TennCare and the Clinton Presidency: Health Care Policy in State and Nation

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In March 1993, Tennessee Governor Ned McWherter announced an ambitious plan to alter the state's Medicaid system pending receipt of a federal waiver to create a new and experimental health care system called TennCare. Shortly thereafter, the Clinton administration and the Tennessee state government embarked on a six-month endeavor to examine TennCare and to accelerate the waiver process. The Clinton Administration then closely followed TennCare's development and monitored its implementation in part because it perceived TennCare and its ability to cut costs and expand coverage to be linked to the administration's national health care reform initiative. For example, in October 1994, Hillary Clinton explained to the Memphis *Commercial Appeal* "that one of the issues that you have to look at with TennCare or with any of the states that are experimenting is whether in the absence of national health care reform, those model programs will be able to continue."[1] Furthermore, TennCare provided the Clinton Administration and the nation with an opportunity to examine the ability of managed care networks to effectively and equitably deliver health care to the poor, including the working poor. Since TennCare's creation 12 years ago, however, its benefits and downfalls remain highly contested and uncertain.

Before TennCare's creation, the state of Tennessee, like most other states, utilized Medicaid to provide health care coverage for poor and low income families. Medicaid was originally signed into law under Title XIX of the Social Security Act on July 30, 1965, by President Lyndon Johnson. Medicaid was created as a federal-state matching

[1] "On the record: Hillary Clinton," *The Commercial Appeal*, 8 October 1994, sec. A.

program, in which medical bills of Medicaid patients were paid by both federal and state funds at predetermined percentages. Medicaid was implemented as a state-administered program, and each state was responsible for determining rules and regulations on such issues as eligibility, payment structure, and medical services.[2] When first created, Medicaid was only provided to people eligible for Aid to Families with Dependent Children. However, over time Medicaid eligibility broadened, especially during the late 1980's when laws were enacted that expanded the number of eligible people and medical services.[3] Additional federal statutes passed in 1988, including 1902(r)(2) provisions of the Social Security Act, gave states the option to alter existing Medicaid rules and regulations in order to expand health care coverage and medical services. It was within these last laws that Tennessee would eventually seek to create TennCare through a federal wavier.

Preceding its receipt of a federal waiver for TennCare, Tennessee faced a budget crisis caused in part by growing health care costs, especially in the state's Medicaid program. From 1987 to 1992, funding for Tennessee's Medicaid program tripled as the number of Medicaid enrollees expanded and the inflationary growth of health care costs accelerated. During this period, Governor McWherter, a conservative Democrat, utilized a variety of financial schemes to cover these growing expenses, including disproportionate-share hospital (DSH) payments, other enhanced provider payments, and a state hospital tax.

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[2] U.S. Department of Health and Human Services, *Medicaid Program and General Information,* 25 April 2006, <http://www.cms.hhs.gov/MedicaidGenInfo/> (12 July 2006).
[3] Texas Health and Human Services Commission, *Medicaid History*, <http://www.hhsc.state.tx.us/Medicaid/Med_info/medhist.html> (12 July 2006).

DSH payment adjustments, which provided Tennessee with millions in federal aid, were created in 1981 by the federal government to provide adequate Medicaid payments to hospitals that treated a disproportionate number of Medicaid and uninsured patients. As these hospitals felt the strain from the costs imported on them by serving the poor and uninsured, Congress and state governments increasingly sought to use DSH payments to support these institutions. From 1989 to 1992, annual DSH payments increased nationally from $600 million to $17 billion. However, state governments, including Tennessee, soon began to use DSH payments to fund other health care costs intended to be entirely supported by state revenue, as well as other non-health care related programs.[4]

As a result of Tennessee's use of DSH payments and other enhanced provider payments, federal funds to Tennessee, in the form of federal Medicaid assistance, rose from the official rate of 67.6 percent to an actual rate of 83.1 percent. Nationwide, the percentage of Medicaid costs funded by the federal government hovered at 57 percent. However, by 1993, new laws enacted by the federal government made such financing techniques illegal, forcing Tennessee to adjust to a loss of $494 million in federal Medicaid aid in fiscal year 1994. This placed tremendous strain not only upon Tennessee's Medicaid system, but also upon Tennessee's general budget. By 1993, Medicaid represented the second largest and the single fastest growing item within the state budget.[5]

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[4] Lynne Davis Boyle, *Medicare Disproportionate Share (DSH) Payment*, <http://www.amac.org/advocacy/library/teachhosp/hosp0003.htm> (8 July 2006).
[5] G. Gordon Bonnyman Jr., "Stealth Reform: Market-Based Medicaid in Tennessee," *Health Affairs* 15, no. 2 (1996): 307.

At the time of the state's budget crisis in 1993, Tennessee insured its poverty population with Medicaid at a higher percentage than most states. For example, sixty three percent of Tennessee's poor received health insurance through Medicaid, while only 54 percent of the nation's poor was covered by Medicaid. Tennessee also provided unusually generous medical coverage to pregnant women and children. In terms of spending, however, Tennessee's Medicaid benefits were modest compared to most other states, ranking forty-second in average Medicaid benefits per person.[6] These spending arrangements placed Tennessee in a precarious position. Even though more poor people per capita were covered by Medicaid in Tennessee than most other state, health care providers and Medicaid recipients paid a higher proportion of the overall medical cost. As a result, any medical reform efforts would necessarily require the state to reduce the cost to health care providers and those unable to afford private insurance in addition to maintaining or expanding the per capita level of coverage previously established. These goals, in conjunction with Tennessee's budgetary problems, made any health care reforms initiated by the state government difficult at best. However, despite having difficulty funding health care and maintaining or expanding health care coverage, several factors in and outside of Tennessee provided incentives for comprehensive health care reform.

For example, as Governor McWherter was entering his second term in 1991, many people throughout the nation began to look toward governors as innovators and as sources of creativity and enterprise. By the early 1990s, governors were no longer simply seen as public leaders, managers, or chief legislators, but also as individuals with the power and the authority to effect significant changes within the states. Some have seen

[6] Bonnyman Jr., 306.

this development resulting from the withdrawal of the federal government from domestic policy leadership in the 1980s, which subsequently forced state institutions, including the governorship, to become more innovative and initiatory. This development became increasingly more evident as the federal government began to reduce its responsibilities in many areas affecting the public, including welfare, human services, the environment, and health care.[7] As a result of these national trends, people in Tennessee, including the state legislature, looked toward Governor McWherter as a possible reformer of Tennessee's Medicaid system and as the ultimate authority to solve the state's budgetary woes.

However, shortly after Tennessee submitted its TennCare waiver to the federal Department of Health and Human Services, many legislators throughout the state expressed concern about Governor McWherter's TennCare proposal. Tennessee Democratic Senator Jim Sasser urged the governor to proceed cautiously, since "the administration and Congress are looking to cut federal spending on Medicaid, not give states more money." Even proponents of health care reform in Tennessee were reluctant to give Governor McWherter their full support. Referring to the TennCare proposal, Democratic Representative Jim Cooper called it the "lesser of two evils" and opposed TennCare's "global budgeting" strategy. In particular, he felt that comprehensive health care reform in Tennessee could not be accomplished until the Clinton Administration undertook national health care reform efforts.[8]

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[7] David Carleton, "The Governorship," in *Tennessee Government and Politics*, ed. Mark Byrnes and John R. Vile (Nashville: Vanderbilt University Press, 1998), 53.
[8] Polly Elliot, "McWherter Presses Clinton for Waiver to Approve TennCare," *States News Service*, 16 June, 1993.

The perception that Tennessee's health care system was in institutional and financial disrepair was mirrored nationally, as most policy makers during the early 1990s believed that the national health care system faced tremendous strains and inefficiencies that threatened to undermine the entire system. To complicate the matter, many individuals lacked medical coverage. By 1994, 20 percent of the adult population, or 37 million Americans in all, lacked health insurance, while those with insurance were witnessing dramatic increases in premiums and out-of-pocket costs. As a result of these problems, many prominent national politicians felt the need to address the issue and offer solutions. Many from the left, such as Senator Edward M Kennedy of Massachusetts, advocated a national health care system analogous to Canada's single-payer insurance system. However, many politicians from the right, such as Senator Minority Leader Robert Dole, vehemently rejected any national health care program because of its perceived intrusiveness upon Americans. They believed that national health insurance would allow the federal government to become involved in individual health care decisions, removing decision making power from patients and their doctors and awarding it to an intrusive bureaucratic, federal agency.[9]

With these various motivations working in tandem with Tennessee's need to address its budgetary crisis and to reform its own health care system, Governor McWherter announced in early 1993 that his state would "withdraw from Medicaid" and begin to develop a new health care delivery system for the poor and the working poor that would be called TennCare. Within two weeks after the governor's announcements, the Tennessee General Assembly passed a two-page statute that gave the governor nearly full

[9] John F. Harris, *The Survivor: Bill Clinton in the White House* (New York: Random House, 2005), 112-113.

discretionary power to seek a federal waiver and implement TennCare under "executive fiat" by 1994. In order to accomplish this task, the state sought a federal Medicaid waiver under Section 1115 of the Social Security Act to alter the state's federal Medicaid spending arrangements and to expand coverage though enhanced eligibility. While TennCare's eventual implementation would be contingent upon the Department of Health and Human Services (HHS) awarding Tennessee with a federal waiver, Tennessee officials began to take preliminary steps. For example, throughout the summer of 1993 Tennessee officials began contracting with health care providers and managed care organizations. More importantly, in the fall of 1993, months before TennCare would be approved by federal officials, Tennessee's Medicaid beneficiaries began receiving listings of managed care organization to join before an enrollment deadline of November 1.

As part of its first draft proposal published in March 1993 by Tennessee's chief financial office, Tennessee officials proposed to broaden eligibility to include Medicaid patients and other poor and insured people in order to provide "comprehensive health insurance for every Tennessean."[10] In all, Tennessee officials proposed that nearly 1.55 million individuals would receive health care insurance under TennCare, an increase of nearly 750,000 uninsured individuals to the state's 800,000 Medicaid enrollees.[11]

At the time of Governor McWherter's decision, two federal statues provided the legal means to accomplish these goals. Under 1902(r)(2) provisions of the Social Security Act, states are permitted to extend eligibility to particular groups, including pregnant women and children, regardless of income. However, to do this, states must bear a certain

[10] Bonnyman Jr., 306.
[11] Duren Cheek, "Governor rebuilds Medicaid entirely: Plans to insure 750,000 more," *The Tennessean*, 4 April 1993, sec. A.

proportion of the cost for the expanded coverage. Under Section 1115 of the Social Security Act, states may be awarded "research and demonstration" waivers which allow them to use innovative measures to address health and welfare problems. In particular, the federal government may exempt states from a specific set of Medicaid rules and regulations, allowing states "to restructure their Medicaid programs to offer health care to new populations." Any adjustments permitted under a federal waiver must be "budget-neutral," meaning that federal Medicaid aid can not be expanded beyond normal levels.[12] However, since Tennessee had already expanded federal aid beyond the official rate of 67.3 percent using various financial mechanisms, the precise amount of federal money that Tennessee could be awarded remained unclear and contentious when it came time for HHS and its Health Care Financing Administration (HCFA) to begin evaluating Tennessee's federal waiver application.

After several month of deliberation, David Manning (Tennessee's Commissioner of Finance and Administration) and Manny Martins (Director of the Medicaid Bureau) developed a new program to overhaul the state's Medicaid systems, and in April 1993 the Tennessee state legislature approved the plan as a state waiver demonstration. Shortly thereafter, in June 1993, Tennessee submitted its TennCare waiver petition to HCFA for review. Governor McWherter followed Tennessee's waiver submission with a visit to the White House on June 16, where he met with President Clinton for more than an hour. At the time of their meeting, it was unclear whether the Clinton administration would approve Tennessee's federal waiver and implement TennCare. For example, prior to Clinton's and McWherter's meeting, Vice President Al Gore had held a meeting with

[12] John Holahan et al., "Insuring the Poor Through Section 1115 Medicaid Waiver," *Health Affairs*, 14, no. 1 (1995): 200.

members of Tennessee's media, explaining that the administration would be reluctant to provide Tennessee with a federal waiver while the nation was on "the verge of a major change" in national health care policy.[13]

As is evident from Gore's statement, the White House quickly began to monitor TennCare's progress and its potential impact upon the administration's health care reform efforts. In an April 6, 1993 memorandum from Charlotte Hays to Vice President Gore , Hayes summarized the various actions taken by the administration in response to Tennessee's TennCare draft proposal, which notified the administration that Tennessee would be seeking a federal Medicaid waiver. Hayes explained that the administration knew that many "waivers are on the way as states try to address deep fiscal problems with the Medicaid program and HHS must assess waivers in light of the health reform plan we are working toward." Hays concluded by advising the vice president to indicate his willingness to closely follow TennCare's federal waiver if contacted by Governor McWherter or state legislatures.[14]

Throughout the summer and fall of 1993, while TennCare was being evaluated by HHS officials and members of the White House staff, a specific set of issues were contentious. Some of the important issues identified by HCFA include: adequacy of state funding, matching charity care, block grant approaches, preserving federal/state matches, and implementation dates.[15] Additionally, members of HHS expressed concerns about Tennessee's ability to implement managed care networks on the scale proposed by

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[13] Elliot.
[14] Charlotte Hayes to Vice President Al Gore, Memorandum, April 6 1993, Clinton Presidential Library Records, William Clinton Presidential Library.
[15] Health Care Financing Administration to White House Officials, Talking Points, November 19 1993, Clinton Presidential Library, William Clinton Presidential Library.
[15] Hayes to Vice President Gore, Memorandum, April 6 1993.

Tennessee officials while protecting medical delivery services for current Medicaid beneficiaries.[16] Before 1993, less than 30,000 Medicaid beneficiaries were enrolled in a managed care network, providing Tennessee with little infrastructure or experience to expand its managed care networks.[17] However, in general, HHS and HCFA officials were willing to grant Tennessee a waiver, as long as TennCare was financially viable, legally approved, and properly implemented with sufficient regulatory and delivery health care systems in place. Thus, HCFA and HHS members indicated persistently throughout the approval process that Tennessee officials needed to address these financial, legal, and operational issues before TennCare could be approved.

One of the first and most important financial issues that members of HHS, HCFA, and the White House encountered involved Tennessee's desire to reduce its overall financial contribution from what it had spent in previous years on its Medicaid program. Prior to 1993, Tennessee generated an estimated $600 million in state revenue from a provider tax paid by hospitals, which drew matching federal contributions of nearly $1.2 billion dollars annually. However, in 1993, health care providers, including Blue Cross Blue Shield of Tennessee, were able to successfully pressure the Tennessee state legislature to repeal the tax. Yet, under the federal waiver submitted to HHS and HCFA, the TennCare proposal sought federal matching funds similar to those received in the 1993 fiscal year without providing any new form of tax revenue that could be matched.[18] Members of Governor McWherter's administration and state officials had claimed throughout the spring of 1993 that TennCare could save the state $6.5 billon dollars by

[16] Hayes to Vice President Gore, Memorandum, April 6 1993.
[17] Bonnyman Jr., 306-307.
[18] Carol Rasco to Mack McLarty, Roy Neel, Jack Quin, Marcia Hale, Joan, Baggett, and Ira Magaziner, Memo, September 16 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

the year 2000 without raising new taxes.[19] However, the exact mechanisms intended to realize these savings included additional matching federal funds as well as other financial mechanisms whose legality and prudence remained unclear.

One of these mechanisms included furnishing Tennessee with Medicaid funds to match a 5 percent charity effort made by providers. Members of HCFA, including its administrator, Bruce Vladeck, contended that charity care funds did not represent state revenue, and therefore could not be matched by federal Medicaid funds. Furthermore, Vladeck and HCFA argued that granting such a request would establish an expensive precedent that would entitle other states to receive similar aid. In all, such an expansion of federal Medicaid spending could cost the federal government nearly $13 billion annually. HCFA also argued that charity aid is often difficult to define, monitor and price, which could provide additional institutional strains.[20] Although possible loopholes existed allowing HHS and HCFA to approve such a financial mechanism, most members of HHS and HCFA were reluctant to sign off on any schemes whose legality remained unclear.

As part of its proposal, Tennessee also sought a block grant from the federal government to help fund TennCare. The legality of such a measure was never in question, but many within HHS and HCFA felt a block grant would allow Tennessee to drastically reduce its share of Medicaid spending. Under the block grant proposal made by Tennessee, the federal government would be required to maintain its original level of Medicaid spending, while Tennessee would not. As a result, HCFA officials feared that a

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[19] Elliot.
[20] HCFA Administrator's Office to White House Staff, Memo, November 8 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

block grant "would significantly alter the Medicaid matching percentages in Tennessee and server the basic federal-state financing relationship."

More importantly, the White House and HCFA received political pressure form Congress to abandon the block grant option and pursue other means of funding. Key members of Congress, including Democratic representatives John D. Dingell of Michigan and Henry Waxman of California, who were considered by the White House to be essential for passage of the administration's health care reform bill, "strongly objected" to the block grant approach, arguing that it would shift future health care costs from state and local governments to the federal government. Furthermore, Dingell and Waxman threatened to curtail the Secretary of Health and Human Services Donna Shalala's waiver authority if the block grant option was not dropped.[21] As a result of these various political and non-political concerns, HCFA and White House officials opposed Tennessee's request for a block grant.

Federal and Tennessee officials also disagreed over the implementation date for TennCare. At the beginning of TennCare's waiver approval process, most health insurance companies, including Blue Cross Blue Shield of Tennessee (the state's largest health insurance provider), Tennessee hospitals, and most physicians tentatively supported TennCare. However, as health insurance companies and physicians complained of the rates to be paid by Tennessee and TennCare's lack of organization, many in the health care community wanted to delay TennCare's implementation date of January 1, 1994. For example, a letter from the Tennessee Medical Association to Carol Rasco, Chair of the Domestic Policy Council, warned that there was "wide patient and

[21] Department of Health and Human Services to Carol Rasco, Questionnaire, 8 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

physician confusion state wide on how TennCare will begin and how it will administer health care services." Furthermore, the Tennessee Medical Association argued that, contrary to Governor McWherter's claims, the TennCare proposal was not receiving the support of physicians across the state and that physicians were delaying their participation. These in turn forced delays in patient registration for TennCare, which, left unchecked, would lead to thousands of uncovered patients at the start of TennCare's implementation.[22]

Newspapers in Tennessee also reported numerous incidents of frustration and confusion as patients and doctors rushed to join managed care organizations before TennCare's implementation. The primary cause for the confusion and frustration stemmed from provider contracts with the state that lacked sufficient information, discouraging doctors from making decisions on a timely basis. As a result, when Medicaid patients, especially those with extensive medical needs, joined a plan, they were unable to determine whether their doctor was in the same plan.[23]

Another major issue swirling around TennCare's implementation involved Blue Cross Blue Shield of Tennessee (BCBST) and its participation in TennCare. At the time of TennCare's approval process in 1993, 40 percent of Tennessee's private insurance plans were with BCBST. Furthermore, nearly 80 percent of Tennessee's physicians belonged to BCBST health insurance plans. As the TennCare implementation date of January 1, 1994 approached, doctors accused BCBST of blackmailing them. They argued

[22] Tennessee Medical Association to Carol Rasco, Letter, 22 October 1993, Clinton Presidential Library Records, William Clinton Presidential Library.
[23] Mike Wilkinson, "Doctors, patients frustrated, upset by TennCare plan," *The Knoxville News-Sentinel*, 1 October 1993. sec. B.

that BCBST unfairly threatened to remove many doctors from BCBST's private insurance plans because they refused to accept BCBST's contract with TennCare.

These issues remained contentious throughout the summer and fall of 1993 as HCFA and Tennessee officials continued to work for compromises and concessions from each other. However, by late summer HHS told Tennessee officials that they would make a final decision on TennCare by September 17. After the September 17 deadline passed with out a decision, Governor McWherter visited Secretary of Health and Human Services Donna Shalala and Carol Rasco individually to promote continued cooperation and "good faith" between HSS, HFCA and Tennessee officials. More importantly, shortly before a meeting between President Clinton and Governor McWherter, the chief financial officer of Tennessee, David Manning, expressed to Carol Rasco that Bruce Vladeck, that HCFA, was working with him in good faith and was a tremendous asset to TennCare and Tennessee's health care reform efforts.[24]

Despite these expressions of good will between federal and Tennessee officials, Governor McWherter appealed directly to President Clinton to resolve the situation and to hasten TennCare's approval in order to achieve the scheduled January 1, 1994, implementation date. In a memo from Carol Rasco to President Clinton dated November 8, 1993, Rasco briefed Clinton on his upcoming meeting with Governor McWherter to be held later that day. She explained that McWherter had requested that HHS and HCFA officials be absent from the meeting. More importantly, Rasco conveyed to Clinton Governor McWherter's message to her that "if the President tells him he has to do what HCFA has directed in order to have the waiver approved – more money and a delayed

[24] Carol Rasco to President Clinton, Memo, 6 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

timeline – then he will accept those facts. We have delayed this meeting as long as we possible could." The most "critical point to keep in mind," Rasco concluded, "is that this meeting must not be seen by the Governor as one in which he came in and got the final approval and/or changes in the conditions" that would eventually result in TennCare's approval by the HCFA.[25]

Prior to his November 8 meeting with Governor McWherter, President Clinton's opinion on the issue remained unclear. However, several sources of evidence demonstrate that Clinton was more willing than HSS and HCFA officials to make certain concessions to Tennessee to allow the state to implement TennCare. As described in Rasco's memo, she and members of HSS and HCFA delayed Clinton's meeting with Governor McWherter as long as possible, meaning that HHS and HCFA officials wanted time to work with Tennessee officials in order to garner concessions before Clinton could have the opportunity to emphasize with McWherter's position and give in to his request.

These concerns were warranted. Bruce Lindsey, a close aide and friend of Clinton, explains that Clinton seemed to be frustrated by the bureaucratic rigidities delaying TennCare's implementation. Lindsey says that this reaction in part "grew out his frustration as a governor, trying to do some things at the state level" and having "the federal bureaucracy stifle him." Clinton was receptive to states like Tennessee who were trying in "good faith" to create innovative solutions to address health care issues. Yet, as Clinton saw it, the waiver approval process administered by HHS was preventing him from helping Tennessee and Governor McWherter. [26]

[25] Carol Rasco to President Clinton, Memo, 6 November 1993.
[26] Bruce Lindsey, Interview, 5 July 2006.

As a former governor, Clinton emphasized with Governor McWherter's position. During their meetings in June and in November of 1993, Clinton drew from his own practical experience as an Arkansas governor, which provided him with a unique perspective different from that of HHS and HCFA. Furthermore, Clinton knew McWherter since the 1970s when he became speaker of the house of Tennessee. McWherter was also a personal friend of Vice President Gore. These relationships, in conjunction with Clinton's affection for Governor McWherter and his unique perspective as a former governor made Clinton, in part, an advocate for McWherter's position in the Administration.[27]

More importantly, according to Lindsey, Clinton believed at the time "that states are the laboratory of experimentation" and the White House "needed to give them more flexibility." As a result, Clinton "pushed early on for [White House staffers] to be involved in waivers" Clinton also "overruled HHS in a number of cases where they were disinclined to give waivers." With TennCare's approval being held up by HCFA, he became increasingly frustrated. Clinton, Lindsey says, wanted to give Tennessee the ability to address its own financial and health care issues, because he believed that Governor McWherter was working in "good faith" with the administration and truly wanted to improve Tennessee's Medicaid and health care systems.[28] As a result of his interest and concerns, Clinton maintained a close watch over Tennessee's reform efforts from 1993 to 1994. Throughout TennCare' approval process, Clinton received various memos describing critical points of disagreement between HCFA and Tennessee

[27] Lindsey, 5 July 2006.
[28] Lindsey, 5 July 2006.

officials, as well as updates on the progress being made and the opinions of Medicaid patients and doctors from Tennessee.

On November 18, after much negotiation, HSS announced its "approval of federal waivers that will enable Tennessee to reform its Medicaid program and extend coverage to many uninsured citizens." In a press release, HHS explained that the TennCare plan was consistent with the administration's policy of encouraging states to development innovative programs to address the health care needs of their people. In addition, Bruce Vladeck, administrator of HCFA, stressed that TennCare will "expand health insurance coverage to the uninsured… while protecting the right of recipients to choose their own health care providers."[29]

In its final form, Tennessee's proposal resolved a host of contentious issues that were debated throughout the summer and fall. Tennessee's approved TennCare proposal was also representative of the cooperation that had occurred between State and federal officials, as well as the various concessions made by both parties. For example, on the issue of state funding, HCFA concluded that Tennessee's financing would be sufficient to fund TennCare and cover future medical costs. However, HCFA stipulated that Tennessee would be required to reduce TennCare's eligibility pool if state revenues and funding became insufficient.[30]

Tennessee's agreement to reopen its enrollment process after the November 1, 1993 enrollment deadline passed represented one of many concessions on Tennessee's part. Prior to TennCare's approval on November 18, Tennessee officials sent

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[29] Department of Health and Human Services, Press Release, 18 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.
[30] Department of Health and Human Services to Carol Rasco, Questionnaire, 19 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

informational packets to Medicaid recipients listing the managed care organizations that would serve particular regions. Yet, at the time, most Tennessee physicians had not decided whether to participate in TennCare and were generally uniformed on major issues of contention, including payment structures and services to be covered under TennCare. As a result, when Medicaid patients began flooding doctor offices with questions on eligibility, health care access, and physician participation, few, if any offices were ready to handle their questions. To complicate the situation, Tennessee officials stipulated that Medicaid enrollees must pick a managed care organization by November 1, or have the state make a final selection. The November 1 deadline and the general lack of information among patients and doctors caused great confusion and frustration throughout the state. The fact that TennCare had not yet been approved by the federal government only served to further perpetuate the confusion and frustration felt among patients and physicians.[31] To resolve this issue, state and federal officials agreed to extend TennCare's enrollment date. HCFA officials also made several concessions such as providing federal matching aid to include the cost of services provided to future TennCare enrollees who decided not to enroll in managed care organizations.[32]

Despite making various compromises and concessions, HCFA officials were not willing to compromise on certain issues. In particular, HCFA rejected Tennessee's request to receive a block grant. In justifying its action, HCFA officials argued that "the original state proposal," which called for a block grant "would have effectively reduced state matching from 33 percent to approximately 15 percent." Furthermore, Tennessee's proposal for a block grant was based on "historically" high levels of inflationary growth

[31] Ed Cromer and Bill Snyder, "Doctors deluged by TennCare calls," *Nashville Banner*, 8 October 1993.
[32] Department of Health and Human Services to Carol Rasco, Questionnaire, 19 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

in health care spending, which were predicted to decrease over time. Cost containment represented one of HFCA's most important concerns. Therefore, HCFA officials saw Tennessee's block grant, which would pass on significant cost increases to the federal government, to be imprudent.[33]

Even though Tennessee did not receive a block grant or other various expansions of federal aid, Tennessee's final proposal was seen by both state and federal officials as supplying an adequate amount of care, while expanding health care coverage to include 500,000 uninsured individuals by 1995.[34] At the same time, HCFA officials predicted that Tennessee could produce savings for the federal government between $1 billion and $3 billion by abandoning its traditional Medicaid programs and proceeding with TennCare's implementation. However, the assumptions underlying these predictions were controversial among Tennessee and federal officials.[35]

For example, Tennessee officials established the per capita rate (capitation rate) to be paid to managed care organizations for each TennCare enrollee at 25% below the projected 1994 Medicaid cost. That rate was established, in part, because Tennessee officials believed that managed care organizations could achieve medical cost reductions of about 35% per person, which would allow them to operate within the capitation levels established by Tennessee under TennCare. However, Tennessee's estimate of a 35% reduction in medical cost did not take into account the administrative cost required to

[33] Department of Health and Human Services to Carol Rasco, Questionnaire 8 November 1993,Clinton Presidential Library Records, William Clinton Presidential Library.
[34] Department of Health and Human Services, Press Release, 18 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.
[35] Department of Health and Human Services to Carol Rasco, Questionnaire, 8 November 1993.

create managed care networks and the institutional mechanisms required to monitor the quality of their care across the state.[36]

To prepare for TennCare's implementation, hospitals across Tennessee conducted training sessions for staff members and provided informational booths for patients. In addition, state officials, including Medicaid chief Manny Martins, made themselves available to local officials to answer any questions and to provide help. However, in the days leading up to TennCare's implementation, most members of the public predicted "months of confusion as patients, doctors, hospitals, and health plans try to adapt to the new system." Critics warned that TennCare would bring new taxes when costs exceeded predictions. More importantly, physicians across the state protested the payments they would receive under the TennCare program. They argued that TennCare's rates were "bare bone" and "disastrous." A group of Tennessee physicians even sued in state court to block TennCare. Despite having their case rejected, other physician groups continued to pursue other means to delay TennCare's implementation. For example, the American College of Physicians wrote numerous letters to federal officials, including Bruce Vladeck and President Clinton, requesting the administration to investigate TennCare's implementation and its compliance to its federal waiver.[37]

Despite the uncertainties surrounding TennCare's financial viability, Tennessee officially implemented the program on January 1, 1994 by transferring nearly 800,000 Medicaid beneficiaries into twelve separate managed care networks. At that time, Tennessee officials began to accept applications from newly eligible individuals. Within

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[36] Thomas Lewis Nelson to Donna Shalala, Letter, 5 November 1993, Clinton Presidential Library Records, William Clinton Presidential Library.

[37] Reed Branson and Jon Hamilton, "TennCare starts today amid hope and hassles," *The Commercial Appeal*, 1 January 1994, sec. A.

the first year, twelve managed care organizations (MCOs) formed and supplied health insurance to TennCare's beneficiaries. On average, each MCO received $101 per enrollee per month. Tennessee withheld 10% of this payment, to be paid at the end of each fiscal year to MCOs that met the performance standards established by the state. Of the twelve managed care programs two functioned state wide; the other ten were limited to particular regions. Thus, each beneficiary had at least two plans to choose from.[38]

TennCare's per capita payment structure placed each MCO at financial risk. There were no additional funds provided to MCOs whose expenditures exceeded the total amount of TennCare's capitated payment. However, MCOs were allowed to bargain with network providers, such as BCBST, in order to shift financial risk from MCOs to health insurance companies. The state also allowed MCOs to negotiated provider fees with insurance companies. However, these fees were capped at a certain level under TennCare rules.[39]

At the time of TennCare's creation, Tennessee had limited experience using managed care networks to provide health care. Only 30,000 of the state's 800,000 Medicaid beneficiaries were enrolled in a managed care network in 1993. The state had the option of either soliciting out of state MCOs to participate in TennCare or encouraging existing insurance companies and other health care providers to develop their own MCOs. State officials eventually decided to pursue the latter course. Some of the plans developed by Tennessee providers had questionable reputations and were "quietly discouraged from applying." Of the plans approved by state officials, most were

[38] Bonnyman Jr., 306-307
[39] Bonnyman Jr., 308

formed just before TennCare's implementation. The MCOs offering these plans had little or no experience administering health care through managed care networks.[40]

Of the various health care organizations participating in TennCare, BCBST was critical to TennCare's ability to function and provide healthcare services across the state. Prior to TennCare's implementation, BCBST operated a preferred provider program called Tennessee Preferred Network. The program represented the largest provider network in the state and provided health insurance to one million people.[41] In addition, BCBST held contracts with the state government to provide health care coverage to its employees. As a result of its ubiquitous presence throughout the state, BCBST's participation in TennCare's implementation "was critical to building a credible state-wide managed care network." The details of the negotiation between the state and BCBST officials remain tightly guarded and occurred mostly during private, off record meetings. However, it is clear that Tennessee officials were able to leverage the state's contract with BCBST officials to persuade the company to become a major participant in TennCare and to require "that all of their network physicians participate in TennCare if they want to maintain participation in the state employee program-a provision physician later termed a cram-down."[42]

As TennCare entered its second month in February 1994, some in Tennessee began to question the extent to which Tennessee officials were complying with the terms of HCFA's waiver.[43] Furthermore, while the majority of TennCare's broad outlines had

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[40] Anna Aizer and Marsha Gold, "Growing An Industry: How Managed Is TennCare's Managed Care?," *Health Affairs* 19, no. 1 (2000): 88-89.
[41] Bonnyman Jr., 308
[42] Gold and Aizer, 88.
[43] Carol Rasco to Dr. Griner and Dr. Grunnar, Letter, 15 February 1994, Clinton Presidential Library Records, William Clinton Presidential Library.

been established, many of its details remained to be resolved and implemented. As a result, many physicians and physician groups brought complaints against TennCare. More importantly, the ability of managed care organizations to deliver health services during the first several months of 1994 proved to be inadequate. Access to medical specialties and general hospital care was problematic and many TennCare enrollees struggled to find doctors within their MCO networks.[44]

Two cases in particular demonstrated TennCare's disorganization and inability to properly deliver care. In one, a mother claimed that Jackson Memorial Hospital initially refused to provide care to her baby because the hospital was not a participant in TennCare. As a result, the baby died. In the other case, an AIDS patient was transferred from a non-participating hospital to a participating hospital. However, because of the patient's critical condition at the time, he died. These cases caught the attention of national news organizations, including 60 Minutes and ABC News. As a result, Kevin Thurm, HHS's Chief of Staff and principal advisor to Donna Shalala, wrote a memo to Carol Rasco and other White House staffers, detailing both incidents. More importantly, Thrum noted that local and national news organizations were in Tennessee "investigating the death of two TennCare enrollees and potentially comparing Tennessee's health reform approach with the Health Security Act, the administration's health reform bill."[45] Because of concerns over medical access for TennCare enrollees, especially in west Tennessee, HCFA regional offices in the state began conducting physician surveys to

[44] Bonnyman Jr., 309
[45] Kevin Thurm to Donna Shalala, Memo, 18 February 1994, Clinton Presidential Library Records, William Clinton Presidential Library.

"verify that adequate numbers of physicians are participating, particularly primary care physicians."[46]

In addition to the worries of HHS and HCFA officials, national health care groups expressed their concern about TennCare and its potential impact upon national health reform efforts.[47] For example, in a letter to the president, members of the American College of Physicians expressed their deep concern about "health reform initiatives at the state level through the HCFA wavier process during the period of transition to full implementation of system wide reform." In the case of TennCare, they argued that there was little or no evidence demonstrating that Tennessee had met the conditions of its federal waiver. For example, despite assurances from the state to members of HCFA that MCOs would be implemented gradually, all plans were immediately certified on 1 January 1994, causing state-wide confusion among patients and doctors. As a result, the American College of Physicians asked the president to request that HHS launch an investigation and to supply him with a report on the implementation of TennCare, "demonstrating with data the extent of compliance or non-compliance with the terms of the waiver."[48]

While the White House was receiving complaints from national physician groups, doctors throughout Tennessee became increasingly frustrated with TennCare's implementation. For example, in a meeting between physicians from northwestern Tennessee and David Manning, the state Finance Commissioner, many doctors complained that they were "being pressured into joining the private health plans that are

[46] Kevin Thurm to Donna Shalala, Memo, 18 February 1994.
[47] John R Hall to Bruce Vladeck, Letter, 1 February 1994, Clinton Presidential Library Records, William Clinton Presidential Library.
[48] John R Hall to Bruce Vladeck, Letter, 1 February 1994.

the heart of TennCare." Other physicians argued that TennCare was simply a political ploy to get more votes by expanding the medical assistance rolls.[49]

Even though complaints from medical groups, such as the National Association of Public Hospitals, continued to arrive in Washington, members of HCFA noted that some progress was being made by late spring of 1994. In an April memo from Kevin Thurm to Carol Rasco, Thurm updated Rasco on TennCare's condition. He began by noting that "beneficiary participation has improved" and that "initial beneficiary and provider concerns about access appear to be diminishing." For example, during the month of March, fewer beneficiaries called HCFA and Tennessee hot lines to ask questions about provider participation and using managed care delivery systems. More importantly, areas throughout Tennessee, especially in parts of rural west Tennessee, experienced increases in provider participation. However, while these improvements were being made, signs of financial instability in the system began to emerge. For example, Tennessee's Medicaid director indicated that Med Access Plus, a MCO that operated throughout the state, was failing to pay claims on a complete or timely manner. Med Access Plus at the time was responsible for providing health care to 38 percent of TennCare's population. HCFA members, including Kevin Thurm, became increasingly concerned over this issue, since Med Access Plus' failure to control cost and pay health care providers threatened the financial viability of the entire TennCare system.[50]

As part of their legal responsibility, HCFA officials closely monitored TennCare's development. In fact, HCFA central and regional offices monitored "the

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[49] Dan Morgan, "Health Reform Battleground in Tennessee; Physicians Resent Loss of Autonomy in Plan," The Washington Post, 7 February 1994. sec. A.
[50] Kevin Thurm to Carol Rasco, Note, 8 April 1994. Clinton Presidential Library Records, William Clinton Presidential Library.

TennCare demonstration to an unprecedented degree." At least six site visits were conducted in late winter, while HFCA personnel remained in continual contact with state officials. For example, throughout the winter and early spring, HCFA received numerous reports from state officials detailing problems experienced by beneficiaries, all of which were investigated by the central and regional HCFA offices in Tennessee. At the same time, members of Congress, including Representative John Dingell, continued their inquiries into TennCare. Dingell requested that the Governmental Accounting Office (GAO), the investigative arm of Congress charged with investigating matters of accounting in government, launch a fact finding study of TennCare. In particular, Dingell wanted to know if TennCare had enough primary care physicians to assure adequate access, if it was reimbursing providers at adequate levels, and if enough federal and state monitoring and oversight efforts were in place in Tennessee. More importantly, Dingell wanted to know what influence TennCare would have upon other states seeking waivers.[51]

As TennCare completed its first quarter of operation in May 1994, it received harsh criticism from most members of the health care industry, including physicians and hospitals. For example, in a late April press release, the National Association of Public Hospitals (NAPH) argued that "Tennessee's new managed care system for the poor and uninsured is deeply flawed." NAPH President Larry Gage even believed that TennCare could lead to a serious deterioration of Tennessee's entire health care system. NAPH cited several key factors that contributed to TennCare's poor performance, including its early implementation date, its lack of administrational infrastructure to support managed care networks, and the inability of state officials to address the concerns and frustrations

[51] Kevin Thurm to Carol Rasco, 8 April 1994.

of Tennessee physicians. As a result, NAPH argued that "the provider networks established by the fledgling MCOs are largely insufficient to provide the necessary level of preventive, primary and hospital services to TennCare enrollees." TennCare's general disorganization had even caused some MCOs to engage in questionable and alleged illegal marketing practices. [52]

The findings of federal and state officials were less critical. In a memo sent from Bruce Vladeck to Carol Rasco on May 18, 1994, Vladeck noted that TennCare's enrollment process and access had improved. However, several problems were drawing the concerns of HCFA officials. In particular, certain areas of Tennessee lacked sufficient institutional infrastructure needed to properly monitor and review the performances of each MCO. HFCA officials also felt that some financial issues remained to be addressed, including the sharing of premium payments between patients, MCOs and the state. However, in general, HCFA members believed that "initial implementation problems that created beneficiary confusion…are receding." and that TennCare would be financially and operationally viable for the rest of 1994. [53] As expected, state officials held an even more optimistic opinion of TennCare's performance. In an August 1994 speech at the Southern Governors conference, Governor McWherter noted that "94.1 percent of Tennesseans now have health care coverage through private insurance, Medicare or TennCare," while Washington was still "talking about a goal of 95 percent coverage by the year 2002." McWherter also mentioned that the savings realized by TennCare's first

[52] National Association of Public Hospitals, Press Release, 28 April 1994. Clinton Presidential Library Records, William Clinton Presidential Library.
[53] Bruce Vladeck to Carol Rasco, Memo, 18 May 1994, Clinton Presidential Library Records, William Clinton Presidential Library.

fiscal year would allow the state to make important improvements to Tennessee's health care network.

The debate over how successful TennCare's design, implementation, and general success were during its first year continues. However, many of the problems TennCare encountered during the winter of 1994 can be attributed to errors made by Tennessee officials during the waiver approval process of 1993. First, many of the erroneous financial assumptions made by state officials, such as the ability of state-wide managed care networks to cut medical costs by 35%, placed MCOs across the state at financial risk. The per capita payment for each patient paid by Tennessee was too low. As a result, several MCOs, including Med Access Plus, were unable to pay health care providers in a timely or complete manner.

Tennessee officials also failed to work with state physicians and address their legitimate concerns. As a result, doctors throughout Tennessee were reluctant to participate in TennCare. Most remained uniformed and many suffered the same sense of confusion and frustration felt by Medicaid beneficiaries during the period of transition to TennCare. For example, in letter to Carol Rasco, Charles White, president of the Tennessee Medical Association, accused McWherter's administration of releasing vital information on TennCare "on a piecemeal basis in hopes the federal approval would be achieved prior to the discovery of TennCare's many flaws."[54] Furthermore, TennCare's contract with BCBST, which required doctors working in BCBST's network to serve TennCare enrollees, made many physicians throughout the state angry. In all, the various concerns and frustrations shared by Tennessee doctors kept a sufficient amount of

[54] Charles White to Carol Rasco, Letter, 11 October 1993. Clinton Presidential Library Records, William Clinton Presidential Library.

physicians from joining TennCare by the time of its official implementation on January 1, 1994. This in turn made access to TennCare within its first several months of operation problematic for many patients.

TennCare's early implementation date also greatly affected its ability to properly function and provide adequate health care. Throughout the summer and fall of 1993, members of HCFA asked Tennessee officials to delay TennCare's implementation. State officials were unwilling to do so, since a state provider tax, which generated $600 million annually, was set to expire in 1994. Tennessee officials needed to have TennCare operating by that time to prevent significant reductions in Medicaid services and access that could no longer be funded under Tennessee's traditional Medicaid program. Furthermore, by the time of TennCare's implementation date, most provider groups, especially the Tennessee Medical association, had "reversed their early position of cautious support and were attempting to block Tennessee's federal waiver." At the same time, media coverage had grown negative. As a result of these circumstances, the McWherter administration believed that "unless the state was already irrevocably committed to TennCare's implementation when the legislature reconvened in late January for its 1994 session, lawmakers would face irresistible pressure to revoke their earlier authorization of the program."[55]

Although these issues proved to problematic for TennCare, the special relationship between President Clinton and Governor McWherter provided McWherter with an invaluable advocate for TennCare. Yet, it is difficult to determine what effect McWherter's relationship with Clinton had upon TennCare's approval. At a minimum, it appears that Clinton was able to accelerate Tennessee's receipt of its federal waiver, since

[55] Bonnyman Jr., 307.

HCFA officials, convinced that certain financial and operationally issues remained unresolved, approved TennCare only reluctantly.[56]

In addition to its effect on Tennessee's health care system, TennCare also affected the Administration's national health care policy making. For example, the mechanisms TennCare used to expand health care coverage in Tennessee, including its broad application of managed care networks, shared many similarities with key provisions of the Administration's proposed Health Security Act. As a result, members of the White House were concerned that any future failures of TennCare could be potentially associated with the administration's national health reform efforts. These concerns proved warranted, since key members of Congress, including Democratic Representatives John Dingell and Henry Waxman, closely watched TennCare's implementation and made known that their support of Clinton's health reform bill was partly contingent upon the administration's handling of TennCare.

That said, TennCare did meet the basic goals it set out to accomplish, at least for a time. Health care coverage significantly expanded across Tennessee, while medical costs were contained and reduced. Even though patients throughout the state became irritated by the states' transition from traditional Medicaid services to TennCare, by mid 1994, most beneficiaries had accepted the new system, while previously uninsured individuals were readily joining TennCare.

[56] Bonnyman Jr., 307.

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