

Achieving a Critical Mission in Difficult Times – TennCare’s Financial Viability

Part 1 of a two-part report

December 11, 2003

This report was prepared by McKinsey & Company based on information provided by the state of Tennessee, TennCare, and a wide variety of other people and organizations with relevant knowledge. The information was evaluated but was not independently verified by McKinsey & Company. McKinsey’s assessment was prepared independently of the people and organizations that provided the information.

Achieving a Critical Mission in Difficult Times – TennCare’s Financial Viability

Executive summary of Part 1 of a two-part report

Launched in 1994, TennCare represents an historic effort to implement managed care for Tennessee’s entire Medicaid population and expand insurance coverage to the state’s uninsured and uninsurable residents. The program’s budget is growing rapidly, from \$6.1 billion in fiscal year 2002 to \$6.9 billion in fiscal year 2003, with the state paying \$2.1 billion of the latter amount. While this increase is not unique to Tennessee (Medicaid expenditures are rising everywhere), the program’s growing costs represent a very serious situation for TennCare and those who depend upon its services.

The state has taken several steps to address TennCare’s costs, but many stakeholders are still very concerned about the program’s financial viability. Given that concern, Governor Philip N. Bredesen asked BlueCross BlueShield of Tennessee, Hospital Corporation of America, the Farm Bureau, 22 hospitals within the Tennessee Hospital Association, and Vanderbilt University to fund an independent study to determine the extent of the problem and potential ways to address it.

The group engaged our firm, McKinsey & Company, to conduct an independent, objective assessment of TennCare’s financial viability over the next 5 years and, if necessary, to identify several strategic options for helping ensure financial viability while still meeting the program’s goal to provide quality healthcare to Tennessee’s neediest citizens. Our approach to this work included the development of a quantitative model based on a defined set of economic scenarios and assumptions, selected analyses, and interviews with more than 150 stakeholders in and experts on the TennCare program. We defined financial viability in terms of two measures of the program’s impact on the state’s overall financial situation: the portion of the state’s total tax appropriations consumed by TennCare’s costs and the portion of new tax appropriations consumed in each fiscal year by the growth in TennCare’s costs. A significant increase in these measures would raise serious issues about the program’s financial viability.

Our assessment is that, even with current and planned improvement efforts and solid program management, TennCare as it is constructed today will not be financially viable. Without additional reform, the program is projected to become so costly that by fiscal year 2008 the state will find it difficult, if not impossible, to both support TennCare and meet its obligations in other critical state programs. TennCare's costs could grow by as much as 80 percent by fiscal year 2008, and its cost growth could represent more than 80 percent of new state revenues in each of the 4 years leading up to that date.

- 1. Very costly program by fiscal year 2008.** Without additional reform, by fiscal year 2008 TennCare is likely to incur total costs of approximately \$12.2 billion, with \$3.8 billion in state spending, driven largely by pharmaceutical, professional services, and outpatient services costs and by enrollment growth that places demands on all parts of the program. These numbers assume moderate recovery in the overall economy, and they represent an increase from the total costs of \$6.9 billion, with state spending of \$2.1 billion, in fiscal year 2003 noted earlier.
- 2. Significant impact on the state's overall financial situation.** This growth has a significant impact on the state's overall financial situation. Again assuming moderate recovery in the overall economy, TennCare will consume 36 percent of total state appropriations in fiscal year 2008 (up from 25 percent in 2003), and its cost growth in that year will represent 91 percent of new state tax appropriations. Because certain temporary supports from the federal government will expire in 2004, the problem could be particularly acute in fiscal year 2005 when TennCare's cost growth could actually exceed the total new tax revenue dollars available to the state through the Department of Revenue.

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Our complete report, which we have prepared to help frame and support debate and discussion among TennCare's constituents and decision makers, follows.

Achieving a Critical Mission in Difficult Times – TennCare’s Financial Viability

Part 1 of a two-part report

TennCare represents an historic effort to implement managed care for Tennessee’s entire Medicaid population and expand insurance coverage to the state’s uninsured and uninsurable residents. Since its inception in 1994, the program has achieved considerable success in expanding coverage; one in four Tennessee residents is enrolled in today’s TennCare. The program has enjoyed somewhat less success on the operational front. Enrollment and eligibility verification have been an ongoing issue, and the unstable financial situation of several of TennCare’s managed care organizations has created a variety of problems.

But the most important challenge facing TennCare takes the form of the program’s rising costs and the very real threat they pose to its financial viability. TennCare’s budget is expanding rapidly, from \$6.1 billion in fiscal year 2002 to \$6.9 billion in fiscal year 2003, with the state paying \$2.1 billion of the latter amount. This cost growth is not unique to Tennessee. While Tennessee’s growth is particularly acute, virtually every Medicaid population in each of the 50 states is facing forecasts of increased medical costs. This broader problem provides important perspective, but it does not change what is truly a very serious situation for TennCare and those who depend upon its services.

While the state has recently taken several steps, such as creating a preferred drug list and reverifying eligibility, to address TennCare’s cost challenge, many stakeholders are still very concerned about the program’s financial viability.

Given that concern, Governor Philip N. Bredesen asked a group of stakeholders – BlueCross BlueShield of Tennessee, Hospital Corporation of America, the Farm Bureau, 22 hospitals within the Tennessee Hospital Association, and Vanderbilt University – to fund an independent study to determine the extent of the problem and potential ways to address it. The group engaged our firm, McKinsey & Company, in a focused effort to address two specific objectives.

1. Assess TennCare’s potential for financial viability over the next 5 years. Assuming successful implementation of current and planned improvement

programs, what is TennCare likely to cost the state of Tennessee during that time period, and what is the impact of that cost on the state's overall financial situation?

2. If TennCare's financial viability proves to be a problem, develop several strategic options for helping ensure financial viability while still meeting the program's goal to provide quality healthcare to Tennessee's neediest citizens. What kinds of initiatives can Tennessee pursue to reduce TennCare costs, and can those initiatives be combined into some number of strategic options that both meet identified stakeholder needs and are operationally feasible?

We were asked to assume, with respect to both objectives, that TennCare would receive no financial relief from new sources of external revenue. We did, however, consider internal sources of revenue such as copays and premiums. Our analysis does not assume any financial relief from the federal Medicare legislation that was passed as we were completing our work. The Congressional Budget Office projects only very modest new funds for the states, especially during the 2004 to 2008 time period of our analysis, and there is still a good deal of uncertainty about how the legislation will ultimately be interpreted and implemented.

Since our work was designed to help address strategic concerns, we did not conduct an historical review of the program's strengths and weaknesses or an operational and organizational audit aimed at developing a detailed view of topics such as pricing, fee schedules, network adequacy, or fraud and abuse.

Our team's analysis included developing a quantitative model based on a defined set of economic scenarios and assumptions to use in projecting TennCare costs and other relevant economic information and in building an understanding of what the state could do to restructure the program. We used raw data supplied by the Bureau of TennCare and others, supplemented with information about projected cost growth from independent sources, in our analyses. We interviewed more than 150 stakeholders in and experts on the TennCare program, including state and federal government officials, health insurance company representatives, healthcare providers, healthcare advocates, TennCare enrollees, and healthcare experts around the nation. The project's funders received no special treatment, in terms of either process or results, because of their role in the project.

We defined financial viability in terms of two measures of the program's impact on the state's overall financial situation: the portion of the state's total tax appropriations consumed by TennCare's costs and the portion of new tax appropriations consumed in each fiscal year by the growth in TennCare's costs. A

significant increase in these measures would raise serious issues about the program's financial viability.

Our assessment is that, even with current and planned improvement efforts and solid program management, TennCare as it is constructed today will not be financially viable. Without additional reform, the program is projected to become so costly that by fiscal year 2008 the state will find it difficult, if not impossible, to both support TennCare and meet its obligations in other critical state programs.

Without additional reform, TennCare is likely to incur total costs of approximately \$12.2 billion, with \$3.8 billion in state spending, by fiscal year 2008, driven largely by pharmaceutical, professional services, and outpatient services costs and by enrollment growth that places demands on all parts of the program. These numbers assume moderate recovery in the overall economy, and they represent an increase from the total cost of \$6.9 billion, with state spending of \$2.1 billion, in fiscal year 2003 noted earlier. Stated differently, we believe that TennCare's costs could grow by as much as 80 percent by fiscal year 2008.

This growth has a significant impact on the state's overall financial situation. Assuming moderate recovery in the overall economy, in fiscal year 2008 TennCare will consume 36 percent of total state appropriations (up from 25 percent in 2003), and its cost growth will represent 91 percent of new state tax appropriations. Again assuming moderate recovery in the economy, more than 80 percent of new state revenues will be consumed by TennCare growth in each of the 4 years leading up to fiscal year 2008. Because certain temporary supports from the federal government will expire in 2004, the problem could be particularly acute in fiscal year 2005 when TennCare's cost growth could actually exceed the total new tax revenue dollars available to the state through the Department of Revenue.

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We have prepared this report to help frame and support debate and discussion among TennCare's constituents and decision makers. Chapter 1 provides a description of the current TennCare program. Chapter 2 contains a detailed discussion of our assessment of the program's financial viability. Appendix A provides brief background material on our firm, and Appendix B provides details on our modeling methodology and assumptions.

The second part of our report, which we plan to release in January 2004, will outline a set of strategic options for helping ensure TennCare's financial viability while still meeting the program's goal to provide quality healthcare to Tennessee's neediest citizens.

1 The Current TennCare Program

TennCare was designed to expand medical coverage beyond the traditional definition of Medicaid. The state planned to achieve this goal by using managed care techniques across the traditional Medicaid population to generate cost savings that would in turn be used to provide care to Tennesseans who would not otherwise qualify for Medicaid. The idea was relatively new at the time of the program's inception in 1994, and it catapulted Tennessee to the forefront of Medicaid reform in the mid-1990s.

More specifically, Tennessee obtained a waiver from the federal government that allowed the state to receive matching funds for care delivered to nontraditional enrollees under the condition that the new program meet the constraint of budget-neutrality. That is, the Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services¹ (CMS), mandated that the TennCare program could not cost the federal government more than it would have paid to Tennessee in matching funds under the traditional Medicaid program.

Tennessee was granted a second² waiver for TennCare in 2002. Although myriad changes, administrative and substantive, were proposed in the TennCare II waiver, its primary modification was a two-tiered benefit design. Medicaid-eligible beneficiaries would continue to receive benefits as they had under the first TennCare waiver, but the expansion population would receive a less generous plan, TennCare Standard, which had some service limits and income level-based copays. These changes (which our work suggests would not alone have been enough to ensure TennCare's financial viability) were eliminated in mid-2003 as part of a broader effort to settle a series of lawsuits. As a result, today all TennCare enrollees receive essentially the same set of benefits, i.e., those benefits offered under the first waiver. Some members of the expansion population pay premiums and copays.

This chapter describes the essential characteristics of the current TennCare program: its broad eligibility, comprehensive medical benefits, progressive funding

¹ The federal agency responsible for the management and administration of Medicare and Medicaid

² The first TennCare waiver was extended twice

arrangement with the federal government, managed care organization (MCO) management of the provider base, and managed care payment and administration.

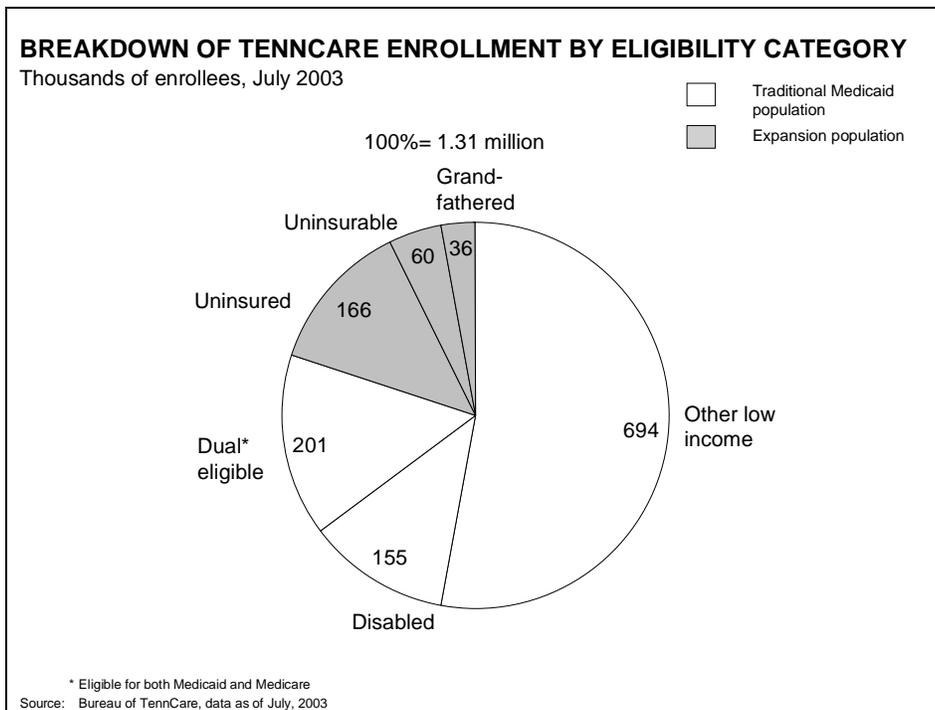
BROAD ELIGIBILITY

TennCare's approximately 1.3 million enrollees fall into two basic groups. The first and largest group is the program's traditional Medicaid population. It numbers just over 1 million enrollees and is composed of families on public assistance and other low income people who are either disabled, pregnant, or under the age of 19. It also includes people who are eligible for both Medicaid and Medicare³ (dual eligibles).

The other group is called the expansion population. It is composed of Tennesseans who are not eligible for traditional Medicaid: certain uninsured or uninsurable people and various "grandfathered" groups who continue to meet prior eligibility criteria⁴.

³ To be eligible for Medicare, one generally must have worked at least 10 years in Medicare-covered employment, be age 65 or older, and be a citizen or permanent resident of the United States; particular disabilities (e.g., end state renal disease) may qualify a person for Medicare prior to age 65

⁴ Grandfathered groups include people at any income level who had Medicare and TennCare (but not Medicaid) as of December 31, 2001, uninsured children under the age of 19 with incomes below 200 percent of the Federal Poverty Level (FPL) who had TennCare (but not Medicaid) as of December 31, 2001, and dislocated workers who had TennCare (but not Medicaid) as of June 30, 2002 as long as their family incomes are under 100 percent of the FPL for adults and under 200 percent of the FPL for children; people in each grandfathered group must continue to meet the eligibility criteria for that group



In July 2002, as part of the implementation of TennCare II, the Bureau of TennCare undertook a reverification effort⁵ to ensure that those individuals on TennCare continued to meet TennCare’s requirements and to correctly categorize enrollees in Medicaid-eligible and expansion categories. The Department of Human Services conducted the reverification, and TennCare funded the effort. As a result of the reverification, total TennCare enrollment declined and the proportion of Medicaid-eligible and expansion beneficiaries shifted. In July 2002, enrollment was approximately 1.4 million, with approximately 60 percent of enrollees categorized as Medicaid-eligible and approximately 40 percent categorized as expansion enrollees.

By May 2003, enrollment declined to 1.3 million, with approximately 80 percent categorized as Medicaid-eligible and approximately 20 percent categorized as expansion enrollees. The reverification process revealed that many expansion enrollees were actually Medicaid-eligible and that a smaller number did not qualify for either program and/or did not respond to requests to verify their eligibility. Per the terms of the TennCare II waiver, this reverification process is scheduled to take place on an annual basis.

⁵ The reverification effort also involved new, lower income levels for uninsured people

Medical spending within the TennCare population is not uniformly distributed. In a representative sample of medical claims⁶, over 75 percent of medical expenses are driven by just 15 percent of enrollees.

Traditional Medicaid population

The approximately 1.05 million enrollees in TennCare’s traditional Medicaid population can be further segmented into two groups: the mandatory population and the optional population. (The data needed to classify Medicaid enrollees as mandatory or optional is not readily available, so we are unable to show the enrollment breakdown between the two groups.)

1. Mandatory population. The mandatory population, as the name suggests, per CMS requirements must be included in the Medicaid program of any state that chooses to offer Medicaid (all 50 states). Mandatory beneficiaries include low-income families with children who qualify for public assistance, disabled and elderly people who are Supplemental Security Income (SSI) recipients, specific groups of low-income Medicare beneficiaries, and pregnant women with family income under 133 percent of the Federal Poverty Level (FPL)⁷. Also included are children whose eligibility varies according to their age and their family’s income. In addition, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires that Medicaid programs provide certain services for persons on Medicaid under age 21 even if those services are not available to the rest of the Medicaid population. Among other services, this includes dental services, organ transplants, and private duty nursing.

2. Optional population. The optional population is eligible to receive federal matching dollars for state money spent on qualifying services, but coverage of this population is at the state’s discretion. Among other classifications, optional beneficiaries include the medically needy⁸, low income institutionalized individuals, and women with breast or cervical cancer. Every state provides coverage to some optional population groups.

⁶ Analysis based on an anonymous sample of 30,000 enrollees, corrected to account for portion of TennCare enrollees with no medical encounter in the past 3 years

⁷ 2003 federal poverty level for the 48 contiguous states and the District of Columbia: \$8,980 for family of 1, \$12,120 for family of 2, \$15,260 for family of 3, \$18,400 for family of 4; incremental \$3,140 per additional family member

⁸ Often referred to as the “spend-down” population, the medically needy are beneficiaries whose resources have been depleted by medical expenses to specified levels and who fall into certain qualifying categories, e.g., aged, blind, or disabled; pregnant women or children under 18; certain caretaker relatives of dependent children

Expansion population

Tennessee's waiver agreement with CMS allows the state to expand its coverage beyond the traditional boundaries of Medicaid eligibility. There are approximately 260,000 enrollees in the current expansion population, approximately 20 percent of the total TennCare membership.

This group is eligible for federal matching funds for which they would not normally qualify under Medicaid rules. For example, under its current waiver, and if an open enrollment period is declared, Tennessee can cover uninsured people with incomes of up to 200 percent of the FPL and uninsurable people at any income level who are deemed medically eligible by virtue of having one of several specific qualifying conditions (e.g., Alzheimer's disease, epilepsy, congestive heart failure) and have no access to employer-sponsored health insurance. Uninsured and uninsurable members with incomes above the poverty level pay premiums as well as copays for most services. The current expansion population also includes enrollees who have been "grandfathered" into the program because they were eligible for TennCare as of December 31, 2001 and continue to meet the qualifying criteria for that time frame.

Tennessee has the latitude to control the growth of the expansion population (unlike the mandatory Medicaid-eligible portion of the population) based on available funds. Specifically, Tennessee can declare periods of "open" and "closed" enrollment under the current waiver. In general, new enrollees can only join the expansion population during a period of open enrollment; there has been no open enrollment since the inception of the current waiver in July 2002. Even though enrollment has been closed since the inception of that waiver, qualifying uninsurable Tennesseans below the poverty limits can be enrolled at any time. Uninsured children under age 19 from families with incomes less than 200 percent of the FPL can enroll at any time.

Under the previous waiver, Tennesseans were eligible to join the expansion population with a qualifying letter from an insurer stating that they were, in fact, uninsurable. This process led to highly publicized claims of abuse. Current administrative procedures are designed to address these concerns in two ways. All potential beneficiaries seeking uninsurable status undergo a mandatory state examination of their medical records, and the reverification process is structured to confirm eligibility for the entire expansion population each year. Reverification has led to disenrollment and reclassification among the uninsurable population. The number of uninsurables is currently about 60,000, down from 110,000 in September 2002. Some enrollees previously classified as uninsurable were found to be Medicaid-eligible upon reverification and have been reclassified as part of the

Medicaid membership. It should be noted however, that Tennessee still has more uninsuredables enrolled in Medicaid than does any other state.

COMPREHENSIVE MEDICAL BENEFITS

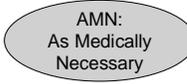
TennCare offers comprehensive medical benefits to its enrollees. Like all states, Tennessee offers mandatory services and some optional services, so its resulting service mix is similar to that of other states. Mandatory services include the inpatient, outpatient, professional, and home healthcare services that must be offered by any state administering a Medicaid program. Optional services are those services that a state may offer at its discretion; they include pharmacy, behavioral health, mental retardation, dental, and institutional (level 1) long-term care services⁹.

TennCare covers claims based entirely on “medical necessity,” with no practical limit to the amount of services used by enrollees. The current design has copays only for expansion population enrollees, and no caps on benefits for either group. As a result, the actual coverage offered by TennCare within each specific service category is relatively generous. For example, Alabama’s Medicaid enrollees are limited to 16 days of inpatient hospitalization per year; TennCare has no such limit on inpatient days. North Carolina limits Medicaid enrollees to six prescriptions per month; again, TennCare enrollees have no such limits. TennCare places few limits on specific benefits, such as pharmacy. The TennCare program operated without a pharmaceutical formulary¹⁰ or preferred drug list from 2000 to mid-2003.

⁹ Skilled nursing facilities (SNFs) are mandatory under Medicaid

¹⁰ A formulary is an approved list of selected pharmaceuticals and dosages felt to be the most useful and cost effective for patient care

| TENNCARE BENEFITS RELATIVE TO OTHER SELECTED MEDICAID PROGRAMS | | | | | | |
|--|--|---|--|---|---|---|
| Service | TennCare | Pre-TennCare Medicaid | Texas | Alabama | Massachusetts | California |
| Inpatient | <ul style="list-style-type: none"> • AMN • \$100-200/admit**** | <ul style="list-style-type: none"> • Provider rates drop after 20 days | <ul style="list-style-type: none"> • 30 days per 60-day period* | <ul style="list-style-type: none"> • 16 days/year • \$50/admission | <ul style="list-style-type: none"> • AMN | <ul style="list-style-type: none"> • AMN |
| Outpatient | <ul style="list-style-type: none"> • AMN • \$5-25 copay**** | <ul style="list-style-type: none"> • 30 visits/year | <ul style="list-style-type: none"> • AMN | <ul style="list-style-type: none"> • 3 visits/year • \$3 copay | <ul style="list-style-type: none"> • \$3 ER copay if non emergency | <ul style="list-style-type: none"> • \$5 ER copay if non emergency • \$1 non-ER copay |
| Professional | <ul style="list-style-type: none"> • AMN • \$5-25 copay**** | <ul style="list-style-type: none"> • 24 visits/year | <ul style="list-style-type: none"> • AMN** | <ul style="list-style-type: none"> • 14 visits/year • \$1 copay | <ul style="list-style-type: none"> • AMN | <ul style="list-style-type: none"> • \$1 copay |
| Home health care | <ul style="list-style-type: none"> • AMN | <ul style="list-style-type: none"> • 60 visits/year | <ul style="list-style-type: none"> • 50 visits/year | <ul style="list-style-type: none"> • 2 visits/week • \$1 copay | <ul style="list-style-type: none"> • short period immediately after hospital discharge | <ul style="list-style-type: none"> • 30 visits per 4 months, with \$1 copay |
| Pharmacy | <ul style="list-style-type: none"> • AMN • \$5/10**** | <ul style="list-style-type: none"> • 7 scripts/month | <ul style="list-style-type: none"> • 3 scripts/month*** | <ul style="list-style-type: none"> • \$0.50 to \$3.00 copay based on Rx cost | <ul style="list-style-type: none"> • \$2 copay | <ul style="list-style-type: none"> • \$1 copay |



* Maternity limited to 24 hours, and maximum provider reimbursement of \$200,000/year per beneficiary
** Annual physicals for adults not covered
*** Up to 6 months' supply may be dispensed per script
**** Copays required for expansion population enrollees with income >100% poverty only
Note 1: By federal regulations, copays do not apply to pregnant women, institutionalized persons, or children; and benefit limits must be lifted for children when additional services are medically necessary
Note 2: Hospitals in the Texas, Alabama, Massachusetts, and California receive DSH payments, those in Tennessee do not
Source: Bureau of TennCare; Texas, Alabama, Massachusetts, and California Medicaid websites; McKinsey team analysis

TennCare’s medical benefits can be grouped into three categories: comprehensive medical care benefits; behavioral health benefits; and long-term care benefits.

Comprehensive medical care benefits

This category includes the four mandatory services of inpatient, outpatient, professional, and home health care and two optional categories, pharmacy and dental care¹¹.

1. Inpatient care refers to care given to a registered bed patient in a hospital or post-acute care facility. It includes treatment and procedures typically associated with hospitalization, e.g., childbirth, heart surgery. TennCare offers inpatient coverage with no limitation on number or type of hospital days.

2. Outpatient care refers to care given to a person who is not assigned a hospital bed. It includes treatment and procedures such as colposcopy, cardiac catheterization, and endoscopy. As with inpatient care, TennCare has no limit on the number or type of outpatient services used by enrollees.

3. Professional care refers to services provided by physicians themselves (both primary care physicians and specialists), in the confines of their offices or the

¹¹ Dental care is required for Medicaid children under age 21 per EPSDT requirements

hospitals in which they practice. For the purposes of our work, professional services also includes transportation, lab/radiology, and durable medical equipment. TennCare places no limit on the number or type of professional services its enrollees use.

4. Home health care refers to a range of healthcare services, including physical therapy and counseling delivered in a patient's home. TennCare places no limit on the number or type of home health care services used.

5. Pharmacy refers to the delivery of outpatient and retail prescription drugs. There are no limits on the number or type of prescriptions that TennCare will cover. TennCare instituted a preferred drug list in 2003.

6. Dental refers to services provided by dentists or other dental professionals for the care of the mouth and teeth. TennCare provides dental screenings and treatment to all children under age 21 and limits care for adults to emergency care. TennCare has recently carved-out its dental services to Doral, a dental benefits manager (DBM).

Behavioral health benefits

TennCare benefits also include this optional service, which refers to the treatment of the mentally ill. Behavioral health benefits include pharmaceutical and non-pharmaceutical (inpatient, outpatient, professional, supplemental housing, and transportation) services. TennCare's behavioral health benefits have no utilization limits.

Long-term care benefits

This group contains two types of services: mental retardation services and certain home and community-based alternatives to institutionalized care. While the first category is optional, the second contains some optional services (e.g., intermediate care facilities) and some mandatory services (e.g., skilled nursing facilities.)

1. Mental retardation refers to a range of services provided to the mentally retarded. It includes spending on state and private intermediate care facilities (ICF/MR) and home and community-based services for the mentally retarded.

2. Long-term care is composed primarily of nursing home care for the elderly, but it can also refer to extended care provided to the disabled, regardless of age. This category also includes certain home and community-based alternatives to

institutionalized care. TennCare is piloting a small amount of home and community-based care.

PROGRESSIVE FUNDING ARRANGEMENT WITH FEDERAL GOVERNMENT

Like every Medicaid program, TennCare receives money from the federal government to help fund the cost of providing care to its neediest citizens. CMS manages these federal funds. Tennessee draws matching dollars from CMS by spending its own (state) dollars on delivery of care for qualified TennCare recipients. The federal government then contributes money on a matching basis. In Tennessee's case, care delivered to those recipients not traditionally covered by Medicaid, but included in TennCare's waiver with CMS, also qualifies for matching funds.

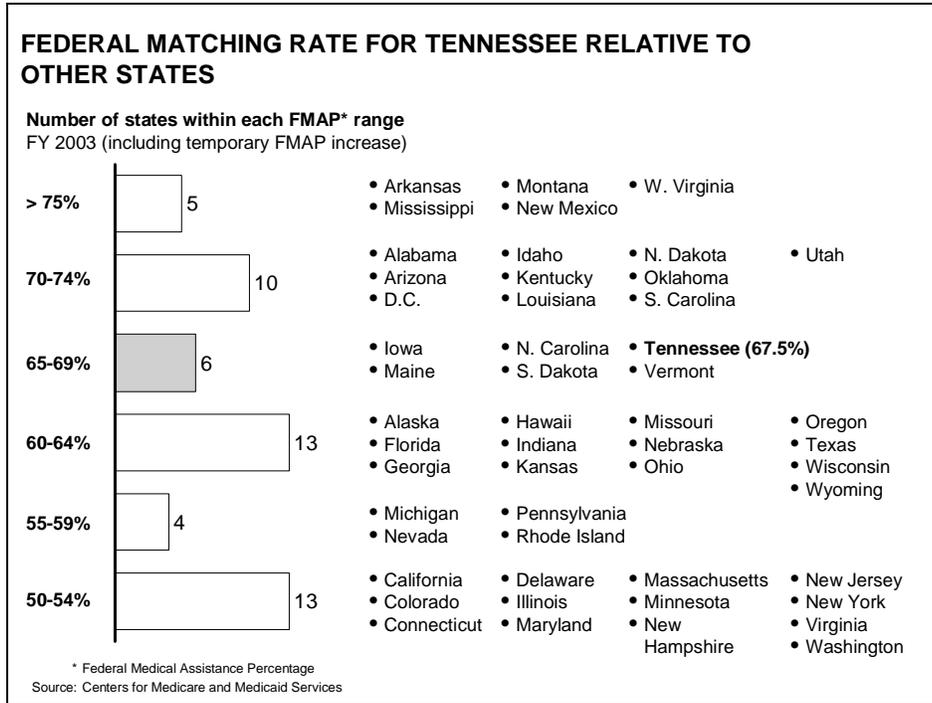
The rate at which funds are matched is determined by Tennessee's relative position among the other states in terms of personal income. CMS uses a national formula to set the match rate, which is called the Federal Medical Assistance Percentage (FMAP), for each fiscal year. States that rank highest in terms of their citizens' personal income receive the lowest match rate (relative to all others), and vice versa. The federal government contributes no less than 50 percent of a state's qualified spending, and no more than 83 percent of that spending. The percentage determined by the national formula applies to most of a state Medicaid agency's spending (i.e., medical cost). Some spending categories are matched at rates other than the FMAP, e.g., administration is matched at 50 percent, certain spending on information technology is matched at 90 percent, as is the operation of a fraud and abuse control unit. Overall CMS wants to ensure that any waiver meets the test of budget neutrality: that inclusion of the expansion population cannot lead to higher managed care costs¹² than those costs would have been without the expansion population.¹³

Currently, Tennessee's basic match rate is 67.54 percent. Generally speaking, this means that the federal government pays for nearly 68¢ of every dollar spent on delivery of care to TennCare recipients. Said differently, CMS currently provides approximately \$2 for every \$1 spent by the state. This match rate includes the

¹² Includes inpatient, outpatient, professional, home health care, dental, pharmacy (BHO and non-BHO), and non-pharmacy BHO costs and supplemental payments

¹³ Budget neutrality under the current TennCare waiver requires TennCare per-member-per-month costs to grow no larger than \$404 for those enrollees over age 65, \$987 for the disabled, \$313 for children, \$613 for adults, and \$230 for dual eligibles by fiscal year 2007

temporary enhancement made by CMS as part of the Jobs and Growth Tax Relief and Reconciliation Act of 2003 (TRRA), which raises Tennessee’s match rate temporarily to 67.54 percent. After June 30, 2004, the match rate will be recalculated based on the standard methodology.



Because TennCare operates under a waiver from CMS, some aspects of its financing differ from traditional Medicaid. For example, physicians and hospitals in every state provide some care at no cost to the patient due to the patient’s inability to pay. Under traditional Medicaid programs, this charity care is partially refunded by the federal government through a Disproportionate Share (DSH) payment. Those hospitals that have provided the most documented charity care receive the most reimbursement. These DSH payments are composed of state dollars matched (at the state’s standard match rate) by federal dollars. Under TennCare’s waiver, the federal government provides a payment called Certified Public Expenditure (CPE) that is meant for the same purpose. Unlike DSH, CPE is not distributed to hospitals, but rather goes to the Bureau ofTennCare for distribution. The CPE payment has been between \$150 million and \$200 million since fiscal year 2000 and is budgeted to be \$210 million in fiscal year 2004.

MCO MANAGEMENT OF PROVIDER BASE

Fundamental to the TennCare design, MCOs act as an intermediary between the state and providers for a defined set of services (i.e., inpatient, outpatient, professional, home health care, and, historically, nonbehavioral health pharmaceutical services). The state deals directly in the provision of long-term care and mental retardation services, and various carve-outs deal with services such as behavioral health.

Within their designated geographic regions, these intermediaries are responsible for developing and maintaining provider networks and negotiating payment rates with providers. In return for a fixed amount of money, called a capitation fee, for each designated enrollee, MCOs were responsible for using no more than that sum, on average, to reimburse providers for care for their membership. Although later adjusted to institute a minimum medical expenditure level in 2001 (i.e., MCOs were required to pay at least 85 percent of their capitation fee revenue in medical expenses), the system was designed on a full risk basis with no additional state payments if costs exceeded expectations and with all unused sums contributing to MCO profit.

In theory, this intermediary design was intended to minimize the provider-related administrative burden to the state while providing a strong incentive for MCOs to manage care. In practice, however, MCO control has been limited for a variety of reasons, including a healthcare system traditionally dominated by a fee-for-service approach, several inexperienced MCOs, and confusion and dissatisfaction among patients and providers. Additionally, court supervision imposed by lawsuits¹⁴ limited TennCare's ability to deny appeals for provision of various services. This has led to less than effective management of utilization and no strong incentive to ensure adequate provider panels.

While falling outside the confines of our particular study, it is important to note that access has become a growing concern in the last few years. This appears especially true in rural areas and for particular physician specialties (e.g., orthopedics, pediatric cardiology). Dissatisfaction with payments, coupled with burdensome administration, raises the risk of critical defections, especially among key specialists and selected hospitals. Although essential access payments are intended, in principle, to provide additional reimbursement to these important institutions, the

¹⁴ TennCare has been subject to a number of legal challenges, including most notably *Grier v. Wadley* (previously *Daniels v. Wadley*), which resulted in a 1996 ruling on the right of Medicaid beneficiaries to contest MCO denials of care

formula for distribution is set at the state level and does not appear to be strictly tied to levels of charity care delivered.

The program's inclusion of multiple and often inexperienced MCOs resulted in highly variable provider payment rates across the state and, ultimately, a series of high-profile MCO bankruptcies that left providers absorbing financial losses for millions of dollars in unpaid claims. These events triggered the state's assumption of ultimate responsibility for provider rates in 2000 and allowed MCOs to move to an administrative services only (ASO) model in July 2002. Although still highly variable across geographic regions and across individual payors, provider rates have been frozen for the past 2 years.

MANAGED CARE PAYMENT AND ADMINISTRATION

Consistent with the program's fundamental notion of using private managed care organizations to reduce costs in order to increase eligibility, the majority of TennCare's payment and administration activities are handled by private organizations. A relatively small amount of TennCare's costs flow more directly to enrollees through various public agencies.

Private organizations

Four types of private organizations handle the majority of TennCare's payment and administration work: managed care organizations, behavioral health organizations¹⁵ (BHO), a dental benefits manager, and more recently, a pharmacy benefits manager¹⁶ (PBM).

1. Managed care organizations. TennCare's MCOs range in size from BlueCross BlueShield of Tennessee, the largest, with over half of the entire TennCare enrollment, to VHP, with only 2 percent of TennCare's enrollment. TennCare currently uses seven MCOs¹⁷; it had used several others that became insolvent, particularly in central Tennessee (i.e., Xantus, Access Med Plus).

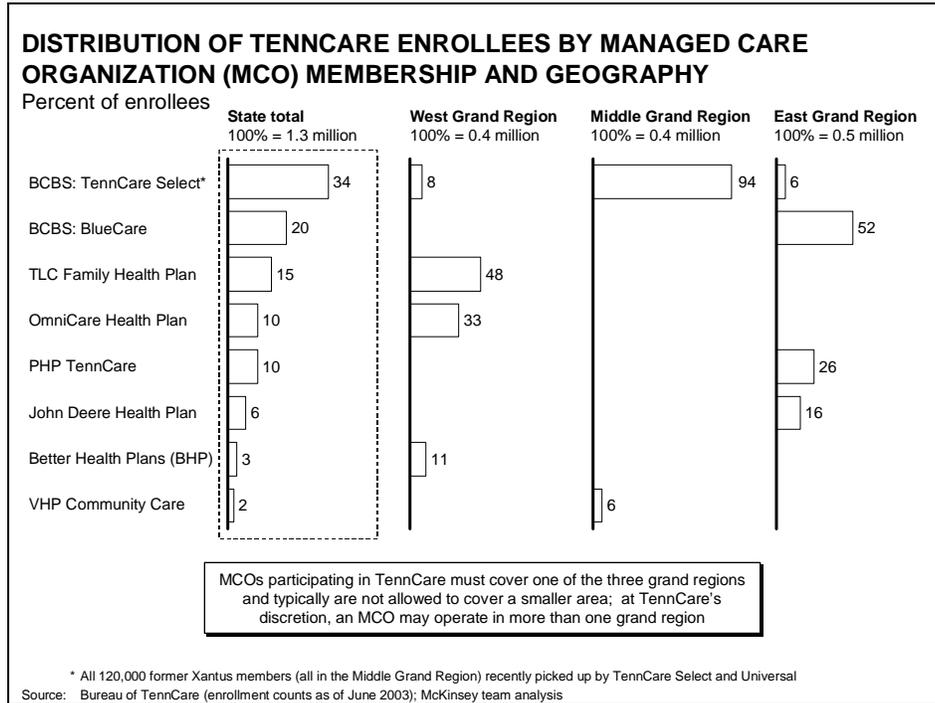
Except for the TennCare Select plan administered by BlueCross BlueShield and originally designed as a back-up plan for enrollees who lived in areas with

¹⁵ Tennessee Behavioral Health and Premier

¹⁶ As of January 1, 2004, TennCare's PBM will be First Health Services Corporation

¹⁷ As of the time of the writing of this report, participating MCOs are: BlueCross BlueShield of Tennessee, Memphis Managed Care (TLC Health Plan), Omnicare, PHP, John Deere, Better Health Plans, and VHP

insufficient MCO coverage and for special populations with complex needs (e.g., children in state custody), MCOs are focused in particular regions (sometimes called divisions) of the state. Most of Blue Cross's TennCare membership is in the eastern and middle portions of the state, while Memphis Managed Care (TLC Health Plan) and OmniCare split the bulk of the western region enrollment.



TennCare uses managed care organizations to administer most acute care to its enrollees (i.e., inpatient, outpatient, professional, home health care, and nonbehavioral pharmaceutical care). This arrangement means that the MCOs handle claims processing and act as the payor, on behalf of the enrollee, to various healthcare providers.

Before July 1, 2002, all MCOs with the exception of TennCare Select were at risk for the healthcare costs associated with their respective enrollees. This meant that the MCOs would receive an agreed-upon payment for each TennCare member on their rolls (and no more), and that the MCO itself bore responsibility for paying that enrollee's healthcare bills from that allotment.

As a result of the state assuming financial risk for the TennCare enrollee population in July 2002, the MCOs have essentially reverted to an ASO role, in which they continue to process claims but pass all enrollee medical expenses through to the state.

2. Behavioral health organizations. Behavioral health services are also managed by a third party on behalf of the state. The behavioral health organizations receive capitation payments to provide and manage behavioral health services on behalf of TennCare enrollees. Unlike the MCOs that act as administrative processors for the state, one of the two BHOs is currently still partially at risk for patient expenses; the other is not. The BHO contract is currently out for bid.

3. Dental benefits manager. Although dental spending is a relatively small component of the total TennCare program (less than 2 percent of total spending), the state has taken actions to control its growth. In fiscal year 2003, TennCare carved out dental benefits to Doral, a dental benefits manager. This action is meant to achieve cost savings by leveraging the expertise of a specialist organization, just as in MCO spending. The use of a DBM will also help expand TennCare's provider network and help the state meet the EPSDT requirements set forth by Medicaid.

4. Pharmacy benefits manager. The state recently awarded a contract to First Health Services Corporation, a pharmacy benefits manager, to take over the administration of TennCare's pharmaceutical benefits. In addition to running the program, the PBM will also help TennCare reduce its prescription drug costs through negotiated, "supplemental" rebates from pharmaceutical manufacturers. These rebates are common overlays on top of federal legislation guaranteeing "best price" for pharmaceuticals purchased by Medicaid programs. Through its preferred drug list, TennCare hopes to leverage its PBM's expertise in managing prescription patterns and utilization to promote the use of pharmaceuticals that are "preferred" based on an evaluation of clinical efficacy and price.

Public agencies

A relatively small amount of TennCare's expenditures are paid within the state government, i.e., to other state agencies for services provided to the Bureau of TennCare itself or, more commonly, to TennCare enrollees. For some of these agencies (e.g., Department of Children's Services), TennCare spending represents a significant amount of total funding.

The largest of the intragovernmental payments is made to the Division of Mental Retardation for the delivery of care to mentally retarded enrollees. TennCare estimates that total fiscal year 2004 payments to this agency will exceed \$500 million.

Another large payment flows to the Department of Children's Services for the administration and delivery of care to children in the TennCare program. TennCare also pays the Department of Human Services to administer eligibility

determinations and the Department of Health for various outreach efforts, including administration of local dental health programs¹⁸.

Smaller payments are made to the Department of Finance and Administration for IT systems costs, the Department of Commerce and Insurance for MCO and BHO oversight, and to various other agencies such as the Commission on Aging and the Tennessee Department of Mental Health and Developmental Disabilities (TDMH/DD).

¹⁸ This is an ~\$8 million preventive dental health program, and it is distinct from dental services in general

2 TennCare's Financial Viability

TennCare's relatively comprehensive approach to meeting the healthcare needs of Tennessee's neediest citizens is proving to be a costly venture. TennCare represents – and will continue to represent – one of the largest components of Tennessee's spending.

Our team looked at TennCare's likely future costs in three economic scenarios, each with explicitly defined assumptions: a "fast recovery" scenario that is essentially an optimistic case, a "moderate recovery" scenario that creates a base case, and a "recession" scenario that represents a pessimistic case. Under each scenario, albeit to different degrees, the current TennCare program (i.e., with current and planned improvements but no additional reform) has large absolute and relative costs.

We estimate that total costs will be \$11.8 billion to \$12.6 billion in fiscal year 2008, with state funds accounting for \$3.7 billion to \$3.9 billion of those total costs. These estimates represent an increase from \$6.9 billion in total TennCare costs, with \$2.1 billion in state spending, in fiscal year 2003. These numbers also represent an increase in the portion of total state tax appropriations¹⁹ consumed by TennCare, from 25 percent in fiscal year 2003 to 34 to 40 percent in fiscal year 2008. Cost growth in fiscal year 2008 is projected to represent from 63 to 144 percent of new state tax appropriations in that year. In the moderate recovery scenario, growth in TennCare costs will consume more than 80 percent of new state tax revenues in each of the 4 years leading up to that date.

The projected increase in TennCare costs, and thus the threat to the program's financial viability, is largely the result of expected spending for pharmaceuticals, professional services, and outpatient services and of the demands placed on all parts of the program by growing enrollment. These growth factors are all influenced, although in different ways, by the same root causes: various elements of TennCare's program design, the general healthcare environment, and some aspects of program execution.

¹⁹ Tax appropriations included were Sales & Use, Gasoline, Motor Fuel, Gasoline Inspection, Motor Vehicle Registration, Income, Privilege, Gross Receipts-TVA, Gross Receipts-Other, Beer, Alcoholic Beverage, Franchise, Excise, Inheritance & Estate, Tobacco, Motor Vehicle Title, Mixed Drink, Business, Severance, and Coin Amusement; non Department of Revenue taxes were excluded, as were tuitions and bonds

Although our team believes that the three economic scenarios used in estimating TennCare costs represent a range of reasonable outcomes, it is important to note that they do not, of course, represent the outer boundaries of what could be possible. For example, a variety of national and state-level factors, e.g., changes to federal Medicaid matching policies or higher-than-predicted growth in Medicaid enrollment, could lead alone or in combination to an outcome that is substantially worse than our recession scenario predicts. So could a repeat of relatively recent history. If TennCare were to grow through fiscal year 2008 at the rate at which it grew between fiscal years 2000 and 2003, total fiscal year 2008 costs would be \$13.7 billion and total fiscal year 2008 state spending would be \$4.3 billion, numbers that are significantly worse than those in our recession scenario. On the other hand, factors such as slower-than-anticipated growth in medical cost increases or increases to Tennessee's federal match rate in future calculations could lead to a more favorable picture for TennCare's financial viability than our fast recovery scenario paints.

LARGE COMPONENT OF TENNESSEE SPENDING UNDER ANY OF THREE LIKELY ECONOMIC SCENARIOS

Our team began its analytical work to assess TennCare's financial viability by using available historical data to construct an economic model of the current program. We then obtained a number of forecasts for future Medicaid spending and enrollment and incorporated those forecasts into the model to calculate future expenses. Some of the future Medicaid spending and enrollment forecasts were directly applicable to TennCare, e.g., MCO per member per month (PMPM) costs were projected at TennCare's historical rates. Others were based on national averages, which we adjusted to apply more directly to TennCare, e.g., Medicaid cost growth for various types of services was obtained from CMS, growth in BHO pharmacy spending was based on commercial forecasts adjusted to TennCare actual drug composition and historical growth rate. We combined the unit cost and enrollment forecasts within the TennCare-specific model to project total program costs through a forecast period of 5 fiscal years. We chose this time horizon because it was long enough to encompass the duration of the current TennCare waiver (which expires in fiscal year 2007), but short enough to be supported by meaningful external projections. We assumed that the current waiver would continue through fiscal year 2008.

Given our definition of financial viability, we then compared the cost projections to projected available funds in two ways: by calculating the simple percentage of the total state budget consumed by TennCare in the final year of the forecast and by

calculating the portion of newly available state revenues consumed by growth in program costs in each fiscal year prior to and including the final year of the forecast.

We varied two critical inputs to the model across the three economic scenarios: the unemployment rate in Tennessee and state tax revenue growth. We assumed that the unemployment rate would rise in accordance with the pessimism of the scenario. This unemployment rate assumption is linked to the Medicaid enrollment portion²⁰ of the total TennCare enrollment forecast through simple regression²¹. We defined state tax revenues as those associated with the Department of Revenue. We based state tax revenue assumptions on those provided by Dr. William Fox, Professor of Economics at the University of Tennessee and Director of the Center for Business and Economic Research, modifying those assumptions in building the economic scenarios. We varied state tax revenue growth across the economic scenarios by adjusting growth rates for the state Sales & Use tax. Although this variable does not directly affect the forecast for TennCare costs, it does affect the available state funding. We used the same assumptions about PMPM medical costs in all three scenarios. (As mentioned earlier, Appendix B provides details on our modeling methodology and assumptions.)

Our analysis led to the following assessment of TennCare's costs and their impact on state finances.

- ¶ In the fast recovery scenario, total TennCare costs in fiscal year 2008 will be \$11.8 billion. State spending on TennCare in that year will be \$3.7 billion, a number that represents just under 34 percent of state tax revenue. Cost growth in fiscal year 2008 will consume 63 percent of new state tax appropriations in that year.
- ¶ In the moderate recovery scenario, total TennCare costs in fiscal year 2008 will be \$12.2 billion. State spending on TennCare in that year will be \$3.8 billion, a number that represents over 36 percent of state tax revenue. Cost growth in fiscal year 2008 will consume 91 percent of new state tax appropriations in that year.
- ¶ In the recession scenario, total TennCare costs in fiscal year 2008 will be \$12.6 billion. State spending on TennCare in that year will be \$3.9 billion, a number that represents just under 40 percent of state tax revenue.

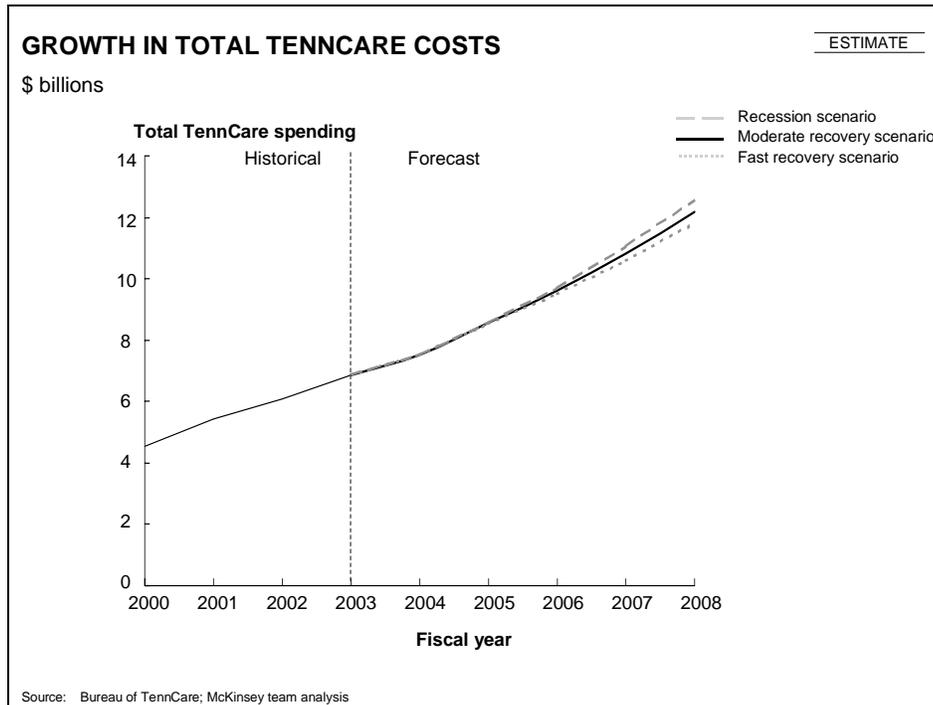
²⁰ We assumed that no open enrollment would be declared for the expansion population, thus only the Medicaid portion could grow significantly; we assumed some growth in the expansion population, driven by growth in uninsurables

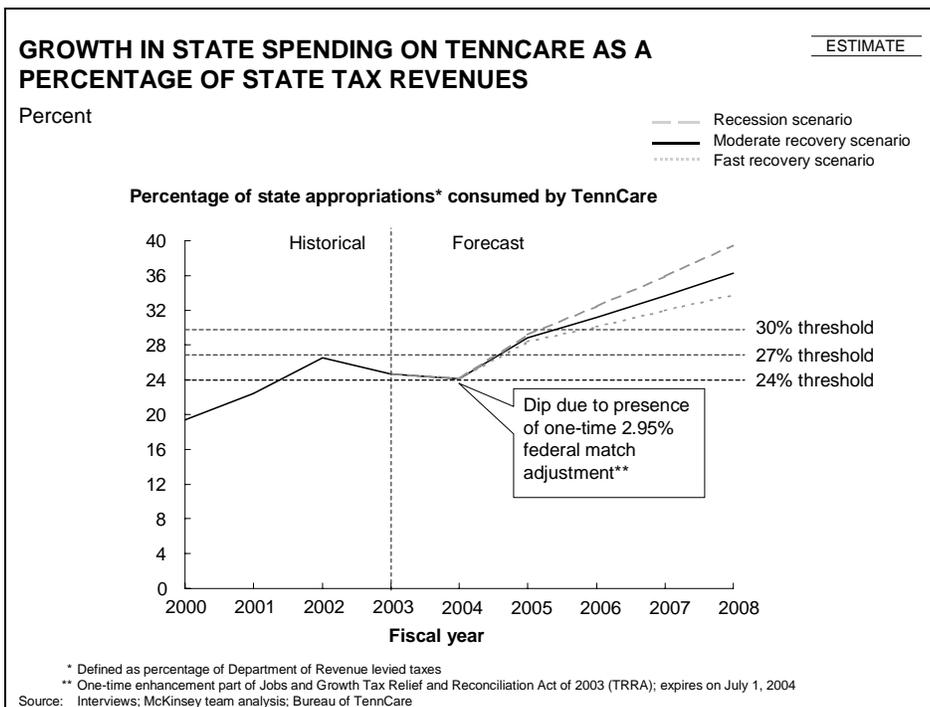
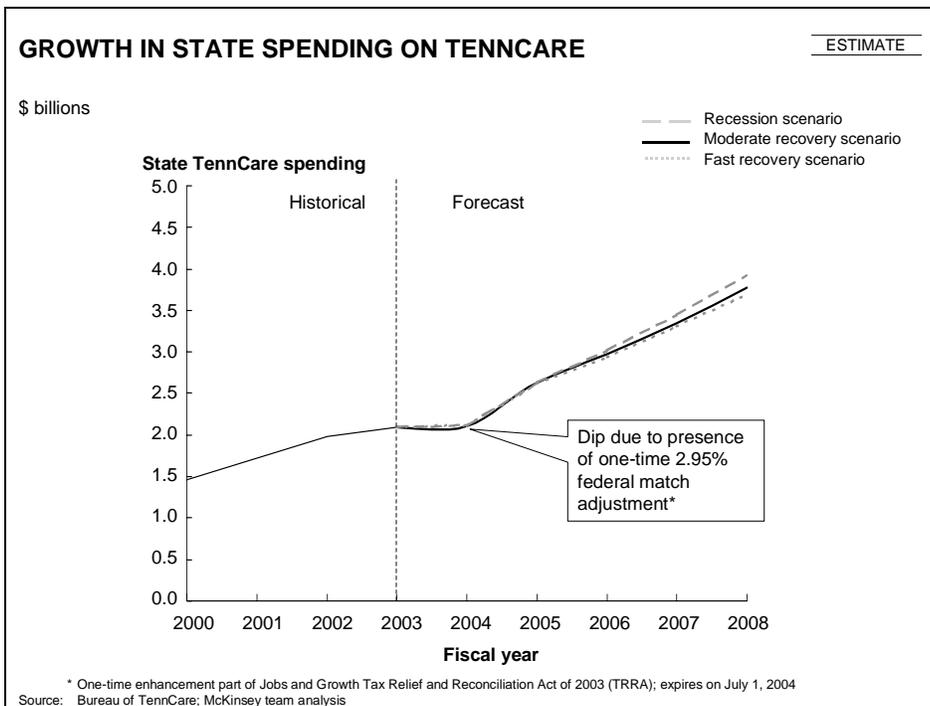
²¹ Based on historical enrollment trends in periods of economic growth, we held enrollment constant (rather than dropping it) when the unemployment rate forecast dropped

Cost growth in fiscal year 2008 will consume 144 percent of new state tax appropriations in that year.

By way of comparison, as noted earlier, in fiscal year 2003 total TennCare costs were \$6.9 billion. The state was responsible for \$2.1 billion of those costs, a number that represented 25 percent of state tax revenue in that year.

The next three exhibits show recent and estimated (i.e., forecasts for the three scenarios) future growth in total TennCare costs, in state spending on TennCare, and in state spending on TennCare as a percentage of state tax revenues.



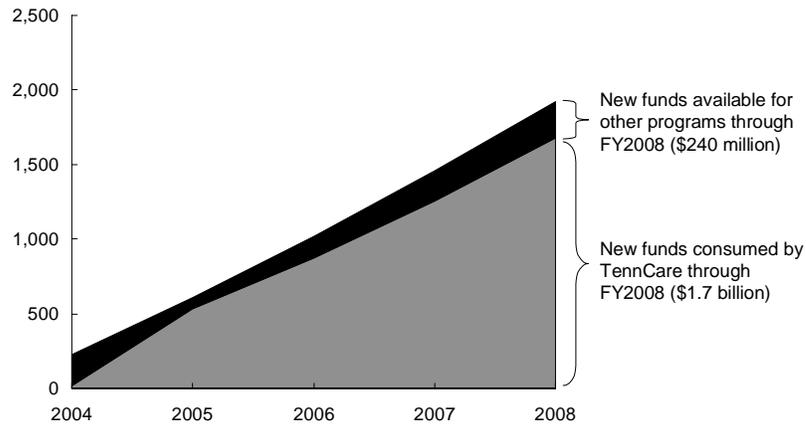


The following exhibit shows the impact (in the moderate recovery scenario) of TennCare cost growth on new state tax appropriations through fiscal year 2008.

GROWTH IN TENNCARE COSTS AS A PERCENTAGE OF NEW STATE TAX APPROPRIATIONS* – MODERATE RECOVERY SCENARIO

ESTIMATE

Cumulative dollars (millions)



* Defined as taxes levied by the Tennessee Department of Revenue
 Source: McKinsey team analysis; Bureau of TennCare; Tennessee State Budget Office

Fast recovery scenario

In the case of a strong economic recovery, we project the TennCare program to grow to approximately \$11.8 billion in total spending by fiscal year 2008, with the state shouldering approximately \$3.7 billion of that spending. This state spending will represent 33.7 percent of state tax revenue in that fiscal year. Incremental TennCare costs will represent 63 percent of incremental tax appropriations in fiscal year 2008.

This scenario assumes that the current relatively rapid growth in TennCare’s Medicaid-eligible enrollment will slow throughout calendar year 2004. We held Medicaid membership constant from January 2005 through the end of the forecast period, June 2008. We considered early models for the fast recovery scenario that included a declining Medicaid enrollment but rejected them based on historical Medicaid enrollment patterns in times of economic recovery, e.g., 1997 to 2000, when Medicaid enrollment growth occurred in Tennessee as well as nationally. We assumed the constant value for Medicaid-eligible enrollees from 2005 to 2008 to be approximately 1.12 million (up from approximately 1 million at the end of calendar year 2003) and total TennCare membership to be 1.4 million at the end of fiscal year 2008.

We assumed that state tax revenue would grow more quickly in this scenario than in the others, due to more rapid growth in the Sales & Use tax. We assumed this tax to grow by 6 percent annually to \$7.1 billion by fiscal year 2008 (versus an estimated \$5.6 billion in fiscal year 2004), which helps drive a total tax revenue value of \$10.9 billion in that period (versus an estimated \$8.7 billion in fiscal year 2004). As in all of the scenarios, the model assumes no fundamental change in Tennessee's state tax structure.

Moderate recovery scenario

In this base case scenario, TennCare's total fiscal year 2008 costs are projected to be \$12.2 billion. The state's share of these costs will be \$3.8 billion, over 36 percent of the state's appropriations for that year. Incremental TennCare costs will represent over 80 percent of the new dollars appropriated each year between fiscal years 2005 and 2008. In fiscal year 2008 they will represent 91 percent of new tax dollars.

While the difference between our moderate recovery scenario estimates for fiscal year 2004 at \$7.5 billion and TennCare's expectation for total spending of \$7.1 billion in fiscal year 2004 is significant, the projected costs are in line with national estimates for healthcare costs in general. In addition, the growth rate implied by the fiscal year 2004 projection is slightly lower than recent rate of growth in TennCare costs.

For the moderate recovery scenario, our team assumed that Medicaid enrollment growth would slow from the current relatively rapid levels but not stop during the forecast period. Under these assumptions, total membership grows to 1.46 million enrollees by fiscal year 2008 (from approximately 1.31 million at the beginning of fiscal year 2004), with Medicaid-eligibles representing almost 1.20 million of the total 1.46 million enrollees.

The Sales & Use tax is assumed to grow by 4 percent annually, to just over \$6.5 billion in fiscal year 2008, which drives overall state tax revenue to approximately \$10.4 billion in that period.

Recession scenario

If the economy does not recover quickly, total TennCare program costs could be \$12.6 billion in fiscal year 2008, with a state share of \$3.9 billion. In this scenario, the program consumes just under 40 percent of the fiscal year 2008 state budget,

and incremental TennCare costs represent 144 percent of incremental state tax appropriations in that period.

This scenario was meant to model the effects of a prolonged period of stagnant or very slow growth, although not necessarily a “double-dip” recession. This type of outcome is particularly damaging because Medicaid is counter-cyclical with the economy: Medicaid expenditures tend to rise as the economy deteriorates, due to increasing poverty-based enrollment.

The recession scenario assumes continued rapid growth in Medicaid-eligible enrollment, to a total of approximately 1.22 million Tennesseans by fiscal year 2008, and expansion population growth to a total of 295,000 enrollees, combining into total TennCare membership of just over 1.5 million.

This high enrollment forecast drives significant spending increases within the program, which are compounded by a slow-growth estimate for state tax revenue. The Sales & Use tax is forecast to grow by 2 percent annually, to only \$6.1 billion by fiscal year 2008 versus \$7.1 billion in the fast recovery scenario. Total state tax revenue is projected to be approximately \$9.9 billion in that period, versus \$10.9 billion in the fast recovery scenario.

COSTS DRIVEN BY SPENDING IN THREE AREAS AND GROWTH IN OVERALL ENROLLMENT

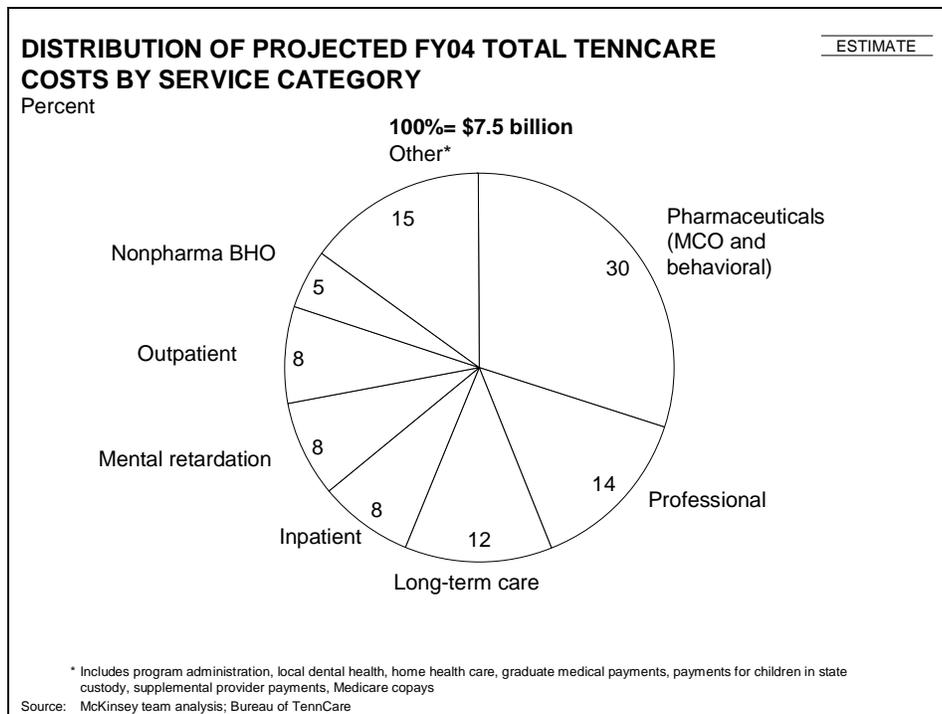
Although virtually every aspect of the TennCare program has grown in recent years, spending in three areas (pharmaceuticals, professional services, and outpatient services) and enrollment growth will be the key drivers of TennCare costs between fiscal year 2004 and fiscal year 2008.

A number of TennCare stakeholders have expressed a belief that fraud and abuse, which is not on our list of key cost drivers going forward, represents the major cost issue for the program. Although we did not conduct a detailed diagnostic of TennCare’s procedures to combat fraud and abuse, we believe that there is an opportunity for improvement in this area. The program is currently hampered by data availability problems, although that is expected to change in early 2004 with the launch of a new IT system meant to improve data sharing among agencies within Tennessee. Access to a broader set of data is likely to help reduce fraud and abuse losses as well as increase the state’s ability to collect on third party

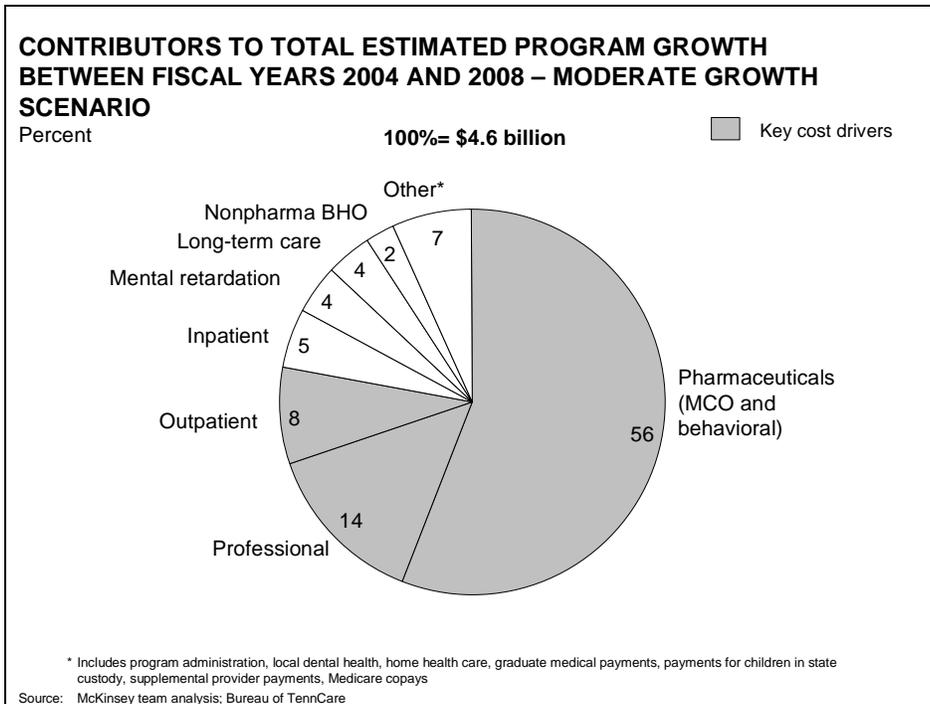
liabilities²². These IT changes represent important improvements and should be rigorously pursued. While it is impossible to know how much benefit will be captured, we believe that improvements in fraud and abuse alone will not be sufficient to restore TennCare to viability.

Spending in three areas

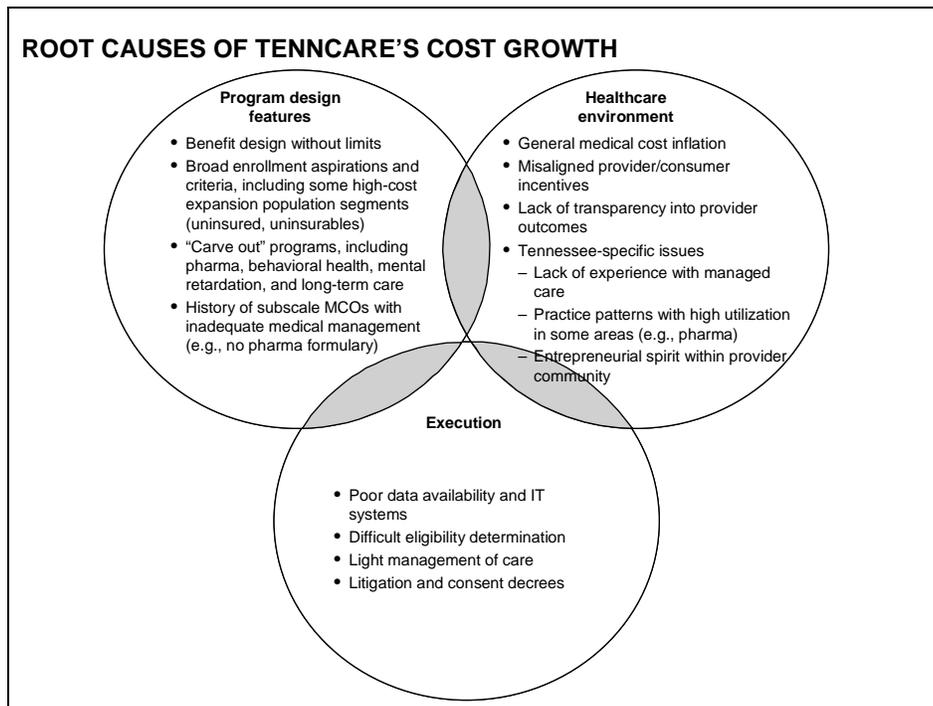
While our analysis points to pharmaceuticals, professional services, and long-term care as the service categories driving TennCare’s fiscal year 2004 costs (as shown in the first of the two following charts), our projection of future spending on major medical services paints a slightly different picture. In this analysis outpatient services costs, instead of long-term care costs, are the third driver. While outpatient costs have historically been smaller than long-term care costs, we project them to grow more quickly than long-term care costs. Spending in the three areas highlighted on the second chart – pharmaceuticals, professional services, and outpatient services – drives nearly 80 percent of program growth going forward.



²² These third-party liabilities include payments from other insurers that should be made before TennCare becomes liable; for example, an auto insurance policy should pay for medical coverage in an auto accident before TennCare does



Each of these three key cost drivers share, albeit to differing degrees, the same root causes: specific aspects of TennCare’s program design, conditions in the overall healthcare environment, and execution issues on the part of TennCare and its partners.



1. Pharmaceutical costs. Pharmacy costs are the single most significant source of future cost increases in our forecasts, driving nearly 60 percent of total growth through fiscal year 2008 and contributing nearly \$2.6 billion in total cost growth during that period. Each of the two major categories of pharmaceutical cost within TennCare, MCO pharmaceuticals and BHO pharmaceuticals, will see significant growth between fiscal years 2004 and 2008.

- a. MCO pharmaceuticals.** These are drugs that fall under the general managed care category; they include medications such as cholesterol inhibitors and gastric acid reducers. We project this category to represent about \$1.4 billion in total cost to TennCare (equivalent to just under \$500 million in state spending) in fiscal year 2004, after rebates. We believe that this expenditure could grow to approximately \$2.5 billion (approximately \$900 million in state spending) by fiscal year 2008, after rebates. This equates to growth on a per member per month basis of just under 14 percent through that period.

Our forecast includes an estimate of the impact of the state's recent implementation of the preferred drug list and its assumption of pharmaceutical purchasing. Specifically, we assumed that the state would receive an additional 13 percent in drug rebates from manufacturers over what it received during the past several years. These additional rebates reduce MCO drug spending by almost \$250 million in fiscal year 2008.

- b. BHO pharmaceuticals.** This category of pharmaceutical spending includes antipsychotics, antidepressants, and other drugs used in the management of behavioral disorders.

BHO pharmaceuticals are modeled distinctly from MCO pharmaceuticals, and the two categories have very different characteristics. BHO drugs are not included on TennCare's preferred drug list, and we assumed that they would not be during our forecast period. For this reason, we assumed no increased pharmacy rebates for BHO pharmaceuticals.

Spending for drugs in this class has been rising at a very high rate, not just for TennCare, but also for payors nationwide. Since fiscal year 2000, TennCare's annual cost increase for BHO drugs per member per month has been over 35 percent. The lack of programs to control BHO costs and utilization (e.g., preauthorization programs) has contributed to this cost growth. While we foresee this growth trend abating

somewhat, there is no reason to believe that significant change will occur without action on the part of the state.

In forecasting BHO drug expenditures, we used commercial expenditure forecasts by individual drug types and built an average forecast growth rate adjusted to match TennCare's "market basket" of typical BHO drug purchases. This leads to a per member per month growth trend that declines to approximately 28 percent growth annually but still results in a very large increase in BHO drug spending – from approximately \$520 million total (approximately \$180 million from state funding) in fiscal year 2004, after rebates, to approximately \$1.6 billion total (approximately \$540 million from state funding), after rebates, by fiscal year 2008.

Under the original TennCare program design, pharmaceuticals were managed by MCO intermediaries in a broad effort to control costs in accordance with the basic principles of managed care. Faced with unexpectedly high growth rates in pharmaceutical costs, the MCOs returned purchasing authority to the state. This shift was consistent with a general trend toward an increasing number of carve-outs to gain the benefits of not only best pricing legislation²³, but also those associated with additional innovations and the specialized capabilities and focus of a carve-out benefit manager. While the new preferred drug list effort is still in its early stages, this design is likely to be beneficial, given its simplicity and its ability to capture value beyond Medicaid best price legislation.

Throughout TennCare's history, pharmaceuticals have been the focus of advocacy pressure, most notably the Grier suit. This case, which predates TennCare by 15 years, culminated in a 1999 consent decree. Among other things, this decree required TennCare to obtain express physician approval to override prescriptions written for pharmaceuticals that were not on an approved drug list. The state's inability to consistently satisfy the physician waiver requirement effectively resulted in an open formulary, exacerbated by the fact that Tennessee citizens (not just Medicaid beneficiaries) use more prescriptions per capita than the citizens of any other state²⁴. While another settlement on Grier was recently reached, the administrative burden for TennCare under the settlement remains high. These negotiations have, however, paved the way for the implementation of some basic utilization control efforts.

²³ One element of the Omnibus Budget and Reconciliation Act of 1990 (OBRA 90) requires that manufacturers sell brand name drugs to state Medicaid programs at the lowest price paid by any private purchaser in the United States

²⁴ Kaiser Family Foundation; Verispan Scott-Levin Source™ Prescription Audit: Special Data Request, 2003

Congress recently passed a Medicare reform bill that provides a prescription drug benefit for seniors, including those in the dual eligible population, who currently receive such benefits via Medicaid. As noted earlier, Congressional Budget Office analysis suggests that the bill may provide only very modest relief to Tennessee and other states over the 5-year period of our analysis, i.e., fiscal years 2004 to 2008. As also noted earlier, the bill's impact on state costs will depend on various factors that are not yet completely clear. These include, for example, future inflation of pharmaceutical prices at the national level, regulatory interpretation, additional legislative changes, and beneficiary behavior.

There is also some potential that there will be no benefit, or that the bill could even cost the state money. Specifically, the bill provides a "claw-back" provision, whereby the vast majority of the cost for drug benefits will continue to be borne by the states. States will face new administrative costs, there is potential for the loss of pharmaceutical rebates (at a minimum on this population), the ability to capture pharmaceutical savings for the dual-eligible population is lost, and spending will increase for newly enrolled dual-eligibles.

The ultimate impact of the Medicare bill will be particularly sensitive to the growth trend in pharmaceutical costs in Tennessee versus the nation, as the federal "claw-back" provision appears to be based on historical state-specific spending levels projected forward at *national* pharmaceutical inflation rates. If the underlying growth trend in pharmaceuticals in Tennessee proves to be substantially higher than the national average (as has been the case in recent years), the state would bear a smaller burden for the pharmaceutical costs of dual eligibles beginning around fiscal year 2006. Conversely, if Tennessee were successful in managing costs at a substantially lower rate than the national average, the state would begin bearing a larger burden around fiscal year 2006.

Due to the large degree of uncertainty surrounding the bill's interpretation and implementation, we have not incorporated its impact into our analysis.

2. Professional services costs. Professional services, the second largest contributor to costs among the service categories, will represent 14 percent of TennCare's total growth between fiscal years 2004 and 2008. Because we felt that historical trend was the best predictor of future growth in this category, we projected professional services to grow at their long-term historical rate on a PMPM basis, adjusted somewhat to account for national Medicaid cost growth projections. We then combined these unit cost projections with our enrollment projections to compute total future costs. These costs will account for total program growth of \$635 million by fiscal year 2008, with \$225 million from state funding.

One particular aspect of TennCare's program design in this area, the lack of benefit limits on professional services, has a fairly significant impact on program costs. We assumed that the design feature of uncapped professional services benefits would continue to be part of the program.

Professional services costs are also strongly influenced by the healthcare environment as a whole. Professional fees in the broader market place have risen over time based in part on rising costs paid by physicians to provide care, and our team has projected an increase in fees.

3. Outpatient services costs. Outpatient services will represent 8 percent of total program growth through fiscal year 2008.

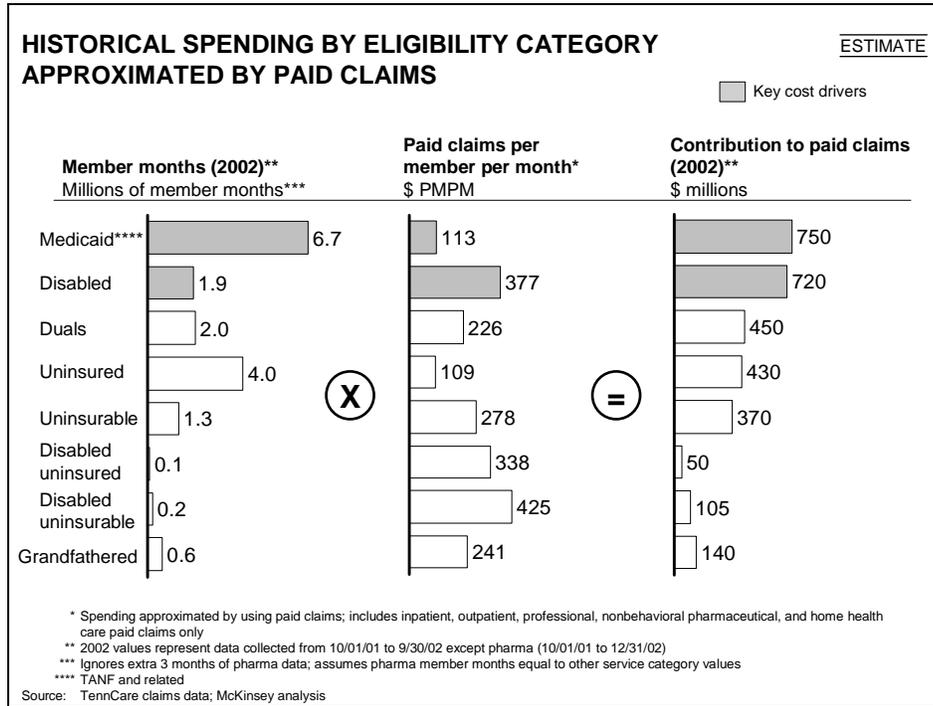
As with professional services, the lack of benefit limits on outpatient services has a fairly significant impact on program costs. We assumed that this aspect of program design would continue to be part of the TennCare program, and we projected outpatient costs, like professional costs, to grow at the rate observed since the program's inception on a PMPM basis. The resulting forecast calls for spending on outpatient services to grow by approximately \$375 million in total spending between fiscal years 2004 and 2008, with approximately \$130 million from state funding.

The healthcare environment has had a notable impact on outpatient services costs. Most important is the fact that outpatient costs have been rising in recent years for all payors, not just TennCare. This increase in per unit cost has driven up, and will continue to drive up, outpatient spending. In addition, many procedures that once were performed in an inpatient setting are now done on an outpatient basis. While this shift will compound the growth in outpatient costs, it should also lead to some decrease in inpatient costs. Given the lack of robust TennCare-specific data regarding this shift from inpatient to outpatient care, we did not directly model this effect. Instead, we assumed that this shift was reflected in the PMPM cost projections for outpatient services and inpatient services relative to one another.

Enrollment growth

Enrollment growth, the fourth key driver of TennCare costs between fiscal years 2004 and 2008, affects program costs in every service category. During that period, enrollment growth will contribute \$900 million to total program growth, with \$315 million in state dollar growth. In our moderate recovery scenario, we projected enrollment to continue to grow at a high rate (approximately 2000 members per week) through the end of calendar year 2003 and then slow through the rest of the forecast period based on unemployment assumptions. As shown below, the large

number of Medicaid and disabled enrollees has historically amplified the cost per member to make these two categories the largest in terms of cost.



Program design could be a root cause of enrollment growth. Under the July 2002 waiver, the Tennessee state legislature is permitted to open TennCare expansion enrollment on a yearly basis. Based on the program’s current economic status, we have assumed that there will be no open enrollment period through 2008. If an open enrollment is, in fact, declared, program design would contribute to enrollment growth.

Environment is strongly linked to the enrollment cost driver. The forecast assumes (based on historical data) that enrollment is directly related to economic conditions. Periods of poor economic performance have generally been linked to high levels of enrollment growth, especially in the low-income category of traditional Medicaid. This relationship is built into the forecast, and it is the reason that medical costs are higher in the recession scenario than in the fast recovery scenario.

Execution issues also play a role in the enrollment growth cost driver. Historically, the program’s inability to effectively verify eligibility at the time of enrollment (due to limitations in IT systems and operational processes), coupled with a lack of ongoing eligibility verification, led to inflation of the expansion population. The reverification process reduced the number of people in this population significantly,

but the process must be continued to ensure that TennCare is covering only those that meet the eligibility criteria.

* * *

Barring substantial reform, TennCare is likely to consume an ever-larger portion of the state of Tennessee's budget. The resulting financial pressure has obvious – and serious – implications for not only TennCare but also for the state's ability to meet its other responsibilities to its citizens.

Our second project objective, to identify several strategic options for helping ensure TennCare's financial viability while still meeting the program's goal to provide quality healthcare to Tennessee's neediest citizens, focuses on this challenge. Our team is in the midst of this work and plans to present its findings in a report that will be released in January 2004.

Brief Background on McKinsey & Company

McKinsey & Company is a management consulting firm that helps leading public, private, and nonprofit corporations and organizations make distinctive, lasting, and substantial improvement in their performance.

During the past seven decades, the firm's primary objective has remained constant: to serve as an organization's most trusted external advisor on critical issues facing senior management. With approximately 7,000 consultants deployed from 83 offices in 45 countries, McKinsey advises clients on strategic, operational, organizational, and technological issues. The firm has extensive experience in all major industry sectors and primary functional areas as well as in-depth expertise in high-priority areas for today's business leaders.