State Coverage Initiatives

TennCare Reform, One Year Later:

An Assessment of the Impact of the 2005-2006 Changes in the TennCare Program

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EXECUTIVE SUMMARY

Once regarded as "one of the nation's most comprehensive efforts to cover its uninsured population," TennCare has undergone radical changes.[1] Beginning in 2005, in an effort to control the rapidly escalating state costs caused by the continuation of the TennCare program in its then-current form, most of the TennCare expansion population recipients – about 170,000 adult residents, or approximately 3% of all Tennesseans – were removed from TennCare.[2] Limitations on prescription benefits to five prescriptions per month were imposed on those adults remaining on TennCare: persons who were institutionalized and persons who were receiving services in a Home and Community Based Services (HCBS) waiver were exempt from benefit limits.

The rapid change in health insurance status for such a significant percentage of the state's population was unprecedented. Many predictions were made as to the economic and health impacts of these changes to the program.

The Community Research Council

– a Chattanooga based non-profit policy and research organization – conducted an analysis to assess the impact of changes in the TennCare program. The goal was to provide an independent assessment of the economic and health care impacts of the TennCare changes over the first year to provide decision makers, advocates, and citizens with the necessary information to make rational policy changes going forward.

Based on survey research, publicly available information, data collected from a sample of hospitals in the state, and a series of roundtables conducted with current TennCare participants, former participants, social service workers and health care providers from Tennessee's fourth largest county, we can begin to assess the early impacts of this dramatic change in health insurance coverage:

- Many disenrollees with multiple chronic health conditions have been unable to obtain affordable health insurance.
- Loss or reduction of health care coverage forces both disenrollees and those still on TennCare to make difficult medical and economic choices.
- Some disenrollees are fairly successful in negotiating the complicated safety net system to learn about available services, while others languish and do not access available services for which they are qualified.
- Primary care is generally available to disenrollees, both through emergency room visits and Safety Net programs, especially in the more populated areas of the state. A survey of the state's largest hospitals found a 25.5 percent increase in use of emergency room services by uninsured patients in the first full year after implementation of the changes in TennCare. While the number of uninsured patients with prior TennCare coverage is unknown, it is reasonable to assume that TennCare disenrollment was a significant contributor to the increase.
- Hospitals have absorbed the cost of providing care to an increasing number of uninsured patients: a survey of large hospitals found that the number of admitted uninsured patients had more than doubled during the first year of changes. To meet patient needs in the new payer environment, some hospitals have moved to limit emergency room treatment for non-emergent or non-urgent patients.
- In response to TennCare changes, several social service agencies have made significant programmatic changes in an effort to better meet the needs of disenrollees.
- As of May 2007, nearly 35 percent (5,685) of TennCare disenrollees with serious and persistent mental illness (SPMI) have not registered for Mental Health Safety Net (MHSN) services for which they are eligible.[3]
- Key indicators of the State's economy reflect national trends and, to date, do not reflect economic declines predicted as a result of the TennCare changes.

It is important to note that these findings reflect a series of snapshots at different points in time. Recently, the State of Tennessee has begun to implement Cover Tennessee, a new program for the uninsured that is a separate program from TennCare.[4] Also, in some cases, providers have suggested that some of the most profound impacts of the changes in TennCare have yet to occur. For example, it may take longer than a year for disenrollees lacking access to specialty care or prescriptions to feel the full brunt of health effects. Nevertheless, we believe that these initial findings point to the need for continued monitoring.[5]

BACKGROUND

TennCare Implements Unprecedented Overhaul

In 1994, the State of Tennessee launched TennCare, extending health insurance coverage to the Medicaid eligible population in the state and to individuals who were determined to be uninsured or uninsurable. [6] Through managed care, TennCare was designed to both control costs of the Medicaid population and reduce the number of uninsured.

In its May 1999 assessment of the impact of TennCare, Azer, Gold and Schoen found that:

- Enrollment of eligible residents in the optional groups had been very limited since 1994.
- Participation by managed care plans remained strong, but there were signs of potential future problems including financial difficulties stemming from inadequate capitation rates and multiple changes in TennCare leadership.
- The State had strengthened its administrative structure and oversight activities.
- TennCare had improved access to health insurance.[7]

By 2004, ten years after the program's inception, Tennessee was first among all states in percentage of population covered through Medicaid, with 22.3 percent of Tennesseans covered by TennCare.[8] Similar to the experiences of many other state Medicaid programs, despite a series of reform efforts, TennCare's costs had continued to spiral upward. By 2004, fully one-third of the State budget was devoted to TennCare.

The fiscal pressure of increasing TennCare costs was particularly acute because of Tennessee's status as one of seven states that do not impose a personal income tax. Growing health care costs, a stagnant national economy and a political culture that made it difficult to impose or increase taxes created a dynamic that made further change in TennCare inevitable.

Further, Tennessee is one of only two states that do not have a permanent Medicaid Disproportionate Share Hospital (DSH) payment. The DSH payment is made to offset some of the costs associated with providing hospital charity care. As a result of expanding the population eligible for TennCare, Tennessee was no longer eligible for DSH payments to hospitals.

In 2004, Tennessee Governor Phil Bredesen proposed a series of reforms designed to reduce cost and avoid any enrollment reductions. However, the original design hinged on obtaining relief from consent decrees in effect as a result of the Tennessee Justice Center's (TJC's) litigation. In January 2005, when negotiations with the Tennessee Justice Center failed to produce a cost saving resolution, Governor Bredesen proposed sweeping changes to the program.

- The revised proposal called for eliminating all benefits for 25 percent of TennCare enrollees not eligible for the core Medicaid program that is, uninsured and uninsurable adults. The 323,000 enrollees who would have been terminated from the program included 121,000 otherwise uninsured adults, 97,000 non-pregnant adults in the medically needy spend down category, 67,000 uninsurable adults, and 38,000 individuals eligible for both Medicaid and Medicare (dual enrolled).[9]

- The revised proposal called for a significant reduction in benefits for individuals continuing to receive TennCare benefits. Physician visits would have been limited to twelve annually; covered inpatient care limited to 20 days per year; a limit of 8 outpatient visits per year; lab work and x-rays limited to ten times per year; and pharmacy benefits limited to 4 scripts per month.

Tennessee was granted a waiver amendment on March 24, 2005, to end coverage of adults in the expanded eligibility categories. However, changes to the program implemented in July 2005 differed from the revised proposal.

The State did not go forward with the elimination of coverage for 97,000 residents in the medically needy spend down category. The reason for this was a Memorandum of Understanding agreed to by the state and plaintiffs-intervenors in the *Grier* lawsuit regarding steps the state would take if relief were granted in *Grier*. Benefits were terminated for the 170,000 enrollees in the uninsured and uninsurable expansion groups. While dual enrollees were also dropped from TennCare, these individuals would continue to have Medicare coverage – losing prescription coverage until implementation of Medicare Part D in January 2006. For those non-institutionalized adults remaining on TennCare, the number of covered prescriptions per month was increased to five, with a maximum of two brand name drugs.[10] Non-pharmacy limits were postponed indefinitely.

Concurrently, while changes to TennCare were being implemented, the state also launched a $140 million Health Care Safety Net program designed to reduce the impact of changes to TennCare disenrollees. This initiative included a series of programs:

- RxOutreach provides disenrollees some 55 generic drugs free of charge. The RxOutreach formulary includes medications to treat some of the most common diagnoses, including diabetes, hypertension, lipidemia, depression, anxiety, allergic rhinitis, bacterial infections, and reflux disorders. In addition, diabetic disenrollees were eligible for insulin and diabetic supplies, with a $5 co-pay for diabetic supplies, until June 30th. All disenrollees received a drug discount card, which provided discounts up to 10 percent for brand and 50 percent for generic prescription medications, and information about pharmaceutical patient assistance programs and a toll-free number for assistance with the application processes. Individuals with a diagnosis of severe and persistent mental illness (SPMI) enrolled in the Mental Health Safety Net (MHSN) are also eligible for a variety of assessment and case management services and had access to one atypical anti-psychotic medicine and one mood stabilizer, subject to a $5 co-pay. Originally scheduled to expire on June 30, 2006, this benefit was extended until the end of 2006. A replacement program was competitively bid and implemented January 1, 2007, expanding the list of generics to over 200 drugs and retaining the SPMI and diabetic assistance.

- Several programs were implemented as part of the Safety Net program to assist TennCare disenrollees with specialized needs, such as those with whole organ transplants, hemophilia, those on dialysis, and those needing cancer treatments.

- The Health Care Safety Net also focused on increasing access to primary care throughout the state. Forty-seven rural county health departments added or expanded available primary health care services, with sliding scale fees based on income.

- In addition to state-sponsored programs, a number of community and faith-based organizations provide assistance, although programs are concentrated in metropolitan areas. Many of these organizations received State Health Care Safety Net grants. In 2006, over $12 million in Safety Net funds were designated for Tennessee's 23 federally qualified heath centers (FQHCs) and FQHC look-alikes as well as to 64 faith-based, community-based, and rural health centers who serve the uninsured. Awards of similar amounts for 2007 were announced in February.

- Several programs were implemented as part of the MHSN to provide essential mental health services to those persons who were disenrolled from TennCare and were identified as SPMI. The Department was appropriated $11.5 million to cover core, vital mental health services that people with serious mental illness must retain to continue leading functional, productive lives.

Persons who are registered into the MHSN are eligible to receive mental health services such as assessment, evaluation, diagnostic, and therapeutic sessions; case management; psychiatric medication management; lab work related to medication management; and pharmacy assistance and coordination.

Impact of TennCare Changes

There was much speculation about how the overhaul of TennCare would affect the health care sector and the state's economy. Anecdotal evidence suggested that TennCare beneficiaries uncertain of their future benefits increased their utilization before changes took effect. There was also great concern regarding disenrollees' ability to obtain other health coverage. Likewise, the loss of or reductions in prescription coverage was expected to negatively impact those affected.

Some predicted that the changes would have a significant negative effect on the state's overall economy. Tennessee hospitals faced the possibility of reduced credit ratings and increased borrowing costs. On the other hand, state officials projected substantial budgetary relief, predicting that 2005-2006 TennCare spending would account for approximately one-fourth of state tax revenue, as compared to one-third of revenue in 2004.

The Community Research Council conducted an "on the ground" assessment of the impact of TennCare changes. The goal was to provide an independent assessment of the economic and health care impacts of the TennCare changes over the first year to provide decision makers, advocates, and citizens with the necessary information to make rational policy changes going forward.

Two different methods were employed to assess impact.

- A series of roundtable discussions with Chattanooga area health care and social service providers to discuss the impacts of changes on their organizations and on their patient population.[11] CRC also conducted roundtable discussions with TennCare recipients and former recipients to discuss the result of the loss of or reductions in TennCare coverage. In all, more than 98 individuals participated in a series of 7 roundtables over a 10-month period.
- An assessment of critical indicators to determine impact on the health care system and the State's economy.

MAJOR FINDINGS

1. Many disenrollees with multiple chronic health conditions have been unable to obtain affordable health insurance.

According to the feedback from roundtable participants and a series of indicators many of those disenrolled from TennCare have not obtained health insurance and have joined the ranks of the uninsured.

For example, in Hamilton County, the decline in TennCare enrollment coincided with an increase in the percentage of the uninsured adult population. A 2006 quality of life survey of Hamilton County adults found that 20 percent of Hamilton County adults were uninsured for at least some time during the previous twelve months. Of that population, 18% of the uninsured respondents indicated that they were uninsured because they lost TennCare.[12] By comparison, the Hamilton County 2004 Behavioral Risk Factor Surveillance Survey (BRFSS) found that 13 percent of all adults were uninsured at some time during the prior twelve months.

Roundtable participants reported that private insurance was unavailable, unaffordable, or inadequate. Health insurance companies were legally obligated to offer health insurance to individuals who were on TennCare for 18 months or more because of the Health Insurance Portability and Accountability Act (HIPAA). Roundtable participants reported quoted monthly premiums for single coverage ranging from $75 to over $1,200, with the average premium at $475, as compared to the national average of about $354. Two participants had briefly enrolled in low cost policies only to learn that none of their medications were covered.

Table 1: Adult Risk Factor Comparison Before Reform TennCare versus Total Under Age 65

Risk Factor (self-reported)	Have TennCare	Total Under Age 65
Fair or poor health	38.0 %	13.7 %
Diabetes	18.5 %	7.2 %
Asthma	19.5 %	8.1 %
Smoke	46.3 %	17.7 %

Source: 2004 Hamilton County Behavioral Risk Factor Surveillance Survey

Medical and social service provider roundtable participants reported that the overwhelming majority of their disenrolled patients or clients remain uninsured. 67,000 disenrollees were – by definition – uninsurable and too sick to otherwise qualify for health insurance. However, providers also noted that some disenrollees had access to employer sponsored health plans, but chose to enroll in Tenncare for its superior prescription coverage. It should be noted that TennCare had crowd-out provisions in place to prevent individuals with employer-sponsored insurance from enrolling in the program. Although the number of individuals on TennCare that had access to employer sponsored insurance cannot be quantified, it does raise concern regarding the amount of crowd-out that may have occurred with the generous coverage provided by the TennCare program.

We know that TennCare recipients in Hamilton County were less likely to be in good or excellent health (see Table 1). Although comparable national data are unavailable, studies demonstrate that lower socioeconomic status is associated with poor health and higher prevalence of behavioral risk factors.[13] Most TennCare and former TennCare roundtable participants reported multiple serious health problems. Some of the most frequently mentioned health conditions included diabetes, hypertension, emphysema, heart failure, and other heart conditions -- it was not unusual for one participant to have all of these conditions.

According to provider roundtable participants, some disenrollees are applying for disability, which if and when granted, would qualify them for TennCare. However, it takes several months, and in some cases years, to obtain disability benefits, during which time the applicant has no health care coverage and no guarantee of qualifying for benefits. Moreover, provider roundtable participants believed that many of those intending to apply for disability were not actually disabled.

But other disenrollees indicated that they did not want to apply for disability or other social assistance programs, indicating that they wanted to continue working and remain as self-reliant as possible.

2. Loss or reduction of health care coverage forces both those still in TennCare and disenrollees to make difficult medical and economic choices.

For those former and current recipients who have not been able to meet their needs through the state's Safety Net initiative and other programs, there are a series of challenging choices related to health care and personal finance that must be addressed.

For example, a small percentage of TennCare recipients take more than five prescription drugs and seem to be struggling to manage their medications. While they may have worked out a strategy for getting by with five medications for their chronic illnesses, any new acute medical problem can throw that equation out of balance.[14]

Many individuals with multiple health conditions are forced to choose which conditions to treat. One strategy has been to treat the conditions with the most immediate results, while other conditions go untreated. This may have serious future consequences; for example, untreated hypertension, a condition that usually has no symptoms, can lead to stroke.

Patients may ration their medications by taking every other dose, or may go without some medications. Some reported sharing medicine with friends or relatives. Others chose between medication and other necessities like rent, utilities, and food. Some social assistance agencies noted that they have had more requests for assistance with rent, utilities, and food from those paying for medicine that was once provided by TennCare.

Prescription limits have been particularly challenging for mental health patients. Many mental health patients have had to change a medication regimen which has helped stabilize their illness.

TennCare recipients are not eligible for prescription assistance programs (PAPs), which are designed for people with no prescription coverage. One community health clinic official reported that it is often easier to treat a patient with no coverage than one with TennCare, as patients with no coverage has access to a wider variety of drugs through PAPs.

On the other hand, restrictions on prescription drugs have led some patients to be more proactive with their health care. According to medical providers, patients are more likely to question the necessity of some prescription medications and are beginning to ask for less expensive drugs. Some have decided to make lifestyle changes. One roundtable participant, a diabetic, lost 20 pounds after losing TennCare coverage and now has better blood sugar control and lower blood pressure. Health care providers report that a few of their patients have made similar changes, however, they stress the overwhelming majority have not adopted healthier habits.

Table 2: Geographic Distribution of 2006 Primary Care Expansion Endowment Grants: Faith Based, Community-Based, and Rural Providers

Health Region	Total # Grants	Grant Total	Percent of Funds
Metros			
Shelby	11	$1,680,000	27.7 %
Davidson	9	$1,393,125	23.0 %
Knox	4	$471,875	7.8 %
Hamilton	1	$62,500	1.0 %
Sullivan	1	$37,500	0.6 %
Rural Regions			
West TN	13	$710,000	11.7%
East TN	7	$442,656	7.3%
South Central	6	$440,625	7.3%
Upper Cumberland	6	$398,125	6.6%
Mid-Cumberland	2	$230,000	3.8%
Northeast	3	$161,875	2.7%

Table 3: Chattanooga Area Community Health Clinics Patient Payer Sources Before and After TennCare Reform

Clinic Group	Reporting Period	Total Patient Volume percent Change	Uninsured Volume percent Change	Medicaid/ TennCare Volume percent Change	$$ Un-reimbursed Care percent Change
1*	FY 2005-2006	-16.4 %	78.6 %	-41.6 %	4.7 %
2	Calendar Yr 2004-2005	9.0 %	11.8 %	-21.6 %	NA
3	Calendar Yr 2004-2005	9.3 %	16.6 %	-2.3 %	2.9 %
3	Jan-July 2005 & 2006	2.9 %	15.0 %	-8.1 %	NA

** Clinic Group 1 closed one of its 3 clinics in this time period, primarily due to ongoing building maintenance problems.*
Sources: Chattanooga/Hamilton County Health Department, Southside/Dodson Avenue Community Health Centers, Memorial Primary Care Clinics.

3. After initial confusion, some disenrollees are now fairly successful in navigating the complicated safety net system, while others are not able to access available services for which they are qualified.

A significant amount of confusion accompanied the implementation of TennCare reform. The major changes announced in January 2005 were implemented in August 2005. Up to, and even after, the changes were implemented, elements of the reform seemed to change almost daily. Staying abreast of policy changes was frustrating for social service providers, especially during the first few months of the changes.

Provider roundtable participants described the frustration of trying to help clients navigate a new system which they didn't understand themselves. This may have contributed to the confusion and apprehensions of those most directly affected by the policy changes. They believed that a more gradual phase in of program changes could have made for a smoother transition.

Despite significant media coverage, many disenrollees were unaware of the program changes until they either received notification that they had been dropped or were denied medical services. Several roundtable participants indicated that the state had done a poor job of notifying them of dropping and/or reinstating coverage.[15]

While some cases are more extreme than others, many roundtable participants reported that they had been dropped in the midst of treatment for very serious medical conditions.

Both service providers and TennCare recipients were confused as to the criteria for losing TennCare. Many did not understand how they could lose their coverage while they were so sick. Several disenrolled roundtable participants indicated they were on disability and did not understand why they were disenrolled.

A number of disenrollees reported that they had succeeded in accessing care, but that the effort had become almost a full-time job. One roundtable participant assembled a reference book of services she has accessed or tried to access. Her network includes assistance from various health-based non-profit organizations outside of Tennessee. Other disenrollees were less successful. Often, this was the result of not knowing what services were available to them, especially during the first few months after disenrollment.

Some disenrollees were successful at navigating the Health Care Safety Net program to get their medications. Through various PAPs and Safety Net prescription programs, they have been able to obtain most of their required medications. The MHSN consumers also benefited from having a pharmacy assistance coordinator available through all of the MHSN providers. The most successful disenrollees were proactive and had the capacity, patience, and the support of friends or family to negotiate the complicated patchwork system of assistance.

But some patients found that using the State Safety Net formulary required them to change the medicines they had been taking. In some cases, the formulary drugs were less effective. Others indicated that the formulary met few or none of their needs.[16]

Many former recipients were able to obtain medications through prescription assistance programs (PAPs). Paperwork was reported to be confusing, if not overwhelming, especially given the relatively low literacy levels of many applicants. Safety net clinics and some social service providers have been helping patients with their PAP applications, while others received help from family and friends. The patient's physician serves as the middleman – the physician completes the paperwork and mails the completed application and prescriptions to the pharmaceutical company, which returns filled prescriptions to the physician's office and are picked up by the patient. Reportedly, some physicians avoid participating in PAPs, charging patients as much as $50 for their services.

4. Primary care is generally available to disenrollees, both through emergency room visits and Health Care Safety Net programs, especially in the more populated areas of the state.

As disenrollees lost access to private physicians, many turned to the Health Care Safety Net programs established by the State.

As a result of the Safety Net initiative, the state opened adult primary health care clinics in 28 rural counties and expanded existing adult primary care services in 19 other county health department clinics. Health department clinics offer primary care for a sliding scale fee, with a $5 minimum charge.

The State awarded over $6 million to faith-based, community based, and rural health care centers in 35 counties that serve the uninsured. Over half of these funds went to providers in the state's two most populous counties, Shelby County and Davidson County.

The State awarded an additional $6 million to Tennessee's 23 federally qualified health centers to offset some of the losses from treating more uninsured patients.

In the Chattanooga area, community health clinics report small to moderate increases in overall patient volume after the TennCare disenrollment. Clinic data from three Chattanooga organizations that operate a total of five primary care clinics demonstrate that, for the most part, clinics were seeing the same volume of patients. That is, increases in uninsured patient volume were offset by declines in TennCare patient volume.[17]

Table 4: Changes in ED Use by Payer

	Number of Visits				Percent Difference	
	FY 2004	FY 2005	FY 2006		2004-2005	2005-2006
Uninsured	65,921	64,931	81,507		- 1.5 %	+ 25.5 %
TennCare Total	150,777	154,456	139,536		+ 2.4 %	- 9.7 %
Private Coverage	136,740	133,440	121,201		- 2.4 %	- 9.2 %
Medicare Total	71,270	72,907	79,498		+ 2.3 %	+ 9.0 %
All Other	13,370	19,799	21,732		+ 48.1 %	+ 9.8 %
Totals	438,078	445,533	443,474		+ 1.7 %	- 0.5 %

Sources: 2005 JAR and hospital reports of 9 responding hospitals with an ED. Two other hospitals provided FY 2006 data; however, ED payer data for these two hospitals supplied for the 2004 and 2005 TN JAR reports were included in the "all other" payer category, making data incomparable.

5. Hospitals have absorbed the cost of providing care to an increasing number of uninsured patients: a survey of large hospitals found that the number of admitted uninsured patients had more than doubled during the first year of changes.

Hospital emergency departments report a similar phenomenon regarding uncompensated care. Not surprisingly, some disenrollees are including hospital emergency departments (ED) as part of their personal safety net, knowing they would be treated regardless of ability to pay. Chattanooga area hospital officials reported significantly higher uninsured ED patient volume since the TennCare changes, noting that not all were new patients: rather, many were TennCare disenrollees accustomed to receiving treatment in the ED, whether or not their condition warranted emergency department care. In fact, a 2006 study found that 40 percent of TennCare enrollees visiting a hospital emergency department were "not urgently or emergently ill." [18]

Using data from the Tennessee Joint Annual Report of Hospitals, CRC compared 2004 and 2005 emergency department utilization for the 86 Tennessee hospitals operating on a calendar year. Calendar year comparisons only reflect differences that may have occurred from July to December of the second year. Nevertheless, while emergency department volume increased 4.8 percent, uninsured patient volume increased 18.9 percent, while Medicaid/TennCare patient volume was relatively flat – increasing by only 0.2 percent.

To supplement the 2004 and 2005 Joint Annual Report data, CRC also conducted a survey of the 21 largest Tennessee hospitals (over 175 beds) with fiscal years ending on June 30.[19] The survey requested preliminary 2006 utilization, financial, and ED data. The FY 2006 data reflect activity for a full year following changes to the TennCare program and are comparable to previously published Joint Annual Report data from 2004 and 2005.

Hospitals providing information on 2006 ED use by payment source in the TennCare Impact Survey indicate that in the 12 months following TennCare reform, uninsured ED patient volume jumped 25.5 percent over the previous year. Uninsured ED patient volume had previously been relatively stable and had actually decreased 1.5 percent from FY 2004 to FY 2005.[20]

While disenrollees generally have access to primary care through emergency rooms and Safety Net clinics, many who are critically ill do not have access to specialty care. Uninsured patients who have been hospitalized are usually referred to a community health clinic for follow-up care. Often, community health clinics are able to provide the needed follow-up care. Most community health clinics, however, are not equipped to meet a patient's specialty care needs, for example cancer treatment. In such instances, the clinic tries to find specialists that will provide charity care, but specialists are not able to accommodate all requests.

Programs such as Project Access in Chattanooga and Knoxville, Bridges to Care Plus in Nashville, and Church Health Care in Memphis coordinate specialty charity care for uninsured patients meeting income and residency requirements. Shortages of volunteer physicians in some specialties, such as neurology, gynecology, and orthopedics, mean that not all persons qualified for these programs are able to get the care they need.

Residency requirements for coordinated charity care programs also restrict participation to residents of the county where the program is located, effectively excluding about three-quarters of the disenrollees. While these programs hope to extend enrollment to residents of surrounding counties, they currently do not have the required capacity or infrastructure.

Since its April 2004 launch, the Hamilton County Project Access Program has provided over $11.8 million in donated care to 1,261 patients, including $1.9 in donated physician care and $9.9 million in donated hospital services.[21] It is difficult to ascertain how much TennCare disenrollment affected applications, since the program was still fairly new when program changes were made. However, Project Access officials report that the avalanche of applicants newly disenrolled from TennCare that they expected did not occur. Based on feedback from hospital ERs, the program's Executive Director believes that many TennCare disenrollees turned to area emergency rooms for their immediate need, while others "simply went without care." [22]

6. To meet patient needs in the new payer environment, some hospitals have moved to limit emergency room treatment for patients with non- emergent or non-urgent conditions.

Joint Annual Reports and supplemental information based on a survey of major hospitals suggest a dramatic increase in hospital visits and costs associated with uninsured patients since implementation of the changes in TennCare.

Using 2004 and 2005 Tennessee Joint Annual Report of Hospitals, CRC compared one-year changes in utilization and financial data of hospitals reporting on a fiscal year to hospitals reporting on a calendar year. Only hospitals on a calendar year should have seen an impact based on changes in TennCare. In addition, CRC received preliminary FY 2005-2006 utilization and financial data from 13 hospitals responding to the TennCare Impact Survey: These data cover the first full year of implementation of the changes in TennCare and could be compared to 2004-2005. Both analyses show significant increases in uninsured patient volume and charity care in the reporting periods after changes in TennCare compared to the pre-change reporting period. Most notably, among the thirteen TennCare Impact Survey hospitals, uninsured inpatient volume increased 141.1 percent.

The shift from TennCare to charity care has prompted major hospitals in the Chattanooga area to collaborate in a process to reduce cost by reducing inappropriate emergency department use.

Chattanooga's three major hospital systems and the Chattanooga Hamilton County Medical Society worked together on an initiative "designed to appropriately focus emergency department resources on emergent and urgent medical conditions, reduce wait times for emergency department patients, and help refer non-emergency patients to primary care homes in the community."[23] This program, called QMP (Qualified Medical Provider), was implemented in October 2006.

Under QMP, all patients who present in the ED undergo a medical screening by a qualified medical person, in conjunction with the ED physician if needed. Patients who do not have an emergent or urgent medical condition are redirected to alternative community health resources. Alternatively, patients may remain for ED treatment for a flat fee (about $200) payable at the time of visit or, if they are insured, the cost of their co-pay. Deferred patients receive a list of area safety net providers, including community health clinics. To ensure that deferred patients are seen in a timely fashion, area community health clinics have agreed to reserve up to five appointments per week for deferred patients.

One month after implementation, officials at two area hospital systems reported that about 5 percent of their patients have been deferred treatment. The third system has deferred only about 1 percent of ED patients, but reported that it has had a similar system of deferral for several years and has been seeing fewer non-emergent patients.

Most patients reportedly accept the new rules. Some patients were satisfied to learn their symptoms were not serious. Many were grateful to receive the list of area safety net providers, stating they had believed the ED was their only option since they were uninsured.

Few patients, however, have followed up with community health clinics, who report seeing only about one patient per week deferred from the ED. Telephone follow-up has been difficult as patient phone numbers are often incorrect or phones have been disconnected.

7. In response to TennCare changes, several social service agencies have made significant programmatic changes in an effort to better meet the needs of disenrollees.

During the early phases of implementation of changes to TennCare, many social service agencies changed their program to meet anticipated increased demand for emergency assistance. Eligibility requirements for assistance were

Table 5: Summary of Hospital Utilization and Charity Care 2004-2006

	TN JAR data		TN Impact Survey & JAR Data	
	Half Year Post TennCare Changes	Pre TennCare Changes	Pre TennCare Changes	Full Year Post TennCare Changes
	CY 2004-CY 2005	FY 2004-FY 2005	FY 2004-FY 2005	FY 2005-FY 2006
# Hospitals Reporting	**(86)**	**(67)**	**(13)***	
Admissions				
Total Admissions	- 1.0 %	- 1.9 %	+ 2.9 %	+ 5.4 %
Uninsured	**+ 37.0** %	+ 1.1 %	- 2.6 %	**+ 141.1** %
TennCare	-2.3 %	- 1.9 %	+ 5.5 %	- 6.6 %
Outpatient Visits				
Total	+ 1.7 %	+ 0.4 %	+ 0.9 %	+ 6.9 %
Uninsured	+ 21.5 %	- 0.1 %	- 4.5 %	**+ 73.3** %
TennCare	+ 0.8 %	+ 20.3 %	- 4.1 %	- 10.0 %
Financial				
Charity Care	**71.8** %	+ 16.4 %	**33.9** %	**52.9** %

Sources: Hospital JAR data for 2004 and 2005;
Preliminary 2006 data submitted by 13 non-profit hospitals in 9 counties
**Only 12 hospitals provided outpatient data*

Table 6: Chattanooga 211 Requests for Assistance

	Total Requests #	Comparison to 2004 (Percent Change)
July 1 – November 8, 2004	6,171	NA
July 1 – November 8, 2005	6,400	+ 3.7 %
July 1 – November 8, 2006	5,457	- 11.6 %

Source: United Way of Greater Chattanooga 211

tightened at some agencies: for example, new restrictions were placed on the number of times they provide a family with emergency assistance. At least two Chattanooga area agencies designated all of their emergency assistance funds for prescription medicine assistance.

Other social service organizations re-evaluated the role of emergency assistance programs in their organizations. One Chattanooga-area agency reported that it has moved away from direct financial assistance and is working toward developing a sense of empowerment among its clients by placing more emphasis on lifestyle education, preventative education, and budget counseling.

Social service agencies also reported increased requests for assistance with food, rent, and utilities as families used money budgeted for these necessities to purchase medicine.

Many agencies reported spending significant staff resources assisting people with their medication needs. This included not only helping patients get medicine, but also advising patients how to best maximize their prescription budgets. Even case workers and other social service personnel were asked for advice on rationing medicine, raising some concerns about potential medical liability. One pharmacist reported spending as long as 30 minutes on the telephone with individual patients explaining the new medication policy and helping them make decisions on filling prescriptions.

Community health clinics and several social service agencies provide assistance with filling out forms for PAPs. Some agencies have been able to designate employees for which such assistance is their main duty, while others have added this task to an already full workload. At least one local clinic is trying to reduce their dependence on prescription assistance programs and free up staff resources by directing patients to fill prescriptions at one of three chain discount stores which, between the three stores, offer over 350 generic drugs at a cost of four to five dollars per month.[24]

Not all social service agencies were faced with a need to reallocate resources to meet increased demand. One way to gauge overall demand for social services in the community is through the 211 system. Sponsored by the United Way, 211 functions as a community-wide source of referrals for individuals needing assistance. Records from 211 do not suggest dramatic jumps in requests for assistance. In the three-month period immediately following TennCare program changes, requests for assistance were up 3.7 percent over the same time period the previous year. During this time, however, many people displaced by Hurricane Katrina relocated to Chattanooga and contacted 211 for assistance. During the same time period in 2006, 211 processed 11.6 percent fewer requests than in 2004, prior to TennCare reform.

The AIM Center, a non-medical non-profit community organization that provides vocational and social services for the chronically mentally ill in the Chattanooga region, expected a big crush of clients in crisis resulting from changes in prescription medications. The agency reports that the volume of patients in crisis has been stable, and similar to the crisis volume before TennCare changes.

Anticipated spikes in crisis intervention services and mental health institute hospitalization among the severe and persistent mental illness (SPMI) population did not occur. One community mental health center added five beds for crisis intervention: however, there has been little demand for the new beds.

In some cases, the changes in TennCare resulted in a decrease in the demand for services. For example, agencies providing medical transportation for TennCare patients had fewer patients to transport, forcing staff reductions for some. In the first twelve months after TennCare program changes, Special Transit Services, TennCare's transportation service provider for Hamilton County, provided 18 percent fewer medical related trips than the same time period the previous year and now employs only about half as many drivers as it did in 2004.[25]

8. As of May 2007, nearly 35 percent (5,685) of TennCare disenrollees with serious and persistent mental illness (SPMI) have not registered for Mental Health Safety Net (MHSN) services for which they are eligible.

The Tennessee Department of Mental Health and Developmental Disabilities developed the MHSN "to provide essential mental health services to those persons who were disenrolled from the TennCare program due to TennCare reform and were identified as SPMI."

Initially, TennCare officials identified 20,775 individuals on TennCare with SPMI for disenrollment. Of that number, after appeals, 16,478 were actually disenrolled.

Several agencies coordinated efforts to enroll eligible disenrollees in the MHSN. Registered individuals with SPMI are eligible for assessment, evaluation, diagnostic and therapeutic interventions; psychiatric medication management; laboratory services related to medication management; community transitional support; and pharmacy assistance and coordination. They are also eligible for RxOutreach, with an expanded formulary of generic drugs (six additional medications) and access to one atypical anti-psychotic medicine, subject to a five dollar co-pay.

The Tennessee Chapter of the National Alliance on Mental Illness (NAMI) conducted 29 community forums throughout the state, and the TennCare Partners Advocacy Line and the community mental health centers reached 60 percent of eligible persons by telephone.[27] In addition, some community mental health centers also went out in the field to look for these patients and sign them up for the MHSN.

Roundtable participants representing community mental health agencies have generally been pleased with MHSN services, but are concerned about the SPMI population who did not enroll. As of May 2007, 10,793 of the 16,478 (65.5 percent) of the disenrollees known to have SPMI had registered for MHSN services. Outreach efforts identified other disenrollees eligible for the MHSN – individuals not among the original 16,478 – and registered 2,886 newly identified individuals with one of the community mental health agencies.

The percentage of disenrollees with SPMI not registered in the MHSN varies widely by county. At the low end, approximately one-fourth of disenrollees in four counties are not registered – Gibson

County (13.8 percent) has the smallest percentage of non-registered disenrollees. However, over half of the disenrollees in six counties are not registered: for example, in Monroe County, 63.0 percent of disenrollees never registered (See Map 1 and Appendix A for county-by-county details).

Medical providers participating in the round-tables noted an increase in patients with mental health issues. In a provider roundtable six months after the TennCare changes, one participant indicated that mental health related emergency room volume seemed to have tripled.

Yet, the Tennessee Chapter of NAMI reports that "neither hospitalization nor use of crisis services has spiked since disenrollment."[28] While projections based on year-to-date data suggest that admissions to state mental health institutes increased slightly in the current fiscal year ('06-'07), the rate of increase was less than half the rate the previous year and significantly less than the 10 percent to 16 percent increases just a few years earlier. And use of crisis services actually declined over the past year. State-wide quarterly reports from the TennCare Partners Roundtable show that contacts to mobile crisis units from April through June 2006 were down 5.9 percent from the same time period in 2005.

There is speculation that some disenrollees have moved out of state, especially if they lived near the border of one of Tennessee's eight bordering states. Despite being prohibited by TennCare regulation, some of these individuals

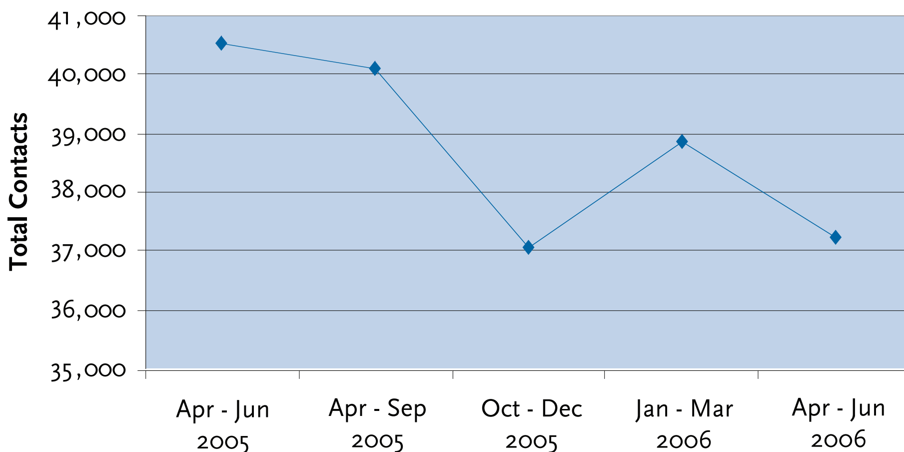
Table 7: Tennessee Mental Health Institutes Admissions Data 1999-2007

Year	Annual Admissions	Percent Annual Change
1999-2000	9,905	--
2000-2001	10,945	10.5 %
2001-2002	12,443	13.7 %
2002-2003	14,483	16.4 %
2003-2004	14,667	1.3 %
2004-2005	14,090	-3.9 %
2005-2006	14,811	5.1 %
2006-2007 (projected)	15,100	2.0 %

Source: State of Tennessee Fiscal Information

may have actually lived in a bordering state but used a Tennessee address in order to qualify for TennCare.

It is also possible that some of the SPMI population may have become homeless or incarcerated, conditions often associated with untreated mental illness. For example, approximately 30 – 40 percent of homeless individuals in the Chattanooga region are said to have serious mental illness.[29] Local incarceration data are not available, but national figures indicate than people with untreated mental illness were twice as likely as healthy individuals to have contact with the criminal justice system.[30] A State survey of jail administrators and county sheriffs in Tennessee suggests that the percentage of jail inmates may be declining: but that same survey, in 2006, also found that more than half of all responding counties reported that there had been an increase in the number of individuals with mental illness in their jail over the past year.[31]



Source: TennCare Partners Roundtable

9. Key indicators of the State's economy reflect national trends and, to date, do not match economic declines predicted as a result of the TennCare changes.

Many predicted the changes to the TennCare program would have a disastrous effect on the State economy. The Center for Budget and Policy Priorities predicted thousands in lost revenue and jobs that would result in an $800 million reduction in state economic activity in FY 2005, increasing to $2.4 billion in 2008.[32]

One year into TennCare reform, leading financial ratings agencies praise Tennessee's economy. Both Fitch and Standard and Poor's upgraded their ratings on Tennessee's general obligation bonds from AA to AA+. According to Bloomberg News Service, Tennessee is one of only 16 states that currently have an AA+ rating from Standard and Poor's. Moody's, a third provider of independent credit ratings, raised Tennessee's credit outlook from "stable" to "positive." All three organizations indicated that the restructuring of TennCare contributed to the boost in ratings.

Rather than losing thousands of jobs as predicted, total non-farm employment in Tennessee increased by 34,000, or an increase of 1.2 percent. Unemployment rates decreased 16.4 percent (from 5.5 percent to 4.6 percent). Employment in the health care sector increased as well, with the healthcare and social assistance sector reporting 2.3 percent higher employment than before TennCare reform. Within the larger category of health care and social assistance, ambulatory health care services employment increased 3.0 percent, hospital employment increased 2.4 percent, and nursing and residential care facilities increased 1.8 percent.

Table 8: TennCare: One Year Later Economic Indicators

	Tennessee	United States	Sources	Time Frame
Employment by Sector:				
Total Non-farm Employment	+ 1.2 %	+ 1.5 %	*BLS*	7/05 - 8/06
Health Care and Social Assistance	+ 2.3 %	+ 2.3 %	*BLS*	7/05 - 8/06
Ambulatory Health Care Services	+ 3.0 %	+ 3.0 %	*BLS*	7/05 - 8/06
Hospitals	+ 2.4 %	+ 2.4 %	*BLS*	7/05 - 8/06
Nursing and Residential Care Facilities	+ 1.8 %	+ 1.8 %	*BLS*	7/05 - 8/06
Unemployment Rate:				
1 yr decrease	- 0.9 pts	- 0.5 pts	*BLS*	9/05-9/06
Percent Change	- 16.4 %	- 9.8 %	*BLS*	9/05-9/06
Personal Income	+ 6.8 %	+ 7.3 %	*BEA*	2nd Qtr 2005-2006
State Bond Ratings	From AA to AA+	NA	*Fitch, S&P*	October 2006

One year into reform, Governor Bredesen achieved his goal of limiting TennCare spending to 26 percent of tax revenues. The addition of two new programs – the Health Care Safety Net and Cover Tennessee — however, brings State spending on health care programs for the uninsured up to 27.5 percent of tax revenues. Reducing the number of people covered by TennCare reduced state spending by $647 million. This spending reduction, however, was accompanied by a $644 million loss in federal matching funds. The State also lost $30 million in revenue from premiums paid by some of the disenrollees.

In 2006, the combined costs of the three programs, TennCare, Health Care Safety Net, and Cover Tennessee, are expected reach $2.8 billion -- 8 percent more than the cost of TennCare before reform. State officials indicate, however, that the rate of spending growth has slowed to a more manageable rate. TennCare spending growth approached 18 percent in 2004: state officials expect TennCare spending to grow only one half of one percent in the current year, although the new programs will add to health care expenses.[33]

While the increase in charity care has had a fiscal impact on hospitals, it has not deterred some facilities from going forward with ambitious expansion projects. In 2006, Tennessee hospital and medical facilities have petitioned the State for permission to proceed with building projects totaling close to $2.3 billion – a 400 percent increase over 2005. The three largest requests include $320 million for a hospital expansion project in Chattanooga, $28.35 million to relocate a hospital in Murfreesboro, and $234.4 million for a hospital expansion in Nashville.[34]

Considerations

One year after implementation of the recent round of changes in the TennCare program, it is important to consider some possible lessons learned – both from the process and from early outcomes.

Necessity for sufficient planning, policy development, and communication

The programmatic overhaul to TennCare was put into place within months of it first being proposed. It did not occur in a vacuum, however. After negotiations with advocacy groups to reduce costs to the hemorrhaging program failed, it was a strategy of last resort. Some critics have said that the program changes occurred without adequate planning and detailed policy development. On the other hand, the state believes it invested a significant amount of time and energy towards planning the TennCare changes – particularly with the Centers for Medicare and Medicaid Services (CMS) – and finalizing the amendments required to make such changes to the program. It is hard to determine whether the reform initiative would have led to the same containment of cost with less of an impact on the health of current and past TennCare participants had it been rolled out differently.

But then again, the program adopted by the Legislature was never fully implemented.[35] Throughout the process, the State sought to "fine tune" various aspects of the policy reforms. Without constant monitoring of impact, the outcomes to date could have been different.

It is clear, however, that there was a high level of confusion for some individuals as reforms were being implemented. Absent a phase-in period, participants were frequently confused – and understandably apprehensive – about the changes. Health and social service providers often lacked sufficient information to provide to clients. And, during these early stages, individuals slipped through the cracks and went without care.

While the State worked to communicate these changes as they were occurring, communication efforts seem to not have been sufficient.

Access to Health Insurance vs. Access to Care

Many predicted that the result of the changes to TennCare would be that tens of thousands of Tennesseans would be left without health insurance and without access to health care. In the short term, that has not been the case. While it appears that it has been challenging for TennCare recipients who lost coverage to gain new coverage, most have continued to access health care. However, the difference now is that more of the cost of their health care is being absorbed in the growing cost of charity care.

And, while some alternative volunteer programs expected to bear the brunt of providing this care, the reality was that former TennCare recipients relied on hospitals for their health care needs. Again, this phenomenon may only be short term: it is too soon to tell what, if any, effect the new Qualified Medical Provider program will have or whether hospitals will take other steps to limit their role as an informal safety net. Also, as hospitals continue to try to meet the demands related to the growth in charity care, they may have to scale back even more.

Impact on Vulnerable Populations

We don't have enough information to know about the real impact of the cuts in TennCare to those individuals with SPMI. Like other former recipients who did not know how to access alternative means of obtaining care, these individuals may have fallen through the cracks. Individuals with untreated SPMI are particularly vulnerable.

As this paper has also highlighted, a portion of the disenrollees have become 'silent' to an extent. In some circumstances, the changes in TennCare resulted in a decrease in the demand for services. There are many reasonable explanations for this. The larger question, however, is when will these individuals re-appear in the system, and in what state of health will they be?

Not Just Health Care Providers

The provider roundtables suggest that the practical impact of the rapid changes in TennCare fell at least as much on social service agencies as it did on health care providers. While state officials were able to put a Health Safety Net in place, there was no comparable "back up" to the redirection of emergency assistance to health care.

Economic Impacts

Dire predictions of lost jobs and closing hospitals have not yet been fulfilled – at least in those areas that were the focus of this study. Arguably, the increase in health care employment in Tennessee would have been even greater had TennCare continued to grow at its past rates. But, at least in the short term, the loss of funding has not led to dramatic reductions in employment. One reason may be that so much of the reduced funding was in the area of prescription costs, not labor costs. Thus, the impact of the cuts may have fallen disproportionately on out-of-state pharmaceutical companies, not in state health care workers. In terms of hospitals, an October 2006 report by Moody's Investor Services found that the TennCare reform "has not been as significant as originally anticipated, allowing hospitals an opportunity to successfully offset the majority of the unfavorable changes through revenue enhancement and cost control initiatives."

As Tennessee continues its implementation of the Cover Tennessee program, it will be important to see how the TennCare program settles in as a far more modest program. As mentioned earlier, there are clearly long-term implications of the changes that cannot be assessed at this time. In the interim, however, this report highlights the real consequences of these changes by giving a voice to those affected.

TennCare was implemented as an experiment in substantial reform; by doing so, the state had to accept the risks that come with attempting something new. The entire health care sector evolved in the state as the TennCare program grew. Likewise, with its retrenchment, patients, providers, and the state will have to realign and make the system work, hopefully in a more effective manner.

Endnotes

1 Christopher J. Conover, Hester H. Davies, "The Role of TennCare in Health Policy for Low-Income People in Tennessee," Urban Institute, 2000, http://www.urban.org/url.cfm?ID=309341

2 According to the state, 40,000 of the 170,000 persons who were disenrolled were dual eligibles, meaning that they were Medicare beneficiaries. These people would not be considered 'uninsured.'

3 According to the state, nearly 9,000 TennCare disenrollees with serious and persistent mental illness (SPMI) have not registered for Safety Net services for which they are eligible: in 16 Tennessee counties, over half of eligible disenrollees have not registered. Of the 20,775 originally identified as SPMI only 16,816 were actually disenrolled from TNCare. (This reduction in the number of SPMIs who were disenrolled was in part the result of enrollees exercising their appeal rights.) Of those disenrollled, 10,934 were registered with one of the 20 MHSN providers. By October 2006 in spite active outreach efforts by National Alliance for the Mentally Ill (NAMI) approximately 6,000 of the identified SPMIs had not contacted a Community Mental Health Agency (CMHA) to register for services.. There was a liberalization of the MHSN criteria for eligibility and by October 27, 2006, 2083 individuals--who had not been identified previously as SPMI (out of the 190,000 who were disenrolled) were registered with a CMHA in the MHSN.

4 According to the state, nearly 6,000 TennCare disenrollees with serious and persistent mental illness (SPMI) have not registered for the Mental Health Safety Net (MHSN): in 12 Tennessee counties, nearly half of eligible disenrollees have not registered. Of the 20,775 originally identified as SPMI only 16,478 were actually disenrolled from TennCare. (This reduction in the number of SPMIs who were disenrolled was in part the result of enrollees exercising their appeal rights.) Of those disenrolled, 10,793 were registered with one of the 20 MHSN providers. By May 2007, in spite of active outreach efforts by National Alliance for the Mentally Ill (NAMI) approximately 6,000 of the identified SPMIs had not contacted a Community Mental Health Agency (CMHA) to register for services. There was a liberalization of the MHSN criteria for eligibility and by May 21 2007, 2,886 individuals disenrolled from TennCare who had not been identified previously as SPMI were registered with a CMHA in the MHSN.

5 It should be noted that the number of uninsured people in Tennessee had been growing, separate and apart from the disenrollments that occurred in 2005. TennCare commissions a yearly survey that provides estimates of the number of uninsured people in the state. These estimates have been climbing each year since 2002.

6 Members of the TennCare expansion group were subject to monthly premiums. Premiums were set on a sliding scale based on income for individuals with incomes up to 400 percent of the federal poverty level. Individuals with incomes at or above 400 percent of federal poverty levels could buy-in to the program and pay non-subsidized premiums. By the end of 1994, TennCare enrollment was approaching capacity and the State closed enrollment to people in the uninsured category. Enrollment remained open in the uninsurable category.

7 Anna Azer, Marsha Gold and Cathy Schoen, "Managed Care and Low-Income Populations: Four Years' Experience with Tenncare," Kaiser/Commonwealth Low-Income Coverage and Access Project, May 1999.

8 http://www.tennesseeanytime.org/governor/AdminCMSServlet?action=viewFile&id=18

9 Prior to disenrollment, the State conducted an internal review to determine whether individuals were qualified for TennCare under the new eligibility guidelines. Potential disenrollees received a request for information with a form to be completed to determine continued eligibility under the core Medicaid program.

10 TennCare did set up a process to allow enrollees who were subject to benefit limits to get additional drugs even if they had reached their limit. One process, called the Auto Exemption process, consists of a list of over 500 drugs that do not count against the benefit limit. Another program, launched in February 2007, called the Prescriber Attestation process, consists of over 600 medications that can be accessed when a prescriber attests to TennCare that there is an urgent need for his patient to have the drug.

11 The city of Chattanooga (2000 population: 155,509) is wholly located within Hamilton County, Tennessee (2000 population: 307,896), the largest county in Southeast Tennessee. Hamilton County health care providers and many social service agencies serve residents of nearby counties as well.

12 Community Research Council, *The 2006 State of Chattanooga Region Report*, November 2006.

13 A 2005 study found that the proportion of non-elderly former and current welfare recipients reporting fair or poor health was three times that of the general population. (Tyrone Chang, The Impact of Welfare Reforms, Health, and Insurance Status on welfare Recipients' Health Care Access, Journal of Health Care for the Poor and Uninsured 16.3, 2005.) National BRFSS data indicate that adults with less than $15,000 household income were three times more likely to have diabetes, 2.3 times more likely to smoke, and 1.9 times more likely to have asthma than adults with $50,000 or more in household income. (Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.)

14 See footnote 8

15 According to the state, enrollees were notified several times, and well in advance, of being disenrolled. An initial notice with a "Request for Information" was sent to enrollees asking them to send information that would have helped the state determine eligibility for a Medicaid category. If the enrollee did not respond to the initial notice or they did respond but were determined ineligible, they then received additional notices announcing the disenrollment and offering appeal rights.

16 For example, the formulary does not offer the more specialized medications for less common illnesses, such as rheumatoid arthritis, seizure disorders and other neurological disorders, psychiatric disorders, and gastroenterology conditions. Further, for the illnesses the formulary does treat, some generic drugs do not work as well as the brand drugs for many patients.

17 Clinic Group 1 operates on a fiscal year, and comparisons to the previous year reflect a full year of post TennCare reform data. Clinic Group 3, however, operates on a calendar year, and comparisons to the previous year reflect only a half year's post TennCare reform data.

18 Bureau of TennCare, "Proposal to Reduce Inappropriate Utilization of the Emergency Department by TennCare Enrollees," August 2006.

19 All Tennessee hospitals that report on a June 30 fiscal year are nonprofit or government-run.

20 TennCare Impact Survey - Surveys were mailed to the chief executives of the 21 largest Tennessee hospitals reporting on a June 30 fiscal year. A total of 13 hospitals responded, although only 9 provided requested information on ED use.

21 Hamilton County Project Access Program Report, November 2006.

22 Correspondence with Rae Young Bond, Executive Director, Hamilton County Project Access.

23 Chattanooga and Hamilton County Medical Society correspondence, September 20, 2006.

24 Programs available at Wal-Mart/Sam's Club, K-Mart, and Target. Tennessee law prohibits the sale of prescription drugs at prices below cost, which affects an additional 51 generic drugs. These 51 additional drugs may be purchased for $9 for a 30-day supply.

25 Special Transit Services (STS) data. STS made a monthly average of 4,250 medical trips month from July 2004 through June 2005, and an average of 3,480 medical trips during the same time period the following year, a decrease of 18.1 percent.

26 Tennessee Department of Mental Health and Developmental Disabilities: Division of Recovery Services, "Mental Health Safety Net Information Packet," October 23, 2006.

27 Sita Diehl, "TennCare Changes, Effects on Children and Adults with Mental Illness," TennCare Oversight Committee, NAMI Tennessee, April 10, 2006.

28 Ibid.

29 City of Chattanooga and the Chattanooga Homeless Coalition, "The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years," 2004.

30 P. Ditton, "Mental health and treatment for inmates and probationers," Washington, DC: Bureau of Justice Statistics, 1999.

31 D. Ducote and P. DeWitt, "County Jails in Tennessee: Third Survey Report," June 28, 2006. According to the survey, the percentage of inmates with diagnosed mental illness dropped from 18% in 2002 to 15.6% in 2005. Unfortunately, while 2002 and 2003 surveys were based on responses from officials representing all or nearly all of the county jail facilities in the state, the 2006 survey had a much lower response rate: for example, only 38% of all counties responded to the question asking for an estimate of the number of inmates diagnosed with mental illness. A higher percentage responded to the question of whether there had been an increase or decrease in number over the last year – twenty five reported an increase, six reported a decrease and fifteen reported no change. In addition, according to the report, "three counties report experiencing an increase in the population of inmates with mental illness due to lack or loss of insurance benefits in the community."

32 Center on Budget and Policy Priorities, "Will the New TennCare Cutbacks Help Tennessee's Economy?" July 8, 2004.

33 Chattanooga Times Free Press, "Medical growth a shot in the arm for economy," October 8, 2006.

34 Ibid.

35 The State did not go forward with the elimination of coverage for the 97,000 residents in the medically needy spend down category, although enrollment in this category was closed to non-pregnant adults. For those remaining on TennCare, proposed limits on physician visits, covered inpatient and outpatient care were postponed indefinitely. (See Background section)

Appendix A

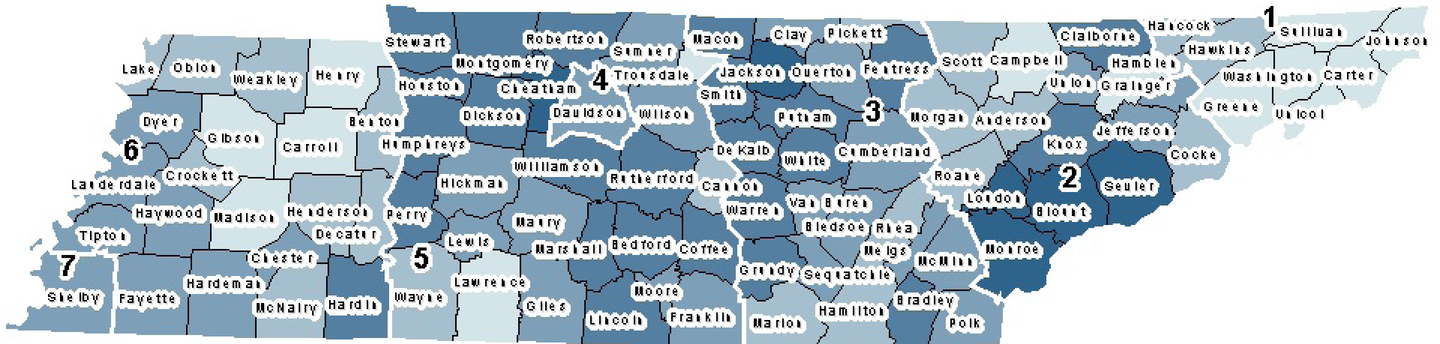
Table 7: Registration with the Mental Health Safety Net by County					
County	Number Disenrolled SPMI	Registered		Not Registered	
		Number	% Disenrolled	Number	Percent Disenrolled
Monroe	127	47	37.0%	80	63.0%
Sevier	301	119	39.5%	182	60.5%
Cheatham	104	44	42.3%	60	57.7%
Loudon	144	63	43.8%	81	56.3%
Blount	397	182	45.8%	215	54.2%
Jackson	27	13	48.1%	14	51.9%
Bedford	110	56	50.9%	54	49.1%
Fentress	43	22	51.2%	21	48.8%
Humphreys	62	32	51.6%	30	48.4%
Perry	31	16	51.6%	15	48.4%
Lincoln	87	46	52.9%	41	47.1%
Houston	34	18	52.9%	16	47.1%
Grundy	48	26	54.2%	22	45.8%
Knox	1,067	584	54.7%	483	45.3%
Dickson	198	109	55.1%	89	44.9%
Marshall	115	64	55.7%	51	44.3%
Macon	75	42	56.0%	33	44.0%
White	69	39	56.5%	30	43.5%
Montgomery	320	181	56.6%	139	43.4%
Stewart	47	27	57.4%	20	42.6%
Hardin	92	53	57.6%	39	42.4%
Robertson	156	90	57.7%	66	42.3%
Coffee	174	101	58.0%	73	42.0%
Bradley	228	134	58.8%	94	41.2%
Claiborne	117	69	59.0%	48	41.0%
Warren	140	83	59.3%	57	40.7%
DeKalb	52	31	59.6%	21	40.4%
Smith	33	20	60.6%	13	39.4%
Putnam	160	97	60.6%	63	39.4%
Rutherford	343	210	61.2%	133	38.8%
Williamson	124	76	61.3%	48	38.7%
Lewis	75	47	62.7%	28	37.3%
Overton	54	34	63.0%	20	37.0%
Hamblen	153	97	63.4%	56	36.6%
Tipton	209	134	64.1%	75	35.9%
Lauderdale	134	86	64.2%	48	35.8%
Davidson	2,082	1,340	64.4%	742	35.6%
Bledsoe	51	33	64.7%	18	35.3%
Giles	142	92	64.8%	50	35.2%
Franklin	117	76	65.0%	41	35.0%
Wilson	178	116	65.2%	62	34.8%
Cumberland	165	108	65.5%	57	34.5%
Clay	29	19	65.5%	10	34.5%
Polk	35	23	65.7%	12	34.3%
Haywood	63	42	66.7%	21	33.3%
Moore	15	10	66.7%	5	33.3%
Sequatchie	51	34	66.7%	17	33.3%
Van Buren	21	14	66.7%	7	33.3%

County	Number Disenrolled SPMI	Registered		Not Registered	
		Number	Percent Disenrolled	Number	Percent Disenrolled
Hickman	145	97	66.9%	48	33.1%
Dyer	174	117	67.2%	57	32.8%
Sumner	330	222	67.3%	108	32.7%
Hardeman	69	47	68.1%	22	31.9%
Jefferson	138	94	68.1%	44	31.9%
Union	91	62	68.1%	29	31.9%
Chester	44	30	68.2%	14	31.8%
Meigs	41	28	68.3%	13	31.7%
McMinn	194	133	68.6%	61	31.4%
Maury	307	213	69.4%	94	30.6%
Shelby	1,447	1,005	69.5%	442	30.5%
Fayette	60	42	70.0%	18	30.0%
Cocke	189	133	70.4%	56	29.6%
Wayne	75	53	70.7%	22	29.3%
Pickett	14	10	71.4%	4	28.6%
McNairy	74	53	71.6%	21	28.4%
Marion	92	66	71.7%	26	28.3%
Hamilton	716	516	72.1%	200	27.9%
Crockett	36	26	72.2%	10	27.8%
Morgan	38	28	73.7%	10	26.3%
Scott	46	34	73.9%	12	26.1%
Roane	128	95	74.2%	33	25.8%
Rhea	121	90	74.4%	31	25.6%
Anderson	189	141	74.6%	48	25.4%
Decatur	67	50	74.6%	17	25.4%
Hawkins	185	139	75.1%	46	24.9%
Obion	89	67	75.3%	22	24.7%
Lake	49	37	75.5%	12	24.5%
Cannon	29	22	75.9%	7	24.1%
Weakley	87	66	75.9%	21	24.1%
Benton	84	64	76.2%	20	23.8%
Henderson	163	125	76.7%	38	23.3%
Hancock	26	20	76.9%	6	23.1%
Carter	152	118	77.6%	34	22.4%
Washington	310	243	78.4%	67	21.6%
Trousdale	28	22	78.6%	6	21.4%
Madison	309	243	78.6%	66	21.4%
Sullivan	463	366	79.0%	97	21.0%
Greene	171	136	79.5%	35	20.5%
Johnson	47	38	80.9%	9	19.1%
Grainger	63	51	81.0%	12	19.0%
Henry	105	85	81.0%	20	19.0%
Unicoi	77	63	81.8%	14	18.2%
Lawrence	192	158	82.3%	34	17.7%
Carroll	113	93	82.3%	20	17.7%
Campbell	138	114	82.6%	24	17.4%
Gibson	159	137	86.2%	22	13.8%
Out of State	15	2	13.3%	13	86.7%
TOTAL	16,478	10,793	65.5%	5,685	34.5%

Source: Tennessee Department of Mental Health and Developmental Disabilities: Division of Recovery Services, Mental Health Safety Net, May 22,2007

Map 1

Tennessee Mental Health Safety Net Non-enrollment: Counties and Regions



Mental Health Regions

Map ID	Region
1	Upper East Tennessee
2	East Tennessee
3	Southeast Tennessee
4	Davidson County
5	Middle Tennessee
6	West Tennessee
7	Shelby County

Counties

Percent not enrolled

- 49.1 - 63.0
- 37.4 - 49.0
- 29.6 - 37.3
- 22.4 - 29.7
- 13.8 - 22.4

Source: Tennessee Department of Mental Health and Developmental Disabilities: Division of Recovery Services, Mental Health Safety Net, May 22, 2007.
Names for Regions 2, 3, and 5 given by CRC.
Regions are identified by white boundary lines.

Note: Jenks Natural Breaks was the method used to create data categories in the map. This method identifies break points in the data by picking classes that best group similar values and that maximize the differences between the classes.