitation payments made.	Not included in capitation rates.

Exhibit 2

Comparison States – Treatment of Non-Traditional Beneficiaries

STATE	Total Medicaid		Non-Traditional Groups
	ELIGIBLES	MANAGED CARE ENROLLMENT*	MANAGED CARE ENROLLMENT*
TENNESSEE	1,260,000	1,260,000	430,000
GEORGIA	900,000	21,000	None
ILLINOIS	1,296,000	168,000	KidCare: 900
KENTUCKY	517,000	153,000	CHIP: 20,000
MINNESOTA	400,000	285,000	100,000
OREGON	370,000	307,000	CHIP: 17,000; OHP: 90,000; GA: 3,000
VIRGINIA	492,000	99,000	CHIP: 2,000
WASHINGTON	733,000	444,000	None

* Does not include PCCM