

Tennessee's
BUSINESS

taking the pulse of

TennCare

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EDITOR'S NOTE

TennCare, the state's \$3.4 billion healthcare program, covers nearly 1.4 million low-income, disabled, and previously uninsured citizens—almost one-fourth of Tennessee's population. At the beginning of this year, the state had contracts with eight private managed care organizations (MCOs) that process and pay claims to healthcare providers.

Last fall, an 18-member panel appointed by Governor Sundquist and led by former state comptroller William Snodgrass concluded TennCare, although troubled, should be preserved essentially intact, offering more than 50 recommendations to make the program "more affordable, equitable, and sustainable." A major problem the panel faced is that companies often deny coverage to employees with illnesses, knowing TennCare will pick them up as "uninsurable," leading to a huge influx of sick people into TennCare and making it difficult for MCOs to adequately pay providers.

The panel recommended two new programs to cover TennCare's 500,000-plus enrollees who previously lacked private insurance or were classified uninsurable because of preexisting medical conditions. TennCare Assist would provide lower-income people assistance to pay premiums in employer-sponsored healthcare coverage, with employers also contributing a reasonable amount. TennCare Standard would provide benefits to those lacking access to employer-sponsored insurance or declared uninsurable; participants would pay premiums on a sliding scale, and the existing MCOs would provide their benefits.

TennCare receives two matching federal dollars for every state dollar. With Tennessee's budget crisis, the fear at the beginning of the current legislative session was that TennCare would have to be scaled back, knocking many uninsureds out of coverage. However, a "catch-22" faces lawmakers in any scale-back: to remove 350,000 uninsured and uninsurable people from TennCare would save millions of state dollars each year, but would result in the loss of the matching federal dollars. County governments would have to take up the slack by providing charity care to the uninsureds, possibly by raising local property taxes.

In his budget for the fiscal year beginning July 1, Sundquist made TennCare and long-term care services for the elderly and disabled his second priority (behind education), proposing that the program grow to \$3.7 billion, with state spending increasing by 12 percent or up to about \$1.1 billion. Raising rates paid to MCOs and adding 80,000 enrollees to TennCare account for much of the increase.

To keep providers in TennCare, in late January Sundquist caused nearly \$110 million in extra funds to be paid to essential providers, some of whom had complained about inadequate reimbursement for services provided.

BlueCross/BlueShield of Tennessee (BCBST)—by far the largest operator of the eight MCOs, covering almost half of TennCare patients—had threatened to pull out of TennCare by June 30 because of rising costs. Without its participation, the program had little chance of survival. In late February, BCBST agreed to continue participation at least through 2002, cutting the size of its MCO in half and serving only East Tennessee. To fill the void, the state has added two new MCOs. Fortunately, BCBST earned almost \$2 million from TennCare last year despite earlier projections it would sustain multimillion-dollar losses.

TennCare enrollees were recently given the choice to change their health plan for the first time in two years. Although TennCare is not "out of the woods," certain actions since the first of the year have enhanced its odds for survival.

—Horace E. Johns, Editor

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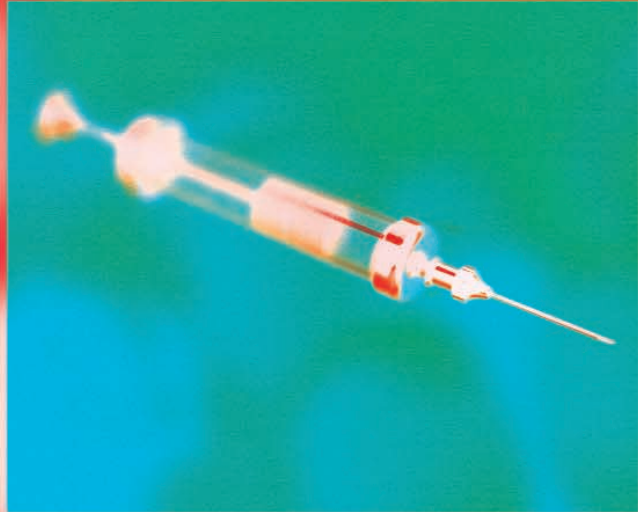
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TENN CARE



PROBLEMS, PROGRESS, AND PROGNOSIS

TennCare Appears To Have Accomplished the Impossible—Demanding and Receiving Greater Efficiency from the Health Care System

by Gordon Bonnyman

TennCare is a tangle of seeming contradictions. The program has expanded health coverage to the uninsured, yet still saved taxpayers hundreds of millions of dollars. By this feat, TennCare has achieved the status of one of the most successful efforts at state health reform of the past decade, with much to teach the rest of the nation. However, the program remains mired in controversy within Tennessee and largely ignored or disparaged in national health policy discussions. Built on a solid, stable design, TennCare nonetheless faces an uncertain future.

Unfortunately, much of the discussion around TennCare and its future has been dominated by a focus on the “*crisis du jour*” and has lacked the broader perspective essential to a fair assessment of the program or constructive discussion about how to shape its future. To make sense of these apparent contradictions, it is essential to place the program in both historical and national contexts and sort out political rhetoric from operational reality.

TennCare in Context

For more than half a century, the U.S. has struggled unsuccessfully with inflation in healthcare costs and a corresponding erosion of the ability to pay for care. Since the establishment of Medicare and Medicaid in 1965, healthcare costs have risen from 5.7 percent to 13.5 percent of gross domestic product, or GDP (U.S. Department of Health and Human Services 1999). Under the pressure of these rising costs, growing numbers of Americans were crowded out of the health insurance market to the point where currently more than 40 million people lack health coverage.

Technology and cultural expectations have fed inflation in health costs throughout the industrialized nations. In America, additional factors have also fueled our healthcare inflation rate:

- fee-for-service purchasing arrangements;
- the inflationary effects of Medicare and other government subsidy programs; and

- the absence of a national policy explicitly designed to ensure universal coverage while containing costs.

The U.S. is distinguished from other industrialized nations as the only one other than South Africa without universal health insurance and the country on earth with the most expensive healthcare by far. The percentage of the American GDP spent on healthcare is half again as much as Canada’s and twice as much as that of some Western European nations (Anderson and Poulter). Despite the dedication and skill of providers and technical virtuosity that makes American medicine the best in the world in certain specialized areas, the U.S. healthcare system overall is outperformed by a number of countries that spend far less, according to objective measures of morbidity and mortality. In other words, the U.S. healthcare system is both costly and inefficient by international standards.

The growth of managed care over the past decade has been spurred by the desires of both government policymakers and business (the purchasers of coverage for most privately insured Americans) to impose greater efficiency on the healthcare system. The key to these efforts has been to replace fee-for-service financing with so-called “risk contracting.” While some of what has been loosely referred to as “managed care” has been merely discounted fee-for-service purchasing, *real* managed care has been distinguished by its reliance on risk contracts that fundamentally alter the incentives and therefore the behavior of healthcare providers.

“Managed care organization” (MCO) is a generic term encompassing health maintenance organizations (HMOs) and other variants. Under a risk contract, an MCO is prepaid a fixed premium or capitation rate in return for providing all medically necessary services defined within the scope of the agreement for the insured population. The MCO thus assumes financial risk, as do other types of insurance entities, that the aggregate

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gate amount of premiums or capitation payments received will exceed total medical care and administrative costs. By restricting enrollees' access to specific authorized providers over whom it can exercise some degree of resource utilization management, an MCO goes beyond the passive role of a traditional health insurer and actually manages healthcare costs.

The shift to risk contracting fundamentally reverses the financial incentives created by fee-for-service purchasing, which is inherently inflationary because healthcare providers can increase revenues and usually profits by providing more, or more intensive, services. By contrast, under a risk contract, revenues are limited in advance by the capitation rate, so that in order to maximize profits vendors must reduce costs.

In spite of the backlash by healthcare providers and the public, managed care is generally credited with curbing medical inflation during the past decade. Although some of the savings are due to price discounts exacted from providers as a concession to the MCOs' bulk purchasing power, managed care appears to have achieved some real efficiencies—typically reducing inpatient hospital utilization by two-thirds or more, without any measurable reduction in clinical outcomes. Employing a growing body of research that documents widespread disparities in clinical practice patterns across the country without any apparent justification in terms of patient well-being, managed care has fostered much greater cost-consciousness among healthcare providers and more critical assessment of the use of medical resources.

Since the creation of Medicare and Medicaid in the 1960s, efforts to extend health coverage to uninsured Americans have generally not attempted to address the inflationary dynamics that have made health insurance unaffordable to so many Americans. Reform efforts by both political parties at federal and state government levels have largely accepted the inefficiencies of the current system as given and simply added more revenues to the system to buy coverage for more of the uninsured population. Medicare's use of that approach is credited with fueling much of the inflation in the late 1960s and early 1970s. The same approach in the Medicaid program meant that expansions of coverage in the '70s were followed by a wave of budget crises in

most states, including Tennessee, in the 1980s and early 1990s.

The TennCare Experiment

TennCare was a truly radical departure from traditional American health policy because it attempted in a serious way to tackle the problems of inflation and inefficiency while expanding health coverage. The fact that it did so accounts for both TennCare's success and much of the controversy it has engendered.

For various interest groups, TennCare has served as a convenient whipping boy, regardless of its actual merits.

During the late 1980s and early 1990s, Tennessee's Medicaid budget, like those in other states as well as private health insurance programs, was beset by double-digit inflation. Shrewd state officials pioneered the use of hospital and nursing home taxes as a creative way to draw increasing amounts of federal matching funds to offset Medicaid's rising costs. When Congress imposed legislative restrictions on the states' ability to employ such schemes in 1993, Tennessee faced the potential loss of \$600 million. This would not only have devastated the Medicaid program but also posed a serious threat to the entire state government budget and healthcare infrastructure.

TennCare was born of this budget crisis. No longer able to pass along the burden of inflation by drawing more federal revenues, state officials resolved to tackle the cost side of the Medicaid budget. Having benefited from the experience of converting the state employees' health insurance plan to managed care and through the openness to state experimentation by the then-new Clinton administration, Governor Ned McWherter's staff designed a reform plan that moved the entire 800,000 Medicaid population into risk-contracted managed care overnight. Beginning in January 1994, with only about a 10 percent

increase in funding, the reformed program expanded coverage by more than 50 percent to approximately half a million formerly uninsured Tennesseans. The beneficiaries of the new TennCare program were working families in or near poverty. However, TennCare also covered a significant number of families who were relatively well off but lacked access to commercial insurance because of preexisting medical conditions. They were charged premiums and were subject to cost-sharing based on a sliding scale reflecting ability to pay. Coverage for lower-income families is free or partially subsidized. Middle-income households' premiums more than pay for their cost of coverage, and higher-income families generate significant "profits" for the program.

The "shock therapy" approach to the quick conversion from fee-for-service Medicaid to risk-contracted TennCare produced a chaotic period of initial implementation. It also generated enormous controversy that persists. The fact that TennCare was the state's first taste of managed care on a large scale increased provider resistance and public apprehension.

Nevertheless, TennCare was an extraordinary success. As recently reaffirmed by the state treasury's comptroller, TennCare has saved the state hundreds of millions of dollars compared to the old Medicaid program. The state realized these savings even while dramatically expanding coverage to the uninsured. The percentage of Tennessee's population that currently lacks coverage (about six percent) is among the lowest in the nation (University of Tennessee Center for Business and Economic Research; Kaiser Commission on Medicaid and the Uninsured). TennCare did all of this without damaging the healthcare infrastructure. There is evidence that the program has also produced modest improvements in patient outcomes. (For a comprehensive history and assessment, see F. Sloan and C. Conover, *The Role of TennCare in Providing Health Coverage to Low Income Tennesseans*, at the Urban Institute website, www.urban.org.)

TennCare appears to have defied traditional health policy wisdom in the U.S. by doing something assumed impossible—demanding and receiving greater efficiency from the healthcare system. The state successfully asked the healthcare system to cover a substantially greater number of people with only slightly greater revenues. Most hospitals continue to report to the state health department that they are prof-

itable, and the American Medical Association's annual survey of physician income continues to report Tennessee physicians' incomes among the country's highest.

Precisely because TennCare defied the common wisdom, national health policy experts have been slow to acknowledge its success. TennCare employs private insurance entities and market forces to explicitly contain the costs of a social insurance program, evoking the skepticism of liberal analysts. At the same time, TennCare has greatly expanded social insurance to a largely disenfranchised constituency, making conservatives wary. Because the program was designed by state officials without significant involvement of the national health policy establishment, policymakers and experts have disdained TennCare as a mere "budgeting gimmick" unworthy of consideration as legitimate health policy reform.

Precisely because TennCare is as much an instrument of budget discipline as it is a generous extension of health coverage, the program is an important example for the whole country. Despite its many problems, the main lesson of TennCare is that the health system is capable of great efficiencies and that demanding such efficiencies is the key to solving the seemingly intractable problem of growing numbers of uninsured Americans. Pouring more money into an inefficient system is not the only, or even best, answer. Risk contracting, properly designed and implemented with the right incentives for both MCOs and healthcare providers, holds important promise for improving the accountability, accessibility, and affordability of healthcare in America.

The Future of TennCare

If it is such a success, why is TennCare in perpetual crisis? What are its prospects?

First, much of the controversy surrounding TennCare has more to do with unrelated political issues than with the merits of the program itself. The state's hospital industry, experiencing some softening of profits as a result of congressional changes in federal Medicare payments three years ago, has found it useful to blame TennCare for its woes, thereby extracting additional state appropriations for direct hospital subsidies. Proponents of a state income tax advanced their cause by claiming that TennCare was underfunded and needed more revenues. Opponents of tax reform have attacked the program as a budget-devouring monstrosity whose elimination would solve the

state's budget problems. For these various interest groups, TennCare has served as a convenient whipping boy, regardless of its actual merits.

The program does have real problems. Inconsistent state administration has permitted longstanding problems, such as MCO oversight, to fester. Poorly conceived and executed restructuring of TennCare's coverage of behavioral healthcare (mental health and substance abuse treatment) has caused serious damage to parts of the mental health infrastructure. Widely publicized computer problems have spawned lawsuits and undermined confidence in the reliability of TennCare eligibility determinations.

The state successfully negotiated BCBST's continued participation in the program.

While none of the problems has threatened the fundamental soundness of TennCare, MCO instability has. In April 1999, the insolvency of Xantus, the third-largest MCO in TennCare, left thousands of providers unpaid; displaced 130,000 TennCare enrollees; and dealt a serious, long-term blow to the program's credibility. Continuing financial problems with Access Med Plus, the second largest TennCare MCO, culminated in the state's recent efforts to place it in involuntary rehabilitation. While the court rejected the state's takeover effort, the MCO's chronic late payment of providers has further eroded confidence in TennCare. These problems do not reflect on the soundness of the program's design or the adequacy of its funding, but on years of inadequate oversight by state regulators and poor management by administrators of the affected health plans.

The state recently averted a potentially fatal threat to TennCare's survival by successfully negotiating BlueCross BlueShield of Tennessee's (BCBST's) continued participation in the program. BlueCare, the company's TennCare product, covers more than 40 percent of all TennCare enrollees. The company's participation provides cred-

ibility essential to inducing providers to participate in TennCare. Without BCBST, the ability of less established MCOs to maintain adequate provider networks could have been jeopardized.

Despite BCBST's complaints about the state, the fundamentals of the TennCare-BCBST relationship have always been solid. BCBST profited from TennCare when most MCOs across the country, including BCBST's own commercial MCO business, lost money. In an industry where market share is crucial, the huge TennCare book of business has reinforced BCBST's dominance of the state's health insurance market.

Governor Sundquist has announced the company is returning to TennCare as a risk contractor. BCBST will reduce its TennCare enrollment but continue to play a major role in East Tennessee. Other plans, including two new MCOs with Medicaid experience in other states, will increase enrollment to make up the difference.

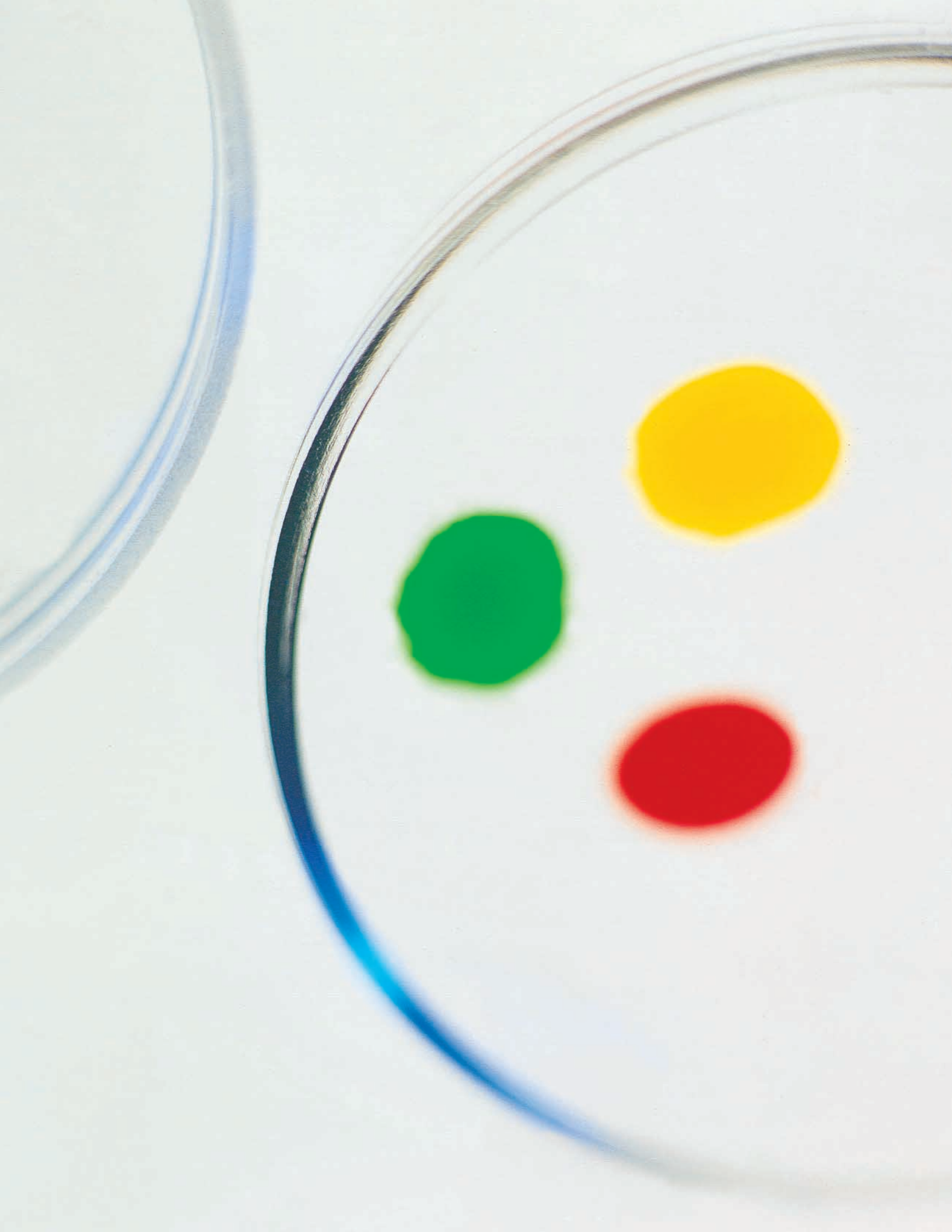
The state also intends to reopen enrollment to the uninsured. As originally designed, TennCare was to reopen enrollment to the uninsured for two months each year, but enrollment of uninsured adults closed in January 1995 and has never reopened. The effect of excluding this generally healthy group while continuing to enroll a sicker population of Medicaid and uninsurable beneficiaries was to distort the actuarial underpinnings of the program. The TennCare enrollee profile became sicker. Reopening enrollment to the uninsured will not only benefit the families affected, but will correct this problem.

Despite the challenges it faces, TennCare is important to the state's budget, and preserving health coverage for the 1.3 million Tennesseans TennCare covers is a political necessity. These two factors are enough to assure the program's future. ■

Gordon Bonnyman, legal aid attorney and TennCare advocate, has been heavily involved in its design and implementation.

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CULTIVATING TENNCARE

THE ROAD TO RECOVERY

by John Tighe

TennCare, the state's managed health-care program for 1.3 million Tennesseans, is well on the road to recovery, with evidence to prove it.

Governor Don Sundquist's administration has worked hard to reform the program, convincing lawmakers, the healthcare industry, and providers the program can work with the right structure, which may have finally emerged.

More than a year ago, TennCare faced the exodus of its largest healthcare plan, BlueCross BlueShield of Tennessee (BCBST), which covered half the program's enrollees. For years BCBST complained the program was woefully underfunded. Other health plans had left the program—most recently, Prudential, which pulled out completely in 1999. A remaining healthcare plan was on the state's life support system. Phoenix Health Care, renamed Xantus Health Care, had been taken into state receivership after leaving providers holding the bag for unpaid care provided to members. The plan still owed more than \$80 million to doctors and hospitals in Tennessee. On top of that, the state was looking for another TennCare director after seeing six people enter and leave the office as “temporary” or “acting” directors.

As a former chief executive at St. Thomas Health Services and St. Thomas Hospital and a newly appointed health policy advisor to the governor, I was charged with leading the effort to implement the following state game plan for fixing the problems:

- Secure adequate funding for healthcare plans to operate in TennCare;
- Bring new managed care organizations (MCOs) to the table to replace BlueCross, and distribute the membership more evenly;
- Renew provider confidence in the program by holding MCOs more accountable, with a new director who can deliver results.

Funding was a key motivation for forming TennCare in 1994, when Tennessee's Medicaid program, like most others in the nation, was consuming larger and larger chunks of the state budget. TennCare would also offer healthcare coverage to people without access to healthcare and those denied healthcare because of prior conditions. Governor Ned McWherter convinced President Bill Clinton, who had served concurrently with McWherter as a Southern governor, to commit a greater than two-to-one match of federal to state dollars for Tennessee to manage its own Medicaid program. The TennCare model carried additional appeal to the Clinton administration, then working on its own healthcare plan. TennCare would accomplish its goals of budget control and expanded health coverage by placing its entire membership into several MCOs, allowing the state to see a reduction in spending for public healthcare.

Tennessee comptroller John Morgan has estimated the state would have spent an additional \$250 million and would be providing healthcare to the existing Medicaid population only had it kept a Medicaid program in place.

Additionally, TennCare is responsible for injecting Tennessee's economy with more than \$650 million a year in federal funds. An Associated Press report in December 2000 quoted a Harvard University study tallying that the Volunteer State received about \$5.3 billion more than it sent to the federal treasury in 1999, ranking it among the top 10 states that received more than they paid and totalling an extra \$961 per capita.

TennCare's healthcare outcomes have been noted nationally, with great admiration. TennCare members experience better health and healthcare under the managed care program than under the previous Medicaid program.

“Under TennCare, people are much more likely to see a primary care doctor and get good

**How the
Sundquist
administration
has worked
to reform the
program**

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preventive care,” said internist James Bailey, associate professor in the Department of Preventive Medicine at the University of Tennessee (UT) Health Science Center, which performed a six-year study of healthcare outcomes among the Tenn-Care population. “Mammogram rates have doubled, childhood screenings have markedly increased, and care for serious illnesses like diabetes, asthma, AIDS, and coronary artery disease has significantly improved,” Bailey added.

“Quality of care indicators show clearly the TennCare population is better cared for under the managed care model because it has a primary care physician to turn to at the onset of a healthcare problem and because of expanded access to health services,” said David Mirvis, M.D., director of the UT Center for Health Services Research in Memphis.

Additional recent studies support the conclusion that TennCare has improved healthcare for its members:

- A September 2000 report from the Center on Budget and Policy Priorities in Washington, D.C., concluded that in the three states to expand Medicaid coverage to parents early—Tennessee, Oregon, and Hawaii—coverage of eligible young children rose by 16 percent between 1990 and 1998. The center reported Tennessee’s Medicaid expansions increased the use of preventive health services such as Pap smears for women and dental checkups for children. (View the report online at <http://www.cbpp.org/9-5-00health.htm>).
- A TennCare study released in July 2000 shows children with asthma are receiving better primary and preventive care since the beginning of the TennCare program: emergency room visits, inpatient discharges, and visits to physician offices or hospital outpatient clinics all decreased significantly in the first five years of TennCare.
- Annual surveys conducted by the UT Center for Business and Economic Research (CBER) show a progressively higher proportion of TennCare recipients are seeking initial care for a medical need at a primary care physician’s office rather than seeking more expensive care in a hospital emergency room.
- TennCare studies show favorable increases in immunizations, prenatal care, and mammography screenings as

well as an increase in primary care physicians participating in TennCare.

- An Urban Institute study released earlier this year highlighted an increased use of preventive services among TennCare recipients, improved coverage of uninsured or high-risk patients, improved health for low-income people compared to pre-TennCare levels, and “significant” financial savings for the state compared to Medicaid fee-for-service costs.
- A Duke University study reported in the *American Heart Journal* demonstrated TennCare enrollees receive the same level of tertiary care as the privately insured. TennCare enrollees underwent revascularization procedures within 30 days of infarction as often and had the same health outcomes as those with private insurance; both measures were better for TennCare than Medicaid enrollees.

TennCare is healthier now than it was 24, 12, or just six months ago.

We built a new TennCare model, with the state offering healthcare plans various options to share their financial risk in managing care for TennCare members. We used an actuarial study from PriceWaterhouse-Coopers to show lawmakers how much funding the program required and instituted new requirements to make the MCOs more accountable for the money the state spends.

With legislative leadership behind the TennCare budget, the average per member per month capitation rate increased in July 2000 to about \$173, based on nearly 20 separate rates paid for TennCare members, varying by gender and age but also geography, more closely mimicking the commercial healthcare insurance world.

With step one of the governor’s mission accomplished, TennCare hired a new director, Swarthmore- and MIT-educated Mark Reynolds, formerly manager of the Medicaid program in Massachusetts. Almost immediately Reynolds was pulled into negotiations, both those with new MCOs and those revolving around the legal challenges facing TennCare.

Four months later, the state was looking at eight proposals from MCOs and signed

contracts with three of them in the fall of 2000. Only two would be able to meet the state’s new stricter financial requirements.

Step three, renewing provider confidence, the toughest challenge facing the Sundquist administration, remains. The governor has called physician and hospital leaders into his conference room, asking them to stay in the program. In January 2001, Sundquist made a commitment to take the following steps.

- Continue the effort to pay off remaining debt to providers owed by the former Phoenix Health Care, now under state rehabilitation and renamed Xantus Health Care. Although the state has no legal obligation to do so, it has so far reimbursed providers for more than \$30 million of the debt.
- Establish a \$25 million TennCare physician fund, to be paid quarterly to physicians who have unreimbursed costs and are contracted TennCare providers.
- Continue to “aggressively and uniformly” enforce the prompt payment of providers set forth in the Prompt Pay Act of 1999.
- Work with providers and MCOs to resolve issues related to prior approval for services, billing procedures, standard formularies, standardized billing, and other issues.

TennCare is healthier now than it was 24, 12, or just six months ago. In addition, a major legal issue was recently resolved—TennCare’s ability to disenroll uninsured and uninsurable members, challenged on the grounds that too large a potential existed for some people to be taken off TennCare without reason. The resulting agreement will allow TennCare to begin disenrolling members that swelled the total population to over 1.38 million and replace them with people who have no access to health insurance. TennCare closed its rolls to uninsured adults in 1995 when the program reached 90 percent of its federal cap on enrollment, a mandate spelled out in the Medicaid waiver.

In February, Sundquist announced BCBST had committed to stay in the TennCare program as a full-risk MCO serving East Tennessee. A smaller healthcare plan, John Deere, had notified the state in the summer of 2000 that it, too, planned to exit the program this year, but because of changes made in the program, decided to remain in TennCare.

“BlueCross’s commitment to TennCare speaks volumes of the progress we’ve

made in recent months toward making our state’s healthcare program a viable and reliable one,” Sundquist said.

In March Sundquist announced the state’s agreement with advocacy groups to offer healthcare coverage to uninsured adults who have not had access and to develop a process that ensures those on the program are eligible.

The agreement, which will settle the Rosen vs. Commissioner of Finance and Administration lawsuit, will outline steps for the state to remove ineligible uninsured and uninsurable enrollees from the TennCare program.

Perhaps the greatest evidence TennCare has stabilized was its April offering of a choice among several MCOs to enrollees across the state.

“We can offer choice now—for the first time in more than two years—because we’ve reformed the program enough to bring in new MCOs and keep organizations like BlueCross that have been so important to TennCare members,” said Sundquist.

Here are further developments:

- Tennessee has been selected to participate in a national program to assist the state in developing new oral health policies for children in TennCare. The program provides dental services for more than 600,000 children and adolescents under the age of 21. Tennessee and eight other states (Arkansas, Delaware, Kentucky, Missouri, South Dakota, Utah, West Virginia, and Wyoming) were selected to participate in the National Governor’s Association (NGA) Center for Best Practices Policy Academy on Improving Oral Health Care for Children. The formal Policy Academy convened in Nashville in May. Prior to this, NGA staff will help the state develop and begin implementation of a specific action plan as well as follow through with the state to help assure the plan’s success.
- TennCare has restructured its enrollee cost-sharing provisions to make cost sharing more convenient for members and consistent with the commercial healthcare industry; the recent changes affected a portion of the non-Medicaid population in TennCare. Only those with incomes above 100 percent of poverty who are not institutionalized (i.e., in nursing homes) are subject to the co-payment schedule.
- This spring, the state is inviting the public to meetings to discuss the recom-

Before TennCare (1993) and Now (1999-2000)

INDICATOR	BEFORE	NOW
Number of people enrolled ^a	770,000	1,350,000
Estimate of uninsured people in Tennessee ^b	8.9%	6.5%
Estimate of uninsured children in Tennessee ^b	Not available	4.1%
Infant mortality rate in Tennessee ^c	9.7 per 1,000 live births	7.7 per 1,000 live births
Percentage of TennCare 24-month-olds who are completely immunized ^d	66%	86.5%
Percentage of deliveries to women who began prenatal care in the first trimester of pregnancy ^e	80.8%	83.1%
Mammography rates among female enrollees ages 50-65 ^f	15.8%	35.8%
Percentage of enrollees who go to an emergency room when initially seeking care ^b	14%	6%
Percentage of enrollees who go to a doctor’s office or clinic when initially seeking care ^b	69%	78%
Percentage of enrollees who report having weekly or monthly appointments with a doctor ^b	18%	31%
Percentage of enrollees who rate their healthcare as “excellent” or “good” ^b	58%	61%
Number of hospitalizations for children with asthma ^g	202 per 1,000	42.7 per 1,000

Sources: a: Medicaid and TennCare enrollment data. b: Lyons and Fox, UT Center for Business and Economic Research, “The Impact of TennCare: A Survey of Recipients,” September 2000. c: Bureau of TennCare, “Women’s Health Issues,” December 1999; news release, Tennessee Department of Health, October 25, 2000. d: Tennessee Department of Health, “1999 Survey of the Immunization Status of 24 Month Old Children.” e: Bureau of TennCare, “Women’s Health Issues,” December 1999. f: Bailey et al., Departments of Medicine and Preventive Medicine, UT Memphis, “The Impact of Medicaid Managed Care on Screening Rates for Breast Cancer in Tennessee,” American Cancer Society, 2000. g: Bureau of TennCare, “Pediatric Asthma and Health Services Utilization in TennCare: A Retrospective Analysis,” July 2000.

mendations issued last year by the Commission on the Future of TennCare (McWherter, Columbia/HCA CEO Tom Frist, Hamilton County Executive Claude Ramsey, and Dr. Clay Good of Clinton, Tenn., along with other providers, managed care professionals, and educators), including the following:

- Cover Medicaid-eligible members in a managed care program, as TennCare is currently structured;
- Create different programs for different population needs, i.e., the uninsured and uninsurable;
- Continue expansion of coverage to the low-income uninsured;
- Continue expansion of coverage to uninsurable without access to insurance;
- Continue TennCare Partners, the program’s behavioral health services;
- Reduce the “hassle factor” for providers;
- Support employer-sponsored coverage;
- Enforce eligibility rules;
- Institute co-payments and benefits comparable to employer-sponsored plans; and

- Broaden the base of financial support for the program.

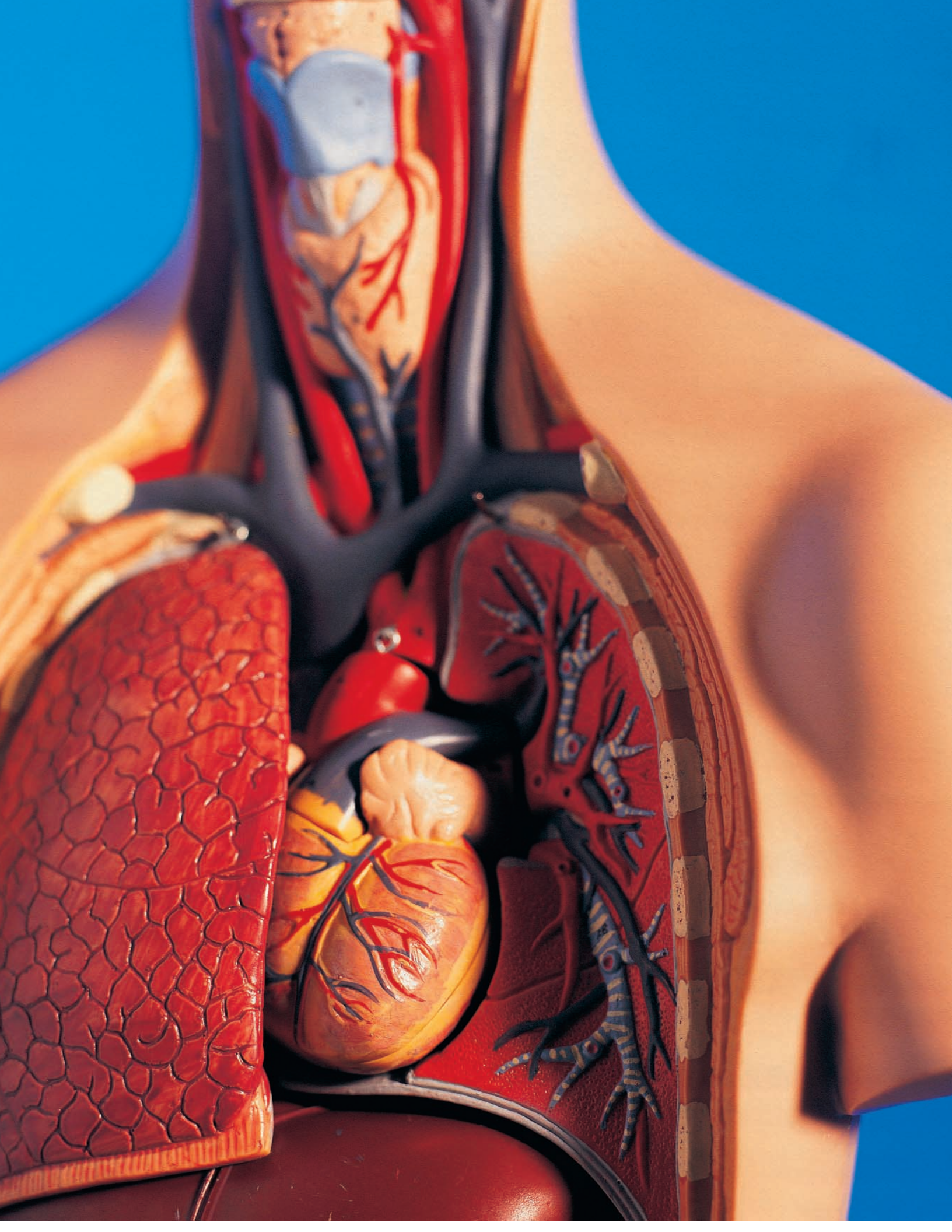
To complement the strides Tennessee is making in healthcare, Sundquist has been active in national healthcare issues. He’s been asked to lead the NGA on health issues with Governor Howard Dean of Vermont.

“I’ve said all along that TennCare is more than just a program; it’s a relationship,” said Sundquist. “Like any good relationship, it’s about finding common ground. It’s about agreeing on a workable solution.

“... (we) will continue working to make TennCare a program that serves those in need of health insurance while being accountable to the citizens of Tennessee.

“While I am pleased with the direction in which TennCare is moving, we still have work to do. We still need doctors and providers to come on board. We still need advocates and MCOs to continue to work with us to make improvements. I am proud to say, however, that TennCare is on the road to recovery.” ■

John Tighe is deputy commissioner of the Tennessee Department of Finance and Administration and the state’s top health-care executive.



DISSECTING TENNCARE

A PRESENTATION ON ITS STATUS

by William E. Young

The TennCare program became effective January 1, 1994. It was created virtually overnight pursuant to a Section 1115 waiver granted by the federal government. TennCare was intended to accomplish two goals. First, TennCare was designed to reduce, if not eliminate, the escalating cost of the state's Medicaid program, which at that time was running a double-digit increase on an annual basis. TennCare was also intended to expand healthcare coverage to the uninsured (the working poor who could not qualify for Medicaid) and the uninsurable population (those who could not obtain healthcare insurance in the commercial market).

The goals of TennCare were to be accomplished through the relatively new concept of managed care. The state would pay a monthly capitated rate per enrollee to contracted managed care organizations (MCOs), which in return would put together provider networks to furnish defined health care

services to TennCare enrollees.

The TennCare Bureau, the successor to the state's Medicaid Bureau, would manage this approximately \$3.4 billion program. Pursuant to the terms of the waiver agreement granted by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services to the State of Tennessee, every dollar spent by the state government on TennCare would be matched by a contribution from the federal government of approximately \$2.

Effective July 1, 1996, the state instituted the TennCare Partners program to apply the same concept of managed care to the delivery of mental health services to qualified individuals, including TennCare enrollees.

TennCare Positives

As of November 30, 2000, TennCare provided healthcare services to about 1,355,733 enrollees. Of this total, 795,612 are Medicaid-eligible enrollees, whereas 560,121 are uninsured/uninsurable enrollees. Of the latter, approximately 150,000 are uninsurable. According to the state, TennCare has saved approximately \$2.5 billion since its inception. TennCare has also provided broader healthcare benefits to Medicaid-eligible recipients and afforded healthcare benefits to an additional 550,000 formerly uninsured and uninsurable persons who did not qualify for Medicaid, according to an editorial in *The Jackson Sun* on December 5, 2000, urging citizens to support retention of the TennCare program.

Undoubtedly TennCare has succeeded from a human, personal standpoint by providing healthcare services to those who did not have them in the past, illustrated in a poignant series produced by the Public Broadcasting System (PBS) reviewing the ups and downs of the TennCare program.

TennCare Negatives

However, despite the apparent benefits associated with the program, TennCare today suffers from a number of fundamental problems that threaten the program's continued existence in its current form. Many of these issues will be debated as the state determines whether to seek a renewal and/or revision of the current TennCare waiver from the federal government, which

**The Tennessee
Hospital Association
explains how
TennCare has
affected Tennessee's
hospitals**

continued on page 12

expires December 31, 2001.

Specifically, the collective financial experience of TennCare managed care contractors (MCCs) over the six-year history of TennCare has been negative. The TennCare health maintenance organizations (HMOs) have lost more than \$35 million since the beginning of the TennCare program in 1994.

The largest TennCare HMO, Blue Cross Blue Shield of Tennessee (BCBST), serving approximately 574,754 TennCare enrollees, provided the state notice in December 1999 of its intent to leave the program. BCBST, after sometimes tense and drawn-out negotiations with state representatives, decided in late February 2001 to remain in TennCare, albeit on a much more limited basis. BCBST's TennCare enrollment will be significantly reduced, from its current 574,754 TennCare enrollees to a maximum of 300,000 enrollees. Moreover, BCBST will completely leave middle and west Tennessee and provide coverage only to TennCare enrollees in east Tennessee. The remaining BCBST enrollment will be distributed among two new MCCs, neither of which currently provides any insurance coverage in Tennessee, and the remaining state MCCs. It is too early to tell whether the removal of BCBST as the state's "anchor tenant" in TennCare will create further problems for the program. BCBST has agreed to provide a backup network, TennCare Select, if problems arise.

The second largest TennCare HMO, Access MedPlus, serving approximately 361,191 enrollees, was placed under state supervision effective May 2000 because of concerns about the company's financial stability and ability to process claims. This supervision order was extended until June 2001 because of the state's apparent belief Access MedPlus has not corrected these problems and concern about Access MedPlus's deteriorating condition. The state recently tried unsuccessfully to place the company under court-supervised rehabilitation and has now appealed the Chancery Court's denial of the state's petition.

The third largest TennCare HMO, Xantus, currently serving 133,146 enrollees, has been in receivership since April 1999.

Providers furnishing TennCare healthcare services have had a significant negative financial experience since the inception of the TennCare program. This fact was confirmed by two actuarial studies the state

commissioned to determine the TennCare program's financial soundness.

The latest joint annual reports for Tennessee hospitals, for the year 1999, show Tennessee hospitals' financial situation continues to deteriorate, partially as a result of the lack of adequate reimbursement from the state's TennCare program.

In 1993, approximately 98 percent of reporting hospitals' costs were covered under the state's Medicaid program, whereas the TennCare program has covered only about 60 percent of hospitals' costs.

From 1993 to 1999, the cost of inpatient care has risen from \$910 to \$1,114 per day.

Collectively, the 122 acute-care hospitals filing joint annual reports with the state reported a profit margin of only two percent, the lowest since the beginning of the joint annual reports filing requirement.

Most disturbing of all, 55 of the 122 reporting hospitals had negative operating margins in 1999.

TennCare now provides healthcare coverage to one in four Tennesseans.

As a result of providers' negative financial experience with TennCare and their continuing hassles getting claims paid by TennCare MCCs, providers, especially specialists, are exiting the TennCare program.

The state continues to battle a number of federal lawsuits filed by various enrollee advocates asserting the TennCare program is violating various federal and state requirements. These lawsuits address the adequacy of the appeals process for enrollees who have had a reduction or termination of healthcare services, the state's process for verifying and reverifying the eligibility of TennCare enrollees; whether the state's TennCare program meets federal standards for early and periodic screening, diagnosis, and treatment for children (EPSDT); and whether the program offers adequate home health services to enrollees.

The Tennessee Hospital Association (THA) and Hospital Alliance of Tennessee (HAT) are particularly concerned about the consent order entered in the *Grier* litigation. *Grier* requires the state to establish various new procedures to ensure enrollees' due process rights are protected on their appeals of any decision to terminate

or reduce healthcare services. THA and HAT believe this consent order goes well beyond the rights granted enrollees by other commercial and governmental plans and will significantly increase the cost of an already financially strained program.

The state's administration of the TennCare program continues to appear understaffed with a lack of clear direction as to the program's ultimate goals. The program still operates with an antiquated information system, hampering its ability to provide useful data to evaluate the program's successes or failures.

According to *The Harkey Report*, published by Health Leaders Inc. October 16, 2000, TennCare "may have become the preferred plan for uninsurables in the entire nation." Per *The Harkey Report*, the "uninsurable pools" run by numerous states around the nation cover about 125,000 people altogether. TennCare matches that figure. Whereas TennCare was originally designed to cover only between 10,000-20,000 uninsurables in 1994, it now covers six or seven times that number. According to *The Harkey Report*, the "crowding in" impact is severe and threatens the continuing viability of TennCare.

Fixing TennCare

In an effort to fix TennCare, the administration has

- increased funding for TennCare, with the legislature's approval, by approximately 250 million state dollars, raising the funding of the program with the federal match by approximately \$700 million;
- assembled two committees of TennCare stakeholders to assist in developing proposals to reform TennCare: the TennCare Steering Committee, an informal "board of directors" for the TennCare Bureau that concentrates on day-to-day issues, and the Commission on the Future of TennCare, which examined the direction Tennessee should take once the current TennCare waiver from the federal government expires on December 31, both of which have issued reports recommending significant changes in TennCare;
- proposed a number of reforms to move TennCare to "TennCare II," including requiring that 85 percent of the capitation payments to TennCare HMOs be used to pay for medical expenses, increasing certain premiums due from TennCare enrollees, and reducing certain benefits in the TennCare program;

- sought to solicit new TennCare HMOs through a “request for response” and approved two of five HMOs initially identified as potential new players in TennCare—Universal and Better Health Plans; and
- removed certain services/individuals from its TennCare contracts with the MCCs including mental health prescription drugs, prescription drugs for “dual eligibles” (enrollees who are on Medicare and TennCare), and children in state custody.
- End the state practice of retroactive assignment of enrollees to MCOs/BHOs and pay interim claims with MCOs/BHOs responsible only for the cost of services delivered after the date of notification of assignment.
- Exclude from the TennCare managed care population individuals/groups whose care cannot be managed (dual eligibles, children in state custody) and provide healthcare services to these populations through the state or an administrative services organization (ASO) single contractor;

TennCare Future

One of the most critical challenges facing the state’s leadership today is the future of TennCare, which continues to be under sharp public attack. Nonetheless, the governor and various legislative leaders have emphasized their continuing commitment to the goals of TennCare while admitting the program needs to be significantly restructured.

The state has come to a crossroads and must decide which path to follow to revamp the current TennCare program. The question facing Tennesseans and the state’s leadership is whether they are willing to pay the cost of a program that essentially provides a healthcare safety net to all Tennesseans who become unable to obtain commercial health coverage.

The governor’s various committees that have examined this problem, as well as THA and HAT, have encouraged our state’s leadership to consider a number of potential changes that would improve the program including, but certainly not limited to, the following.

- Fund TennCare actuarially; have in place and enforce oversight standards for the MCOs; revamp the benefit package for uninsured/uninsurables to more closely track benefits for small employer groups; and restructure and enforce eligibility criteria for the uninsured/uninsurables.
- Immediately develop and implement an information systems plan, including a secure website to identify basic information regarding TennCare enrollees (i.e., MCO plan; primary care physician, or PCP; contact numbers).
- Develop incentives/disincentives to increase availability of commercial insurance for Tennesseans and consider requiring a financial contribution to the TennCare program from potential beneficiaries of the program.
- Cap the risk exposure of its MCO/BHO contractors because it does not benefit the state to place its contractors at full financial risk in a program where contractors have no control over benefits or eligibility.
- Encompass as part of TennCare incentive pools for providers that furnish a disproportionate share of TennCare/charity care. Because TennCare historically has the lowest reimbursement for a commercial/government insurance product, the vast majority of other states have disproportionate share hospital (DSH) payments, and such payments would enhance participation in TennCare networks.
- Make TennCare the insurer of last resort, denying access to TennCare if an individual has access to commercial insurance (unless the individual qualifies for Medicaid) or as a supplement to commercial insurance or Medicare (unless Medicaid eligibility requirements are met); consider income caps on uninsureds and a more comprehensive definition of qualifications for uninsureds.
- Enhance standards for evaluating provider network adequacy, particularly for specialists.
- Quickly and effectively deal with troubled MCOs/BHOs by either assisting these entities in ensuring their compliance with the state’s statutory and con-

The collective financial experience of TennCare’s MCOs over the program’s six-year history has been negative.

tractual requirements or replacing these entities with companies that can properly administer their responsibilities.

- Set a date to sell Xantus to a viable MCO or reassign its enrollees.
- Retain current key MCO contractors with minimums/maximums on TennCare enrollment.
- Revise *Grier* consent decree to create a workable and equitable appeals process.
- Immediately develop a workable appeals unit with a medical director involved in a leadership role.
- Continue close communication with stakeholders by having monthly meetings with HMOs, provider associations, and enrollee advocates; create an independent TennCare Policy Panel composed of stakeholders as a check and balance to the TennCare Bureau; and hold meetings of representatives of state and stakeholders with HCFA to discuss developing a consensus on TennCare reforms.
- Explore and, if possible, implement residency requirements for the uninsured/uninsurable.
- Establish a different benefit package for uninsured/uninsurables more closely resembling benefits provided for employees of small-business employers.
- Address and resolve pharmacy issues, considering a single formulary and creating a task force to establish the formulary and review other options, with a deadline for recommendations.
- End the division of delivery of medical/mental healthcare between MCOs and BHOs; consider placing care of severely and persistently mentally ill persons/seriously and emotionally disturbed children (SPMIs/SEDs) under one organization or the state.
- Create a task force to study the Health Insurance Portability and Accountability Act’s (HIPAA’s) impact on TennCare.
- Restructure management of the TennCare Bureau, whose primary responsibility is now oversight of TennCare HMOs, not paying claims, and consider making the TennCare Bureau an independent, quasi-public entity, with oversight by a board of key stakeholders. ■

William E. Young, Tennessee Hospital Association’s general counsel and senior vice president for policy, was formerly Hospital Alliance of Tennessee president and Tennessee Department of Commerce and Insurance deputy commissioner.



T THE CURE FOR ENN CARE RUN IT LIKE A FAMILY BUSINESS

by James E. Bailey
and Cyril F. Chang

**The Tennessee
“family” decided to
start its own business
and run an insurance
program that would
have its own interests
at heart.**

Prescribing a cure for TennCare, Tennessee’s statewide Medicaid managed care program, would be a difficult task for any physician, and any wise person would be reluctant to venture a quick opinion as to its condition and best medicine. A good doctor or

businessperson must understand his client’s history, current symptoms, and physical findings to diagnose the client’s ills before attempting to prescribe a cure. In this case, the client is a business (TennCare), and the owner (Tennessee) is not a single person, but a collective, like a family. It is appropriate to examine TennCare as if it were a family business. Rather than venturing our opinions about the best future course of

TennCare, we’ll begin by telling the story of this family business to discover its ills and then consider the cures many members of the Tennessee family have suggested.

The History of the Family Business

Tennessee is not a rich state. Like a family on a budget, it must allocate its resources wisely. When it comes to healthcare, the Tennessee family needs certain things: (1) an insurance plan it can trust to provide essential benefits to all members without fuss or waste, and (2) providers that will put the family members’ interests first and focus on keeping them well and working to continue to support the rest of the family.

These are simple needs—but why TennCare? Why should the family own and develop

its own insurance program? If we think back to the situation Tennessee faced prior to TennCare, the reasons become obvious. State healthcare expenditures were increasing dramatically, consuming more and more of the family’s budget. The healthcare Tennesseans received was not always high-quality, effective, or focused on prevention.

Even worse, the insurance business owners outside the family were proving to be untrustworthy. Family members who became sick were often disenrolled. Some of the insurance companies proved not to have strong allegiance to the family’s interests, but spent much of their time making it hard for family members to get needed care so the companies could keep more of the family’s healthcare money. Tennessee insurers and healthcare providers were increasingly placing the interests of their stockholders ahead of the interests of their patients. The family decided to start its own business and run an insurance program that had its interests at heart, guaranteeing coverage to everyone the private insurance companies did not cover.

These were laudable goals for the Tennessee family. Given the constraints with which the family business had to work, namely a cumbersome governance system and a rapid startup and implementation schedule, the business was remarkably successful. Tennessee obtained substantial resources from its richer relative states through federal subsidies (now \$700 million annually) to match its smaller contribution. The close relatives were happy to help their poorer, beloved cousin. Because the family did not have extensive experience running a large managed care insurance program, it hired 12 companies it trusted to manage its healthcare resources responsibly and developed a cooperative plan with them to administer these resources at a local level. It also directed the managed care organizations (MCOs) to struc-

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ture benefits using a primary care gatekeeper model so the family members would be encouraged to get preventive care before they became ill rather than waiting to get expensive emergency care later.

The Business Successes

Despite well-documented startup problems, the model the family chose was remarkably successful in meeting many of its basic goals (Mirvis et al. 1995). Overnight, all of its family members with serious illnesses were guaranteed healthcare coverage. Before TennCare began, Tennessee's Medicaid program covered only approximately 850,000 citizens. Now TennCare covers 1.32 million enrollees (one-fourth of Tennessee's citizens), including more than 500,000 citizens previously without health insurance. TennCare has dramatically increased access to insurance for persons with expensive chronic illnesses such as HIV and AIDS in Tennessee (Bailey, Van Brunt, and Baker 2000). TennCare made it much easier to get insurance for those in Tennessee with chronic illnesses who often lost or were denied insurance by private companies.

Researchers studying the family business found quality of care improved dramatically in virtually every area because of increased emphasis on primary care and prevention. More than 10 major studies consistently demonstrate improvements in preventive care, acute disease care, chronic disease care, and outcomes under TennCare. Specifically, studies have shown substantial improvements in mammography rates for women served by TennCare (First Mental Health 1997; Bailey et al. 1999), well-child visit rates (First Mental Health 1997), coronary revascularization rates for patients after a heart attack (Sloan et al. 2000), quality of diabetes care (First Mental Health 1997; Bailey et al. 2000) and quality and outcomes of care for HIV and AIDS (Bailey, Van Brunt, and Baker 2000). Research has also shown marked decreases in emergency care and hospitalizations for asthma (First Mental Health 1997) and either no change or slight improvement in prenatal care, infant mortality, and the occurrence of low birth weight in Tennessee (Ray et al. 1998; Phillippi 1997). Simultaneously, the num-

ber of persons who had a regular physician and received primary instead of emergency care increased dramatically.

Signs of Illness

What went wrong? Some of the companies the family chose to manage its health-care resources embezzled the family's resources for personal gain. Some MCOs derived substantial profit from participation while avoiding payment for services enrollees received. The family did a poor job of supervising these contractors whose lack of accountability was threatening the program's future.

Some MCOs derived a substantial profit from participation while avoiding payment for services enrollees received.

The private insurance companies, particularly those not participating in TennCare, kept receiving premiums for most of the family members who were healthy and needed little healthcare. Their insurance premiums did not contribute to caring for the sickest family members, most of whom were soon enrolled in the family's health-care plan. TennCare became a foster family for neglected children, and the private insurance companies had a free dumping ground for all members no longer wanted by private insurers. As a result, despite so many additions to the TennCare roster, the percent of Tennesseans who remain uninsured fell only from 13.2 percent in 1993 (before TennCare) to 11.5 percent in 1999 (Campbell 1999). There has been little change in the overall number of uninsured Tennesseans because (1) fewer Tennesseans are being offered employer-sponsored insurance, (2) private insurers are becoming less likely to insure persons with preexisting conditions, and (3) many people added to TennCare as uninsured or uninsurable were actually previously in-

sured but changed to TennCare because of its generous benefits package.

Furthermore, access to care may have actually decreased for many Tennesseans remaining uninsured because of substantially decreased funding for safety-net providers that provide a large percentage of unreimbursed care in many Tennessee communities. Large special Medicaid payments for hospitals providing a disproportionate share of unreimbursed care were stopped in Tennessee when TennCare began and payments supporting education were decreased. While funding for unreimbursed care has decreased, unreimbursed care has actually increased for some essential safety-net hospitals since the introduction of TennCare. Loss of critical support funds in the face of increasing charity care needs is leading to the loss of essential safety-net providers.

Family leaders have seen their best hospitals, academic medical centers, and health plans decimated since the introduction of TennCare. Academic medical centers provide critical expertise in complex care that saves lives. Multiple large national studies have demonstrated that death rates for common illnesses are lowest in major teaching hospitals and highest in for-profit hospitals. Per person flat payments under TennCare punish non-profit and academic medical centers that provide more care for the more severely ill people that go to them (Bailey et al. 1999).

Substantial variation in quality among the TennCare MCOs threatens the lives of the people they serve. One Tennessee researcher found newborn infants enrolled in one MCO were three times more likely to die in the first 60 days of life than those in other MCOs, and this worst MCO had less access to neonatal intensive care (Cooper et al. 1999). Some MCOs were found to have placed excessive barriers in the way of patients attempting to obtain needed care and discouraged enrollment by those with preexisting conditions (Mirvis et al. 1995).

Administrative burdens and costs have increased under TennCare. Surveys have shown physicians report greatly increased paperwork and other administrative requirements that diminish time devoted to direct patient care. Despite significant improvements in access and quality achieved through expansion of the family business, ongoing financing and organizational problems could adversely impact providers,

healthcare delivery systems, and public health throughout the state.

New Goals

In the face of these problems, the family brought together some of its elders who had the family's interests close to heart and saw that the family had lost sight of many of the ultimate goals for which the program was originally started. The elders decided that, in order to get the best service, they must first be very clear about the family's needs and the appropriate goals of health programs serving the family.

They carefully derived a set of principles or goals as a starting place to guide all decision-making regarding the family business and healthcare expenditures (see table), proclaiming their belief that all health systems serving the family, not just those owned and operated by the family, should follow these fundamental principles if family members were to get the best value in healthcare.

The Cure: A New Way Forward

The directions these principles mandate for TennCare are fairly clear. They correspond largely with the recommendations of the governor's Commission on the Future of TennCare and the directions currently being taken by state leaders of the family business (Commission on the Future of TennCare).

Demand Health-Focused Health Systems. From now on TennCare should contract only with MCOs and insurance companies primarily committed to serving the health of their enrollees. In order to enact such a policy, the leaders of the family business should develop standards to assess this commitment and apply those rigorously with wide discretion, independence, and authority consistent with responsibilities of a corporate CEO and board of directors. Although not mandatory, not-for-profit status should be one important indicator in assessing the corporate will of the managed care organizations (MCOs). MCOs should determinedly strive for efficiency and savings, like the most aggressive for-profit corporation, but their primary purpose is to serve the family's interest by providing value in healthcare.

As a condition for participation in TennCare, MCOs of good will should be required to cooperate with one another as partners for health and encouraged to compete on the basis of quality. TennCare cor-

Justice in Healthcare Principles

■ Health	Health systems should pursue health as their primary goal.
■ Access	Health systems should provide care according to need rather than ability to pay.
■ Accountability	Consumers, providers, and healthcare institutions must take responsibility for health and the healthcare resources with which they are entrusted.
■ Choice	Consumers must have the ability to choose their health systems, providers and treatments in order to seek the best value in healthcare for themselves.
■ Education	Education of consumers, providers, and institutions regarding value and quality in healthcare is necessary for responsible and informed health choices.

Source: Justice in Health Care Foundation 2000

porate leaders could require that participating MCOs use their marketing expenditures to promote health and healthy lifestyles rather than the health plan itself. In order to serve the family's health more efficiently, participating plans should be required, encouraged, and given incentives to work together to standardize key operating procedures and processes including:

Physicians report increased paperwork and other administrative requirements that diminish time devoted to direct patient care.

- a TennCare medication formulary developed and updated cooperatively by all participating plans;
- provider credentialing procedures;
- billing and authorization procedures; and
- data-reporting formats and requirements.

The TennCare Bureau has done well to reassure providers it will take major steps to lower overly burdensome and costly

administrative requirements related to having multiple MCOs. Family business corporate leaders must commit themselves to working with providers and MCOs to develop streamlined and standardized procedures for all MCOs. Uniformity and cooperation in these areas should be required as a condition for participation.

Expand Access. Tennessee healthcare leaders should recommit themselves to the laudable initial goal of TennCare, the expansion of access to healthcare insurance to all Tennesseans. The first requirement for meeting this goal is to make sure the family's healthcare system has adequate capacity.

Toward this end, able state leaders of the family business have worked tirelessly to insure physicians and key managed care organizations remain in the program. They have repeatedly advocated that providers hold MCOs accountable for prompt and adequate payment and encouraged them to discontinue participation in unreliable MCOs. State leaders have held insurance companies accountable to the public interest by insisting major insurance providers stay in the family's program, making it clear that if these insurers are going to service any of the family members, they should demonstrate their commitment to serve all. Key family leaders throughout the state realized that if TennCare went out of business, hospitals and other providers throughout the state dependent on TennCare revenues would go out of business and all of Tennessee's family would suffer. The recent addition of new MCOs and the action of BlueCross BlueShield of Tennessee (BCBST) to

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remain in the TennCare program should be applauded and assure the future viability of the program.

In order to continue to expand access through TennCare, it is important to develop and implement systems that keep as many Tennesseans as possible within the commercial health insurance system. This is at the heart of the recommendations of the governor's Commission on the Future of TennCare 2000. TennCare's benefit packages must be similar to those available in the commercial sector in order to be a competitive alternative for health insurance and avoid flight of those who want their medications paid for in full into TennCare. Legislators and state administrators should make TennCare benefits and costs for the uninsured and uninsurable similar to those provided by private insurance plans and mandate that all insurance providers share some responsibility for providing insurance to those with chronic illnesses. Expanded benefits should be available only to those who meet very strict eligibility criteria, subject to verification. Past payment should be required and strict consequences result for those found to be misrepresenting their eligibility status. A recent federal court settlement paves the way for the state to resume reverification efforts and should allow TennCare resources to be made available once again for expansion of the program to those who really need it.

In order to continue to expand access through TennCare, we must explicitly support critical providers and facilities that provide more than their share of care for the poor and remaining uninsured. Safety-net facilities, academic health centers, and other health programs vital to the overall well-being of all the state's citizens should be specifically supported. Although the state has taken some steps to do this, these steps should be expanded.

Demand Accountability. Consumer, provider, and institutional accountability for health and healthcare resources must be encouraged at every level.

Consumer Accountability—The TennCare program should explicitly encourage individual accountability. Consumers should be assisted in taking ownership, governance, and responsibility for their

healthcare resources. All family members should contribute to the family's healthcare costs according to ability. Loyal family members should guard one another as true friends do and make sure members contribute their share. Universal access and participation cannot be encouraged without universal payment according to ability to pay. This means TennCare should be as efficient at collections as the most motivated for-profit health plan. Although benefit packages should reflect the differing health needs of enrollee groups, enrollees who pay a larger portion of their own premiums should receive some additional non-essential benefits or incentives to encourage their participation in payment according to ability. Unless there is some advantage associated with making a greater contribution to the family business (perhaps in terms of convenience, greater choice, or participation in dividends), members will naturally be inclined to obtain extensive benefits without bearing their share of the cost.

It's important to develop and implement systems that keep as many Tennesseans as possible within the commercial health insurance system.

Provider Accountability—Provider accountability should similarly be encouraged through the application of both incentives and penalties to promote participation. TennCare Bureau leaders have done an extraordinary job of maintaining provider participation, but much remains to be done. Providers and delivery systems who contract with MCOs and employers who promote commercial insurance among their employees should be rewarded as contributing to the state's mission of assuring adequate healthcare to citizens in the form of supplemental payments, tax-based incentives, or other rewards that encourage the desired behavior. Penalties for those who choose not to participate or who vio-

late the plan's procedures should also be substantial. Providers should also be held accountable for providing high-quality, evidence-based healthcare through ongoing monitoring and feedback, explicit statewide TennCare practice guidelines, and strict requirements for continuing medical education (CME) devoted to guideline-supported scientific practice.

MCO/Insurer Accountability—The state has made great strides in trying to assure the contracted MCOs are held accountable for the healthcare resources with which they have been entrusted. The state and MCOs should work together to guard family resources from profiteers who would divert these essential resources from their natural life-giving purposes. We can assist good providers and insurers by holding MCOs accountable for making payments to providers on time and making wise use of healthcare resources. Ideally, the best plans would be owned by the family members themselves so that great care would be taken in allocating healthcare resources. To insure MCO accountability, enrollees should be given a full and detailed annual accounting of all health plan expenditures. Furthermore, the family health plan cannot survive if most of the sicker members are adversely selected into it while healthier members are enrolled in private health plans sponsored by their employers. This "cherry picking" behavior with private health plans dumping the sicker and more costly members into a publicly funded program will eventually bankrupt the communal system. To avoid this and to maintain the viability of TennCare, the legislature must take steps to prevent private companies from denying insurance coverage to those with poor health and pre-

existing conditions. One such strategy is the "pay or play" type of legislation that requires private insurance companies either to insure everyone or pay the extra costs of those deemed too costly to insure (Zedlewski and Winterbottom 1992). Another strategy is the use of "community rating" to set uniform insurance rates for all residents in a state based on the cost history of the entire population. When insurance companies are not allowed to discriminate against individuals on the basis of their medical conditions, the likelihood of cherry picking and patient dumping is greatly reduced. At a minimum, TennCare must not encourage cherry picking and

patient dumping by enrolling anyone who has simply obtained a letter of insurance denial from a private company.

State/Corporate Accountability—To encourage responsible program leadership, Tennessee should form a single state organization with broad responsibility, accountability, and authority to coordinate all TennCare operations and oversight. State operation of TennCare is dispersed among several departments, each with numerous and potentially conflicting agendas in addition to TennCare. A single cabinet-level department responsible for all aspects of TennCare can achieve better program integration and accountability. TennCare needs a corporate culture committed to accountability, a CEO expert in running an efficient organization, and deeply motivated concern for the family's interests. If the TennCare insurance program is to remain fiscally solvent, it must continue to take steps to run itself as a corporation. It must improve collections, demand accountability from its contracted MCOs, and compete for enrollees on a more level playing field with the private insurance marketplace.

Encourage Informed Choice. In order to encourage competition by providers, insurers, and MCOs on the basis of quality, the state must expand choice and information about value in healthcare. The most pressing threat to TennCare has been that consumers were losing their choice because some large insurers and many providers were pulling out. BCBST is to be commended for continuing to serve TennCare enrollees. Likewise the state is to be commended for recruiting two new MCOs to serve Tennesseans. To improve TennCare the state must promote competition on the basis of quality, requiring a choice of MCOs and providers. Private insurers, the state, and the providers are to be commended for their work to allow consumers that choice.

Consumers can help by encouraging insurance companies and providers to do all they can to participate in and improve the program. Coalitions of citizens have spoken up to encourage their providers and insurers to participate in TennCare, proclaiming that they will choose and prefer insurance companies and providers who commit to serving all Tennesseans.

Educate about Value. The family business needs academic health center leadership to guide the public and providers in pursuit of value. TennCare must explicitly support scientific evidence-based practice by establishing statewide practice guidelines developed by Tennessee's best scientific leaders. Too many citizens still receive unnecessary and dangerous procedures and drugs. The state needs to enlist its best providers to help standardize practice patterns and obtain uniform high quality. The public should have ready access to these guidelines in easy-to-understand formats so it can know whether it is receiving the best evidence-based care. As other states wanting the highest-quality healthcare available, Tennessee should require all licensed providers in the state to participate in continuing medical education, devoted to cost-effective care for common diseases based on science rather than drug advertising.

To improve TennCare the state must promote competition on the basis of quality, requiring a choice of MCOs and providers.

TennCare has had many notable successes, and the nation is watching its progress. Tennessee's leaders and citizens must rededicate themselves to TennCare's improvement through reforms based on fundamental goals for the program. All health systems serving the family, not just those owned and operated by the family, should follow these fundamental principles if family members are to get the best value in healthcare. Tennesseans should demand health-focused health systems that expand primary care access to all citizens; promote consumer, provider, and institutional accountability for healthcare resources; encourage informed choice; and educate consumers about value in healthcare. With

this good prescription, TennCare can become a national-model healthcare program. ■

James E. Bailey, associate professor of medicine and preventive medicine at the UT Health Science Center, is board chairman of the Justice in Health Care Foundation. Cyril F. Chang is an economics professor at the Fogelman College of Business and Economics at the University of Memphis. Both authors are associates in the UT Center for Health Services Research.

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WHERE DO WE STAND WITH TENNCARE?

Comments of the Tennessee Medical Association

by Dr. Barrett Rosen

Since its inception, TennCare has been “under construction,” like a website that is still getting its act together and will launch when it is ready for business.

Unfortunately, TennCare launched before it was ready in 1994 and has been trying to catch up ever since. Many professionals in the healthcare industry question whether it ever will.

Governor Sundquist most recently visited the legislature on its turf to lay out the options for

TennCare and the future of healthcare for Tennessee’s most needy citizens. His extremely meager offerings were only two alternatives—fix TennCare as we know it or go back to the old Medicaid system. (Of these options, the governor prefers tweaking TennCare.)

As an organization that represents 6,600 of the state’s medical doctors, the Tennessee Medical Association (TMA) has never been at a loss for suggestions to improve TennCare or even overhaul the entire program.

Throughout multifarious summit meetings, blue ribbon panels, legislative testimony, commissions on the future, and every other “study to end all studies” on our state’s healthcare woes, TMA has stayed a course that reflects its initial warnings to then-Governor Ned McWherter. From the rhetoric of the most recent discussions and “official reports,” it is beginning to look as though those with the ability to make changes to the program are finally hearing the logic and reasoning of those in the healthcare trenches.

As an organization representing 6,600 of the state’s medical doctors, TMA has never been at a loss for suggestions to improve TennCare or even overhaul the entire program.

Now is the Time

When the legislature assembled in January, its holiday hangover consisted of a funding deficit and the continuing question of how to make TennCare the program originally envisioned. The TMA has a number of suggestions to improve TennCare while making participation in the program more attractive to physicians and other healthcare providers.

Under the impression that swift action was necessary to keep TennCare from imploding, TMA successfully petitioned the governor a year ago to establish a review panel or commission with the authority to revamp TennCare and implement sweeping changes if necessary.

TMA has come to realize the state is in no haste to do anything with TennCare. From the state’s perspective, TennCare is saving a bundle of money and insuring twice as many people—case closed. From the viewpoint of the state’s accounting rather than patient service or medical quality, TennCare is an unqualified success.

Many folks have misdiagnosed TennCare as terminally ill and warn that the program has only six months to live. Meanwhile, TennCare’s 1.3 million enrollees wonder where and from whom they will receive care and who will pay for it. The longer it takes to develop answers to these questions, the less likely TennCare can be saved.

What is the best medicine for TennCare? The TMA and its member physicians believe the first step to recovery is for legislators, the governor, physicians, enrollees, hospitals, and managed care executives to convene at the same table. Everyone needs to have a voice in TennCare’s continuation.

Recommendations for Reform

As the physicians of Tennessee, we recommend that, to turn TennCare into the health insurance plan it should be, the state should do the following.

- Transform TennCare into a single provider network, with a single drug formulary and

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set of rules. The state or one or more managed care organizations (MCOs) acting as an administrative services organization (ASO) could administer this. Physicians and hospitals cannot simultaneously untangle red tape and treat patients as effectively and efficiently as possible.

- *Set up appropriate review panels to ensure accountability.* Reviews should be based on scientific studies that recommend practices leading to better outcomes and cost-effective care. The use of evidence-based medicine should help improve both cost and quality.
- *Ensure strong financial oversight so money intended to help patients is going to patient care and not wasted by administrative inefficiencies and bureaucracy.* A cooperative oversight group consisting of the stakeholders would work in consort with the state comptroller's office.
- *Set fee levels at or near Medicare levels to encourage physicians and other healthcare providers to participate in the program.* Such payment would allow high-volume TennCare providers in underserved areas to survive.
- *Accept responsibility for TennCare finances.* This may actually cost less than one might think after factoring in all the support and analysis spent propping up failing or faltering MCOs.
- *Spend funds on accurate eligibility determi-*

nation and eliminate loopholes that encourage patients to move from private insurance into TennCare. The current incentive to shift high-risk individuals to TennCare is expensive.

- *Ensure the next version of TennCare includes all stakeholders at each stage of its planning, regulation, administration, and oversight.* The current system of unilateral decision-making has irreparably damaged TennCare's credibility with participating MCOs, physicians, hospitals, and even patients. The leadership vacuum is obvious given how often TennCare has been kicked between state departments and the bureau has hired new directors.
- *Avoid the temptation to separate care, as with the behavioral and mental illness carve-outs.* All health services should be offered through one program arrangement. Splitting care services continues to exacerbate an already horrible situation; equal access to care has become of great concern to physicians throughout the state.
- *Split the program into two different programs—one for traditional Medicaid patients and another for those high-risk enrollees deemed uninsurable, considering whether and to what extent their care merits different reimbursement levels and disease management efforts.*
- *Foster an environment of trust by taking financial responsibility for past payment defaults by MCOs, paying those providers the money owed for services.*
- *Bear the risk for Tennessee's healthcare program rather than passing it off to the MCOs and participating providers.*
- *Prosecute those who abuse and jeopardize the program for all others.*

Reforming TennCare from a purely financial perspective is what got us here; we need to be careful not to fall into that same trap again. Before arbitrary changes are made to the program that will affect the long-term well-being of patients, the state should consult its doctors.

The ever-decreasing number of providers willing to accept new TennCare patients or willing to sign with new MCOs is a strong indication that TennCare is on a course to failure. With careful planning and expeditious but calculated changes, Tennessee can re-establish a healthcare plan to serve everyone in an effective, efficient manner, making the best use of its limited healthcare dollars. ■

Dr. Barrett F. Rosen, a Nashville orthopedic surgeon, is the immediate past president and a current member of the Board of Trustees of the Tennessee Medical Association.

BLUECROSS BLUESHIELD OF TENNESSEE LIMITS ITS RISK

Risk was the key factor in BCBST's 1999 decision to withdraw from TennCare and its recent decision to accept a new, more limited arrangement with the state

by Ron Harr

When the TennCare program was introduced in 1993, it was heralded as a “public-private partnership.” The state needed a cost-containing alternative to its existing Medicaid program, and planners decided that providing managed care to Medicaid recipients would be the ideal solution. Managed care had been proven in other areas of the country to reduce costs by developing networks of providers, focusing on primary care managers, offering preventive care, evaluating services for medical necessity, and building case management programs for the chronically ill.

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Planners decided to add an element of market competition to the program by signing up numerous managed care organizations (MCOs) that would compete for TennCare members. They believed this “managed competition” would trim costs to the absolute minimum, saving so much money that coverage could be expanded to uninsured and uninsurable Tennesseans without additional funding.

The problem with this logic, and perhaps the most serious flaw of the TennCare program, is that TennCare denies the fundamental nature of health insurance.

Health insurance is simply a financial arrangement that takes the high cost of caring for the few who get sick and spreads it among a large group of healthy people. Insurers predict future medical costs for a particular group and establish premiums that will cover these expected medical expenses, in addition to the costs of administering the insurance program and contributing to reserves.

If the insurer makes an accurate prediction and sets adequate premiums, the insurer makes a profit. If the insurer does not, and medical and other costs exceed premiums collected, the insurer takes a loss. In other words, the very heart of an insurer’s business involves taking carefully calculated financial risk.

This issue of risk, the key factor in the

controversy over BlueCross BlueShield of Tennessee’s (BCBST’s) participation in the TennCare program, explains its 1999 decision to withdraw from TennCare and its recent decision to accept a new, more limited risk arrangement with the state.

When market forces are allowed to work, the business of taking risk can pay off. In fact, many large employers such as TVA, Wal-Mart, Dollar

General, Eastman, and the state (on behalf of its employees) choose to take risk for their own health insurance and retain any profits made from the financial arrangement. BCBST negotiates contracts and prices with these customers, who pay BCBST for its expertise in paying claims, building provider networks, and managing medical costs.

These arrangements, whether BCBST is at risk or simply providing administrative services for a fee, all involve market-rate negotiations over premiums, benefits, and eligibility as well as careful forecasts of anticipated medical costs.

In the case of TennCare, the state has denied insurers all of these basic tools of the trade and determined eligibility, benefits, and premiums, with no room for negotiation or adjustment and, until recently, no actuarial analysis of medical costs. From the beginning, MCOs have been given one simple choice: sign the contract and be in the program on the state’s terms, or leave the program altogether.

In spite of the market-defying parameters of TennCare, BCBST has a great deal of respect for the goals of the program and has always wanted to help make it work. BCBST signed up amidst the rush of implementing the TennCare program in 1993 and built claims processing, medical management, and disease management programs of which it is proud.

BCBST developed the third largest HMO in the country almost overnight, in a state with very little exposure to HMOs before the advent of TennCare. Studies show BCBST and the other MCOs in this program have actually improved the health of the Tennesseans served by TennCare with fewer emergency room visits and more prenatal care, mammograms, and immunizations. The state estimates TennCare, in spite of its great expense, has saved the state more than \$2 billion compared to what costs would have been under the old Medicaid program.

In spite of the great benefits offered by TennCare, there have been many problems. The scope of the program has grown beyond what anyone envisioned—like a dinner prepared for four stretched to feed seven or eight. The state of Tennessee was poorly equipped to manage the needs of a program with 1.3 million members. The state’s computer systems have been inadequate to the task of maintaining current eligibility files, and the program has been underfunded for most of its existence.

In addition, TennCare has been plagued by court orders that have created a hostile environment for MCOs trying to serve the program. Advocates for TennCare enrollees have succeeded in making benefits so generous, eligibility so broad, and appeals so expensive as to



Any losses BCBST might sustain will be limited to \$33 million, the amount of gain it has seen over the lifetime of the TennCare program.

**A partnership
between business
and government is
not impossible, but
the state cannot ask
any business partner
to violate the rules
that govern its
existence.**



actually threaten the viability of the program about which they care so much.

In 1999, BCBST analysts forecast substantial losses for the upcoming calendar year 2000 and faced a painful decision.

Although BCBST is a not-for-profit organization, this status simply means it does not pay dividends to investors. BCBST does not get special tax breaks or have charitable funds to support a program such as TennCare.

BCBST could never ask its commercial customers to carry the burden of losses sustained through its involvement in TennCare. It would not be fair to ask them to subsidize the TennCare program beyond the taxes paid by all citizens of the state or expect them to stay with BCBST if its premiums were higher than its competitors because of TennCare losses.

BCBST had no choice; it could not continue at risk in the TennCare program when even its most optimistic calculations predicted certain losses.

BCBST decided that it must withdraw from TennCare, knowing the state could require it to continue to serve under an administrative services only (ASO) arrangement. This change signaled to the state that there were significant problems with TennCare requiring high-priority attention and provided an opportunity to start thinking about serious reform. It also allowed

BCBST to continue providing services to its TennCare members without imposing on its commercial customers.

Now BCBST has again agreed to assume a limited amount of risk in the TennCare program. Under its new agreement with the state, any losses BCBST might sustain will be limited to \$33 million, the amount of gain it has seen over the lifetime of the TennCare program. In the event this \$33 million gain is depleted, the state will assume the risk for any additional losses.

Additionally, BCBST has offered to provide healthcare benefits under an ASO arrangement as a program safety net. Initially, the state will assign all Department of Children's Services and Social Security Income children to this arrangement. In the future, if the state needs BCBST to take additional members, it will be willing to accept those enrollees.

It has never been BCBST's goal to make money on the TennCare program, but simply to break even. Ideally, BCBST would like to make enough for the program to build its own reserves. The current agreement allows BCBST to participate while protecting its commercial customers. It doesn't fix all the problems of TennCare or change the nature of the program.

TennCare is an entitlement program, not health insurance, which is bound by the rules of the marketplace. Governments can choose to violate these rules, and indeed must do so if the purpose of an entitlement program is to serve those who cannot be served by the private market. A partnership between business and government is not impossible—the state employee insurance program is a good example—but the state cannot ask any business partner to violate the rules that govern its existence. TennCare is a social welfare program planned and implemented by state government, and that is where its ultimate responsibility must lie.

BCBST has offered compromise in entering this recent agreement with the state. Other parties have also compromised—the state, hospitals, and physicians who would like to have a better program in which to participate. The short-term challenge will be to convince TennCare advocates they, too, must be willing to compromise to save this important program.

BCBST will continue to help where it can within the laws of the marketplace and hopes its recent agreement will give the state time to fix what is wrong with TennCare so that, by 2003, MCOs and providers will readily sign up to serve Tennessee's neediest citizens through the TennCare program. ■

Ron Harr is vice president of communications for BlueCross BlueShield of Tennessee.



Travel Lines

Line of Marriage

Line of Apollo

Line of Saturn

Life Line

Head Line

Island Line

THE FUTURE OF TENNCARE

Executive summary of the report by the Commission on the Future of TennCare

Governor Don Sundquist formed the Commission on the Future of TennCare in January 2000. The governor's charge to the commission was to:

- assess the effectiveness of the TennCare waiver from the perspectives of cost, efficiency, and effectiveness of service delivery and overall benefit to the people of Tennessee;
- examine the state's options with respect to continuing or revising the TennCare waiver or adopting an alternative plan;
- obtain broad-based public comments on the state's future directions in publicly funded health care; and
- make recommendations to the governor regarding continuation or revision of TennCare or the adoption of an alternate plan.

Principles

Over the last several months, the commission has heard from a broad spectrum of interests regarding the provision of healthcare to Tennessee's medically underserved citizens and studied numerous reports, court decisions, and regulations. After extensive discussion, the commission reached consensus on the following principles that have guided its deliberations.

- TennCare should be a health insurance program of last resort to help those most in need.
- The state should provide health insurance coverage to as many Tennesseans in need as possible without designing a program the state cannot afford or displacing employer-sponsored coverage.
- All Tennessee children should have access to health insurance.
- TennCare must be structured in an actuarially sound manner within the limitations of the state budget, even if that requires restructuring the existing program.
- Within the context of publicly funded programs, providers should be reasonably and promptly compensated by TennCare. TennCare cannot continue to achieve its cost savings by inadequately compensating providers.
- TennCare must significantly reduce the "has-

sle factor" for providers and improve trust and communication between members, providers, and contractors.

Conclusions

During the course of deliberations, it became quite clear to the commission there were no quick and easy solutions to the problems identified; the needs were extensive and the issues complex. After analyzing the wealth of information it had received, the commission reached several broad conclusions.

- Despite the recognized shortcomings in the structure and administration of TennCare, the program has exceeded expectations in improving the health of many Tennesseans most in need.
- Supplementing available state funds with federal dollars to finance a health insurance program such as TennCare brings with it federal constraints on how the program can be structured and operated. At least some of these constraints seem antithetical to providing quality healthcare at the lowest cost. Nevertheless, not accepting federal dollars would almost certainly result in inadequate healthcare for Tennessee's most fragile citizens—an unacceptable alternative. Until federal health policy provides greater flexibility for state-operated programs or federal/state goals are aligned, implementation of a thoroughly rational health insurance program does not seem achievable.
- Managed care is the most cost-effective approach to the delivery of healthcare. When properly executed, the managed care organization (MCO) concept is fundamentally sound. For the most part, providers' frustrations with TennCare have not been with managed care itself but are the consequence of managed care not having had the opportunity to perform optimally because of:
 - inadequately prepared MCOs;
 - lack of adequate funding and oversight;
 - inadequate information systems;

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- inconsistent leadership; and
- inadequate policies and rules.
- It is unlikely, however, that the health-care needs of all of those eligible for TennCare can best be met by a “one size fits all” model. Alternative delivery approaches should be explored for the special needs population and as a backup to the managed care model.
- The current TennCare program requires significant structural changes to become more affordable, equitable, and sustainable.
- TennCare’s policies and rules inadvertently undermine the role of employer-sponsored health insurance coverage.

Recommendations

The commission has submitted more than 50 detailed policy recommendations in its full report, some of which may be politically difficult to implement, offered as the commission’s best effort to envision a stable program affordable for taxpayers, fair to providers, and adequate to preserve and improve the health of Tennesseans most in need. These are some of the key recommendations.

- TennCare should continue as a managed care program.
- There should be a continued funding partnership with the federal government, but strenuous efforts should be directed toward negotiating terms more compatible with managed care rather than oppositional to it.
 - The state should pursue federal approval to renew the current TennCare 1115 waiver and keep from destabilizing the healthcare coverage on which about 500,000 people in the current TennCare expansion population now rely.
 - Once an evaluation of the effectiveness of the reforms in TennCare II has been completed and a work plan developed to ensure the smooth transition of current members, the state should submit the appropriate elements of the commission’s recommendations as a new 1115 waiver.
- Substantial improvements need to be made to TennCare by investing the resources necessary to make the program work, including appropriate staff resources, adequate information systems and technology, and continued actuarial funding.

- TennCare should:
 - adopt uniform billing procedures and create a centralized credentialing process and standardized drug formulary for participating providers;
 - develop policies that better align the financial risks and incentives among the state, MCOs, and providers;
 - aggregate encounter and other data and make these publicly available for research and publication; and
 - develop and enforce quality standards.

The commission thanks the governor for the opportunity to serve the public’s interest in formulating these recommendations.

- Health insurance benefits should be provided through TennCare for:
 - people who are Medicaid-eligible, with a benefit package similar to that proposed in TennCare II;
 - people in need but not eligible for Medicaid by the creation of the following products in place of the current expansion of TennCare to the uninsured and uninsurable:
 - ▲ TennCare Assist, a premium assistance program to assist certain low-income Tennesseans to buy into employer-sponsored healthcare coverage, including family coverage, when it is available to them; and
 - ▲ TennCare Standard, a second TennCare product for individuals without access to employer-sponsored health insurance coverage and/or individuals uninsurable from an underwriting standpoint. The benefits should be comparable to those most frequently offered by employer-sponsored small group plans. Premium rates for TennCare Standard should be actuarially determined, with premiums increasing on a sliding-scale basis.

- As a priority, all Tennessee children should have access to health insurance.
- TennCare’s governing or overseeing body, currently the Steering Committee and the legislative Oversight Committee, should be replaced with a board of 12–15 individuals qualified to oversee a program of the size and significance of TennCare. In addition, consideration should be given to the transition of TennCare as a governmental entity to a public/private organization or an alternative governmental agency.
- The state should continue the behavioral health program *TennCare Partners* and ensure there is meaningful choice of managed care plans.
- There should be strong enforcement of the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA) to enable people with pre-existing conditions to access employer-sponsored health insurance coverage.
- The TennCare Bureau and/or its agents should determine eligibility and income verification carefully and consistently. Due process should be afforded to all members deemed ineligible for the program.
- While the goal should be to have all Tennessee providers participating in TennCare and therefore sharing in the provision of services to those most in need, the program should continue to compensate “disproportionate share providers” through an annual special payment methodology until the goal is reached.
- Adequate notice should be given to those currently receiving TennCare coverage who would not be eligible under revised programs recommended by the commission.

The commission thanks Governor Sundquist for the opportunity to serve the public’s interest in formulating these recommendations. ■

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THE DEAN'S CORNER

by E. James Burton

Dear *Tennessee's Business* readers:

I will resist the terrible urge to tell you everything I know about TennCare's problems, because that would leave entirely too much white space on this page. Instead, allow me to share some other thoughts.

I completed my graduate work at the University of Illinois and passed the CPA exam in 1976. For a few years I believed my preparation for teaching college accounting was complete. I taught the accounting I was taught and used the teaching processes used on me. Then my contented little world began to crumble.

The Financial Accounting Standards Board created new rules and regulations faster than textbooks could be updated. Principles unchallenged for many years were discarded. Paradigms did not just shift, but fractured into a thousand pieces. The personal computer brought great benefits and even greater changes into my professional life as a teacher and accountant.

I recently became aware of a little book that explores such change in a unique, insightful way—*Who Moved My Cheese?* by Spencer Johnson, M.D.

Four fictional characters, two mice named Sniff and Scurry and two little people named Hem and Haw, find themselves in Cheese Station C with all the cheese they can imagine. Each day they return to Station C and have their needs met, and they come to believe Station C is the answer to all of their problems forever. They don't seem to notice that the stock of cheese is, in fact, diminishing. One day they come to Cheese Station C and find the cheese is all gone.

The mice don't over-analyze the situation. They begin to "sniff" and "scurry" around trying to find new cheese. Hem and Haw, however, think they are entitled to the old system and that, if they wait, it will return.

I recommend the book if you haven't read it. It is interesting to see how Hem and Haw cope with the problem. You will probably see yourself and several people you know in the characters. The book makes several points:

- Cheese never lasts forever, no matter how big the pile or strategic advantage or how deep the financial pockets.
- There is no one right way to respond when the cheese is gone; you can sniff, scurry, hem, or haw, but you had better respond, and



the sooner, the better.

- No one owes you cheese; just because you had cheese doesn't mean you have the right to cheese in the future. You have to get out and look for new cheese.

Perhaps the most thoughtful question posed in the book is: "What would you do if you weren't afraid?"

Getting back to what I know about TennCare: maybe the problem with TennCare is that someone moved the cheese and we are acting like Sniff, Scurry, Hem, and Haw.

By the way, do you know who moved my cheese?

Sincerely,

A handwritten signature in black ink that reads "E. J. Burton". The signature is written in a cursive, flowing style.

E. James Burton, Dean
The Jennings A. Jones College of Business
Middle Tennessee State University

Facing the task of reforming TennCare, we might wonder: Who moved the TennCare "cheese"?