



January 2006

A Critical Case Study of Program Fidelity in TennCare

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A CRITICAL CASE STUDY OF PROGRAM FIDELITY IN TENNCARE

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Carole Lynn Myers

May 2006

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ACKNOWLEDGEMENTS

I am immensely grateful for how selflessly each of the people I interviewed shared their time and perspectives with me. Although respondents shared a plurality of perspectives about what is “right” and what is “wrong” with TennCare and TennCare Partners, and what the programs intended to accomplish and what was actually accomplished, I was profoundly impressed with the singular purpose and dedication of each interviewee to the idea of access to high quality health care for all citizens of Tennessee. The fact that this goal has not yet been accomplished is not a reflection of their commitment, but rather it is testimony to the complexity of the problem of health care delivery and the need for a new paradigm that must be developed through broad-based dialogue of all stakeholders beginning at the national level and reaching deep into each state.

I am indebted to the Gamma Chi Chapter of Sigma Theta Tau for their funding of my research and the consultation and encouragement I received from members, most notably Drs. Mary Gunther and Linda Mefford.

A key to success in life is to surround yourself with good people. Any success I have achieved in the conduct of this study is a reflection of my visionary, pragmatic and encouraging Dissertation Committee Chairman, Dr. Sandra Thomas; my close and essential confidant, Dr. Marian Roman; the inspiration and challenge Dr. Joanne Hall instills in me like few others; the willingness of Dr. Craig Ann Heflinger to allow me to enter her world on the promise that I would share her dedication to policy research for the purpose of improving the delivery of health care for the less fortunate among us; and to Dr. Dulcie Peccolo, a noteworthy teacher who possesses a keen and adventurous intellect.

Lastly, we are not whole without close and loving personal relationships. The unfailing support and love of my husband and son, Glenn and Graham Myers, makes the work I do and my life a joy.

ABSTRACT

A Critical Case Study of Program Fidelity in TennCare

Purpose: The purpose of this study was to evaluate the *fidelity* of the design of Tennessee's Medicaid managed care program in comparison to the actual program operation. Program fidelity is a broad measurement of how true the implemented program is to the intended program (Heflinger & Northrup, 2000).

Background: In the span of only 15 years, the introduction of managed care and other market-based strategies from the private sector precipitated a transformation of the delivery of Medicaid services in the United States. These monumental changes remain poorly understood. The implementation of managed care in Tennessee's Medicaid program is an excellent public policy exemplar because of the far-reaching scope of the program and the ongoing development of the program.

Method: A hallmark of case study research is that detailed information is collected from multiple sources (Creswell, 2003; Feagin, Orum and Sjoberg, 1991; Stake, 2000; Yin, 2003). Source data for this single case study design included interview data from key stakeholders and a variety of documents. Documents analyzed included: newspaper and journal articles; correspondences; the original TennCare and TennCare Partners waiver applications; judicial decrees; legislative documents; task force reports; and other case studies. Interviews were conducted with 26 informants, including two former Governors of Tennessee; a former HCFA Administrator; a variety of state government and managed care executives and advocates; and a complement of provider representatives including administrators, managers and caregivers.

Themes were developed to organize the vast amount of interview data. The salience of themes that emerged in early interviews were challenged, clarified and further distilled by an iterative process of content analysis and data triangulation that included multiple close readings of interview transcripts and documents, clarification and testing of ideas with selected stakeholders and confirmation of details with document sources. The triangulation of retrospective recollections of events and key impressions captured in recorded interviews with a wide variety of time-stable documents provided a rich understanding of people and events that shaped the development and operation of TennCare. Each theme was also organized and developed through the construction of a chronological history of events.

Findings: An intricate web of circumstances and people shaped the initial development and evolution of TennCare. Although TennCare has been successful in extending health care coverages, this success has been overshadowed by a myriad of operational problems.

Thematic analysis illuminated both the promises and failures of TennCare. Three themes were prominent in the telling of the TennCare story: *authority*, *management* and *fragmentation*. Governor McWherter (1987-1995), the creator of TennCare, established a strong executive authority to model and implement TennCare; a void was created when he left office. Subsequent administrations have not adequately transitioned to a more balanced and inclusive authoritative structure, nor have they developed an adequate oversight model. Continued mismanagement of the administration of benefits and failure to meet established care standards set the stage for the imposition of federal judiciary authority.

Management of the operational phase of TennCare has largely been reactionary and politicized and, in many instances, inappropriately abdicated or conferred upon the wrong or unprepared people or entities. Turmoil and turnover in state government hindered stabilization of the program. The stability and evolution of the marketplace that McWherter expected has not been broadly realized; the state has retreated from basic managed care principles.

The state failed to integrate the management the health, behavioral health and pharmacy carve-outs. This fragmentation resulted in diffuse accountability across vendors and within state government, unnecessary duplication of services, gaps in the delivery and management of patient care and increased patient hassle and frustration. More broadly, the state was found to have conflicting roles as both the manager of the behavioral health vendors and a direct provider of behavioral health services.

The web of connectivity between themes changed over time, as themes presented as a cause, catalyst or consequence of the others at different times in TennCare's history. A poignant example of this connectivity is how the mismanagement of TennCare program after the initial implementation led to the breakdown in key alliances and the eventual imposition of federal judicial authority in the form of the consent decrees. Consent decrees resulted in reactive and disjointed management which significantly contributed to the gap between what was envisioned for TennCare and what actually resulted.

Conclusions: The study illustrated that an intricate web of circumstances and people shaped the initial development and evolution of TennCare, a program designed to solve a state-level problem with national implications. Although TennCare has been successful in increasing the number of Tennesseans with health care coverage, these successes have been overshadowed by pervasive operational problems, a failure to fully implement basic building blocks of managed care, such as risk-sharing and competition, and effectively manage the vendors employed by the state. Conclusions related to the three themes show a pattern of missed opportunities and a troubling inability to transition from the chaos of TennCare's implementation to effective program operation. The illuminated themes will be informative to planners of similar state initiatives.

TABLE OF CONTENTS

	Page
Chapter 1: Introduction to the Study	
Introduction	1
Problem Statement	1
Research Aims	2
Research Question	2
Delimitations	3
Limitations	3
Study Significance and Focus	4
Chapter 2: Policy-Making and Evaluation Paradigm	
Introduction	7
Perspective and Purpose	7
Critical Theory	9
Deliberative Democracy	15
Responsive Policy Evaluation	19
Research in Policy-Making	20
Program Evaluation	22
The Integrative Paradigm	23
Conclusions	24

	Page
Chapter 3: Literature Review	
Introduction	26
Tracing the History of Medicaid	26
Looking at Managed Care	30
Public Mental Health Services	42
Looking at TennCare	42
Serious Emotional Disorders	44
Conclusions	45
Chapter 4: Methodology	
Introduction	47
Approach	48
Methodological Specifics	52
Conclusions	71
Chapter 5: TennCare Vision and Development	
Introduction	72
TennCare Development	73
TennCare Enrollment	85
Conclusions	85

	Page
Chapter 6: Introduction to Findings and the Theme of Authority	
Introduction to Findings	90
Emergent Themes	90
Introduction to Authority	91
Federal Legislative and Budgetary Authority	92
Keen Vision and Power: The Executive Authority of Governor McWherter	94
The Influence of Presidential Authority	95
Federal Judicial Authority	96
TennCare Oversight	121
Authority of a Different Kind	124
Thoughts on TennCare Oversight	125
Reflections on the Theme of Authority	127
Chapter 7: The Theme of Management	
Introduction	129
The Birth of the Idea: TennCare Implementation	129
“Into the Fire”: TennCare Operation	132
Financial Risk and Management	155
Reflections on the Theme of Management	161

	Page
Chapter 8: The Theme of Fragmentation and Concluding Remarks on the Study Findings	
Introduction	162
Plan Administration	162
Care Delivery in TennCare Partners	188
Information Management	206
Reflections on the Theme of Fragmentation	208
Concluding Remarks on the Study Findings	209
Health Care Reform: Ten Years Later	212
Chapter 9: Reflections	
Introduction	217
The Failed Promises of Market-Oriented Reforms and Managed Care	219
The Lack of Transparency and Engagement in Public Policy	236
The Right to a Decent Minimum of Health Care	241
Putting It All Together: A Vision	245
Chapter 10: Recommendations for TennCare	
Introduction	247
Authority	247
Management	248
Fragmentation	249
Conclusion	249
References	251

	Page
Appendices	
Appendix A: Glossary of Terms	288
Appendix B: List of Acronyms	291
Appendix C: Behavioral Health Care Carve-Out Arrangements	293
Appendix D: Continuum of Types of Managed Care Plans	294
Appendix E: Sample Consent Form for Providers	295
Appendix F: Sample Transcriptionist’s Confidentiality Agreement	298
Appendix G: Sample Consent Form for Non-Providers	299
Appendix H: Sample Introduction to Study Information	302
Appendix I: Sample Transcript Cover Letter	304
Vita	305

LIST OF TABLES

Table	Page
1. Profile of Identified Study Informants	55
2. Profile of Anonymous Study Informants	68
3. Tennessee Governors and U.S. Presidents: Affiliations and Terms	74
4. TennCare Development and Implementation Timeline 1992-1994	86
5. TennCare Eligibility Categories	86
6. TennCare Enrollment Timeline	87
7. TennCare Law Suits and Consent Decree Descriptions	99
8. TennCare Consent Decrees Timeline	102
9. TennCare MCO History	137
10. TennCare Directors	143
11. Behavioral Health Care History in TennCare	167
12. History of Magellan's Involvement with TennCare Partners	179
13. TennCare Reform Efforts Timeline	214
14. TennCare Eligibility Categories Affected by 2005 Changes	216
15. Proposed TennCare Benefit Changes	216
16. Summary of Recommendations for TennCare	250

LIST OF FIGURES

Figure	Page
1. Integrative Paradigm for Policy-Making and Evaluation: Key Components	24
2. Total TennCare Enrollment by Year	89
3. TennCare Enrollment by Eligibility Category	89

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

In the short span of less than 15 years, the delivery of Medicaid health services in the United States has been transformed. The effects of this transformation, largely precipitated by the introduction of managed care and other market-based strategies from the private sector, are not yet understood. One aim of the present study is to provide in-depth scrutiny of one state's experiment with managed care in its Medicaid program.

In this chapter, the use of managed care in Medicaid will be introduced and issues associated with the rapid implementation of this model of care for Medicaid beneficiaries will be outlined. Research aims and study questions, limitations and delimitations will also be presented. The chapter will conclude with comments on the significance and focus of the study.

The reader is directed to the Appendices. A Glossary of Terms (Appendix A), A List of Acronyms (Appendix B), and diagrams of Behavioral Health Care Carve-Out Arrangements (Appendix C) and a Continuum of Types of Managed Care Plans (Appendix D) are included.

Problem Statement

Medicaid covers more than 50 million people nationally and pays for one in five health care dollars. From 1990 to 2002, the national Medicaid population grew by 60 percent (Draper, Hurley & Short, 2004). At the state level, Medicaid spending is the second largest and fastest growing state budget item (Haslanger & Tallon, 2004). From 2002 to 2004, 34 states resorted to cutting elements of their public health insurance programs because of unacceptable cost increases (Haslanger & Tallon, 2004). However, Tennessee had undertaken a radical experiment in 1994. Following the demise of President Clinton's national health reform, Tennessee was granted a waiver

by the Health Care Financing Administration (HCFA) to implement managed care for the state's Medicaid population. Tennessee's medical managed care plan, called TennCare, was implemented in 1994 after less than one year of planning. By 1996 the provision of all behavioral health care for Medicaid recipients was moved to two selected managed behavioral health care companies. Tennessee's move to managed care is noteworthy for three reasons. Tennessee implemented managed care earlier than most states. Tennessee added managed care as a full replacement for traditional care, rather than just as an option. The move to managed care took place on a very accelerated timetable.

The TennCare program was beset with a myriad of start-up and operational problems, including funding woes and troubled relations with contracted managed care organizations (MCOs) and the state's providers, primarily physicians. Evaluation of the TennCare program is an important component of the policy-making cycle.

Research Aims

The aim of the case study was to evaluate the fidelity of the design of Tennessee's Medicaid managed care program (TennCare) to the actual delivery of the program through a review of pertinent literature and documents and interviews with various stakeholders. The study examined the complex contextual factors that influence the TennCare program, providing a multi-perspective view and examination of expected and unanticipated program results. The goal was a rich understanding and insight about an important public policy initiative.

Research Question

A single research question was used as the general guided for the study. The question was: *In what ways has the implementation of TennCare been true to the original strategic aims of the program?*

Delimitations

Several delimitations were originally specified. Delimitations narrow the scope of the study (Creswell, 2003). Originally the case to be studied was specified as the *managed behavioral health care* program in TennCare, known as TennCare Partners. The case was also further delimited to the study of access to care for school-aged children and adolescents (ages 4-17) with serious emotional disorders (SED). These delimitations were deleted once interviews commenced for reasons outlined in Chapter 3 on methods. The study proceeded with the case being defined as the entire TennCare program, including TennCare Partners. In a case study the researcher must establish and provide sound rationale for limiting what is relevant to the study and what will not be included. It is not possible to “tell the whole story.” The emergent nature of issues and themes in a case study mandates a flexible and reflexive approach that can not be fully explicated in advance of data collection.

Interviews with caregivers or providers were confined to a subset that resides or provides services in the East Tennessee Human Resources Agency (ETHRA) catchment area as originally specified. This catchment area includes the sixteen county area of Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union.

Limitations

Limitations, which are specified, are projected weaknesses of the study (Creswell, 2003). By nature case studies are about the particular and so there are limitations about whether findings may be generalized. The purposive and selective sampling methodology can limit the generalizability of the findings.

Since the researcher is the instrument of analysis, subjectivity or researcher bias is always a potential limitation. Strategies that were employed to manage researcher

bias include the clear identification and analysis of assumptions, as well as an ongoing process of challenging conclusions against these assumptions. Secondly, experienced researchers serving on the researcher's dissertation committee were used to analyze and verify content.

The complexities associated with the delivery of health care services and managed care and the challenges presented by the population served by Medicaid posed a challenge in the management and interpretation of the data. It is recognized that the analysis conducted was not comprehensive.

Study Significance and Focus

The current trend of moving Medicaid beneficiaries to managed care programs has not been adequately evaluated. This situation is particularly concerning because of the special needs and vulnerabilities of individuals enrolled in public health programs. The speed, at which the change is being made, in the absence of good research and program evaluation, is another concern. It is not known whether research findings from the private sector, which are mixed, are applicable to the Medicaid population. The many variations of managed care that exist make evaluation difficult and conclusions may not be generalizable.

Managed care is the strategy most frequently used by states to manage increased program costs and to accommodate increased enrollments. Of the 40 million beneficiaries enrolled in Medicaid in 2002, 23 million or nearly 58 percent were enrolled in a managed care plan. This represents a ten-fold increase from 1990 to 2002 ((Draper, Hurley & Short, 2004; Haslanger & Tallon, 2004).

Managed behavioral health care (MBHC) is also prevalent in Medicaid nationwide. In the early to mid 1990s, seven states, beginning with Utah in 1991 and followed by Arizona (1992), Massachusetts (1992), Washington (1993), North Carolina

(1994), Colorado (1995), and Iowa (1995) introduced managed behavioral health care in the state Medicaid program (Coleman et al., 2005). By 1999, 42 states had implemented some form of Managed behavioral health care for over 17 million beneficiaries (Coleman et al., 2005). In 1999, more than one-half of all Medicaid beneficiaries were enrolled in a MBHC plan. This represented a seven-fold increase from 1991 (Rowland, Garfield & Elias, 2003). Ten states (California, Michigan, Tennessee, Massachusetts, Pennsylvania, Maryland, Washington, New York, Texas and Oregon) accounted for 80 percent of these enrollees. California, Tennessee and Michigan alone accounted for one-half of the national enrollment (Coleman et al., 2005).

Between 1999 and 2000, six states, including Alabama, Arkansas, Kentucky, New Mexico, Montana and North Carolina terminated their Medicaid managed behavioral health care programs. Montana reverted to fee-for-service (FFS) because providers were unwilling to accept Medicaid reimbursement rates. North Carolina allowed its waiver to expire to facilitate development of a new statewide delivery system. New Mexico withdrew its program under the threat of termination of the state's entire Medicaid managed care plan if behavioral health care services were not carved-out (Coleman et al., 2005).

The impact of the rapid implementation of managed care plans in the public sector has not been studied extensively. Research from the private sector, which is not definitive, can not be generalized to Medicaid due to plan and patient differences. Interestingly the managed care programs for Medicaid are generally referred to as *experimental* in the literature.

Medicaid beneficiaries need strong policy advocates; nurse researchers should be more influential in the policy-making process. In evaluating public policies, nurses have the opportunity to improve patients' environment of care. These environmental

factors are important since issues of access, cost and quality, including specifically the complement of services delivered and their effectiveness, significantly impact patient outcomes. Nurses have not assumed a role in policy-making commensurate with their professional position and perspective. It is imperative that nurses get involved in policy research and other policy-making activities to improve outcomes for patients based on sound evidence and with a strong sense of advocacy. The need for involved nurses is poignantly true when you consider the special needs of patients with behavioral health disorders served by Medicaid.

Using a critical orientation, which was specifically guided by the interpretive paradigm presented in the next chapter, the *fidelity* of Tennessee's managed behavioral health care program to selected strategic aims was addressed. Fidelity was analyzed by looking at the results or outcomes of the implementation of the TennCare program.

As is true with any public policy, there are multiple stakeholders and perspectives relative to TennCare. This evaluation of the TennCare program was designed to include an examination of the complex contextual factors that influence the program and a multi-perspective view, as well as an examination of expected and unanticipated results. The chosen design, a case study permits this broad examination.

CHAPTER 2: POLICY-MAKING AND EVALUTION PARADIGM

Introduction

An integrative paradigm for policy-making was constructed and used to orient study design, data collection, analysis and the development of recommendations. This integrated paradigm was derived and synthesized from the work of critical theorist, Jurgen Habermas, deliberative democracy advocate John Dryzek and proponents of responsive evaluation, including Jennifer Greene, Michael Patton and others. Understanding of the value of the integrative paradigm is enhanced by an explication of the researcher's perspective and purpose, as well as a discussion of the process of policy-making.

Perspective and Purpose

American society has undergone radical change since the 1960s and our society has become inherently more complex, pluralistic and fractured. Gone is the stable political, cultural and social environment many of us knew before then (Chrislip and Larson, 1994; Greenwald and Beery, 2002). In turn, we have seen a fragmentation of power, marginalization of a wide variety of groups and persons and the lack of effective social policy processes. We are impotent in addressing difficult social issues that have emerged with these major shifts. Our social policy-making processes are not responsive. Although the major emphasis of the integrative paradigm is developing an orientation for addressing health policy issues, often it is difficult and counter-productive to separate health from the other concerns of social policy.

A Stunning Paradox

In health care we are faced with a stunning paradox in the United States. We have the most technologically advanced delivery system and we spend a greater proportion of our gross national product on health care than any other industrialized

nation (Center for Medicare and Medicaid Studies, n.d.). At the same time we have over 44 million Americans with no health care insurance (Institute of Medicine, n.d., a; Institute of Medicine, 2004 January) and a shameful situation where ethnic and racial minorities receive a lower quality of care than their non-minority cohorts (Smedley, Stith and Nelson, 2002). Even the quality of care received by the non-minority population is not as high quality as many would assume (Chassin and Glavin, 1998; Institute of Medicine, n.d. b). Few can deny that the Institute of Medicine's report on patient safety (Corrigan and Donaldson, 2000), which asserted that 44,000 to 98,000 patients die annually as a result of medical errors in acute care hospitals, was a call to action.

The United States lacks effective health and other social policies that reflect the needs and values of Americans. Recent reform efforts have only broadened the gaps between the various constituencies. Patients are marginalized by the very system that is intended to help them. Elected officials and industry leaders are unwilling or unable to break the impasse. Special interest groups and other power players have fragmented and thwarted efforts to produce significant, balanced and coordinated change. Nurses have generally not participated in the policy-making process in a role commensurate with their professional experience and expertise.

John Gardner coined a phrase, "the war of the parts against the whole" (a primary source for this phrase was not found), to describe the fragmentation of power that is so prevalent in our country today. Empowerment, originating in and epitomized by the various liberations of the 1960s, and the rise in grassroots politics, eventually gave way to a variety of special interest groups and the politics of advocacy, which devolved to the polarization of the citizenry that is so prevalent today. Another issue is individualism. Citizens of the United States have long valued individualism. Our history has not fostered a broad sense of caring and social responsibility (Chrislip and Larson,

1994). In many ways this individualism has thwarted needed civic action. In health care, our individual focus has prevented a rational, population-based focus on health.

Increasing complexity and fragmentation have led to a situation where authority, responsibility and the ability to act have become so diffuse that no one person or group can successfully address difficult issues. Lack of confidence in leaders and institutions is pervasive. Chrislip (n.d.) further contends that political leaders are not leading. Instead they “too often divide citizens, erode civil society, and undermine trust in the democratic ideal” (Chrislip, n.d., para 1).

Starting with a Specific Purpose

Failures and deficits in policy-making support the need for an alternative understanding and commitment to the development and continual improvement of policies which are responsive to all. Critical theory, particularly the work of Jurgen Habermas, provides an orientation characterized by a critical view of existing social structures and a call for revealing inequities for the purpose of producing beneficial change, especially for disenfranchised groups. Embracing a critical orientation for policy-making clearly telegraphs intentions to critique policies, raise consciousness and upset unequal power relationships (Patton, 2002). Deliberative democratic theory provides a basic framework for the evaluation of policy-making. Responsive program evaluation provides the means for producing needed change.

Critical Theory

Critical theory is a term coined by Max Horkheimer, one of the most influential and prominent members of the first generation of an interdisciplinary group of German scholars associated with the Institute for Social Research, which is now commonly referred to as the Frankfurt School. The scholars associated with the Frankfurt School,

either in Germany before the start of World War II or later in exile, primarily in the United States, were most interested in interpreting twentieth century history.

Basic Assumptions and Beliefs

The basic assumptions and tenets of critical theory, defined first by Horkheimer and his associates, are relevant to the discipline of nursing and particularly germane to policy-making. These assumptions and beliefs concern the nature of knowledge and truth, social order and the purpose of critical theory. The early critical theorists believed that knowledge is created, not discovered. Knowledge and truth are not universal. Instead, knowledge is contextual, historically situated and subjective. Truth is also subjective and reflective of values and ideology. The early critical theorists contended that societal order was reflective of power inequities that perpetuate race, class and gender oppression. The critical theorists focused on criticizing society's ideology and discovering contradictions in social arrangements. The central purpose of critical theory was explicitly directed at social change (Browne, 2000).

Habermas

Habermas is the leading second generation critical theorist from the Frankfurt School. Born in 1926, he lived under Nazi rule and is still an active writer. Using psychoanalysis as his springboard, with its purpose of developing an intersubjective relationship in which the therapist and patient breakdown communication barriers and make previously repressed motivations accessible to conscious understanding and control, Habermas conceived that critical social theory could do the same for society. This conception was based on the premise that society was also unable to recognize the true source of its history (Calhoun, 1996; Held, 1980). Habermas centered on communication as the means for liberating human and societal capacities (Held, 1980).

A basic understanding of the works of Habermas that are most pertinent to policy-making can be gained from his explication of the concepts of *rationality*, *communication*, *knowledge*, *truth* and the *public sphere*.

Rationality and communication. In his work, Habermas centered on communication and collective social action as the means for liberating human capacities (Calhoun, 1996; Stevens, 1989). Habermas's concept of *rationality*, which is explicitly linked to communication, differentiates his theories from his predecessors (Ray, 1992; Scrambler, 2001). Instead of subscribing to the idea of *instrumental rationality*, or the process of coordinating means to given ends, Habermas promoted *communicative rationality*, which is the art of reflecting on background assumptions, and opening these to questioning and negotiations, something instrumental rationalists ignore (Blackburn, 1996; Dryzek, 2002; Held, 1980; Ray, 1992; Scrambler, 2001).

Habermas viewed rationality as being actualized in freedom and justice, and manifested as non-coercion and consensus. In turn, rationality has two central values, autonomy and responsibility (Browne, 2000). Truth is linked to the idea of rational consensus attained through discourse. Standards of truth or evidence are always social and all meaning and truth must be interpreted within the context of history (Blackburn, 1996; Stevens, 1989).

According to Habermas, all modes of communication rely on rational capacity (Ray, 1992). In creating the Theory of Rational Communicative Action, Habermas looked at communicative competence in the context of a search for a comprehensive theory of rationality (Ray, 1992). The core of the Theory of Rational Communicative Action is language and the concept of an *ideal speech situation* where rationality is revealed through discourse. Discourse is "speech that suspends all conversational motives other than that of reaching an understanding, to be achieved by withholding

judgments about the superiority of certain values and the existence of certain states of affairs” (Agger, 1991, p. 166). Fundamental to the idea of an ideal speech situation is the belief that *all speech is oriented towards the idea of genuine, discursively achieved consensus which is rarely realized* (Held, 1980). Habermas advanced the idea that the “potential for reason resides centrally in the capacity to arrive at un-coerced agreements concerning validity claims on the basis of reasons open to intersubjective assessment” (Hoy & McCarthy, 1994, p. 39). According to Habermas, *the very structure of speech serves to foster a life where truth, freedom and justice are possible* (Held, 1980). Habermas has conceived all linguistic communication as having a background of consensus and an orientation to truth. He outlined four non-reducible validity claims for consensus. These claims include: the comprehensibility of the utterance; truth of the content; legitimacy or rightness of performative content; and the veracity of the speaker. Although ideal speech can be rarely achieved, if ever, *the ideal form of discourse can be used as a normative standard for a critique of distorted communication. Distorted communication is present in every communicative situation in which consensus is achieved under coercion* (Held, 1980).

Reflection is a central concern of Habermas. In creating the Theory of Rational Communicative Action, Habermas was addressing concerns that the dominance of positivism (which was bemoaned by the first generation exiles) led to diminished reflection. *To transcend systems of distorted communication, individuals must engage in critical reflection and criticism. Critical reflection and criticism lead to emancipation, which entails transcending systems of distorted communication* (Bronner, 2002; Browne, 1995; Held, 1980).

Before the Theory of Rational Communicative Action, the social paradigms of the *system* and *lifeworld* were separate and competitive. The system paradigm represents

the functional and structural view of society and the lifeworld paradigm represents interpretive view. In creating the Theory of Rational Communicative Theory, Habermas connected them with his schema of the three cognitive aspects of knowledge (Ray, 1992). This connection is essential because conflicts arise at the interface of the system and the lifeworld (Bronner, 2002; Ray, 1992; Scrambler, 2001).

Knowledge and truth. Certain beliefs about knowledge and truth are foundational to the work of Habermas. Like the first generation critical theorists, Habermas believes that knowledge is created, not discoverable or universal (Habermas, 1971). Unlike his predecessors, Habermas believes that the creation of interpersonal knowledge is grounded in language and that knowledge is socially constructed through human actions (Habermas, 1971). Habermas's idea of knowledge was derived through a combination of *empirical-analytical* and *historical-hermeneutic knowledge*; he reconciled the limitations he saw in the combination through a synthesis of the idea of *emancipatory knowledge* (Habermas, 1971; Holter, 1988). The three types of knowledge Habermas generated (also called cognitive interests) represent specific viewpoints for apprehending social reality (Habermas, 1971; Holter, 1988; Scrambler, 2001). Empirical-analytical knowledge (also called technical knowledge) represents knowing and controlling and is evident in the objective sciences. Technical knowledge includes the economic and administrative spheres. Technical discourse is functional and structural and it serves the purpose of prediction, confirmation and is useful in understanding purposeful rational social action. Historical-hermeneutic knowledge (also called practical knowledge) represents understanding and is prominent in the phenomenological sciences. This knowledge includes the social, cultural and personal spheres. The discourse of practical knowledge is interpretive. Practical knowledge facilitates the comprehension of social situations from the perspective and context of

another, which fosters mutual understanding. Emancipatory knowledge, represented by the critical sciences, is concerned with the power relationship between technical and practical knowledge and the power relationships that emanate from *systematically* distorted communication. Emancipatory knowledge fosters the process of reflection. The discourse of emancipatory knowledge is assertoric. The purpose of emancipatory knowledge is to remove distortions from understanding (Habermas, 1971; Holter, 1988; Ray, 1992; Scrambler, 2001; Stevens, 1989). Emancipatory knowledge involves “the fundamental transformation of individual and collective identities through liberation from previous constraints on communication and self-understanding” (Habermas, 1971, p. 310).

The public sphere. In Habermas’s schema, the public sphere is distinguished from the state and economy. Most other scholars do not separate out the economy. The public sphere is a conception of the arena that includes free speech, free press, town hall meetings and the educational system. The public sphere is where civil liberties reside and equality, common sense and liberty are put into practice (Ray, 1992; Scrambler & Martin, 2001). While his mentors were concerned with the subjectivity of the subject, Habermas was concerned with the institutions of advanced industrial society and the possibility of what he later called *democratic will formation*. Habermas was alarmed that the public sphere, once a vital political arena, was increasingly being defined by the same forces of instrumental reason exhibited by the state and economy. The loss of the moderating influence of the public sphere was Habermas’s primary concern. It was Habermas’s view that the public sphere could influence affairs of the state and society (Ray, 1992; Scrambler & Martin, 2001).

The pursuit of an ideal society. According to Habermas, knowledge of sociocultural phenomena requires an understanding of linguistics and context (Holter,

1988). Habermas envisions the ideal speech model as a model for ideal society. Power imbalances evident in society originate from systematically distorted communication. Habermas's goal is to uncover how people communicate to uncover distortions and constraints that impede free, equal and un-coerced participation in society (Stevens, 1989).

Deliberative Democracy

John Dryzek is an example of the new breed of theorists who are proponents of using critical theory to construct alternative solutions for dealing with repressive and exploitive social relations. Dryzek, who was born in the United Kingdom and educated in the United States, holds a PhD in Government and Politics. He is currently Head of the Social and Political Theory Program in the Research School of Social Sciences at the Australian National University. Dryzek advocates that the objective is to effect change, not just criticize. The means that Dryzek proposes for producing change is ingrained in his image of *deliberative democracy*.

Deliberative democracy refers to a concept of a democratic government that places *reasoned political discussion* at its center (Cooke, 2000). The importance of deliberation, the defining characteristic of deliberative democratic theory, lies in the *transformation*, not aggregation, of preferences (Dryzek, 2002; Squires, 2002).

Deliberation is a social process where participants are open to changes in preferences or judgment during the course of interaction. The point of deliberative democracy is to manufacture or create the common good, rather than discover or aggregate it.

Deliberative democracy is rational; decisions made are based on reasons given during the course of deliberation and not by simple aggregations, prejudices or demands (Dryzek, 2002; Squires, 2002).

“Deliberation is fundamentally a cognitive process, grounded in reasons, evidence, and the principles of valid argument” (House & Howe, 2000, p. 8). In the classic philosophical sense, deliberation is a process of decision-making. Deliberation is the source of *legitimacy* in democracies. Legitimate decisions do not represent the free will of all. Instead legitimate decisions represent the process of deliberation. Deliberation is inclusive (Dryzek, 2002; Squires, 2002). Although everyone may not agree with a legitimate decision, each participant understands how and why a outcome was reached (Squires, 2002). Unanimity is not required for each individual decision to be legitimate. Unanimity is required for major principles and rules from which decisions flow (Manin, 1897).

One way to appreciate the significance of the deliberative democratic model is to compare it with the model of advanced or contemporary liberal democracy. In advanced democracies, people give reasons to support their position and convert people to their side. Adherents are won over by bargaining, attacking and making alliances. Contemporary liberal democracy is a representative democracy, such as exists in the United States. There are competitive elections and, with them, substantial opportunity for pressure on the state (the term state is used interchangeably with government; it is the preferred term for many critical theorists, like Dryzek). In a contemporary liberal democracy, there is a tension between individual rights and the state. In the vision of a participatory or deliberative democracy, people give and listen to reasons in order to reach a consensus. Alliances and bargains are not made and voting is not the primary process for decision-making. Instead decisions are made through deliberation and the forging of a consensus. In a participatory democracy, politics are more pedagogical and discursive. The concern is public, rather than private, ends (Dryzek, 2002; Levinson, 2003).

A comparison of policy-making in contemporary liberal democracy and in participatory democracy may also be illuminating. In a liberal democracy, policy outcomes are highly sensitive to the relative power of different interest groups. Outcomes are too often characterized by brokered compromises that are not particularly responsive to concerns (Dryzek, 2002). In contrast, participatory democracy policy-making strives for consensus, while accepting the inevitability of conflict (Dryzek, 2002). The objective is the “reconstruction of private or partial interests into publicly defensible norms through sustained debate” (Dryzek, 1990, p. 124).

It is important to note that both models can exist together; they are not mutually exclusive. Indeed John Stuart Mill and John Dewey, both liberal democrats, advocated in their work for more participation. Unfortunately since then, participation has waned to the point that ordinary citizens are often excluded or disenfranchised (Dryzek, 2002).

Current deliberative democratic theory is a broad-based collection of ideas. There are two major tendencies in current discussions, one is critical and the other is most often characterized as liberal constitutionalism. One major distinction between the two is that liberal constitutionalism advocates see constitution-making as the venue for deliberation, while those with a critical orientation find this too constraining and believe that deliberation is important and essential in many other venues, particularly the public sphere (Dryzek, 2002). Dryzek is a proponent of a critically oriented deliberative democratic theory. There are many parallels between critical social theory, especially the strand exemplified by Habermas, and Dryzek’s conception of deliberative democracy. In deliberative democratic theory, legitimacy is “seen in terms of the ability or opportunity to participate in effective deliberation on the part of those subject to collective decisions;...claims on behalf of or against such decisions have to be justified to those people in terms that, on reflection, they are capable of accepting (Dryzek, 2002,

p. 1). Deliberation is a social communicative process where participants are “amenable to changing their judgments, preferences, and views during the course of interactions, which involve persuasion rather than coercion, manipulation, or deception” (Dryzek, 2002, p. 1).

Critical deliberative democrats and discourse theorists emphasize the importance of a free public sphere, separate from the state, as a place where citizens can freely deliberate and engage in democratic will formation (Charney, 1998). Public spheres are linked to the political concept of *civil society*. Civil society has traditionally been distinguished from the apparatus of the state. Civil society encompasses everything from non-governmental organizations to sports clubs, religious organizations and informal community groups. Historical examples of civil society include the polis, the Roman idea of *res publica*, the medieval free town and the New England town meeting (Bronner, 2002; Dryzek, 2002; Scrambler & Martin, 2001). Habermas described civil society as existing at the interface of the private and public spheres in the lifeworld.

Discourse in the public sphere is generally distinguished as dialogical, whereas decision-making in the state spheres is generally monological (Squires, 2002). Habermas though believes that public deliberation is important for both the formally organized processes of political decision-making *and* will formation. He also advocates that prevailing laws and policies must be open to objections formulated through will formation. Oppositional civil societies and public sphere are a source of democratic critique and renewal (Dryzek, 2002).

Dryzek (1990) has advocated that policy analysis that combines democratic and problem-solving rationality can become a force for emancipation. A mobilization of basic principles of deliberative democracy can produce more inclusive and rational policy-

making processes through the use of deliberation. From this thinking, the practice of responsive policy evaluation has emerged.

Responsive Policy Evaluation

Responsive policy evaluation is a broad rubric with multiple variants.

Robert E. Stake, an expert in case study methodology, began talking about responsive evaluation as early as 1975. Stake's approach emphasizes the importance of personalizing and humanizing evaluation processes. His suggestions include face-to-face contact with program participants and learning firsthand about diverse stakeholders' perspectives and experiences (Abma & Stake, 2001). Jennifer Greene (1997), an educational psychologist, has promoted a form of responsive evaluation that focuses on advocacy (Greene, 1997). Michael Patton is also an advocate of responsive evaluation techniques. Patton (2002), in outlining guidelines for responsive evaluation, emphasized the,

Identification of issues and concerns based on direct, face-to-face contact with people in and around the program; use of program documents to further identify important issues; direct personal observations of program activities before formally designing the evaluation to increase the evaluator's understanding of what is important in the program, and what can/should be evaluated; designing the evaluation based on issues that emerge in the preceding three steps, with the design to include continuing direct qualitative observations in naturalistic program setting; reporting information in direct personal contact through themes and portrayals that are easily understandable and rich with description; and matching information reports and reporting formats with different audiences (pp. 171-172)

House and Howe are proponents of responsive evaluation who have made direct links to deliberative democracy theory. They have created a framework for judging evaluations based on their potential for democratic deliberation. The justification for this framework, which links program evaluation to the larger sociopolitical and moral structures is the assertion that program evaluation can not be removed from the society in which it is embedded (House and Howe, 2000).

The framework of deliberative democratic evaluation created by House and Howe includes three requirements: *inclusion*, *dialogue* and *deliberation*. Genuine democratic program evaluation requires that interests of all stakeholder groups be central and that the interests of any relevant party be represented.

Research in Policy-Making

Policy-making is multi-dimensional and multi-faceted. There are many inputs to the policy-making process. Research is but one of a number of competing and often contradictory sources that inform and influence the process (Rist, 2000). Too often the role of research is relatively minor.

The process of policy-making is ongoing and constantly evolving. Even choosing not to act or ignoring problems is part of the process and a frequent outcome. There are basically two levels of decision-making in policy-making. The first major level is the establishment of broad parameters of government actions, such as the “War on Poverty” or Medicare, as initially proposed. The second level is the translation of intentions into policy and programmatic results, usually rules and regulations associated with a certain broadly defined legislative bill. Oftentimes the second level of policy-making is protracted and the linkage between the first and second levels is obscured. A contemporary example is the new patient confidentiality protections which were recently implemented five years after the passage of the authorizing legislation. There is a gap between what was being implemented and what was originally envisioned.

Research has the greatest utility within the second level (Rist, 2000). The second level involves the cycle of policy formulation, policy implementation and policy accountability (Rist, 2000). Policy accountability is the focus of this research. I have selected *fidelity* as the theme I will use to assess how access changed for enrollees in

Tennessee's managed care program. At the highest level, the question is whether or not policy objectives were met. Such a question allows for the study of both anticipated and unanticipated outcomes and an examination of influential forces. Changes in understanding and perceptions can be tracked. Social changes that resulted from policy implementation can also be examined. In looking at the outcomes of policy implementation, examination of the administrative and organizational structures that support the policy is important. Tracing and accounting for changes in the original goals and objectives of the policy are also critical (Rist, 2000).

Policies are dynamic and reflective of the socio-political milieu in which they exist. As such, funding levels and other indicators of support, leadership and staff stability and effectiveness and target population changes must be considered. Importantly, the degree of change that has occurred in the problem addressed by the policy must be assessed (Rist, 2000).

Osborne (1997) presented a schema for considering health policy. He stated that most analyses of health policy adopt a reactive view of the relationship between health and policy, meaning policy is viewed as a reaction to objective problems of health need and provision and conversely, health is viewed as the product of policy. He further explicated three reactive responses: a meliorist, critical, or anti-medical approaches. A meliorist approach looks at health policy in terms of the progressive adequacy of health knowledge and delivery. As increased knowledge ameliorates health problems and challenges, new ones emerge. A critical approach views policies as the outcomes of negotiations between different interest groups. An anti-medical approach claims that health policy creates its own concerns and that health problems are always contextual.

Program Evaluation

Program evaluation is a research technique that is used to clarify the intent of programs and improve program efficiency, effectiveness and responsiveness (Wholey, 1979). Program evaluation is an important part of the policy-making cycle. Program evaluation involves the assessment of one or more program domains, including program need, design, implementation and service delivery, impact or outcomes and efficiency (Rossi, Freeman & Lipsey, 1999).

Programs are defined as an “organized set of resources and activities directed toward a common set of goals” (Wholey, 1979, p. 1) and “an organized, planned and usually ongoing effort designed to ameliorate a social problem or improve social conditions” (Rossi, Freeman & Lipsey, 1999, p. 2). *Program evaluation* is “the measurement of program performance, the making of comparisons based on these measurements, and the use of resulting information in policy-making and program management” (Wholey, 1979, p. 1). Using a more focused social science orientation and expanding the definition to include contextual factors, Rossi, Freeman and Lipsey (1999) define program evaluation as “the use of social research procedures to systematically investigate the effectiveness of social intervention programs that is adapted to the political and organizational environments and designed to inform social actions in ways to improve social conditions” (p. 2). *Program performance* includes the “resources that go into the program, the program activities undertaken, and the outcomes and impacts of those program activities—including both progress towards program objectives and side effects on those served and on the environment in which the program operates” (Wholey, 1979, p. 1).

There is an important and demonstrated distinction between the formulation and adoption of a policy or program and the program implementation. Implementations are

influenced by administrative agencies, governmental and non-governmental, and program interpretation by the courts and regulating bodies. These distinctions are representative of the differences between policy *enactors*, usually legislators, and policy *executors*, the various administrators that implement and interpret policy (Mazmanian & Sabatier, 1983).

Formulation and implementation of policy are not always dichotomous. In *adaptive or interactive* implementations, adjustments are made by the various stakeholders between goals and objectives and strategies. Another approach, while not allowing for alterations in basic program goals or strategies, does recognize the need to modify goals and programs in recognition of various constraints and changing circumstances (Mazmanian & Sabatier, 1983). The dynamics of policy-making, which emphasizes continually changing contexts, demands and priorities, are best conceptualized in a model that includes policy formulation, implementation and reformulation in a continually evolving, fluid cycle.

The Integrative Paradigm

Deliberative democracy theory arose from critical social theory, which rather than being a theory is more of a philosophical orientation. Deliberative democracy is less conceptual than critical theory and as such is more specific and prescriptive. Responsive policy evaluation is even more specific. Tenets of critical social theory, deliberative democracy and responsive policy evaluation were used to create an integrative paradigm which was used to guide this study.

Figure 1 provides a graphic representation of the integrative paradigm that was created to guide this case study.



Figure 1: Integrative Paradigm for Policy-Making and Evaluation: Key Components

Conclusions

You can not separate health policy from the interconnected web of social policy. A holistic view of health recognizes the importance of social issues, such as violence, poverty and ethnic diversity. Health issues are broad-based societal issues, no one sector has the perspective, expertise or resources to achieve significant progress (most efforts to-date have been woefully inadequate). Just as it is important to look at the connectivity of social problems, it is important to look at the multiplicity of players that are needed to address problems. Also it is a priority to be responsive to citizens who have been disenfranchised by the current health care delivery system. Effective leadership in health care has generally been missing. This is especially true for nurses. The fact that nurses have been slow to engage in the development and evaluation of health policy should not prevent them from entering the debate as honest brokers and advocates of a more inclusive and broad-based process. The paradigm presented in this paper creates a segue for nurses to participate in policy-making activities, including research and activism.

Critical theory provided the general orientation for this study. This suggests that the proposed policy evaluation was oriented towards critiquing inequities in the design and delivery of health services and programs. It also suggests that the goal of policy evaluation is to produce change that will benefit the spectrum of stakeholders that programs impact. Just as Habermas has proposed that the ideal speech situation can be used as a model for the ideal social situation, it is suggested that the principles of deliberative democracy can be a model for policy-making.

CHAPTER 3: LITERATURE REVIEW

Introduction

In the span of only 15 years, the introduction of managed care and other market-based strategies from the private sector precipitated a transformation of the delivery of Medicaid services in the United States. These monumental changes remain poorly understood. To facilitate an understanding of this transformation, the history of various forces that contributed to the rapid growth of managed behavioral health care in the public sector will be reviewed. Understanding these forces and how they interacted requires an understanding of the definition and history of Medicaid and the prevailing political and social forces that influenced change over time, as well as an understanding of the concept of managed care.

The implementation of managed care in Tennessee's Medicaid program is an excellent public policy exemplar because of the far-reaching scope of the program and the ongoing development of the program. Opportunities still exist to influence the evaluations and improvement of the program. Additionally, an emphasis on a state health reform initiative is important because state reform has filled the void left by the failure of national health reform.

Tracing the History of Medicaid

Medicaid is one of the Great Society programs implemented in the mid-1960s during the administration of President Johnson. The program that was implemented and the one that exists today are vastly different. The original intent of the Medicaid program was to make federal matching funds available to the states to provide medical coverages for women, children and people over the age of 65 who were concurrently receiving welfare assistance (Rowland, Garfield & Elias, 2003).

Since the inception of Medicaid, there have been four major reform movements that have significantly changed the delivery of care to clients with behavioral health disorders. These are the community mental health movement of the 1960s, the deinstitutionalization that predominated in the 1970s, the widespread establishment of community support programs that characterized the 1980s and the rehabilitation and recovery movement that started in the 1990s and continues today. Concurrently, in the 1990s, some of the public purchasers of Medicaid services began to transform their purchasing practices. This transformation was made possible through the use of waiver authority granted through the Health Care Financing Administration (HCFA) which paved the way for the states to use commercial, risk-bearing managed care organizations (MCOs) (Croze, 2000).

The introduction of Medicaid, with the addition of alternative funding and the push for changes in the delivery of care, induced changes in the SMHAs. By the late 1970s the states had begun to contract with community mental health centers (CMHCs) and other non-profit service agencies. The role of the SMHAs changed from a constrained provider of primarily institutional services to a manager of a wide array of provided and contracted services and a variety of revenue sources, including the states, the federal government, grants and third party payments. The advent of managed care added new complexities to the role of the SMHAs.

Today, with more than 47 million low income beneficiaries, Medicaid is the nation's largest health insurance program (Rowland et al., 2003). Between just 1986 and 1999, Medicaid spending increased four-fold (Ridgely, Giard, & Shern, 1999). Within the enrolled population, approximately one-third of the beneficiaries have a disability, another one-third are children who meet age and income requirements and one-third are

pregnant women and caretakers of children eligible for Medicaid, as well as other low income people (Rowland et al., 2003).

There are two major classes of Medicaid beneficiaries. The largest group includes those who qualify because they are recipients of Aid to Families with Dependent Children (AFDC). The health care needs of this cohort are most similar to private sector plan enrollees (Holahan, Zuckerman, Evans & Rangarajan, 1998). Most of the mentally ill population qualifies because of a disability for which they are receiving Supplemental Security Income (SSI). Of the current SSI recipients, ages 18 to 64, 34% have a mental disorder. Four percent of all Medicaid beneficiaries qualified because of a mental illness. Since the late 1980s, SSI recipients with mental illness have been the fastest growing segment of the Medicaid population (Frank, Goldman & Hogan, 2003). The SSI population with the medically needy and Medicare recipients that are dually eligible for Medicaid are the most costly of the Medicaid beneficiaries (Holahan et al., 1998).

Medicaid mental health benefits are generally more comprehensive than other plans. Drug therapy, the mainstay of the current treatment of mental illness, is a covered expense under Medicaid (Rowland et al., 2003). The significance of this feature from both a cost and care perspective is highlighted by the twelve-fold increase in spending for psychotropic drugs in non-HMO plans between 1991 and the third quarter of 2000 (Frank et al., 2003). In addition, Medicaid does not have restrictions on certain levels of care, such as residential treatment or plan limits, which are both common in private plans. Medicaid also pays for services such as transportation assistance, supportive services in the home, respite care and case management (Rowland, et al., 2003); these are generally not covered in private plans.

Medicaid is essentially an open-ended entitlement program that is funded jointly by the federal and state governments. The states are attracted to Medicaid because the federal government pays 50 to 70% of expenditures, depending on the state. There is no cap on the federal government matches. Whatever the states spend on eligible beneficiaries, the federal government matches (Rowland et al., 2003). Because of this, states have been able to expand services for fewer state dollars and obtain financial assistance for services, such as institutional care, which previously were paid for solely with state funds (Frank et al., 2003). The expansion of services has precipitated changes in patterns of care, such as deinstitutionalization, and a concomitant increase in community-based care and the use of outpatient drugs.

Just as was true in the private sector, the growth of managed care in the public sector was the result of a complex convergence of forces. Medicaid did not originally pay for specialty mental health services. Mental health treatment costs were initially covered only under the general categories of physician and hospital care. With the move to deinstitutionalization in the 1970s during the Carter administration, the Government Accounting Office (GAO) recommended the optional addition of mental health services. Even today, most mental health benefits in Medicaid are provided by state choice, not by a program mandate (Hogan, 1999).

After the failure of President Clinton's proposed Health Security Act, the states became a new incubator for health reform, following the long-standing reform efforts spearheaded in the private sector by large employers. Other factors that contributed to reform in the states were the federal budget controversy of Clinton's first term and the escalation of the federal budget. Both prompted the Clinton administration to remove obstacles to the states managing Medicaid costs by accelerating the approval of waivers from the established Medicaid requirements. Waivers are used to broaden the covered

population and services. Waivers have also been used to reduce benefit levels and increase cost-sharing (Rowland et al., 2003). The growth of managed behavioral health care in the private sector led to the saturation of the market and declining profits for the managed behavioral health care organizations which, in turn, led to aggressive marketing and lobbying by these organizations. In addition, early successes in states, such as Massachusetts led to the surge in the growth of managed behavioral health care in Medicaid (Hogan, 1999). The Balanced Budget Act of 1997 also facilitated the growth in managed care by allowing the states to require mandatory enrollment in managed care and permitting states to contract with health plans that served populations composed entirely or predominantly of Medicaid enrollees (Hanson & Huskamp, 2001).

Along with these national trends, forces within the states were also fueling the growth. The implementation of managed behavioral health care in Washington and California supported existing mental health reform efforts. The addition of managed behavioral health care in the Medicaid programs of Tennessee, Oregon and Arizona was a part of a larger Medicaid reform effort and a move to managed care for other services. In Massachusetts and Utah, managed care was introduced for behavioral health care specifically to slow spending. Iowa and Nebraska added managed care to be able to expand services (Croze, 2000).

Looking at Managed Care

There is no doubt that managed care has changed the health care delivery system in the United States. Managed care has successfully controlled costs or leveled the rate of increases. However, the use of managed care has also caused a significant public backlash (Hogan, 1999). Despite its far-reaching influence, managed care is not a well-defined or researched phenomenon.

Ask ten people to define managed care and you will likely get ten different responses. In the past, the term managed care was reserved for the prepaid, capitated financial arrangements that characterized HMOs. As managed care has become more pervasive, this distinction is no longer valid. Managed care is a concept that is no longer tied to a single financial model. The essence of managed care is far more complex than putting providers at risk. Managed care is more about information systems and managed care tools such as utilization management (Rand Research Highlights, 2000). This shift was made possible by the highly competitive national market that emerged in the 1980s. Also the internal care and cost management processes in place at the health plans are now common across product lines, regardless of funding mechanisms. The organizational processes that were originally put in place in capitated plans are now recognized as effective strategies for enhancing customer retention, corporate reputation and identity and for facilitating success in a competitive marketplace (Goldman, McCulloch & Strum, 1998).

“The managed care revolution has been both uneven and incomplete” (Hogan, 1999, p.SP71). What we know as managed *care* is largely managed *costs*. Discounting provider fees and utilization control are relatively developed and tested. The same can not be said for care management and coordination (Durham, 1995; Hogan, 1999), which are inherent in a sophisticated definition of managed care.

Hogan (1999) claims that variations among geographic regions and payors are impeding a more complete development of managed care. In some cases, the variations in managed care are reflective of the market variations (Goldman et al., 1998). Managed care for Medicaid enrollees is often defined by the providers who are willing to serve the population. Often the pool of providers that are willing or able to assume risk in a state contract is very limited (Robinson & Clay, 2000). It is also noteworthy that

Medicaid is often the main revenue source for the providers that do care for Medicaid patients. Revenues from Medicaid represent 18% of state mental hospitals revenues, 24% of the revenues for psychiatric services within general hospitals and 24% of community-based providers revenue (Frank et al., 2003). Additionally, Medicaid was designed to accommodate state-by-state variation. Managed care has added to the proliferation of this variation (Goldman et al., 1998).

Variations are also attributable to program elements. Key elements that shape the type of managed care in Medicaid behavioral health care programs include which groups are eligible; whether enrollment is voluntary or mandatory; if the program is state-wide or regional; what percentage the Medicaid enrollees represent of the overall plan's enrollees; whether the program includes mental health care, care for substance abuse or both; and what other state mental health services are included (Goldman et al., 1998). Little is known about the relationship of these various elements to performance. Interestingly the managed behavioral health care programs present for Medicaid are generally referred to as *experimental* in the literature.

In the public sector, managed care is an even more ill-defined concept. Understanding of the concept comes mostly through case examples, an approach with limited usefulness because each managed care initiative is shaped by local forces and is constantly changing. Each managed care program in the public sector is defined by local structures, history, geography and politics (Hoge, Jacobs, Thakur & Griffith, 1999).

The debate about managed care in the United States can be quite polarized. Some see managed care as market-driven, efficient and accountable. Others are concerned with the negative effects on access and quality. A central point to each of these opinions is economics. Because managed care is often utilized as a cost control strategy and the benefits of care management are usually not featured, many are leery.

Despite this current reality, general managed care and managed behavioral health care have been shown to have a positive effect on various performance indicators. With managed behavioral health care, an overall increase in the use of mental health services, reduced costs and improved patient outcomes have been shown (Coleman et al., 2005; Mowbray, Grazier & Holter, 2002). Cost savings are greatest in the first year (Goldman et al., 1998; Ma & McGuire, 1998). Other studies have not shown that cost savings are sustained. Costs may actually increase because of added administrative costs associated with managed care plans (Haslanger & Tallon, 2004). Utilization patterns change with the implementation of managed behavioral health care. The biggest and most consistent change is a reduction in inpatient admissions and length of stay (Goldman et al., 1998; Ma & McGuire, 1998). General findings about the utilization of health care services have been limited because of the practice of enrolling non-disabled children and their parents in Medicaid managed care plans when these categories represent a minority of total Medicaid enrollees (Haslanger & Tallon, 2004).

Concerns about the effects of managed care on the delivery of mental health services are important when we consider the vulnerabilities of those individuals with mental illnesses are considered, especially severely and persistently mentally ill individuals. A stigma associated with mental illness is still pervasive in our society despite progress since the creation of Medicaid. Unfortunately there are still too many people who see mental illness as a character flaw, rather than a serious health problem (Hanson & Huskamp, 1998; Thomas & Leavitt, 2002).

Opinions about the use of managed care for Medicaid mental health services are mixed. Former providers fear unfair competition, the assumption of risk, a disregard for tradition, bureaucracy, greed and the diversion of care costs to administrative burden. They are concerned about the move from a *catchment* model to a model of *competition*.

Historically community providers were granted franchises for slices of public sector territory. They believe competition could destabilize a very fragile population, focuses on the wrong factors and gives for-profit entities entry to a market where they do not belong. Proponents of competition counter that competition challenges the status quo, may raise the bar on standards and expectations and allows the purchaser to evaluate the price and quality of service of several products. Public stakeholders have protested the added administrative costs associated with the MCOs and the profit motivation of most of these organizations (Croze, 2000).

Managed care often adds new services and products; these include utilization, case and quality management; various patient protections such as grievances and appeals processes; performance and outcome measures; and information management capabilities. The concern about the cost of these added capabilities can be mitigated if quality and effectiveness of service and care is improved. Iowa is a good case example of this point. With the approval of the managed mental health initiative, the legislature reduced the budget by 10%. Fifteen percent of the payments to the MCO were for administrative and care management, effectively reducing the amount of care dollars in the new arrangement by 25%. Even with these cost reductions, there was an expanded array of services and improvement in specific quality indicators (Croze, 2000). Just as managed care is erroneously identified with capitation, the transformation of Medicaid behavioral health care has been incorrectly identified as the privatization of the system. This label is inaccurate since providers have been an integral component of the behavioral health care delivery system for many years. Croze (2000) has taken the position that the profitization of the Medicaid system is the essence of the current transformation. Even this term is problematic. There have been public purchaser/private contractual arrangements that have demonstrated that it is the diligent

management of the medical loss ratio (the amount spent on direct care services), not the MCO's tax status that is the true measure (Croze, 2000).

According to a 1998 profile, 46 of the states had or were in the process of implementing managed behavioral health care; 10 of these had virtually no fee for service financing. Twenty-five of the states used risk-based contracts; of these 17 used carved-out programs. Two states had terminated managed behavioral health care programs (Croze, 2000).

Changing Roles of the States and MCOs

The introduction of managed care has required realignment in the roles of state agencies, behavioral health care providers and the health plans or MCOs. The experiences the SMHAs and other state agencies had working with very limited resources, dedicated public delivery systems and rigid bureaucracies are not readily transferable to working within the competitive managed care environment, using traditionally private MCOs and providers. Traditionally state governments either directly provided or contracted out mental health services to non-profit or quasi-governmental mental health centers while directly administering institutional programs, such as state mental hospitals. Now they have assumed a radically different role as they enter into multi-million dollar contracts with private companies who often assume financial risk (Robinson & Clay, 2000). In a very short period of time, state agencies have been transformed from managers of institutional services and negotiators with community agencies to contract managers of costly, complex and often capitated health plans in a very competitive and rapidly evolving market. From a policy perspective, the growth of Medicaid and the involvement of the federal government in care that historically has been shaped at the state and local level is also a major shift (Aday et al., 1999).

State purchasing agents are very different developmentally and otherwise than their private sector counterparts. Traditionally state agencies have been most focused on *process* metrics. The private sector has migrated to a focus on *outcome* measures, or a balance of process and outcome measures (Robinson & Clay, 2000). States make contracting decisions within a political context (Bailit & Burgess, 1999) that is not comparable to what is seen in the private sector.

The MCOs have also faced a steep learning curve. MCOs, with a legacy of working in the very different private marketplace, need new knowledge and capabilities as they adjust to new requirements and a significantly different patient population. MCOs have been forced to become familiar with a new type of purchaser and patient population. There is a marked difference between the privately insured clientele that the managed behavioral health care companies have experience with and the severely and persistently mentally ill patients with complex comorbidities that Medicaid covers. Public mental health authorities have spent several decades building support systems and developing the expertise needed to provide appropriate community-based care. There is a major difference in what the managed behavioral health care organizations have done and what the public mental health system has accomplished (Mechanic, 1999).

Commercially experienced behavioral health care organizations have underestimated the magnitude of system changes inherent in a move to managed care. There have been several instances of underpricing & lack of necessary resources to facilitate the change. Because of their purchasing clout, it is not uncommon for state purchasers to negotiate rates well below private market rates. This underpricing, in turn, precipitated a declining supply of providers and concerns about quality (Frank et al., 2003). The behavioral healthcare organizations have also had to contend with unrealistic expectations. Managed care is not a panacea for chronic problems. There

have been failures. Both North Carolina and Montana have abandoned previously implemented managed behavioral health care programs for their Medicaid beneficiaries (Croze, 2000). Tennessee's Medicaid carve-out for behavioral health care was fraught with start-up problems (Chang et al., 1998). Just as purchasers are gaining savvy in these new arrangements, so are the MCOs. The once aggressive companies have become more judicious. Some MCOs have modified their thinking about the desirability of public sector business and they have become more discriminatory in their bids. When the state of Arkansas released a request for proposals for their children's behavioral health care program, only one vendor responded (Croze, 2000). Likewise, there has been a move away from capitation.

There were early Medicaid managed behavioral health care successes, at least in terms of reduced costs. Colorado saved \$6.5 million in the first year of their program. Massachusetts saved \$47 million, which was a 22% reduction (Coleman et al., 2005; Croze, 2000; Ma & McGuire, 1998). Since that time costs have been difficult to sustain. Early savings, derived from use of a gatekeeper and provider discounts, are more easily realized than savings associated with improved quality, coordination of care and reductions in practice variation (Coleman et al., 2005). In other instances costs have been reduced, but only because of reduced access to services and cost-shifting to other public agencies. The price for these savings has also been high member dissatisfaction (Heflinger & Northrup, 2000).

Corporate buyers of health care precipitated a major change in the buying process when they began to purchase health care services using the same strategies that had long been employed for the acquisition of other goods and services. Their transition to a more systematic, disciplined and competitive buying process caused a major shift from a revenue-generating/ provider dominated system to a cost-control/

payor dominated system (Lindenmuth & Burger, 1998). As states begin to utilize the competitive purchasing model refined in the corporate world, there will be a steep learning curve and the possibility of significant variations in what the states will experience given the wide range of their needs and resources.

Before managed care, the providers of public mental health services worked collaboratively with state mental health authorities. Many of the providers utilized existed solely to serve the Medicaid and other state beneficiaries. There was little competition for contracts (Bailit & Burgess, 1999).

Organizational Capabilities and Learning

Health plans can take many organizational forms (see Appendix A). On one end of the continuum are staff model Health Maintenance Organizations (HMOs), which are fully accountable for all aspects of delivering and managing care. A close derivative of the staff model HMO is group model HMOs where the health plan and the independent provider groups are integrated to various degrees. At the other end of the spectrum are “virtual” health plans who basically serve as an intermediary between purchaser and providers. In these types of arrangements, the level of care management varies considerably. Preferred provider organizations (PPOs) and Point of Service (POS) plans are examples of virtual health plans.

Carve-outs are a commonly used method for the provision of behavioral health care services. A carve-out is a managed care approach in which a separate system of care is contracted for a distinct set of services and/or a defined population (Feldman, 1998; Robinson & Clay, 2000). Often a defining characteristic of carve-outs is independence. Carve-outs are “freestanding organizations that are not subunits of, nor financially dependent upon, a general health care organization” (Feldman, 1998, p. SP59). Carve-outs can take three primary forms (Appendix B). In some instances, the

purchaser contracts directly with a specialty organization. In other instances, the health plan, with which the purchaser has a contractual relationship, sub-contracts with the specialty organization (Frank et al., 2003; Hodgkin, Horgan, Garnick, Merrick & Goldin, 2000). In some cases, the health plan creates a specialty department within the organization which, by definition, is not independent or a true carve-out. “There are still diverging opinions and ongoing debate about the relative merits of carve-out versus carve-in (integrated) behavioral health care” (Findlay, 1999, p. 119). Carve-outs assume varying degrees of risk and use a variety of strategies to manage the cost and utilization of services. For Medicaid managed behavioral health care, states have contracted with mainstream carve-outs or carve-outs created primarily to service Medicaid contracts. Fragmentation or poor coordination between primary and behavioral health care services is a concern about carve-outs (Tietelbaum, Rosenbaum, Burgess & DeCourcy, 1998).

Fundamentally, health plans manage costs and quality. These can be conflicting objectives. In addition, three of the major stakeholders--purchasers, the health plans and patients--have different priorities. Typically health plans want to provide appropriate, evidence-based care and avoid inappropriate care, but they must do this in a highly competitive and financially constrained environment. Patients often place quality above costs and generally do not understand, and may not accept, evidence-based care recommendations. Requests for specific medications or treatments are not uncommon. Purchasers are generally cost-oriented, yet many of their requirements cause increased administrative burden and costs. Within this environment, plans implement care management and administrative processes to achieve the varying objectives. These processes do not inherently manage costs and

quality; it is how these processes are implemented and managed that create the value difference (Wholey et al., 2003).

Health plans generally manage in three ways. Management strategies include selective contracting; the utilization of programs that support the care delivered by various providers; and the implementation of protocols and management processes that affect the provision and use of health care services. Importantly, health plans also manage information (Wholey et al., 2003).

Adding to this complexity is the fact that it is ultimately the management and delivery of care that defines the plan's effectiveness, not just the plan model. A high-functioning POS plan may perform better than some group model HMOs. A plan's performance is also circumstantial. A plan that may perform well with one population may not perform with another. Hogan (1999) states that "public sector managed behavioral health care is not monolithic; when done well it produces positive results, when done poorly, it does not" (p.33). Also, it is not uncommon for health plans to contract out specific administrative and care management functions, such as claims processing or case management and disease management.

Public agencies have often struggled to acquire the tools needed to effectively manage the delivery of care. Risk-based contracts increase the needs for information and administrative systems (Croze, 2000). Information management is the currency of the managed care industry. Information management drives care management and supports performance-based contracting. Few states have the financial resources or the motivation to create and maintain the information technology needed to support managed care.

Performance generally improves with experience. Organizational learning defines evolving industries, such as managed behavioral health care which came into

existence less than 20 years ago (Argote & Epple, 1990; Strum, 1999). Strum showed that, when controlling for other factors, the initial cost savings achieved by private employers with the move to managed behavioral health care were sustained through organizational learning.

Where Are We Today?

In 2002, the states' tax revenue declined by six percent. This annual decline was the first since World War II. Overall, the states faced a \$37 billion deficit in fiscal year 2002. This deficit was expected to grow to \$70 billion by 2004. This trend has reinforced the states' strategy to replace programs paid for with state-only dollars with those supported by matching funds (Rowland et al., 2003).

"State fiscal conditions rebounded notably in fiscal 2005" (National Governors Association, 2005 December, p. ix). During this time revenue increased strongly. Estimates for 2006 are more modest. Growth in revenue is expected to slow and the pressure to increase expenditures that previously were cut is high (National Governors Association). As 2005 closed, United States House and Senate negotiators were beginning to wrestle with how to restrain federal spending for Medicaid, as called for in President Bush's 2006 budget (New York Times, 2005, December 12). Any cut will have a significant impact on state budgets.

Even though federal dollars are used to offset the cost of state programs, Medicaid will continue to be a target for state budget reductions. Medicaid is often the second most costly line item in a state budget, behind education. For fiscal year 2003, 45 states instituted cost-containment mechanisms for prescription drugs in their Medicaid programs, 37 froze or reduced payments to providers and MCOs and 25% reduced benefits and eligibility. Unfortunately, the reductions disproportionately affected people with mental illnesses. People with mental illnesses, who represent 11% of the

total Medicaid population, account for one-third of the high cost beneficiaries. People with mental illness often have complex health needs that often require very costly drugs (Rowland et al., 2003).

Competition, which is nourished by choice and supports purchaser efforts to negotiate strong performance-based contracts, has been impacted by the consolidation of the managed behavioral health care industry that has predominated in recent years. There is now a tremendous concentration among the mostly for-profit companies. In 1998 the top two managed behavioral health care companies had a combined market share of 48.9% and the top five had a 68.6% share (Findlay, 1999).

Public Mental Health Services

Since colonial times, there have been multiple efforts directed at the provision of public mental health services. The implementation and evolution of Medicaid has precipitated the most significant changes since the emergence of public mental health care. Historically changes have centered on the delivery system for care, the financing of care and lately on the introduction of managed care, which influences delivery systems and the financing of care.

Most recently and prior to the inception of Medicaid, the states provided the majority of mental health services through entities called state mental health authorities, or SMHAS. SMHAS, primarily accountable for managing care for patients with serious mental disorders, traditionally operated on a very limited budget of state funds. The most common model for the delivery of services was the direct provision of services, with a predominance of hospital-based care (Essock & Goldman, 1995).

Looking at TennCare

TennCare is the managed Medicaid program in Tennessee. TennCare was developed primarily because of fiscal concerns in the state. Between fiscal year (FY)

1987 and FY 1993, Medicaid expenditures nearly tripled. In addition, a strategy used by Tennessee to finance hospital payments for indigent care was curtailed by the federal government. In turn, Tennessee levied a 6.75% gross receipts tax on hospital and professional services. When the Tennessee Hospital Association and others threatened legal action, the state concluded that Medicaid would have to be radically changed and alternative revenue services found (Conover & Davies, 2000; Rocha & Kabalka, 1999).

In early 1993, Governor Ned McWherter presented a draft plan for Medicaid reform to the General Assembly. After limited debate and no public hearings, a detailed plan was developed and submitted to HCFA on June 16, 1993. HCFA approved the waiver November 18, 1993, and TennCare was implemented January 1, 1994 (Matthews, 2000).

TennCare was designed to expand coverages to low-income people and rely on private MCOs to manage the health care benefits of the newly eligible beneficiaries and those traditionally covered by Medicaid. The developers of Medicaid intended to finance the expansion of the state's Medicaid program by saving money through managed care efficiencies, by converting federal and state payments to hospitals for indigent care to payments for insurance coverage and by adding new state revenues (Conover & Davies, 2000).

Initially there was a partial carve-out of behavioral health care services to five state-run regional mental health hospitals and 26 community mental health centers for the seriously and persistently mentally ill (SPMI) adults and seriously emotionally disturbed (SED) children. All other behavioral health care benefits were initially provided by the established MCOs (Conover & Davies, 2000; Saunders & Heflinger, 2003).

In November 1994, HCFA approved a waiver that integrated care for SPMI adults and SED children into the MCOs with the requirement that the MCOs contract with

approved MBHC companies. The implementation of this program was delayed until July 1, 1996, to accommodate a change in governors. Effective this date, all behavioral health care services for all TennCare enrollees were provided through full carve-out programs with two statewide MBHC companies (Conover & Davies, 2000).

Serious Emotional Disorders

Among the TennCare enrollees, there is a cohort of children and adolescents with serious emotional disorders or SED. SED is a term used in education to describe students with any type of behavioral, emotional or mental health disorder. Disorders can range from mental health problems, such as depression, Attention Deficit Hyperactivity Disorder (ADHD) or obsessive-compulsive disorders, to developmental disorders, such as autism (University of Illinois, Chicago, n.d.). A SED diagnosis requires a level of clinical symptoms consistent with the assignment of a diagnosis *and* impairment in psychosocial functioning (Heflinger, 2002).

It is estimated that there are 3.5 million children and adolescents with SED in the United States (University of Illinois, Chicago, n.d.). Dr. Craig Anne Heflinger and her associates at Vanderbilt University have studied children and adolescents with SED. One study conducted by Heflinger (2002) projected that 26 percent of all TennCare school-aged children meet SED criteria; another 21 percent have clinical symptoms *or* functional impairment, meaning almost one-half (47 percent) have significant behavioral health problems.

A 2002 literature review (Saunders & Heflinger, 2003) showed that children enrolled in public managed behavioral health care programs, primarily in Massachusetts, North Carolina and Colorado, had improved overall access; reduced use of inpatient services and increased use of case management services, but the programs had questionable effects on children's use of outpatient services.

In a separate multi-state analysis of secondary data (Heflinger, Simpkins, Scholle & Kelleher, 2004), researchers analyzed parent/caregiver satisfaction with their child's Medicaid plan and behavioral care providers. The sample was taken from three states: Tennessee, which has managed care as the only option; Mississippi, which has traditional fee-for-service care only; and Pennsylvania, which has both managed care and traditional. The sample included children enrolled in Medicaid, ages 4-17, with a diagnosis of SED. In a contradiction to prior studies, the researchers found that parents/caregivers of children enrolled in a managed care plan were less satisfied than those enrolled in a traditional plan. The difference among the plan types was reflective of satisfaction with the MCO characteristics, not the provider characteristics.

Conclusions

The TennCare program, a major public policy program designed to leverage certain strategic advantages of managed care practices from the private sector, offers a unique opportunity to study the phenomenon of Medicaid managed care. There are conflicting conclusions from the research in the private sector about the efficacy of managed care. Data from the public sector is still emerging. There are contradictions in findings. Often studies have been limited in their approach or scope.

Heflinger and her associates (and others) have studied children and adolescents with SED extensively. They have been active in the evaluation of TennCare. Despite the work done by Heflinger and others, there are still gaps in our understanding of TennCare and the efficacy of care received by school-aged children with SED, as well as the impact of managed behavioral health care in the public sector.

This case study differs from other examinations of TennCare, particularly those of Heflinger and her associates, because case study research goes beyond analysis of cost and utilization indicators and other one-dimensional views. A case study approach

facilitates an understanding of the context in which the managed behavioral health care program of TennCare was developed, implemented and exists. Because the case study is about a particular public policy initiative, the study will highlight the situational aspects of the impact of the program. Seeking the perspectives and experiences of multiple stakeholders acknowledges the absence of a singular or one-dimensional understanding and affirms the importance of inclusion and deliberation in the process of policy-making. This approach supports a richer understanding. A case study, which is holistic and naturalistic, is conceptually aligned with a nursing conception of health. The concluding section of the case report will highlight opportunities to advocate on behalf of people served by TennCare's managed behavioral health care program.

CHAPTER 4: METHODOLOGY

Introduction

A single case study design was employed to evaluate the *fidelity* of Tennessee's Medicaid managed behavioral health care program to selected original strategic aims. In this chapter, the methodological approaches and specific strategies for the study will be described.

"Fidelity implies strict and continuing faithfulness to an obligation, trust or duty" (Merriam-Webster's, 2000). Program fidelity is a broad measurement of how true the implemented program is to the intended program (Heflinger & Northrup, 2000). According to Lowenstien & Grites (1993), "fidelity commands us to live up to commitments that we have made, both explicitly and implicitly" (p. 54).

Case study research entails an *in-depth, multi-faceted* exploration of a single social phenomenon. Phenomena that have been studied using this approach include programs such as TennCare, events, activities, processes and one or more individuals. According to Yin (2003), "a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident" (p. 13). A hallmark of case studies is that *detailed information* is collected from *multiple data sources* (Creswell, 2003; Feagin, Orum, & Sjoberg, 1991; Stake, 2000; Yin, 1997 & 2003). Additionally case studies are characterized by data richness that results from the examination of a phenomenon in its real life context, the field collection of data (although this is not absolute) and more variables of interest than data points (Yin, 1997). Case study evaluation strategies have been used to investigate important practical and policy questions in health care (Keen & Packwood, 1995) by inherently dealing with a wide variety of evidence that other strategies do not (Yin, 2003). The contextual nature

of programmatic decisions, their linkages and evolution is best understood through this examination of multiple data sources and perspectives. Thus, participants representing the variety of stakeholders, what Yin (2003) call “key respondents” (p. 90), were selected for interviewing as a purposive sample (Creswell, 2003; Polit & Beck, 2004).

Fundamental to the case study is the idea that people have complex social and public relationships. Case studies offer a unique opportunity to examine the relationships and patterns that define social situations. Case studies permit the grounding of observations and concepts in a naturalistic way. Case studies are holistic in that they provide information from a number of sources over time, which adds the dimensions of time and history (Feagin, Orim & Sjoberg, 1991). Case studies are valuable in that they “deal with reality beyond appearances, with contradictions and the dialectical nature of social life, as well as with a whole that is much more than the sum of its parts (Sjoberg, Williams, Vaughn & Sjoberg, 1991, p. 39). “Well-crafted case studies can tell the stories behind the numbers, capture unintended impacts and ripple effects and illuminate dimensions of desired outcomes that are difficult to quantify (Patton, 2002, p. 152).

A case study is not a methodological choice. Instead a case study is a choice of what is to be studied. Case study refers to both a process and the product of the process.

Approach

What is a Case?

Cases are *units of analysis* (Patton, 2002). A case is also a *bounded system*. “A case has working parts; it is purposive; it often has a self” (Stake, 2000, p. 436). In addition, a case is an integrated system with patterned behavior in which coherence and

sequence are prominent (Stake, 2000). A case is simply “one among others” (Stake, 2000, p. 436) and with case study research we concentrate on that one.

“A case is a complex entity operating within a number of contexts-physical, economic, ethical, aesthetic and so on” (Stake, 2000, pp. 339-340). To understand the case of TennCare, detailed descriptions and analyses of the nature of the program; the program’s historical background; the setting of the program; important contexts, such as economic, political and legal influences; and the major stakeholders will need to be constructed. These contextual influences and complex interactions necessitate a holistic understanding of the program, what Stake calls the “coincidence of events” (p. 440), and the recognition that some are purposive, some situational and most inter-related.

The proposed case is the TennCare *program*. TennCare is a public policy exemplar worthy of study because the program is still evolving and there is an opportunity to influence the improvement of the program through an evaluation of the program implementation. The reality that the states are incubators of health reform, rather than the federal government, is what makes this case so compelling.

Framing the Case

Most case studies are about the particular, not about the general. The descriptive case study conducted is a type of case study called an *instrument case study* (Stake, 2000). According to Stake, an instrument case study is conducted to provide insight into an issue or to redraw a generalization. Although the focus was TennCare, the case study may be informative more generally about managed care in the public sector. With an instrument case study, it may be possible to forge some generalizations about the phenomenon being studied. As such, the case of TennCare has been examined to not only understand the specific program, but also to provide insight into the broader issue of managed care in Medicaid.

TennCare is an important public policy initiative. This case study should inform the debate about the use of managed care strategies for vulnerable populations. The generation of public policy, referred to as policy-making, is multidimensional and multifaceted. Policy-making is a highly contextual process, which ebbs and flows, with multiple stakeholders. The paradigm that most have of policy-making is one of *event decision-making*. This paradigm is erroneous. The more accurate paradigm is one of *process decision-making* (Rist, 2000).

Research is just one of a number of forces that influence and inform the process of policy-making. All too often, research has minimal influence. One way to increase the utility and importance of policy research is to abandon the event decision-making paradigm and recognize that research can best be leveraged to *enlighten* policy over time, rather than *engineer* at its inception. Case study research can help policy-makers and other stakeholders achieve contextual understanding that is essential when looking at intricate social policy and its effects (Rist, 2000).

Scope of the Case Study

The original intent was to limit the case to the study of access to care for school-aged children and adolescents (ages 14-17 years) with serious emotional disorders (SED) enrolled in TennCare. The study focus shifted to the more general issue of managed care in the TennCare program when it became apparent that the majority of people interviewed did not focus on this particular population as a priority in their interviews nor were they conversant about the specifics of care delivery for this specific cohort within TennCare. This adjustment in focus is consistent with qualitative research philosophy that informants will emphasize what is most important to them and that the researcher should follow the direction taken by study participants. Data and analysis about the delivery of mental health services in general, and to children and adolescents

with behavioral health problems specifically, are included as an integral part of this case study, however the focus of this study is now more inclusive than first conceived.

Interviews with individuals in management and supervisory positions in provider organizations were limited to those that provide services in the East Tennessee Human Resources Agency (ETHRA) catchment area. This catchment area includes the sixteen county area of Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union.

One of the challenges of case study research is the lure of wanting to tell the whole story. This is not possible. "The whole story excels anyone's knowing, anyone's telling" (Stake, 2000, p. 441). The case study was further delimited by the establishment and use of general opening questions for each category of informants and by pursuing topics and issues that pertained to the three themes that emerged in early interviews and predominated with later informants and by pursuing additional details, reflections and perspectives about these themes. Throughout the data collection and analysis (which overlapped), correspondence between the events still unfolding in TennCare, various observations and findings gleaned from informants and the review of documents was sought. Emergent issues and these were pursued without regard to pre-conceived expectations or understandings.

Program Evaluations

Evaluation of outcomes is an important goal in the analysis of the effectiveness of a public policy program such as TennCare. Primary to any evaluation of outcomes is the determination of whether the program is operating according to design (Patton, 2002). Program evaluation procedures informed the proposed case study. The aim of program evaluation is to inform and improve services, programs, policies and public discourse (Greene, 2000). Although basic tenets of the process of program evaluation

were used to inform the researcher, this case study is not a true program evaluation. However, a case study that evaluates the implementation of a public policy program, such as TennCare, has the elements of a good story, telling “what happened, when, to whom and with what consequences” (Patton , 2002, p. 10).

With public policy program evaluation, deviations from intentions are common and natural. Programs are implemented incrementally (this was true for TennCare). Furthermore, programs are influenced by local conditions such as the availability of MCOs and the willingness of providers to become involved, and by organizational dynamics (including the changes in governors, other elected and appointed state officials, and Federal officials, that occurred since the inception of TennCare, as well as MCO vicissitudes). In Tennessee the continuing financial crisis has had a significant impact on how the program was implemented and now managed.

Methodological Specifics

Data Sources

Consistent with case study research, multiple data sources were utilized. Generally, in case study research, there are six sources of evidence: documents, archival records, interviews, direct observations, participant-observations and physical artifacts (Yin, 2003). This case study of TennCare included the review and analysis of documents and interview transcripts. Documents that were reviewed included: newspaper articles; correspondences, including e-mails; journal articles; the original TennCare waiver application; the TennCare Partners waiver application; judicial decrees; legislative documents; state, consultant, independent and task force reports; other case studies. Informants that were interviewed included: two former Governors of Tennessee; a former HCFA Administrator; a variety of state government executives, advocates and managed care executives; and administrators, managers and caregivers

from two community mental health centers, one integrated community health center and one Federally-qualified community clinic.

Interview Specifics

Interviews were conducted during a five month period in 2005. Twenty-six individuals were interviewed in twenty-one separate interviews. A pilot interview was also conducted. A profile of study informants and interview specifics appears in the following section.

Open-ended interview techniques were used to assess the perspective of the person being interviewed (Patton, 2002). A presumption of this approach and key to the study was that the perspectives of the complement of interviewees are “meaningful, knowable, and able to be made explicit” (Patton, 2002, p. 341). Interviews were used to capture a variety of perspectives and experiences. Interviews were arranged in advance and all participants knew the general focus of the interview. Rather than following a rigid interview protocol, the researcher maintained flexibility to be able to pursue whatever direction seemed appropriate. Many questions flowed from the immediate context; others resulted from the ongoing document review. As such, a predetermined set of questions was not possible. This approach allowed the researcher to be highly responsive to individual differences and perspectives. It is exactly these rich and contextual differences that the researcher was seeking and obtained. Interviewees were free, of course, to decline answering questions if they chose. Few did. Interviews with all identified informants and the majority of anonymous ones were one hour or more in length; some of the interviews were significantly longer than one hour.

Profile of Study Respondents and Interview Details

Informants were divided into two broad classes. The first group consisted of public officials and senior level managers of BHO and provider organizations who did not

have accountability for direct patient care. The second group consisted of mid-level managers and supervisors in provider organizations and other informants that asked that their identity be protected. Sixteen of the interviewees are identified; the identity of ten of the interviewees is protected.

Table 1 provides a description of all identified study informants. In addition a more detailed description of selected key informants follows.

Ned Ray McWherter-46th Governor of Tennessee. Governor McWherter is a political legend to many in the state of Tennessee and throughout the south. He was first elected to the Tennessee House of Representatives in 1968. Prior to being elected the 46th Governor of Tennessee in 1897, McWherter served as a popular Speaker of the House under four Governors, Buford Ellington, Winfield Dunn, Ray Blanton and Lamar Alexander. McWherter was elected Speaker of the House after only two terms in the State Legislature and he served longer in the position than anyone else in Tennessee history. As Speaker of the House, McWherter worked primarily with Republicans; two of the four Governors McWherter served under were Republicans; only Ray Blanton was a Democrat (Tennessee Encyclopedia of History & Culture, n.d.; University of Tennessee-Memphis, n.d.; Wikipedia, n.d. b).

Governor McWherter is remembered as a progressive and honest leader (Wikipedia, n.d. b). As Governor, McWherter appointed the first African American committee chairman in the south. Other noteworthy accomplishments include assisting women legislators gain leadership roles in state government and the passage of the state "Sunshine Law". McWherter also worked closely with his predecessor as Governor, Lamar Alexander in reforming and enhancing the prison and education systems in the state (Tennessee Encyclopedia of History & Culture, n.d.; Wikipedia, n.d. b). During his

Table 1: Profile of Identified Study Informants

Interviewee	Profile
Former Tennessee Governors	
Ned Ray McWherter	Democratic Governor of Tennessee who served from 1987-1995.
Don Sundquist	Republican Governor of Tennessee from 1995-2003.
Former Tennessee Commissioners	
David Manning	Commissioner of Finance and Administration during the entire McWherter administration. Currently Director of Finance for Metro Nashville.
Manny Martins	Director of Medicaid Bureau during the McWherter administration and then TennCare Director under three governors. Retired from state government in July 2005.
Dr. Warren Neel	Tennessee Commissioner of Finance and Administration during the Sundquist administration from 2000-2003. Currently Executive Director of the University of Tennessee's Corporate Governance Center.
Former Federal Commissioners	
Dr. Bruce Vladeck	Administrator of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services from 1993-1997, directing the Medicare and Medicaid programs. Currently a Principal in the Health Sciences Advisory Services practice of Ernst & Young LLP, and East Coast Director of its Academic Medical Center service line.

Table 1: Continued

Interviewee	Profile
Representatives from the Advocate Community	
Gordon Bonnyman	Co-founder of the Tennessee Justice Center (TJC); has served as the organization's Executive Director since the organization's inception. TJC is a non-profit public interest law firm which serves poor citizens of the state of Tennessee. A key figure in the development of TennCare and actively involved in the program since.
Tony Garr	Executive Director of the Tennessee Health Care Campaign, a state-wide advocacy organization committed to affordable, accessible and quality health care for all Tennesseans. Involved since before the inception of TennCare and currently as an advocate and coordinator of grassroots efforts.
Charlotte Bryson	Executive Director of Tennessee Voices for Children (TVC) since 1995. TVC is an organization formally organized in 1990 as a statewide coalition of individuals, agencies and organizations working together to promote children's mental health service. Remains active with efforts to promote the care of children throughout the state.
Dick Blackburn	Executive Director of Tennessee Association of Mental Health Organizations (TAMHO), a state-wide trade association representing primarily community mental health centers (CMHCs).

Table 1: Continued

Interviewee	Profile
Kelly Lang-Ramirez	Associate Executive Director of TAMHO at the time of interview; has since left the organization.
BHO Representatives	
Dr. Rene Lerer	President and Chief Operating Officer of Magellan Health Services
Dr. Russ Petrella	Chief Operating Officer of their Public Sector Division of Magellan Health Services; President of Tennessee Behavioral Health and Premier
Ann Boughtin	Director of the Service Center and General Manager of Magellan Health Services for the TennCare Partners Program at the time of the interview; has since left the organization.
Executives of Provider Organizations	
Brian Buck	Chief Operating Officer of Ridgeview, a community mental health center with facilities in five counties in east Tennessee
Glenda Sublett	Administrator and Vice President for Peninsula Hospital; Peninsula Hospital provides mental health and alcohol/drug crisis stabilization services for adults, adolescents and children

tenure, McWherter created a legacy of balanced budgets, new roads, a streamlined state government and increased funding for public education (Tennessee Encyclopedia of History & Culture, n.d.).

McWherter was a popular Governor who was re-elected to a second term with almost two-thirds of the vote. In his bid for a second term, McWherter was supported, tacitly and fairly openly, by many prominent Tennessee Republicans. There is general consensus that had it been permitted and McWherter desired it (he did not), McWherter could have easily won a third term (Wikipedia, n.d.).

Governor McWherter's belief in the need for health care was born of his own experience growing up poor as a sharecropper's son. Despite being a millionaire by the time he was elected Governor, McWherter never forgot his roots. When I met with McWherter he related a story that I later learned was somewhat legendary. He said,

[President] Clinton used to say, "Keep your hand on your pocketbook. Here comes the poor guy." I was born on a round oak table in my mother and daddy's kitchen. That's the way people were born back then in the country...I think [when] people need health care services...we need to make them available and when you're really in trouble, you need the latest technology that money can buy...I believe a poor person's entitled to the same as a rich person (transcript of a recorded interview, 2005, February 2, lines 941-950).

Governor McWherter is not a partisan man. Rather than being divisive, he is focused on finding common ground among diverse parties. This is the foundation of his success as a legislator, later as Governor and finally as senior statesman of the Democratic Party. Bill Clinton has said, "He is a very good man, and he relate[s] well to everyone. These so-called red and blue divisions we have today are more about culture and clan than real issues" (Hillman, 2004, December 26b). A young politician who benefited from his tutelage said of McWherter, "I was amazed at how he could bring people who didn't want to talk to each other into his office and he would work things out and achieve a consensus. That was the best education, to sit in a corner of his office

and watch him interacting with people” (Matt Kisber as quoted in Hillman, 2004, December 26b). Lois DeBerry, a prominent African-American and second-ranking member of the Tennessee House of Representatives said of McWherter,

He erased lines of race, party affiliation...Ned was just the real test of a politician. He really removed partisanship from the legislature. He believes in working for the common good, and it doesn't matter if you're Republican or Democrat. That's the kind of attitude he has. When you can walk with kings and queens, and you keep in touch with the ordinary person-he is that kind of man. You know, you can get along with anybody when you have fairness, values and integrity, and he does (Hillman, 2004, December 26b).

Governor McWherter is a big man with a large presence. He fills a room and you are drawn to him. He is kind, warm, gracious and gregarious. He is very approachable with little pretense. The simplicity of Governor McWherter's presentation of his ideas and speech belie the complexity and tenacity of his vision. Bill Clinton has said, "He'll act like 'country come in,' but he's smart as the devil" (Hillman, 2004, December 26b).

I was impressed with his abiding faith in the goodness of people and his optimistic outlook. McWherter clearly sees the possibilities in situations, instead of the obstacles. Former President Jimmy Carter said of McWherter,

We're similar in our style, which is based on the bedrock of where we came from. We both come from small towns, and we grew up where your word is your bond. You do what you think is right and follow your conscience. He advised me to follow my core values and faith in Washington. Sometimes that's costly politically, but that is the right thing to do. We have both lived our lives in that way. Ned is such a wonderful person, so smart and so fair. The caring he has for the people has always led him to do the right thing for Tennessee (Hillman, 2004, December 2004b).

In listening to the Governor, you are impressed with his personal involvement. He is very "hands on" and revels in the personal relationships and stories which characterize his career and accomplishments.

I met Governor McWherter at his condominium in Belle Meade not from the state capitol in Nashville. I was met at the door and led up to a traditional and elegant parlor

by an aide to the Governor who then left the premise. The Governor joined me in the parlor and promptly asked if it was okay to meet in the kitchen “where it is more comfortable’. For over one and one-half hours we sat at the kitchen table as the Governor told me about himself, his personal and political beliefs and how TennCare was created.

Don Sundquist-47th Governor of Tennessee. Don Sundquist has the current distinction of being the Governor for the longest tenure since the inception of TennCare. Despite expressing opposition to the program during his bid for Governor, he became convinced of the value of the program. Sundquist, a political conservative, ran for Governor of Tennessee (against Phil Bredesen, the current Governor, who he surprisingly beat by a wide margin) in 1994 after serving six terms as a U.S. Representative from the Sixth Congressional District. Sundquist succeeded McWherter who was barred from seeking a third term (Wikipedia, n.d., a).

Sundquist is most known for the immensely unpopular stance he took in support of a state income tax in a state very adverse to the plan. Although the issue of a state income tax dominated Sundquist’s second term (to which he was easily elected over John Jay Hooker) and he was able to garner some support from the Republican business community and from many Democrats who relished the idea of being able to implement a tax while being able to blame the Republicans, the idea failed and was instrumental in the political fall from grace that Sundquist experienced (Wikipedia, n.d., a). The contentious debate about a state income tax detracted from other priorities during Sundquist’s administration, notably TennCare.

Governor Sundquist has a keen interest in health care and reform at the national and state level. He is currently serving as the head of a national panel appointed by President George W. Bush to improve Medicaid.

I met with Governor Sundquist on two occasions at Bank East in downtown Knoxville. Sundquist is a member of the bank's Board of Directors. On both occasions, Governor was accompanied by Dr. Warren Neel who served as the Commissioner of Finance and Administration for a period of time (2000-2003) during Sundquist's administration.

I did not expect Don Sundquist to care so deeply about the value of providing health care to the neediest Tennesseans. I was impressed with his candor and his thoughtfulness about what needs to be done about health care. I sensed he was frustrated by barriers he encountered in the management of the TennCare program. I found Sundquist to be contemplative about how we can solve the issues of health care access and costs in our country. What impressed me each time I interviewed Governor Sundquist and in subsequent discussions was that although his motivation for wanting affordable and accessible health care was different from Governor McWherter's (when Governor Sundquist talks about health care, it is less personal and more linked to the financial impact that issues of cost and access have on the state and national economy), he is no less committed to the idea than anyone else I interviewed. Next to Dr. Vladeck, Governor Sundquist talked most about the interface between national and state reform efforts.

In summary, Don Sundquist illustrated for me how complex issues of health care access and costs are. Sundquist also showed me that traditional paradigms about Republican and Democratic differences are dysfunctional and detract from the common ground that can be forged when reasonable people are brought together for common purpose despite their motivations.

Gordon Bonnyman, Jr.-Executive Director of the Tennessee Justice Center.

Gordon Bonnyman seems like an unlikely advocate. He was raised in a wealthy

Knoxville family and received his baccalaureate degree from Princeton (he later received a Law degree from the University of Tennessee). But a strong sense of social justice, rooted in a strong faith, propelled him to advocacy and representation of low income clients in a variety of civil matters, including housing and consumer law, prison reform, public benefits, rights of disabled individuals, nursing home reform, juvenile procedures and civil rights. Before the inception of the Tennessee Justice Center, Mr. Bonnyman was a Legal Services attorney for 23 years. Since he co-founded the Tennessee Justice Center in January 1996, where he has served as the Center's only Executive Director, he has focused on health care access for poor and uninsured persons (Tarr, 2001, June 25; Tennessee Justice Center, n.d.).

Gordon Bonnyman was part of Governor McWherter's inner circle in the creation of TennCare. Over time, rather than being part of the inner circle, Mr. Bonnyman became the main figure in legal and other challenges to the operation of the TennCare program in the Sundquist and Bredesen administrations and in the reform efforts more recently initiated by Governor Bredesen. Mr. Bonnyman's transition from ally to adversary is a key factor in the telling of the TennCare story.

Consistent with my experience with others I approached with a request for an interview, Mr. Bonnyman was immediately open to the idea. Like others, he seemed eager to share his thoughts on TennCare. Although he was the first that I was able to contact for an interview, actually conducting the interview was toughest of all. Mr. Bonnyman was always gracious, but gaining access was difficult because of the last minute (and eventually failed) negotiations between Governor Bredesen and Bonnyman at the end of 2004 and later in early 2005 because of the preparations necessary to challenge the eventual plans of Governor Bredesen. Initially Mr. Bonnyman was reluctant to commit to a specific meeting time. He did call on two occasions for an

impromptu phone interview which was logistically not possible either time. On a separate time, we arranged a phone interview in advance, but Mr. Bonnyman was not available at the appointed time. When Mr. Bonnyman called at a later time, I happened to be on a break between a series of scheduled interviews in Nashville. Although Mr. Bonnyman initially resisted my suggestion that I come immediately to his office, he eventually yielded to my insistence.

Mr. Bonnyman's office was undoubtedly the most humble of all I visited. It was small and with stacks of papers and books everywhere. The office could easily have been one of a mid-level manager in a rural public health department or some similar official. All of this was quickly invisible once the interview began and proceeded at breakneck speed.

Mr. Bonnyman is keenly intelligent, eloquent, persuasive, passionate, exceedingly polite and unassuming. He is able to deftly and quietly capture you with a weaving of words and ideas. Although you have to strain to hear what Mr. Bonnyman is saying at times since he is so soft-spoken, you are quickly caught-up in a strong wave of ideas and passions. When Mr. Bonnyman talks, it is so much about the people he is dedicated to serving and so little about himself.

I was also impressed with Mr. Bonnyman's strong and personal feelings for the people that he sees as barriers to his missions. Mr. Bonnyman is a passionate partisan. He makes no effort or pretense about considering contextual influences or alternative views. Mr. Bonnyman presents himself as a single-minded reformist.

My hour with Gordon Bonnyman passed quicker than any other interview. Mr. Bonnyman has been very gracious in responding to requests for additional information and clarification since I met with him. He is meticulous, exacting and exceedingly gracious.

Dr. Bruce Vladeck-Former Administrator of the Health Care Financing

Administration. I was referred to Dr. Bruce Vladeck by Dr. Donna Shalala (who is the current President of the University of Miami and the former Secretary of the Department of Health and Human Services during the Clinton administration) when I requested an interview with her. She suggested that Dr. Vladeck would be a better informant. My initial disappointment was borne of ignorance. I was not aware how valuable it would be to meet with Dr. Vladeck and how impressive he would be. I was not aware of Dr. Valdeck's role or his activism in the delivery of health care benefits in the public sector.

Dr. Vladeck majored in government at Harvard University. He received a Ph.D. in political science from the University of Michigan where he was mentored by Dr. John Kingdon who formulated the Policy Streams Model that is widely used by those interested in agenda setting in public policy. Dr. Vladeck was the Administrator for the Health Care Financing Administration (HCFA), the predecessor to the Centers for Medicare and Medicaid Services (CMS) from the spring of 1993 through 1997 where he had oversight of the Medicare and Medicaid programs. In this role he had direct involvement with TennCare. Dr. Valdeck is a respected policy scholar with frequent publications and a history of collaboration with other scholars.

I met with Dr. Vladeck at his office in New York City where he is currently employed as a Principal in the Health Sciences Advisory Services practice of Ernst & Young LLP, and the East Coast Director of its Academic Medical Center service line. Interestingly I was subjected to more security screening and procedures in my visit with Dr. Vladeck than I was with any other interviewee. I attribute this to Dr. Vladeck's office location and the aftermath of the destruction of the World Trade Center.

Dr. Vladeck was very personable and kind. I was privileged to be part of an interview that was more of an intimate intellectual discourse than any other. Dr. Vladeck

was able to deftly share his experience and perspective on TennCare while centering the discussion on important political and philosophical questions. Years of government experience have made Dr. Valdeck very pragmatic, but his pragmatism is rooted in a very studied and compelling philosophical and political worldview.

David Manning-McWherter's Commissioner of Finance and Administration.

David Manning was the Finance and Administration Commissioner during the entire McWherter administration. He was an example of a McWherter's interest in and success with identifying young talent, cultivating that talent and providing invaluable support. Manning is also an example of the loyalty and effectiveness that resulted from this practice.

David Manning reminded me of many corporate controllers I have worked with previously. He is extremely confident and very competent. You also get the impression that Mr. Manning is very cunning. He has a keen wit and a sly sense of humor. When I met with him, he was very forthcoming with facts and ideas, but he revealed little of himself. He was welcoming without the genuine warmth of a man like Governor McWherter or Dr. Valdeck.

David Manning was very factual when I met with him. He was precise and definitive in his recollections and assessment of events and issues. What impressed me about Manning was his single-mindedness of purpose and his ability to evaluate options and deflect criticisms by his adherence to well thought-out principles that ground his visions. I was impressed that he was the glue that held together the idea of TennCare in the beginning. In his interview, he was dogmatic about the ideas that defined TennCare (e.g., the virtues of managed care and market-based competition) and unabashed in his criticism of the failings in program management since Governor McWherter left office.

The interview with Mr. Manning was conducted across his very large desk in his spacious office in Nashville. From Mr. Manning's office you can look up to Manny Martin's office. Despite the proximity, the two former partners seemed worlds apart. Manning lamented how ineffectively Martins was being used and was critical of Governor Bredesen's handling of TennCare. Manning's criticism seemed to emanate from his conviction that the TennCare concept was still viable, and one way to actualize its promise was to better deploy Manny Martins.

Manny Martins-Director of the Medicaid Bureau and TennCare Director. You might pass Manny Martins on the street without a second look, but you will never forget him once you have had the privilege of talking with him like I did. When I think of Mr. Martins, I am first reminded of his compassion. He is the epitome of the tireless, committed public *servant* who is genuinely concerned about those he serves. I am also immediately reminded of how grounded Martins is. He is very accomplished by virtue of his many experiences (in state government, private sector business and higher education administration), yet he is constantly searching for the evidence to enlighten his experiences.

Mr. Martins is not flashy, but he is rock solid. He is the kind of person that engenders trust and confidence. He is not a partisan, as evidenced by his service under three Governors. Mr. Martins has the unique distinction of serving as the first TennCare Director in the McWherter, twice in the Sundquist administration and once again during the Bredesen administration.

I met with Mr. Martins in his 27th floor office in the Tennessee Tower in Nashville. The Tennessee Tower is a state office building that is a prominent point in the Nashville skyline. From his vantage point, Martins has a panoramic view of Nashville. I equated this expansive view with Mr. Martins' expansive view of TennCare and his perspective as

an accomplished state administrator contemplating his legacy and transitioning towards his departure from state government.

Tony Garr-Executive Director of the Tennessee Health Care Campaign. My interview with Tony Garr, the first after my pilot interview, was conducted in Knoxville following a meeting he led with representatives from the social services community. In this meeting I observed Mr. Garr's grassroots advocacy. The attention that the organization Mr. Garr heads, the Tennessee Health Care Campaign, brought to the issue of health care access for marginalized people was instrumental in the inception of TennCare and has been a complement to the work of other advocates ever since.

Mr. Garr has been very helpful since I first contacted him. He is very resourceful and efficient in garnering and using resources. Garr deflected any personal attention, always putting his clients first and he was very deferential to his colleagues, most notably Gordon Bonnyman.

Table 2 provides a profile of anonymous study informants.

Informed Consent and Other Participant Protections

Methods and procedures used with anonymous informants differed from those used for all other informants. The confidentiality of anonymous respondents has been strictly protected (see Appendix E for a sample consent form used with providers). Only the researcher, transcriptionist and the dissertation committee chairman know the names of the anonymous respondents. The transcriptionist signed a confidentiality agreement (see Appendix F for a sample agreement).

Because of the public visibility of all non-provider respondents, they were asked to *not* be anonymous (see Appendix G for a sample of the consent form used with non-provider respondents). However, each respondent was given the option of not being publicly identified. One of the respondents in this class selected this option.

Table 2: Profile of Anonymous Study Informants

Category	Profile
Member of the TennCare Partners Roundtable	A federally-funded Medicaid researcher
Managers and Supervisors of community-based organizations	Director of Children and Youth Services employed by an East Tennessee community mental health center
	Top-level administrator of residential and outpatient services for a full-range behavioral health care provider
	Admissions Director employed by an east Tennessee full-range behavioral health care provider
Direct care providers or mid-level managers of care delivery	A Master's-prepared social worker employed as a case manager
	Intake Coordinator of an east Tennessee full-range behavioral health care provider
	Customer Services Specialist from an east Tennessee full-range behavioral health care provider
	A pediatrician practicing in a full-range community health care clinic as the primary provider of an integrated multi-disciplinary team delivering primary care services to a primarily Medicaid population
	A Master's-prepared social worker practicing in a full-range community health care clinic as a provider of an integrated multi-disciplinary team delivering primary care services to a primarily Medicaid population
	A Family Nurse Practitioner employed in a federally-qualified primary care clinic

Verbal and written explanations (see Appendix H) were provided to each potential interviewee prior to obtaining informed consent, and a copy of the explanation and consent forms were given to applicable participants along with researcher contact information. Signed consents were obtained prior to beginning the first interview. In addition, letters of approval from the applicable department or agency head, as well as IRB approval, were secured prior to approaching any individual employed in the respective department or agency. The original signed consent forms and agency letters of approval were delivered to the dissertation committee chair for secure storage. In addition, copies of the agency approval letters were delivered to the University of Tennessee Office Of Research, as requested.

All interviews were audio-taped using a digital voice recorder. Digital voice files were uploaded to the researcher's personal computer. All digital audio files of interviews are stored on a password-protected personal computer in the researcher's locked home office. These audio files will be destroyed at the direction of the dissertation chairman once all requirements for a successful defense have been met. Printed typed transcripts are stored in the researcher's locked home office. The transcripts of confidential sources do not contain personal or other information that could be used to identify these individuals; only pseudonyms are used. Copies of the digital audio files were burned to compact disks (CDs) for transcription. All CDs have been returned to the researcher. The CDs are stored in the researcher's locked home office. They will be destroyed at the same time that the audio files are destroyed.

Transcripts and Field Notes

All informants were mailed a copy of their transcript and given the opportunity to review their transcript for any additions or changes. A self-addressed, stamped

envelope was included in the mailing for return of corrected transcripts. Informants were notified that transcripts would be considered accurate if the transcript was not returned with any modifications, additions or deletions within 10 days of the postmark date. A sample of the cover letter that was included is shown in Appendix J.

Ten of the transcripts were returned with edits. The edits that these respondents made were not substantial with the exception of one respondent who deleted comments that could be sensitive if misconstrued.

The researcher dictated field notes at the end of each interview. These notes were transcribed with the interviews and are included with the printed copies (field notes were not included with the transcript copies sent to each respondent). Field notes included observations made during the interviews, and any information obtained from study participants before or after the tape recorder is turned off were recorded as field notes. Additional field notes also included researcher impressions, feelings, thoughts or experiences. Field notes were also used to begin the explication of emerging ideas.

Data Analysis

Data collection and analysis occurred simultaneously in a fluid, interactive and dynamic process. Interview questions were continuously refined and focused as patterns and themes emerged. By its nature, case study research involves following the threads of such patterns and may require additional resources in order to adequately build the database (Yin, 2003).

Themes were used to organize the vast amount of interview data. The salience of themes that emerged in early interviews were challenged, clarified and further distilled by an iterative process of content analysis that included multiple close readings of interview transcripts and documents. The goal of content analysis was to identify prominent and recurring themes and patterns among the various data sources (Patton,

2002; Polit & Beck, 2004; Waltz, Strickland & Lenz, 1991). Themes were further developed through the clarification and testing of ideas with stakeholders and confirmation of details with document sources. Each theme was also organized through the construction of a chronological history of events.

Analytical quality was enhanced by data triangulation. The retrospective recollections of events and key impressions captured in recorded interviews were triangulated with a wide variety of time-stable documents. Triangulation is “the process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” that “serves to clarify meaning by identifying different ways the phenomenon is seen” (Stake, 2000, p. 443).

The purpose of triangulation is to test for consistency. It is not expected that different data sources will yield the same results (Patton, 2002). Each data source and analysis yields a new perspective. With a complex phenomenon like a public health policy, differences are expected and were examined closely to derive new meanings and perspectives.

Analysis also involved primary reflection by the researcher and interaction with members of the researcher’s dissertation committee skilled in the techniques of qualitative research and details about the TennCare program.

Conclusions

A case study researcher needs to be mindful about threats to validity and reliability. There are special challenges in case study research because the researcher is the primary instrument of analysis and because the researcher needs to be flexible, and open and responsive to emergent issues. Careful thought, planning and collaboration are necessary for maximizing the potential of case study research while maintaining focus and rigor.

CHAPTER 5: TENNCARE VISION AND DEVELOPMENT

“I believe that people in need are entitled to accessible, available, and affordable health care. That’s my three As” (transcript of a recorded interview with N. McWherter, 2005, February 02, lines 399-400).

“We believed that it was important to move the...[Tennessee] Medicaid Program...to a managed care system and put competitive pressure on the health care system that at the time didn’t exist...what we attempted to do was...to cover not only the eligible Medicaid population but to cover the uninsured/uninsurable population” (transcript of a recorded interview with M. Martins, 115-136).

Introduction

A convergence of factors paved the way for the development of the TennCare concept, a concept consistent with a long-held vision of Ned Ray McWherter to provide accessible and affordable health care for all Tennesseans. McWherter and his team of David Manning and Manny Martins capitalized on these factors to fulfill these lofty objectives...and to avoid a fiscal collapse in the state.

Factors that were influential in the development of TennCare related to people, purpose and context. Among the most influential factors were an impending crisis in Medicaid funding precipitated in part because of unfunded federal mandates, the demise of the funding strategies employed by the state of Tennessee in response to the growing financial crisis, recommendations developed by the Tennessee Medicaid Task Force appointed by McWherter and the state’s experience and eventual success with introducing managed care to state employees.

A host of other factors facilitated the acceptance of TennCare. These included: the election of Bill Clinton as President of the United States, an unlikely alliance forged by the McWherter administration, the dominance of Blue Cross Blue Shield of Tennessee and a very calculated strategy to exclude detractors of McWherter’s ideas and move at a very rapid pace.

TennCare Development

The Conception of a Radical New Idea

Several experiences, collaborations and agreements (explicit and tacit) were employed by Governor McWherter, Manny Martins and David Manning to support the acceptance and development of the concept of TennCare. The success McWherter had in addressing issues with Tennessee prisons was instrumental in paving the way for TennCare. In addition, the experience the McWherter administration had with the State Employee Health Insurance Plan and their collaboration with Blue Cross provided the experience, organizational structure and needed contingencies to launch TennCare. Prior to the development of the concept of TennCare, Governor McWherter appointed a Blue Ribbon Task Force, headed by current U.S. Senator and Majority Leader, Dr. William Frist, to secure support for the need for a radical restructuring of the state's Medicaid program. In addition, the past experiences the McWherter administration had working with the Tennessee Legislature had created a pattern of cooperation that was leveraged in the creation of TennCare. Finally the McWherter administration, in a departure from the status quo, solicited the support and involvement of the advocacy community while severely limiting the influence of the traditionally dominant provider community.

Governor McWherter served two terms as Governor from 1987-1995 (see Table 3 for a summary of the terms and political affiliations of recent Tennessee Governors and U.S. Presidents). It was during the waning days of his administration, after addressing his other key objectives of better education, roads, jobs and prisons that he turned his attention to access to health care for the state's most needy (Friar, 1999). In early 1993 he presented his draft plan for Medicaid reform to the Tennessee General Assembly. In six weeks he had secured their endorsement and submitted a detailed

Table 3: Tennessee Governors and U.S. Presidents: Affiliations and Terms

U.S. President	Tennessee Governor
Ronald Reagan (R)-1981-1989	Lamar Alexander (R)-1979-1987
George H. Bush (R)-1989-1993	Ned Ray McWherter (D)-1987-1995
Bill Clinton (D)-1993-2001	Don Sundquist (R)-1995-2003
George W. Bush (R)-2001-present	Phil Bredesen (D)-2003-present

waiver application and plan to HCFA (McWherter, 1993). That approval was received five months later and the program was implemented 46 days after that, a total of just over six weeks! Several events and key decisions facilitated the radical and rapid deployment of TennCare. A discussion of these follows.

A Crisis in Medicaid Funding

A crisis in Medicaid funding that had actually begun in the prior administration of Governor Lamar Alexander (1979-1987) and then escalated in the McWherter administration, was the impetus for the creation of TennCare. Between 1984 and 1991, the federal government issued regulations that first allowed and then *required* states to expand Medicaid eligibility to pregnant women and children. When Governor McWherter assumed office the state budget for covering the 500,000 Medicaid enrollees was \$1 billion. By 1993 costs had tripled to \$3 billion and enrollment had doubled (Manning, 1995). According to David Manning these increases were due to,

An aggressive series of what became known as *unfunded mandates* [emphasis added] on states, where [the administration of President George H. Bush] was fairly aggressively expanding coverage, a lot of it focused on children and pre-Medicare [enrollees]....but they weren't providing any relief for the states and they weren't making it optional. (transcript of recorded interview, D. Manning, 2005, March 11, lines 59-65)

Tennessee's response, developed by Governor McWherter, Manning and Medicaid Director Martins, paved the way for the eventual restructuring of Medicaid in

Tennessee through the creation of TennCare. By leveraging the availability of federal matching funds and permissive regulations that allowed them to broker a provider tax supported by the Tennessee Hospital Association, their plan was able to avoid new state-initiated taxes and cuts in the Medicaid program. This was essential, given the McWherter administration's negative experience with proposing additional state taxes.

The state of Tennessee initially funded the escalating costs by using "voluntary" provider donations and later by provider taxes and fees. According to Manning,

We took that opportunity to solicit those donations, and we received them and other significant amounts and were able to expand coverage particularly for pregnant women, as well as children, at a rate which was considerably faster than would otherwise have been possible. Somewhere toward the end of the "80s, maybe the very early "90s, Congress and the first Bush administration looked up and said, "This is working too well, and we need to do something to discourage this because the States are...being too effective at doing this." So they attempted to regulate more directly what you could do. That got a little bit of push back from the States. By the early "90s, there was a change made in that regulation, but it was a change made by Congressional act that really didn't restrict it; it opened the door much broader to what you could do to generate Federal revenue for Medicaid programs. So we did. We were able to expand to sustain the growth of the program and the opportunities that had been created for expanding coverage. About that time, though, the Bush administration really engaged and said they would have to write a change by regulation those things and stop that practice from occurring. We worked closely with the National Governors' Association and was able to block the Bush administration's efforts in that area and then worked a compromise for the National Governors' Association to essentially enable Tennessee to continue doing at the same levels much of what it had been doing in the past. All of those machinations that occurred at the State and Federal level did wind up causing us to change what had been a "voluntary donation" program into a provider tax program. That provider tax program was about to run out because it had some set provision in it toward the end of 1993, and in order to address the funding problem that would create, something significantly different had to be done. (transcript of recorded interview, 2005, March 11, lines 70-97)

The experience of dealing with the voluntary donations and the provider tax laid the foundation for the success of the team of McWherter, Manning and Martins in creating TennCare.

Blue Ribbon Task Force

The focus of the Blue Ribbon Task Force, appointed by Governor McWherter and headed by Dr. William Frist, was to discuss the problems the state faced with increasing Medicaid costs and “help to educate the general public and the General Assembly about what the state would encounter if we were to try to cut our way out of the problem”, according to David Manning (transcript of recorded interview, 2005, March 11, lines 178-182). The Task Force concluded that the state had three options. These were to increase taxes, a very unpopular idea; reduce Medicaid services, an idea Governor McWherter opposed; or significantly reform the delivery and financing of the state’s Medicaid program, an idea that had some traction nationally and appealed to McWherter and his team. The task force paved the way for justifying the need for the radical reforms that were proposed when the plans for TennCare were unveiled. The task force helped “the public understand the consequences of the rather dramatic cuts that would occur if in fact the changes were not made” (transcript of recorded interview, D. Manning, 2005, March 11, lines 137-138).

The State Employees Health Insurance Plan

In addition to rising Medicaid costs, Governor McWherter was challenged with the same in the State Employees Health Insurance Plan. To solve the problem, David Manning turned to Blue Cross-Blue Shield of Tennessee in 1988 to develop a managed care plan. The state was able to wield influence with Blue Cross-Blue Shield because they were one of Blue Cross-Blue Shield’s largest customers. Working closely and exclusively with Blue Cross-Blue Shield, the state was able to roll-out a statewide network of providers for the alternative delivery of health care services for state employees. The Tennessee Provider Network, known as TPN, was implemented in

1988 as a capitated plan. TPN eventually became the backbone of the TennCare delivery system.

According to David Manning, there was a “great deal of controversy” about the state employees managed care plan when it was introduced, and it took “Blue Cross about two years to sell it to a million Tennesseans” (transcript of recorded interview, 2005, March 11, lines 168, 164-165). The experience laid the foundation of the strategy that would eventually define TennCare and gave the McWherter administration the confidence to propose and eventually implement a radical change in their Medicaid program. Manning recalled that, “We...understood that you could change the structure of your programs, provide a level of consistent care, in cases improve care, and reduce costs if you are willing to use the marketplace to make that happen. That backdrop, that experience, even though it had been controversial, led us to believe that you could do the same things with Medicaid” (lines 168-173).

Many providers and state employees resisted the start of the TPN. However, over time, employee concerns diminished and by the early 1990s the TPN was serving over one million Tennesseans through private health plans (Manning, 1995). According to Manning, “the development of TPN clearly demonstrated that any effort that really creates a change in the health care system will be politically controversial, but the fact that we survived the strife and achieved cost control and quality of care made a lasting impression” (p. 24).

A Unique Alignment of People and Purpose

Governor McWherter, David Manning and Manny Martins had unique and complementary experiences and expertise matched with a common vision. McWherter was a savvy, popular and well-connected political leader in the waning days of tenure as governor who was willing to expend political capital on his long-term vision of helping

disadvantaged people. Manning was a bold financial innovator with great political acumen and negotiating insight. Martins, a solid and pragmatic administrator, understood the Medicaid program.

According to Manny Martins,

The Governor wanted to provide comprehensive health insurance to people...He truly wanted to do that. The Commissioner of Finance at the time, David Manning,...[is] a very sharp individual, very smart, and [he] understood the dynamics of financing and health care. He had his heart in the same place as the Governor's. I happened to be the Medicaid Director at the time. I happened to have my heart in [TennCare] also...All of us were in the position to make TennCare happen. All of us philosophically, management-wise, every other way, saw [TennCare] as something we really wanted to get done. I had staff in here at the time that was very, very good as well....It just jelled. I mean, it really jelled. So I think the fact that David [Manning] was where he was, the Governor was where he was, I was where I was, really, really helped. I think all of us had a certain amount of credibility with the Legislature. (transcript of recorded interview, 2005, March 11, line 672-688)

Tony Garr adds Gordon Bonnyman to the inner circle of essential creators of TennCare, saying,

It wouldn't have happened without Governor McWherter. It would not have happened without David Manning, and it wouldn't have happened without Manny Martins. And I think I could say it wouldn't have happened without Gordon Bonnyman. So there were four key players: Gordon, Manny, David, and the Governor....I think the two key players were really David Manning and Gordon Bonnyman. David Manning came to the point where he said, "I can't beat Gordon, and so I've got to figure out a way to work with Gordon." And Manny Martins and David Manning came up with this sketch [of] what it might look like. I think, I may be wrong, but I think probably after David Manning talked to the Governor about it, probably the very next person he talked to was probably Gordon Bonnyman. Or if it wasn't Gordon Bonnyman, it was probably Blue Cross-Blue Shield. I think they recognized early on that Gordon played an important role. I think also that administration realized that this is really a political animal in that unless there was some political considerations given to this, unless they realized it was a political animal, it was never going to pass. And so, David Manning was very good politically. And it's my understanding that Manny Martins made it clear to David Manning, "I'll be glad to run this thing. I'll be glad to run this thing. I can make the nuts and bolts work together. But I'm not going to stand in front of the legislative committees explaining this or trying to do this, so you're going to have to do that." I think there was an unspoken agreement that David Manning would do all the talking, and he was the one that did. He was the one that appeared before all the legislative committees. (transcript of recorded interview, 2005, March 11, lines 105-116)

Dr. Bruce Vladeck supported Garr's idea of the vital role of Gordon Bonnyman saying, "one of the pivotal supporters of TennCare in the summer and early fall of 1993 was Gordon Bonnyman, who wrote us a number of letters and called me a couple of times" (transcript of recorded interview, 2005, March 4, lines 185-187). Dr. Vladeck also related that a year or so later "when Gordon [Bonnyman] was complaining about some part of the program and giving us a very hard time, and he can be very obnoxious when the mood strikes, and I saw him at a conference, he said, "How can you let this happen?". I said, "Gordon, this whole program would not be there if you hadn't been one of its major supporters" (lines 193-197).

Relying on the Bench Strength of Blue Cross-Blue Shield

Both the organizational capabilities of Blue Cross-Blue Shield and its success with the State Employees Health Insurance Plan were essential to being able to accomplish the TennCare roll-out in the timeframe developed. Blue Cross-Blue Shield was the "organization that had the capacity to do the whole thing, if they had to do the whole thing" (transcript of recorded interview, D. Manning, 2005, March 11, lines 202-203). Although the administration "didn't really want one organization to do the whole thing" (lines 203-204), they were confident Blue Cross could, if necessary.

Changing the Seating at the Table

Providers, including physicians, hospital representatives and others, have been traditional powerbrokers in any debate about the delivery of health care services. Frequently consumers of health are excluded from meaningful participation. With TennCare, the McWherter administration changed these dynamics. Governor McWherter made a deliberate decision about who would be included in the development of TennCare; he made the unorthodox decision to include the consumer advocates and exclude the providers.

An important battle with providers had been won with McWherter administration's roll-out of the TPN with Blue Cross-Blue Shield for state employees. As they prepared to address the Medicaid crisis, McWherter, Martins and Manning formulated a new strategy. Rather than drawing powerful provider groups and representatives into the fold for discussions about the reform of the state's Medicaid program, they turned to the advocates, most notably Gordon Bonnyman and Tony Garr, who represented the people the program served. The McWherter team thought it was essential to "have the advocacy community with us" (transcript of recorded interview, D. Manning, 2005, March 11, lines 204-205). Manning recounted how the administration "spent a great deal of time, early in 1993, and perhaps a little in late 1992, conferring with Blue Cross and conferring with Gordon [Bonnyman] on behalf of the enrollee groups and [we] developed a good working relationship (transcript of recorded interview, 2005, March 11, lines 211-215). "Initially skeptical to the initiative, advocacy groups eventually supported what they labeled as a "labor/management" deal with state administrators because of the goodwill generated with the state's earlier use of provider taxes and DSH payments to expand the Medicaid program and their recognition that more poor families could be given health insurance under managed care" (Friar, 1999, p. 6).

Manning further related that, "we were able to move forward with a cooperative approach that presented a united front to what was known as HCFA in those days" (transcript of recorded interview, D. Manning, 2005, March 11, lines 216-218). The TennCare application for a Section 1115 Demonstration Waiver submitted by Governor McWherter to Secretary Donna Shalala of the Department of Health and Human Services (McWherter, 1993), who Dr. Vladeck reported to, included numerous letters of support, including one from Gordon Bonnyman who was then with Legal Services of Middle Tennessee, as well as one from Glen C. Watson Jr., a Senior Vice President with

Blue Cross-Blue Shield of Tennessee. In addition to Blue Cross-Blue Shield and the advocates, the state also garnered the support and assistance of the Tennessee Primary Care Association, the Appalachian Regional Commission, the state's chapter of the American Association of Retired Persons (AARP), nurse practitioner and physician assistant associations, the perinatal association and the psychological association (Gold, Frazer, Schoen, 1995).

By bringing Bonnyman and the advocates into the fold, McWherter's team not only removed a barrier to being granted the requisite federal waiver. They also secured some cover from the inevitable fall-out associated with TennCare's accelerated timeline and the magnitude of change imposed. A part of the group that worked on the development of TennCare, Gordon Bonnyman made apparently tacit agreements regarding inevitable problems. According to Tony Garr, a close colleague of Gordon Bonnyman,

David Manning knew that starting a whole new program was going to create a whole new set of problems that he hadn't dealt with before. I think he was smart enough to basically bring Gordon on board early on saying that, "There's going to be problems. You know, we're not going to do everything right. We don't have the data systems to handle this as good as we'd like to. We'll do the best job we can, and we want you all to be partners with us and not fight me in court because somebody gets terminated inappropriately." I...don't think anything was ever written down. There was certainly an understanding between those two that Gordon wasn't going to haul him to court because things went wrong. (transcript of recorded interview, 2005, January 19, lines 190-200)

In exchange for tolerance during the transition, Bonnyman was able to realize the goal of the advocates of securing more coverage for more people. Mr. Bonnyman also had the opportunity to prospectively craft solutions rather than respond to issues once they were manifested. This opportunity, granted by Governor McWherter and his closest allies, created a new power dynamic that they saw as part of the reform of TennCare. Bonnyman offered tolerance for coverage. Because of this, McWherter and his team

were willing to withstand the resultant firestorm to make their vision of a new health care delivery system a reality.

A Strategy of Exclusion

In contrast to the close alliance the state forged with Blue Cross-Blue Shield, representatives of the advocacy community and the selected groups cited, there was very limited public interaction with other key stakeholders in the creation of TennCare. The decision to not seek a consensus among a broad spectrum of stakeholders was deliberate. Among those excluded were state officials outside the circle of Manning and Martins (Gold, Frazer, Schoen, 1995). The state departments of Commerce and Insurance and the Health were purposely were not involved to a great extent in formative discussions about TennCare (Gold, 1997). The McWherter administration thought that time constraints necessitated and justified not involving other stakeholders. According to Manning (1995), “We recognized that consensus was not likely on any proposal that would effectively address the problem and that there would be opportunity to debate TennCare both in the state legislature and as part of the federal waiver process” (p. 23).

The debate in the state legislature was basically a token one though. When questioned about the exclusion of certain stakeholder groups, Manny Martins related that,

We had open meetings for the Legislature, the advocacy groups. We felt like the groups that we really needed to have on board with us were the advocates, the Legislature, as well as some of the big insurance companies like Blue Cross-Blue Shield. We couldn't pull it off without them. We held meetings with other groups. We held meetings with TMA. We held meetings with every provider organization. It was apparent that they were opposed to managed care. It wasn't necessarily they were opposed to health care. They were opposed to managed care. It seemed to us that we had to implement this thing rapidly. And I used to say, “We did this at warp speed” because we really did that. [There] would have a long drawn out debate process and it would never have gotten us to the point we got to. Whether that's good or bad is another issue. But we had the right groups on board. We had the Legislature. We had the advocates....Did we involve TMA enough? Did we involve the medical groups enough? Did we involve public

enough? I don't know. I don't know. I don't know where you draw that line.
(transcript of recorded interview, 2005, March 11, lines 750-767)

The Tennessee Hospital Association (THA) was not involved with the inner circle on the planning for TennCare, yet they did not actively oppose the state's efforts since they were initially encouraged by the elimination of the 6.75 percent provider tax (Becker, 1995). Tony Garr related that the THA, "stayed on the sideline. They did not oppose it; they did not support it. But of course, one of the major reasons why they did not oppose is it because part of the deal was eliminating the hospital tax" (transcript of recorded interview, 2005, January 19, lines 84-87).

Major opposition to TennCare came from the Tennessee Medical Association (TMA.). The TMA aggressively campaigned for HCFA to reject the Medicaid waiver application submitted by Governor McWherter. Although TMA's strategy was to not oppose managed care and instead focus on the speed of the implementation, many physicians were adamantly opposed to managed care in general, as well as the level of capitation payments and the requirement that participation in the TPN network for state employees was conditional on participation in the state's managed Medicaid program (Gold, 1997; Manning, 1995). During TennCare's first year of operation, the Tennessee Medical Association filed suit against the state charging "an unconstitutional delegation of authority to the executive branch" (Mirvis, Chang, Hall, Zaar & Applegate, 1995, p. 386). The specific contentions of the TMA included inadequate involvement, increased enrollment without adequate funding (i.e., inadequate capitation), perceived secrecy about TennCare and MCO financials, increased provider liability and the transfer of risk to physicians. The physicians also argued that TennCare was not a managed care plan, as presented, but rather a heavily discounted fee-for-service plan. The suit was subsequently withdrawn, but opposition lingered. The National Association of

Community Health Centers also filed suit to block the implementation of TennCare. Their opposition centered on the short time allowed for implementation and to develop needed infrastructure (Mirvis et al., 1995).

The provider opposition was exactly what the McWherter administration expected. Whether this opposition justified the exclusion of providers from any meaningful role in the development and launching of TennCare remains a contentious issue.

Holding the State Legislature at a Distance

Manny Martins cited past experience in dealing with the Tennessee Legislature on Medicaid as key to winning their support along with specific strategies that were employed when the push was on for the approval of TennCare and permission was sought to request a waiver from the federal government. Martins recalled,

Over a period of time, we were able to be pretty innovative in our funding of Medicaid. We were the first State in the nation to really do disproportionate share money coming into the State. The Legislature, I think, probably looked at that and saw that and said, "My goodness, you know. We're at the forefront of being able to get these dollars coming in to this State, and it's helping the State manage its Medicaid program. It's taking pressure off of the Legislature to have to deal with financial issues." We'd be before committees on, you know, on a weekly basis. And my approach had always been, "You just tell it like it is." You know, I'm not going to get before a Legislative Committee and distort or tell an untruth or lie. I'm going to get up there and say, "Here's what's going on." Well, I think over a period of time, we built some credibility along those lines. And I think David Manning did, and I think Governor McWherter did. So when we went to the Legislature, they began to believe what we were telling them because our record had always been one of being honest. And so when we developed TennCare and explained it and went through it and the Governor was great because he would have people... he would have the Legislature... he'd bring them in. We had meetings where we would brief the Legislature 24 hours a day. We set up a room in the Legislative Plaza, and we said, "Any Legislator that wants to know about TennCare, we will be here. Come." We sat there; we manned that room; we had staff in that room. We did the same the thing, by the way, with advocates. We said, "If you have any questions, concerns, anything, you come talk and we'll be here." So I think that approach kind of, you know, allowed people to understand and know what was going on with the process. We were able to implement TennCare, as I recall I think I made the suggestion by simply changing one or two words in the TennCare law... in the Medicaid law

that basically allowed the State to pursue an 1115a waiver. That, I think, was a break-through in itself because one of the failures of national health insurance was, and one of the failures many times in these laws are that they go into so much detail and everybody and their brother wants... you know, by the time your lobby groups get through with it, you have such a watered-down piece of Legislation that you know, you don't know what you've done. So this enabled us to really go forward. The Legislature passed it. But the Governor was instrumental in that. We had credibility with the Legislature, and we essentially opened it up to anybody that wanted to look at it. (transcript of recorded interview, 2005, March 11, lines 705-739)

Table 4 provides a summary of events in the development of TennCare.

TennCare Enrollment

In creating TennCare, the state of Tennessee went further than any other state in reforming the delivery and financing of health care. Although the changes that were introduced in 1994 went beyond what any other state had done, by introducing managed care as a full replacement and providing access to more uninsured and uninsurable individuals, the full scope of the changes Governor McWherter, David Manning and Manny Martins envisioned remains an elusive goal. Managed care has not matured and a competitive marketplace has not emerged. In 2005 Governor Bredesen, prompted by a projected state budget crisis, set in motion a plan to reform TennCare by reducing enrollment and benefits. At the same time, the prospects of national health reform care are stalled.

Table 5 shows eligibility categories for TennCare. Table 6 details enrollment changes over the course of TennCare's. Figures 2 and 3 provide an overview of enrollment numbers since TennCare's inception.

Conclusions

The development of TennCare was bold and very necessary. Decisions that were made in the development of TennCare had significant and lasting impact on the implementation and operation of TennCare.

Table 4: TennCare Development and Implementation Timeline 1992-1994

Date	
November 1986	Ned Ray McWherter elected as Governor of Tennessee; he ran on a platform that included promises for better education, roads, jobs, prisons and health care.
November 1992	Tennessee Medicaid Task Force appointed by Governor Ned Ray McWherter; first meeting held in December 1992 (Ferrar & Humphrey, 1992, December 11; Rawlins, 1993, July 6).
Early 1993	Task Force presented three options to State Legislature: increase taxes, reduce Medicaid services or reimbursement to Medicaid providers or significantly reform the delivery and financing of the state's Medicaid program
Early April 1993	TennCare concept approved by State Legislature (Chang & Steinberg, May 2005).
June 16, 1993	Application for a Section 1115 Medicaid submitted to HCFA for review (Chang & Steinberg, May 2005).
November 18, 1993	Waiver approved as a five-year demonstration; providers notified by the state of January 1, 1994 start date (Chang & Steinberg, May 2005; Tennessee.gov, n.d. c).
January 1, 1994	TennCare implemented
November 1995	Don Sundquist elected as Governor to succeed Ned Ray McWherter

Table 5: TennCare Eligibility Categories

Category	Description
	Medicaid-eligible categories
1	Medicaid-eligible individuals
2	Medically needy spend-down-optional Medicaid category
	Expansion categories (also called waiver categories)
3	Uninsured individuals who lacked access to health care insurance
4	Uninsurable individuals-those people denied commercial health insurance because of a medical condition
5	Waiver dual eligibles-individuals eligible for TennCare Standard and Medicare

(Long, W., 2005, March 29; Tennessee.gov, n.d. c)

Table 6: TennCare Enrollment Timeline

Date	Event
January 1, 1994	TennCare implemented; TennCare covers categories 1-5
December 31, 1994	Enrollment for category 3 closed; enrollment remains open for all other categories (Chang & Steinberg, 2005; Tennessee.gov, n.d. c)
April 1, 1997	Enrollment re-opened to uninsured (category 3) children under age 18 (Chang & Steinberg, 2005; Tennessee.gov, n.d. c)
May 21, 1997	Enrollment opened to dislocated workers ⁽¹⁾ (Chang & Steinberg, 2005; Tennessee.gov, n.d. c)
January 1, 1998	Age limit for uninsured (category 3) children extended to 19 th birthday (Chang & Steinberg, 2005; Tennessee.gov, n.d. c).
February 12, 2002	Sundquist administration filed major modification plan with CMS (Tennessee.gov, n.d. c).
July 1, 2002	New and modified TennCare waiver ⁽²⁾ approved for implementation; included changes in eligibility requirements and creation of TennCare Standard. These changes were slated for implementation January 1, 2003. TennCare expanded to include females with breast and cervical cancer, a new optional Medicaid category ⁽³⁾ (Chang & Steinberg, 2005; Tennessee.gov, n.d. c).
December 2002	District Judge William Haynes hands down a decision that prevents the state from implementing TennCare changes approved July 1, 2002 and required the reinstatement of every person disenrolled since the approval of the new waiver). (Chang & Steinberg, 2005).
March 28, 2002	Governor Bredesen announced that benefit reductions would be effective April 1, 2003. This was plan was rescinded because of continuing negotiations on a Settlement Agreement (Tennessee.gov, n.d. c.).

Table 6: Continued

Date	Event
August 26, 2003	The state and plaintiffs enter into a joint motion that withdrew proposed benefit cuts and cost-sharing increases, maintained EPSDT coverage for non-Medicaid children eligible for TennCare, modified terms of the <i>Grier</i> Consent Decree and allowed a grace period for persons who had lost TennCare coverage under new criteria (Tennessee.gov, n.d. c).

⁽¹⁾ Dislocated workers defined as persons losing employment through a bona fide plant closing; there were no income limits for this category and access to COBRA benefits was not a disqualifying criterion (Tennessee.gov, n.d. c).

⁽²⁾ TennCare was divided into three separate programs: one for Medicaid-eligibles (TennCare Medicaid), one for demonstration eligible individuals (TennCare Standard) and one for low income persons needing assistance in purchasing available insurance (TennCare Assist). Each of these programs was slated to have a separate benefit structure, e.g., the benefits available for TennCare Standard and all adult beneficiaries were to be less than those available in TennCare Medicaid; copayments were also required introduced (Chang & Steinberg, 2005; Tennessee.gov, n.d. c).

⁽³⁾ This new Medicaid eligibility category provided coverage for uninsured women under age 65 who were determined to be in need of treatment for breast or cervical cancer by a Centers for Disease Control (CDC) site (Chang & Steinberg, 2005; Tennessee.gov, n.d. c).

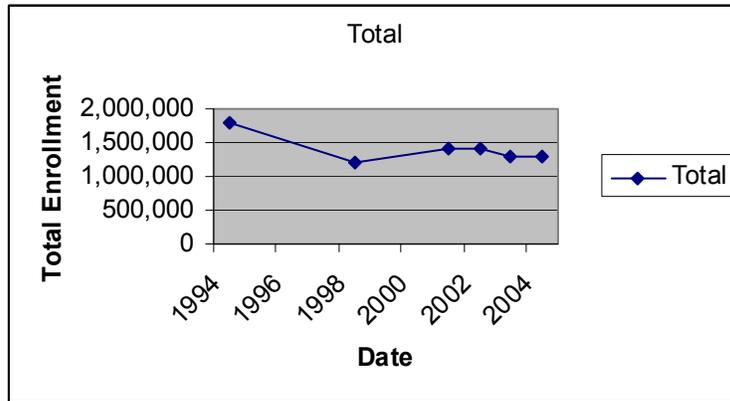


Figure 2: Total TennCare Enrollment by Year

Source: Chang & Steinberg, May 2005; McKinsey, 2003, December 11.

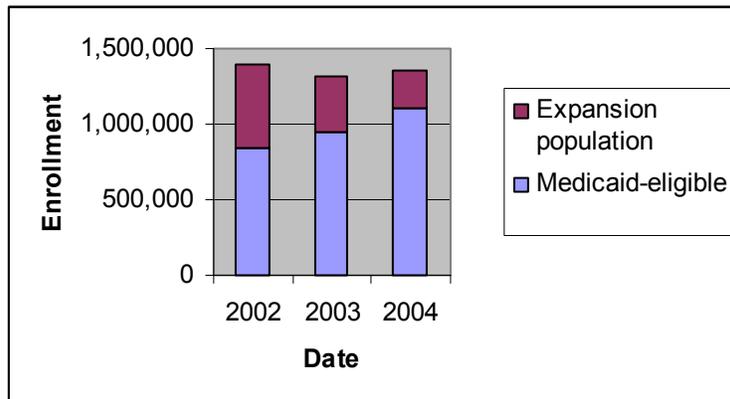


Figure 3: TennCare Enrollment by Eligibility Category

Source: Chang & Steinberg, May 2005; McKinsey, 2003, December 11.

The building blocks of TennCare are high-performing, competitive MCOs and BHOs, effective performance management and financial risk-sharing. As will be seen in the ensuing chapters, these building blocks were not assembled and the edifice remains a shaky construction.

CHAPTER 6: INTRODUCTION TO FINDINGS AND THE THEME OF AUTHORITY

Introduction to Findings

TennCare is one of the most significant and expansive health reform efforts of the past thirty-five years. Just as the nation watched the creation and initial ten years of operation, the nation is now watching events, local and national, surrounding attempts to reform (or dismantle, depending on your perspective) TennCare. Interestingly it is against this background of intense scrutiny, change and the positioning and polarization of stakeholders that this dissertation has been conducted. Although this dissertation is not specifically focusing on current and recent events, these events are a manifestation of the history studied.

An intricate web of circumstances and people shaped the initial development and evolution of TennCare. The unique alignment of people and purpose that made the program a reality is an excellent public policy exemplar. The examination of the program's history illuminates many lessons. Although TennCare has been successful in achieving selected strategic aims, these successes have been overshadowed by a myriad of operational problems and a failure of the program to evolve and achieve expected results.

Emergent Themes

An iterative process that relied on the triangulation of multiple data sources was used to develop this case study of the TennCare program and examine the principle of fidelity. A view of TennCare was constructed that is not a traditional history or analysis, but rather an emergent perspective of the key themes that illuminated the organizing concept of fidelity. Three themes were prominent in the telling of the TennCare story.

These themes have been explored by balancing and evaluating the perspectives offered by the key stakeholders interviewed and relating these to other sources of data. A discussion of these themes illuminates the promises and failures of TennCare. The themes that integrate the key findings of this study are diffuse *authority*, *management* failures and *fragmentation* of efforts. A discussion of authority is included in this chapter. The discussion of management and fragmentation follow in chapters seven and eight respectively. Each of the themes had an influence on or was influenced by the other themes. It is important to appreciate the web of connectivity between the themes.

Introduction to Authority

Issues of authority are integral to the story of TennCare. Authority is a concept with multi-layered meanings and connotations. In public policy, the term authority is used to indicate individuals or agencies that have jurisdiction or control. Longest (2002) has referred to health policy as “the set of *authoritative* [emphasis added] decisions made within government that pertain to health and the pursuit of health” (p. xx). In this framework, authoritative decisions can be made anywhere, at any level within the three branches of government within the legitimate domain of the decision-making individual or body (Longest, 2002).

Authority also connotes expertise, control, influence, force and power (Merriam-Webster’s, 2000). Authority is derived not just from office, position or station, but also from opinion, respect, esteem or character (Quotes & Dictionary, n.d.; Brainy Dictionary, n.d.). Authority also denotes dominion (Brainy Dictionary, n.d.). Informal authority can be conferred to advocates, researchers and others who have established credibility and success in influencing policy processes.

Authority in TennCare has been the subject of debate, intrigue and controversy. In understanding TennCare, it is important to examine how lines of authority have been drawn or assumed, the perceptions of various stakeholders, and how authority has been used *or not used*. It is also important to see how the theme of authority has been impacted by the other two themes, management and fragmentation. Various ways authority has been manifested in TennCare, including executive, judicial, legislative and other types, will be discussed.

Federal Legislative and Budgetary Authority

The federal government has two primary mechanisms for funding programs. Funding can be provided via *block grants* or through payments for *entitlement programs*. “Block grants are programs for which the federal government gives states or local governments a fixed amount of funds for administering or providing certain services” (Lambrew, 2005, p. 41). Entitlement programs, in contrast, “create a government obligation to finance a benefit or service for a prescribed set of people, with no aggregate limit on funding” (Lambrew, 2005, p. 41). The nomenclature used to differentiate federal spending associated with block grants and entitlement programs is very telling. Spending for block grant programs is classified as *discretionary* whereas the funding of entitlement programs is *mandatory*. Authorizing legislation for discretionary spending, which accounts for approximately one-third of all federal spending, specifies the basis for operating programs and a specific level of funding (either as a fixed amount or as *sums as necessary*) during the annual budget process. In contrast, entitlement programs are authorized by permanent laws. Through entitlement programs, including Medicaid, Social Security, veterans’ benefits and Food Stamps, individuals receive benefits *because they meet eligibility requirements for the program*. To change the level of spending for mandatory programs, Congress and the

President must change eligibility requirements (Longest, 2002; White, 2002).

Participation in Medicaid is not mandatory. States have the option to participate in Medicaid or not. However, participation is contingent upon adherence to federal statutes, regulations and policies regarding eligibility (White, 2002). The federal statutes, regulations and policies which govern Medicaid give each state the authority to “1) establish its own eligibility; 2) determine the type, amount, duration and scope of services; 3) set the rate of payment for services; and 4) administer its own program” (Center for Medicare & Medicaid Services, n.d.).

Throughout Medicaid’s history there have been two major efforts to transform Medicaid into a block grant program. The first effort occurred during the Reagan administration (1981-1989). Similar efforts, eventually defeated by a concerted personal campaign of President Bill Clinton, were revived by Republicans in 1996 as part of the budget showdown between the President and federal lawmakers led by Representative Newt Gingrich. In his strategy to win the budget battle, Clinton laid the groundwork for incremental expansion of the Medicaid program and the transformation away from an entitlement for the poor to a broad-based program reaching into the middle class. Interestingly, the National Governors’ Association favored the Republicans’ block grant proposal, in part because of the flexibility afforded by block grants and because of the relative good times of adequate state revenues and the early successes of Medicaid managed care seen during the time of the debate (Grogan & Patashnik, 2003). According to Dr. Bruce Vladeck, HCFA Commissioner at the time, “the sticking point came to be whether, from a legal point of view, Medicaid beneficiaries would still be entitled to seek enforcement of the law in federal courts” (transcript of recorded interview, 2005, March 4, lines 536-537). Manny Martins commenting on another concern with block grants said, “anytime you go to a block grant, you cap. You cap the

amount of money that comes to you from the federal government” (transcript of recorded interview, 2005, March 11, lines 639-640). Once again, the current administration of George W. Bush, looking for ways to cut back federal spending for Medicaid, is contemplating trying to move to block grants *and* decreasing the amounts of money states receive for Medicaid.

Keen Vision and Power: The Executive Authority of Governor McWherter

In creating TennCare, Governor McWherter envisioned a strong role for the state’s Governor. In describing his instructions to aides drafting the original legislation needed for the Governor to seek a waiver from the federal government, Governor McWherter said,

I want you to write me a small short statute, and...I want it on one piece of paper and I don’t want it to be more than that....I want you to give the Executive Branch and the Chief Executive Officer of the state of Tennessee (you don’t have to call names, but positions) the *authority* [emphasis added] to enter into an agreement for a health care alternative to Medicaid. And it says something like that...that word is in there, authority,...gives [Governor] Bredesen, and it gave [Governor] Sundquist and it gave McWherter...the authority. (transcript of recorded interview, 2005, February 2, lines 202-213)

Although the enabling legislation was actually four pages in length, it contained “broadly permissive language [that] authorized the Tennessee Executive Branch to design and define [TennCare] through administrative regulations. These regulations, which are the legal authority for the TennCare waiver, were established using a streamlined rulemaking process” (Gold, Frazer, & Schoen, 1995, pp. 4-5). Dr. Bruce Vladeck concurred that Governor McWherter had secured “authority from the Legislature that was very broad to design a new program without great specification and detail (transcript of recorded interview, 2005, March 4, lines 45-48).

The action of the Tennessee General Assembly that permitted the creation of TennCare occurred in the context of limited debate and no public hearings. In part this

was because the confidence the Democratic legislature had in their strong leader, and in part this was because the legislature did not want to be accountable for TennCare or any associated political fallout. Limited public discourse has been an issue at other key junctures in the history of TennCare and continues to be an issue.

The authority bestowed on McWherter by virtue of his office was significantly complemented by personal and political clout and involvement. Governor McWherter came to office as the longest serving Speaker of the House in Tennessee history with an excellent reputation for effectiveness based on his style of seeking consensus and inclusiveness.

Governor McWherter's executive authority was challenged during TennCare's first year of operation by the Tennessee Medical Association (TMA). The TMA, which argued that the TennCare program was not a managed care program, but instead a heavily discounted fee-for-service program, rallied against "an unconstitutional delegation of authority to the executive branch" (NEED Citation). The suit was eventually withdrawn.

The Influence of Presidential Authority

President Clinton's involvement in the creation of TennCare was linked to his role as president, his experiences as a former governor and his close, personal relationship with Governor McWherter.

According to Dr. Bruce Vladeck,

President Clinton came to us as a former governor who had been very frustrated about Medicaid and very frustrated with what he perceived as bureaucratic rigidity at HCFA. We had very clear marching orders to make encouragement of state flexibility and state waivers a priority and to be as responsive and supportive to the states as we could. (transcript of recorded interview, 2005, March 4, lines 71-75)

David Manning, the Finance Commissioner during the McWherter administration, related that “before we took the waiver to Secretary Shalala, we took it to the President” (transcript of recorded interview, 2005, March 11, lines 395-396). Manning also related that, “McWherter and the President had a nice visit” (line 398), an indication of their close personal relationship. The President, his wife, Hillary Rodham Clinton, and Governor McWherter met on the Truman Balcony at the White House. Manning recalled, “when [the Governor] came out, we went down to the Secretary’s office and delivered the waiver” (lines 410-411).

Federal Judicial Authority

Federal judges have a role in the administration of Medicaid programs, including TennCare, because the programs are jointly sponsored by the federal government and the states. Even more specifically, consent decrees pertaining to Medicaid are permissible because Medicaid is an entitlement program, rather than a block grant program. Because federal laws specify eligibility requirements for entitlement programs, individuals have the right to seek enforcement of the provisions of the law in the federal courts.

Under Medicaid, the federal government has defined certain categories of individuals who are entitled as a matter of federal law to receive certain benefits. If the state, which has administrative responsibility under that law, fails to provide them with the benefits, they have the right to seek redress in federal court because it is fundamentally a federal responsibility. (B. Vladeck, transcript of recorded interview, 2005, March 4, lines 543-552)

It is this specification that permitted the filing of the civil class action suits pertaining to TennCare. No such protection exists with block grants.

Consent Decrees

Beginning in the mid-1990s, Governor Don Sundquist signed the first of four legal agreements called consent decrees in response to the civil class action suits filed on

behalf of TennCare recipients by the Tennessee Justice Center and one filed first in 1979 (Briefing, n.d.). Merriam-Webster's (2000) defines a consent decree as "a judicial decree that that sanctions a voluntary agreement between parties in dispute". More specifically, "a consent decree is an agreement in the form of a judicial order between two parties that ends a lawsuit by decree rather than by trial" (Brooks, 2005). Consent decrees have been described by Professor Tim Westmoreland of Georgetown University as "a settlement in court rather than a settlement out of court" (transcript of recorded interview on National Public Radio's *All Things Considered*, 2005, June 21). Consent decrees have been used to resolve class action suits against public officials and agencies for years. Consent decrees have been issued over time to cover a wide range of topics, including health care, education and prison conditions (Roxe, 2005). Consent decrees "subject the state administration of federal programs...to ongoing judicial oversight and management" (civilrights.org, n.d.). Most commonly, consent decrees are judicial orders that result "from agreements brokered between public officials and plaintiffs engaged in civil court actions" (Alexander, 2005, para 3). "Consent decrees spell-out exactly how a state or local government should solve a problem that led to the lawsuit, often over a number of years" (J. Rovner, transcript of recorded interview on National Public Radio's *All Things Considered*, 2005, June 21).

Consent decrees offer important protections. According to Susan Brooks, a clinical professor of law at Vanderbilt University, "Consent decrees save money and protect rights" (2005). Money is saved by avoiding litigation costs and having both parties negotiate the terms of the agreement, rather than having the agreement imposed. Charlotte Bryson, the Executive Director of Tennessee Voices for Children, noted that, "consent means just that...parties agree on what the best outcomes are" (transcript of recorded interview, 2005, February 24, line 527-528). The protection of

rights through a system of checks and balances is the centerpiece of justice in our country (Brooks, 2005).

TennCare Consent Decrees

Consent decrees are an important storyline for TennCare. In many ways, views of consent decrees are emblematic of the polarization of stakeholders that has characterized discussions about TennCare. The consent decrees notably address the state/federal government interface, the level of TennCare benefits, quality of care and service issues, as well as who is eligible for the TennCare program. The consent decrees are particularly important because they represent the breakdown of important tacit agreements that supported the development of TennCare and because they are a result of pervasive management problems (discussed in the next chapter) and the lack of strong effective leadership.

The advocates and others with similar perspective think that consent decrees are necessary to protect rights and that the rights of beneficiaries were violated in the administration of the TennCare and TennCare Partners program. Some informants spoke of the consent decrees as unrealistic and complained about the untoward effects of the terms of the consent decrees negotiated. Governor Bredesen and members of his administration contend that the consent decrees thwart efforts to manage program costs, and they worked vigorously and successfully to eliminate or modify the TennCare decrees. Supporting Governor Bredesen in his efforts to limit the reach of the consent decrees, Senator Lamar Alexander and Representative Jim Cooper introduced federal legislation in early 2005 to limit consent decrees issued in federal courts.

The reader is directed to Tables 7 and 8 which describe the four TennCare consent decrees and show a timeline pertinent to the consent decrees.

Table 7: TennCare Law Suits and Consent Decrees Descriptions

Consent Decree	Description
<i>Grier v. Goetz</i>	<p>Order modified an existing 1979 Consent Decree known as <i>Daniels</i>. The <i>Daniels</i> case was a challenge to the denial of medical services under Medicaid (<i>Grier v. Goetz</i>, 1996, Tennessee.gov, n.d., c; Tennessee Justice Center, 2005). “The Grier consent decree provide[d] appeals for TennCare patients when the state or its managed care contractor (HMO) denied coverage for a needed medical service” (Tennessee Justice Center, 2005, June 13). A key component of this consent decree required TennCare to obtain express physician approval to override prescriptions not on an approved drug list (Alexander, 2005, April 04; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003 August 27; Humphrey, 2003 August 27; Locker, 2003 August 27). Initially this decree essentially resulted in an open formulary, hampering the state’s ability to manage prescription drug costs. The Grier consent decree also spelled-out appeals procedures. In 2005 the Grier consent decree was substantially modified.</p>

Table 7: Continued

Consent Decree	Description
<i>John B. v. Menke</i>	<p>This class action suit was brought on behalf of all TennCare enrollees under the age of 18; suit alleged that the state of Tennessee failed to meet obligations under the federal EPSDT mandate which governs the provision of medical services to Medicaid-eligible children (Chang & Steinberg, 2005; <i>Grier v. Goetz</i>, 1996, Tennessee.gov, n.d., c; Tennessee Justice Center, 2005). In this decree, the state was given five years to close the gap between the state's actual performance and the federal standards regarding screening and preventive care for children. Little or no progress was made subsequent to this. In 2001 the court found the state in violation of each of the major components of the 1998 consent decree and a Special Master was appointed because the state was not in compliance with the order. In 2002 the state requested that expansion population children not be included in the decree (Alexander, 2005, April 04; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003 August 27; Humphrey, 2003 August 27; Locker, 2003 August 27; Tennessee Justice Center, 2005, June 13).</p>

Table 7: Continued

Consent Decree	Description
<p><i>Rosen v. Commissioner of Finance and Administration</i></p>	<p>This case was a challenge to the state’s eligibility process for TennCare beneficiaries in the expansion population (Alexander, 2005, April 04; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003 August 27; Humphrey, 2003 August 27; Locker, 2003 August 27). Plaintiffs for the case included uninsured and uninsurable TennCare enrollees who alleged that the state of Tennessee failed to provide an adequate system for assuring due process regarding premium assessment, premium disputes, denial of TennCare eligibility and termination of TennCare eligibility (Chang & Steinberg, 2005; <i>Rosen v. TN Commissioner of Finance and Administration</i>, 1998; Tennessee.gov, n.d., c; Tennessee Justice Center, 2005). Particularly noteworthy about this decree was the stipulation that Judge Haynes must approve <i>any</i> reduction in enrollment (Alexander, 2005, April 04). In 2005, Judge Haynes did authorize the disenrollment of TennCare beneficiaries from the expansion population.</p>
<p><i>Newberry v. Menke</i></p>	<p>The Newberry case challenged inappropriate denial of home health services for people with disabilities enrolled in TennCare (Caughorn, 2003, August 27; de la Cruz, 2003 August 27; Humphrey, 2003 August 27; Locker, 2003 August 27). The settlement, later known as <i>Newberry v. Goetz</i>, required the state to pursue a budget-neutral home-based program for elderly TennCare beneficiaries and for the TennCare MCOs to pay more for home health care for poor, disabled and elderly TennCare recipients (Chang & Steinberg, 2005; <i>Newberry v. Menke</i>, 1998; Tennessee.gov, n.d., c; Tennessee Justice Center, 2005).</p>

Table 8: TennCare Consent Decree Timeline

Date	Event
August 1996	An Agreed Order, known as <i>Grier</i> , entered. (<i>Grier v. Goetz</i> , 1996, Tennessee.gov, n.d., c; Tennessee Justice Center, 2005).
February, 1998	<i>John B. v. Menke</i> filed in U.S. District Court (Chang & Steinberg, 2005; <i>John B. v. Menke</i> , 1998; Tennessee.gov, n.d., c; Tennessee Justice Center, 2005).
March 1998	The <i>John B.</i> Consent Decree signed (<i>John B. v. Menke</i> , 1998& Tennessee.gov, n.d., c).
July, 1998	The <i>Rosen v. Commissioner of Finance and Administration</i> lawsuit filed in federal court (Chang & Steinberg, 2005; <i>Rosen v. TN Commissioner of Finance and Administration</i> , 1998; Tennessee.gov, n.d., c; Tennessee Justice Center, 2005).
December 1998	The <i>Newberry v. Menke</i> lawsuit was filed in federal court on December 7, 1998 (Chang & Steinberg, 2005; <i>Newberry v. Menke</i> , 1998; Tennessee.gov, n.d., c; Tennessee Justice Center, 2005).
September 1999	The state of Tennessee entered in a Consent Decree with plaintiffs for the <i>Rosen v. Commissioner of Finance and Administration</i> (Chang & Steinberg, 2005; <i>Rosen v. TN Commissioner of Finance and Administration</i> , 1998; Tennessee Justice Center, 2005).
October 1999	Revised Consent Decree governing appeals in TennCare is filed in federal court as a follow-up to the <i>Grier</i> case; the revisions concern appeals (<i>Grier v. Goetz</i> , 1999; Tennessee.gov, n.d., c).
July 2000	Revised Consent decree governing TennCare appeals modified (Tennessee.gov, n.d., c).
September 2000	Request for stay of implementation of the term of the <i>Grier</i> settlement denied (Tennessee.gov, n.d., c).
January 2001	The Tennessee Justice Center filed a complaint in federal court regarding breaches of the John B. settlement (Tennessee.gov, n.d., c).
December 2001	The Court found the state of Tennessee to not be in compliance with the terms of the original <i>John B.</i> Consent Decree; a Special Master was appointed to oversee the state's compliance (Tennessee.gov, n.d., c).

Table 8: Continued

Date	Event
August 2003	Governor Bredesen and Gordon Bonnyman negotiated changes to the four TennCare Consent Decrees. The state and plaintiffs agreed to a grace period for all persons who lost coverage under new TennCare eligibility provisions proposed July 1, 2002: state agrees to withdraw proposed benefit reductions and cost-sharing increases, continue EPSDT coverage for children enrolled in TennCare regardless of Medicaid eligibility; plaintiffs agreed to reduce requirements for receiving prescription drugs from 14 days to 3 days without prior authorization (Tennessee.gov, n.d., c).
October 2003	Settlement Agreement reached with plaintiffs in four TennCare lawsuits (Tennessee.gov, n.d., c).

Three of the consent decrees relative to TennCare originated from lawsuits filed in 1998 by the Tennessee Justice Center, headed by activist attorney Gordon Bonnyman. Each of the lawsuits was filed in an attempt to halt efforts initiated by the state to curtail benefits of the TennCare program or reduce the number of beneficiaries (Locker, 2003, August 27). The first of these, the Rosen case, was a challenge to the state's eligibility process for the Medicaid expansion population. This consent decree was signed by U.S. District Judge William Haynes in 1998 with several orders after that modifying the decree, most substantially in 2002 (Alexander, 2005; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27). Particularly noteworthy about this decree is the stipulation that Judge Haynes must approve *any* reduction in enrollment (Alexander, 2005).

The Newberry case challenged alleged inappropriate denial of home health services for people with disabilities enrolled in TennCare (Caughorn, 2003, August 27;

de la Cruz, 2003; Humphrey, 2003, August 27; , August 27, 2003). The John B. filing concerned medical screening and treatment services for children under age 21. This consent decree was signed in 1998 by U.S. District Judge John Nixon after 18 months of negotiations. In this decree, the state was given five years to close the gap between the state's actual performance and the federal standards regarding screening and preventive care for children. Little or no progress was made subsequent to this. In 2001 the court found the state in violation of each of the major components of the 1998 consent decree and a Special Master was appointed because the state was not in compliance with the order. In 2002 the state requested that expansion population children not be included in the decree because they were not covered by the entitlement provisions of Medicaid (Alexander, 2005; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27; Tennessee Justice Center, 2005, June 13).

According to Bonnyman, the concerns that the advocates had that precipitated the filing of the John B. lawsuit did not originate in TennCare. In a 2005 personal interview, he stated that,

The background for John B. was that children had not been getting services, medical and behavioral, for some time. Again if you go back far enough, the problem was lack of community services and a grossly inappropriate reliance on inpatient psychiatric hospitalization. So it's not as if there was some policy one day in the past when things were good and they fell apart under managed care. They were flawed, they were troubled, and they lurched in a new damaging direction with the launch of TennCare and TennCare Partners, when it came to behavioral health for severely emotionally disturbed children. (transcript of recorded interview, 2005, February 15, lines 361-369)

In addition to the Rosen Agreed Order and the John B. Consent Decree, the most significant consent decree relative to TennCare is the Grier Consent Decree (Briefing, n.d.). The Grier case has a long history. The Grier lawsuit, filed fifteen years before the start of TennCare in 1979, resulted in the signing of a consent decree by

Judge John Nixon in 1999. The case has been opened on several occasions, including 1986, 1996 and 1999, because of compliance failures. As a result of a 1999 opening, a revised agreement was approved by the court in February 2003. Another revised agreement was approved five months later in August (Alexander, 2005; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27; Tennessee Justice Center, 2005, June 13). “The Grier consent decree provides appeals for TennCare patients when the state or its managed care contractor (HMO) denies coverage for a needed medical service” (Tennessee Justice Center, 2005, June 13). A key component of this consent decree required TennCare to obtain express physician approval to override prescriptions not on an approved drug list (Alexander, 2005; Briefing, n.d.; Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27). Initially this decree essentially resulted in an open formulary, hampering the state’s ability to manage prescription drug costs. The Grier consent decree also spells-out appeals procedures.

A temporary truce. Although consent decrees can not be appealed, they “can be modified whenever one party can convince the court it is no longer equitable that the decree be enforced as agreed” (Brooks, 2005). Consent decrees can be modified or terminated as conditions change (Brooks, 2005).

Governor Phil Bredesen included TennCare reform as a priority in his campaign. He emphasized that reform was necessary, not only to stabilize the beleaguered program, but to also shift the balance in the budget to fund other social program priorities, particularly education. In August of 2003 Governor Bredesen and Gordon Bonnyman negotiated changes to the four outstanding consent decrees concerning TennCare in an effort to facilitate Bredesen’s reform agenda. The optimism seen at that

time quickly faded, calling into question the actual impact of the consent decrees and the role they play in bringing about needed changes.

The changes that were agreed-to in August 2003, and were subsequently approved later in the year in the federal courts by the judges presiding when the decrees were originally constructed, included, most significantly, the lifting of the Grier consent decree until December 31, 2005. The previous 14-day appeal process reverted to a three-day appeal limit in accordance with existing federal law and precedent. This change coupled with an earlier move by the state to single preferred drug list (PDL) or formulary allowed the state to extend the use of less costly generic drug alternatives and benefit from bulk purchasing discounts and pharmaceutical company rebates. Together these changes were projected initially to save \$100 million annually (Caughorn, 2003a; Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27). When the August 2003 settlement to the Grier case was announced Governor Bredesen said, "Today's announcement gets the state...back in the driver's seat with TennCare. It clears the way for critical reforms we need to make, some critical cost savings items we need to deal with" (as quoted in Caughorn, 2003, August 27). When requisite papers were submitted to the federal court in September 2003, the state said the agreement would "enable the state to achieve substantial savings, thereby obviating other TennCare reductions in benefits and/or eligibility that would be harmful to members of the plaintiff class" (as quoted in Tennessee Justice Center, 2005, June 13). Additionally the state agreed to withdraw proposed reductions in home health care and private nurse benefits, the key impetus of the Newberry case. Governor Bredesen and Gordon Bonnyman also agreed that prior TennCare recipients that did not meet new eligibility requirements specified under a new federal waiver re-verification process would have a one-year grace period to reapply. The significance of this change was not

that it was expected that there would be a large number of beneficiaries re-instated, but rather that the threat of a court-ordered full re-instatement was eliminated along with the projected \$200 million cost of such a ruling.

The state's agreement to allowing reapplication was supported by their prior experience with the process. Originally 200,000 were affected by the new eligibility requirements. Of these, 150,000 previously had the opportunity to reapply; only 5,000 of these were eventually reinstated (Humphrey, 2003, August 27). Finally the state reaffirmed their commitment to the terms of the John B. consent decree, agreeing that screening and treatment services for children under age 21 in TennCare, packaged under the rubric Early Periodic Screening Diagnosis and Treatment (EPSDT) would be included for all children, meaning the children in the expansion population would not be excluded. Bredesen projected that the cost of changes to the Newberry, Rosen and John B. cases would be \$20 million (Caughorn, 2003, August 27; de la Cruz, 2003; Humphrey, 2003, August 27; Locker, 2003, August 27; Tennessee Justice Center, 2005, June 13).

Short-lived optimism. Despite the anticipated savings that Bredesen projected when the compromise on the consent decrees was announced, it was just several months later, on February 17, 2004, when Bredesen announced that radical benefit and beneficiary cuts would have to be made to make TennCare financially viable for the state. With the announcement, the Bredesen administration launched a new battle using the Grier consent decree as a lightning rod for the ensuing controversies. Following the very public war of words that ensued, state of Tennessee officials, advocates and representatives for each found themselves in Judge Nixon's court once again beginning June 29, 2005 arguing about the terms of the Grier consent decree. The Bredesen administration argued that they needed relief from the decree so that they could proceed

with their reform plan. Previously, in March of 2005, CMS had approved the cutbacks in enrollment proposed by the administration. Then in April, the Sixth Circuit Court of Appeals in Cincinnati overruled a prior ruling from a federal judge in Nashville who had called for a temporary halt in the Governor's plan to disenroll 323,000 TennCare beneficiaries. The Court of Appeals ruling also gave Judge Haynes Jr. the authority to oversee the state notification procedures and to assure that appeal processes would protect beneficiaries' rights (Fly, 2005, May 28, May 28; Johnson, 2005, August 14; Wadhvani & de la Cruz, 2005, April 16, April 16). The Bredeesen administration then proposed that 97,000 of the sickest TennCare enrollees targeted for disenrollment could be spared *if* additional changes were made to the Grier consent decree. The advocates and enrollees vehemently disagreed with further changes to the consent decrees and disputed the rationale given for their need. The advocates and their constituents did not prevail.

Although Governor Bredeesen was directly involved with Gordon Bonnyman in the negotiations that led to the re-working of the consent decrees in 2003 and he praised the progress afforded by the changes, spokespersons for the Governor never indicated that he had secured all the changes that would be needed as some assumed. Both Governor Bredeesen and Manny Martins knew that it would be problematic to not cover drugs on the Preferred Drug List (PDL), after a three- day emergency supply of the off-list drug had been issued if the dispute had not been resolved. This issue was also a key reason that the state was seeking prior authorization of all off-list drugs.

The Executive branch's call for additional changes was prompted by the release of the first of two reports by McKinsey and Company on December 11, 2003. The report, commissioned by the state, painted a grim picture about TennCare's financial viability. One conclusion of the report authors was that an unchanged the cost of the

TennCare program would escalate from accounting for 25 percent of the annual state budget to 34 to 40 percent depending on economic conditions. Moreover it was projected that the TennCare program would consume from 63 to 144 percent of all available new tax revenue if the program was not changed (McKinsey, 2003).

The McKinsey and Company analysis identified that spending for the areas of most cost increases, pharmaceuticals, professional services and outpatient services, would drive almost 50 percent of the growth of future spending with pharmacy cost growth as the single most significant source of future growth. The growth in pharmaceutical costs is not unique to TennCare, but within the McKinsey projections are specific aspects of TennCare's design and delivery that are fueling the dramatic cost increase (McKinsey, 2003).

Armed with the second McKinsey report (2004), the state of Tennessee claimed it needed to modify the Grier consent decree to save money and preserve coverage for 97,000 of the sickest enrollees among the 323,000 to be disenrolled. Officials from the Bredeisen administration cited several specific issues with the Grier consent decree. The issues related to the appeals process, definitions of medical necessity, a generous drug benefit which had no limits on the number or cost of drugs prescribed and the MCOs insistence that the current terms make the assumption of risk for program costs untenable (Wadhvani, 2005, July 01).

Administration officials also wanted to change the definition of medical necessity so that a medical service would have to be the *least costly* treatment that is adequate to be deemed medically necessary. Opponents to this approach argued that the least costly treatment is not always the most cost-effective (Wadhvani, 2005, July 01). There was also concern that changes to the medical necessity definition would limit care for children stipulated by the John B. agreement (Tennessee Justice Center, 2005, June

13). The Bredeesen administration also proposed a five prescription limit for all adult enrollees (two brand name scripts and three generic) with a prior authorization process for all prescribed drugs to foster the use of cheaper but similar drugs on the PDL (Wadhwani, 2005, July 01).

Gordon Bonnyman countered that the financial savings the administration projected were questionable. “The numbers are derived from politics. This is not about savings. For them [the legal agreement] is cover. They’ve got their story. They’ve been telling it for a year. And they sticking to it” (as quoted in Wadhwani, 2005, July 01). Bonnyman also questioned the state’s ability to manage the volume of prior authorizations TennCare would require (most prior authorization review processes in the private sector focused only on high cost drugs or drugs with unexplainable patterns of variation in prescribing, not all drugs as was proposed for TennCare). Implicit in Bonnyman’s charge were two important points. The first was that the state does not have a good management track record. Secondly the need for additional reforms could be tempered by better management (the consent decrees and management of the TennCare program will be discussed further in the next section). In the federal court hearing that commenced June 29, 2005, Charles Cooper, an attorney representing the state of Tennessee, blamed the Grier consent decree for “[turning] TennCare’s system of managed care into a system of unmanaged care” (as quoted in Wadhwani, 2005, June 30).

Perhaps the state and the MCOs are more accountable for the lack of management than this statement reflects. Dr. Harry Jacobson, vice chancellor for Health Affairs at Vanderbilt University, who supports the state’s more restricted definition of medical necessity, did concede on cross-examination that the state’s MCOs do not

have the infrastructure to effectively manage care delivered in TennCare according to available evidence (Wadhvani, 2005, June 30).

The TennCare appeals process in place prior to the 2005 changes was unique in that an appeal was allowed even when the appeal was not initiated by a provider (Johnson, 2005, July 01). Additionally the appeals process allowed patients to secure services that the state did not cover in the TennCare program (Wadhvani, 2005, July 01). According to the terms of the Grier consent decree before the most recent changes, “defendants and others acting on their behalf are prohibited from denying appeal rights on any ground whatsoever” (as quoted in Johnson, 2005, July 02). When the Grier consent decree was originally negotiated the state agreed to provide special protections to particularly vulnerable patients. In 2005 the state of Tennessee sought to limit appeals to only *factual* disputes. This is the most prevalent standard for appeals in the private sector and for most Medicaid programs (Johnson, 2005, July 02).

In early August 2005, Judge Nixon ruled that the definition of medical necessity could be changed and that plans to require prior authorizations for all pharmaceuticals and limit the number of prescriptions covered for most beneficiaries to five per month could be implemented. He also agreed that it was no longer necessary for the state to supply drugs while an appeal was in process (“Court Orders Help Stabilize TennCare, 2005, August 14; Johnson, 2005, August 03; Johnson, 2005, August 14; Wissner, 2005, August 10).

How significant are the TennCare consent decrees? Controversy preceded the issuance of the TennCare consent decrees and controversy has characterized their history. Whether you view the consent decrees as an essential response to serious mismanagement by the state and the MCOs and BHOs, or you think the consent decrees have been the source of serious problems in the program, there is no doubt that

the consent decrees have been an important subplot for the TennCare story. Few would dispute the impact of the Grier consent decree when a 14-day supply of drugs was required while an appeal was pending. Prior to the inception of TennCare, the state of Tennessee already had one of the highest prescription drug rates in the country (McKinsey, 2003, December 13). After the Grier consent decree was implemented, pharmacy costs skyrocketed in TennCare. The true impact of the other consent decrees is not known and views are widely divergent.

Dr. Russ Petrella of Magellan said prior to the most recent changes that the TennCare consent decrees had been a serious management liability. He stated,

The consent decrees have created a situation in the state that makes managing these programs virtually impossible from the state perspective and from our perspective. Many of the issues have been painted with a broad brush and so that by trying to solve some issues for an extraordinarily small number of people have created obligations for larger numbers of people that waste money and create inefficiencies. (transcript of recorded interview, 2005, February 25, lines 122-124)

Dr. Petrella cited an order regarding discharge planning as an example of the “using an elephant gun to kill a mouse”, explaining,

They are very concerned, for example, that people will not be discharged from the hospital without a discharge plan. So now there is something in place that if a person chooses not to be discharged from the hospital, they can get extra days in the hospital even though everyone agrees that it is not medically necessary. Now if you took all the extra days that people spend in the hospital that are paid for that the medical folks believe aren't necessary, you'll have an extraordinary amount of money there. And so it's a protection that... it's kind of a false protection because what it ends up doing is watering down the overall program, watering down the benefits for other folks. (transcript of recorded interview, 2005, February 25, lines 125-134)

Manny Martins dismissed the idea that the consent decrees, other than Grier, had far-reaching implications (even before changes). He did though bemoan the hassle associated with the consent decrees. He said,

My sense is that you can manage your way around the consent decrees. There are some things as a manager that I would never have signed if I were here and

were asked to sign those consent decrees because I think some of the things in those consent decrees are not possible to reach. They are good goals, but, you know, they're not that possible to reach. As an example, can we ever reach a 90 percent screening rate for kids?...Have we ever been hurt significantly for not having reached that? I don't think so, and I think as long as we're progressing to reach that and we're doing what we can to reach that, it's a nuisance. Though depending on where you are and what you have to do, that nuisance can sometimes divert resources.

As an example, I have had to divert a large number of staff when I was in TennCare to deal with a process set up by a special master that was tedious and required a huge amount of tedious work. And I had to divert high-level ranking people that could have been utilized to, you know, help us monitor where we were on a preferred drug list, what do we need to do to keep drug costs down, and so on. But because of this tedious approach, I've had to redirect them. That's been more of a nuisance than anything. The Grier consent decree with the original fourteen days" supply of drugs was a problem because it essentially overrode the formularies that the State had. We re-negotiated that consent decree to three days. Once we did that, it would be my belief that that became an insignificant issue for us. We implemented the PDL [Preferred Drug List] with that consent decree when the days were reduced from fourteen to three. We have over 90percent compliance with the PDL, so I can't be very concerned about that. (transcript of recorded interview, 2005, March 11, lines 581-608)

Should Consent Decrees be Limited?

The TennCare consent decrees have bedeviled two governors. The debate that has been occurring in Tennessee about the TennCare consent decrees has been complemented by a national effort to curtail consent decrees. National debate about consent decrees has been prompted by the introduction of legislation March 1, 2005 to limit the impact and duration of the consent decrees by Senator Lamar Alexander, a Republican from Tennessee who also served as the Tennessee Governor from 1979 until 1987, and Congressman Roy Blunt, the Republican Majority Whip from Missouri at the time the legislation was introduced (in late September, Blunt was picked to replace Tom DeLay as the Majority Leader of the U.S. House of Representatives). According to Alexander, "Once these decrees are set, they are very difficult to change, making reform and common-sense adjustment over time virtually impossible" (2005, para 3). Because

of this and the constraints Governor Bredesen perceives in his efforts to deliver on a campaign promise to reform TennCare, Alexander is seeking to make it easier for newly elected officials to modify or rescind terms of consent decrees when an election results in an office changing hands, or every four years. Additionally, the burden of proving the ongoing necessity of the an existing decree would become a responsibility of the original plaintiff, in contrast to the current practice of requiring defendants to “prove” that the consent decree is no longer needed (Alexander, 2005; Sullivan, 2005).

One of the major complaints about the consent decrees is their duration, which can span decades. Existing federal law though permits modification or termination of consent decrees (civilrights.org, n.d.). Consent decrees are also in place to address a wide variety of social and other policy and program deficiencies. Change needed to remedy such deficiencies often takes years to implement and stabilize. The federal courts play a role in fostering and monitoring change.

Opponents of consent decrees such as Alexander and Blunt say that consent decrees have been used to inappropriately extend federal programs and violate the principles of federalism. Besides a fundamental concern about abuses of federal power, Alexander and others of like mind see consent decrees as inefficient and cost-ineffective (American Enterprise Institute for Public Policy Research, 2005, July 01a).

Those that oppose Alexander’s proposed legislative efforts are concerned about the prospect of defendants being able to avoid continuing obligations, which were often signed to avoid lengthy trials and the potential of even more burdensome terms. Opponents think that this move is part of a larger assault by conservatives who perceive the consent decrees to be inappropriate judicial activism. Proponents say that out-dated consent decrees interfere with needed reform and changes needed for responsive government (Alexander, 2005).

Dr. Russ Petrella was careful to draw a distinction between the consent decrees issued relative to TennCare and the general concept of consent decrees. He related that,

I've done a dozen consent decrees in other states where I was either brought in as the monitor or one of the reviewers, or participated with the special master, and the whole idea is to make them doable and to focus on what problem they're trying to solve. And some of the solutions here I don't think make sense...I've been doing public sector policy for 30 years for both the government side and private side, and some of these things just have created an untenable situation which now has reached a crisis point unfortunately. (transcript of recorded interview, 2005, February 25, lines 136-144)

Governor McWherter, reflecting general opposition to consent decrees, has asserted that he "would not enter into a consent decree" (transcript of recorded interview, February 4, 2005, line 159). Gordon Bonnyman has called into question the realism of this assertion, saying, "No governor ever enters into these things without the belief that it is in his interest or the state's interest to do so" (Sher, 2005, March 1), noting most usually fear losing in court.

According to Dr. Bruce Vladeck (1999), consent decrees regulate individual manifestations of systems rather than fundamentally reform systems. This view is consistent with the position of Gordon Bonnyman. He related that the TennCare consent decrees were necessary because of serious lapses in the delivery TennCare services and the violation of beneficiary rights. The consent decrees were not an effort to produce changes in the design of TennCare and TennCare Partners, but rather a reaction to serious lapses in the delivery of TennCare services. According to Charlotte Bryson, "consent decrees are the due process that people have used if they have found that their rights have been violated...or they did not get the services they were supposed to get through TennCare" (transcript of recorded interview, February 24, 2005, lines 524-526).

Bonnyman asserts that complaints about the TennCare consent decrees are “basically cover; they’re a distraction” (transcript of recorded interview, 2005, February 25, lines 620-621). Furthermore,

The problem that the State has gotten itself in with these consent decrees is it didn’t...comply with the law. And it hasn’t done sound policy. John B. and EPSDT reflect well-accepted, established pediatric care standards and if we had been living up to that, if the State had been living up to that, we wouldn’t have gotten into trouble to begin with. We need to live up to it instead of complaining about the role of the courts. (lines 599-605)

Referring to Governor Bredesen’s assault on the consent decrees, he stated,

I think as a result of management problems, he found that he needed the cover, and so he picked up the means that George Wallace left behind for southern governors...that says, “if you’ve got management problems that are beginning to cost you politically, blame it on the Federal courts”. And then you saw the State of the State address where he got a standing ovation for pillorying those people who were unelected, which of course he’s referring not only to me, but he’s referring to the Federal judges. (lines 608-617)

Charlotte Bryson also countered Governor Bredesen’s claim that the consent decrees prevent his administration from reforming TennCare, saying,

I am concerned so much blame has been placed on the consent decrees because the consent decrees just pointed out what some of the problems of TennCare are. The important thing is to look at what the problems are and to address and fix the problems. The consent decrees are not the main cause of the difficulties we are having in TennCare. There are such broad and big issues that we need to work on like an efficient data system, accountability, as well as drug utilization review. None of that is prohibited in the consent decrees. [What] I would like to see us do is look at the consent decrees for what they are, playing out some problems with our service delivery, fix those problems and...develop a strategy to deal with the major problems in TennCare. (transcript of recorded interview, 2005 February 24, lines 530-539)

Interestingly, Congressman Blunt contends that “elected officials often use consent decrees to excuse inaction on which they—not the federal courts—should be responsible” (American Enterprise Institute for Public Policy Research, 2005 July 01).

Taking this idea further, Blunt said,

I really think this is more about inactive public officials than overly active judges. Consent decrees are too often used by elected officials as the reason that they can’t do anything about an area that should be their responsibility. The principal

goal of this bill is to get the responsibility for public policy and public institutions back in the hands of elected officials...Consent decrees, in my view, have become a place for public officials to hide behind, both in the area of the consent decree specifically affects and as an excuse not to do things in other areas where public officials should have responsibility. (American Enterprise Institute for Public Policy Research, 2005 July 01)

Although Congressman Blunt noted that the problem with consent decrees is generally not the federal judges, Dr. Michael Greve, a political scientist who directs the Federalism project at the American Enterprise Institute for Public Policy Research, has said that the judges are the problem with the TennCare consent decrees. He has said,

Judge Haynes, who's been running TennCare for the past years and thinks he owns it, has not been reversed once by Sixth Circuit. He has been reversed repeatedly and he doesn't care what the Sixth Circuit says. The same is true for Judge Nixon, who runs the other half of TennCare. But I think these judges are now really the exception. (American Enterprise Institute for Public Policy Research, 2005 July 01)

Governor Sundquist implied that Judges Haynes and Nixon were selected by the advocates because of their sympathetic views when he said,

I don't know what you do about Federal courts. Federal courts bear a huge responsibility for the costs of health care increases. And when advocates can pick and choose their judges, which is what they do in some form or another, because they know this judge or Judge Nixon or whomever, is the one they're going to go to because they know it's like fishing in the bathtub. And they know what the results are going to be. I'm not saying it's dishonest or anything; it's just a fact of life. (transcript of recorded interview, 2005, March 15, lines 885-890)

There is a certain irony that Congressman Blunt and Gordon Bonnyman agree that consent decrees are used for cover and yet they make such dissimilar conclusions about their merit. It is also noteworthy that Governor Sundquist's observations about Judges Haynes and Nixon are shared by some outside observers.

A Contrasting History of Judicial Involvement

In an interesting aside, both Governor McWherter and Gordon Bonnyman offered unprompted comments about their joint experience with another consent decree;

Bonnyman also compared experiences. Both McWherter and Bonnyman had experience and interactions with a federal court order related to the Department of Corrections prior to the implementation of TennCare. McWherter inherited the court order from the administration of former Governor Lamar Alexander (1979-1987); events leading to the execution of the order actually began in the administration of Governor Ray Blanton (1975-1979). Both McWherter and Bonnyman stated that their experience with this court order was instrumental in shaping their perceptions of judicial oversight in state-administered programs, although their perspectives led to different conclusions.

In 1982 a federal district court judge appointed a special master to oversee prison reforms in Tennessee. This was a result of a determination that parts of the state prison system were unconstitutional (Lee & Rogers, n.d.). Relating to the assumption of this court order and his experience with the order, McWherter stated, "I would not enter into a consent decree until he [apparently referring to Gordon Bonnyman] carried me to the Supreme Court. I learned that from the experience in the Corrections Department" (transcript of recorded interview, February 2, 2005, lines 159-160).

Bonnyman recently described his eighteen-year history involving efforts reform state prisons (transcript of recorded interview, 2005, February 15). In doing so he highlighted the importance of the court's role. He started by delineating the court's role in saying, "the courts were necessary, but not sufficient" (line 548). Explaining that the value of the court's involvement was that,

They were the constant pressure and accountability mechanism out there that held State government to account. Did not micro-manage. Did not dictate. But at crucial points, the special master in the prison litigation, who was former Commissioner of Correction himself and who brought in experts whose resources were made available to the State, played a very important role both in coercion and accountability, and also in technical support and leadership in a very politically subdued, but crucial, sort of way. (transcript of recorded interview, 2005, February 25, lines 550-555)

The good experience that Bonnyman described with the special master in the prison litigation was not replicated in the John B. case. From his perspective,

The last administration and this administration, the current administration, have very effectively...(this last administration less so, but certainly the current administration) exploited the mere existence of consent decrees, using litigation as cover for its own mismanagement and claiming that problems are not due to what are pretty serious management lapses by the state. And it remains to be seen whether that...strategy will work over time. And the weakness of litigation is obvious. I mean, the courts can't manage things. The courts can't... all they can do is hold people to account and hope that the coercion will force them to do the management and the leadership and the reforms that are necessary. But there is a staying power about the courts that other institutions don't have. I mean, they don't go away. (transcript of recorded interview, 2005, February 25, lines 570-582)

To address the issues and continuing problems associated with prison overcrowding, the General Assembly established an Oversight Committee. Bonnyman recounted that reform efforts were ultimately successful, despite turnover in judges, legislators, governors, Department of Corrections Commissioners and middle managers, saying,

The one thing that helped was that there was an oversight committee appointed by the...Legislature with members from both Branches and both Houses, both the Senate and the State House of Representatives, that was allowed to hire professional staff that was knowledgeable and could solve this. And that developed a body of expertise that could effectively discharge the oversight functions, and it also tended to insulate what was a politically-charged Department and system from inter-meddling by both Branches, both Houses of the Legislature. There was a place where the Legislature could discipline itself by making sure that there was responsible and informed professional oversight. And it could also upgrade the quality of its oversight function and regulatory function through those same resources. That was significant. (transcript of recorded interview, 2005, February 25, lines 487-500)

Significantly Bonnyman also highlighted the value of involvement of the public press, saying,

But there was also sustained attention by the news media to the prison system, to the problems of the prison system, and it was well-informed and sustained. There were several reporters, several media outlets, that paid attention to the

prison story, stayed on it, developed expertise, had institutional memories as politicians came and went, and were able to educate the public so that even something as subject to demagoguery as prisons and correction and law enforcement got to the point where elected officials understood they needed to pay attention to this....They were not going to make political hay out of it. If they tried, it would bite them, and they needed to get real. They needed to have the right people, give them the latitude, give them the resources, and hold them accountable, and stand back. (transcript of recorded interview, 2005, February 25, lines 500-513)

Bonnyman does not think that effective legislative or executive oversight exists in TennCare commenting,

We don't have any of that from the health system, and we don't have any of that in mental health services for children, specifically. So what you're talking about is something, an enterprise, [that] is ultimately, publicly accountable, and... therefore its fate is going to be determined for better or ill in the political sphere. And if politics works appropriately, it will depend upon the media being informed through a rigorous and professional well-informed news media, the Legislature having the resources and the seriousness of purpose to do its oversight functions, and the Executive Branch...receiving the resources and then committing the appropriate executive leadership and political support to people to identify problems, develop solutions, and carry them forward. And all of that with the political will that if there's going to be contracting of those services, [to] the Behavioral Health Organizations and others, the State has an internal capacity to write good contracts and hold its contractors accountable. (transcript of recorded interview, 2005, February 25, lines 515-528)

Bonnyman also reflected on the parallels between the privatization that occurred with the Tennessee prisons and the Medicaid program with the advent of TennCare, saying,

I saw good things and bad things of privatization in the corrections contracts. The problem with privatization is that there, in my view, it tends to be an ideological agenda that says, 'We're going to privatize this, and the genius of the private sector will do a better job of the public sector. We can wash our hands of this and be gone.' No, you've got to have enough residual capacity within state government to hold your contractors accountable. And so that's a critical function that you've got to have, you know, and reasonable people can differ about whether privatization is appropriate at what level, for what functions. I'm somewhat agnostic on that, but I'm not agnostic at all and I feel very strongly, and I think the record supports it, that if you're going to do privatization, you've got to have internal capacity to hold your entities responsible. (transcript of recorded interview, 2005, February 25, lines 528-538)

Final Thoughts on Consent Decrees

When you sort through all the rhetoric and posturing about the consent decrees, three things are apparent. First, conceptually consent decrees are a necessary option to protect rights. Secondly, though sometimes the remedy seems extreme, it must be remembered that serious grievances are often the genesis of the need for the relief offered by consent decrees. Thirdly, a distinction must be made between intent and execution. The intent of consent decrees is consistent with the balance of governmental power envisioned by our country's founding fathers. Poor execution is no excuse to "throw the baby out with the bath water". Even with the dismantling of the TennCare consent decrees, the state still has the legacy of mismanagement of the TennCare program. The consent decrees are not the root cause of TennCare's troubles and their removal will not alleviate the longstanding deficiencies in the design and delivery of TennCare. Nevertheless, consent decrees have had a key role in reordering priorities and shifting focus in the program's operation.

TennCare Oversight

A variety of state, legislative and other entities have jurisdiction over TennCare. The TennCare Oversight Division is a part of the Department of Commerce and Industry. The TennCare Oversight Committee, also referred to as the Select Committee on TennCare Oversight is a joint House and Senate committee of the state Legislature. The TennCare Partners Roundtable is a forum that includes providers, consumers, MCO and BHO representatives and other interested parties (Milbank Memorial Fund, 1999; Tennessee Blue Book, n.d.; Tennessee.gov, n.d.).

The TennCare Oversight Division examines and monitors MCOs and BHOs that participate in TennCare. The group also monitors market practices and tracks

complaints (Milbank Memorial Fund, 1999; Tennessee.gov, n.d.). It is important to remember that Tennessee's experience with managed care was very limited, even in the commercial sector, prior to the start of TennCare.

The role of the Tennessee Legislature relative to TennCare was minimized from the outset, in part because of the leadership position Governor McWherter was willing and able to take, and in part because of the legislators' reluctance to confront hard political realities. Faced with raising taxes or slashing Medicaid benefits, the legislators were more than willing to defer to Governor McWherter initially and subsequently to his successors. Members of the TennCare Oversight Committee are appointed by the respective speaker of each house to oversee TennCare. All legislative proposals that might impact TennCare come before this committee. The major actions of this committee pertain to annual appropriations (Milbank Memorial Fund, 1999; Tennessee.gov, n.d.).

The TennCare Partners Roundtable was created by Governor Sundquist (Milbank Memorial Fund, 1999). The Roundtable is viewed as an important venue for various stakeholders to come together. There is concern though about the erratic meeting schedule, which for behavioral health care is coordinated by the Department of Mental Health and Developmental Disabilities (DMHDD). During the Sundquist administration when Elizabeth Rukeyser was the Commissioner for the DMHDD, the group met regularly on a monthly basis. During the Bredesen administration, the group has not met regularly to discuss behavioral health issues (personal e-mail, C. Heflinger, 2005, June 3).

The TennCare Bureau is a state agency within the Department of Finance and Administration. The Bureau of TennCare and the Department of Mental Health and Developmental Disabilities (DMHDD) jointly oversee the BHOs (the Department of

health is not similarly involved in overseeing the MCOs). There were off-the-record references to the dominance of the Commissioner of Finance and Administration, David Goetz, and Deputy Commissioner J.D. Hickey of the Bureau of TennCare in the determination of strategy, particularly as it related to the Bredesen administration's development of a reform strategy. Administrators in community health centers and behavioral health care providers frequently mentioned interactions with DMHDD staff on program administration issues and many cited an improvement in the responsiveness of the department in the last few years.

Unfortunately no informant from the DMHDD was interviewed. Interviews that were scheduled with Commissioner Virginia Trotter Betts; Candace Gilligan, who serves as the Executive Director for the TennCare Partners program; Dr. Frieda Outlaw, Executive Director of Special Populations; and Dr. Judy Regan, Executive Director of Clinical Leadership were blocked by Cynthia Clark Tyler, the Director of the Office of Legal Counsel. In a personal communication, she stated,

This is to confirm our telephone conversation this afternoon regarding your interviewing several members of the TDMHDD staff, including Commissioner Virginia Trotter Betts, as part of your dissertation. As we discussed, due to pending federal court litigation, i.e., *Grier, John B., Brian A and Rosen*, I have advised TDMHDD staff to not participate in these interviews. Once the litigation is closed we may be free to discuss the issues surrounding your dissertation subject. I regret that this may adversely impact your dissertation. Should you have any further questions, please feel free to give me a call. (e-mail communication, 2005, January 31)

When an attempt was made to reschedule interviews in April after Commissioner Betts suggested that circumstances may have changed, Tyler responded to the Commissioner in an e-mail that,

In an abundance of caution I would recommend that senior staff at MHDD not participate in Ms. Myers' project at this time. Until the lawsuits are settled it would not be to our advantage to have comments or opinions from MHDD on the TennCare program on the record. There is no legal coverage that would prohibit obtaining the material, which could be used against the Department or the State

in the on-going litigation. I appreciate the fact that a good deal of the information may have been provided to the press and/or introduced in the litigation. It was my understanding, however, that the project was not focused so much on the facts and data around TennCare but was an attempt to gain some quantifiable* insight into the policy and history of the TennCare program. The possibility for misunderstanding would be greater in that instance rather than in a presentation of hard data. My recommendation is made in an attempt to avoid the prospect of a misunderstanding as well as to protect the State and the Department from potential use of material that could be misconstrued to our disadvantage. (forwarded copy of a personal e-mail from C. Tyler to V. Betts, 2005, April 8)
* *Most likely Ms. Tyler meant qualitative, not quantifiable.*

The authority that is conferred on state and elected officials arises from the people they serve. The DMHDD inability to discuss issues related to TennCare with a researcher is a sad and disturbing commentary on how dysfunctional the administration of TennCare and TennCare Partners has become and serves as another example of inappropriately limited public discourse. The position taken by Ms. Tyler is very different from other informants. Manny Martins epitomized the response received from other public figures when he said, "there is a story to be told" (personal conversation, 2005, March 11).

Public programs by their very nature should be transparent and responsive. Public programs serve citizens, and public officials and employees serve at the will of citizens. The pervasive problems of TennCare management have resulted in state officials running for or creating cover, instead of standing in the bright light that public service demand.

Authority of a Different Kind

Gordon Bonnyman's direct involvement with the leveraging of federal judicial powers has already been described in relation to TennCare and prison reform in Tennessee. In addition to this formal use of authority, Bonnyman and other key advocates used their personal expertise, influence and power to advocate for the need for TennCare and to shape the design and delivery of the program.

The accumulated clout of the advocacy community was instrumental in the establishment of TennCare. According to David Manning, the Commissioner of Finance in Administration during McWherter's entire tenure as governor,

We also were convinced that there were two groups that we had to have working with us. One was BlueCross because we had to have an organization that had the capacity to do the whole thing if they had to do the whole thing. We didn't really want one organization to do the whole thing, but if you were going to have one, that had to be it. So we had to have BlueCross. The other was we thought we had to have the advocacy community with us. (transcript of recorded interview, 2005, March 11, lines 197-205)

In the contentious debate about TennCare since its inception, the advocates "have been the only check and balance in forming public policy since Bredesen took office. With nearly all lawmakers shirking their responsibility to vet Bredesen's cuts this past session, advocates have been the only voice for thousands of Tennesseans" according to Tim Chavez (2005, August 05), a writer with *The Tennessean*, a Nashville newspaper that has covered TennCare extensively. Mr. Chavez's activism is a good exemplar of the strong and engaged public press mentioned by Gordon Bonnyman, and clearly he recognizes the authority that Gordon Bonnyman and others have been able to wield.

Thoughts on TennCare Oversight

Many have contemplated an alternative state Executive and Legislative oversight model for TennCare. Former Governor Don Sundquist and Dr. Warren Neel suggested that the TennCare program would be better served if it was insulated from the vicissitudes of politics and governed by "some independent organization" (transcript of recorded interview, D. Sundquist, 2005, March 15, line 625). They suggested a model similar to the Federal Deposit Insurance Corporation (FDIC) or a Port Authority. Neel related that he told Governor-elect Bredesen that, "you can not manage TennCare the way it is" and he added, "my solution is that you have got to get it out of the Legislature.

Now that does not mean...that you are not accountable to the Legislature” (transcript of recorded interview, 2005, March 15, lines 594, 604-609). Neel suggested that the Governor and Legislature should appoint people to such a body “who have experience...and understand complexities” (lines 616-618).

Dr. Bruce Vladeck does not agree with the concept of an independent governing board, asking, “what could be more important for the people’s elected representatives to pay attention to than the single biggest thing on which tax dollars are spent?” (transcript of recorded interview, 2005, March 4, lines 663-666). Taking the idea further, Vladeck asserted,

If the political system is incapable of addressing the health needs of the population,... we need to fix the political system....We’ve got to find ways to get people re-engaged in politics at the community level. We’ve got to find ways to deal with information and communications since the current ways aren’t working very well at public interest and public education. (lines 671-678)

Gordon Bonnyman echoed with a similar perspective, stating,

It’s [referring to TennCare] funded with public funds. It intersects with all sorts of other public agencies. There is accountability for the legislature to approve the budget and oversee the expenditure of funds. I don’t think that there is any way, practically speaking, to insulate it from politics and in fact it is not appropriate or desirable to insulate it from oversight by the legislative branch and by the executive branch. I don’t think that there is any substitute for electing the right Governor who gets it... who makes it a priority, will keep it a priority, appoints the right people, and gets them the resources and the latitude to both set goals and pursue those goals over time without being disrupted by fits and starts and new initiatives and new political gambits and so forth. (transcript of recorded interview, 2005, February 25, lines 466-478)

Governor Sundquist convened a panel of experts in 2000 to assess the future of TennCare in anticipation of the expiration of the original waiver. The final report issued by the commission contained recommendations about oversight and governance (Commission on the Future of TennCare, 2000, November 17). The commission concluded that, “the TennCare Bureau might, in the long run, benefit from a different structure. The future structure might include features of public/private organizations or

of alternative government agencies” (Smith & Snodgrass, 2000, p. 20). The commission also suggested replacement of the legislative Oversight Committee and others with oversight function with “a board of 12-15 individuals qualified to oversee a program of the size and significance of TennCare” (p.20). Finally the commission recommended the designation of the TennCare bureau as a separate Department of state government with the TennCare Director as a Commissioner and the establishment of an advisory commission to “serve as an advisory board of directors for the TennCare program, and as a critical public voice in evaluating the direction of the TennCare Program” (pp. 52-53).

Regardless of what the “right” model or structure for oversight is, it is safe to say that the stakeholders who came together to create TennCare are no longer working in concert. It is also safe to say that *everyone* must reach a consensus and workable strategy for assigning authority for the TennCare and TennCare programs to succeed. Those in authority, as the term connotes, must possess the expertise and have the legitimate, recognized and conferred power and will to control their clearly demarcated domain.

The discussion about authority in TennCare also illustrates the value of governmental checks and balances. Government in the United States is set up with a structure that seeks to prevent abuses of power and creates an avenue to remedy the violation of rights that can occur from abuses or lapses in the exercising of authority. The debate concerning authority in TennCare shows the value of these checks and balances.

Reflections on the Theme of Authority

The strong executive authority of Governor McWherter was needed to make TennCare a reality. A void was created when Governor McWherter left office. There

was a failure to transition to a more balanced and inclusive authoritative structure after McWherter left office. An adequate oversight model has yet to be developed. The continued mismanagement of program operations set the stage for the imposition of federal judicial authority which created a cadre of new issues. The strong authority and hands-on involvement that Governor McWherter envisioned and embraced was not duplicated by his successor, Governor Don Sundquist. Nor was Sundquist able to establish an effective leadership infrastructure to give direction to program management. Governor Bredesen has been a strong authoritative executive, but he has not shown a willingness to collaborate with stakeholders. A discussion of Governor Bredesen's exercise of authority is included in the discussion on TennCare reforms in a subsequent chapter.

CHAPTER 7: THE THEME OF MANAGEMENT

Introduction

Management is a central theme in the creation and implementation of TennCare and the ongoing program operations. Management is a key to envisioning and operationalizing the program components. Management, which includes exercising executive, administrative and supervisory direction (Merriam-Webster, 2000) transverses all levels of operation from the setting or translation of strategy to the execution of the activities that support the mission of the program. Management conveys “the judicious use of means to accomplish an end” (Brainy Dictionary, n.d.; Merriam-Webster’s, 2000).

Managing includes skill and caring; to succeed in managing is to succeed in accomplishing strategic objectives. Management is purposeful, and the act and art of managing includes directing, controlling, guiding, operating, carrying on and using for a purpose. Contrasting words for managing include collapsing, failing, giving up and falling down (Brainy Dictionary, n.d.).

The management of the creation and implementation phases of TennCare was purposeful and proactive. Management of the operational phase of TennCare has largely been reactionary and politicized and, in many instances, inappropriately abdicated or conferred upon the wrong or unprepared people or entities.

Birth of the Idea: TennCare Implementation

Governor McWherter and his team made two key management decisions during the implementation phase for which they have been both praised and condemned. The first of these concerned the implementation timetable and the second decision is commonly referred to, not kindly, as the “cram down”.

A Very Tight Timetable

TennCare was purposely created and implemented quickly. By most accounts, the McWherter team anticipated start-up problems. They were aware of the downside associated with undertaking such a major change in such a compressed time with so little infrastructure to support the change. Governor McWherter, Manny Martins and David Manning made a deliberate choice that a rapid implementation was preferable to a longer one. The trio of McWherter, Manning and Martins felt pressured by time because of the need to generate immediate savings in the Medicaid program and avert a looming budget crisis in the state and to limit political opposition. The thinking was that an imperfect program was preferable to no program (Gold, Frazer, & Schoen, 1995).

The decision to proceed with a rapid implementation was made with cognizance of the risks of the approach. According to Gold (1997), "TennCare developers were well aware of the operational challenge of the schedule, but thought they could address short-term problems as they arose" (p. 651). When McWherter announced his intentions for implementation to HCFA, Dr. Vladeck reflected that, the Tennessee representatives "were on a very tight timetable that we thought was unrealistic and we kept suggesting to them that they stretch it out, and they resisted. They said [because of] their political situation, however accurate it was, whatever it was, they had to go live by January 1st or the whole thing would blow up" (transcript of recorded interview, 2005, March 4, lines 125-130). The TennCare creators apparently wanted the program implementation to occur before the legislature was convened for the 1994 session. Dick Blackburn, the Executive Director of the Tennessee Association of Mental Health Organizations (TAMHO), said

It just was done willy-nilly. I remember Governor McWherter saying, when you asked him,..."If we had to wait until everybody was [ready] and everything was set, we never would get this off the ground, so we'll just do it and, you know, let

the chips fall where they may. We'll deal with what happens afterwards". (transcript of recorded interview, 2005, January 25, lines 89-92)

Even after the chaos of the first year of operation, McWherter, Martins and Manning held this view. In defending the rapid implementation, Manning wrote,

Critics contend that we moved too quickly in implementing TennCare, but TennCare had to be implemented in a very short period of time, and the problems created by massive changes were understandable. State officials readily acknowledge that there would be widespread confusion as those covered by the new program, the managed care organizations and provider struggled to cope with the massive changes taking place. But without TennCare, they were quick to point out, the problems resulting from an almost complete collapse of the Medicaid program would have been much worse. Taxes would have to have been raised, provider fees would have been slashed, and Medicaid patients would have suffered. Instead, TennCare's crash implementation was, as one of the state's leading editorial writers recently put it, "a bold escape from disaster". (Manning, 1995, p.22)

The lack of preparedness necessitated by the very tight timetable created many issues, some that persist until today. Some of these issues did not originate with TennCare and others could have been remedied.

The Cram-Down: Mandating Provider Participation

One of the defining characteristics of the TennCare implementation was what is referred to as the "cram down". This approach required all providers participating in the Blue Cross-Blue Shield TPN network utilized by state employees to participate in TennCare with the same contractual terms, but a different fee schedule. It was a bold approach, "the one thing that the people of the state of Tennessee did that state officials everywhere in the country were unwilling to risk" (transcript of recorded interview, B. Vladeck, 2005, March 4, lines 207-208).

Although at one time 2,000 of the 7,000 TPN physicians cancelled their contracts with Blue Cross-Blue Shield because of the cram-down, the network composition eventually stabilized. Despite these initial difficulties, the cram-down, according to

Vladeck “was the most brilliant part of the whole implementation...and that’s what made it go” (transcript of recorded interview, B. Vladeck, 2005, March 4, lines 217-218).

“Into the Fire”: TennCare Operation

Once TennCare was implemented, attention turned to the delivering on the promises of the program. A colloquialism that is used to refer to an ordeal, commonly an initial experience, is “baptism by fire” (Phrase Finder, n.d.). Certainly the early years of TennCare and later TennCare Partners were a baptism by fire for those in state government, the vendors and TennCare members.

The rapid implementation of TennCare produced the expected problems, and more. When Don Sundquist was inaugurated as governor, one year after the start of TennCare, his administration inherited a host of residual start-up problems. These problems were further exacerbated by inevitable issues related to underlying deficiencies in the infrastructure and competencies of the state and their contracted vendors.

The stability and evolution of the marketplace that the McWherter administration expected in the TennCare program after a rough start was never broadly realized. The reasons for this failure are hard to dissect. The failure, in part, can be attributed to decisions made by both the McWherter and Sundquist administrations. Often hard decisions were made with few good options. Problems were worsened by the lack of managed care expertise and experience, especially as it applies to a specialized population like Medicaid recipients. Performance management capabilities, the key to the successful deployment or delivery of managed care, were lacking both in the state and the largely immature MCOs (the BHOs will be discussed in the following section on fragmentation). The untoward intrusion of partisanship into the management of TennCare was also a deterrent to success.

Accountability for Performance Management

The ability of state officials to manage and continually improve a program like TennCare or TennCare Partners, where contracted vendors, such as the MCOs and BHOs, and a large cross-section of staff are accountable for day-to-day program administration, is contingent upon adept *performance management*. Managers do not transfer accountability when they delegate or contract-out tasks. Their challenge is to manage the performance of staff and contractors and answer for results. Performance management begins with a clear and specific articulation of requirements and priorities and is realized through the design and execution of processes designed to meet or exceed expectations. Performance management will be discussed in relation to the state's accountability to manage contracted vendors, the state's management of the performance of the services and functions for which they are directly responsible for, and MCO and BHO accountabilities.

The failure to manage performance is one of the most important issues plaguing TennCare and TennCare Partners. The reasons for this failure are both related to fundamental deficiencies within the state and with vendors, and a lack of the priority and focus needed to correct these deficiencies. The state did not have the right mindset, staff, processes or systems in place to be effective in performance management. The MCOs, most newly created with the start of TennCare, lacked experience, organizational capabilities, financial resources and information management systems. Furthermore, when significant deficiencies were identified within state government or in the performance of the contracted MCOs and BHOs, the state was unwilling or unable to cancel contracts, find adequate replacements or mobilize the right resources.

Management confers accountability for performance. In a program as complex as TennCare, state officials either delegate or contract out many responsibilities and

functions to staff or vendors. For TennCare Partners, performance management is the primary accountability of both the Bureau of TennCare and the Department of Mental Health and Developmental Disabilities. It is imperative that state managers oversee the performance staff and vendors and be proactive when performance does not meet expectations.

Accountability includes three essential components: *who* should manage, *what* should be managed and *how* management is accomplished (Emanuel & Emanuel, 1996). The state as a purchaser of health care services has the accountability for managing the services it provides and the performance of the MCOs and BHOs it contracts with to provide services. It is incumbent upon the state to define required specifications, identify the staff resources and contractors best able to meet requirements and manage performance for the purpose of continuous improvements in serving beneficiaries. State departments and the MCOs and BHOs are responsible for having management processes and resources in place for the delivery of services to beneficiaries and the support of contracted providers. In addition the contacted MCOs and BHOs must have the capabilities to meet the needs of the state as a purchaser. Furthermore, the MCOs and BHOs must consistently deliver on contractual promises. Interviewees, and the literature, primarily focus on the “who” and, to a lesser extent, the “what” of accountability. There was very little discussion of the “how” of accountability. By most accounts, the state administrators and most of the managed care companies contracted to provide TennCare managed care services were ineffective.

In performance management, a term that is sometimes used to describe processes that produce quality outcomes is *in control and capable*. In control refers to processes that have minimal variation, meaning that performance is consistent and predictable, a key quality characteristic. For example, an in control administrative

process, such as answering the phone when members call with questions or issues, would consistently show that members calls were answered in conformance to a measurable specification. An example would be that 95 percent or more of all members' calls were answered within 30 seconds. Capable denotes high-performing processes that are designed specifically to meet or exceed customer specifications. Capable processes are those that are linked to desirable outcomes. The underlying relationship that supports the goal of capable processes is the basis for the model developed by Donabedian (1988) that directly links process and outcomes. Performance quality requires the complement of in control *and* capable processes.

The tendency to place blame on others is a common human and political practice that, even when justified, is commonly divisive and non-productive. The story of the administration of the TennCare and the TennCare Partners programs is riddled with blame. Governor McWherter and his team, driven by a looming financial disaster and a desire to leave a legacy of increasing access to health care services, launched TennCare cognizant of the issues associated with such a massive change in an incredibly compressed period of time. Chaos reigned during the first year of TennCare. Shortly after the first year of operation, Governor McWherter's term ended and Don Sundquist assumed office, inheriting the ongoing evolution of problems expected with a change of the magnitude of TennCare.

Many charges have been made about mismanagement during the Sundquist administration. The validity of the many charges is not clear. What is clear is that the forward thinking, expertise, cooperation and commitment to change that epitomized the launching of TennCare was lacking in the Sundquist administration or completely overwhelmed by the sobering reality of the program's fallout.

Following is a discussion of the management failures related to TennCare. Topics that will be discussed include the lack of state staff experience and expertise related to managed care and vendor performance management, confused strategic objectives and priorities and ineffectual MCOs (BHOs will be discussed in the next section).

A Cracked Foundation

When TennCare was launched, 12 MCOs were under contract with the state (See Table 9 for a history of the TennCare MCOs). Most of these MCOs had been created after April 1, 1993 in mere months leading up to TennCare's implementation. Only one of the participating MCOs, Access Med Plus, had any prior Medicaid experience and this was on a limited scale (Access Med Plus had less than 35,000 total enrollees in a limited geographic area). Few of the contracted MCOs had *any* managed care experience. Statewide, in the private and public sectors, only 300,000 people of 5.7 percent of the total population of Tennessee were enrolled in HMOs at the inception of TennCare. About one million were enrolled in a Blue Cross-Blue Shield PPO plan, but these enrollees were primarily employees of the state or other large employers (Gold, 1997). By 1999, there were nine TennCare MCOs.

With the first TennCare enrollment in 1994, 800,000 beneficiaries were placed in managed care plans. Fifty percent of all TennCare enrollees selected Blue Cross-Blue Shield during the first enrollment and another 25 percent selected Access Med Plus. By January, 1995, the TennCare enrollment had grown to 1.2 million.

Access Med Plus, who projected that their enrollment would grow from 35,000 to 100,000 to 150,000, saw their enrollment grow at a rate twice the expectation. The company, with just 50 staff members, no claims processing system and no specialty providers under contract, was overwhelmed (Gold, 1997).

Table 9: TennCare MCO History

Date	
January 1994	12 MCOs available when TennCare was implemented: 6 HMOs ⁽¹⁾ and 6 PPOs ⁽²⁾ : <ul style="list-style-type: none"> • Two plans were offered in every county (Blue Cross Access Med Plus) • Two plans withdrew because they were required to participate for 18 months (Gold & Aizer, 2000)
January 1997	All four PPOs converted to HMOs per state requirement (Chang & Steinberg, 2005, May; Gold & Aizer, 2000)
March 31, 1999	Xanthus (third largest MCO) placed in receivership (Tennessee.gov, n.d. c).
April 1999	State assumed control of Xanthus Health Plan of Tennessee (formerly known as Phoenix) after Xanthus reported negative net worth of \$24 million in 1998 (Chang & Steinberg, 2005, May).
June 1999	Prudential (second smallest HMO serving only Shelby county) gave notice it would leave TennCare effective December 31, 1999 (Tennessee.gov, n.d. c).
November 1999	State provided Xanthus with a \$26 million loan to pay providers (Tennessee.gov, n.d. c).
December 15, 1999	Blue Cross (largest HMO) gave notice it would leave TennCare effective July 1, 2000; this notice was later removed (Tennessee.gov, n.d. c).
March 2000	Access Med Plus placed under state supervision (Chang & Steinberg, 2005, May; (Tennessee.gov, n.d. c).
May 2000	Access Med Plus placed under involuntary supervision and assets frozen by the state (Chang & Steinberg, 2005, May; (Tennessee.gov, n.d. c).
July 2000	Risk-sharing provision of Blue Cross contract terminated (Tennessee.gov, n.d. c). John Deere (second smallest HMO after the departure of Prudential) gave notice it would leave TennCare effective January 1, 2001; this notice was subsequently withdrawn (Tennessee.gov, n.d. c).
December 2000	Access Med Plus files a \$160 million lawsuit against the state alleging inadequate funding (Chang & Steinberg, 2005, May).
May 2001	TennCare officially cancelled contract with Access Med Plus (Chang & Steinberg, 2005, May).
July 2001	Two new MCOs added to TennCare: Better health Plan and Universal Care (Tennessee.gov, n.d. c).
October 2001	Access Med Plus contract terminated (Tennessee.gov, n.d. c).
April 2002	Universal Care contract terminated (Chang & Steinberg, 2005, May).
June 2002	TLC signed a contract that eliminated risk-sharing provisions of contract through December 31, 2003 (Chang & Steinberg, 2005, May).
July 2002	TennCare "Stabilization Plan" implemented. Plan was originally intended to provide MCOs with an eighteen month timeframe to operate under no-risk contracts (Chang & Steinberg, 2005, May).
January 2003	State assumed 100 percent financial risk for all TennCare covered benefits (Chang & Steinberg, 2005, May).
June 2003	Contract with Universal terminated; enrollees move to TennCare Select (Tennessee.gov, n.d. c).
August 2003	Contract with Xanthus terminated; enrollees moved to TennCare Select (Tennessee.gov, n.d. c).

⁽¹⁾ The six HMOs were Access Med Plus, John Deere, Phoenix/Xanthus, TLC, Total Health Plus and Vanderbilt ; nly two of the HMOs existed before TennCare and only Access Med Plus had Medicaid experience

⁽²⁾ The PPOs were Prudential, Health Net, Blue Cross Blue Shield, Omnicare, Preferred Health Partnership and TennSource

There were serious problems with several of the MCOs that became apparent as time passed. The process used to select the MCOs created problems that plagued the start-up and early years of TennCare and persist to this date. This negative legacy has consistently overshadowed the good track record of certain MCOs. Numerous informants cited shortcomings in the state's ability to manage the MCOs. Many discussions centered on the state being unable or unwilling to successfully manage vendors and insurmountable issues with certain vendors. Some of the issues originated with the selection process which was dictated by the state of managed care in Tennessee, the speedy implementation and concerns about the program's design.

MCOs were not selected through a competitive bid process. According to David Manning, "there really was not a round of bids....There was an offer to consider proposals" (transcript of recorded interview, 2005, March 11, lines 285-286). Twenty MCOs applied to the state to be TennCare providers. Twelve were accepted. Two of the MCOs, Blue Cross-Blue Shield and Access Med Plus, had statewide offerings. Manny Martins added that,

We put out, as I recall, [request for] proposals that would have allowed individuals to come in and provide Managed Care services to the entire Medicaid population, with the exception of long-term care, through a managed care system. We, as I recall, divided the State up into regions. We said you either had to take an entire region or do it Statewide. (transcript of recorded interview, 2005, March 11, lines 181-186)

Acceptance criteria primarily included a willingness to meet state terms and accept the state's financial terms. Manny Martins related that,

[The MCOs] put up their money and met the requirements for HMOs under the Tennessee Commerce and Insurance laws. If they could meet those requirements and were willing to contract with the state, prove they had a provider network [and] show the state signed contracts, then they would be allowed to enter into a contract with the state. (transcript of recorded interview, 2005, March 11, lines 390-395)

The fact that the Department of Commerce and Insurance was minimally involved in prospective discussions about TennCare and there was so little time to develop processes to meet the demand imposed with the introduction of TennCare, speaks to the pervasive effects of strategic decisions like the cram-down, the hasty implementation, and stakeholder exclusion.

Manny Martins acknowledged that some of the initial MCOs selected were not good ones. He noted that, “I think one of our failures was that some managed care organizations did come in that were homegrown. And those managed care organizations were not good managed care organizations. That hurt us, and it hurt TennCare, I think” (transcript of recorded interview, 2005, March 11, lines 357-361).

Governor Don Sundquist and Dr. Warren Neel, who served as one of Sundquist’s Commissioner of Finance and Administration, related their perspectives on how the MCOs were selected. Sundquist said,

I think there were a lot of political decisions made as to who the MCOs were.... They were not always good business decisions, but they were political decisions as to who would operate the MCOs geographically, racially, and in other ways. (transcript of recorded interview, 2005, March 15, lines 51-54)

Neel added that, “the MCOs, because some were politically selected, were not just poorly managed; they were undercapitalized and had no experience” (transcript of recorded interview, 2005, March 15, lines 56-57).

David Manning justified the selection of less than stellar MCOs by saying,

The state’s obligation was to not enter into...contracts with organizations that it knew were going to fail. And, you know, there’s some legitimate criticism there of what we did at the time, but I think what we did at the time makes sense given where we were and what we were dealing with. (transcript of recorded interview, 2005, March 11, lines 367-372)

After a period of time, Manning thinks the state made a “critical mistake [when] they basically began the process of assuring that the MCOs could not fail” (lines 329-

330), further asserting that, “they have to allow them to fail and take them out. That’s what they didn’t do” (lines 346-348).

The discussion about failures of the MCOs and eventual efforts to shut down a few is an interesting one. There is general consensus that the failure of some of the MCOs was expected, and, to some, part of the maturing process of managed care was letting poor performers fail. How failing MCOs were handled tells a tale about management of the TennCare program. Some have been critical of the Sundquist administration’s management of the failing MCOs. Governor and Dr. Neel related being constrained in their ability to take action against failing MCOs.

Manning attributes the state’s reluctance to not let MCOs fail to “provider politics” explaining,

Basically, there was a little reluctance on the part, I think, both of the Sundquist administration and the General Assembly to say to a provider group, “You entered into a contract with a group to pay for health care. And they have been going out of business. And just as if, you know, another HMO down the street went out of business, you have to write some of that loss off. You just have to. That’s just... that’s the world in which you’re now operating.” There is no risk if you’re not going to allow somebody to fail and people lose money. (transcript of recorded interview, 2005, March 11, lines 359-365)

Manning disagreed with “propping [the MCOs] up even though [they] were about to fail” (lines 371-372). He argued that,

Your real obligation there is not to the provider, it’s to the patient to insure that you move them to another organization that has the wherewithal to carry out your obligations to them. Now I think the State does have an obligation not to enter into contracts with people who are not doing business well or who are going to fail, which was... and they should have withdrawn from them. They should not have held... tried to hold everybody harmless. (lines 375-380)

Manning specifically said,

The state needs to manage the MCOs, not the care they deliver necessarily, except at 50,000 feet, but they need to manage the MCOs. And they have to allow them to fail if they do fail and take them out. And that’s what they didn’t do.

When Xantus failed, and it did, the effort was to try to rehabilitate it. Well, that's okay. I mean, there's insurance provisions to do that. And I think they asked myself and Manny Martins to help with some of that work at the time, and we did come back and try to do that. But you don't go in and pay off all the creditors which is what they tried to do. And then Xantus came along and they tried to do the same thing. You let them fail. (lines 343-355)

Dr. Warren Neel explained some of the difficulties associated with closing MCOs had to do with how the MCOs were structured and how the contracts were originally structured. He said,

The construct of the MCO organization was a management company superimposed on an operating company. And all of the regulatory relationships that were established at the time they were brought in were focused on the operating company....You could not get to the information in the holding company, i.e. the capital. So they had structured themselves to preclude any what would now we'd call in the financial markets as 'transparency of the operating companies'. The operating companies didn't show anything except a bunch of people on the payroll. But all of the flow-through and the capital was in the holding company. So if we got ready to try to close one down or alter it was a heck of a mess. (transcript of recorded interview, 2005, March 15, lines 114-122)

The state Department of Commerce and Insurance used existing regulations for due diligence regarding the TennCare MCOs. Per Neel,

Commerce and Insurance was charged [to think] just like an MCO were an insurance company. The only difference though is you don't have a rating agency, which is what you have in an insurance business, called AM Best. You don't have the equivalent for an MCO. You don't have any way nor do you have the same sort of regulatory relation of the capitalization as you would with the Financial Institutions Commissioner and Banks. You just simply... you don't have that. You didn't have it. (transcript of recorded interview, 2005, March 11, lines 127-134)

Turmoil and Turnover

The revolving door of appointed TennCare Directors during the Sundquist administration was indicative of the management turmoil that characterized TennCare during this period of time. Governor McWherter appointed Manny Martins to serve as the first TennCare Director, a post he held from January 1994 through April 1995 in the early days of the Sundquist administration and again from July 2002 until July 2004

during the waning days of the Sundquist administration and early days of the Bredesen administration. In between Martins' two tenures, Governor Sundquist appointed seven TennCare Directors. Table 10 has a listing of all TennCare Directors. Currently J.D. Hickey is the TennCare Director, a post he has held since July 2004.

Adding further to the turmoil was a move to consolidate certain state departments. This effort, initiated early in 1997, created further management chaos. Part of the planned consolidation included moving the Department of Mental Health and Retardation (the Department was later renamed the Department of Mental Health and Developmental Disabilities) into the Department of Health as a cost-cutting measure. While the move was under consideration, there was uncertainty and confusion which was a distraction. The failure to consummate the consolidation after several years perpetuated a diffusion of accountabilities, unneeded variations and inefficiencies.

There was significant fallout during the time departmental consolidation was being discussed. Key staff left the Department of Mental Health, the department was basically impotent and accountability was inappropriately transferred to the BHOs. In an interview with Dick Blackburn and Kelly Lang-Ramirez of TAMHO, they relayed their perspective about the proposal to move the Department of Mental Health and Retardation into a mega-Department of Health. According to Blackburn, at the beginning of the Sundquist administration,

There was a caretaker Commissioner of Mental Health at the time. They basically had the Deputy Commissioner function as your Commissioner, so there was really no one with any real voice around how things ought to be done. Then...they decided what they wanted to do was consolidate the Department [of Mental Health] into...a mega...Department of Health. All of the mental health stakeholders opposed that notion. And the battles began to rage. (transcript of recorded interview, 2005, January 25, lines 458-471)

Table 10: TennCare Directors

Tenure (Appointed by)	Director
January 1994-April 1995 (Ned Ray McWherter)	Manny Martins
April 1995-May 1996 (Don Sundquist)	Rusty Siebert
May 1996-March 1998 (Don Sundquist)	Theresa Clarke
March 1998-January 1999 (Don Sundquist)	Dr. Wendy Long (Interim Director)
January 14, 1999-January 31, 1999 (Don Sundquist)	Glen Jennings
February 1, 1999-September 27, 1999 (Don Sundquist)	Brian Lapps
September 27, 1999-June 2000 (Don Sundquist)	John Tighe
June 2000-June 2002 (Don Sundquist)	Mark Reynolds
June 2002-early July 2004 (Don Sundquist/Phil Bredesen)	Manny Martins
July 2004-present (Phil Bredesen)	Dr. J.D. Hickey

Blackburn added that,

There was a person in charge at that time, Commissioner Nancy Menke....Her experience...primarily was in education...but she had been a lobbyist for a number of years and knew the Legislature. During that time, there still was a caretaker Deputy Commissioner at the Department of Mental Health who couldn't do anything because the Governor had made the decision, "nobody needs to do anything: I'm putting all of this in the Department of Health". This lasted almost two years. (lines 473-480)

Lang-Ramirez related, "The Department of Mental Health...just evaporated or got shifted over to TennCare Bureau...So it wiped out a good core-like expertise of the Department" (lines 499-502). Blackburn added,

They had no power, I mean, basically no role except to administer, oh maybe \$17... \$18 million dollars worth of block grant and different kinds of grant programs, and to run the state hospitals. That's it. Period. Everything else, Manny Martins or one of the eight TennCare directors, I can't remember exactly what sequence they came in, but one of them said, "We don't need your help. We'll run this." So the BHO just had a field day during that time. And I mean, that was a horrible time...A lot of things that really happened, that happened during that time, that are irretrievable. I mean you never, never get back to where you were with the... with some of that. (lines 505-513)

In Blackburn's view, "The BHO was setting policy, was calling the shots, was deciding everything" (lines 491-494).

When Elizabeth Rukeyser became the Commissioner of Mental Health, the situation changed. Blackburn related that,

When Commissioner Rukeyser came, she negotiated with Manny Martins a memorandum of understanding, which was the first point at where the Department began to try to recover some power, or gain some authority over behavioral health. And so basically, they worked out an arrangement where they had all the responsibility... authority over policy, and the only thing that the Department... that TennCare had responsibility for was the budget, the money. But they would have... they couldn't necessarily veto what happened with the money, but they... at least they were advised of something that was going on there, or something, you know. So they had a lot more information, a lot more interface with the TennCare powers than they'd ever had. And they had, you know, authority to make certain decisions. For example, September... well, probably about the second year, Rukeyser, Commissioner Rukeyser was there, the managed care company put out a memo saying, "We've decided we're not going to fund adult continuous treatment teams anymore." Well we had... you

talk about outcome data, we had enough to fill this room and that showed how effective they were at keeping people out of the hospital. And it was just a cost-cutting measure that they, you know, they didn't feel they ought to be spending the kind of money they were spending to accomplish that. Just let them go to the hospital, I mean, we already got our 9 percent, 10 percent administrative fee; what do we care where they get the services. So Commissioner Rukeyser basically said, "No, you're not going to do this." And that is the first indication that the memorandum of understanding had produced a, you know, a change in the Department in that they could make decisions like that and enforce them. So that's one service that is still around. It's kind of on shaky ground, but it's still around. But I think some of the things that you're talking about [are] irretrievable. (transcript of recorded interview, 2005, January 25, lines 515-539)

Less significant, but still an issue, was shuffling of the TennCare Bureau. When Don Sundquist was inaugurated in January of 1995, one of his first executive orders was to move the TennCare Bureau to the Department of Finance and Administration. In January of 1997 the TennCare Bureau was moved back to the Department of Health and subsequently in October of 1999 back under the Finance Department.

III-Prepared Staff

Manny Martins is the one individual whose experience with TennCare spans time in the administration of all three governors since the inception of TennCare. After helping to launch TennCare during the McWherter administration, Martins returned during the Sundquist administration as the Deputy Commissioner of Commerce and Industry where he was in charge of TennCare regulation for the express purpose of dealing with some of the struggling MCOs. Martins' assessment upon his return of TennCare management was , "we weren't managing it well from the MCO side; we weren't managing it well from the policy administration side" (transcript of recorded interview, 2005, March 11, lines 227-228). Then when Mark Reynolds, the seventh TennCare Director during the Sundquist administration, departed, Martins again assumed the position of TennCare Director, a post he also held during the early days of the Bredesen administration to facilitate the transition between governors. When

Martins returned to TennCare, he noted, “management was in disarray. Middle management was essentially not coordinated” (transcript of recorded interview, lines 244-245).

In the original waiver application (McWherter, 1993), state officials outlined a plan to reorganize, but not otherwise change staff. The problem of this approach was that when the transition was made to the TennCare program (and later the TennCare Partners), significantly different staff requirements were imposed, requirements which state government was inappropriately staffed to fulfill. Many factors may have contributed to this issue. State employees are relatively protected. It is difficult to recruit managed care experts to state government because of the relatively low salaries and politics. Some state employees were ambivalent about, or even opposed to, the changes precipitated by the introduction of TennCare.

David Manning remarked that, “State government had no experience in *purchasing* [emphasis added] health care services. State government had lots of experience in *paying* [emphasis added] for health care services” (transcript of recorded interview, 2005, March 11, lines 242-243). He further reflected that, “the problem with... state government...was that it did not have the capacity, nor does it have today, to be an intelligent purchaser of health care” (lines 255-256).

Manny Martins elaborated, saying,

You have to recognize that the Medicaid staff did not have a great deal of experience in managed care. In fact even the second time I came back, I was kind of appalled by the lack of understanding within top management of managed care systems and how they worked. So that was clearly an issue. (transcript of recorded interview, 2005, March 11, lines 403-406)

“Fighting Fires”: A Pervasive Mentality

The lack of agreement about priorities and the constant pressure to react to relevant and extraneous issues has been a key impediment to managing TennCare effectively. State officials and employees and MCO and BHO staff were frequently consumed with designing capable processes at the same time they were trying to get administration of the program in control. Frustration with short-term thinking and a “fighting fires” mentality were expressed by interviewees both inside and out side of government.

Gordon Bonnyman commented,

Part of the problem is that TennCare has been a political football since ‘98 and ‘99, relating to totally extraneous issues like whether we’re going to have a state income tax or not. I mean, that shouldn’t be that important to whether the service is being delivered to SED kids who are eligible for Medicaid in any event. But it has been because what we’ve seen is that year after year, people in charge with running [TennCare] go to work one day and find that the Governor, whoever the Governor might be at the moment, has just set some dramatic new policy direction that forces them to drop whatever they were doing and suddenly be in work groups, on task forces that are designing some new concept, or executing some new plan. And it’s difficult to sustain any forward momentum around clear management objectives like drafting new contracts, bidding out the behavioral health services, monitoring compliance. Basic nuts and bolts sort of management gets neglected. We’ve seen it over and over again. It occurred in the Sundquist administration. It certainly happened within the past 15 months in the Bredesen administration. (transcript of recorded interview, 2005, February 25, lines 404-419)

When referring to a work group created to improve the delivery of behavioral health care services to children under the auspices of the Department of Children Services as an example, Bonnyman expressed frustration that,

If you have people in the State government who are tasked with trying to work on those issues and develop those systems, and suddenly Governor Bredesen says in a speech on February 17, 2004, at the Joint Session of the General Assembly, that says, “I’m going to take us off on some whole new area, and by the way, tomorrow I’m going to tell the Commissioner of Finance and Administration David Goetz to strip his department, the TennCare Bureau, the Department of Human Services, the Department of Mental Health and Developmental Disabilities, of all available middle managers to create task groups or work groups to work with

McKinsey and Company and who knows what other consultants to design a new TennCare Reform Program.” Well, you know, you just shot your efforts in the head. And we’ve seen that happen over and over again across the administrations. (transcript of recorded interview, 2005, February 25, lines 446-458)

From a different perspective, Manny Martins recounted a similar frustration related to the consent decrees. He related having to,

Divert resources to meet the meticulous requirements of [consent decrees], and that I think hurt us...because you only have a certain amount of resources, and when you have to redirect those resources to meet what you consider to be from a management perspective ineffective, inefficient, tedious paperwork, then that does create a problem. (transcript of recorded interview, 2005, March 11, lines 629-631)

All Deals Are Off: Changing Players, Problems and Relationships

A coalition of potential adversaries found common ground and a way to work together in designing and launching TennCare. The coalition was strained and eventually dissolved in the delivery of TennCare.

It was during the watch of the Sundquist administration, after the turbulence of the implementation, that the tolerance for “start-up” problems expired and new refractory issues, including problems with MCO and BHO stability and performance and cost escalation became prominent.

The Sundquist administration has been vilified for what happened with the TennCare program, despite the fact that they were dealing with intractable national issues and the residual effects of choices made to facilitate the compressed implementation. Nevertheless, the Sundquist administration did not make appropriate adjustments to move the program forward, and they made missteps that impeded progress.

Prominent among the issues that became intolerable to the advocates and enrollees included problems with the administration of the drug formulary (laying the

groundwork for the Grier lawsuit) and burdensome prior approval processes. Turmoil in the management of the Sundquist administration was also an incendiary point.

The cumulative frustrations with the administration of the TennCare program and the lack of meaningful progress in remediation eventually led to the demise of any agreement to be tolerant regarding “start-up” problems. There came a point when Bonnyman, Garr and others felt that they had tolerated the expected initial problems enough. Tony Garr related this history of the growing frustrations,

During the first year of TennCare, the managed care organizations... they were like the fox guarding the hen house. If someone had a problem because they couldn't get a service that they were supposed to get, and they were supposed to report that grievance to their MCO. And you know, at the end of the year when they're supposed to report how many grievances did you have, when someone like Access MedPlus, which was one of the most problematic of all the MCOs, report that maybe they had two grievances, you knew something was wrong. We as advocates knew something was wrong. We knew that a lot more people were not getting care than what was being reported. And so, after the first year and the way, you know, the waiver that the grievances...the grievance procedure was established, we knew early on there needed to be a new method. And Gordon began working with the Sundquist administration trying to come up with a new grievance procedure, and there were lots of agreements. They executed an agreement, I think in '96, and “this is how it should work” that did not work very well. They came up with another agreement in '97 or in '98, a couple of years later, which actually, I think, began to work. And so now we have... what happened, I think, is Judge Nixon realized that when you have a managed care organization, when they can make money by denying care, there needs to be a different process. You couldn't let the fox guard the hen house. And so at that point, and I can't remember exactly when it was, they set up... there's going to be an independent unit at TennCare who will handle the grievances and then we have administrative law judge to decide over these agreements, 'cause what was happening is the grievances were going to the MCOs and they weren't going anywhere else there. The MCOs were dealing with these as complaints as opposed to grievances. And many times there was no record of these complaints. And so there was nothing to track or trace. And so at a point in time, there was an independent procedure that wa... an independent body of a set-up in TennCare that began to see... field procedures. And I think that happened in '96. Now what happened in '96 is that the State can intervene on behalf of the MCO where, and I'm not sure, this is what you have to talk with Gordon about, the way that was working is that many times the State was actually doing the dirty work for the MCO. In other words, it really wasn't working. And finally there had to be a point where, you know, the State could not speak on behalf or for an MCO, that they had to act independent as the independent broker that, you know, these are services that are being sought by this MCO, now we need to

allow an independent voice. And also if the enrollee has a doctor that wants to weigh in on this, we need to let them weigh in. So a lot of times the only people who were making any of the decisions was the TennCare medical director and it wasn't anybody else involved. And so, I think what happened... what finally came out of there, maybe it was in '98 or so, was really a very good grievance procedure well laid out. The only problem was around prescription drugs. They still couldn't figure that one out since that was a service that was being the most prescribed, and it wasn't a matter of dealing with thousands but millions of... the State did not have the capacity to deal with all the grievance around prescription drugs. People were being denied; the appeals weren't going right, and so they had to... this is where the Grier got into it, where there had to be a separate process that needed to be looking at... around prescription drugs. (transcript of recorded interview, 2005, January 19, lines 221-272).

Adding to the frustrations and break-down of cooperation was a change in relationships and perceptions. The advocates and other like-minded individuals did not have the same cooperative working relationship with the Sundquist administration that had been cultivated with the McWherter administration. Tony Garr expressed some of these frustrations, saying,

It's never been a good relationship after McWherter and Manning and David Manning left office. It's always been very antagonistic. Governor Sundquist appointed people like Rusty Seibert as TennCare director, who is an independent entrepreneur... didn't know anything about public programs and rights of people. I think they did a lots of crazy, stupid things that just made it easy for Gordon to sue 'em. I mean, Rusty Seibert decided he was going to terminate people because he got this one group that could identify property that was zoned... Rusty had this thing that a lot of people in TennCare lived out-of-state. So Rusty got this information... a company did a contract with them and got them to find the names of everybody who was a TennCare enrollee if they owned property somewhere else. And so we found there were some cases where a person who really lived in Tennessee but they owned a piece of property in Alabama, well they ended up being terminated without being given a right to appeal. They were just terminated "cause you're not living in the State of Tennessee, but they were. So you had Rusty Seibert who was just doing some crazy idiotic things, who didn't understand the public programs. Then you had someone like Brian Lapps, who also was a, I don't know what... maybe he was a right-wing apostle, thinking he was going to come in to cure the program and fix the program. Interesting thing about Brian Lapps is that he was on TennCare until he was hired by the State. Actually, Brian Lapps owed several months worth of... he was actually overdue. He owed premiums. So all of the sudden, we had a TennCare Director appointed by the Governor, and we understand he was appointed by the Governor because he had written a letter and didn't do a whole lot of research on his background. And to everybody's embarrassment, he actually was on

TennCare at one time, which was not an embarrassment. The embarrassing part was that he owed the State of Tennessee thousands of dollars of past due premiums. TennCare premiums. And he was supposed to come in and clean up the Program? So anyway, the Sundquist administration, by their management decisions, they just created just a real problem. And not only were these people that they were hiring, you know, didn't understand public policy, but had no recognition that people had rights. And they just were making decisions that I think was contrary to the public interest and to the rights that were given to enrollees by Medicaid law. So just because we had an expansion population and many of the TennCare rules were waived, people's rights were not waived. (transcript of recorded interview, 2005, January 19, lines 283-322)

The growing embitterment culminated in the filing of all but one of the lawsuits that eventually led to the negotiation of the consent decrees that have in many ways characterized the breakdown between the state and the advocates. If the state had managed the TennCare program well and been responsive to beneficiary issues, it is unlikely that the state's authority would have been challenged in the courts.

A Vicious Cycle

Mismanagement contributed to the imposition of the consent decrees. In turn the consent decrees created a whole new version of mismanagement. This distressing cycle has adversely impacted all involved parties.

In benefits administration, the most immediate needs relate to basic administrative processes and the interface between vendors (including MCOs and BHOs) and members and providers. In the industry it is said that you must be able to "block and tackle" before you can do anything else, meaning simply that basics come first. Examples of basic administrative processes include enrolling members, answering phones and responding to member and provider needs, educating providers and members, contracting with providers and paying providers.

Because of the short timeframe, immaturity of managed care markets and companies in Tennessee, inexperience of state employees and the special needs of the

Medicaid population, the majority of failures and attention in the initial years focused on responding to problems created by not being ready to do the basics. Ill-prepared staff was overwhelmed. “Fighting fires” and being reactive, rather than proactive, too often characterized management efforts. “The short implementation timeframe required a focus on urgent administrative and oversight systems. Instead of preventing problems before they arose, TennCare systems in the first year dealt with problems after they arose, addressing most problems on a case-by-case basis” (Aizer, Gold, & Schoen, 1999, p. 30). Although the reasons changed for this mentality over the years, the practice did not.

A Missing Management Tool

Information management, which requires sophisticated information management systems, is the currency of managed care. Since TennCare was implemented, the lack of information management has been a significant barrier to managing the program successfully. Different types of information are needed by different players. The state should have access to information management systems that facilitate program management and the management of their contracted vendors. In turn, MCOs and BHOs need systems that help them manage contracted providers, the care delivered and administer the benefit program. Both the state and many of the contracted vendors lacked needed information management capabilities.

Data drives managed care in innumerable ways. Manny Martins envisioned the state using data in a variety of ways. He said,

We knew that early on that we would need encounter information, diagnostic information, because we had to develop actuarial rates. We wanted to understand what was happening with the health care of people. We knew we wanted to look at health outcomes. We wanted to look at what MCOs were delivering the good care, what the health outcomes for...patients in particular MCOs [were]. We had envisioned developing report cards that not only would rate the MCOs, but we would actually go farther and rate the providers, the

hospitals, things like, you know, who's surviving open heart surgery and who's not. And we were even looking at things back then like single medical records across the board. (transcript of recorded interview, 2005, March 11, lines 434-445)

When TennCare was implemented and for years afterward, the lack of good information has been a liability. Martins explained,

We patched a MMIS Medicaid system to actually implement TennCare. That system was never intended to be the system to transition into managed care. When I came back the second time whenever it was ten years later, I was shocked to see the same patched-up system being utilized by TennCare with modifications. (lines 445-452)

He concluded, "the idea of the patched-up system and keeping that system as the ongoing legacy system for TennCare was the wrong management decision to make. When the State did that, I think it created a significant issue for the program" (lines 473-477).

Dr. Neel agreed, saying that there was a "hodge-podge of systems" and that "there was no integration....All systems within all agencies...none of them were integrated" (transcript of recorded interview, 2005, March 15, lines 216, 221-224).

David Manning concurred that not having an adequate information management system was "a major flaw". He related that,

It's a major problem that Bredesen inherited, but unfortunately [the administration] has not done a great deal to resolve. When we started TennCare, we did it with the old Medicaid system. We didn't have a choice. But one of the things we said to the incoming Sundquist administration is your top priority ought to be getting a state-of-the-art information system in place. They couldn't keep anybody in place long enough to do it. They had so many directors. And then, and I'm not sure... I was never sure how much they focused on... but they had a... you know, late in the administration, just before... sometime before Manny went back over there, they got involved in the system that is now up and running, I think. And I think it's a better system, and it may have the potential to be the kind of analytical system that they need. (transcript of recorded interview, 2005, March 11, lines 576-591)

Upgrading the information management systems to meet the demand of the complexity of TennCare program was a stated priority of the Sundquist administration, but the group was unable to transition to a new system until very late in their second term. According to Neel,

We kept trying to craft an RFP. And it was... I'll just give you an example. When we first started this...I was under a lot of pressure down on the Plaza to select a certain firm to do the RFP because of people who were in that firm. It was only \$35 million more in the bid than was the case with the lower bid of a very competent company...it was that sort of pressure. It took us a long time, as you can imagine, that's a very comprehensive project. And the bill kept rising.... We put it in place the year before we left. (transcript of recorded interview, 2005, March 15, lines 205-213)

Despite system upgrades, even today, there is little integration across systems or even within systems. Lack of data integration is both a root cause and a symptom of the problem of fragmentation that will be discussed in the next chapter.

David Manning also relayed that there is wide variation in the information capabilities across contracted MCOs. He said,

I think Blue Cross is closer to a having the data infrastructure, more than anybody else. I would suspect that John Deere and a few of the folks here who have been serious about this business for a long time have good information systems, although I've seen a few that have existed for a long time and have lousy information systems. CIGNA is an excellent example. But I think that you have to put into place that kind of data, and I think...it's not the same system that the MCOs should have. But this system to be able to...analyze what's going on, to be able to project, to be able to monitor the kinds of quality issues that you ought to be able to monitor, to be able to help MCOs, and be able to effectively look about strategies that may help you contain costs as you do contracts. And the vision we had...when TennCare began, that would have been the major role of the State, and that's a piece of it that has never come together, and it's unfortunate because...I think that's one of the key problems. (transcript of recorded interview, 2005, March 11, lines 596-609)

Fallout from the lack of an information technology infrastructure in TennCare took many forms. During the early days of TennCare, there was a failure to collect \$37

million in TennCare enrollees because of a backlog of applications and the failure to distribute payment booklets.

There was other fallout related to enrollment. In October 1993, prior to the original TennCare waiver being approved, enrollment forms were sent to 714,000 Medicaid beneficiaries. No MCOs were yet under contract. Several identified MCOs subsequently elected not to participate in TennCare and provider panels had not yet been assembled. In addition, more than 40% of the enrollment forms were not returned. Because of these factors, a second enrollment was conducted in December 1993 (Mirvis et al., 1995).

Financial Risk and Management

It is impossible to talk about TennCare or the TennCare Partners program without talking about program funding and costs. Finances and financial management are an inextricable part of the story. Although this study does not focus on financial concerns, it is impossible to ignore the impact that financial influences have had on TennCare and TennCare Partners and how financial issues have dominated the discourse about TennCare. Although TennCare has accomplished many of the original goals regarding access and coverages, these accomplishments have been overshadowed and impeded by financial concerns. Financial concerns were a primary driver in the inception of TennCare, just as they were in the radical cuts in eligibility and coverages instituted by the Bredesen administration in 2005.

The original TennCare proposal was based on financial assumptions that have been called into question. Few questioned Governor Bredesen's assertion in late 2003, following the release of the first McKinsey report, that the state of Tennessee could no longer afford the cost of the TennCare *as it existed*. Whether poor financial performance or prognosis is an indicator of poor design, poor delivery or some combination is

debatable. What is important for this study is how financial concerns have either caused or resulted from issues discussed in this study. What also is apparent is that financial concerns (along with sustainability) have been the most significant factor in both the genesis and recent revamping of TennCare. Lack of experience and unrealistic expectations have been significant deterrents.

Capitation, Risk-Sharing and Global Budgeting Strategies

In an effort to control cost escalation and be able to afford the cost of the addition of new Medicaid beneficiaries and expanded benefit coverages, the state intended to put the MCOs, at later the BHOs, at full risk through capitated payments. In addition, the state initially developed a global budget. Overlaid over these requirements was the federal government's requirement of budget neutrality. Unfortunately, the history of MCO and BHO risk has been disappointing. By most accounts, the original global budget was set too low, and, by some accounts, the methodology and adjustments used to create the budget were unsound.

Regarding the MCOs and risk assumption, David Manning recalled,

We contracted with them on two bases, one of two bases. One was an "at-risk", and the other was basically an ASO-type arrangement that we would allow to occur for the first few years and then it would have to transition to an "at-risk". (transcript of recorded interview, 2005, March 11)

In addition to the assignment of risk, the state made adjustments to address longstanding issues with health care costs in the state, as well as projected issues. Issues included cost of the uninsured, cost-shifting due to uncompensated care, "patient dumping", charity care and disproportionate shares payments to traditional safety net facilities.

According to Mirvis, Bailey and Chang (2002),

The global budget was initially set at the then-current Medicaid budget, which was deemed sufficient to support an expanded population in a healthcare system

functioning under managed care principles. Capitation rates were then determined administratively by, in essence, dividing the previous Medicaid budget by the number of anticipated enrollees. This rate was discounted by 20.4% to consider ongoing charity care; by 1.7% for local governments' contributions to health care; and by 3.9% for the TennCare mandated cost-sharing. (p. 61)

Additionally the state put in place processes to monitor "patient dumping". The state, according to Manny Martins, wanted to be proactive in managing instances of either employers or the insurance industry state abandoning their accountabilities to the state. He related that,

We were very concerned, as part of our approach, that there might be some shifting of the employer-based system to TennCare if we established a program like TennCare that covered the uninsured/uninsurable population. And we were also concerned that insurance companies might also begin dumping into the market. So as part of that process of going to the Federal government through the waiver, we tried to set up some approaches to deal with those kinds of things. We said that we would look at employer-sponsored health insurance on an annual basis and develop a baseline; and if we saw that dropping, we would cut off enrollment to the uninsured/uninsurable population. And we also initially contracted with, I think, the Farm Bureau, if my memory serves me right, to review all applications...to determine whether the individual was eligible for employer-based insurance. So anytime we got an application, it would have been sent to our contractor. The contractor would verify whether the person was employed, could get insurance through their employer or not; and based on that, we would make eligibility determinations. (transcript of recorded interview, 2005, March 11, lines 141-154)

No other informants spoke of the process Martins described.

When the global budget was created, the state took a novel, and controversial, approach to handling charity care. According to Manny Martins,

We also recognized that within the State, there was a great deal of charity care funding that was out there, that was being utilized by the health care system.... We knew, as an example, that the uninsured/uninsurable were not paying for that service...and that that was then earmarked or identified by hospitals largely as charity care....We recognized that the cost of that is built into the rates, so it had been cost-shifted to rates....We recognized that by taking on the uninsured/uninsurable population, we would suddenly be paying again for that cost-shifted charity care. So we identified that charity care in the system, and we discounted our actuarial rates by the amount of that charity care in the system, recognizing that we didn't want to pay twice for the care. That was probably

something that was very innovative, that most people to this day do not understand. And that became one of the ways we funded the program. (transcript of recorded interview, 2005, March 11, lines 157-170).

Another issue the state had to deal with in the creation of the original TennCare budget was the disproportionate share payments. When the TennCare budget was created, “the idea was that if you cover everybody or if you insure everybody that you no longer have to make disproportionate payment shares to the hospitals” (transcript of recorded interview, 2005, March 04, lines 231-234). This approach became problematic because of the burden of uncompensated care rendered to residents of other states. Dr. Vladeck recalled that in late 1994, the Regional Medical Center in Memphis began complaining. He explained,

And they did have a problem because they provide a lot of uncompensated care to Mississippi residents and Arkansas residents. Under the old system, under the old DSH-subsidies, they had been treated very generously and they were a major TennCare provider, obviously. They didn’t have any complaint against the Tennessee TennCare residents, but they still have this big hole in their finances from the uncompensated care of the out-of-state residents. And we went back and forth. Manning...was still in Finance at the time, and he didn’t want to do anything for them. And there were some [who said] “That’s Memphis. That’s Harold Ford territory. We’re not... we don’t like them anyway,” and you know, of course Congressman Ford was on the Ways and Means Committee so he was on our case. And then that sort of dragged out for a while. And then you got U.T.-Chattanooga came in with a complaint that there was no subsidy for the teaching stuff, and so the UT folks got organized and started banging on Manning, and the people in Nashville. So finally we modified the Program to make some additional sort of teaching, safety net hospital payments.

Inevitable Issues and Criticism

Numerous interviewees commented on specifics about how the TennCare budget was derived. Dr. Warren Neel was particularly critical of how the budget was developed, saying, “[the McWherter administration, particularly David Manning] had absolutely no experience in taking a new program with an expanded population and doing any sort of cost trends. They had no actuarial studies behind it” (transcript of recorded interview, 2005, March 15, lines 82-84). Mirvis, Bailey and Chang (2002) also

decried the lack of adequate reference points in developing the budget, saying, “Rates were set administratively without assessing market conditions by competitive bidding or price negotiations” (p. 65).

Apparently budget adjustments were not made for the richness of the TennCare benefits package either. In addition to the required mandatory services (including inpatient, outpatient, professional and home health care services), the TennCare program also includes pharmacy, behavioral health, dental and long term care services. The TennCare program, unlike the Medicaid program in place previously (or most private plans), has minimal or no benefit limits. Additionally, the TennCare program had no formulary or PDL in place from the year 2000 through most of 2003.

During the Sundquist administration there was an attempt to limit the scope of plan coverages. These efforts ultimately failed. The original TennCare waiver was extended twice. In 2002, the Sundquist administration submitted a new waiver application, called TennCare II. This waiver outlined a two-tiered benefit design in which the traditional Medicaid population’s benefit would be unchanged and those in the expansion population would be reduced. This plan was abandoned in mid-2003 as part of a legal settlement.

In addition to having a rich plan design in TennCare, the number of Tennessee citizens covered by the plan is noteworthy. In FY 2001 28 percent of Tennessee’s population was enrolled in TennCare. This gives Tennessee, along with the District of Columbia, the distinction of being number one in this category in the nation (Kaiser statehealthfacts.org).

Alarming Sequelae

Lack of experience hindered appropriate risk allocation more than any one factor. The state was inexperienced with capitation and so were the majority of the MCOs.

Inexperience led to the bankruptcies of Xanthus, Access Med Plus and Universal. Access Med Plus, the largest of the TennCare MCOs at the time, was shut down by the state in late 2001 because of a negative net worth of \$54 million. In 1999 the state took over the day-to-day operations of Xanthus. This plan was shut down in August of 2003 after it was determined that the plan's negative net worth was \$77 million. Another small TennCare MCO, Universal Care, was closed in June 2003 because of a negative net worth of \$54 million. In response to these events, the state assumed accountability for setting provider rates in 2000. Before this time, provider rates were highly variable across the state and across vendors. In 2002 the state then eliminated all risk-sharing provisions in the MCO contracts. Similar ASO contractual arrangements are also seen in one of the BHO contracts and the pharmacy and dental benefit manager contracts. The Bredesen administration has announced plans to reinstitute risk into the MCO contracts as a part of their overall reform strategy.

The Projections

In the McKinsey and Company report (2003), it is projected that total Medicaid costs of \$6.9 billion (\$2.1 billion in state spending) for FY 2003 will increase to \$11.8 billion total and state spending of \$3.7 to \$3.8 billion in 2008. The percent of total state spending for TennCare is projected to increase from a 2003 level of 25 percent to 34 to 40 percent in 2008. The primary drivers of the projected increases are pharmaceuticals, professional services and outpatient services cost increases, as well as increased enrollment. The McKinsey and Company attributes the projected growth in these categories to "TennCare's program design, the general health care environment and some aspects of program execution" (p.19).

Reflections on the Theme of Management

The initial chaos that members of the McWherter administration and their allies accepted in exchange for the promise of TennCare was more extensive and damaging than anticipated. Even more formidable and far-reaching was the weak infrastructure which could not bear the weight of the ambitions of the program or the speed of change. Whether a concerted, well-managed and sustained strategy for dealing with the initial fallout and remediating deficiencies in state leadership and staffing, the MCOs and information technology could overcome these gaps will never be known. The unfortunate legacy of TennCare is one of mismanagement. The results of financial mismanagement have been the most damaging to the program as far as public perception and viability, although it will be argued later that management of some of the cost escalators is out of the control of the state of Tennessee and indicative of a more systemic national problem.

CHAPTER 8: THE THEME OF FRAGMENTATION AND CONCLUDING REMARKS ON THE STUDY FINDINGS

Introduction

The third theme that is prominent in the telling of the TennCare narrative is fragmentation. A fragment is a broken-off or incomplete part (Merriam-Webster's, 2000). Fragmentation, the act or process of making something fragmentary, denies the intrinsic and synergistic value of wholeness. There are multiple instances of deliberate fragmentation of the TennCare program beginning with the "carve-out" of the behavioral health care and pharmacy programs. Another sequela of fragmentation is an over-emphasis on one fragment to the detriment or exclusion of other parts of the whole. A classic example of this is case management in the TennCare Partners program. A fragment, detached from the whole, is disconnected. In many respects the state's management of the BHOs was detached and disconnected from the basic tenets of performance management. The state's "hands-off" approach created a situation where actions were not aligned with purpose.

Elements of fragmentation which will be discussed include plan administration, care delivery and information management. The primary focus of this discussion on fragmentation will be the TennCare Partners program.

Plan Administration

Plan administration focuses on all non-care delivery functions related to selection and management of the BHOs, and performance of the state and the BHOs. In this section, descriptive information and commentary will be presented about how TennCare Partners started and evolved over time.

The Advent of TennCare Partners: The Behavioral Health Carve-Out

When TennCare was first being developed by the McWherter administration, the intent was to have behavioral health care fully integrated with medical care and to have a single vendor accountable for the delivery of both medical and behavioral health care services. This plan was derailed abruptly, and temporarily the McWherter administration thought, by opposition to the plan (Chang et al., 1998).

Dick Blackburn shared his thoughts on the beginnings of the carve-out when he commented that the partial carve-out was an “after-thought” (transcript of recorded interview, 2005, January 25, line 58). He related that,

There was never any intention...on the part of the McWherter administration to put mental health into the waiver demonstration because a great deal of work had happened between the previous...three years; and we were two and a half years into what was called “the Mental Health Master Plan”... which over that period of time they’d put \$27 million dollars into the mental health system. And at that time, that was a lot of money....That had been done through selling off the state hospital property in Nashville, and using part of the proceeds to build a new, more modern acute care facility for the state hospital there, and to close down some of the beds and shift the operating dollars that had gone into those beds into the community. So...everybody was happy with how that was working. We added some Medicaid-optional programs, the case management option, and the rehabilitation option, and were able, with the new state dollars, to draw down additional Federal dollars for mental health and put a lot of new services in place. So everybody was happy, but somewhere in the negotiations [to get] the Federal “powers-that-be” to agree to put as much Federal money into Tennessee as was being requested, there had to be some more state money to match what we were asking for....Most of us feel that the state mental health dollars... that was what they offered up. So after the fact, to the surprise of everyone including...the commissioner and the assistant commissioner to the department, we learned that upon the approval of the waiver that mental health was, in fact, included. (lines 58-77)

The influence of the Federal government in the decision to implement the partial carve-out initially was not corroborated by other sources.

Kelly Lang-Ramirez also noted that, “substance abuse is even more of an after-thought, thrown in at the last minute” (transcript of recorded interview, 2005, January 25, line 79). Blackburn also related that,

There had been absolutely no thinking at all about how to transition the Master Plan to managed care, there was a two-year interim period before anything really happened. They had to complete a procurement process to get the behavioral health organizations in place. They had to design the benefit package, and what they said initially was... the state Medicaid and financial people said, “Well, if this will just improve the Master Plan, we’ll just duplicate the Master Plan benefit structure; but we’ll administer it through managed care, and there will be all these additional sophisticated providers that are much better than mental health centers that will be coming in to Tennessee and doing all these wonderful things.” So they sold families and consumers on that basis and legislators and everybody else. So, but there was a... for two years we... there was no Partners program. We just billed the Department of Mental Health instead of Medicaid, the way we had been doing, at the rates that were in place in ‘93 that were based on ‘92 costs and billed in part on a fee-for-service basis, and then they billed TennCare....That’s the way we operated for two years. (transcript of recorded interview, 2005, January 25, lines 93-110)

Several other factors led to the decision by the McWherter administration to partially carve-out behavioral health care services. Although the MCOs said they were willing to accept capitated payments, they were concerned about how the global rate was derived and whether it was adequate. Questions about how mental health costs were projected were particularly prominent. The five state regional mental health institutes (RMHIs) and the community mental health centers (CMHCs), who were the key safety net providers for the most vulnerable populations, including children with SED and SPMI adults, were most concerned. Among the reasons causing concern for these players were the prospect of waning influence of the Tennessee Department of Mental Health and Mental Retardation (TDMHMR) and the CMHCs, the increasing influence of managed care and the possibility of adverse selection for safety net providers and favorable selection for the MCOs (Chang et al., 1998). Assumptions about selection were based on the projection that the SPMI and SED populations would continue to use

the traditional safety net providers and other, less severely ill patients, would use private providers.

Because of these factors, TennCare was implemented with a *partial* carve-out of behavioral health care services. In this arrangement, the TDMHMR contracted with the five state-run regional mental health hospitals and 26 community mental health centers, the traditional safety net providers, for the provision of care for seriously and persistently mentally ill adults and children with SED. Behavioral health services for all other populations were initially provided by the MCOs (Chang, et al, 1998; Conover & Davies, 2000; Saunders & Heflinger, 2003).

Funding of the partial carve-out had two components. The state, through the TDMHMR, funded services for SPMI adults and SED children through direct grants and contracts with the RMHIs and CMHCs and through fee-for-service payments to private providers. For all other populations, the MCOs either directly managed behavioral health care or subcontracted with a BHO with funding from the global capitated rate (Chang et al., 1998).

For the behavioral health care services that were not part of the carve-out, the MCOs subcontracted with BHOs to manage the delivery of health care benefits or the benefits were managed directly by the MCO. Either way, the MCOs retained ultimate accountability and risk.

The goal of the McWherter administration was to integrate all behavioral health care services into the TennCare program. Although HCFA approved a waiver in November of 1994 to integrate care for SPMI adults and SED children into the MCOs with the stipulation that the MCOs contract with approved BHOs, this was not accomplished before the administration ended.

When Governor Sundquist was inaugurated in January, 1995, a decision was made by his administration to delay the implementation of the plan outlined in the November 1994 waiver and to make revisions to the proposed plan. The revised plan the Sundquist administration submitted (Tennessee Department of Mental Health & Mental Retardation, 1995) for approval was significantly different. The proposal for a full carve-out of all behavioral health care services for all TennCare enrollees, was approved though and implemented July 1, 1996 (Conover & Davies, 2000). How this change was accomplished is very telling. The launching of the new plan, called TennCare Partners, marked the beginning of an unstable and unfortunate period of time. The strategy used by the state to “select” the BHOs, the state’s hands-off approach and the emergence of Magellan as the primary vendor created a shameful level of neglect and chaos for the most needy beneficiaries in the state of Tennessee. TennCare was created with minimal external influence (Chang et al., 1998). The same can not be said for TennCare Partners. Many groups weighed-in on the program design and it appears that the Sundquist administration was influenced by this input. Table 11 provides a history of behavioral health care in TennCare.

A Flawed Contracting and Implementation Strategy

History repeated itself with the implementation of TennCare Partners. TennCare Partners was implemented eight months after the submission of the necessary waiver and only three months after the program was approved by HCFA. Chang et al. (1998) noted that TennCare Partners “started chaotically and soon deteriorated” (p. 864). The way the state contracted with the BHOs contributed to the operational problems seen when TennCare Partners was implemented.

Table 11: Behavioral Health Care History in TennCare

Date	Event
1/1/94	TennCare implemented with a partial carve-out of behavioral health care services: TDMHMR contracted with five state-run regional mental health centers and 26 CMHCs for the provision of care to SPMI adults and SED children; behavioral health care services for all other populations was provided by MCOs (Chang, et al., 1998; Conover & Davies, 2000; Saunders & Heflinger, 2003).
11/94	HCFA approves a waiver submitted by the McWherter administration to integrate all behavioral health care services into the TennCare program (Conover & Davies, 2000).
1/95	Governor Sundquist inaugurated; decision made to delay implementation of plan approved 11/94 and make programmatic revisions (Conover & Davies, 2000)
9/95	Revised plan submitted to HCFA (Tennessee Department of Mental Health & Mental Retardation, 1995).
1/96	Revised plan approved by HCFA (Chang, et al., 1998).
3/96	After a bid process, state signs risk contracts with five BHOs (Merit Behavioral Health Care, Tennessee Behavioral Health, Greenspring, Value Options and Columbia HCA.
5/96	At the state's urging, the five BHOs are consolidated into two, Tennessee Behavioral Health Care (which consisted of Merit Behavioral Health Care and Tennessee Behavioral Health*) and Premier (consisting of the three other companies).
7/1/96	TennCare Partners implemented.
7/98	Pharmacy benefits for TennCare and TennCare Partners carved-out to a separate entity.
6/03	Mobile crisis services carved-out to a separate vendor.

* Tennessee Behavioral Health (TBH) was a wholly owned subsidiary of Preferred Health Partnership (PHP); PHP is a wholly owned subsidiary of Covenant Health. TBH had a contract with Merit Behavioral Health of Tennessee to perform all administrative, management, financial and operational functions of TBH.

Merit Behavioral Care, Tennessee Behavioral Health, Greenspring, Value Options and Columbia HCA. Two months later, at the state's urging, the five consolidated into two for the TennCare Partners business. The first BHO, consisting of Merit Behavioral Care and Tennessee Behavioral Health, was called Tennessee Behavioral Health (TBH). The second, called Premier, consisted of the other three companies. The consolidation was designed to minimize the risk of adverse selection (a risk that grows as population size decreases) and create administrative efficiencies while still maintaining some competitive tension. Both of the BHOs were offered statewide. The financial terms for TBH and Premier differed. The TBH contract was partial risk and the Premier contract was ASO.

Ann Boughtin, who was serving as the General Manager of Magellan Health Services (Magellan is the holding company for all of the TennCare Partners BHOs; information on Magellan follows) for the TennCare Partners Program when she was interviewed (she has subsequently left Magellan) offered this telling of the contracting process,

In '96 the TennCare Partners [contract] was awarded to five Behavioral Health Organizations. About two months before the "go live" date of July 1, '96, the State determined that there were too many points of interface between the Behavioral Health Organizations and the MCOs. So they asked that the companies pick partners so that there would only be two Behavioral Health Organizations. At that point, Merit Behavioral Care and Tennessee Behavioral Health formed a partnership; and Greenspring, which is the legacy company of Magellan Health Services, Greenspring partnered with I think it was Value... Options,...HCA and Foundations. So when we went live July 1st, we had two companies whose names were known as Premier Behavioral Health, which was the three companies, and Tennessee Behavioral Health, which was the other two companies. Those contracts remained in place until an RFP process was initiated in the fall of 2003. (transcript of recorded interview, 2005, February 25, lines 39-50)

The state originally planned to have each of the MCOs contract with one of the five selected BHOs. Because of the complexity of this approach, the state engineered the creation of two hybrid BHOs. Each MCO was assigned to one of the two newly created BHOs; participants were required to enroll in the BHO assigned to their selected MCO. Enrollees were not required to make an annual BHO selection, as they did for MCOs. This blunting of competitive pressures was initially an issue. Over time the issue became moot as will be discussed in a later section. The contrived construction of two BHOs, each composed of traditional competitors, was problematic from its inception and did not meet two of the three objectives outlined in the original TennCare waiver related to efficiencies and competition over time, nor did subsequent contracts. Gordon Bonnyman shared his view on the consolidation of the five BHO bidders when he projected the state saying, “we’re not going to have [five] different vendors in here....We’re going to oversee a “shot-gun wedding” and require these [five] to merge into two consortiums” (transcript of recorded interview, 2005, February 25, lines 271-273).

Concerns about administrative efficiencies led to the creation of a company called AdvoCare. When Greenspring, Value Options and HCA came together they agreed to create a free-standing entity to provide all administrative services to their BHO, Premier. This free-standing entity, AdvoCare, was created as a subsidiary of Greenspring. AdvoCare today is a Magellan entity that both Premier and TBH pay an administrative fee to essentially run the two BHOs (personal communication via phone with R. Petrella, 2005, August 09).

The consolidation of the competitors into two state-wide BHOs created a new cadre of difficult problems. There were questions about which of the provider networks would be used, which risk contracts would be honored and how plans would be

administered. Bonnyman observed that, “They had different corporate cultures. They had different business models. They had different computer systems. They were competitors, and suddenly they were supposed to be partners. It was a very ill-conceived sort of thing” (transcript of recorded interview, 2005, February 25, lines 273-277).

None of the CMHCs or RMHIs singularly or collaboratively was able to meet the requirements to be a BHO. To offer some protection for these providers, the state designated them as “essential providers” and required that that each BHO contract with them. The CMHCs were not savvy about managed care or negotiating contracts with national companies. In a move to protect their interests and protect their viability, the CMHCs turned to their trade organization, the Tennessee Association of Mental Health Organizations (TAMHO). What happened after this was described by Gordon Bonnyman,

The Community Mental Health Centers, which were going to be providing the basic network of services, had been bargaining through their trade association with the plans. At [this] point Columbia HCA, which plays hardball and played hardball, and was involved in one of the major entities in Premier...made a complaint to State officials about antitrust violations, and not just civil antitrust. This is criminal antitrust. So there’s a grand jury investigation in Memphis, and suddenly the executives in the trade association and their member team of mental health centers found themselves the target of a criminal investigation. I mean, you talk about playing hardball ...you took relatively unsophisticated non-profit agencies that were having to learn how to now enter into very complex contracts with much bigger, tougher, more experienced business entities, with their major revenue streams on the line, this is a very challenging environment. Suddenly they couldn’t talk to each other. They couldn’t talk to their trade association. It just gave the whip hand to the Behavioral Health Organizations, these new conglomerates. And as a result, those contracts that were thrown together were pretty much imposed on the Community Mental Health Centers. There’s not much of a “give-and-take” that one would have expected, and that would have been better....The gestation of TennCare Partners was really unfortunate. (transcript of recorded interview, 2005, February 25, lines 278-299)

Added to these issues, again, was a short lead time. Organizations that opposed the TennCare Partners' abbreviated implementation timetable included the Tennessee Medical Association, the Tennessee Association of Family Physicians and Tennessee Alliance for the Mentally Ill (TAMI). Unlike as was seen with the rapid implementation of TennCare, few national groups leveraged complaints about TennCare Partners and no lawsuits were filed to block the program's implementation (Chang et al., 1998).

Dr. Bruce Vladeck offered one explanation concerning the speedy implementation. He said,

There was time pressure because there was a court order relative to deinstitutionalizing the State hospital, the big State hospital [Arlington]. And [the carve-out] was going to be the vehicle through which they provided services to the SPMI population that was being communally relocated from the State hospital...They had had a...very limited bidding process for the carve-out, and we weren't very happy or very comfortable with how all that had gone or the firms that got the contract. But it had been technically not in violation of any of our rules, just by a little bit...Sundquist was hearing from the losing competitors or other folks...they knew about and really sort of wanted to rebid it, but there was time pressure because of the court order on the deinstitutionalization, so I think that's what caused the implementation date to be exactly what it was. (transcript of recorded interview, 2005, March 4, lines 272-291)

Regarding the TennCare Partners program following the hasty implementation, Dr. Bruce Vladeck said,

It just flat out didn't work. The plans [BHOs], first of all, didn't do what they promised to do....They didn't have the capacity to meet the needs. But they had also committed themselves to contracting with the Community Mental Health Centers, who are the primary providers, and then making sure that patients who had been primarily... patients of Community Mental Health Centers would stay in that system, and they didn't do it. They didn't turn in the contracts. They didn't follow up on it. They just didn't do it. And so patients continue to show up at the Community Mental Health Centers who now [had] no way of getting paid. (transcript of recorded interview 2005, March 4, lines 292-300)

Governor Sundquist concurred that the rapid TennCare Partners start-up was related to a judicial decree. He said, "I don't know what you can do about the federal judges....We were in office two weeks when we got the Arlington decision. Ned

[McWherter] told me it was going to happen” (transcript of recorded interview, 2005, March 15, lines 780-782). The Arlington decision called for the deinstitutionalization of residents of a state-run development center.

The Use of Carve-Outs

Full carve-outs can create a host of problems that impact patient outcomes and hinder efficient and effective management. There are strategies that can be employed for minimizing these adverse effects, but few were used in TennCare Partners.

Carve-outs can disrupt holistic care. According to Manny Martins, a carved-out behavioral health care program “tends to take the individual apart” (transcript of recorded interview, 2005, March 04, lines 203-204). He explained,

A big deal of mental health issues are found in your primary care visits. And suddenly with the carve-out, and actually just to this day, you have the BHO saying, “Well, that’s not a mental health responsibility.” You have the primary care physicians dealing with some of the mental health issues and...prescribing psychotropic drugs. There’s a big question as to what is a mental health service and what is a primary care service, and who’s paying for what. When you split it like that, you have two pieces and points of responsibility. I kind of liken it to the days when I first came into public health years ago. We had different clinic days in local health departments. We’d have a sexually disease transmitted day. We’d have a maternal and child health day. We’d have a nutrition day. And it’s almost like you carve the person apart, and you can’t really do that and be effective and efficient in your delivery system. (transcript of recorded interview, 2005, March 04, lines 206-216)

Carve-outs also diffuse risk. David Manning cited this as a concern in his opposition to the full carve-out, saying,

I thought the carve-out was a major mistake. I still think it was a major mistake. I had a little bit of experience on...the BHO carve-out, when I was working at Columbia HCA, after I left State government. Columbia HCA owned a piece of, actually owned a BHO that [submitted a proposal] when the Sundquist administration made the decision to carve [behavioral health care] out. [The Sundquist administration] made two mistakes. First was the mistake was to do it. I have believed for a long time, and I still believe, that a great deal of the acute care that is consumed in this country is consumed for behavioral reasons....Symptoms that are treated medically...really have a behavioral basis and that you can never truly incentivize the system to do what it should do to try

to address those kinds of issues if you carve the liability out and put it over here....So if I've got the medical risk, my goal now is to convince somebody that I want to move you over here into this other pool, and then I can wash my hands of you. I really think that was wrong, and that's the reason we didn't do it that way when we set TennCare up. We said that [the MCOs] had to, within a reasonable period of time, contract with a qualified organization, a Behavioral Health Organization, to manage the care, but under their contract, not under a separate contract. (transcript of recorded interview, 2005, March 11, lines 614-634)

Gordon Bonnyman expressed similar concern, saying,

My own view is that the concept of managed care is that you have an entity that is responsible for delivering services and producing outcomes, and you make payments to that entity, and then you hold it accountable for those outcomes. Obviously every time you do a carve-out, you weaken the ability to hold any single entity responsible, and you create incentives for cost-shifting and distortion of services at the boundaries between your different contractors. And so I'm generally skeptical about the wisdom of different carve-outs. If you're going to do managed care, you ought to hold a single entity responsible in my view. (transcript of recorded interview, 05, February 25, lines 260-267)

David Manning was blunter in his summation of the full carve-out. He said,

"There is no accountability, and there's the problem" (transcript of a recorded interview, 2005, March 11, line 674).

Fragments of a Fragment

On January 1, 1998, the TennCare Partners program was further fractured when the state carved-out pharmacy benefits. One of the reasons given to support the strategy of using a specialty carve-out, such as a BHO or pharmacy benefit manager (PBM), is the need for specialized management expertise. Yet because the BHOs "do not manage pharmacy in any way" (transcript of recorded interview with A. Boughtin, 2005, February 25, lines 617-618), accountability is diffused and expertise is not leveraged to maximize patient outcomes. Pharmacy management is completely dissociated from behavioral health care management. The BHOs bear no financial risk for the use of psychotropic drugs and the BHOs have no access to pharmacy data.

Since so much behavioral health treatment integrates the use of psychotropic drugs, this disconnect is a concern.

The need for specialized behavioral health care management of psychopharmacology was illustrated in a recent study by Cooper, Hickson, Fuchs, Arbogast and Ray (2005). In their study, these researchers showed that “the proportion of TennCare children who were new users of anti-psychotics, adjusted for demographic characteristics, nearly doubled from 23/10,000 to 45,000/10,000 in 2001 (adjusted incidence ratio, 1.98; 95 percent confidence interval, 1.82-2.16). In 1996, 6.8 percent of new users received an atypical antipsychotic, by 2001 this had increased to 95.9 percent” (p. 755). Beside the obvious concern of the high incidence drug use is the concern about “off-label” uses of atypical antipsychotic drugs. In 2003 and 2004 Saunders and Heflinger demonstrated the dramatic increase in the use of medication management while other outpatient therapeutic services declined.

Since June 2003, all mobile crisis services in the TennCare Partners program have also been carved-out to a single state-wide entity. Although there was good intent in defining the need for a state-wide vendor, including unevenness of service across the state, the implemented solution has not remedied concerns and, in some case, has caused deterioration in service.

One of the reasons given for the move to a carve-out for mobile crisis services was variability. In concept, a statewide vendor, it was reasoned, would manage this variability and, in a complementary way, the state would manage the vendor. According to a member of the TennCare Partners Roundtable, this did not happen.

Everyone thought the Department of Mental Health was still in the game. We wanted them in the game....The message that we keep getting is, and I think this is like the State took with all the MCOs, “We contracted this out. We’re not micro-managing. We’re paying these people to manage”. Even when it was issues like...”Is this the best way to handle crisis management and really build a

coordinated system?”, the response...that people at the Roundtable got was , “This isn’t the Department of Mental Health’s decision to make. We contracted this out. It’s the BHO’s decision to make”. (transcript of recorded interview, 2005, February 24, lines 258-265)

Gordon Bonnyman offered a poignant example of poor performance prior to the carving-out of mobile crisis services when he recounted testimony from the John B. lawsuit. He said,

In the John B. case, which is the Federal case having to do with the enforcement of Early and Periodic Screening Diagnosis and Treatment, or EPSDT standards, the Federal Medicaid standards for children, there was testimony that the dynamic would be that a child was in crisis [and] Mobile Crisis teams [were] called. They may or may not come. They may or may not come in a timely fashion....The people who come are not particularly sophisticated....They will ask a series of questions of the child or others that are designed to elicit the question of whether the child is immediately dangerous to self or others because the child is either homicidal or suicidal. And not only does the child have various intentions, but does the child have a practical plan for acting on that. A couple of examples from the court record... a 5- or 6-year-old who’s been diagnosed as SED for two or three years, living in a rural community, sets fire, hears voices, dead uncle saying, “Burn down the house”. [He] burns down the family home....The family is outside watching the house burn. The child hears voices of dead uncle saying, “Run into the fire. Run into the fire”. They restrain the child. Mobile Crisis comes, talks to the child about the child’s thoughts of harming self or others. The child says... [he] plans to burn down the family home whereupon the Mobile Crisis leaves, saying the child does not meet standard for inpatient or residential treatment because the home has already been burned and there’s no immediate risk that the child acting on that ideation. Another example... an adolescent, is talking about shooting himself. The psychiatrist is trying to get re-certification to extend the psychiatric inpatient care of the child. The BHO, or I guess it was AdvoCare on behalf of the BHO, makes a judgment that the child does not meet the hospitalization standards because there are no... the specific idea was using a gun, and there are no guns in the hospital, so the child’s not a risk to self or others. The child is released and goes home and shoots himself with his father’s gun that he finds at his parents’ home. (transcript of recorded interview, 2005, February 25, lines 191-219)

Turning mobile crisis services over to a separate vendor did not necessarily remedy these problems, and certainly created other problems such as duplication of services, diffuse accountability, care disconnects and increased patient hassle. The member of the TennCare Partners Roundtable commented, relative to adding Youth

Villages (the mobile crisis vendor) that, “it is kind of crazy to be putting in additional providers when we need to have better coordinated services” (transcript of recorded interview, 2005, February 16, lines 249-251). A Master’s-prepared clinical social worker, who works in a full-service community health center, noted,

We used to be the ones that did the hospitalization for children. Now that contract has been [let to] another agency for kids 18 and under. One problem that we have is we have to call that agency to come after we’ve already done the assessment, enough to know that they need to come. That work’s been done. Then they have a two-hour window to get here, and then they do the assessment that we’ve already done. And so a patient can be here four or five hours before that’s completed and a decision’s been made about hospitalization. That has been a challenge. (transcript of recorded interview, 2005, May 13, lines 412-420)

When asked about instances where the provider does not agree with the patient disposition recommended by the Youth Villages Mobile Crisis Team, the informant added,

What I’ve found is that we’ve been the ones kind of more pushing hospitalization. And when the agency comes in and completes their evaluation, they want to try maybe some...less intensive treatment first before going that route when we feel like the child might need” (transcript of recorded interview, 2005, May 13, lines 431-434).

When asked how this was handled, she added,

“Generally, it involves getting...a clinical supervisor involved. If we think the child really needs to go to the hospital and the agency that comes doesn’t, then we have to call TennCare. We have to call that agency’s highest level supervisor which is in another city across the State. And usually some kind of decision is made among the supervisors what we’re okay with doing. Sometimes we agree and then, you know, it’s not a big issue. There have been times when we haven’t. (lines 441-447)

The Demise of the Guise of Competition

Ultimately through acquisitions and other changes Magellan became the primary principal behind both of the state’s BHOs, essentially negating any semblance of

competition. Compounding the issues associated with the loss of leverage possible through the use of competing vendors was Magellan's precarious financial footing.

Magellan became the sole principal in TBH when Merit Behavioral Health was acquired in 1998. With Magellan's acquisition of Greenspring and Value Options drop-out, Premier became a 50-50 joint venture of Magellan and HCA (Wade, 2000, April 7; Wade, 2001, August 24). In 2000 Magellan attempted to buy-out HCA's interest in Premier Behavioral Systems. The state blocked the request (Wade, 2000, April 7). In 2001 Manny Martins, serving as the TennCare Director, invoked a contract clause to keep HCA from terminating their participation in Premier as they planned (Lewis, 2003, March 12). In another move in 2003, officials with Premier sought to dissolve the partnership. The state also opposed this plan (Lewis, 2003, March 12). In each case the state's opposition stemmed from concerns about financial viability and the fear of creating a monopoly (Associated Press, 2002, July 17; Lewis, 2003, March 12; Wade, 2000, April 7; Wade, 2001, August 24, August 24).

Magellan's aggressive acquisition of companies, loss of contracts and increased demand for services in the aftermath of the terrorists' attacks on September 11, 2001 culminated in the company filing for Chapter 11 bankruptcy on March 11, 2003 (Lewis, 2002, March 12 & Wade, 2001, August 24, August 24). Magellan's deteriorating financial status had been monitored by the TennCare Bureau and Department of Insurance and Commerce prior to this (Associated Press, 2002, October 5).

In each of these instances, advocates, including Gordon Bonnyman, raised alarms about what had already happened and what was being proposed. Bonnyman explained,

The State became totally dependent upon Magellan which was over-leveraged financially, was financially unsound. Obviously it ultimately went into Chapter 11. But before that, it was well known that it was failing. And the State was in a

position where it had a pretense of having two Behavioral Health Organizations, but Magellan was the principal behind both. And so here it was totally dependent upon an entity you didn't know each time you got up in the morning every day whether you're going to look and see that Magellan had finally gone into bankruptcy. That meant that the State was unwilling to enforce financial sanctions to hold them accountable. The providers were living on tenterhooks, and who would want to sign up in their networks when you didn't have a way of knowing you're going to get paid....The main entity that the State was depending upon, they felt that it could not hold it accountable, and the entity itself was failing. Financially, it was pre-occupied with some survival and with meeting Wall Street and financiers' expectations. So you talk about tightening the perverse incentives, if you ever had a situation where you could look at it from the outside and say, "Do you want to create such powerful, compelling, ruthless incentives for under-service?", as what you have when you create contracts that give the single Behavioral Health entity enormous power, very unequal relationships with their providers, and on the other hand, give the State almost no practical way to hold it accountable, and then to enhance those perverse incentives, you throw that Behavioral Health entity into financial crisis, so that its very survival is at issue and have got tremendous pressures to under-serve, beg, borrow, and steal from whomever it can to keep its doors open from one day to the next. I mean, that's what we were talking about. (transcript of recorded interview, 2005 February, 25, lines 324-337, 342-356)

According to Dr. Rene Lerer, the President and Chief Operating Officer of Magellan Health Services and Dr. Russ Petrella, not long after Magellan filed for bankruptcy in the waning days of the Sundquist administration, the state put a seizure order on Magellan. This eventually resulted in added contractual supervision. Because of these events, the new Bredesen administration's intent was to initiate a request for proposals (RFP) for the TennCare Partners business soon after assuming office. Had the RFP gone out while Magellan was in bankruptcy, they would not have been allowed to respond to the RFP. However, because of struggles the TDMHDD encountered with mounting a bid process, Magellan was able to participate since they had reached approval from the bankruptcy judge on their plan of reorganization (phone conversation with R. Lerer, 2005, January 14; phone conversation with R. Petrella, 2005, August 09). Table 12 details Magellan's involvement with TennCare Partners.

Table 12: History of Magellan’s Involvement with TennCare Partners

Date	Event
1998	Merit Behavioral Health acquired by Magellan, making Magellan the sole principal in Tennessee Behavioral Health. Magellan acquired Greenspring; since Value Options had already dropped-out of Premier, this BHO now became a 50-50 venture between Magellan and HCA (Wade, 2000, April 07; Wade, 2001, August 24).
2000	Magellan attempted to buy-out HCA’s interest in Premier; this move was blocked by the state (wade, 2000, April 07; Lewis, 2003, March 12).
2001	Manyy Martins invoked a contract clause to keep HCA from terminating participation in Premier (Lewis, 2003, March 12).
2003	Officials with Premier sought dissolution of the Magellan/HCA partnership; the state blocked these efforts (Lewis, 2003, March 12).
March 11, 2003	Magellan filed for bankruptcy. In turn, the state put a seizure order on Magellan; previously the state had placed the organization under contractual supervision.
9/03	The TDMHDD issues a request for proposals for BHO services (Lewis, 2003, September 13).
11/03	TDMHDD announced that BHO business for Middle and West Tennessee awarded to Value Options and business in East Tennessee awarded to Tennessee Behavioral Health (Lewis, 2004, January 31).
1/05/04	Magellan emerged from chapter 11 bankruptcy reorganization
1/31/04	The state, citing failed negotiations with Value Options, awards business for Middle and West Tennessee to Premier (Lewis, 2004, January 31).

A Second Try is a Little Better

In 2003 the TDMHDD re-bid the BHO contracts. Gordon Bonnyman related the following,

We had a failed effort to re-bid that [went] along for a couple of years. The state saying,..."We're about to bid [the business]". They couldn't get the bid out; they didn't get responses. They got close to contracting with Value Options, but then that fell by the wayside. There's a limited number of vendors out there to choose from....As experience with Magellan attests, those that are out there are not well-qualified to do the work that would be expected of them. (transcript of a recorded interview, 2005, February 25)

Another informant who asked to not be identified added,

Who knows what happened behind closed doors. The rumors that spread was [Value Options] wanted to take some of the money being put into their original Mental Health Institutes and put them into community-based care, and the state wasn't willing to go there. The Department of Mental Health wasn't willing to go there. So [Value Options] said, "Never mind if you're not serious about community mental health". (transcript of recorded interview, 2005, February 24, lines 337-342)

In the RFP, the TennCare business was divided by the three grand regions of the state, East, Middle and West Tennessee. Magellan only bid on the East Tennessee business because the financial terms were most appropriate given prior experience. CompPsych bid on the business for West Tennessee and Value Options bid on East, Middle and West Tennessee. Value Options was selected for the business in Middle and West Tennessee and Magellan was selected for East Tennessee (phone conversation with R. Lerer, 2005 January 14; transcript of recorded interview with A. Boughtin, 2005, February 25; phone conversation with R. Petrella, 2005, August 09; email from R. Lerer, 2005, August 10). The state was not able to come to contract terms with Value Options. Because of this, the state determined there was no viable bidder which allowed them to waive standard procurement requirements (phone conversation with R. Lerer, 2005, January 14; phone conversation with R. Petrella, 2005, August 09).

The state subsequently asked Magellan to retain their current contracts in Middle and West Tennessee and they agreed. This resulted in Magellan, through TBH, being awarded a full risk contract based on the merits of their proposal for East Tennessee and essentially continuing the TBH and Premier contracts in Middle and West Tennessee with TBH being a partial risk contract in these areas and Premier being an ASO arrangement (phone conversation with R. Lerer, 2005, January 14; phone conversation with R. Petrella, 2005, August 09; email from R. Lerer 2005, August 10).

Conflicting Roles and Disconnects

When a vendor, such as a BHO, is employed, the contractor, in this case the state, must articulate requirements and hold the vendor accountable for performance. The foundation of performance management includes a clear specification of expectations, generally through contracts and other discussions and agreements, and active and ongoing oversight with adjustments, as needed. The vendor and contractor must be continually engaged in a common purpose, and that purpose, in the case of the delivery of health care services, must be customer-focused. The evidence in the case of TennCare Partners points to the state being either unwilling or unable to oversee the BHOs. Many of those interviewed described the state as unengaged. As a result, outcomes suffered.

Previously factors which hindered the state in their management of the TennCare and TennCare Partners programs were discussed. In addition, there are other factors related to TennCare Partners which contributed to disappointing results. These other factors include fragmented roles, untoward organizational splits and a hands-off approach by the state.

The TDMHDD is fragmented and encumbered because of their multi-faceted roles and objectives. The TDMHDD has the “dual role of being a provider of services as

well as a contractor for the manager of services” (transcript of a recorded interview with an unidentified member of the TennCare Partners Roundtable, 2005, February 24, lines 343-347). Glenda Sublett, Administrator for Peninsula Hospital in Louisville, Tennessee, presented a similar view, saying, “The Department (from an inpatient perspective) has to wear two hats. They are the ultimate COO and CEO of the State Institutes, but yet they have to manage the TennCare Partners benefits as well as the overall needs. I know that can be a delicate balance at times” (transcript of recorded interview, 2005, January 11, lines 567-572).

Further complicating this split is the fact that the state is accountable for the safety net. The state also oversees the Regional Mental Health Institutes (RMHIs). The same member of the TennCare Partners Roundtable labeled the RMHIs as “a huge state political issue” (line 348). In many ways the RMHIs are “sacred cows” (line 362). The state, as overseer of the RMHIs is a large employer. This fact is significant when you consider that the RMHIs are often located in rural or semi-rural areas. When there have been discussions about reallocating money traditionally earmarked for the RMHIs to community-based providers, there has been “a lot of resistance that comes up through the legislature” (lines 359-360).

It was also mentioned that conflicts in roles concerning the stewardship of the RMHIs and the management of the TennCare Partners program may have been a factor in the state’s inability to consummate a contract with Value Options, a major national competitor of Magellan, when the business was out to bid in 2003 . The same unidentified source said,

The rumors that spread was [Value Options] wanted to take some money being put into [the RMHIs] and put them in community-based care and the state wasn’t willing to go there. The Department of Mental health wasn’t willing to go there. So Value Options said, “Never mind if you are not serious about community

mental health” (transcript of a recorded interview with an unidentified source, 2005, February 24, lines 337-341).

Another split that is seen in the delivery of behavioral health care services in TennCare Partners is organizational. Substance abuse oversight is under the purview of the Department of Health whereas mental health oversight rests with the TDMHDD. A Masters-prepared social worker who directs services for children and youth noted that this separation has caused problems. He said,

They don't work together. In fact, we just had a site visit for one of our programs that's funded through the Department of Mental Health, but it's a co-occurring provision program. He was talking about the difficulties in the State of Tennessee of enveloping co-occurring programs because they're two separate departments, and they don't cooperate (transcript of recorded interview, 2005, March 02, lines 484-490).

The separation though is not unique to state government. Sterling explained,

You've got the TAMHO...and you've got TAADAS which is the Tennessee Alcohol & Drug Association. There's a whole lot of conflict between the two. Often we've tried at TAMHO,...and TAADAS is trying, I think, to try to blend some of that; but there's still a lot of animosity between the two. It's kind of been...this artificial separation. I think they're not helping that at all (lines 519-525).

One of the most significant deficiencies in the TennCare Partners program emanated from how ineffectively the state managed the BHOs. According to Gordon Bonnyman deficiencies were fundamental and persistent. He said, “There's not appropriate oversight...Appropriate contracts were not written...Resources were not committed to holding the BHOs accountable” (transcript of recorded interview, 2005, February 25, lines 241-242).

Many informants expressed concern that the state took a “hands off” approach to managing the BHOs. Others spoke of how ineffectively the state managed the BHOs and administered contractual terms.

The state contracted with the BHOs to manage the delivery of behavioral health care benefits to all TennCare enrollees. The principles of effective performance management specify that in such a relationship the state should maintain accountability for the performance of their selected agents. By many accounts the state abdicated their accountabilities to the BHOs and this created perverse incentives for poor performance.

By far the greatest concern about state's management of the BHOs was related to their lack of meaningful involvement and oversight. When persistent problems were brought to the attention of the TDMHDD, they deferred to the BHOs. One informant who asked to remain anonymous related that,

One of the concerns is that everyone thought the Department of Mental Health was still in the game. And we wanted them in the game. The message that we keep getting is, and I think this is like the State took with all the MCOs, is "we contracted this out" (transcript of recorded interview with an unidentified informant, 2005, February 16, lines 257-260)

When issues concerning coordination of care and crisis management arose and were brought to the attention of the TDMHDD,

The response...that people at the Roundtable [got was], 'This isn't the Department of Mental Health's decision to make. We contracted this out. It's the BHO's decision to make.' or 'This is between you and the BHO. We're not going to get in between the BHO and their contractors' (transcript of a recorded interview with an unidentified informant, 2005, February 16, lines 263-265, 80-81)

Similar sentiment was expressed by Dick Blackburn. In his view during the Sundquist administration, "the Department totally abdicated all responsibility for anything....The BHO was setting policy, was calling the shots, was deciding everything" (transcript of recorded interview, 2005, January 25, lines 485-489). Kelly Lang-Ramirez agreed, saying,

The accountability factor seemed to go away entirely. They had a hard time reining in the BHO, much less trying. And they certainly never wanted to get involved in anything between the BHO and the providers. They were just totally

hands off. “You guys, don’t worry about... we’re out of this.” You know, ‘Not our problem.’ (transcript of recorded interview, 2005, January 25, lines 569-573)

Whether the TDMHDD distanced themselves from the problems associated with the administration of the TennCare Partners program as a deliberate strategy, because of a power hierarchy among state departments, or both, is unclear. Dick Blackburn attributes the TDMHDD’s stance to a power differential between the Bureau of TennCare and the TDMHDD. Kelly Lang-Ramirez cited the fallout from Governor Sundquist’s plan to create a mega-Department of Health. She said,

[The TDMHDD] lost, I don’t know, how many staff positions to the TennCare Bureau? This is when they were trying to make that mega-Department and they thought people needed to have the knowledge of the inner workings of Medicaid and grants and claims processing, and all that. And the Department of Mental Health...either... just evaporated or got shifted over to TennCare Bureau. So it wiped out a good core-like expertise of the Department (transcript of recorded interview, 2005, January 25, lines 493-499)

Blackburn said,

[The TDMHDD] had no power, basically no role except to administer, oh maybe \$17... \$18 million dollars worth of block grant and different kinds of grant programs, and to run the state hospitals. That’s it. Period. Everything else, Manny Martins or one of the eight TennCare directors,...I can’t remember exactly what sequence they came in, but one of them said, “We don’t need your help. We’ll run this.” And so the BHO just had a field day during that time....That was a horrible time....A lot of things...that happened during that time...are irretrievable. I mean you never, never get back to where you were with the... with some of that (transcript of recorded interview, 2005, January 25, lines 500-510)

This changed, in Blackburn’s view, when Elizabeth Rukeyser became the Commissioner in 1999. According to Blackburn,

When Commissioner Rukeyser came, she negotiated with Manny Martins a memorandum of understanding, which was the first point at where the Department began to try to recover some power, or gain some authority over behavioral health. And so basically, they worked out an arrangement where they had all the responsibility... authority over policy, and the only thing that... [the] TennCare [Bureau] had responsibility for was the budget, the money....But [the TDMHDD]...couldn’t necessarily veto what happened with the money, but...at least they were advised of something that was going on there....So they had a lot more information, a lot more interface with the TennCare powers than they’d ever

had. And they had authority to make certain decisions. For example,... the second year Commissioner Rukeyser was there, the managed care company put out a memo saying, 'We've decided we're not going to fund adult continuous treatment teams anymore.' Well we had...outcome data, we had enough to fill this room and that showed how effective they were at keeping people out of the hospital. And it was just a cost-cutting measure that they...didn't feel they ought to be spending the kind of money they were spending to accomplish that. Just let them go to the hospital, I mean, we already got our 9%, 10% administrative fee; what do we care where they get the services. So Commissioner Rukeyser basically said, 'No, you're not going to do this.' And that is the first indication that the memorandum of understanding had produced a change in the Department, in that they could make decisions like that and enforce them. So that's one service that is still around. It's kind of on shaky ground, but it's still around. (lines 516-534)

It is important to note that a few informants mentioned that the current TDMHDD staff has been more engaged than previous staff. Brian Buck of Ridgeview noted that, "[The current staff] has a really good understanding of the services that are being delivered...and the role that the BHO plays in terms of our relationship with the BHO" (transcript of a recorded interview, 2005, April 05, lines 527-529).

"The Current Dragon We're Trying to Slay"

While Magellan representatives made note of the fact that they have continuously held a contract with the state of Tennessee for the TennCare Partners business (transcript of recorded interview with Russ Pertrella, 2005, February 25, lines 660-661), the implication of stability belies the tumultuous history of the relationship and the perception of contracted providers. The mismanagement and fragmentation of the TennCare Partners program caused tremendous chaos for the CMHCs, the essential community-based providers. Brian Buck is the CEO of Ridgeview, a CMHC based in Oak Ridge, Tennessee; his quote is the title for this section (transcript of recorded interview, 2005, April 05, line 388). Reflecting on change, he made note of there originally being seven BHOs, these in turn consolidated into two organizations for the TennCare Partners business, the financial difficulties of Magellan, the aborted contract

negotiations with Value Options and the recent introduction of TennCare reforms (lines 287-300). He noted, “The only consistent has been change. One of the things that hasn’t changed [though] is the mental health needs of...kids and adults in the community....The need is always there” (lines 300-313).

In this environment of constant change, Buck said, “one of the biggest challenges...is to not become overwhelmed with not knowing what the big picture is going to look like. {you need to} just stay focused on delivering care, delivering care in an environment that is going to change” (transcript of recorded interview, 2005, April 05, lines 308-311). He expressed the resolve that the CMHC had to “adapt, improvise and overcome limitations in terms of delivering services” (lines 133-135).

Buck cited uncertainty about funding being prominent, saying, “It’s the funding piece of it that keeps changing and is really the difficult part in trying to plan for the future, take care of things now with all of this uncertainty” (transcript of recorded interview, 2005, April 05, lines 317-319). Buck related that,

There are so many question marks that it’s a matter of planning for the future not knowing what the future holds, and that’s the hardest part. That’s the hardest part to retain staff. It’s the hardest part to deliver services with any real stability that things aren’t going to change because you know they’re going to change. (lines 370-376)

Is there hope in slaying the dragon? The question is difficult to answer. There are signs of encouragement amongst the concern and the turmoil of change. The signs of encouragement come from the advocates, compassionate policy-makers and others that remain committed to not letting our state forget the needs of those suffering from mental illness. His commitment was exemplified by Brian Buck when he said,

The need will not go away. SED kids and SPMI folks will not go anywhere. The need remains. The mission of Ridgeview [and other CMHCs] is to meet that need. That’s what has really sustained us through a lot of this change and transition. One of [our] strengths is to stay focused on what we do best, and to

figure out how to make this work so that we can do what we do best. That really helps get us through this [change]. A lot of times the players will change and the rules will change and the funding mechanisms will change, but it seems to come back around to that we still have this need and we still have folks that are going to meet this need, and that carries us through. (transcript of recorded interview, 2005, April 05, lines 424-435).

Care Delivery in TennCare Partners

The changes in health care delivery brought about by TennCare Partners were far-reaching. An explosion in access was followed by a shift in the complement of care available to beneficiaries. Some of the changes that were anticipated never materialized. Many informants mourned changes in relationships and roles and the impact these changes had on care delivery. Another hasty implementation, prompted by external events again, produced avoidable problems.

The fallout from the implementation. During the tumult of the early days of TennCare Partners, patient care suffered. Delivery of care and therapeutic relationships were disrupted. CMHCs faced severe financial difficulties. Even the BHOs threatened to not renew contracts because of financial losses.

A 2003 study by Ray, Daugherty and Meador demonstrated what many already perceived about disruption of care. In their comparative study of the continuity of care before and after the implementation of TennCare, the researchers found that the post-implementation cohort of adults with SPMI had an 18 percent increase in the odds of a loss of continuity of therapy ([95 percent confidence interval, 1.07-1.30]; P=0.001). When high-risk patients were segregated, this difference increased to 79 percent ([95 percent confidence interval, 1.45-2.2]; P<0.001). In addition to discontinuous care, the researchers also found that participants experienced a 4.2 days shorter mean duration of antipsychotic therapy ([95 percent confidence interval, 1.7 70 6.7], P=0.001). On the same measure, the high-risk cohort experienced a 14.4 days reduction [95 percent

confidence interval, 9.4 to 19.4]; $P < 0.001$). The high risk patients experienced disruption immediately after the implementation of TennCare Partners and this disruption persisted for one year.

Although the predominant impression is one of the state not being engaged, this was not the case when TennCare Partners was first implemented. Instead the state attempted to maintain central regulatory control in the beginning which, it is alleged, undermined the BHO's ability to manage care and effectively complete tasks such as developing and managing care plans. Early on, it was not uncommon for the state to overturn many care denials issued by the BHOs. The BHO's ability to perform case management was further hampered by the state's mandate that no patient could be moved to an alternative form of care for three months after the implementation of TennCare Partners (Chang et al., 1998).

During the early days of TennCare Partners, the BHOs were having difficulty stabilizing networks and providers and patients grew increasingly frustrated with bungled plan administration. CMHC suffered significantly during this time. Revenues plummeted placing many of the organizations in precarious financial positions. Some CMHCs eventually closed down and many of the CMHCs were forced to turn away new patients during the transition. Some of the CMHCs notified the state that they would not renew future contracts with BHOs, extending the threat to the safety net (Chang et al., 1998).

The rampant discontent and disruption resulted in the Tennessee Department of Health announcing on February 13, 1997 that TennCare Partners would be folded back into TennCare effective January 1, 1998. Although this plan never materialized, it was indicative of how troubled the program was. This was further confirmed when HCFA began an investigation into TennCare Partners in February, 1997. As a result of this investigation, the state had 30 days to institute corrective actions to assure that patients

received care and BHOs fulfilled contract obligations, provided separate funding for SPMI adults and children with SED, reduced provider financial risk and reduced the rate of inpatient care (Chang et al., 1998).

Hope Gives Way to a New Reality

Hopes regarding the continuation of the continuation of the Master Plan for Mental Health, increased access, better care and the ongoing partnership of the state and the CMHCs gave way to a whole new reality once TennCare Partners was implemented. Views about this reality are complex and evolving. Most interviewees spoke of some level of disillusionment. Some spoke of the need for changes that TennCare Partners precipitated. Most acknowledged the important legacy of creating more access for children. The criticisms regarding access mainly center on the question of *access to what?*

Many advocates spoke of the Mental Health Master Plan as being an ongoing template for reform when the TennCare program was being developed. According to Dick Blackburn,

A great deal of work had happened [the three years prior to the start of TennCare]. We were two and one-half years into what was called the Mental Health Master Plan, which over that period of time, they'd put \$27 million into the mental health system. At that time, that was a lot of money. That had been done through selling off the state hospital property in Nashville, and using part of the proceeds to build a new, more modern acute care facility for the state hospital there, and to close down some of the beds and shift the operating dollars that had gone into those beds into the community....Everybody was happy with how that was working. We added some Medicaid-optional programs, the case management option, and the rehabilitation option, and were able with the new state dollars to draw down additional Federal dollars for mental health and put a lot of new services in place. So everybody was happy. (transcript of recorded interview, 2005, January 2005, lines 60-70).

The Master Plan did not address children, but prior to the start of TennCare Partners, the CMHCs had initiated a model of case management for children. A member of the TennCare Partners Roundtable said,

The hope was that the BHOs and TDMHDD were going to basically support best practices including case management, and that this would be a way of enforcing it statewide because there was great variation across the state in terms of quality of care....The assumption was that there would be a more statewide level playing field and the BHOs and state would continue to reinforce the good things that were there. (transcript of recorded interview, 2005, February 24, lines 100-105, 121-123)

Another hope was that “it didn’t just have to happen with the community mental health centers...that other people could get reimbursed from Medicaid. That had not happened before” (lines 146-147).

Unfortunately the Master Plan was not continued as envisioned and a new complement of providers never became a force in TennCare Partners. Dick Blackburn’s recollection of planning for TennCare shows how little deliberation actually occurred about the Master Plan. He said,

[The planning] just was done ‘willy-nilly’. I remember Governor McWherter saying..., ‘If we had to wait until everybody was [ready], everything was set, we never would get this off the ground, so we’ll just do it and let the chips fall where they may. We’ll deal with what happens afterwards.’ So there really wasn’t very much [planning], but because there had been absolutely no thinking at all about how to transition the Master Plan to managed care, there was a two year interim period before anything really happened. (transcript of recorded interview, 2005, January 25, lines 89-94)

More telling is how the results that were being seen with the Master Plan changed in TennCare Partners. Kelly Lang-Ramirez explained,

The goal of the Master Plan [was] they were going to decrease inpatient and expand community services. That’s what you would want to have happen, obviously. It was going along quite well doing that. And Partners came along, and for a whole variety of reasons, inpatient has gone up. Total costs of inpatient have gone up. Now the length of stay went down, but total days have gone up. Even right now they’re seeing increases in residential services for kids....Everything is really misaligned, with the incentives of the whole service delivery system; it’s not putting resources where they should be. (transcript of recorded interview, 2005, January 25, lines 413-430)

Nor did the advent of TennCare Partners,

Open the door for private providers. A lot of the folks who access those private providers were kids that weren’t as sick...or [from] families who were educated.

TennCare has a broad spectrum of those who qualify for it and who prefer not to go through the public sector and wanted to have someone. But the providers found out real quickly that they may be eligible for reimbursement, but boy what a pain it was to get reimbursement. So they started like dropping like flies, [saying]... 'I'm not going to get reimbursed \$25 for what I would get reimbursed \$75 by another managed care company...so, I think, in large part, that network that started out looking good kind of faded away. (transcript of recorded interview with an anonymous informant, 2005, February 24, lines 159-173)

Adding, "I think there are a lot of providers, especially in the urban and the surrounding urban areas, that are trained and were willing and then found that it was just a hassle, and they weren't getting reimbursed basically" (lines 201-203). Dick Blackburn noted,

There really haven't been any new providers as such. Our membership and it has a different structure as we said, but it is still basically the same providers out there. [The CMHCs] provide more than 90% of the services and have all along. There have been a few, what I would call 'specialty agencies' that have developed. The major ones there have developed because the BHO funded their development at the start and offered grants or enhanced kinds of financing mechanisms that helped them get off the ground. They did that in several cases that didn't make it, but in a few cases they did make it and they're still around; but they're very small and insignificant. (transcript of recorded interview, 25 January 25, lines 161-170)

The inability to attract available providers is a concern because there is not an adequate enough provider base for all the demand that was created when access was expanded. This concern could be addressed by a concerted effort of the BHOs and the state, if it became a priority. More perplexing problems, less amenable to direct intervention, are the dearth of certain needed specialties, such board certified child psychiatrists, and the difficulty of attracting providers to rural areas.

The CMHCs, the backbone of the public sector delivery system (along with the RMHIs), underwent significant change as a result of TennCare Partners and other forces that preceded TennCare. There were 33 CMHCs when the Master Plan was developed. By 1996, there were 28. Kelly Lang-Ramirez related that,

Starting just prior to Partners, a lot of consolidation [was] going on and that continued through at least the first couple of years of Partners, and it's leveled

out [now] to some degree. (transcript of recorded interview, 2005, January 25, lines 122-124)

The consolidation was prompted primarily by “survival” according to Lang-Ramirez, although it “may have benefited some care coordination...it was more trying to gain economies of scale and survive” (lines 127-129). Dick Blackburn added,

We knew that there was going to be less money in the system, less funding, because when the managed care companies take nine, ten percent off the top, then there’s going to be less money going into direct care right off the bat. And we knew that administrative costs would go up because of all the requirements that they put in place. And so, many of the centers got together and decided that they would consolidate under one management structure and in that way they didn’t have to have two chief financial officers and two accounting offices and so forth. They would have one. They probably did save some administrative costs by doing that type of thing, but a lot of it was...to gain clout with the managed care companies because...the BHOs..., in negotiations, basically come in and say, “If you’re not willing to do ‘X’ for this amount of money, we’ll just go to the next county and they’ll be glad to serve this in the county where you are. (transcript of recorded interview, 2005, January 25, lines 131-144)

Prior to the start of TennCare Partners, a major paradigm shift had already occurred that had significant implications for CMHCs. The CMHCs were no longer “enfranchised”. The implications of this change became more apparent as competition was introduced by the advent of managed care.

Historically the CMHCs had very specific geographic catchment areas.

Beginning sometime in the Reagan administration, laws were changed such that CMHCs,

were expected to be competitors with each other, whereas up to that time, [they] really looked at each other almost like a single system and that [each was] a component in the system and real partners with the state in trying to ensure that [the CMHCs] were carrying out the state’s mission through contracts....[The CMHCs] were [now] expected to be competitors with each other. (transcript of recorded interview with Dick Blackburn, 2005, January 25, lines 204-219)

Because the shift was still unfolding, there was ambiguity in roles. Dick Blackburn explained,

What I've often said is the state now uses [the CMHCs being competitors] to their advantage, in that when we need to be lean, mean, competitive machines out there and not live off of state funding or are expected to do something a lot more efficiently, then that's what they say, ...[you] ought to be competitors just like any other business. But when they want us to be like an arm of state government almost, just quasi-state entity that they want more control over and want to use to deliver some service that they don't have the money to pay for, then they come back and talk about mental health centers like they were before TennCare that, you know, that they have this community mission, this responsibility to the state's citizens. So they really kind of like to have it both ways, and it puts us at a real disadvantage....A lot's happened and things are unbelievably different; it's like a whole different world. Legislators, for the most part, still look at their Community Mental Health Center in their community as almost a public entity than instead of a private entity, which it's always been but... when we operated in full partnership with the state in delivering these services, it operated like a public entity....Many legislators, they think people who work at mental health centers are state employees, like it's a state agency almost....A lot of them, even those who've been around a long time, still don't understand that we are no different now than a private construction company that contracts with the state to build a bridge. That bridge is going to cost 'X' amount and have certain specifications they have to meet, and if the state says, 'Okay, we'll provide that amount', then you got a deal. They can do it. If they say, 'No, you...have to meet the same specifications, [but] we can only provide 70% of what you're asking for', then most of those companies will say, "I'm sorry; you're going to have to go somewhere else. (transcript of recorded interview, 2005, January 25, lines 219-252)

Despite all the changes, the reality still is that TennCare Partners or any other public assistance program for behavioral health care benefits can not exist without the CMHCs.

Over the past ten years, the CMHCs, in varying degrees, have positioned themselves better for the reality of today's marketplace. Kelly Lang-Ramirez related that,

[The CMHCs] all are very heavily dependent on TennCare as the payer-source for the people they serve. But it does vary from agency to agency....Some... specialize in other arenas and are leveraging more private-pay, commercial insurance contracts than others, so there's a bit of a mix. But I'm not sure if any of them could just totally, you know, drop the TennCare contract. (transcript of recorded interview, 2005, January 25, lines 258-262)

Dick Blackburn added that, "on the average...60-65% of the [CMHCs] operations statewide are funded with TennCare....Some centers are down to maybe 25 to 30%,

and some are at 85%” (transcript of recorded interview, 2005, January 25, lines, 263-265).

One of the things that has suffered in the transition is the sense of partnership enjoyed by the state and the CMHCs. Blackburn explained further using the bridge builder analogy,

I think the centers are doing as much as possible....The things they did before TennCare in terms of trying to find some way to provide services to someone who has no resources....Some do a better job of that than others. I'm just saying that if 'push came to shove', [the CMHCs] would have every right to [walk away from the state] because of the relationship...with the state. It is no different than a bridge builder...they can walk away and say, 'I can't do this work for you because you can't meet my price. I would lose money doing that". We're in the same situation whereas before the relationship was more of a partnership. We would say, 'We recognize you are not paying full costs, what it takes to provide these services, but if you contract with us and tell us exactly what you want us to deliver, we'll rely on other sources. We'll use other parts of our budget to supplement the cost of care for people who have no other way to pay for it'. That's the kind of relationship we had. (transcript of recorded interview, 2005, January 25, lines 267-284)

The CMHCs also saw a significant change in the complement of care. A good illustration is what happened with children's services. According to Kelly Lang-Ramirez, "the higher cost, [more] intensive services dried up" (transcript of recorded interview, 2005, January 25, lines 297-298). An example cited was therapeutic nurseries. There were close to 30 therapeutic nurseries in the state prior to TennCare. Lang-Ramirez related that,

Those have dried up to the point [where] there are two left in the state and that's just because the private foundations are keeping it going. I still hear testimony from school systems today about how effective that early intervention, intensive level of care is. So that's one example of how...[TennCare Partners] rationed care differently. It seemed to give less to more people, but unfortunately some of the critical components of a full continuum of care went away entirely. There may be something to be said for reducing something or planning a more efficient way to do it, but there were just literally components of care that the network cut out. (transcript of recorded interview, 2005, January 25, lines 305-313)

The Shift to Case Management

With case management there is a disconnect between the promise and the reality. Case management, an initiative with momentum prior to the institution of TennCare Partners, was envisioned as an over-arching added function that would complement care being delivered. Instead case management became a poor substitute for care.

A member of the TennCare Partners Roundtable relayed this history of children's case management,

Right before TennCare, the Department of Mental Health had done this huge [case management project]. The Master Plan did not address kids. This happened simultaneously. All the community mental health centers had a model of case management. They were doing all this training, and they were using some of their block grants to do children's case management. So word is coming [about managed behavioral health care]. TennCare had come in '94, but it wasn't coming to behavioral health until '96. In these two years, the community mental health centers didn't quite know what was coming. They knew something was coming. [Meanwhile] case management was going....The TDMH children's director was worried about what was going to happen to kids' management. They felt they had a really good kids' case management model. (transcript of a recorded interview, 2005, February 24, lines 34-45)

The continuation of this work on children's case management was included in the waiver request the TMMHMR put together (Tennessee Department of Mental Health & Mental Retardation, 1995, September). The TennCare Partners Roundtable member recalled,

What was envisioned was taking the best of the services, including the case management model like they wanted it, and having that as one of the specified preferred models of care. The hope was that the BHO and the Department were going to basically support best practices including the case management and that this would be a way of enforcing it statewide because there was great variation across the State in terms of quality of care. The assumption was that there would be more Statewide leveling playing ground and that the BHO and the State would continue to kind of reinforce the good things that were there. (transcript of recorded interview, 2005, February 24, lines 98-105, 121-123)

The state's specifications for case management were operationalized by the BHOs. Ann Boughtin, a former General Manager of Magellan Health Services for the

TennCare Partners account, explained how this BHO views case management. She said,

There are many, many different models of case management. There are treatment models of case management. There are brokering models of case management. There are supportive models of case management. And the current array of services that we have provide some of each. The more intensive services, the treatment-oriented services, are pretty limited in terms of their availability across the state. Case management, though by and large in the system of care right now, is more of a brokering or supportive model. And there are a couple of additional distinctions...that I think are important to make relative to case management. That is that case management can either be defined as a service or a person in your life. Some members need case managers, someone who's there with them frequently to make sure that their basic needs are met, that they're accessing their appointments, and if additional supports or services are needed, go out and find them. Others, depending on the nature of their illness and what's happening for them at a moment in time, may need some case management support that could be provided by the therapist, by the social worker that they're seeing, and that tends to be somewhat more intermittent and short term. We have a system in which case management is provided to a vast array of people for very long term. (transcript of a recorded interview, 2005, February 25, lines 564-581)

A Master's-prepared social worker, who is now part of a CMHC management team, lauded the inclusion of case management in TennCare Partners. He said,

We didn't have case management really to speak of back pre-TennCare. On the adult side, that's where some of the more recovery-oriented services came in, like psychiatric rehabilitation and the drop-in centers and supportive employment and some of those kinds of things. They're a much cheaper alternative that meet people where they're at in their communities [by] trying to help them adapt to the world that they live in while adapting and learning to control their mental illness and fill the gap that existed years ago [when] all of those functions that were not being performed by professionally trained licensed people simply because that wasn't what they were trained to do and the system couldn't afford to pay psychiatrists and psychiatric nurses and LCSWs to go out and do these kinds of tasks. So to me, one of the good by-products of [case management] is that I think it has forced us to get more creative, and it's forced us to become more outcome-focused....If the only way you know to practice a profession [and] deliver mental health services is that old medical model that only includes the social worker, psychologist, nurse, and doctor, then you are missing a big piece of what is happening in a person's life who has a mental illness whether it's the child that's SED or the adult that's SPMI; you are missing it. I mean, I look back on those days and I think, wow, we weren't very effective at dealing with the person in their world. We dealt with their symptoms. We dealt with controlling those symptoms. We dealt with some insight-oriented kinds of issues for people that had that capacity. But we weren't dealing with those practical matters of

living in the world with a mental illness. That seemed to make so much difference. (transcript of recorded interview, 2005, March 01, lines 79-113)

Children's case management was often cited by informants as a service that did increase in the TennCare Partners program. The problem is that, in many instances, case management may have a substitute for care rather than an adjunct. A Medicaid researcher commented that a lot of emphasis has been placed on case management, but everything else has been neglected. The researcher asked, "If kids are getting case management and nothing else, what is that? We see quite a few...kids that are in case management only" (transcript of recorded interview, 2005, February 24, lines 784-785) This same researcher suggested that substituting case management for actual therapy is related to capitation. The informant said,

We see quite a few of those kids that are the case management only. Where do we put our incentives? [There are incentives for increasing case management.] When you have a case rate of, whatever it is, \$250 a month, that you have to do 'X' number of case management contacts and then have to see the psychiatrist, where's there...money to provide family therapy and group therapy, and consulting with the school teacher? So they're being paid to provide case management and case management, obviously if you don't have enough resources, that's [what] they're going to go. So who's monitoring for best practice? And if you've got a kid with ADHD, they're supposed to be doing behavioral component and the meds component. What about people with bipolar and depression? Every one of those that have practice standards says there's supposed to be therapy component and/or family component along with the meds. (transcript of a recorded interview, 2005, February 24, lines 786-798)

Utilization data can be used to understand access, including the number of users of service and the number of services each uses. Saunders and Heflinger (2003) showed interesting trends in utilization of services before and after the implementation of TennCare Partners. The researchers used four categories of metrics to analyze the utilization of behavioral health services, including overall access, use of inpatient services, use of specialty outpatient services and use of supportive services which include case management and medical management.

The study (Saunders & Heflinger, 2003) confirmed an overall 50 percent increase in the absolute number of school-aged children (ages 4-17) that received a behavioral service from the state between 1995 and 2000 (TennCare Partners was implemented in state fiscal year 1996). During this same time, TennCare enrollment grew by 19 percent, resulting in an increased annual access rate increased from 72.7 per 1000 to 91.7.

Between SFY 1995 and 2000, the rate of use of inpatient services was relatively stable at 5 per 1000. However the proportion of inpatient services for all youth who were treated declined from 69.9 to 53.4 per 1000 users during the study period. Length-of-stay also decreased from 26.2 days to 11.3 days per admission. During the same time, the rate of readmissions within 30 days increased from 9.2 to 12.2 percent (Saunders & Heflinger, 2003).

The proportion of outpatient services for all youth who were treated declined from 617.7 users (62 percent) to 581.6 per 1000 users (58 percent). There was an initial decrease in the rate of access and number of youth receiving individual and group therapy, but the post-implementation rates eventually surpassed pre-TennCare Partners levels. Rates of family treatment utilization increased from 2.8 to 15.4 per 1000 users (Saunders & Heflinger, 2003).

Although rates of access increased, the average overall number of specialty services fell from an average number of treatment days of 18.51 to 6.4. The average number of individual therapy treatment days declined from 6.08 to 4.62; day treatment and partial hospitalization days declined from 46.26 to 8.40. The average number of treatment days for family therapy increased from 2.79 to 3.27 days (Saunders & Heflinger, 2003).

Saunders and Heflinger's analysis (2003) showed a dramatic increase in the rate of access to case management from 2.7 per 1000 enrollees to 21.2 from SFY 1995-2000. The average number of treatment days also increased from 3.32 to 11.51. For medication management, the increases were similar. The rate of access increased from 3.9 to 25.9 per 1000 enrollees and the average number of treatment days increased from 2.08 to 3.60 days.

Although the study by Saunders and Heflinger (2003) lends credence to the concern that case management is being used with children and adolescents as a substitute for needed care since the inception of the TennCare Partners program, it does generally not tell us how this change has impacted patient outcomes. The increase in patient readmissions within thirty days is a concerning outcome measure, but the other measures do not tell us if the utilization changes have adversely impacted patient outcomes.

Bad Options

Even the discrete fragment that the BHOs have clear accountability for, the management of the delivery of behavioral health care services, is incomplete. Behavioral health care services, including assessment and management, provided by contracted providers in the TennCare program are not managed in any way by the BHOs. This is very concerning given the large percentage of behavioral health care services in the outpatient setting are provided by primary care providers, not behavioral health care specialists.

An advanced practice nurse from a rural primary care clinic in East Tennessee described a troubling situation that shows how unmanaged the behavioral health care is in primary care (and also illustrates nagging access questions, as well as cultural appropriateness of care). She said, when referring to her pediatric patients with a

variety of behavioral health care problems, including ADHD, depression, bipolar disorder, substance abuse and other problems, that,

There's really not a good resource for referring these kids. We have a really hard time finding a place to see them. There's a psychologist in the area, but they are booked up for months...Sometimes he will eventually see the child, and he'll send us a letter about what to do. We usually will prescribe the medicine he recommends. Some of these kids have to be seen by a child psychiatrist. That's the trouble now. We don't know where to send them (transcript of recorded interview, unidentified source, 2005, February 18, lines 31-41)

There is not a child psychologist in the county to meet the specialized needs of children with SED and "a lot of [the children's] parents can not take them other places" (line 45).

The "fix" for this problem, like so many others discussed, creates new problems. According to the APN, she is "really uneasy [about] prescribing [psychotropic drugs] to kids when they have not seen a child psychiatrist. I'm just going by the psychologist's recommendations" (transcript of recorded interview, unidentified source, 2005, February 18, lines 51-54). The alternative, untreated children, is even worse.

The issue of lack of coordination between the triad of the MCOs, BHOs and PBM was mentioned by a CMHC director of services for children and youth. He asserted that, "a lot of the over-medication of children...[is] coming from primary care doctors, not psychiatrists" (transcript of recorded interview, 2005, March 02, lines 268-270). He also observed that primary care providers not only over-medicate, they mis-diagnose, saying,

Out of the kids that came in...on medication for ADHD, and diagnosed ADHD by a family care doctor, based on our diagnosis, probably 10% were actually ADHD. The majority were coming from violent situations [with] tremendous pain and turmoil [and] a lot of anxiety disorder. You know, they really need an anxiety medication rather than a stimulant. [There's] a lot of depressed kids. It really concerns me here that so many kids were getting this medication based on maybe a fifteen minute interview that the primary care doctor had had with them. And here they were on, you know, heavy-duty medication. (lines 316-326)

Hope Shines Through

There are examples of delivery systems that are thriving, minimally constrained by the introduction of TennCare Partners. A pediatrician and clinical social worker employed in a full-range community health center where 80 percent of the clientele are TennCare recipients were interviewed. Because both providers are direct links to children receiving care, their identities will not be revealed, nor their specific location. Their story though is worthy of attention.

The pediatrician described the practice setting and staff alignment, saying,

I'm a general pediatrician, so I see children between the ages of 1 day and 18 years of age. I see children from all walks of life. We do not limit who we see, so they can have insurance, no insurance. The lack of ability to pay does not keep us from seeing patients....[We are in] a non-profit organization [where] we do integrated health care, so we have general medical plus behavioral health all under the same roof, and actually not just co-located but actually has behaviorists in the clinic with me seeing patients as well. (transcript of recorded interview, 2005, May 13, lines 22-28)

The clinical social worker that works with the pediatrician added,

My discipline is clinical social work. I'm a licensed clinical social worker working as a behavioral health consultant in the pediatric clinic along with the psychologist who's also a behavioral health consultant there. And our role is to be a consultant to the primary care providers. We assist a lot with assessment, intervention, health promotion...and act as kind of a liaison between the clinic and more specialty mental health care. If children need to access that, we help get that set up for them. (transcript of recorded interview, 2005, May 13, lines 30-36)

Elaborating on her role, the pediatrician said,

As far as I'm concerned, I act really as the medical home for...children. You can consider it as a team [and] I'm the coach of the team. Whenever a child needs to see some specialist, access the mental health side, has issues at school, I will help coordinate all those different disciplines and efforts and make certain that the child is receiving all the health care that he or she needs and receiving the services at the school that he or she needs. (transcript of recorded interview, 2005, May 13, lines 49-56)

The pediatrician maintains the coach role even when the child has a behavioral health problem. This was illustrated in the following scenario that was described. The pediatrician said,

[If] a child comes in and is depressed and needs help acutely,...instead of me spending time bogged down if you will, because, you know, I'm a general pediatrician, so I'll have a schedule that's already full or maybe even double-booked. I can't spend 45 minutes with that one patient, but that child needs care right then. So I will talk about the fact that I have a behaviorist with me in the clinic and that we can go ahead and start providing help. And then that's when the behaviorist will come in, go ahead and assess the patient further. And then she'll come out, discuss the case with me; and if I see, based on what I hear, if there's a need for medication, then I'll go ahead and start it that day and talk about the side effects and risks and all that and monitor them closely. So basically, she's able to get a lot of the past medical history, the social history, school history, things like that that are important and will be in the record; and I can review it, but I don't have to hear it for the very first time. So, it's time efficiency. (transcript of recorded interview, 2005, May 13, lines 259-275)

The pediatrician maintains primary accountability for medication management and other ongoing care needs. The charts that are used in this practice are also integrated with all members of the team recording in a similar format.

The pediatrician also stressed that because of the close collaborations with the behaviorist (and psychiatrist) on the treatment team, the clinic is able to meet most of the needs of their clients, including children with SED, without having to refer to other providers. Many informants talked about the many patients who do not follow-through with referrals or they are lost to the practice once the referral occurs. Her social worked colleague agreed, saying,

[With] some of the less severe emotional behavioral disorders that we see in children, we're often able to manage them in the pediatric clinic, meaning a behavioral health consultant meets with them regarding intervention and education. Our primary care physicians will be prescribing for them, such as the ADHD, mild to moderate depression, those kinds of issues which then opens up space in the traditional psychotherapist's schedule to see children that have more severe disorders which we tend to think of as being things like bipolar disorder,...reactive attachment disorder, autism, and those kinds of issues. (transcript of recorded interview, 2005, May 13, lines 677-684)

The pediatrician added,

I can move from that and say that all our children that have ADHD and no core premorbid diagnoses, the pediatricians may [treat] that solely. They are not seen by the psychiatrists, and they are not seen by another therapist. They're not seen in the traditional behavioral health system. Of those children who have ADHD and another premorbid diagnosis, I would say less than 25% of those see a psychiatrist. So what I was saying before was that I feel that because we are an integrated clinic and I have a behaviorist in my clinic that I have greater comfort in treating children who have behavioral health problems or SED or depression, anything like that, better than someone who does not have a behaviorist in their clinic. And that's because...we're able to cross train, if you will. So I can share some information regarding medications and some physiology and things like that with the behaviorist, and they can share with me some techniques and other pointers that I can share with families. So there's some cross-training going on there and increased comfort levels. That goes on a daily basis. Every day we work together. (transcript of a recorded interview, 2005, May 13, lines 685-705)

The social worker elaborated, saying,

The one thing that's nice about it is then there's an integrated treatment plan; and if the child then comes back for an ear infection and she still knows that they're recommended in intervention for her ADHD, and she can in two minutes just say, "I just want to make sure you're doing 'X', 'Y', and 'Z'. Have you had any obstacles to that?" Then if so, somebody can come back in and help problem-solve with the family. (transcript of recorded interview, 2005, May 13, lines 706-713)

This model of integrated practice has not been constrained by the administrative requirements of TennCare and TennCare Partners or the financial structure of the programs. This is refreshing since all too commonly, providers abdicate their responsibility to provide high quality care, using the excuse that "the MCO (or BHO) won't let me do what I want to do".

Although the appeal of integrating primary health care services with behavioral health care services is strong, it is imperative that there be patient outcomes data to substantiate the effectiveness of this model of care. Additionally this data must discriminate between different delivery systems and provider within those systems.

A Look Back

Understanding how the introduction of TennCare Partners impacted the delivery of behavioral health care services requires an understanding of the delivery system in Tennessee prior to the inception of the program and how the industry has evolved nationwide since. A social worker that is currently an administrator of a behavioral health care organization, has the advantage of multiple levels of involvement in the delivery of behavioral health care services in east Tennessee over a number of years. When asked to reflect back on care delivery before and after the introduction of TennCare Partners, he cited first the need for change, saying,

Now in my mature years, I am able to look back and see that in some ways I think our profession was a runaway freight train at that time, and we probably did not make efficient use of the benefits that were available. But I didn't see that at the time (transcript of recorded interview, 2005, March 01, lines 54-58).

He added,

I now realize that at the time, we were not doing a great job looking at outcomes [or] managing utilization. I believe many people in our profession back in the '80s just kind of believed that we should be paid because we were doing holy and noble work and therefore shouldn't be questioned; and we should be paid. I think we dispensed a lot of resources without really thinking about what's the most focused way to reach outcomes and make sure that people are getting better and that their lives are changing for the least amount of money possible (lines 64-71).

The influence of managed care was hastened and extended by the implementation of TennCare Partners turning the world Petty described upside down. Petty remembered that "prior to Partners, we had begun to see managed Medicaid...the first signs of that [were] reducing admissions to all kinds of higher level programs, reducing length of stay, reducing reimbursement....That's what providers see as the primary goal and desired outcome for implementing a managed care program (transcript of recorded interview, 2005, March 01, lines 48-52). He added,

You know the old expression necessity is the mother of invention? Well, we have been forced [by the introduction of TennCare Partners] to be more creative, to look at lower-cost alternatives, to check some of our paradigms about the way things are and ought to be, and ask the question... or the question has been asked for us... we have been allowed to participate in the answer if we wanted to. Are there not some cheaper services that can also provide some of the things or better outcomes for people? (lines 71-77).

Few would dispute the need for change (at least in retrospect). Many do though lament the nature and extent of the change. One respondent used the analogy of a pendulum and cautioned about “the pendulum swinging too far”, noting,

Any time the pendulum swings from no rationing to considerable rationing, then somebody’s going to get lost in the shuffle. Over on this side of no rationing, you’re going to be delivering some services that probably don’t need to be delivered. When you get into extreme rationing, then you’re going to miss some people getting some service that need to be. So, I would offer that as one of the downsides. I don’t see that as something that’s just inherent in TennCare or in managed care or in health care. That’s just kind of one of those facts of life that pendulum swinging...you’re going to live at one extreme or the other, and the ideal is to find that happy medium. Rarely do we do that. I think its human [nature]. That’s one of the things that I think is lost (transcript of recorded interview with Steve Petty, 2005, March 01, lines, 117-127).

Information Management

There is a whole myriad of other instances of fragmentation in the TennCare and TennCare Partners programs. There is no information technology (IT) or other significant linkages between the pharmacy and behavioral health vendors and the MCOs. It is not possible to use data to construct meaningful episodes of care or evaluate patient outcomes or provider performance. This lack of meaningful information hampers efforts to manage program costs and utilization and ultimately improve patient outcomes by minimizing variation to improve practice. According to the unidentified member of the TennCare Partners Roundtable,

There are insurance companies across this country that make lots of profit off of providing health care services. And they manage them using data. When they see prescriptions going through the roof, they have ways of dealing with it. (transcript of a recorded interview, 2005, February 24, lines 411-414)

Interestingly, the advocates have been pressing for a strategy that leverages IT to manage prescription drug costs. They see this approach as a far more viable and responsive strategy to manage costs than cutting beneficiaries or severely limiting coverages. The idea of identifying outlier beneficiaries and prescribers and managing variations has far more resonance than across-the-board cuts that do not address the root cause problem or ultimately facilitate the maturation of managed care in the state. There is even a lack of integration within the operations of contracted vendors. The same researcher explained that Magellan has a system to monitor hospital authorizations, but the system was not linked to other data and it takes a long lag time to integrate the data into meaningful records.

Disjointed data systems, in some respects, are also symptomatic of the lack of integration around care. Some of this is driven by the way care is financed and how risk is allocated. According to a member of the TennCare Partners Roundtable who choose anonymity,

We've still got this fabricated system....We have a pot of money over here for...the people who are responsible for community care, [but] aren't also responsible for what happens when they're not in community. [Could all] of our Community Mental Health Centers...take that risk? No. Could some of them? Yes. Would that promote coordination of care? Well, it sure seems like it to me. (transcript of recorded interview, 2005, February 24, lines 572-577)

The current annual budgeting cycle and vicissitudes of leadership change in a political environment are also deterrents to innovation that is needed to better integrate TennCare and TennCare Partners. Much of what was done to launch the two programs was done without precedent or careful planning and staged implementation. Although there are instances where the BHOs have funded innovation (e.g., video conferencing for court hearings), the annual budget cycle and ineffective long-term oversight and

planning has thwarted innovation. One way that innovation can be tested and ideas improved is through demonstration projects. However the current oversight and funding structures do not support demonstrations. The Roundtable member further observed,

The problem is when you've got year-to-year budgeting process that can't go in the red,...how can you make a five-year plan, or a four-year plan? Say you're at the beginning of an administration, and it takes you a year to figure out what's going on. So can you make a three-year plan to do some of that? That...is the whole nature of government [with] the constant change of the leaders at the top. How can we have a strong State agency level that keeps the ball rolling? (transcript of recorded interview, 2005, February 24, lines 587-593)

Data is used by the vendors to manage the delivery of care and provider performance. In turn the state uses data to manage the performance of the BHO. When asked how the state had fulfilled their role in managing the BHOs, Charlotte Bryson replied, "There has never been an adequate data system....There has not been the accountability in place overall. There have not been data to provide the information to do comprehensive management. So, I do not think we've been effective about it" (transcript of recorded interview, 2004, February 24, lines 145-149). This issue is not peculiar to the BHOs. The MCOs also have inadequate data systems and there is minimal emphasis placed on performance indicators.

Reflections on the Theme of Fragmentation

Although good rationale exists for the carve-out of behavioral health care services and the practice is relatively widespread with good results in other instances, it is hard to make a case for what has happened with the TennCare Partners carve-out. Fragmentation in the design and delivery of TennCare and the TennCare Partners program has caused pervasive negative effects.

One of the reasons given for the value of carve-out programs is the specialized expertise and focus that the specialty vendors bring. This is an important and compelling reason for the use specialty vendors. In the case of TennCare Partners,

there have been numerous barriers to leveraging the potential expertise and focus of the BHOs. These barriers originate from fragmented accountabilities.

Proper construction of carve-outs and expert and ongoing performance management can mediate the ill effects of fragmentation that were seen in accountability, management, risk, care delivery, and data integration in the TennCare Partners program. Strategies and tactics that segregate types of care and providers are incongruent with the reality and possibilities of care delivery and management.

Concluding Remarks on Study Findings

The themes that emerged from the analysis of transcripts of interviews and review of a variety of printed sources were each discussed separately in the preceding chapters. The distinctions between each of these themes are important, but it is also important to note the web of connectivity between the themes. Each of the themes had an influence on or was influenced by the other themes. Mismanagement was a significant contributor to challenges to the TennCare authoritative hierarchy and status quo. Likewise fragmentation of accountability hindered good program management.

Throughout the discussion of TennCare, program *design* has been differentiated from program *delivery*. The pervasive and persistent issues with program delivery dominated the discussions with all informants. Issues of design were seldom mentioned. The distinction between design and delivery is congruent with the distinction made by proponents of theory-based program evaluation who link the quality of program implementation with program results. Weiss (1997) has said that sufficient quality, intensity and fidelity to the program plan will yield expected results consistently. You could similarly say that if delivery is consistent with design, results will be what were anticipated. The delivery or implementation of the TennCare and TennCare Partners

programs demonstrate the corresponding negative of Weiss' assumption. In this case, poor delivery or deviations from the program plan yielded negative results.

This disconnect between design and delivery, or plan and implementation, can be used to evaluate the concept of fidelity. The TennCare and TennCare Partners implementations were inconsistent with plans that were described in the waiver applications and what was said to the various stakeholders in various venues. The fact that the TennCare and TennCare Partners results were not what were predicted is entirely consistent with theory-based evaluations, given the poor delivery.

But there is another piece which Weiss, or the other advocates of theory-based evaluation, including Chen, Rossi, Bickman, Lipsey, Pollard and others, do not address which is germane to this analysis, and this is the adequacy of the program design. In most of the writings reviewed on theory-based evaluations, good design seems to be assumed or established. It is uncertain whether this can be said of the design of TennCare and TennCare Partners.

It seems intuitive that poor design, even with good delivery, will yield results that are inconsistent with expectations. This analysis though did not focus on issues of design. Even informants as articulate and analytical as Gordon Bonnyman were relatively ambivalent about design issues in their interviews. David Manning and Manny Martins spoke of the foundational design of TennCare, but little of what they said was evidence-based or very specific. Only Dr. Bruce Vladeck substantially touched on design issues. Issues of design, which are more conceptual, are more difficult to discern and they are too often over-shadowed by the perceived urgency of problems associated with delivery. In the next chapter, the experience with market-oriented reforms in Tennessee and evidence concerning managed care in Medicaid will be discussed further.

The concept of fidelity to design was the lens that has been used to evaluate the question of what TennCare and TennCare Partners were designed to do and what the results actually were. To understand the answers to these questions, a broad consideration of contextual factors have been included. This analysis had led to many conclusions. The state did not have nor were they aggressive in acquiring the expertise needed to run the programs. Accountability was seriously missing in the state leadership, particularly after the initial implementation of TennCare. There were serious deficits in the state infrastructure, most notably in information technology. The Tennessee marketplace was too underdeveloped for rapid and extensive implementation of TennCare and later TennCare Partners. The state was unable to partner with established, stable and proven national vendors. This void was filled by ill-prepared, hastily assembled vendors. The initial exclusion of providers from early discussions and the massive problems associated with the start-up of both programs deeply alienated a key constituency. Ultimately the inability or unwillingness to deal with urgent provider and member issues led to the breakdown in the carefully crafted relationship and agreements with the advocates. The state never made the transition to being an astute purchaser of services with a commitment to embrace their new accountability of performance management. The state failed to be broadly inclusive in the program design or ongoing oversight.

All this said, it is conceivable that even with effective delivery, the program may have had too many liabilities that were out of the control of the state to succeed long-term. Fundamental considerations, many of which will require a national response, will eventually need to be addressed.

A commentary on market-oriented reforms and managed care, incremental reform, transparency and engagement in public policy and the right to a decent minimum

of health care will be discussed in the next chapter. The TennCare story will be used to frame a discussion about health policy-making health care reform.

Health Care Reform: Ten Years Later

As we undertake this journey of change, we clearly must preserve what is right with our health care system—the close patient-doctor relationship, the best doctors and nurses, the best academic research, the best advanced technology in the world (President Clinton, as quoted in ibiblio.org, n.d.)

Just as it would be irresponsible to change what is working in the health care system, it is equally irresponsible for us to not fix what we know is no longer working (Hillary Rodham Clinton, as quoted in ibiblio.org, n.d.)

Introduction

It has been just over ten years since the introduction of TennCare and the failure of President Clinton's Health Security Act. In the ensuing time, the number of uninsured in the United States has continued to grow, costs have continued to escalate, questions about quality have not abated and concerns about managed care remain unanswered (Budetti, 2004). The costs for TennCare expanded more than 13 percent in one year from \$6.1 million in fiscal year 2002 to \$6.9 million in fiscal year 2003 (Mc Kinsey & Company, 2003, December 11). In July of 2005, the twelfth year of the operation of TennCare, Governor Bredesen, in a retreat from the vision for TennCare outlined by Governor McWherter, began the implementation of his reform plan to manage TennCare program costs by disenrolling nearly 200,000 adult beneficiaries from the expansion population and imposing benefit limits on all adult TennCare beneficiaries. Ironically Governor Bredesen's plan was set in motion at the same time the Governor of Massachusetts was promoting a plan to insure universal access for all citizens of the state.

Governor Bredesen's TennCare Reforms

During the conduct of this study, Governor Bredesen's reforms of the TennCare program were proposed and debated. Before the analysis was completed, changes in the program were occurring. In numerous ways, the changes reflect issues that have been highlighted during the study and the polarity of views surrounding how the program is designed and delivered. The changes that are discussed in the following paragraph were only implemented after contentious debate culminating in changes in the terms of the Grier and Rosen consent decrees.

In 2004 Governor Bredesen set in motion a series of efforts to reform TennCare. In July of 2005 the final hurdle was cleared, permitting the implementation of Governor Bredesen's plans. Table 13 details TennCare reform efforts. Table 14 shows how various eligibility categories are impacted by Governor Bredesen's cuts. Table 15 shows the benefit changes.

A Plan to Provide Access to All Massachusetts Citizens

In contrast to the state of Tennessee's partial dismantling of TennCare is an effort initiated by Republican Governor Mitt Romney of Massachusetts. Governor Romney has introduced legislation to provide coverage for health care services to all Massachusetts citizens through a free market system. The plan is based on an *individual mandate*, whereby those that can afford it would be required to buy a relatively inexpensive health insurance policy and those that need assistance would receive subsidies to purchase coverage. In addition, a concerted effort would be made to get eligible persons signed-up for Medicaid. Subsidies would be funded by monies currently used to pay for care for uninsured individuals. The premise of the plan is similar to the one used for automobile insurance where it is a widely accepted civic responsibility, sometimes a mandate, to have coverage. Governor Romney sees health care as no

Table 13: TennCare Reform Efforts Timeline

Date	Event
Sundquist administration	
January 2000	Governor Sundquist appointed the Commission on the Future of TennCare to develop recommendations about what should be done when TennCare waiver expired December 2001 (Tennessee.gov, n.d. c).
March 2000	Sundquist hosted Summit on the Future of TennCare, seeking input from physicians, managed care executives and Tennessee lawmakers about the future direction of the program (Tennessee.gov, n.d. c).
November 17, 2000	Commission on the Future of TennCare presented recommendations to Sundquist (Tennessee.gov, n.d. c).
February 12, 2002	Sundquist administration filed new waiver request with CMS; please refer to Table 6 for additional details (Tennessee.gov, n.d. c).
May 2002	Proposal for TennCare II presented to the State Legislature by John Tighe, then the TennCare Director; plan called for a new business model for TennCare and greater accountability. Plan also called for active recruitment of new MCOs (Tennessee.gov, n.d. c).
Bredesen administration	
March 28, 2003	Governor Bredesen announced that benefit reductions approved during the Sundquist administration would be implemented April 1, 2003. The reductions were not implemented though because of progress that was occurring on a Settlement Agreement (Tennessee.gov, n.d. c).
August 26, 2003	State and plaintiffs entered into a joint motion; see Table 8 for more details (Tennessee.gov, n.d. c).
October 6, 2003	Settlement Agreement reached with plaintiffs in the four TennCare lawsuit: <i>Grier, John B., Newberry and Rosen</i> ; see Table 8 for additional details (Tennessee.gov, n.d. c).

Table 13: Continued

Date	Event
December 11, 2003	Part one of the McKinsey report is released (McKinsey & Company, 2003, December 11).
February 11, 2004	Part two of the McKinsey report is released (McKinsey & Company, 2004, February 11).
February 17, 2004	Bredesen announced his reform plan called "TennCare Transformation" which called for decreased enrollment in expansion categories (children would not be affected by cuts), implementation of benefit limits for all adult enrollees, a return to managed care and challenges to the TennCare Consent Decrees in federal court (Long, W., 2005, March 29; Tennessee.gov, n.d. c).
November 10, 2004	Bredesen announces plans to scrap TennCare (Locker, 2004, November 10; Locker, 2004, November 11). Impetus for this announcement included increasing costs, reduced federal spending and ongoing litigation from the Tennessee Justice Center
November 11, 2004-early 2005	Bredesen announced a cooling-off period and talks proceed between the Governor, Gordon Bonnyman and other interested parties (Locker, 2004, December 26).
January 10, 2005	Governor Bredesen announced TennCare overhaul after attempts to forge an agreement with Gordon Bonnyman and others failed (Johnson, 2005, December 18).
January 28, 2005	Judge Haynes blocked Governor Bredesen's plan to cut 323,000 adults from TennCare (Johnson, 2005, December 18).
April 12, 2005	The 6 th Circuit Court of Appeals ruled that the state of Tennessee did not need approval to cut TennCare enrollment (Johnson, 2005, December 18).
April 28, 2005	Judge Haynes ruled that approximately 300,000 of the adults in TennCare slated for disenrollment can seek an appeal hearing (Johnson, 2005, December 18).
May 27, 2005	Judge Haynes ruling is overturned (Johnson, 2005, December 18).
June 2005	State began disenrollment by sending out notices requesting information (Johnson, 2005, December 18).
July 1, 2005	Tennessee Legislature approved Governor Bredesen's budget proposal which included TennCare benefit and enrollment cuts.
July 2005	State announced that approximately 191,000-200,000 adult beneficiaries in the expansion categories will lose TennCare coverage and 97,000 of the sickest in the expansion categories will retain coverage; state also announces all adult beneficiaries will have benefits curtailed. Disenrollment begins immediately and benefit cuts are implemented effective August 1, 2005 (French, 2005, July 30; Johnson, 2005, August 4; Wadhvani, 2005, August 4).
August 2005	U.S. District Judge Nixon approves changes to the Grier consent decree; Governor Bredesen announced that this would allow him to maintain coverage for 97,000 of the sickest TennCare enrollees slated for disenrollment (Johnson, 2005, December 18).
August-December 2005	Appeals for disenrolled individuals proceeded and state officials incrementally announced decisions to delay cuts in enrolment for certain groups of beneficiaries (Johnson, 2005, December 7; Powers, 2005, December 21).

Table 14: TennCare Eligibility Categories Affected by Proposed 2005 Changes

Category	Detail	Adult enrollment
Medicaid categories		
Medicaid-eligible	Not affected	1 million
Medically needy spend-down	Eligibility will be granted for 12 months; category closed to non-pregnant adults	97,000
Expansion categories		
Uninsured	Category previously closed to new enrollment	121,000
Uninsurable		67,000
Waiver dual eligibles	Category previously closed to new enrollment	38,000

Note: Enrollment preserved for 612,000 children, including 112,000 in expansion categories and medically needy/spend down categories.

(Long, W., 2005, March 29)

Table 15: Proposed TennCare Benefit Changes

Service	TennCare Limits	TennCare post-2005 Reform Limits
Physician	None	12/year*
Lab	None	10/year*
Inpatient hospital	None	20 days/year*
Outpatient services	None	8/year*
Prescriptions	None	5/month (2 brand; 3 generic)

As of January 1, 2006, these changes had not been implemented.

(Long, 2005, March 29; Tennessee.gov, n.d.c)

different and bases the mandate on the concept of the *common good* (Appleby, 2005, July 4; Klein, 2005, December 12).

CHAPTER 9: REFLECTIONS

Introduction

The tangled story of TennCare encompasses great promise and equally tragic failures in execution. In embarking on a radical new reform plan for providing access to nearly all Tennesseans, the state created a new vision in a time of an ever-growing crisis of health care coverage and access in the United States. Unfortunately this vision quickly faded, overshadowed by forces that the state could control and did not, as well as forces outside the control of the state. The attempts to reform the delivery of health care to Medicaid beneficiaries in the state of Tennessee fared little better, and in certain aspects far worse, than other national or state reforms. Reflection on what happened in TennCare segues to a discussion about factors that have contributed to the failure of health care reform in this country.

TennCare's long and hard fall from grace, traced from the early days of bold and compassionate promises to the disappointing dismantling of the program we are now witnessing, offers many lessons to those who remain committed to idea of broad access to affordable, high quality health care. In reviewing the history of TennCare, it is important to separate issues of design from those of delivery, and to separate initial start-up problems from persistent ongoing problems. Start-up problems were inevitable and acceptable given the speed of implementation and the lack of readiness. The inability to recover from these problems and build the needed infrastructure and competencies to be successful is unacceptable. The inability to avoid past mistakes is particularly alarming. Governor McWherter and his team braced themselves for the fallout from the implementation of the program. In the year between the program start-up and the end of the administration key administration officials, including the Governor himself, demonstrated a resolve to actively manage problems and do what was need for

sustained success. That same effective resolve and commitment was not evident in the subsequent administrations. The inability or unwillingness to build an effective information technology infrastructure and make a continued and strong commitment to performance management doomed the program.

It was not the consent decrees, as many asserted, that prevented the TennCare and TennCare Partners from being successful. Had there been responsive and efficacious management there would not have been the need for court-imposed authority. The breakdown in the cooperation that Governor McWherter and his team was able to forge with Gordon Bonnyman and the other advocates was pivotal in the eventual tarnishing of a vision of health care access for all Tennesseans. Many have decried Mr. Bonnyman's exactness and idealism, but it must be acknowledged that Mr. Bonnyman was pragmatic enough to join forces with Governor McWherter fully cognizant that the start-up of TennCare would be difficult. It was only when the subsequent administrations were entrenched in a pattern of mismanagement that Mr. Bonnyman was compelled to seek relief in the courts.

The inclusion of the advocate community in the early discussions about TennCare demonstrates that when reasonable people come together for a common purpose, solutions can be forged. The power of the alliance of the McWherter administration with the advocates is undeniable, but without the other major stakeholders it was not powerful enough. When governmental deliberations and actions became insular it was evidence of how impotent the state government had become in the management of TennCare.

The failures of TennCare we have so sadly witnessed through its history and most recently with the disenrollment of 290,000 beneficiaries and the unsound assaults on substantial building blocks of an effective health care delivery program, are due to

factors that the state clearly could have, but did not, address. In contemplating the TennCare story, it is tempting to think the story is peculiar to Tennessee. It is not. While there are certainly innumerable instances where the state did not execute well, the underlying crisis regarding health care coverage in the United States can not be dismissed as a state problem. There are fundamental national issues that must be addressed for meaningful and sustainable reform to progress. There are other factors that made fulfillment of the promise virtually impossible. These factors relate to the very principles that were used to ground the program. Beneath all the turmoil of and ill-effects of poor management are fundamental design flaws. The model of health care reform the state used as a vision has never lived up to expectations or produced continued results. For any health care reform to be successful there needs to be a new vision that is embraced by a broad consensus of stakeholders.

The ensuing discussion addresses three key design issues including the failed promise of market-oriented reforms and managed care, the lack of transparency and engagement in public policy and the right to a decent minimum of health care.

The Failed Promises of Market-Oriented Reform and Managed Care

Americans are deeply ambivalent about the organization and financing of health care. We are skeptical about the role of government in matters affecting our medical care and profess a faith in the ability of markets to shape the health care system. At the same time, we are squeamish when we see financial motives and corporate self-interests at work controlling services that we regard as humanitarian. Of such muddled thinking, muddled health policy is born. (Bonnyman, 1999, p. 264)

The promise of TennCare, enhanced access and management of cost escalation, was built on a foundation of managed care and the promised of market-oriented reforms. This foundation, weak at the outset, collapsed under the overly ambitious promises of the program.

An understanding of how reliance on market-oriented reform doomed TennCare requires a historical perspective and an exploration of Americans' values. The nature of health policy in the United States and how this policy is forged is essential to a discussion of health reform and an understanding of why reform has not succeeded to-date. A review of health care cost trends highlights one of the failures of market-oriented reforms, the inability to manage costs. Other failures will also be discussed.

Historical Health Policy Paradigms

For most of the 1900s two major paradigms framed thinking about health care in the United States. The first, dominant for most of the century and actually rooted in the prior century, reflected the prevailing paternalistic approach to the delivery of health care services whereby physicians shielded patients from the complexities of health care and maintained an elitist and relatively insular position. Policy that arose from this view centered primarily in the extension of scientific knowledge for physician use and the training of an adequate number of physicians. After the Great Depression, a new idea of medical care as a "societal right" emerged. This idea was translated into policy in the mid-1960s with the birth of Medicare and Medicaid. In the 1970s support for another paradigm, market-oriented care, began to gain traction in policy debates (Schlesinger, 2002, Starr, 1982). Market-oriented care relies on competition in the marketplace to manage the costs and quality of health care.

The allure of market-oriented care had appeal across the political spectrum. The appeal though was rooted in very different ideologies among the constituents. Conservatives were drawn to the idea of bringing health care delivery more in line with traditional markets while liberals were attracted to the concept because of the appeal of patient empowerment (Schlesinger, 2002) and the opportunity to potentially increase access through projected cost savings.

By the 1990s, Alain Enthoven, an economist and health researcher, had developed the idea of *managed competition*, a market-oriented reform model (Enthoven, 1993). Subsequently, Enthoven and his colleague, Paul Ellwood, a physician, shepherded the development of a plan called “Responsible Health Choices” with an informal group of health professionals, government officials, business leaders, academic and other experts who became known as the “Jackson Hole Group” because their meetings were held in living room of Ellwood’s home in Teton Village, Wyoming (Ellwood & Enthoven, 1995; Enthoven, 1993).

Managed competition, a sophisticated offshoot of market-oriented health care, “relies on a sponsor to structure and adjust the market for competing health plans, to establish equitable rules, create price-elastic demand, and avoid uncompensated risk selection” (Enthoven, 1993, p. 24). Sponsors were generally conceived as large employers or purchasing alliances of employers and consumers. Managed competition, as conceived of by Enthoven (it has come to mean many other things) combines competitive *and* regulatory strategies (Enthoven, 1993). The Clinton health reform proposal used managed competition as its centerpiece (one criticism of the Clinton plan was that the balance was tipped too far towards regulation).

The “Responsible Choices” plan broadened the scope of managed competition to include Medicare, Medicaid and small employers. This expansion was designed to offer beneficiaries of these added groups the same choices as those of large employers and to extend the successes of the large corporate purchasers to governmental and small employer purchasers (Ellwood & Enthoven, 1995).

Managed competition includes the idea of separating the choice of a health plan on a prospective basis, usually annually, from the more immediate decision of seeking actual care. In this model, plan sponsors, such as employers and other purchasers have

the value-added role of managing the performance of plans offered, providing their sponsored beneficiaries with information to make informed choices and eliminating poor performing plans (Enthoven, 1993; Schlesinger, 2002). An understanding of recent efforts to reform health care requires an understanding of past reform efforts.

Health Reform in the United States

An understanding of the history of health reform efforts in the United States and how these efforts have been influenced by politics and deeply held American values provides good insight into how TennCare was constructed and promises perceived. An historical perspective also helps us to understand the factors which led to the many failures that have been discussed. An examination of past reform efforts and discussion of American values, attitudes and political structure follows.

Federalism in health care. The federal government has had a relatively minor role in health care delivery and policy for most of the country's history. American views on health care and policy are the legacy of English traditions. The idea that public health is a local responsibility is an English precedent that has long shaped American thinking and actions. Likewise the conception of public welfare as an approach only for the "deserving poor" emanates from the English example. Even in the 1930s when President Franklin Delano Roosevelt radically expanded social welfare programs, it was with a clear delineation that preserved local responsibilities. Since the New Deal federalism that Roosevelt spearheaded and instituted, the federal government has been accountable for social *insurance* programs (e.g, Social Security) whereas the states have primary accountability for social *welfare* programs (Sparer, 1998). This division has resulted in the states having major accountabilities for the administration, regulation and, to a lesser degree, the financing of health care for poor and indigent people. Medicare though is a health care program for which the federal government is primarily

accountable. Medicare has traditionally been held in high regard. The same can not be said of Medicaid.

Historical high and lows. Calls for reform of the U.S. health care system have converged in significant national debate in various times in recent history, including in 1912, 1973 and 1993. At the heart of these calls is the common denominator of alarms about the number of uninsured and escalating costs (Oberlander, 2003). Despite the ability of proponents to focus and sustain national debate at these times, there have been repeated failures because of the inability to win politically or change deep-seated values.

Barriers to Reform: Incrementalism and Vested Interests

The healthcare system is like a fabric woven from many different threads. One cannot work on the fabric one strand at a time; instead one must work on the whole cloth. (Reforming States Group, 1998, p. 184)

One of the most significant barriers to meaningful and sustained health care reform is a mentality that favors incrementalism. According to Dr. Bruce Vladeck (2001), “American political science is pre-occupied with incrementalism” (p. 153). In U.S. policy-making, incrementalism is a description of the status quo and a justification for strategies that maintain the status quo. Vladeck has said,

As is always a risk in social sciences, the explanatory power of incrementalism in characterizing the status quo can too easily migrate into a normative prescription. Because the world works in a certain way, the argument implicitly becomes, efforts to change it have to be grounded in the realities of the system, so that incrementalism as a descriptor is used to justify incrementalism as a strategy (pp.153-154).

Oberlander (2003) echoed similar sentiments when he said, “Incremental reform may not be sustainable in the long run, for the very same reason that makes it politically popular now: It does not change the status quo of the health system” (p. W3-391).

Vladeck asserts that American public opinion supports incremental, meliorist policy change rather than substantial change. Incrementalism though is a fundamentally flawed approach that has failed. “It has become increasingly clear that neither the government (at any level), nor the private sector, acting alone, can be expected to make significant progress in addressing problems of quality, access and costs” (Reforming States Group, 1998, p. 184).

Incremental reform fails because it fails to address the complexity and interconnectedness of health care delivery and financing. Relationships must be understood and managed and unneeded variations that contribute to needless variation must be eliminated. Coordinated strategies are essential for success. A graphic analogy comes to mind: health care is like a giant balloon. If you push on one side, the other side pops out. That is the problem with incrementalism. When you try to “fix” one sector, problems arise in another. Efforts by the federal or state governments to increase coverage can (and have in the case of TennCare) lead to decreased private coverage. Likewise as cost rise in the private sector and employers and other plan sponsors decrease coverages or increase employee premiums and deductibles, copayments and coinsurance, cost are shifted to individuals thereby reducing access and maybe increasing public burden.

Dr. Vladeck (2001) has also noted a lack of congruence in the public’s view of health policy. He observed,

Since the early 1950s public opinion polls have repeatedly shown support for expansion of public health insurance programs, although not always at the same level....Such broad consensus tends to fracture when translated into specific, concrete proposals. Antigovernment instincts in American political culture remain as powerful as ever. (p. 159)

Vested interests have blocked reform efforts. Special interest groups and other power players (remember Harry and Louise who were created by the health insurance industry in opposition to health systems reform?) have fragmented and thwarted efforts to produce significant, balanced and coordinated change.

Fundamental reform poses a threat to interests invested in maintaining the medical status quo, including physicians, hospitals, insurers, pharmaceutical companies and suppliers of medical technology—the entire medical-industrial complex. National health spending represents these parties' income, and they are opposed to any reform that will slow down the resources society is transferring to them. These groups are well-organized, well-funded, and willing to take advantage of fragmented institutions that provide multiple opportunities to block legislation deemed as hostile to their interests. (Oberlander, 2003, August 23, pp. W3-394-W3-395)

To understand the impact of the ability of parties with vested interests to block substantial health reform efforts, one only needs to recall the “Harry and Louise” ads that the health insurance industry effectively deployed to create a negative backlash against the Clinton health reform efforts in the mid-1990s.

Added to these barriers are peculiarities of the American political system. In the United States, it is not uncommon for the President and the majority of members of the Congress to be of different political parties. Nor does party affiliation necessarily predict voting preferences. The American legislative process also makes it difficult to achieve legislative consensus. Despite this, Medicare, which represents a rare example of substantial health reform in the United States, passed as a single payer system. This was because President Lyndon Johnson, a federal activist, was strongly supported by a large Congressional majority, a unique set of circumstances.

Competition in Health Care: Market-Oriented Reforms

Competition is the center piece of market-oriented reforms. The focus of competition can be price, non-price factors (e.g., quality or amenities), market segmentation or some complement of these factors. The differentiation of these factors

is blurred in health care for several reasons. End-consumers of care, patients, are shielded from pure price issues because the consumer is generally is not the payer. Health care is unusual in that it is disproportionately supply-driven, not needs-based. America has excess capacity, most notably in bricks and mortar and technology, and perceptions, not evidence, drive the use and allocation of services. Price comparisons are virtually impossible in health care because of unneeded complexity and variation in benefit plan designs and plan administration, as well as a “black box” persona and a cloak of secrecy the health care industry has assumed.

The propensity to make managed care plans more attractive by minimizing patient deductibles, co-payments and coinsurance has only exacerbated the problem by insulating people even more, at the time they seek care, from a financial stake in the consequences of their choices. Several informants in this study bemoaned the lack of patient co-payments in the TennCare.

Understanding market forces in health care. Health care is notoriously unique in that the supplier of services has significant impact on the definition of need. Most consumers of health care services do not have access to information that would facilitate making informed choices. In many cases the information is not informative and in other cases it is not user-friendly or relevant.

It is also a perverse incentive that the prevailing mindset in health care is to expend significant resources in mounting heroic responses to the effects of chronic and often preventable conditions while not supporting prevention or early treatment (in this regard the single-mindedness of the advocates concerning EPSDT should be commended). The inclination to rely on expensive, relatively low yield high-tech tertiary care is evidence of supply driving need.

There is little evidence of competition based on quality in health care. Quality measures are relatively immature and the complexity of health care super-imposed over naturally occurring human variations in response to disease and treatment make measurement challenging and beyond the understanding of most consumers (some would say providers also). Also little has been done in the U.S. to reward quality performance. Competition based on market segmentation is more evident. Efforts to compete based on market segmentation is evidenced in TennCare by the health plans that specializes in Medicaid and specialty services, such as the management of behavioral health care and pharmacy benefits management.

Managed care: The name is a dream. To be competitive in market-oriented approaches, most health plans rely on varying degrees of managed care. The name managed care says it all. It is through the management of care that success will be achieved and not through a series of administrative constraints and overlays. Unfortunately managed care, more often than not, refers simply to managed costs and sometimes utilization management which is more cost-focused than outcomes-focused rather than the full complement of managed costs, utilization and quality. This is very true of TennCare which is first and foremost a funding strategy.

Managed care (in its conceptual form, not the bungled variants so frequently seen) is built upon the rational allocation of resources. The objective of managed care is to move to a needs orientation where evidence about the cost of care are weighed against the benefits expected of the care and less expensive or intensive alternatives are considered. The rational allocation of resources relies on evidence to drive decisions, which is a move away from the status quo of a predominant supply-driven allocation of resources and unmanaged demand.

Health care quality management. The management of care quality has the two primary components that were described in regards to the concept of “in control and capable”. Capable refers to setting a high performance goal and in control refers to minimal variation. The goal of quality management in health care then is to cluster provider performance around a standard and minimize non-value-added variation that does not contribute to the objective of maximal patient outcomes. This definition leads us to a discussion of the evidence that should be used to set standards of care and the issue of variation in health care. First, the evidence that quality is a problem will be presented.

Health care in the United States was issued an indictment in the Institute of Medicine report entitled “Crossing the Quality Chasm: A New Health Care System for the 21st Century”. Simply stated, the report charges that “the U.S. health care delivery system does not provide consistent, high quality medical care to all people” (Institute of Medicine, n.d. b, p.1). The report authors contend that the difference between our current health care and what is currently possible is not just a *gap*, but rather a *chasm* (Institute of Medicine, n.d. b, p.1). One quote aptly summarizes the concern, “At its best, health care in the United States is superb. Unfortunately, it is often not at its best.” (Chassin and Galvin, 1998, p. 1001). Care frequently does not meet needs and the care delivered is often not based on the best scientific knowledge. Too frequently patients do not receive the full benefits of care available and too often care harms patients. How can this be possible in such a technologically advanced and prosperous country?

There are numerous reasons, none of which justify ignoring quality management. Most studies provide only a limited perspective on quality. Studies tend to focus on single conditions, a small slice of the appropriate quality indicators, small geographic

areas or persons with a single payment mechanism (McGlynn et al., 2003). Because of this, we do not have a comprehensive view of the quality of care given to the average person in the United States. Paradoxically, most patients are satisfied with their own care and providers, but express dissatisfaction with the general health care delivery system. Care is very fragmented. There is not a single provider that is fully accountable or knowledgeable about the patient. Often care is not coordinated across providers and settings. Generally providers have difficulty moving from an individual patient focus to a group or system focus (Berwick et al., 1999).

To keep perspective, much of what is done in health care in the United States is very good. Immature or otherwise critically ill infants and older adults afflicted with acute coronary heart disease are living longer than ever (Blumenthal, 1996). There are many other success stories. Quality improvement should preserve our many advances while focusing on the specific areas that need improvement (Agency for Health Care Research and Quality, 2002; Blumenthal, 1996). The need for quality management is driven by the wide and unnecessary variations that exist in health care and the fact that evidence is not widely used in the process of delivering health care services.

Variations in health care delivery. In the early 1970s respected researchers at Dartmouth published their findings about the routine treatment of health care problems in different geographic areas and health care settings. The wide variation seen in the processes of care delivery and patient outcomes were startling and not easily explained (Wennberg and Gittleson, 1973). Thirty years later the real indictment is not that the variations existed when the work was first published. Some variation is expected in a process as complex as the delivery of health care, but not to the degree discussed in the 1970s and still apparent today. The real indictment is that the variations are not yet

adequately explained, justified or remedied, and that there is not widespread understanding and acceptance about which health care processes produce the best patient outcomes (Blumenthal, 1996). This variation indicates that practice is not consistent with the available scientific evidence.

A more recent study (Fisher, Wennberg, Stukel, Gottlieb, Lucan and Pinder, 2003a & 2003b) showed 60 percent variation in the care received by Medicare recipients, as well as the cost of care. This variation was not attributable to some patients being sicker than others. There is no evidence that the quality of care was better for those that received more care. In some cases, the care was actually worse.

An Institute of Medicine report on unequal treatment in health care in the United States (Smedley, Stith and Nelson, 2002) begins with the following statement: "Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patient's insurance status and income, are controlled." (p. 1). The fact that the quality of health care varies according to skin color, gender and economic status is perhaps the most significant health care quality issue and a social outrage.

Ignoring the evidence. The science of health care is good. We are deficient in disseminating and using the evidence that science has produced. It takes an average of 17 years for new knowledge generated by random trials to be incorporated into practice. The use of clinical evidence to drive clinical decision-making is uneven at best (Institute of medicine, n.d., b). We must assure that we are providing services based on our best scientific knowledge. This means doing the right thing for the right patients and avoiding doing the wrong things for any patient.

Is managed care more cost-efficient? Despite many claims to the contrary, the evidence that managed care saves money is inconclusive.

The issue...is not whether HMOs reduce utilization rates below FFS levels, nor whether HMOs and preferred provider organizations extract discounts from providers and drug companies that FFS cannot get. It is well established that HMOs reduce utilization rates and that managed care companies can compel their suppliers to offer larger discounts. The issue is, rather, whether medical costs equal total costs. They clearly do not. Total costs are the sum of medical costs plus profit or surplus....Evidence indicates that managed care has driven up administrative costs. (Sullivan, 2000, p. 140)

The administrative burden (and cost) of managed care.

The exceeding complexity of the health care system in the United States is evident to every decisionmaker in the public and private sectors. The financing system alone contains thousand of different payers or plans, each with its own incentives, operating in an extremely competitive environment facing increasingly sophisticated and demanding purchasers. (Reforming States Group, 1998, p.82)

It is interesting to note that those that fear a role for the federal government in the delivery of health care services in a national plan seemingly accept the choking bureaucracy that exists today of private and public insurers and payers, providers of all types, specialty vendors, auditors, consultants and numerous other players. Those that decry the value of coordinated management seem to willing accept the unneeded costs, tremendous administrative burden, unnecessary variation and complexity of a system of silos. This defies reason. If the United States continues to resist a universal health plan, it is imperative that the country at least better coordinate the efforts and roles of government and the private sector. Interests of both should be more closely aligned and coordinated. If nothing else standardized claims forms, data protocols, reporting requirements and mandatory health reporting would help to eliminate would help to unnecessary variation and added costs.

In an important 1992 analysis, Dr. Kenneth E. Thorpe, who holds a doctorate in public policy, explained that health care administrative expenses in the United States

were 24 percent of total spending, whereas the same number in Canada (with a single payer system) was 11 percent. Even in the U.S., private plan expenses were three times higher than Medicare or Medicaid. There are several components of administrative expenses, including “transaction-related costs, benefits management, selling and marketing costs (to allow consumers specific choices regarding the level of risk they bear) and regulatory/compliance costs” (p.43).

After an examination of each of these expenses, Thorpe (1992) concluded that “many transaction-related expenses could be streamlined if a universal health insurance program were adopted. A single payer could produce the single largest reduction in system-wide administration. Continued growth in prepaid practices and standardized electronic billing and claims filing in the fee-for-service sector would yield additional reductions” (p. 54).

Some of the administrative burden of managed care is due to low yield management processes. This was clearly demonstrated in late 1999 when United Healthcare, a managed care behemoth, made the decision to discontinue prospective utilization review because the cost of the process was three times the savings generated.

Consumer cost-sharing. Health care costs are the product of several factors. Most simply cost equals price per unit of service multiplied by the number of services. Cost is also a factor of acuity, which relates to how sick patients are and the intensity of services they receive. Basic strategies that are used by managed care plans to manage costs focus on both of these factors. Price per unit of service is managed by the negotiation (some would say imposition) of discounted fee schedules with providers and facilities. The number of services is controlled by various utilization management

strategies. We know that with TennCare strategies to manage costs and utilization were employed.

Another way that costs are managed is through plan design and the administration of that plan design. Plan design encompasses what services the plan sponsor will pay for and at what level payments will be made. The TennCare plan design, like most managed care plan design, is very comprehensive. TennCare recipients pay virtually no copayments or coinsurance. There are few limits on benefits, such as annual maximum benefits.

In 1971 the Rand Corporation, the first organization to be called a “think tank”, created an insurance company (with funding from the federal government) and conducted an 15-year comparative study on health care costs, utilization and outcomes. The Rand researchers found that the experimental groups with higher copayments had reduced overall spending. The implication was that people consume unnecessary care when the charge per service is free or low. This was further supported by the finding that there were minimal health status differences across the various experimental groups (Keeler, 1992).

The problem with the Rand Health insurance experiment is the emphasis on routine, low-cost services and the exclusion of elderly participants from the study and the protection of a \$1000 cap on annual out-of-pocket expenses per patient (Bodenheimer, 2005d; Robinson, 2002, March 20). According to Bodenheimer, 10 percent of the population incurs 70 percent of annual health care expenditures. It is unrealistic (and unwise) to think that cost-shifting to higher cost, sicker beneficiaries will yield the same change in utilization of health care services such as were seen with less sick beneficiaries seeking more discretionary care.

The Broad-Based Appeal of Market-Oriented Reforms

Managed competition and other market-oriented reforms appeal to a broad spectrum of policy and decision-makers and have figured prominently in recent reform efforts. Liberals laud the potential benefit of competition making the health care marketplace more responsive to consumers. Conservatives are attracted to the strategy as a means to control escalating health care costs.

The broad ideological appeal of managed competition had particular resonance with the New Democrats and their leader, Bill Clinton. Managed competition seemed to be the vehicle which would allow expanded coverages through market forces without increasing funding. The demise of Clinton's Health Security Act did not dampen enthusiasm for managed competition. Instead the idea spread to public health programs, most notably Medicare and Medicaid.

In a fascinating discussion of the results of two surveys, Schlesinger (2002) dissected the underlying values of policy-makers (what the author calls "policy elites" who are actually Congressional staffers with primary accountability for health care) who support market-based reforms. Schlesinger also compared policy-makers with the general public. Schlesinger found wide divergence in the underlying values of policy-makers and interesting differences in the acceptance of market-oriented reforms between policy-makers and the general public.

Support for the concept of individual choice, a cornerstone of market-oriented reforms, links conservative and liberal policy-makers who favor market-oriented reforms. Beneath this façade of consensus are wide variations in the underlying values of conservatives and liberals.

Value differences. On measures of equity and fairness in health care, conservative policy-makers strongly favor individual responsibility and the allocation of

medical care based on choice and productivity. In contrast, liberals reject the notion that health care should be an individual responsibility. Although liberals, like conservatives, support choice-based allocations, they reject an emphasis on productivity. Instead liberals are bound together in their commitment to the concepts of need and equity (Schlesinger, 2002).

The attitudes of policy-makers are sharply divided from those of the general public. While 58 percent of policy-makers endorse market-oriented reforms, only 41 percent of the general public embraces this approach. Those from the general public that support market-oriented care are less likely to support individual choice than their policy-maker counterparts. Another difference is that the general public is substantially more supportive of equality as a norm for health care and slightly more supportive of need criteria. The preference for individual choice seen in policy-makers is also seen in the general public (Schlesinger, 2002).

The difference in attitudes about equality and need between pro-market policy-makers and citizens is interesting. Schlesinger showed, through a series of comparisons, that the differences emanate from different perceptions about the nature of health care and health policy. Policy-makers, compared to the general public, “see health care as less essential for equal opportunity and are more likely to fear that government programs will be unduly burdened by fraud and abuse” (Schlesinger, 2002, p. 911).

Schlesinger (2002) also showed differences between how power is viewed by market advocates and those who do not espouse the approach. Market advocates support a shift in the locus of decision-making power from the medical profession to employers (in the private sector) who monitor performance in market-based systems. The general public viewed professional authority more favorably (Schlesinger, 2002).]

Realities have not met expectations. Policy-makers' readiness to embrace managed competition was never matched by the end-users of health care services, patients. Despite an intrigue that has never been proven through a sustained demonstration of success, policy-makers of varying ideologies continue to support managed competition.

The Lack of Transparency and Engagement in Public Policy

The heart of American democracy---and of any democracy---is meaningful, active participation by its people in government decisions that touch their lives. The soul of [democracy] is the ability of its citizens to hold government accountable for their actions. Known as "transparency", this essential democratic process takes many forms, but all allow concerned citizens to see openly into the activities of their government rather than permitting these processes to be cloaked in secrecy. (USINFO.STATE.GOV, n.d.)

Transparency refers to the state of being frank, open, honest, candid, sincere, genuine and direct (Merriam & Webster's, 2000). In the public arena, access to information is the cornerstone of transparency (Carter Center, n.d.). "Transparency implies openness, communication and accountability. It is a metaphorical extension of the meaning used in physical sciences; a "transparent" object is one that can be seen through" (Wikipedia, n.d.).

In the recollection of TennCare's creation, operation and recent changes, there have been many and significant demonstrations of a lack of transparency. The limited public debate that characterized the start of TennCare, as well as recent the processes used to develop a "reform" strategy has limited public discourse and involvement. The unreliability of public oversight of the operation of TennCare, limited inter-governmental involvement and inaccessibility of current administration officials are further demonstrations of a policy of secrecy.

By creating a shroud of secrecy and isolation relative to the management of TennCare, most notably in the Bredesen administration, government officials have ignored the voices of the general public, blocked stakeholder participation and stifled the diverse voices of the legislature. There have been few opportunities for Tennessee citizens and other interested individuals and groups to have an impact on policy-making, regulations and the administration of the TennCare program. Without transparency, there is no accountability.

Transparency as a Cause and a Symptom

The lack of transparency in public policy-making is symptomatic of deep-seated problems that have contributed to the inability to implement successful health care reform. The inability of our federal government to address the issues of health disparities, uneven quality, ever increasing health care costs and the growing number of uninsured reflects a lack of leadership, a corruption of our political processes by special interest groups and legislators's self-interests, as well as a lack of meaningful engagement. Recent reform efforts have only broadened the gaps between the various constituencies. Patients are marginalized by the very system that is supposed to help them. Elected officials and industry leaders are unwilling or unable to break the impasse. Special interest groups and other power players have fragmented and thwarted efforts to produce significant, balanced and coordinated change (sadly, nurses have generally not participated in the policy-making process in a role commensurate with their professional experience and expertise). The lack of transparency also inhibits engagement in public policy.

Defining Collaboration

Leadership and new ways of addressing problems are clearly needed to develop, implement and evaluate policies that promote health and general social well-being.

Collaboration is a means to engage the citizenry in the resolution of urgent problems. Collaboration profoundly changes how we effect change and our views of leadership (Chrislip & Larson, 1994). “Collaborations have the power to deal with difficult issues while embodying fairness because they include voices otherwise excluded (American Assemblies, 2002). Chrislip and Larson (1994) see collaboration as “not simply another strategy or tactic for achieving an end. It is something broader, more encompassing, and more powerful” (p. 11). Americans have a history of building communities by accident and out of crisis. The efforts following September 11, 2001 certainly demonstrate the latter (American Assemblies, 2002). This paper is about building community *by design*.

To Greenwald and Beery (2002), “collaboration signifies association of individuals or organizations with divergent histories, interests, and perspectives working together on projects of common purpose” (p. 3). Individuals or groups who collaborate seek to set aside their differences to focus on their common interests (Greenwald and Beery, 2002).

Inners and Booher (1999) elaborate by describing collaborations as a strategy for dealing with conflict when others have failed (others have defined collaborations as an extension of more traditional negotiating strategies that deal with differences or conflict). They also see collaboration as a societal response to an increasingly networked society where power and information are widely distributed and the gaps in knowledge and values among individuals and communities are growing.

The American Assemblies convened a group of American thought leaders in 1999 under the auspices of their *Uniting America* series to look specifically at collaborations and its linkage to democracy. Included in the report released by the group were the characteristics of successful collaborations. These include

demonstrated needs and concrete problems; clear visions and tangible goals; well-defined roles; participants having shared values relative to the problem; a process that supports respect and trust; strong champions; the opportunity for all participants to derive clear benefits; adequate funding; participants who are close to the problem; genuine involvement; and broad-based participation (American Assemblies, 2002).

Chrislip and Larson (1994) identified keys to successful collaborations through a study of six exemplary cases to create preliminary conclusions and the subsequent testing of these conclusions with an 46 additional cases. The selection criteria for the exemplary cases were production of concrete, tangible results; a sufficiently complex cross-sectoral problem; significant barriers and obstacles to overcoming the problem; many and diverse stakeholders; and widespread acknowledgement and recognition of the collaboration's success. The keys to successful collaboration identified were good timing and clear need, strong stakeholder groups, broad-based involvement, credibility and openness of the process, commitment and/or visibility of high-level and visible leaders, support or acquiescence of established authorities or powers, successful handling of mistrust and skepticism, strong process leadership, interim successes and a shift to broader concerns (from narrow, parochial interests).

Collaboration that involves players from the public sector, business and non-profit organizations has been termed *cross-sectoral* collaboration (Logsdon, 1991). Cross-sectoral collaboration is particularly applicable to complex social problem-solving (American Assemblies, 2002; Austin, 2000; Drucker, 1999; Logsdon, 1991). Cross-sectoral collaboration has been used for a variety of societal problems, including workforce development, environmental stewardship and preservation, improving education, homelessness and community and cultural development (American Assemblies, 2002.; Logsdon, 1991).

The primary research available on cross-sectoral collaboration is case studies. Case studies and related work in the field of inter-organizational relations have contributed to the development of conceptual models and other descriptors. Gray (1985) has identified six issues which must be addressed during an early collaboration. These are common definition of the problem, commitment to participate, identification of stakeholders, acceptance of the legitimacy of the other stakeholders, presence of a convener and identification of resources.

Logsdon (1991) proposes that six issues identified by Gray (1985) must be addressed in initial collaborations, but more important are two essential pre-conditions for any collaborative effort. These two factors are “the interests or *stakes* of the organization in the outcome” and “the perceived *interdependence* with the groups” (Logsdon, 1991, p. 25) dealing with the problem. Using these two essential factors, Logsdon (1991) developed a matrix for assessing the potential for cross-sectoral collaboration and to track the dynamic evolutions of cross-sectoral collaborations. The matrix has four categories, including low stakes/low interdependence, low stake/high interdependence, high stakes/low interdependence and high stakes/high interdependence. Collaborative potential is highest with high stakes/high interdependence and lowest with low stakes/low interdependence.

Two predominant patterns of the evolution of collaborative efforts can be explained by the matrix. One pattern involves the movement from low stakes/low interdependence to low stakes/high interdependence to high stakes/high interdependence. The other pattern is the movement from low stakes/low interdependence to high stakes/ low interdependence and on to high stakes/high interdependence (Logsdon, 1991). I was not able to find any research that tested the model for the essential features of collaboration presented in the matrix. Such research

is needed to enhance the utility of the model for predicting the potential success of collaborations and to analyze failures or difficulties with collaboration.

Linking Deliberative Democracy and Collaboration

Collaboration and consensus are closely aligned with *deliberative* democratic theory. In deliberative democratic theory, legitimacy is defined as the ability or opportunity to participate (or not participate) in effective deliberation. Essential to this definition is the concept that decisions resulting from deliberation are justified on reflection, where reflection embodies the idea that preferences are transformed through deliberations. Deliberation is a social process where participants are open to changes in preferences or judgments during the course of interaction. It is essential in deliberation that these changes result from persuasion, not coercion, manipulation or deception (Dryzek, 2002). Many see deliberation as the true essence of democracy, rather than voting, rights or even self-government.

The defining characteristics of what Chrislip and Larson (1994) call the *collaborative premise* parallel characteristics of deliberative democracy. The collaborative premise is that “if you bring appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing shared concerns of the organization or community” (Chrislip and Larson, 1994, p.14).

The Right to a Decent Minimum of Health Care

Freedom...requires that basic human needs...must be met if freedom itself is to endure. Life is a necessary condition for the enjoyment of all things and it is, therefore, the necessary condition if freedom is to exist. Life, in a sense, enables freedom. The ability to live depends on a decent minimum of basic necessities. Freedom to starve or die of a remediable condition is a mockery. Individual freedom requires life and the health to enjoy that life. (Loewy, 1987, p.790)

There are many worthy ethical and moral arguments that can (and have been) set forth to support a call for a decent minimum of health care for all U.S. citizens. Some of the arguments include the assertion that all citizens have a right to a decent minimum of health care. Rather than pursue these arguments and explore the merits of the rationale of each, more pragmatic and accessible points will be made to argue for a decent minimum of health care. I assert that it is imperative that arguments be developed that resonate with policymakers, politicians and the public to break the impasses about health care reform at the national level and ground the public debate which is essential for success.

A Decent Minimum of Health Care

What is meant by a decent minimum? The Stanford Encyclopedia of Philosophy (n.d.) defines a social minimum (of which a decent minimum is a corollary) as “that bundle of resources which suffices in the circumstances of a given society to enable someone to lead a minimally decent life” (para 2). Dr. Lawrence Schneiderman, a Professor with the Department of Family and Preventive Medicine at the University of California San Diego, is a prominent advocate of a decent minimum of health care for all Americans. He defines a decent minimum of health care as that which “enables [a person] to hold a job, obtain an education, raise a family, in other words, participate successfully in society” (University of California San Diego, 2004, p. 4).

The Personal and Economic Costs of Uninsurance

The pragmatic arguments that support providing a decent minimum of health care for all Americans are economic. The societal burden of a large number of uninsured has become untenable. It is untenable from a strictly financial perspective, and it is incompatible for a country with a legacy of compassion to ignore the human toll.

Despite the innovation the Medicaid waivers permitted, the number of uninsured continues to grow in the United States. One in eight Americans, 43 million, does not have any health insurance (Quadagno, 2005). To lend some perspective, the number of uninsured was approximately 37 million when President Bill Clinton was elected. In any given year millions more Americans lack coverage for shorter periods of time (Institute of Medicine, 2004). The majority of American without health coverage are part of working families (Quadagno, 2005). The United States stands alone as the only advanced country without national health insurance of some sort (Krugman, 2005, June 13).

The individual health consequences of being uninsured are profound. Uninsured people are more likely to receive too little health care & receive it too late; as a result, they are sicker & die sooner. Consider these sad findings: Uninsured adults have a 25 percent greater mortality risk than adults with coverage; uninsured women with breast cancer have a risk of dying that is 30-50 percent higher than insured women; uninsured car crash victims were found to receive less care in the hospital & had a 37 percent higher mortality rate than privately insured patients; uninsured individuals with diabetes, cardiovascular disease, end-stage renal disease, HIV infection & mental illness have consistently less access to preventive care & have worse clinical outcomes than do insured patients; if common childhood conditions such as asthma, anemia and middle ear infections are left untreated or improperly controlled (which is common if the family lacks insurance), they can affect mental & language development, school performance & hearing; women with no insurance are more likely to receive no prenatal care than their insured counterparts (15 percent versus 4 percent); and the uninsured receive far less preventive & screening services, as well as medicines & treatments that meet professional standards (Institute of Medicine, n.d.a).

Societal costs are also high. According to the Institute of Medicine (2003, June),

Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in programs like communicable disease surveillance. These consequences affect everyone, not just those that are uninsured.

The economic viability of the country is diminished by productivity lost as a result of poorer health and premature death or disability of uninsured workers. Medicare, Social Security Disability, and the criminal justice system probably cost more than they would if everyone had health insurance up to age 65. For example, when an uninsured woman with diabetes turns 65 years old and gains Medicare, her condition is likely worse and requires more intensive treatment than had she been previously insured. Similarly, uninsured persons who are mentally ill often do not get appropriate treatment and may end up in the criminal justice system at significant but potentially avoidable costs. (p. 1-2)

Dr. Schniederma says his support of a decent minimum is grounded in pragmatism. He explains,

It's in everyone's self-interest. It's in my self-interest that you are healthy enough to hold a job, that you contribute your work and taxes to society, that you have time to raise a family that isn't going to be a problem for me; it's in my self-interest that you had diabetes, you don't wait until you need hospitalization to get your treatment, that somebody's educated about your diabetes so you can take most of your treatments on an outpatient basis. (University of California San Diego, (2004, August, p. 5)

An IOM analysis (2003, June) showed that the care delivered to individuals without health insurance in 2001 was valued at \$99 billion. It is estimated that this same group would incur \$34-69 billion more in health care if they were insured. Adding health care insurance to all who lack it would return \$65-130 billion annually. Because of this, the IOM study committee concluded that, "the estimated benefits across society of providing health insurance coverage are likely greater than the additional social costs of providing coverages to those who lack it" (p. 4).

A Changing Paradigm

A changing paradigm about the public's health may facilitate a willingness to let concerns about the common good become more prominent in the health care reform debate. Gostin, Boufford and Martinez (2004) said,

Public health has a long history of designing the built environment to reduce injury (workplace safety, traffic calming, and fire codes), infectious diseases (sanitation, zoning, and housing codes), and environmentally associated harms (lead paint, asbestos, and toxic emissions). The United States is facing an epidemiological transition from infectious to chronic diseases such as cardiovascular disease, cancer, diabetes, asthma, and depression. The challenge is to enable communities to facilitate physical and mental well-being. (p. 102)

Essentially the authors are saying that we need to reconceptualize what we view as our pressing health challenges. The epidemic of lifestyle-related chronic diseases mandates that we mount a response just as we did in earlier times to defeat the devastation of infectious diseases. The IOM has shown that for five chronic conditions, diabetes, cardiovascular disease, end-stage renal disease, HIV and mental illness, “uninsured patients have worse clinical outcomes than insured patients” (Institute of Medicine, 2002, May, p. 3). Additionally, the uninsured do not receive care recommended for the management of their chronic disease and they lack regular access to medications which are essential for the management of their diseases. Part of this response must include adequate health insurance, a decent minimum.

Putting It All Together: A Vision

National health care insurance that provides a decent minimum of health care for all Americans should become a policy priority. A national, coordinated strategy must be adopted. Whether a single payer system or a complement of payers is used should be determined through broad-based public discourse, discourse that is transparent and not dominated by special-interests. If an affinity for some of the principles of market-oriented reforms is an agreed-to priority, it is important that there be a commitment to their implementation in a meaningful way. Any reform strategy must be predicated on “the need for state-of-the-art evidence-based medicine and technology assessment information, as well as data comparing quality among providers” (Nichols et al., 2004).

The IOM has adopted five principles regarding health insurance. These should be considered in the debate. They include: health care coverage should be universal; health care coverage should be continuous; health care coverage should be affordable to individuals and families; health insurance should be affordable and sustainable to society; and health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable (Institute of Medicine, 2004, January).

The American Nurses Association (ANA) released a pioneering plan for health care reform in 1991 which embraced the concepts of universal access and a decent minimum of health care benefits. The ANA's Health Care Agenda 2005 continues this advocacy and is more specific on one point that is worth noting. The ANA proposes that,

The system must be reshaped and redirected away from the overuse of expensive, technology-driven, acute, hospital-based services in the model we now have, to one in which a balance is struck between high-tech treatment and community-based and preventive services, with the emphasis on the latter. The solution is to invert the pyramid and focus more on primary care, thus ultimately requiring less secondary and tertiary care. (p. 2).

The keys to success are broad-based engagement and meaningful deliberation. "If you bring appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing shared concerns" (Chrislip & Larson, 1994, p. 14).

CHAPTER 10: RECOMMENDATIONS FOR TENNCARE

Introduction

We are continually faced with a series of great opportunities brilliantly disguised as insoluble problems (Gardner, n.d.)

There are numerous lessons that have been illustrated by this analysis of TennCare. From these lessons, specific recommendations have been developed. These recommendations stem from problems associated with authority, management and fragmentation seen in TennCare. Although there are recommendations that are implied in the preceding chapter which apply to federal initiatives and accountabilities, the purpose of this chapter is to outline specific recommendations for the TennCare program.

Authority

It is essential that a framework for effective TennCare oversight be created. The entity given the accountability for TennCare oversight must be given the authority to oversee the program's operations in a meaningful way. The body that is conferred with this authority must be responsive to the public served and should operate with full disclosure. A collaborative model of oversight is recommended because it is more sustainable and responsive to the citizens of the state. The benefit of including advocates in the development of TennCare was clearly demonstrated. This approach should be replicated and expanded to include providers and other key stakeholders in the ongoing oversight of TennCare. It is imperative that the oversight entity have access to TennCare data and be supported by Medicaid and managed care experts.

There needs to be agreement on basic principles of TennCare's operation to guide the oversight of the program. Changes as significant as the ones on which TennCare are based require sustained nurturing over time. It is imperative that

TennCare oversight be both guided by long-term goals and balanced with responsiveness to immediate and short-term priorities.

Management

A program as complex and far-reaching as TennCare requires adequate planning time for effective implementation of changes. Adequate lead time and preparation for changes are critical in managing the impact of change fostering acceptance. The state needs to minimize patient and provider hassles to the greatest degree possible. Many of the problems seen in the operation of TennCare could have been avoided by better planning to assure implementation readiness and inclusion of key parties. Involving a broad base of interested parties will facilitate the implementation and acceptance of change.

One of the most critical shortcomings of TennCare program management is inadequate and disconnected information management systems. *For responsible stewardship, the state needs integrated management systems to assess needs, establish program priorities and manage and improve performance.* Data concerning TennCare utilization, costs, patient outcomes, quality of care and vendor performance must be readily accessible to stakeholders in a timely manner.

The MCOs and BHOs should be held accountable for performance and be at risk financially; poor performing vendors should be replaced if performance does not improve after a reasonable time through a competitive bid process. Efforts to attract nationally known and proven vendors should be assumed.

The state needs to develop core competencies in vendor performance management. Achieving this objective will require attracting new staff and empowering them to be effective in clearly delineated roles with very specific objectives and accountabilities. Reorganization of state departments and accountabilities within state

government may be necessary to facilitate coordination and integration of functions, avoid redundancies and eliminate gaps in state employees and departments' accountabilities.

Principles of managed care, most notably financial risk and risk for performance and competition for state contracts and member enrollment, must be established. The retreat from the basic tenets of managed care, and the state's failure to effectively manage the utilization of care and progress to the management of patient outcomes and the quality of care has prevented the state from improving results and evolving the program.

Fragmentation

Although there is significant justification for the need for specialized vendors and the expertise they bring to the management of a program as complicated as TennCare, there is no justification for the lack of integration that has plagued TennCare. *The state needs to establish single points of accountability and integration across vendors, departments and processes.* A holistic view of health requires a more integrated view of the management of health care services.

Table 16 provides a summary of recommendations.

Conclusion

The recommendations outlined are necessary for the long-term viability and progress of TennCare. These recommendations transcend the many changes and iterations of TennCare that have been seen since the original inception of the program.

Table 16: Summary of Recommendations for TennCare

Theme	Recommendation
Authority	It is essential that a framework for effective TennCare oversight be created and maintained effectively.
Management	A program as complex and far-reaching as TennCare requires adequate planning time for effective implementation of changes.
	For responsible stewardship, the state needs integrated management systems to assess needs, establish program priorities and manage and improve performance.
	The MCOs and BHOs should be held accountable for performance and be at risk financially; poor performing vendors should be replaced if performance does not improve after a reasonable time through a competitive bid process.
	The state needs to develop core competencies in vendor performance management.
Fragmentation	Principles of managed care, most notably financial risk and risk for performance and competition for state contracts and member enrollment, must be established.
	The state needs to establish single points of accountability and integration across vendors, departments and processes.

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APPENDICES

APPENDIX A

Glossary of Terms

General Terms

Aid to Families and Dependent Children (AFDC)-A program that “provides transitional financial assistance to needy families. Federal and state governments share in its cost. The federal government provides broad guidelines and program requirements, & states are responsible for program formulation, benefit determinations, & administration. Eligibility for benefits is based on the state’s standard of need as well as the income and resources available to the recipient”. (Administration for Children & Family, n.d.).

Behavioral health care (BHC) - includes both mental health and substance abuse care, which are often categorized together because of a relationship between the two.

Health plans-the names health plans and MCOs are used interchangeably to reflect organizations used to manage the cost and delivery of health care services.

Managed behavioral health care organization (MBHCO) - MCOs that specialize in the management of mental health and substance abuse care. In this document, the more generic MCO term is often used to refer to MBHCOs.

Managed care-“a system designed to maintain the quality of health care in a cost-effective manner. It encompasses both the delivery of health care and the payment for those services. Instead of simply paying claims submitted by independent physicians and hospitals, organizations enter into formal

Glossary of Terms *continued*

agreements with providers, set guidelines for health care providers and monitor their effectiveness” (Managed Care Terms & Definitions).

Managed care organization (MCO)-“may be a physician group, health plan, hospital or health system-i.e., any organization that is accountable for the health of an enrolled group of people. In contrast to organizations that provide services at a discount but do not attempt to coordinate care, managed care organizations actually have responsibility for the health of enrollees, and, as a consequence, seek improvements in both results and cost-effectiveness of the services provided. Most managed care organizations still care for those with traditional indemnity insurance” (Managed Care-A Brief Glossary, n.d.).

Managed care plan-“any health plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract” (Managed Care Health Plan Definitions, n.d.).

Medicaid-“Federal program (Title XIX of the Social Security Act) that pays for health services for certain categories of people who are poor, elderly, blind, disabled, or who are enrolled in certain programs, including Medicaid waivers. Joint Federal/State funds are used to support the Medicaid program” (Health Care Definitions, n.d.).

Medicare-federal health insurance program for older Americans and the disabled.

Supplemental Security Income (SSI)-A federal income supplement program funded by general tax revenues which is designed to help aged, disabled and blind people who have little or no income (Social Security Online, n.d.).

Glossary of Terms *continued*

Types of Managed Care Plans

Carve-out-“an arrangement whereby the health plan or an employer eliminate coverage for a specific category of service and contracts with a separate set of providers for those services according to a predetermined fee schedule” (Health Care Definitions, n.d.). A diagram of behavioral health care carve-out arrangements is shown in Appendix B.

Health Maintenance Organization (HMO)-“a health care financing and delivery system that provides comprehensive health care for enrollees in a particular geographic area” (Managed Care Health Plans Definitions, n.d.).

Financing Mechanisms

Capitation-fixed monthly or annual rate paid to a health plan or provider, regardless of how few or many services are used.

Fee-for-Service-traditional payment mechanism where a provider is paid a fee for each service performed.

Risk-sharing-a financial arrangement where the MCO and the purchaser share financial risk for the cost of health care services for a specified enrolled population.

APPENDIX B

List of Acronyms

- ADHD**-Attention Deficit Hyperactivity Disorder
- AFDC**-Aid to Family and Dependent Children
- ANA**-American Nurse Association
- BHO**-Behavioral Health Organization
- CMHC**-Community Mental Health Center
- CMS**-Center for Medicare and Medicaid Services
- ETHRA**-East Tennessee Human Resources Agency
- FFS**-Fee-for-service
- FY**-Fiscal year
- GAO**-Government Accounting Office
- GNP**-Gross National Product
- HCFA**-Health Care Financing Organization
- HMO**-Health maintenance organization
- IOM**-Institute of Medicine
- MBHC**-Managed behavioral health care
- MCO**-Managed care organization
- PBM**-Pharmacy benefits manager
- PDL**-Preferred drug list
- POS**-Point of service
- PPO**-Preferred provider organization
- RFP**-Request for proposal
- RMHI**-Regional Mental Health Institute
- SED**-Serious emotional disorders

List of Acronyms *continued*

SFY-State fiscal year

SMHA

SPMI-Seriously and persistently mentally ill

TAADAS

TAMI-Tennessee Alliance for the Mentally Ill

TAMHO-Tennessee Association of Mental health Organizations

TDMHMR-Tennessee Department of Mental Health and Mental Retardation

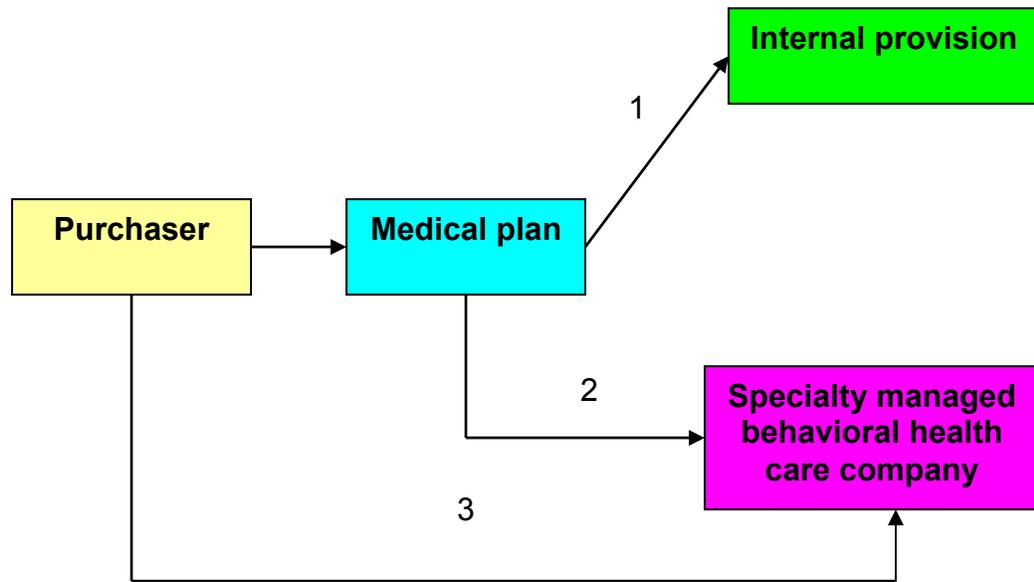
TDMHDD-Tennessee Department of Mental Health and Developmental Disabilities

TMA-Tennessee Medical Association

TNA-Tennessee Nurses Association

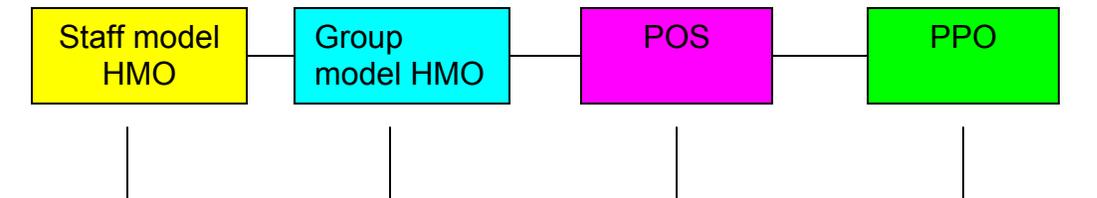
APPENDIX C

Behavioral Health Care Carve-Out Arrangements



Appendix D

Continuum of Types of Managed Care Plans



APPENDIX E

Sample Consent Form for Providers

I am Carole R. Myers, a doctoral student at The University of Tennessee at Knoxville, College of Nursing. I am conducting a case study about the TennCare Partners program and access to care for children with serious emotional disorders (SED) as research for a dissertation.

You are invited to participate in a study that will explore your perspective about the TennCare Partners program and/or access to care for children with SED. A goal of this study is to understand the strategic objectives of the TennCare Partners program and the experiences of children with SED enrolled in the program. Another goal of this study is to obtain information that may help state policymakers and administrators, providers and managed care organizations better deliver care to children with SED enrolled in the TennCare program.

You will be asked to participate in a 60 to 90 minute audio-taped interview in a place and time of your choice. You will be asked to share your perspective, insight, experiences, thoughts and feelings about the TennCare Partners program. Other questions will follow based on what you share with me. The interview will be audio-taped in order for me to use your exact words. There will be approximately 15-20 other policymakers, administrators, advocates and providers involved with this study.

All interviews will be typed into written form to allow for analysis of perspectives and experiences. Audio-tapes will be destroyed after transcription and verification. Your name will not appear on the tape or the typed copy and will be known only to me. You may select a pseudonym to be used during the interview. Information on the typed copies will be kept confidential. All copies, with no identifying information, will be kept in a locked file in my home. Your recorded interview will be transcribed verbatim. The investigator may contact you after the interview to make sure she understood your comments and thoughts. Information obtained in this study may be combined with other information for future projects related to TennCare and Medicaid managed behavioral health care.

As a volunteer in this study, you will not be paid for your time and effort in participating in this study. There is little risk to participating in this study. Information obtained from this study may help lend understanding to the experiences of children with SED enrolled in TennCare. This understanding may help state policymakers and administrators, providers and managed care organizations better deliver care to children enrolled in the TennCare program.

Participant's initials: _____

Sample Consent Form for Providers *continued*

You are free to answer or not answer any questions. You may choose not to participate or withdraw at any time during the study without any penalty or loss of present or future benefits to which you are otherwise entitled. Your audiotape will be destroyed if you withdraw from the study.

Contact Information:

Investigator:

Carole R. Myers, RN, MSN-Doctoral Candidate
The University of Tennessee-Knoxville
College of Nursing
1200 Volunteer Boulevard
Knoxville, TN 37996-4180
Phone: (865) 974-7626
email: cmyers9@utk.edu

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1200 Volunteer Boulevard
Knoxville, TN 37996-4180
Phone: (865) 974-7581
email: SThomas@utk.edu

If at any time you have any questions about the study or the procedures, you may contact the Principle Investigator. Contact information appears below. If you have questions about your rights as a participant, contact The University of Tennessee, Knoxville, Compliance Section of the Office of Research at (865) 974-3466, or write them at 404 Andy Holt Tower, The University of Tennessee, Knoxville, 37996.

Sample Consent Form for Providers *continued*

Consent

I have read the above information and agree to participate in this study. I have had the study explained to me and I have been given an opportunity to ask questions. I understand that I may ask further questions at any time. I have received a copy of this consent form.

Participant's name (print): _____

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____

APPENDIX F

Sample Transcriptionist's Confidentiality Agreement

I am Carole R. Myers, a doctoral student at The University of Tennessee at Knoxville, College of Nursing. I am conducting interviews with a variety of stakeholders about their perspectives and experiences with the TennCare program as part of my doctoral dissertation.

As Principal Investigator (PI) in this study, I have contracted with you to transcribe the digitally taped interviews. At no time will any of the information obtained as part of this study be revealed to anyone not directly involved in the research. All files will be destroyed after transcription and verification. All interview transcriptions will be given to the PI. You will retain no information or documents from this study.

If at any time you have any questions about the study or the procedures, you may contact the PI. Contact information appears below. If you have questions about your rights, contact The University of Tennessee, Knoxville, Compliance Section of the Office of Research at (865) 974-3466, or write them at 404 Andy Holt Tower, The University of Tennessee, Knoxville, 37996.

Contact Information

Carole R. Myers, RN, MSN
Doctoral Candidate
The University of Tennessee-
Knoxville
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1200 Volunteer Blvd.
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Cellphone: 865-414-7218

8161 Cedar Creek Road
Townsend, TN 37882
Home phone: (865) 448-2310

I have read the above information and agree to provide transcription services in this study. I have had the study explained to me and I have been given an opportunity to ask questions. I understand that I may ask further questions at any time. I agree to keep in confidence any and all information disclosed to me during any portion of this study. I have received a copy of this confidentiality agreement.

Name (print): _____

Signature: _____ Date: _____

Investigator's signature: _____ Date: _____

APPENDIX G

Sample Consent Form for Non-Providers

I am Carole R. Myers, a doctoral student at The University of Tennessee at Knoxville, College of Nursing. I am conducting a case study about the TennCare Partners program and access to care for children with serious emotional disorders (SED) as research for a dissertation.

You are invited to participate in a study that will explore your perspective about the TennCare Partners program and/or access to care for children with SED. A goal of this study is to understand the strategic objectives of the TennCare Partners program and the experiences of children with SED enrolled in the program. Another goal of this study is to obtain information that may help state policymakers and administrators, providers and managed care organizations better deliver care to children with SED enrolled in the TennCare program.

You will be asked to participate in a 60 to 90 minute audio-taped interview in a place and time of your choice. You will be asked to share your perspective, insight, experiences, thoughts and feelings about the TennCare Partners program. Other questions will follow based on what you share with me. The interview will be audio-taped in order for me to use your exact words. There will be approximately 15-20 other policymakers, administrators, advocates and providers involved with this study.

Unless you specify below, you and your comments will not be anonymous. However, you do have the option to be anonymous. In this case, all information about your identity will be protected.

I consent to being identified. _____ Participant's signature

I do not consent to being identified. I want my identity to remain confidential to all individuals except Carole Myers, the Principal Investigator (researcher).
_____ Participant's signature

All interviews will be typed into written form to allow for analysis of perspectives and experiences. Audio-tapes will be destroyed after transcription and verification.

■ If indicated that you wish your identity to remain confidential, your name will not appear on the tape or the typed copy and will be known only to me. You may select a pseudonym to be used during the interview. Information on the typed copies will be kept confidential. All copies, with no identifying information, will be kept in a locked file in my home. Your recorded interview will be transcribed verbatim. The investigator may contact you after the interview to make sure she understood your comments and thoughts. Information obtained in this study may be combined with other information for future projects related to TennCare and Medicaid managed behavioral health care.

Sample Consent Form for Non-Providers *continued*

- If you indicated that you consent to being identified, you will be given the opportunity to review a transcript of the interview and to make changes. The investigator may contact you after the interview to make sure she understood your comments and thoughts. Information obtained in this study may be combined with other information for future projects related to TennCare and Medicaid managed behavioral health care.

As a volunteer in this study, you will not be paid for your time and effort in participating in this study. There is little risk to participating in this study. Information obtained from this study may help lend understanding to the experiences of children with SED enrolled in TennCare. This understanding may help state policymakers and administrators, providers and managed care organizations better deliver care to children enrolled in the TennCare program.

Participant's initials: _____

You are free to answer or not answer any questions. You may choose not to participate or withdraw at any time during the study without any penalty or loss of present or future benefits to which you are otherwise entitled. Your audiotape will be destroyed if you withdraw from the study.

Contact Information:

Investigator:

Carole R. Myers, RN, MSN-Doctoral Candidate
The University of Tennessee-Knoxville
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Faculty Advisor:

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Sample Consent Form for Non-Providers *continued*

If at any time you have any questions about the study or the procedures, you may contact the Principle Investigator. Contact information appears below. If you have questions about your rights as a participant, contact The University of Tennessee, Knoxville, Compliance Section of the Office of Research at (865) 974-3466, or write them at 404 Andy Holt Tower, The University of Tennessee, Knoxville, 37996.

Consent

I have read the above information and agree to participate in this study. I have had the study explained to me and I have been given an opportunity to ask questions. I understand that I may ask further questions at any time. I have received a copy of this consent form.

Participant's name (print): _____

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____

APPENDIX H

Sample Introduction to Study Information

I am Carole R. Myers, a doctoral student at the University of Tennessee-Knoxville College of Nursing. I am conducting a case study about the TennCare Partners program and access to care for children with serious emotional disorders (SED) as research for a dissertation.

You are invited to participate in a study that will explore your perspective about the TennCare Partners program and/or access to care for children with SED. A goal of this study is to understand the strategic objectives of the TennCare Partners program and the experiences of children with SED enrolled in the program. Another goal of this study is to obtain information that may help state policymakers and administrators, providers and managed care organizations better deliver care to children with SED enrolled in the TennCare program.

You will be asked to participate in a 60 to 90 minute audio-taped interview in a place and time of your choice. You will be asked to share your perspective, insight, experiences, thoughts and feelings about the TennCare Partners program. The investigator may contact you after the interview to make sure she understood your comments and thoughts.

Your recorded interview will be transcribed verbatim. You will be afforded all the protections mandated by the federal government and the University of Tennessee Institutional Review Board, as specified in the Consent Form which will be presented to you before I do your interview.

I appreciate you taking the time to consider participating in this study.

Investigator:

Carole R. Myers, RN, MSN-Doctoral Candidate
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Sample Introduction to Study Information *continued*

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I will follow-up with you in the next ten days. If you agree to being interviewed, we will schedule an appointment at a time convenient to you.

APPENDIX I

Sample Transcript Cover Letter

Dear _____:

As I have completed the interviews for my dissertation and now transition to integrating each person's perspective in my telling of the TennCare story, focusing on the care for children with Serious Emotional Disorders, I am pausing to reflect on my good fortune of having the privilege of being able to do this work and benefit from your knowledge and experience. I am appreciative of being able to interview you and impressed with your understanding and generosity.

As we discussed before we did the interview, I want to give you the opportunity to review a copy of the transcript of your interview and to make any modifications you feel are necessary. I have enclosed a self-addressed, stamped envelope for you to return your transcript with any changes. If I do not receive a corrected transcript from you within ten working days of the postmark date of this letter, I will assume that you agree your transcript is accurate.

My contact information is listed below should you have any questions.

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Sincerely,

Carole R. Myers

VITA

Carole Lynn Myers is a family Nurse Practitioner who founded and operated a rural primary care clinic in the early 1980s. Following this, she established herself as a managed care expert developing, implementing and continually improving a variety of managed care initiatives throughout the United States working as a business consultant to a Fortune 50 company, the Aluminum Company of America (ALCOA), and as a founder and principal of a benefits consulting company, Risk and Performance Management.

Carole has a long-standing interest and involvement with outcomes management, quality improvement in health care and benefits delivery, and organized systems of care. This interest has been cultivated through a variety of experiences including serving as a member of the Board of Directors of the Managed Health Care Association (MHCA) from 1994-1997, as Chairman of the MHCA's Outcomes Management Committee (1995-1997), member of the Accreditation Committee of the MHCA (1993-1997) and member of the Organized Systems of Care Committee of the Washington Business Group on Health (1992-1998). Other key experiences include serving on the State of Tennessee Community Health Access Board (1990-1998), the State of Tennessee Governor's Commission on Nursing (1986-1988), on the Board of Directors of Overlook Mental Health Center (1983-1986), on the Advisory Board of Overlook Center (1990-1997), on the Board of Visitors of the University of Tennessee College of Nursing (1985-present), on the Governance Committee and the Board of Directors of Sigma Theta Tau-Gamma Chi Chapter (2004-present) and in a variety of Tennessee Nurses Association District and State offices and committee positions.

Carole was awarded a baccalaureate degree in Biology from the University of West Florida in 1977 and a Master's degree in Nursing from the University of Tennessee-Knoxville in 1981. In 1985 Carole was selected as the Nurse of the Year for District Two of the Tennessee Nurses Association. Most recently Carole has associated with the College of Nursing at the University of Tennessee where she is involved teaching graduate students.