Failed Promises: The Demise of the Original TennCare Vision

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Managed care was the intended foundation of Tennessee’s Medicaid-replacement program (TennCare) when it was implemented in 1994. By the Summer of 2005, however, when the mandated disenrollment of approximately 200,000 adult TennCare beneficiaries commenced, it was obvious that the promise of managed care had not been realized. The program collapsed under the weight of mismanagement and unrealistic expectations. Whether the demise of the original TennCare vision was the result of fundamental design flaws in the concept of managed care or poor execution of that concept are questions that remain unanswered, subsumed in the aftermath of pervasive failures and disillusionment. This paper identifies lessons learned from the TennCare program.

Efforts to reform Medicaid are important, because of the sheer scope of the program. Nationally, Medicaid programs cover more than 50 million individuals, paying for one in five health care dollars in the United States. From 1990 to 2002, the number of Medicaid beneficiaries increased by 60%.1

Medicaid is the second-largest and fastest-growing state budget item.2 Medicaid reform efforts have been directed at cost reduction, expansion of coverage or access, or some combination of or complement to these factors. In the span of 15 years, the introduction of managed care transformed the delivery of Medicaid services in the United States. TennCare, Tennessee’s Medicaid-replacement program, was revolutionary when it was launched in 1994. However, Tennessee was an unlikely state to host such an ambitious transformation, implementing universal mandatory Medicaid managed care earlier than most states. The move to managed care took place on an accelerated timetable (< 8 mo) in a state with minimal commercial managed care penetration. Yet, the TennCare program expanded access to 400,000 previously uninsured and uninsurable individuals at its implementation.3

The rapid introduction of TennCare would merely be a historical footnote had the state successfully resolved myriad implementation problems and established effective managed care practices. Unfortunately, this was not the case.

THE BEGINNING
Governor Ned Ray McWherter (D-TN, serving from 1987–1995) and his team of David Manning, then the Commissioner of Finance and Administration, and Manny Martin, the Medicaid Director and later the TennCare Director, capitalized on a convergence of factors to fulfill a long-held campaign promise to provide accessible and affordable health care for all residents of Tennessee, and to avoid a fiscal collapse in the state.

In November 1993, President Bill Clinton proposed the Health Security Act of 1993. This legislation was designed to reform the delivery and financing of health care at the national level. Strong opposition to the plan was immediately mobilized, and the Act did not advance past the proposal stage. With the failure of passage of the Health Security Act, the states became a new incubator for health reform, following the
long-standing reform efforts spearheaded in the private sector by large employers.

As a former Governor, President Clinton was frustrated with Medicaid and what he perceived as bureaucratic rigidity at the Health Care Financing Administration (HCFA). He made state flexibility and the availability of state waivers a priority. In addition, President Clinton laid the groundwork for the incremental expansion of the Medicaid program and a transformation away from an entitlement program for the poor to a broad-based program reaching into the middle class. The approval of waivers from the established Medicaid requirements—promoted as a means to broaden the covered population and services, and since used to reduce benefit levels and increase cost-sharing—allowed state innovation and flexibility.

Later in the decade, the Balanced Budget Act of 1997 facilitated Medicaid managed care program growth by allowing states to require enrollment of Medicaid beneficiaries in managed care plans and permitting states to contract with health plans that served populations composed entirely or predominantly of Medicaid enrollees.

A decade earlier, when Governor McWherter began his first term in 1987, the budget for covering Tennessee’s 500,000 Medicaid enrollees stood at $1 billion. By 1993, costs had tripled and enrollment had doubled. Costs had increased in part because of a series of mandatory, unfunded mandates to expand coverage. In addition, creative methods that the State had employed to generate federal revenue for its Medicaid program (such as provider taxes) were set to expire. Despite this, nearly 500,000 Tennessee residents had no health coverage. Among these uninsured were groups that were eventually added to TennCare. Those added were part of the “expansion population,” which included uninsured individuals lacking access to health care, uninsurable individuals and dually-eligible individuals. Governor McWherter and his team used the reality of a looming state budget crisis to gain acceptance for the plan they developed to reform the state’s Medicaid program.

During the waning days of his tenure, Governor McWherter turned his attention to providing health care for the state’s most needy. In early 1993, he stemmed the bleeding of red ink in the state budget. They proceeded on the basis that an imperfect program was preferable to no program. Concerns about political opposition were also paramount. The TennCare creators wanted the program implementation to occur before the legislature was convened for the 1994 legislative session.

IMPLEMENTATION SUCCESSES

Two gubernatorial decisions were pivotal in the launching of TennCare. The first was to leverage the state’s already-established relationship with Blue Cross Blue Shield of Tennessee (BCBST).

Several years before the implementation of TennCare, Governor McWherter faced rising costs in the State Employees Health Plan. At his request, BCBST had organized a state-wide PPO, which lowered state costs and gained the Governor’s confidence. This PPO would later become the cornerstone for the TennCare program. TennCare would never have been implemented or remained operational without the experience and the pivotal role of BCBST.

The second pivotal decision included patient advocates in the design of TennCare. Health care providers are the traditional power brokers in most debates about the delivery of health care services. Consumers are frequently excluded from meaningful participation. With TennCare, the McWherter Administration changed these dynamics. The Governor made a

The McWherter Administration had purposely created and implemented TennCare quickly, and anticipated the start-up problems.
Governor McWherter made a deliberate decision regarding who would be included in the development of TennCare; he chose not only to include consumer advocates but to exclude providers.

reform the state’s Medicaid program, he turned to the advocates, most notably Nashville attorney Gordon Bonnyman, who represented the people the program was to serve. In exchange for assuring tolerance during the transition, Mr. Bonnyman secured more coverage for more individuals. Although the decision to include the advocates was essential for expediency and influence in the granting of the federal waiver, the decision to exclude providers created ill will, which continues today.

OPERATIONAL FAILURES
One year after the start of TennCare, Republican Don Sundquist took office as Governor. His new administration inherited a host of residual start-up problems, which were further exacerbated by inevitable issues related to underlying deficiencies in the infrastructure and competencies of the state and their contracted vendors. The stability and evolution of the marketplace that the McWherter Administration expected in the TennCare program was never broadly realized.

Many of the failures of the TennCare program can be attributed to both the McWherter and Sundquist Administrations. Difficult decisions were often made with few good options. Problems were worsened by the lack of managed care expertise and experience, especially as it applies to a specialized population like Medicaid recipients.

The Sundquist Administration was particularly vilified for TennCare failures, despite the fact that they were addressing intractable national issues and residual effects from choices made to facilitate the compressed implementation timetable. Nevertheless, Governor Sundquist’s team did not make appropriate adjustments to move the program forward, and made many missteps that further impeded progress.

When TennCare was launched, 12 MCOs were under contract with the state (Table I). Most of these MCOs had been created after April 1, 1993, mere months before TennCare’s implementation. Only one of the participating MCOs, Access MedPlus, had Medicaid experience but only on a limited scale (Access MedPlus had < 35,000 enrollees in a limited geographic area). Few of the contracted MCOs had any managed care experience. Statewide, in the private and public sectors, only 300,000 individuals or 5.7% of the total population of Tennessee were enrolled in HMOs at the inception of TennCare. Approximately 1 million individuals were enrolled in a BCBST PPO plan, but these enrollees were primarily employees of the state or other large employers. By 1999, nine TennCare MCOs remained in operation.

When the TennCare enrollment program became operational in 1994, 800,000 beneficiaries were rapidly placed in managed care plans. Fifty percent of all TennCare enrollees selected BCBST during the first enrollment, and another 25% selected Access MedPlus. By January 1995, TennCare enrollment had grown to 1.2 million.

Access MedPlus, who projected that its enrollment would grow from 35,000 to 150,000, saw enrollment grow at twice that rate. The company, with just 50 staff members, no claims processing system, and no specialty providers under contract, was quickly overwhelmed.

Serious problems with several of the MCOs became apparent in the months after implementation. The process used to select the MCOs created problems that plagued the early years of TennCare and persist to this date. Health plans were not selected through a competitive bid process. Twenty MCOs applied to the state to be TennCare providers. Twelve were accepted. Two of the MCOs—BCBST and Access MedPlus—had statewide offerings. Acceptance criteria primarily included a willingness to meet state terms, especially the state’s financial terms.

This negative legacy has consistently overshadowed the good track record of certain MCOs.
shortcomings in the state’s ability to manage the MCOs. Many discussions centered on the state being unable or unwilling to successfully manage vendors and insurmountable issues with certain vendors. Some of these issues originated with the selection process, which was dictated by the managed care environment in Tennessee, the speedy implementation, and concerns about the program’s design.

The state may have helped to direct and manage these fledgling MCOs during the start-up years, but leadership at the state level lacked continuity. The revolving door of appointed TennCare Directors during the Sundquist Administration was indicative of the management turmoil that characterized TennCare during this period of time (Table II). Governor McWherter appointed Manny Martins to serve as the first TennCare Director, a post he held from January 1994 through April 1995 in the early days of the Sundquist Administration and again from July 2002 until July 2004 during the administration’s waning days. Mr. Martins also served as TennCare Director at the start of Governor Bredesen’s tenure. Between Mr. Martins’ two tenures, Governor Sundquist appointed seven TennCare Directors.

Further adding to the turmoil was a move to consolidate certain state departments. This effort, initiated early in 1997, created considerable chaos. At the time the move was being considered, uncertainty and confusion was a distraction. The failure to consolidate the consolidation after several years perpetuated a diffusion of accountabilities, unneeded variations, and inefficiencies in the Tennessee State government.

The TennCare proposal was based on financial assumptions that have subsequently been questioned. In addition, during the operation of the program, strategic decisions had an untoward effect on TennCare’s financial viability. In their effort to control cost escalation and be able to afford the cost of the addition of new Medicaid beneficiaries and expanded benefit coverage, Governor

### Table I: TENNCARE MCO HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>January 1994</td>
<td>12 MCOs available when TennCare was implemented (6 HMOs* and 6 PPOs†)</td>
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<tr>
<td></td>
<td>- 2 plans offered services in every county (Blue Cross, Access MedPlus)</td>
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<td></td>
<td>- 2 plans withdrew, because they were required to participate for 18 months</td>
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<tr>
<td>January 1997</td>
<td>All 4 PPOs converted to HMOs per state requirement</td>
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<td>March 31, 1999</td>
<td>Xanthus (3rd-largest MCO) placed in receivership</td>
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<tr>
<td>April 1999</td>
<td>State assumed control of Xanthus Health Plan of Tennessee (formerly known as Phoenix) after Xanthus reported negative net worth of $24 million in 1998</td>
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<tr>
<td>June 1999</td>
<td>Prudential (2nd-smallest MCO serving only Shelby County) gave notice it would leave TennCare effective December 31, 1999</td>
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<tr>
<td>November 1999</td>
<td>State provided Xanthus with a $26 million loan to pay providers</td>
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<tr>
<td>December 15, 1999</td>
<td>Blue Cross (largest HMO) gave notice it would leave TennCare effective July 1, 2000; this notice was later removed</td>
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<tr>
<td>March 2000</td>
<td>Access MedPlus placed under state supervision</td>
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<tr>
<td>May 2000</td>
<td>Access MedPlus placed under involuntary supervision and assets frozen by the state</td>
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<tr>
<td>July 2000</td>
<td>Risk-sharing provision of Blue Cross contract terminated</td>
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<td></td>
<td>John Deere (2nd-smallest MCO after the departure of Prudential) gave notice it would leave TennCare effective January 1, 2001; this notice was subsequently withdrawn</td>
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<tr>
<td>December 2000</td>
<td>Access MedPlus files a $160 million lawsuit against the state alleging inadequate funding</td>
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<tr>
<td>May 2001</td>
<td>TennCare officially cancelled contract with Access MedPlus</td>
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<tr>
<td>July 2001</td>
<td>2 new MCOs added to TennCare: Better Health Plan and Universal Care</td>
</tr>
<tr>
<td>October 2001</td>
<td>Access MedPlus contract terminated</td>
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<tr>
<td>April 2002</td>
<td>Universal Care contract terminated</td>
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<tr>
<td>June 2002</td>
<td>TLC signed a contract that eliminated risk-sharing provisions of contract through December 31, 2003</td>
</tr>
<tr>
<td>July 2002</td>
<td>TennCare “Stabilization Plan” implemented; plan was originally intended to provide MCOs with an 18-mo timeframe to operate under no-risk contracts</td>
</tr>
<tr>
<td>January 2003</td>
<td>State assumed 100% financial risk for all TennCare covered benefits</td>
</tr>
<tr>
<td>June 2003</td>
<td>Contract with Universal terminated; enrollees move to TennCare Select</td>
</tr>
<tr>
<td>August 2003</td>
<td>Contract with Xanthus terminated; enrollees moved to TennCare Select</td>
</tr>
</tbody>
</table>

*The HMOs were: Access MedPlus, John Deere, Phoenix/Xanthus, TLC, Total Health Plus, and Vanderbilt; only 2 of the MCOs existed before TennCare and only Access MedPlus had Medicaid experience.
†The PPOs were: Prudential, Health Net, Blue Cross Blue Shield, Omnicare, Preferred Health Partnership, and TennSource.

Adapted from Gold M, Alper A: Growing an industry: How managed is TennCare’s managed care? Health Aff 2000;19(5):89-103; TennCare timeline, Cheng CF, Steinberg SC: TennCare timeline. University of Memphis (healthcon.memphis.edu/documents/tenncare_bulletin_timeframe_cheng_steindefg_5_05.pdf), May 2005.
McWherter’s team developed a global budget and planned to put all MCOs and later behavioral health organizations (BHOs) at risk. Overlaid on these goals was the federal government’s requirement of budget neutrality. By most accounts, the original global budget was set too low, and by some accounts, the methods and adjustments used to create the budget were unsound. According to Mirvis and colleagues:

“The global budget was initially set at the then-current Medicaid budget, which was deemed sufficient to support an expanded population in a health care system functioning under managed care principles. Capitation rates were then determined administratively by, in essence, dividing the previous Medicaid budget by the number of anticipated enrollees. This rate was discounted by 20.4% to consider ongoing charity care; by 1.7% for local governments’ contributions to health care; and by 3.9% for the TennCare mandated cost-sharing.”

The authors also decried the lack of adequate reference points in developing the budget, without competitive bidding or price negotiations.

Budgets were not adjusted for the richness of the TennCare benefits package. In addition to the required mandatory services (including inpatient, outpatient, and professional and home health care services), the TennCare program also included pharmacy, behavioral health, dental, and long-term care services. TennCare, unlike the Medicaid program in place previously (or most private plans), had minimal or no benefit limits. Additionally, the TennCare program had no formulary or drug utilization review in place from the year 2000 through most of 2003.

When it was created, Governor McWherter and his team shifted as many state health and welfare programs as possible under the TennCare program umbrella. The rationale for this approach was the long-standing strategy of maximizing matching federal revenue from the Medicaid program. Although this strategy had merit, it also resulted in a decrease in other revenue streams, such as local government payments for indigent care. The result was a weakened safety net.

Compounding the state’s lack of experience with the nuances of managed care was a similar lack of expertise within the majority of the participating MCOs. This inexperience led to the bankruptcies of three TennCare MCOs (Table I). In response, the state assumed accountability for setting provider rates in 2000. Before this time, provider rates were highly variable across the state and across vendors. In 2002, in a key retreat from a managed care principle, the state eliminated all risk-sharing provisions in the MCO contracts. Similar administrative services only (ASO) contractual arrangements were also featured in one of the two BHO contracts and the pharmacy and dental benefit manager contracts.

THE BEGINNING OF THE END
The goodwill and tacit agreement for tolerance by the patient advocates, garnered by Governor McWherter’s Administration, was eventually expanded by Governor Sundquist’s Administration. This tolerance was eroded by a host of pervasive strategic and day-to-day management problems: unresolved and recurring member issues, MCO turmoil and turnover, turnover in key state positions, and unrealized expectations. The expectation of reaching equilibrium at some point during the Sundquist Administration, after some initial confusion and missteps, was not attained. Eventually, a series of legal challenges championed by Gordon Bonnyman were mounted to protect members’ rights and resolve operational problems. The resultant consent decrees, brokered in the federal courts, were later decried as a key impediment to TennCare’s long-term viability.

THE DISASSEMBLY OF TENNCARE
In early 2005, the 12th year of the operation of TennCare, Governor Phil Bredesen unveiled a reform plan to manage program costs by disenrolling up to 323,000 from the TennCare and imposing benefit limits or all adult beneficiaries. Although this number was eventually cut to 191,000 after a lengthy series
of judicial challenges, it was still a retreat from the original vision outlined by Governor McWherter. The disenrollment of adult beneficiaries from the expansion population represented "the largest single increase in the number of uninsured Americans in the nation's history and the deepest cuts ever in funding for a public health program."\textsuperscript{13}

In many ways, history was repeated with the implementation of Governor Bredesen's TennCare reforms. Another projected budget crisis led to another hasty response. When the Governor set in motion the disenrollment of TennCare beneficiaries, he stated that the state's safety net would be strengthened and available for uninsured individuals. A year later, the safety net was not stabilized or adequate. Disenrolled individuals, often the sickest and most needy, were left without access to needed care or prescription drugs.

**LESSONS LEARNED FROM TENNCARE: TOO MUCH, TOO FAST, WITH TOO LITTLE Effective Program Oversight Is Necessary.** The role of the Tennessee legislature relative to TennCare was minimized from the outset. Oversight of the medical, behavioral, and pharmaceutical components of the TennCare program was divided among various state departments with minimal coordination. The responsible state departments had little input and no previous experience in managed care.

The creation of an independent entity with the unhampered authority and accountability to oversee the program's ongoing operations and future directions in a meaningful way may have helped the TennCare program. This oversight committee—comprising such stakeholder representatives as members from the advocate and provider communities, elected and appointed state officials, citizens, and managed care representatives—could have conducted meetings on a regularly published schedule and allowed these deliberations to be transparent to the public.

**Adherence to Key Principles Is Essential for Effective Managed Care.** The failure to adhere to the basic tenets of financial risk, risk for operational performance and competition for state contracts, and member enrollment prevented the state from improving results and delivering on the promises of managed care. Efforts to attract nationally known and proven vendors were never successful. Several of the "home grown" vendors performed poorly and/or failed at significant cost to the state, enrollees, and providers.

A competitive and open bidding process for contracts was necessary, in order for any contracted MCO, BHO, pharmacy benefit manager (PBM) to be held accountable for performance and share financial risk. Poor performing vendors could have been replaced if remediation was unsuccessful.

Ongoing vendor performance management is required when any MCO, BHO, PBM, or other managed care vendor is utilized. When the State of Tennessee executed contracts with managed care vendors, the state retained ultimate accountability. State officials, however, lacked the needed expertise to manage the performance of staff and contracted vendors. Objectives and accountabilities were not specific, and accountability was diffuse within state government. Too often, state officials took a "hands-off" approach towards vendors.

One of the most critical shortcomings of the TennCare program management stemmed from inadequate and disconnected information management systems. For responsible stewardship, the state requires integrated management systems to assess needs, establish program priorities and manage and improve performance. Data concerning TennCare utilization, costs, patient outcomes, quality of care, and vendor performance must be readily accessible to stakeholders in a timely manner. For years, this information was not available or accessible.

**CONCLUSIONS**

TennCare was a bold experiment designed to save Tennessee money while expanding coverage. Faced with an increasing portion of state revenues being consumed by TennCare, Governor Bredesen ordered the disenrollment of the majority of enrollees in the TennCare expansion population in the Summer of 2005. This unidirectional outcome may have been avoided if the state had better managed the TennCare program. The serious and protracted mismanagement of the program makes it impossible to adequately evaluate the effect of managed care and differentiate how much of the failure is a result of shortcomings in managed care. The desire for health care reform must be coupled with attention to the tenets of managed care, the interrelationship among the various components, adequate infrastructure, and a passion for continuous performance management and improvement.

*(Author's Note: This article is derived from the author's doctoral dissertation, a case study of the TennCare program. In conducting her research, Dr. Myers interviewed 26 key informants, including two former governors of the State of Tennessee, a former HCFA Commissioner from the Clinton Administration, a...)*
variety of state government and managed care executives and advocates, and a complement of provider representatives, including administrators, managers and caregivers. In addition, a variety of documents were reviewed, including newspaper and journal articles, correspondence, original and subsequent TennCare and TennCare Partners waiver applications, judicial decrees, legislative documents, task force and other reports, and case studies. The retrospective recollections of events and key impressions of the study informants, captured in recorded interviews, were compared with time-stable documents to develop a unique understanding of TennCare.

REFERENCES
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DISCLOSURE
The author has no relevant affiliations to disclose.

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