

**TENNCARE PARTNERS:**

**BEHAVIORAL HEALTH  
REPROCUREMENT STRATEGIES**

**FUNDED BY:**  
**THE CENTER FOR HEALTH CARE STRATEGIES**  
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## EXECUTIVE SUMMARY

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TennCare is the country's boldest effort to dramatically expand health insurance coverage for the uninsured and individuals who are not able to obtain commercial insurance because of their medical condition, but it has also been one of the country's most troubled health care plans. TennCare Partners, the behavioral health component of TennCare is no exception to this. The program has been ambitious in its design and goals and yet with a high turnover of key personnel, changes from a carve-in to a carve-out, disruptions due to industry consolidation and changes in policy, the program has seemed to always be in some level of crisis or disruption. This is certainly true today with the state's fiscal crisis.

Despite all these changes, there has been a lot of progress in the program, though this has not been very widely recognized. Programmatically, the services have been stable in the last two years and a significant number of new recovery focused services have been developed and implemented. The major provider litigation with the BHO has been settled and there has been a very positive reaction to current management and oversight of the program. The reprocurement and recontracting process provides significant opportunities for further enhancing the quality of services and the effectiveness of the program.

This report summarizes the options available to the state for the reprocurement and recontracting of TennCare Partners. It provides oversight recommendations of a team of consultants funded by the Center for Health Care Strategies. The consultants interviewed a wide range of stakeholders from all different levels of the system and prepared preliminary recommendations for a team of TennCare and DMHDD senior staff. This report summarizes those recommendations.

The major recommendations are<sup>1</sup>:

- Reprocure the carved-out behavioral health services from a single state-wide behavioral health organization to simplify the procurement process and permit greater oversight of the contractor.
- Establish a new designated unit within DMHDD for the TennCare Partners Program oversight
- Seek to eliminate "management by myth". Manage the program more actively with performance data and have key data available readily for state managers and other stakeholders.
- Purchase services using actuarially sound, capitated rates rather than the blended, global budget model currently used.
- Redesign case management services so that these services are more efficiently deployed and consider changes to the provider reimbursement.
- Dramatically reduce and clarify the number of performance measures and schedule of liquidated damages to a more feasible and focused number of measures. "Less is more."

Given the fiscal uncertainty in the state, changes in the waiver, and the past instability of the program, now is not the time for significant program changes. Steady and incremental improvement in the effectiveness and quality of services can be achieved through the steps outlined in greater detail inside this report. This is a significant opportunity to increase the public's confidence in the quality of care and the effectiveness of government services.

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<sup>1</sup> To simplify the task for the busy reader, all the recommendations have been summarized in Attachment B.

# TENNCARE PARTNERS: BEHAVIORAL HEALTH REPROCUREMENT STRATEGIES

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## I. INTRODUCTION

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TennCare is the country's boldest effort to dramatically expand health insurance coverage for the uninsured and uninsurables. TennCare was designed in 1993, in the middle of a crisis in hospital reimbursement, and during the debate over the Clinton administration's health care reform effort. Using a Section 1115 Research and Demonstration Waiver, TennCare pools several sources of public funding including Medicaid dollars, disproportionate share payments, state appropriations for mental health and even some state hospital spending, to create a large health insurance pool. Funds from the pool are used to purchase health insurance from Managed Care Organizations (MCOs). The effort has had many critics, however. Some argue that the TennCare program is too expensive, that it has allowed businesses to shift costs to the state, expenditures have grown excessively, and that coverage is being provided for many people who no longer need or are no longer eligible for the program.

The TennCare Partners Program (TPP), the behavioral health component of TennCare, has been one of its most troubled components. Advocates, consumers, and providers throughout the mental health and substance abuse system have complained and ultimately resorted to litigation. Tennessee's behavioral health consumers and providers have had a roller-coaster ride over the last six years: the system has been carved-in, partially carved-out and then fully carved-out, originally with multiple behavioral health organizations (BHOs) now effectively a single BHO. However, TennCare and the Partners program have achieved many goals.

- The programs provide health insurance for almost 25% of the state's population and cover many individuals with chronic conditions, including mental illness, whose conditions would preclude them from receiving coverage under traditional commercial insurers.
- TennCare Partners has expanded the use of psychosocial rehabilitation within the state and provided for a significant expansion in the availability of case management for adults with serious and persistent mental illness (SPMI) and youth with serious emotional disturbance (SED).
- Consumer operated services have grown significantly over the past several years with the active support of DMHDD; at least one program, the "Bridges" program, is a national model.

Despite these gains, there are many areas in which the TennCare Partners Program (TPP) can improve its operations and services.

The Center for Health Care Strategies funded this review of TennCare Partners to assist with planning for the re-procurement or recontracting of the program in calendar year 2002. The review has sought input from a wide range of stakeholders, reviewed contract materials and related documents, and met with state staff and staff of the behavioral health organization. The recommendations are a comprehensive review of the major features of the program and are intended to inform state staff in the development of a request for proposals and contract for the program.

## **II. PURCHASING PRINCIPLES**

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Purchasing health care services for our neediest citizens, the poor and the disabled, requires thoughtful deliberation and careful planning. The demands of public accountability and regulation, the need for interagency collaboration, the challenges of the disabilities themselves, the political strengths of providers, and the fiscal constraints of the public sector dramatically complicate the challenges involved in purchasing behavioral health services. In a program like TennCare Partners, where there has been and continues to be significant resistance to managed care among many key stakeholders, and where many of the initial design decisions were changed, the degree of difficulty involved with achieving success is multiplied. Early public sector healthcare reform efforts often set unrealistic goals and objectives for themselves in the context of a limited and often diminished pool of available funds. TennCare is no exception to this.

The principles and values of the Center for Health Care Strategies' Purchasing Institute have framed our efforts in Tennessee. These are:

- Contracting for Value
- Purchasing Quality
- Activating Consumers
- Integrating Care

These core values have been incorporated into our review of the key components of the program, and they help to organize our recommendations. Accomplishing each requires that a purchaser has a clear vision, focuses on accountability, develops a trusting and collaborative relationship with its contractor, manages by data, properly aligns incentives for the contractor and implements an effective quality improvement effort. The initial requirements for implementation, and the frequency of change during the first several years of implementation of the TennCare Partners Program, made it very difficult to achieve any of these objectives. Over the last year, however, significant improvement has been realized in many of these areas. The planned reprocurement of the program provides a valuable opportunity to further align objectives between the purchaser and the contractor.

### III. HISTORY AND POLICY MAKING

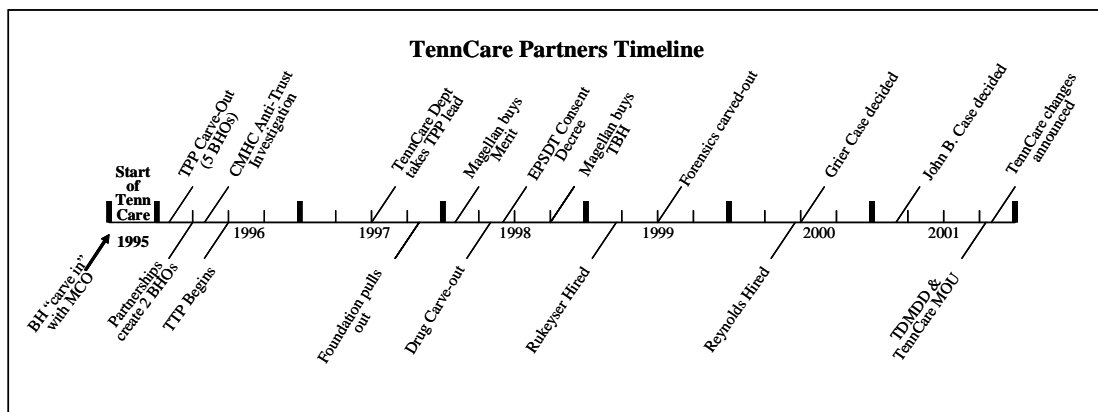
#### *History: Frequent Change and a Turbulent Marketplace*

TennCare was designed as one of the first Medicaid managed care programs and certainly the program with the most ambitious scope. Created as a public/private partnership that was to significantly expand insurance coverage for the uninsured, TennCare was introduced in 1995 into a state whose commercial managed care penetration rate was less than 20%. As a result, neither state policy makers nor the healthcare infrastructure had significant experience with the managed care model. Coupling the introduction of managed care with an unprecedented public, private partnership required a new organizational structure and set of skills on the part of staff and key leaders.

In 1995, behavioral health services were purchased from MCOs, although there was a partial carve-out of some behavioral health services, including state hospital and community mental health services. In 1996, all the behavioral health services were carved out of the MCOs and TennCare Partners services were purchased from specialized behavioral healthcare organizations (BHOs). However, over the past several years, the BHOs in the TPP marketplace experienced a series of transitions precipitated by changes in leadership. Even before the program went live, five BHOs were reduced to two, through hastily formed partnerships. Then, through an acquisition in 1998, the two remaining BHOs joined under one administrative structure. Equally significant was the change in governmental leadership, which has resulted in the following shifts since 1996:

- 7 Directors of TennCare
- 3 Mental Health Commissioners
- 3 F&A Commissioners

The timeline that follows summarizes many of the key events in the program.



With each change in the program, came a different style of leadership, and a different sense of priorities for the program. With each leadership change came a period when staff needed to adapt to new management styles and policy emphasis, and the key participants in TennCare, DMHDD and the BHOs needed to adjust to working together in new ways.

In addition to all these administrative changes, litigation occupied a large amount of time and resources, as consent decrees and court settlements were reached. Providers brought lawsuits regarding payments against the BHOs. Advocates challenged TennCare policies

and operations in a series of lawsuits regarding custody, access to care under EPSDT, appeals, and eligibility and reverification. The resulting consent decrees changed the way in which business was conducted by the BHO, and how its activities were monitored by the state. As a result of the litigation, major new policies were implemented for mental health case management and consumer appeals that have a far-reaching impact for TennCare Partners. With all these obstacles, the progress that has been made in the program is a testament to the hard work of many skilled professionals from the state, the BHO and provider organizations.

### ***Policy-making: Tension between Agencies***

State policy-making responsibilities changed significantly under TennCare. State departments responded by designating one or more staff to coordinate the new program, but often without the additional reorganization that might be needed to improve accountability. The responsibility and authority for DMHDD created under Title 33 and the responsibilities of the Bureau of TennCare as the single state agency for Medicaid created some tension over the early years. TennCare, as the single state agency for Medicaid, clearly has the responsibility under Title XIX to assure that expenditure of Medicaid dollars is consistent with federal law and regulations. Under Title 33-1-201 of the State of Tennessee, "DMHDD.... is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy.... It is the policy of the state to plan ... and to promote the use of public and private providers without regard for funding source...". Tension between the roles played by TennCare and by TMHDD and the changing leadership in the two organizations resulted in the oversight of TPP moving from DMHDD to TennCare and then more recently to a more collaborative effort between TennCare and the Department. The need for more clarity in roles prompted the development of an interagency agreement or memorandum of understanding between TennCare and DMHDD to clarify roles and functions. It is also something that should be in place for federal review.

When the TennCare Bureau took the lead on overseeing the program in 1997, advocates expressed concern that DMHDD was weakened, as it no longer controlled the dollars to support its policy initiatives. The language in the interagency agreement between DMHDD and the TennCare Bureau, for instance, reads that, "TennCare authorizes and designates DMHDD to assist in the administration the State TennCare Partner's Program.... TennCare retains responsibility for the final decisions on all issues affecting the TennCare Partner's Program."

Decision-making about mental health policy and program funding now requires coordination across three entities (the BHO, DMHDD and TennCare). This is a function that rested primarily with DMHDD prior to TennCare Partners. The TPP contract is signed by the BHO and DMHDD, but is subject to approval by TennCare. Service changes proposed by the BHO need to be discussed with TennCare and/or DMHDD. Likewise, since the BHO manages nearly all of the mental health dollars available in the state, DMHDD and TennCare must negotiate with the BHO or amend the contract to implement major policy changes initiated by the state. In an effort to better coordinate efforts with the Bureau of TennCare and to address the administrative needs of the TennCare Partners Program, a new unit has been created within DMHDD to assure that mental health managers play a bigger role in the management of the program by:

- Monitoring the contract;
- Auditing the BHOs and programs;
- Managing data; and

- Assuring that quality studies are conducted and shared with TennCare.

Tennessee currently faces enormous fiscal challenges. The TennCare program, as the single largest line item in the state budget, has become a target for legislators and others seeking to cut state spending. As the Governor's recommendations in late September clearly demonstrated, there are a plethora of public policy questions about TennCare behavioral health services that must be resolved if there is to be any significant restructuring of the program. For now, although the program is serving a smaller population, it seems to be intact. However, with recent court decisions requiring a new plan for children, the future of the entire program is in question. However, whatever ensues, a transition plan to manage the changes must occur. This report covers many of the important policy considerations that will need to be included in the transition or reprocurement. Key among these will be the further clarification of the roles and responsibilities of each of the public agencies charged with meeting the needs of TennCare populations so as to streamline policymaking in the future.



## IV. DATA COLLECTION

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### ***Stakeholder Interviews***

Interviews with key informants from TennCare Partners produced a rich set of observations and findings. In general, the interviews reflected the divergent perspectives of many of the stakeholders. Everyone had suggestions, generally substantive ones, for improvements in the program. However, many people were supportive of the recent changes in the program and felt that progress has been significant on at least three of the key goals of the program, specifically expansion of coverage for the uninsured, implementation of some rehabilitative and consumer run services, and improvement in the pharmacy benefit. There was also a general sense that the current administration was responsive and sensitive to the needs of consumers and other stakeholders. Interestingly, there was a great deal of “mythology” in many of the stakeholders’ perceptions of the program. For example, the data did not support the widespread belief (noted below) that the programs placed an excessive reliance on inpatient services.

Specific stakeholder comments about the problems and failures of the program included the following:

- Insufficient funding, rates that are not actuarially sound and flawed reimbursement methods for the program.
- Misaligned financial incentives for both BHOs and providers.
- Gaps in the number and quality of providers, especially psychiatrists, in several regions of the state.
- Barriers and excessive paperwork related to provider credentialing.
- A perception that there was still an excessive reliance on inpatient services.
- Failure to monitor the contract effectively and a lack of reliable data with which to do so.
- Excessive litigation costs.
- Absence of some services that should be part of an evidence-based continuum of care.
- Need to improve the ways to meet the needs of special populations, including individuals with addictions, those involved with the criminal justice system and children in state custody.

Recommendations from stakeholders for changes in the program included the following:

- Increase flexibility of funding for community services.
- Expand DMHDD's role in managing the contract.
- Update the Master Plan and implement its recommendations.
- Increase the use of “wrap-around” services for children.
- Shift from the current medical necessity criteria to a broader definition of clinical necessity.
- Move to a capitated method of reimbursement.
- Designate key individuals in the BHO to be responsible for inter-agency coordination, including coordination with the Department of Children's Services (DCS) and criminal justice.

There was disagreement among several of the groups about the type of managed behavioral health plan that should be procured. There was some support for moving the

behavioral health benefit back to the MCOs to try to improve the level of integration with primary care physicians. This position was not supported by any behavioral health professionals, however. Advocates and consumers tended to favor a statewide carve-out, as long as choice of providers is available. Provider groups, however, favored efforts to move either to a more regional approach with provider sponsored plans or to a non-risk model of managed care, where the state would contract with an Administrative Service Organization (ASO) that did not hold the risk for claims.

### ***Document Review***

The review of documents and the organizational structure of the program indicated the following:

- While the latest rewrite of the current contract with the BHO represents a significant improvement, there are a number of ways in which the organization and the specific language can still be tightened up. DMHDD and TennCare have another significantly improved draft contract that incorporates several of the changes recommended in this report and that has not been implemented at this time.
- Many of the performance measures in the current contract are not being routinely monitored.
- Liquidated damages and other terms of the contract are not uniformly being enforced.
- The contract contains geo-access standards and certain other performance requirements that may not be achievable in certain areas of the state.
- A large quantity of data is being produced by the BHO without much analysis and utilization by TennCare or DMHDD.
- The MOU, or interagency agreement, between TennCare and DMHDD specifies that the latter implement quality improvement, clinical oversight, policy support and other tasks. Within DMHDD, however, there were only a few staff that could be specifically identified as having TennCare responsibilities; the remainder had shared responsibilities with other functions.

## V. FINDINGS AND RECOMMENDATIONS

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The state, the current BHO and others have been working on many of the problems cited above. Some of the proposed solutions are consistent with the recommendations in this report and have not been implemented either because they await decisions by other state offices or the completion of other tasks. In the sections of the report that follow, each of the key areas of the program is discussed, including: the design of the system, populations served, services and benefits, inpatient care, crisis services, case management, network and utilization management, litigation, claims payment, quality improvement, performance reporting, incentives and reimbursement, contracting, management and oversight and a re-procurement plan. Each of the sections that follow includes some background, analysis and a set of recommendations.

### *System Design*

In considering the options for the design of the TennCare managed behavioral health system, state officials must consider many issues, including the capacity of providers to meet service demands, access to the physical health care system, cost, and the capacity of state officials to oversee the plan. As managed behavioral health care services have been implemented in the U.S. during the last decade, several different system models have emerged. These include:

- Single Statewide BHO
- Regional BHOs (one per region)
- Competing BHOs (consumer choice of BHOs)
- Integrated Plans: Behavioral and physical health combined (carve-in)
- Integrated MCO Plan plus Special Needs Plan for special populations, e.g. children
- Publicly managed BHO
- Non-Risk based Administrative Services (ASO)

TennCare has an unusual history in that it began as an integrated plan with a partial carve-out of BH services, transitioned under TennCare Partners to a variation on competing BHOs (where the carve-out BHO was paired with the MCO selected by consumers) and now has essentially become a statewide BHO carve-out as a result of industry consolidation. However, after more than two years, with Advocare managing the behavioral health benefits for both Premier and TBH, the two plans are contractually separate. This unusual history highlights several key issues that need to be considered in the upcoming procurement. First, the needs of the seriously mentally ill (SPMI) and emotionally disturbed (SED) youth require specialized expertise. When TennCare Partners was implemented in 1996, the decision to fully carve-out behavioral health services was driven by the desire to better coordinate services for individuals with SPMI and SED in TennCare. State officials and others rightly felt that specialized behavioral health organizations were better able to respond to the needs of these populations than were the MCOs. The partial carve-out of state hospitals and community Mental Health Agencies, however, created perverse financial incentives. Over the next year and a half, the BHO industry consolidated significantly and Magellan ended up acquiring all of the BHOs that were in TennCare, except for a minority stake in Premier that continues to be held by another organization.

In considering different options for TennCare under the reprocurement, the opinions of stakeholders were collected, the success of other states with different approaches and the

advantages and disadvantages of each option were reviewed with state officials. A matrix was prepared (Attachment B) for discussions with the state that outlines the advantages and disadvantages of each of the above approaches.

Advocates and consumers generally preferred a single statewide BHO, similar to the current plan. They perceived that they have a stronger voice with a single plan, and that the state has limited capacity to monitor multiple BHOs. Providers seemed to favor one of two approaches. Some voiced a preference for regional behavioral health plans, while others favored an administrative service organization. In either case, implementing their preferences would result in a shift of power from the BHO to regional plans or back to the state. Only one interviewee recommended a separate plan for a special population, such as children. State officials generally favored continuation of the current model, i.e., a statewide BHO, though some wanted an integrated plan with physical health. Some of the people interviewed during this review were quite clear that they did not want managed care, but recognized that the financial realities required that TennCare continue and that it probably had to continue as a risk-based plan.

Regional networks were rejected as an option both because the regional enrollment may not be sufficiently large to provide underwriting stability and because providers do not generally have a sufficient level of capital to be able to absorb the level of risk required in the plans. Furthermore, in many of the state's regions, the competition between providers is significant and the political "noise" that would be created by such a plan (selecting one provider over another) would likely distract from the overall goals of the program. Nonetheless, many states are considering and implementing regional managed care plans because of the belief that regional plans may be able to reduce some of the layers of administration. States such as New Jersey and Florida are moving in this direction with statewide ASOs. County operated plans have been developed in Colorado, Oregon, Washington, California and Florida; in these states, however, counties play a major role in funding the mental health system. It may be feasible for the BHO contract to include a requirement that it develop a pilot for regional provider networks. The purpose of this requirement would be to assess the feasibility of such a model within the state and to build the future capacity to manage care at the regional level. Of course, the BHO may perceive this requirement as an attempt to put them out of business, so the demonstration should be limited to one or two regions, and should include the continued provision of claims payment and financial management services by the BHO.

The ASO, Administrative Service Organization, option can be effective at controlling benefit costs and reducing administrative costs, especially if the contract incorporates appropriate incentives. The use of a non-risk type of reimbursement would likely increase the competition for the contract, as there are several other nationally recognized organizations that would be likely to bid under this scenario. This option was not recommended for several reasons:

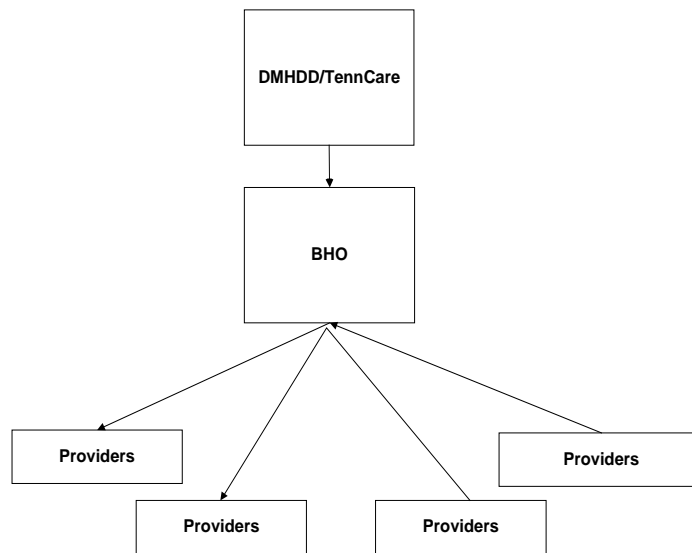
- "Unbundling" the program's financing may lead to a loss of federal support;
- The state's currently weak financial condition also results in the state not being very willing to assume claims risk.

Only one person recommended a population carve-out for children though it has been recommended as a part of the recent John B. contempt order. This is a model that has been used in the District of Columbia with physical and behavioral health services. It will add to enrollment and monitoring costs and will increase problems in aging out with no guarantee of improved performance of health screenings. It is not recommended.

A single statewide risk-based behavioral health organization is recommended for the following reasons:

- It will be simpler to administer and monitor and can provide more targeted services to subpopulations, like children in custody.
- It may lead to lower administrative costs due to economies of scale.
- It eliminates enrollment bias; i.e., differential enrollment by healthier individuals in certain plans.
- The procurement process could be simplified.
- The financial condition of the state minimizes the likelihood of a non-risk (ASO) option.
- It represents the approach preferred by many consumers and advocates, perhaps because they feel that they can exert a greater level of influence over a single organization.
- It may be preferred by many BHOs because of the size of the contract and the simpler relationship with the government client.

## Statewide BHO



If this option is accepted, certain issues need to be considered and addressed in the re-procurement and implementation:

- The state's increased dependence on a single BHO requires stronger state negotiating skills during contract negotiations and as amendments are considered. In the event the BHO fails, the state should have a series of back-up plans including a short-term plan to ensure cash flow to providers, as well as longer term plans to replace the other functions of the MCO.
- The behavioral health carve-out option requires that simple, clear and consistent procedures be implemented to coordinate services with primary care physicians.
- Performance monitoring and quality improvement activities by the state are somewhat more important due to the lack of consumer choice.

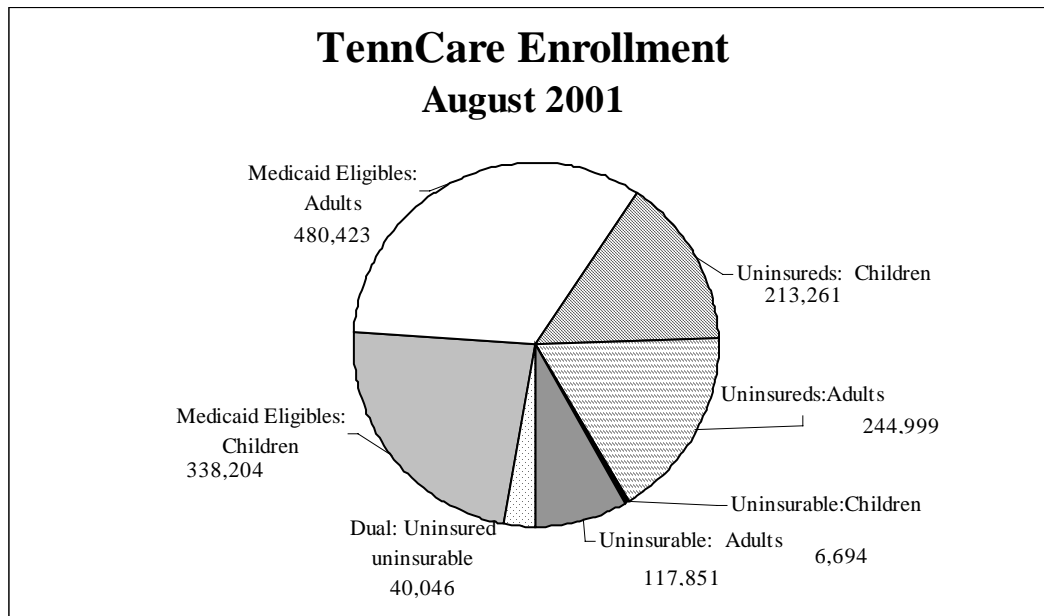
- With a single statewide plan, the state needs to take additional steps to ensure that consumers have a choice of providers. This can be accomplished by having a comprehensive provider network and by educating consumers about their options.
- Politically, accepting the recommendation may appear to be maintaining the status quo, since Advocare is currently the single administrator of the two plans. Some may not see this as enough change.

**RECOMMENDATIONS:**

- The state should procure a single statewide BHO.
- Require the BHO to subcapitate with all the MCOs for primary care services. This ensures that the BHO coordinates care and simplifies the claims process for primary care physicians and the MCOs.
- Consider requiring the BHO to develop a pilot regional provider network or certain lead provider agencies for clinical and service coordination.
- Develop a back up plan.

***Populations & Eligibility***

Since its inception TennCare has grown to become the single largest health insurance program in the state of Tennessee. TennCare currently provides health insurance for 25% of the state’s population, including those eligible for Medicaid, the uninsured and uninsurables<sup>2</sup>. The enrollment figures in August are outlined in the chart below.



<sup>2</sup> Uninsured consumers have no health insurance and meet certain income guidelines. Uninsurables are not able to obtain insurance coverage due to their current health status or condition.

In recent months, a proposal has been presented that would modify the program's eligibility criteria and result in a decrease in the number of people enrolled in the program as well as a narrowing of the scope of services available to certain groups. The three components of the proposed program are described below as they appeared in a summary provided by the state of Tennessee:

- TennCare – Medicaid will be open to those individuals that meet Medicaid requirements. Enrollment will be open to them year-round. There 2001 the total enrollment was 1,441,478. The subpopulations will not be any major benefit changes from what they have today. Medicaid enrollees will continue to have no premiums or co-payments.
- TennCare - Standard will be open to uninsured, low-income Tennesseans (adults below 100% of poverty and children below 200% of poverty) who do not have access to group health insurance. It will also be open to those individuals who do not have access to health insurance and are determined to be “medically eligible” by an independent underwriting agency. Physical health benefits for TennCare Standard will be comparable to those of a commercially available standard HMO plan. Behavioral health services will continue to be delivered by the BHO, with the same benefits as the Medicaid population.
- TennCare - Assist will be available in the future to low-income individuals with access to employer-sponsored health insurance. This program will assist them in purchasing family coverage from their employers.

TennCare Standard and TennCare Assist will have open enrollment periods once a year, subject to budget appropriation by the General Assembly. Individuals meeting the eligibility criteria but needing services will have to receive services funded by other sources or wait for their enrollment. This new enrollment policy coupled with the new income guidelines for TennCare Standard will likely create a need for referrals and/or sliding fees so that providers can assure availability of a safety net of services offering an alternative to emergency room use. These eligibility criteria for the TennCare program and the proposed changes in benefits for TennCare Partners have received significant attention from stakeholders. Of greatest concern was the initial plan for behavioral health services under TennCare Standard which would have been a “carve-in, administered by the MCOs. The TennCare Medicaid benefit was going to continue to be carved out. In response to stakeholder concerns, state officials modified the initial recommendations to propose a carve-out plan for both eligibility categories. Additionally, stakeholders have been quite concerned about TennCare benefits for children and adults with SPMI or SED who may not meet the TennCare Standard income guidelines. In the current TennCare budget, there is no “safety net” of services, as the eligibility for the program is broad enough to allow for people to be presumed eligible if they needed inpatient care. Under the proposed model, safety net funding is needed to pay for mental health services for non-TennCare eligibles.

The special needs of adults with SPMI and children with SED were a major concern of stakeholders in the creation of the TennCare Partners Carve-out. The state therefore created an enhanced benefit and defined these groups as “priority populations”. The priority populations for mental health are currently determined eligible through what are known as CRG/TPG assessments. However, the CRG/TPG instrument was originally designed by DMHDD for tracking purposes only. These assessments have identified over 180,000 people who have met the priority population definition over the life of the program, with fewer than 80,000 in service right now. The CRG and TPG assessments have helped to identify many individuals with serious mental health needs. Unfortu-

nately, these criteria and, perhaps, the financial incentives associated with the enhanced benefit, have resulted in a sizable growth in the priority population, thus reducing the funds available for others to lower and lower levels. As a result, we believe that the state should not use the “priority population” assessments for reimbursement or eligibility purposes. Services should be authorized based upon clinical necessity of each individual consumer.

#### **RECOMMENDATIONS:**

To address the unmet needs of these special populations recommendations include:

- Assure that eligibility verification is ongoing and is done accurately, and that reverification is timely and effective.
- Create a blended benefit package, so that the need to identify a priority population is eliminated.
- Base all services on clinical necessity rather than priority population status. Use CRG/TPG assessments for reporting and monitoring only.
- Require that quality studies be conducted on high need populations including SPMI, SED, individuals with addictive disorders, those with dual diagnosis and children in state custody. This will require special reporting by population groups, including the current priority populations of adults and children.
- Clarify the differences between DCS funded residential treatment and those funded by TennCare, using a crosswalk and service definitions for each of the levels of care. This is essential to clarify the apparently frequent “boundary” disputes between DCS and TennCare.
- Create special services, and track encounter data and funding, for people with special needs.

### ***Children with Special Needs***

Across the country, the needs of children in public behavioral health care systems, have been receiving attention from advocates, providers, policy makers and state administrators. Similar to Tennessee, a number of states are currently involved in litigation related to the provision of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services. Nationally, the needs of children in state and county custody have been documented to require significantly more mental health services than the general population and in many cases these children have been underserved. Case management and service coordination have been shown by most service systems to be especially important with children, who may receive services from several different public agencies (e.g. schools, child welfare agencies, juvenile justice, etc.). Residential treatment services are especially difficult to obtain for children who are not in custody, apparently leading many parents to feel pressured to surrender custody in order to obtain needed services.

During this project, policies were being developed for children in TennCare Partners, negotiations were underway with the BHO for changes in coverage, and court orders regarding children in managed care were issued. As a result, this review does not cover all



of the many details concerning services for children. Many of the recommendations in this report apply equally to children and adults and as a result they will address many of the shortcomings in the system concerning children. For instance, the more systematic collection and reporting of performance data for children and adults are likely to improve policy decision for both populations. In addition, a review of the impact of some of the litigation related to children is included later in the report. In this section, however, several key issues are discussed that warrant the attention of policy makers in the reprocurement: EPSDT; Children in state custody; residential treatment services, and case management services.

**EPSDT:** Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are required under Medicaid for categorically needy individuals and optional for Medically Needy individuals. EPSDT services were initially set forth in the Omnibus Budget Reconciliation Act of 1989 and the statute is outlined in section 1905 of the Social Security Act. The basic requirements of the law and regulations are broad yet simple:

- States must provide for screening, hearing, vision and dental services at periodic intervals determined according to reasonable medical standards;
- The act provides that “any service which you are permitted to cover under Medicaid and that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.”<sup>3</sup>

The regulations outline the frequency and the scope of the screening for children. While the screenings and related immunizations follow generally accepted medical practice for children, they are often not received at the desired frequency by children in Medicaid. Many states do not meet the required screening standards and yet some advocates have argued that federal officials have been slow to enforce the requirements. Tennessee however has been and remains well below average in the national screening data provided to CMS. Tennessee has established annual improvement goals for screening that seek to increase compliance rates incrementally each year. DCS reports that they have successfully screened more than 90% of their children, an admirable achievement given their previous compliance levels, though this figure cannot be confirmed by TennCare at this time. Unfortunately, the overall TennCare goals established in the John B. consent decree for 100% screening rates were not realistic. Improvement in the EPSDT screening rates can only be achieved by setting realistic annual improvement goals and holding contractors (both MCOs and providers) accountable for accurate reporting and performance. Timely and accurate reporting of the screening rates for children by the MCOs is also essential. With concerted effort, the state should be able to achieve significant improvements in screening rates in the two MCOs it controls, Xantus and TennCare Select.

The broad entitlement included in the EPSDT requirements for treatment services was designed to ensure that all needed services were available to children. Since their introduction, Medicaid and managed care programs across the country have been concerned about the potential fiscal impact of these provisions. Managed care contracts that include these EPSDT requirements (as in TennCare) often limit coverage to medically necessary services included in the benefit plan. This serves to limit the fiscal impact for the MCO but may leave the state with the requirement to separately fund other EPSDT related services that may be outside the benefit plan but permissible under Medicaid. The optimal solution for states is to attempt to incorporate as much of the EPSDT mandate

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<sup>3</sup> Health Care Financing Administration, State Medicaid Manual - HCFA Publication 45, Part 5, Section 5110, page 5-5.

into the managed care contract as is possible and then hold the MCO responsible for compliance. Unfortunately, managed care organizations (including BHOs) are usually unwilling to accept this risk without adjustments in their capitation payments. Since this may not have been included in the actuarial calculations of the original TennCare rates it is likely to require additional funds in Tennessee. Most states have great difficulty linking EPSDT screening information with the services needed to treat the conditions identified by the screens. Ultimately this is essential to ensure compliance with EPSDT requirements at a system level; otherwise compliance is determined by anecdote and generalizations from cases that have encountered problems.

As a result of the broad provisions for services, EPSDT provisions can often exacerbate the conflict between health care practitioners and managed care in states. Most of this conflict is likely to occur over legitimate concerns for the welfare of the child. In mental health services, the nature of the condition often makes it difficult to reach agreement on the diagnosis of children. This may increase the influence of financial incentives for both providers and the MCO. It seems fair to say that this is certainly the case in Tennessee. In response to these disagreements and the "John B." litigation, Tennessee has implemented several levels of independent review that seem to be ensuring that children are receiving needed services in a reasonably timely manner. While these responses add costs and layers to the management and oversight of TennCare and the TennCare Partners Program, they are appropriate responses to ensuring that the needs of children are met. Ideally, they are temporary measures that can be eliminated as compliance improves and other consumer protection safeguards are implemented.

***Children in State Custody:*** Across the country, children in state custody have utilization rates of mental health services that are generally more than twice the level of TANF children, similar to those for the disabled. Medicaid is the almost exclusive source of health insurance to children in state custody. Providing an appropriate level of services to these children can be costly and yet critical to their success. Medicaid managed care initiatives in other states sometimes do not include these children out of fear that needed services will be inappropriately withheld. Other states have included child welfare cases in managed care in the hope that the flexibility and the more efficient use of prevention services in managed care would benefit the children. Having elected to include the DCS children in TennCare Partners, Tennessee officials must seek to find a balance between the medical needs of the children and their custodial needs. Often this can lead to conflict between resource scarce systems (DCS and TennCare).

There is no magic bullet to resolving some of the conflict and difficulties that exist between DCS and the BHO. A successful solution lies in an active collaboration between TennCare, the BHO and DCS, where each party understands the perspective of the other. This can be facilitated through more data and routine reporting on the services received by these children and greater clarity about the BHO benefits and the criteria required to access the benefits for these children. Armed with these data, state policy makers will need to make tough decisions regarding the scope of services required for children and adolescents and the financial resources available from each system to meet their needs.

***Residential Treatment Services:*** There has been considerable conflict between DCS, TennCare and the BHO concerning the approval of residential services for youth. Residential treatment services for children are not a traditional health insurance benefit except as a benefit exception and alternative to hospital care. In many states, as in Tennessee, there is also confusion over the extent to which a residential program involves treatment for a mental health condition vs. custody services, which are more likely to be the responsibility of the child welfare agency. DCS has been under a great

deal of pressure from advocates and the courts to expand residential services to children and yet they have had limited resources to accomplish this. As a result they have often sought, perhaps with justification, the approval of residential treatment services for their youth through TennCare Partners. Needless to say, the BHO has sometimes resisted this effort. One relatively simple, yet apparently elusive solution is to agree on a crosswalk of the different levels of residential treatment services and the criteria for placement for each level so that the BHO, DCS officials and others can agree on the appropriate placement options for youth. Clarifying the criteria for referral of DCS children to the different levels of residential treatment is important and is an issue that has created problems in many other states as well. According to stakeholders, there has been significant progress by the BHO in the development of alternative, home-based wrap-around services for children in the last year or two. Many of these services benefit DCS children. The state should continue to encourage these efforts.

**Case Management:** As noted later in this report, case management services have been used extensively in the TennCare Partners program to ensure access to TennCare behavioral health services. The provision of case management services to children in Tennessee is further complicated by the multiple agencies serving children and the litigation in the state. DCS has provided “targeted case management” services, reimbursable under Medicaid for children in state custody. TennCare Partners has separately provided case management for SED children, except for DCS children since they were separately receiving targeted case management through DCS. However, in response to concerns that the mental health services provided to DCS youth were not being properly coordinated, TennCare and Department officials have recently agreed to provide “mental health case management” through the BHO to those DCS children who also have serious emotional disturbance through the BHO. In the last two years, TPP has also developed Comprehensive Children and Family Treatment services (CCFT), a form of intensive case management specifically focused on the needs of children and adolescents. Since October of 2001, DCS children have been referred for these CCFT services when medically necessary. These types of mental health case management services are necessary for a certain proportion of children. Clear criteria need to be developed for each level of case management for DCS children. Unless criteria are selected with great care, many more children will receive case management than really need it.

Specific recommendations for referral criteria and the procurement of case management services are discussed elsewhere in this report. Additionally, the TennCare Partners program should make a distinction between the provision of case management services and the assignment of a case manager. Case managers should be assigned when children and adolescents have had repeated hospitalizations, are being discharged from out-of-home placement or are at risk of out-of-home placement. In addition to face to face visits with the children, parents, teachers and other may need assistance in understanding and supporting the child through their treatment and recovery. Mental health case management services for children should be time limited with a six month or annual review of the continued need for the service. For other TennCare members, case management services provided telephonically (by staff with much larger effective caseloads) can meet the short-term needs of children and families who need short term support to deal with a life event or crisis.

## **RECOMMENDATIONS:**

To address the unmet needs of these special populations recommendations include:

- Incrementally continue to improve EPSDT screening rates, setting realistic improvement goals and holding contractors accountable for both accurate reporting and their EPSDT performance.
- Seek to negotiate as much of the EPSDT service requirements as possible into the BHO rates and develop methods within claims systems to identify and track EPSDT related services.
- Continue to develop an active collaboration between TennCare, DCS and the BHO through regular meetings that review and development child related policies, review data on services to DCS children and that troubleshoot and implement quality improvement efforts for the behavioral health services to children in state custody.
- Develop a cross-walk of DCS funded residential services and the residential services funded by the BHO including service definitions and admission criteria.
- Continue to develop wrap-around services (e.g. CCFT) as an alternative to out-of-home placement for children with mental health needs.
- Ensure that the new “mental Health case management services” being developed for DCS children are reviewed periodically (6 months or annually) for continuing clinical necessity and that they are authorized only for those youth who truly need the service. Provide short-term telephonic case management services for those children who do not need to be assigned to a case manager but who need help with care coordination or an acute episode of services.

## ***Services and Benefits***

Most behavioral health services under TennCare were initially integrated with physical health benefits provided through MCOs. State hospitals and community mental health centers were carved-out of TennCare, however. In 1996 all of the behavioral health benefits were carved out of TennCare and TennCare Partners was formed with a choice of behavioral healthcare organizations. A series of partnerships between BHOs resulted in two BHOs for TennCare Partners: Premier and Tennessee Behavioral Health (TBH). Many community-based services that had been funded with grant dollars were now part of the Medicaid waiver program. To protect the consumers with greatest need, an enhanced benefit package was created to meet the needs of the “priority population” discussed in the previous section.

With this new model, TennCare Partners became the primary funding source for delivery of most public mental health and substance abuse services in Tennessee. In providing behavioral health services to TennCare eligibles a somewhat limited benefit of inpatient and outpatient services, similar to that included in many commercial plans, was made available to the general Medicaid population. In an effort to meet the needs of adults with SPMI and children and adolescents with SED, an enhanced benefit package that in-

cluded community based support services and case management was also included in the TennCare Partners Program.

Services include a range of community based mental health services, including residential and inpatient services. In an unusual policy, Tennessee included state hospital services at the Regional Mental Health Institutes (RMHIs) with the goal of making them more competitive and to capture additional federal matching funds. The basic and enhanced benefit packages are outlined below.

<b>Mental Health and Substance Abuse Benefits</b>	<b>Basic Benefit Package (all benefits must be medically necessary)</b>	<b>Enhanced Benefit Package (for those in the Priority Population) ⇒</b>
Psychiatric Inpatient Facility Services (including State Hospital) Under 21 ①	As medically necessary	As medically necessary
Age 21-65	Limited to 30 days per occasion, 60 days per year per enrollee ②	As medically necessary
Over 65	As medically necessary	As medically necessary
Physician Psychiatric Inpatient Services	As medically necessary	As medically necessary
Outpatient Mental Health Services	As medically necessary.	
Inpatient ③ and Outpatient Substance Abuse Treatment Services Includes Methadone Detoxification and Methadone Maintenance and Treatment of Pain, as Medically Necessary	10 days detox ④ Inpatient and outpatient substance abuse benefits have a maximum lifetime limitation of \$30,000 ④	As medically necessary (no lifetime dollar limit)
Psychiatric Pharmacy Services and Pharmacy-Related Lab Services ⑤	As medically necessary	As medically necessary
Transportation to Covered Mental Health Services	As medically necessary for enrollees lacking accessible transportation  The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee	As medically necessary for enrollees lacking accessible transportation  The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee

<b>Mental Health and Substance Abuse Benefits</b>	<b>Basic Benefit Package (all benefits must be medically necessary)</b>	<b>Enhanced Benefit Package (for those in the Priority Population) ⇒</b>
	regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.	regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.
Mental Health Case Management		Must be offered to all persons with assessments of CRG 1, CRG 2 or TPG 2. As clinically indicated for CRG 3.
24-Hour Residential Treatment		As medically necessary
Housing/Residential Care		As medically necessary
Specialized Outpatient and Symptom Management		As medically necessary
Specialized Crisis Services	As medically necessary	As medically necessary
Psychiatric Rehabilitation Services		As medically necessary

① *If medically appropriate for the patient, the BHO may authorize substitution of outpatient days, partial hospitalization days, or residential treatment days for covered psychiatric inpatient facility days. Two substitute days will count as one inpatient day. No substitute day may be counted toward any other benefit limit. In accordance with federal EPSDT requirements, the Contractor shall be required to exceed service limits when medically necessary for children under the age of 21.*

② *After the 30 or 60 day benefit level is exceeded for the Basic Benefit package, DMHDD assumes the financial responsibility for services from the BHO.*

③ *When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.*

④ *Housing/Residential Care is a covered service only when medically necessary for an individual's living environment to be supervised, structured and/or assisted by mental health staff.*

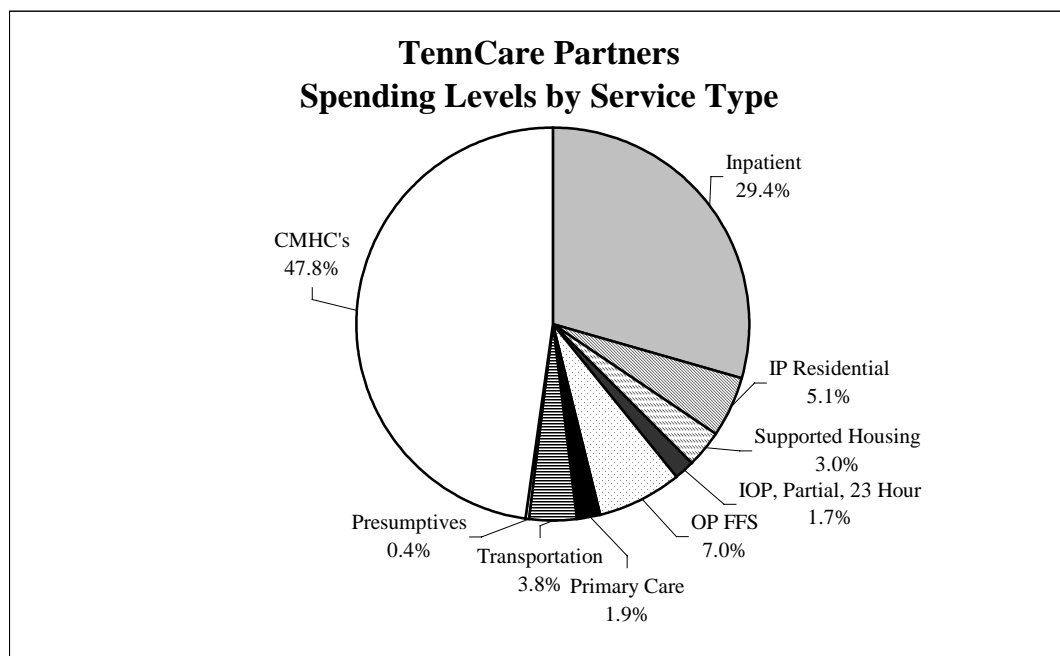
⑤ *The state is financially responsible for all pharmacy services as described in the contract.*

*Assessment as a Priority Participant shall not be required for enrollees under age 21 in order for the enrollee to receive medically necessary services in the Enhanced Benefit Package.*

TennCare Partners has achieved significant programmatic success. Unfortunately, this has not been widely recognized. Advocates and stakeholders reported such successes as the following over the last two or three years:

- Expansion of the benefit to include Assertive Community Treatment (ACT) & Community Treatment Teams (CTT) on a limited basis;
- Implementation of flexible, wrap-around services for children and families;
- Implementation of a program of housing vouchers;
- Use of several methods for eliciting stakeholder input (Round Table and Advisory Boards);
- Independent advocacy line;
- Carving out and expanding the pharmacy benefit; and
- Provision of expanded coverage for the uninsured/uninsurables.

During interviews, advocates and stakeholders voiced concerns and made recommendations regarding availability of and accessibility to all needed services. Stakeholders also complained that TennCare Partners has not decreased utilization of inpatient care; and has failed to meet the demand for community services, appropriate case management for target populations, and increased access for children and youth. Likewise they complained that there are few or no truly mobile crisis services and that consumer and psychosocial rehabilitation services need expansion. Advocates and stakeholders view TennCare Partners as under-funded, and as unsuccessful in fully delivering the services envisioned in the contract. The data do not truly support this, however. In fact, there has been limited use made by stakeholders, advocates and decision-makers of data that were often available within the system. As shown in the figure below, the vast majority of services funded by the BHO were in the community – only 29% of the expenditures were on inpatient or inpatient residential levels of care, including state hospitals. This compares favorably with other public sector plans.



Source: Advocare CY 2000 Financial Statement – Total Spending = \$283,238,291

In the sections of the report that follow, several of these specific service areas will be discussed further.

In 1999, representatives from Tennessee DMHDD and the TennCare Bureau formed a team to review the benefit package and make recommendations to the Commissioner of DMHDD and the Director of TennCare. Highlights of their report included the following:

- Use Rehabilitation and Recovery as the “overarching philosophy of care”;
- Collapse the basic and enhanced benefits into a single package;
- Use medical necessity to determine eligibility for services contained in the enhanced package; and
- Return to the medical necessity definition used in the first TPP contract, so that functional and environmental needs may also be considered.

This *Transition Report* was issued in May 2000 by TDMHDD and the TennCare Bureau.

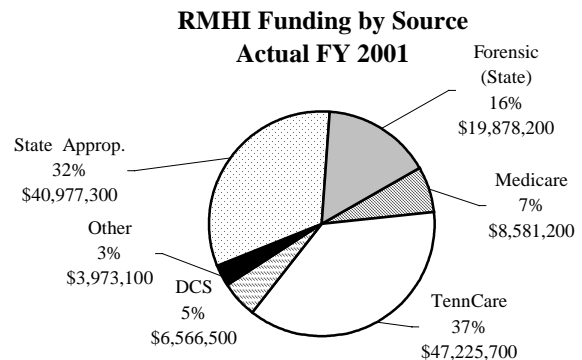
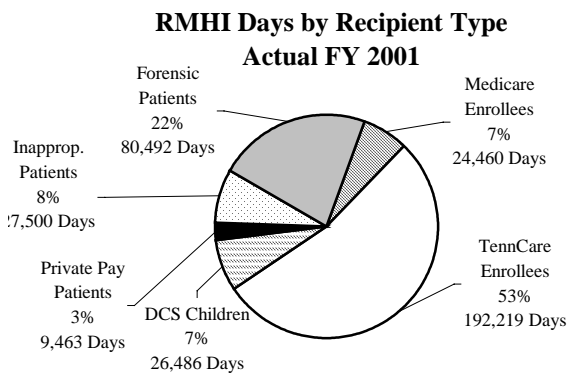
**RECOMMENDATIONS:**

- Revise the benefit plan to eliminate the enhanced benefit for a priority population. Services should be authorized based upon the need for the services. Considerable work has already been done by state staff on this area.
- Continue current efforts to expand rehabilitative and recovery based services, including consumer run services.
- Continue the carved-out pharmacy benefit.
- Maintain the independent advocacy line.

**Inpatient**

Under the current TennCare Partners Program, the basic mental health benefit is similar to that included in many commercial plans. The inpatient benefit is limited to 30 days per occasion and 60 days per year per enrollee for adults 21- 65 who are eligible for basic benefits. After the 30 and 60 day limits have been exceeded, the financial responsibility for inpatient services shifts over to DMHDD. There are no mental health inpatient limits for priority population members. However, for substance abuse, inpatient and outpatient benefits have a combined maximum lifetime limitation of \$30,000. In all other instances, admission to inpatient is determined based on medical necessity.

In meetings with stakeholders, they consistently raised concerns regarding excessive use of inpatient, lengths of stay and rates of admission. However, in contrast to what stakeholders said, a large percentage of the benefit is in fact currently going to community providers. Payments to Community Mental Health Agencies (CMHAs) account for 48% of the benefit. Other services are also provided in the community as a part of the BHO's expansion commitment.



Much of the concern about inpatient services was the result of a high census and increasing admissions at most of the RMHIs. The number of admissions to the RMHIs has increased nearly 50% since the inception of the TennCare Partners Program. During the same period the census at the RMHIs has increased less than 10%. This suggests that long-term patients have declined in number and that acute care has begun to absorb more of the resources at the state hospitals. A closer look at the data suggests that the in-



creases are occurring in forensic and non-TennCare populations. Additionally, as the two charts show above, 53% of the clients served by the RMHIs are in the TennCare program, while 37% of the revenues are from TennCare. This imbalance suggests that the state hospital rates paid by TennCare may be set at a level below their actual cost. Since these rates are significantly below market, RMHI admissions are preferred whenever possible. This may not be desirable in the long run.

**RECOMMENDATIONS:**

- The state should consider increasing the rates paid for state hospital inpatient services and supplement the BHO's funding to compensate for this increase. Funds should be drawn from the existing DMHDD subsidies to the RMHIs.
- Distribute information about inpatient service cost, utilization and quality more widely to make the actual inpatient utilization clear to all stakeholders. Begin to focus on length of stay and readmission rates for inpatient facilities.

## **Crisis Services**

Crisis services are intended to provide community-based interventions to people in crisis in order to help them avoid inappropriate or unnecessary hospitalization. These services are a critical "front-line" in a continuum of care. The current TPP contract requires the BHO to provide emergency services without regard to TennCare eligibility. The Service System Design TAG (Technical Advisory Group) recommended that, "...TPP provide an effective urgent outpatient system that can respond to consumers and family members in crisis".

While there has been a considerable effort to enhance crisis services in TPP, many stakeholders reported that, "Mobile crisis services were not mobile". The current data for mobile crisis services suggest, however, that the efforts to divert people from inappropriate and unnecessary hospitalizations seem to be reasonably effective. While each agency exhibits a different pattern, many face-to-face encounters are occurring in emergency rooms and other locations, and a high percentage of these encounters result in diversions. However, when mobile crisis screening is done routinely in the ER, TennCare enrollees are often faced with transportation issues that result in police transport to the ER— a less than desirable means of transportation.

**RECOMMENDATIONS:**

- The state and the BHO should continue to actively monitor the performance of individual crisis providers including, at a minimum, rates of ER and community assessments, diversion rates and RMHI referrals.
- Efforts should continue to be made to improve diversion rates and increase the number of assessments in the home and community, where possible. The state and the BHO should also seek to develop more crisis respite and residence options for consumers.

## Case Management

Case management services are generally designed to assist people in coordinating their community-based services or in obtaining non-clinical supports to stay in the community. It is generally recognized that effective case management can significantly improve outcomes for seriously mentally ill individuals and children whose mental illness and disability prevent them from accessing treatment services, performing activities of daily living, and/or participating in school or work. However, case management in TennCare seems to have been overused and may not be cost effective unless services and their intensity are redefined. Under TennCare Partners, case management is a service that must be offered to everyone in the priority population and to anyone who is being discharged from inpatient care. As noted earlier, over 180,000 priority members have been identified over the life of the program and 80,000 are in service right now. Of those, about half are receiving case management services.

The BHO reimburses case management services using a set of three blended rates, based upon the number of face to face encounters provided to the priority population in a specific month according to the following levels:

- Tier 1: Provide one or two services per month, one of which must be case management
- Tier 2: Provide at least three services per month, one of which must be case management
- Tier 3: For priority members being discharged from inpatient, an additional fee is paid to the CMHC if a case management service is provided to the member within seven days of discharge

This method of reimbursement may encourage some case managers to provide more direct services to consumers who are easy to locate, not necessarily those with greater need. Hence, many of the stakeholders referred to “drive by” case management in our interviews.

Initial data we reviewed indicated that 47% of TennCare Partners benefits spent on the blended case management rates to community agencies. Since these services are reimbursed using a blended rate, a reliable source of data on the actual types of services received by consumers was not readily available. Recent data made available suggests that approximately 60%-70% of the blended rate is being used for case management services (or approximately 30% of the total benefit). The balance is used for medication management, therapy and psychiatric evaluations. In addition to these “basic” case management services, “intensive case management” services are provided to adults through continuous treatment teams (CTT’s) and to children through Comprehensive Children & Family Treatment (CCFT). These services have an average caseload of 1:10 for adults and 1:6 for children and adolescents. They are provided to members who have very high needs for support to continue to remain in the community. Children in DCS custody also receive Medicaid reimbursed “targeted case management” services from DCS workers and the state has recently added new funds for “mental health case management” for DCS children with SED through the BHO. All of these types of case management comprise a large portion of the benefit and may be reducing the availability of other more effective resources. Case management expenditures in other parts of the country represent, on average, about 20% to 30% of mental health dollars.

All of these layers of case management service types can be confusing and reflect the excessive reliance on case management services and the incremental addition of services to the benefits. In meetings with stakeholders, it became clear that their uses of the term

case management, and their interpretations of the case management definition included in the TPP contract, varied. This was particularly true among officials from the different state departments. In addition, the TennCare Partners program should make a better distinction between case management functions and the role of an assigned case manager. *Case managers* should be assigned when members have demonstrated a long-term inability to manage their illness or activities of daily living. *Case management* services should also be provided in-person and/or telephonically by case managers with larger caseloads to meet the needs of members who generally manage life events successfully, but experience a short-term, social crisis. In these instances, support is provided for a brief period to help the member manage the crisis.

The purpose of case management for adults and children, and the models used to deliver it, should be reconsidered. The literature offers a variety of definitions of case management that include functions such as: gate keeping/utilization management; advocacy; brokering; phone consultation and support; information and referral; home visits; and community support. Basic case management should not have to be provided in order to bill for medication clinics, though certainly it should be available. The assignment of case managers for children and adults should be based on criteria that assess the functional and psychiatric rehabilitation needs of recipients, rather than just the CRG or TPG rating. These criteria might include the following elements:

<b>ADULTS</b>	<b>CHILDREN &amp; ADOLESCENTS</b>
2 or more inpatient admissions in one year	2 or more inpatient admissions in one year
A length of stay in excess of 30 days	A length of stay in residential treatment in excess of 30 days
Homeless or at risk of homelessness	At risk of out of home placement
2 or more ER contacts in 6 months	2 or more ER contacts in 6 months
Dual diagnosis of MH/SA	Dual Diagnosis of MH/SA

Many advocates indicated that because so much money is spent on case management, it has been difficult to provide other care or expand needed services. A report on TennCare Partners prepared by William M. Mercer stated, “Case management ... is not necessarily a service that is needed and/or wanted by all members of this population.” The Mercer report goes on to recommend 3 levels of recovery-oriented case management: intensive, regular and case coordination.” To the general levels outlined in the Mercer report, the current recommendations add an ombudsman function to help resolve specific short-term issues.

## RECOMMENDATIONS:

- A full review of the current populations served and the services provided through the “bundled” case management rates in TPP should be performed. This review should consider new criteria for authorizing case management services as noted above and consider different levels of care in case management. It may be desirable to “unbundle” some of the services that are included in the current “bundled” rates. The details should be worked out in a planning group consisting of state and BHO officials, providers and consumers. The planning group should begin meeting as soon as possible.
- Case management services should include the following levels of care provided by the BHO and/or providers:
  - Ombudsman: Services should focus on resolution of an issue or broker a needed service. This service could be provided by the BHO or contracted out.
  - Short-term and Transitional Case Management: The service includes brokering and community support, as well as advocacy for access to needed services on behalf of individual clients. Services may be delivered by telephone or in-person, as needed by the individual client. The service should be available to consumers on an ad hoc basis. Suggested caseload should range from 20 to 30 clients per case manager and should be time-limited to no more than 3 months.
  - Community Support: Community support should provide assistance and skill training to adults, children or children’s families to enhance community tenure. This service should be provided with a suggested caseload of 30 to 50 individuals, in-person and perhaps in small groups. Provision of this service in medication clinics or with peer support programs may be ideal.
  - Intensive Case Management (ACT, PACT, CTT): This service should be is provided to people who are at high risk of future hospitalization or placement and who need both community support and treatment interventions. The existing level of this service in TennCare should probably be expanded somewhat and the average caseload should be similar to the current CTT and CCFT services.
- Case Management for Children: The above categories of case management should be implemented for adults and children. For children, however, the services should be focused on the child and the natural or surrogate family. Services should work with multiple systems – education, child welfare, etc. Case management for children has become a focus of some of the litigation involving the program and as a result should be better defined in the new contract. It has also been more fully discussed earlier in the report.

## ***Utilization Management (UM):***

Applying medical necessity criteria to determine the appropriateness of services has been viewed by many as a barrier to rehabilitation and recovery treatment for people with serious mental illness. Rehabilitative services provide support to people in their effort to overcome their illness and meet basic personal goals and are generally not designed to address medical conditions. In addition, requiring that the medical necessity standard be met is perceived as a barrier for those who need residential alcohol or drug treatment, because the residential setting is often not needed for medical reasons, but in order to achieve psychological and behavioral change.

A move to “clinical necessity” from “medical necessity” may increase costs by as much as \$1 per member per month, according to estimates provided by the State of Tennessee. However it may be possible to implement the criteria for certain services only, e.g. case management thus limiting the adverse financial impact that might result from changing the standard for all services. For instance, the expansion of services for substance abuse treatment and the use of new utilization guidelines for these services should receive further study because these steps will likely have a significant cost impact. Currently, access to the first few outpatient visits is not subject to UM. This model should be continued.

The current TennCare Partners contract does not include many specific requirements for utilization management. The one section specifically addressing UM area is in the Quality Monitoring attachment to the contract. Utilization management should, however, be closely linked to the quality improvement program to ensure that enrollees are attaining appropriate clinical outcomes. Consistent with this, it is recommended that quality studies be initiated to identify opportunities for procedural change and improvement. Such studies might be used, for example, to review appeals of UM decisions and to collect data on the cost of Grier and other legal settlements.

### **RECOMMENDATIONS:**

- Admission criteria should be based on a new set of clinical necessity criteria, consistent with a psychosocial rehabilitation philosophy. Using clinical necessity will encourage reviewers to consider environmental and social factors in determining the need for treatment, rather than looking only at the medical condition.
- Consumers should have access to assessments and initial outpatient services without prior authorization. Prior authorization or referral should be required for case management services and for all 24-hour levels of care.
- A new section of the contract should be created to specifically identify utilization management standards.

## ***Service Network & Credentialing***

Currently the TennCare Partners service network contains most of the licensed providers in the state, e.g., psychiatrists, community mental health agencies, and psychiatric inpatient units and hospitals. However, there is considerable concern among most

stakeholders that access to care is limited, especially in rural areas. This is substantiated by the fact that some current geo-access standards, i.e. maximum levels for time and distance to some services, are not being met by the BHOs. However, in many instances, there are not enough licensed providers in the state in the right locations to meet the geo-access standards. Hence the problem reflects a need to recruit providers to Tennessee, which may necessitate offering better reimbursement for services.

Most geo-access standards do not measure the capacity of a network to serve the needs of its enrollees. Instead they merely assess the proximity of providers to enrollees. In many parts of rural Tennessee, the standards included in the contract are not appropriate or reasonable. Enrollees in rural areas may be far more accustomed to driving longer distances for all services, and the service volume is often inadequate to support new programs in rural communities.

While credentialing procedures are intended to ensure minimal standards of quality in the provider network, providers complained of the “hassle factors” associated with being admitted to the network and are seeking to have barriers to entry minimized. The criteria for admission to the network need to be reasonable and the processes for application and approval must be streamlined.

#### **RECOMMENDATIONS:**

- Alternative service strategies should be created for areas of the state, especially rural areas, where geo-access standards cannot be met. The geo-access standards could be augmented with other measures of access, thus creating reasonable exceptions, such as:
  - Geographic service capacity, based on the willingness, availability and past history of a provider to offer needed services in the area
  - Availability of intensive home based services rather than program services to meet the standard.
  - Primary care physicians with experience in treating people with mental illness might be the only reasonable alternative for medication and physician care, if no licensed psychiatrist serves a particular geo-access area.
- The state and the BHO should consider implementing an expedited approval process or a policy of “any willing and qualified provider” in certain geographic areas, if such a model can reasonably be expected to close the geo-access gap and if alternatives are not possible. This would mean that in those areas not meeting geo-access standards, the network participation criteria would be similar to those in effect prior to the waiver.
- Since the recruitment of health care professionals to Tennessee appears to be an underlying issue, a broader statewide campaign for recruitment of specialists should be undertaken outside of the TPP program.

## ***Litigation***

Throughout the course of the TennCare Partners Program, litigation has played a powerful role in shaping its policies and operations. The different litigation efforts that currently impact the program emerged from problems in access to care and patients' rights. The consent decrees and settlements resulting from the lawsuits have increased staff and expanded administrative oversight and costs for the program. Many stakeholders therefore reported major concerns about the costs of compliance with the settlements. Others indicated that the impact of some of these cases, notably Grier, was less than had been feared.

The cases having the most impact on Partners include Grier vs. Wadley and John B. vs. Menke. Grier vs. Wadley is a lawsuit that was filed for noncompliance with Medicaid laws and regulations relating to due process and appeal rights of persons on Medicaid. The suit resulted in a Consent Decree, which prompted new TennCare regulations regarding an enrollee's appeal and hearing rights when services are denied, delayed, terminated, reduced or suspended. In John B. vs. Menke, the plaintiffs' complaint alleges that TennCare fails to fulfill its obligations under federal law to provide medical services. The complaint charges that there are systemic failures to screen children according to the prescribed periodic schedule, to properly diagnose their medical (and mental health) needs, and to provide them the full range of health services which they require under EPSDT (Early and Periodic Screening, Diagnosis and Treatment) standards. Plaintiffs allege that for class members, who are in DCS custody, the general problems are compounded by poor coordination of TennCare services by the MCOs, BHOs and the state custodial agency, among which EPSDT responsibilities are shared. Attorneys for the Tennessee Justice Center and representatives of the State have jointly developed an EPSDT Consent Decree that outlines steps the State will take to assure compliance with EPSDT requirements regarding screening, diagnosis, treatment, and the coordination of services with other programs and services. However, in recent weeks the Federal Court has ordered all children in TennCare (500,000 of them) into a separate program. This is because the Court has found that the state failed to provide the level of screening, diagnosis and treatment services for children that was agreed to in the consent decree.

The Grier & John B. consent decrees have resulted in increased administrative costs, expedited appeals, and perhaps improved access to care, yet there has not been any data provided on this. Additional outcomes that occurred as a result of the consent decrees include:

- The number of appeals vastly increased to more than ten times the number that occurred prior to the November 2000 implementation of the final provisions of Grier.
- Additional staff have had to be added to take telephone appeals.
- Since most enrollees request expedited appeal (31 days) rather than the 90-day standard appeal, additional staff has been required in the TennCare Solutions Unit and other state offices.
- The BHO indicated that 14 FTEs were required to comply with the noticing provisions of Grier.
- The Grier pharmacy provisions now require pharmacists to give written notice of a denial of a medication, along with a fourteen-day supply of the medication (rather than the 72 hour supply previously required), unless it is non-covered or medically contraindicated.
- In the John B. consent decree, new staff have been added to the TennCare Team to review cases for residential treatment authorization

and considerable effort has been expended by DCS staff and TennCare staff to increase the rates of EPSDT related screening.

Consistent with the John B. consent decree, specialized mental health case management has been implemented to improve coordination of services for children in custody. This has required considerably more funding within TennCare and DCS and yet judging by the recent ruling, it has not been very successful.

**RECOMMENDATIONS:**

- The costs associated with implementing the existing consent decrees should be reviewed to determine ways in which these consent decrees can be better managed, to account for the costs of legal compliance and also to disclose the requirements of the litigation to potential bidders.
- Additionally, data related to appeals, grievances, and utilization should be reviewed in an effort to assure that members' rights are protected, that services are accessible and available in a timely manner and to identify opportunities for quality improvement. The findings from this data review and recommended changes in policies, programs or operations should be incorporated into the reprourement document.

***Claims Payment and Provider Reimbursement***

During the early years of TennCare, claims were generally not paid on a timely basis by the two BHOs and there were numerous complaints from providers and state officials alike. During the last couple of years, however, with the consolidation of the BHOs to a single administrator (Advocare) the timeliness of claims payment had significantly improved. Then, in the spring of 2001, the effort to implement a new claims system for Advocare (through a new subcontractor, Consultec) resulted in new delays in claims payment. In the months following implementation of the new claims system, Advocare has been fined liquidated damages for not meeting the claims standards. The timeliness has been improving in the last several months, however, and appears likely to be in compliance again soon. One of the biggest risks in the transition to a new BHO is that a new vendor will likely bring in its own claims system and the migration to this new system may produce delays in claims payment. Recontracting with the existing vendor will produce the least disruption, unless for some reason they decide to modify their claims system again.

A full review of the adequacy of reimbursement rates for all services was not performed as part of this study. Providers did complain about the adequacy of rate for some services, particularly case management. Currently, Mental Health Centers and certain other providers are receiving three different blended rates for case management and other community services to the priority population. These blended rates are paid to the Centers based upon the number of face-to-face encounters that take place between case managers and clients during the month. In addition to the required case management encounters, some clients may receive other services, such as medication visits and outpatient services. Though the frequency of these visits is not clear, providers complained about not being reimbursed for them.



Economically, this three-tier payment system provides no incentives for providing less care to some consumers who may be stable and more care to those in crisis. Telephonic care coordination may be appropriate for many consumers and it may achieve the referral, brokering and troubleshooting goals that some adult and child consumers may need. However, under the current model, multiple phone calls from a case manager in the month do not produce a billable event for that month. There has been concern expressed by the state's actuaries that the encounter data maintained by the BHO may not be accurate. The BHO disputes this; however a special study has been implemented requesting data from the Mental Health Centers directly.

State hospital rates paid by the BHO for care is substantially lower than the rates paid to other acute hospitals. DMHDD staff also reported that the Department subsidizes the BHO rates with other funds. Generally the care provided by the Regional Mental Health Institutes (RMHIs) was felt to be adequate or good. This creates an incentive for the BHO to keep RMHI beds full despite the stated intention of the Department to reduce the occupancy of the RMHIs. There is a possibility that some additional federal revenue could be claimed with these higher rates in TennCare.

**RECOMMENDATIONS:**

- Continue to focus on claims timeliness and include penalties when timeliness does not meet contractual standards.
- The reimbursement methods for case management need to be reviewed as a part of the overall review of case management services. For some levels of case management, services may return to fee for service (unit rates) and in other cases the blended rates may be much higher. Long term case management services should all be subject to prior authorization and should be focused on a subset of the priority population of SPMI adults, SED children and children in state custody. Encounter data for case management services that are paid on a blended or case rate must be collected and maintained by the BHO. The contract and the RFP should include specific reference to this.
- Rates for state hospitals should be increased in their provider agreements and the funds that are supplementing the services in the RMHIs should be added to the TPP base in the TPP contract.

## ***Quality Improvement***

The central goals of Quality Improvement (QI) efforts are to improve the quality, effectiveness and efficiency of care to health plan recipients. To accomplish this, health plans must implement an organized method to plan for system improvement by monitoring health plan performance and systematically acting on the findings from these monitoring activities. Successful QI initiatives should include action plans and improvement efforts that are properly supported and effectively implemented. Many organizations fail to fully achieve goals that are established at the beginning of a QI effort because their QI plans were far too ambitious. The experience of most healthcare purchasers is that health plan performance is dramatically improved by a concentrated focus each year on a small number of QI goals.

Tennessee's contract with Advocare requires the implementation of a Quality Monitoring Plan (QMP) (Attachment C). This includes a written plan description, which must out-

line a process that is broad in scope, continuous and systematic. The contract further requires the implementation of a Quality Assurance/Improvement Committee that reports to the Governing Board of the organization and to senior staff. Included in the QMP are standards for credentialing of providers, training, consumer rights, facility and record standards, and utilization review. The Quality Monitoring requirements in the contract are comprehensive and cover most of the needed areas.

**RECOMMENDATIONS:**

- In the future RFP and contract, state staff may want to distinguish quality assurance (licensing, credentialing and certification activities) from quality improvement activities since the differences are significant and often confused. Both activities are essential.
- Certain of the sections included in the Quality Monitoring attachment to the contract should be moved to other sections of the contract (e.g., Utilization Management should be moved to a new Clinical Management section)
- The state should exercise greater leadership over the BHO's QI activities, directing specific activities through annual contract modifications and facilitating interagency improvement activities.
- The contract should contain a limited number of quality improvement initiatives that are mutually agreed upon by the BHO and the state to cover the most important areas. These initiatives should be reviewed annually and revised as necessary.

### ***Performance Measures and Reporting***

The TennCare Partners program and its stakeholders have always been concerned with outcomes and performance measurement of managed care. As with most public managed care initiatives, TennCare began with the sincere belief that clinical outcomes should improve under managed care. The logic was that enhanced accountability and flexibility of benefits will lead to provision of more appropriate services and therefore better results. The problem with this thinking is that the complexity of public mental health systems and public funding can result in a high degree of variation in certain measurement variables as well as frequent disruptions to the system, as this report has observed. Many factors ultimately influence program and clinical outcomes, and these system disruptions increase the difficulty involved in understanding the reasons for any particular outcome. Furthermore, many of the standards selected in the first contract were unreasonable given the nature and scope of the program. Experience suggests that only systematic efforts to measure performance, identify improvement opportunities, plan change and measure the results of these interventions can succeed in significantly improving system-wide quality.

Performance should be measured and reported in managed care programs for two primary purposes: 1) monitoring for quality improvement and 2) determining incentive payments. Reporting requirements generally include routine reports to be prepared and submitted at specified intervals, and special reports (generally for a limited number of ad hoc special reports).

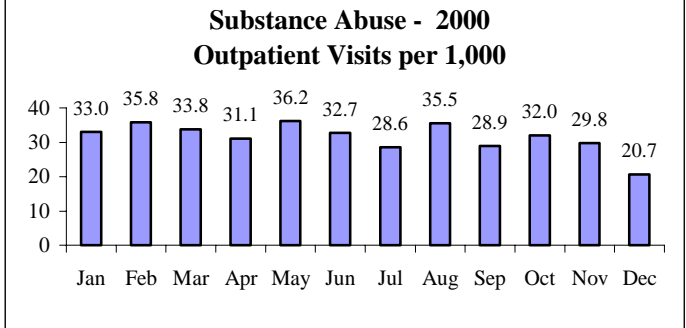
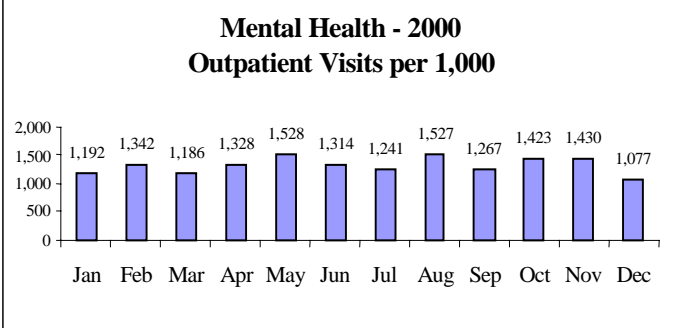
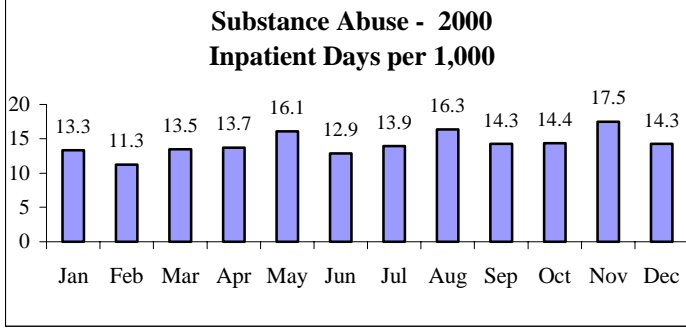
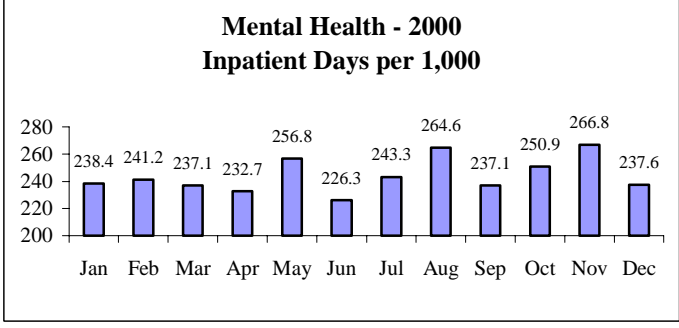
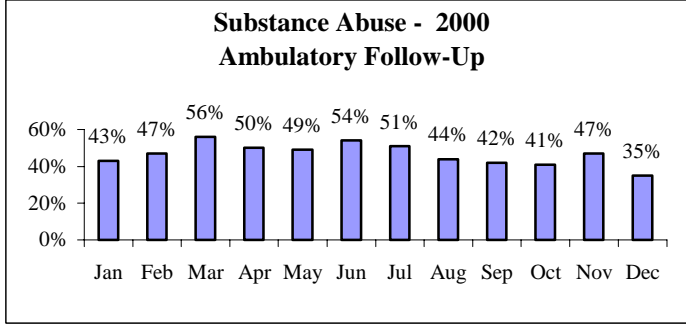
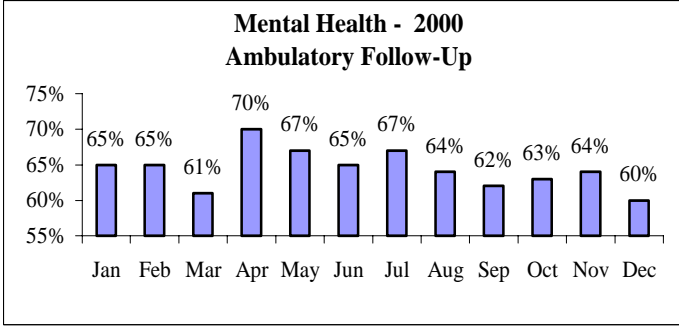
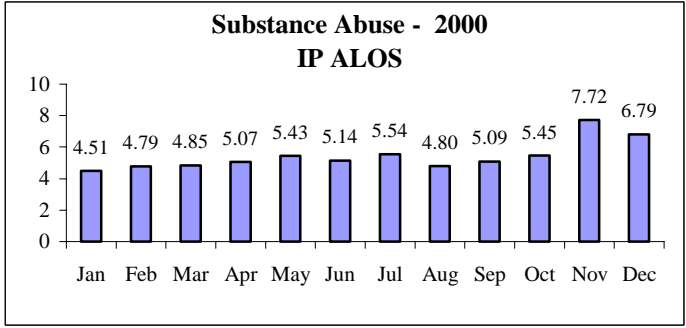
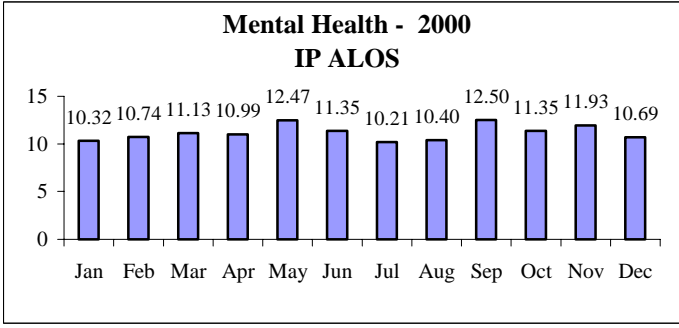
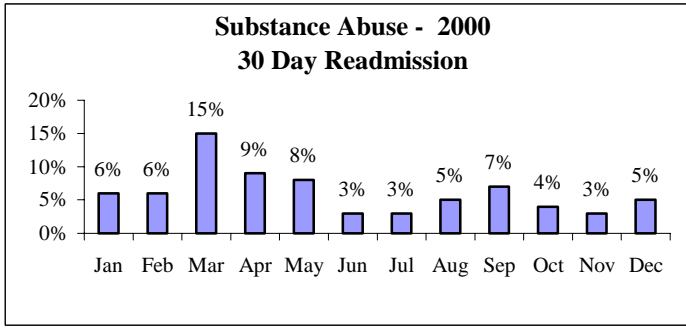
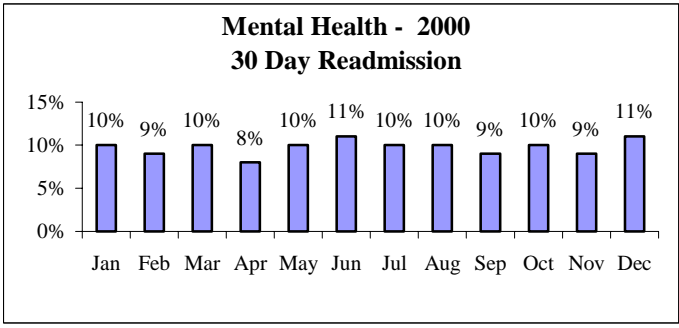
Routine reports are being prepared by the TennCare BHO on a quarterly and annual basis, with certain reports being done monthly. The quarterly reports are very extensive and in some cases comprehensive. However, in many cases there are narrative reports that summarize the BHOs compliance with the contract or activities in certain areas of responsibility. The length and number of these reports make them very hard to use and, not surprisingly, until recently the quarterly reports were not being used very effectively. Performance data from TennCare Partners is not readily available to or utilized by senior state managers.

In most instances special, or ad hoc, reports can be prepared by DMHDD staff directly through the use of the Department's data warehouse. A key staff person has been hired recently and other staff are being added to improve the ability of the Department to analyze the reports and prepare routine measures of performance. These are critical positions to maintain and support. Purchasing high quality and cost effective services cannot reliably take place without the data necessary to assess quality and value, and without the staff expertise to make best use of the data. Managing with data takes time.

As an example of the types of data that are readily available from existing reports, the charts on page 34 were prepared to illustrate the relatively stable trends and generally reasonable levels for many standard performance measures. These measures for calendar year 2000, shown in the charts on the next page, include inpatient days per 1,000; outpatient visits per 1,000; inpatient average length of stay (ALOS); 30-day readmission rate; and percents of discharges with 30-day ambulatory follow-up. These HEDIS and similar measures, which are reported for mental health and substance abuse services, describe a managed care system that has a slightly high number of MH inpatient days per thousand and average length of stay compared to commercial plans, however the 30 day follow-up rates and lengths of stay for substance abuse are quite consistent with national commercial rates. The inpatient data is explained by the inclusion of state hospital services in the plan. These measures should be compared to many other Medicaid plans.

**RECOMMENDATIONS:**

- The existing performance reports should be summarized wherever possible, and trend data should be prepared, similar to the above charts. Key measures of access, cost, and utilization should be included. Considerable work is being done nationally on recommended measures, including the Uniform Reporting System for Block Grants and the recommendations of certain national benchmarking projects.
- Eliminate unnecessary reports (and reduce the length of many of them) to improve overall efficiency. The current ones are not being used. Implement a sunset policy on reports from the BHO. If they are not being reviewed by the state or used for policy making, eliminate them and provide them only on an ad hoc basis.
- Maintain, and if necessary expand, the level of resources devoted to data reporting and performance measurement in DMHDD. These positions are essential to ensuring public accountability of the program.
- Performance data should also be reviewed at a regular meeting with all senior managers, permitting people with different learning styles to ask questions and listen to a discussion of the data rather than just reading the report.
- Develop a quarterly report card of key measures.



Source for all charts: Magellan Behavioral Health Care Performance Entry Sheet 2000

## ***Incentives***

The TennCare Partners contract has an extensive list of performance incentives; or more aptly put, penalties for non-performance. These penalties, or liquidated damages, cover six levels of deficiency and 139 different standards; the measures and their associated penalties were probably established because of the many fears people had about implementing managed care for the mentally ill. When the contract was drafted, there was a belief that the MCOs and the BHOs would respond to financial penalties. The current system, however, is all but impossible to enforce and requires an excessive amount of time to administer. Many of the actual measures are difficult or impossible to measure without new and expensive data collection efforts, and each individual penalty is small. Moreover, many of the standards would be extremely costly or even impossible to implement. The mistake was the assumption that “more is better”, when in fact beyond a certain threshold, the threat of yet more penalties produces avoidance behavior and reduces the effectiveness of existing penalties.

The time required for the BHO to report, for the state to monitor results on each of the different measures, and assess liquidated damages for failure to comply, is excessive. In fact, many of the measures are not being formally assessed. This puts the state in the awkward situation of having to ignore, or at best waive enforcement of, certain contract provisions. This kind of situation is never satisfactory, and the public relations implications are quite clear – it looks bad in the headlines and it weakens the state’s negotiating position with the BHO. The solution ultimately is to focus the number of incentive payments (liquidated damages) on critical areas of contractor performance. In this situation, less is more.

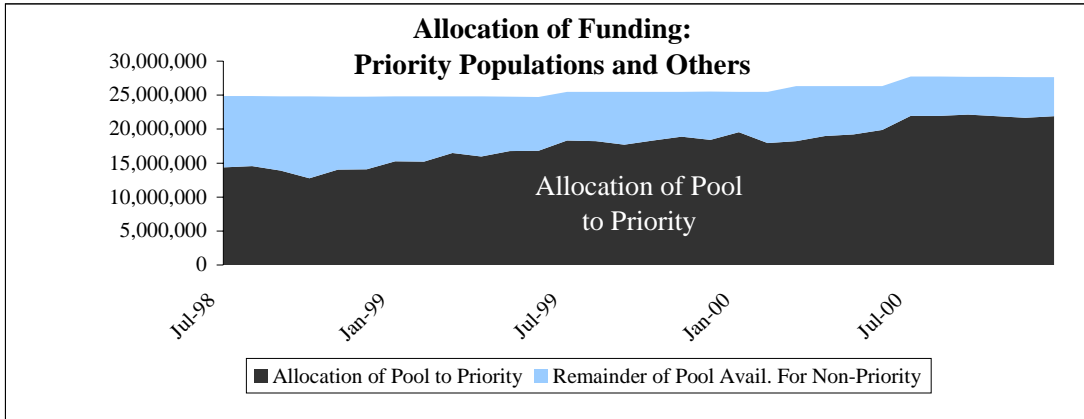
### **RECOMMENDATIONS:**

- The number of existing penalties should be dramatically reduced. Develop a new set of incentives and penalties for the reprocurement that includes no more than 10 to 20 different items. Include rewards for successful performance and implementation of key program initiatives, as well as penalties. Rewards can certainly be “gamed,” but usually produce more reliable and durable behaviors than penalties, and do not produce avoidance behavior. Examples of areas for reward might include the successful implementation of new service standards and reimbursement for case management that expands on the diversity of services available.
- Ensure that the BHO can prepare all necessary reports at a reasonable cost prior to including them in the contract.
- Include provisions in the contract specifying that changes in the incentive provisions will be negotiated annually.

## ***BHO Reimbursement***

The BHO is currently reimbursed using a somewhat unusual combination of techniques. Total state payment is fixed at a single monthly amount (global budget) – currently \$29,799,768 per month. This monthly amount has changed little over the last two or three years of the contract except for the addition of funds to cover certain special populations and expanded benefits. Within the global monthly amount, there is a monthly rate of

\$319.41 paid for Priority Participants to cover the enhanced benefits. The balance of global payments, a figure which changes monthly based upon the number of enrollees in the Priority Population, is used to determine a variable rate for the remaining participants.



The reimbursement system places the BHO in a challenging position, as may be seen from the figure above. The number of enrollees in both the priority and the overall TennCare populations is growing. Litigation and negotiations with the child welfare agency are also driving up costs for administration and claims. There is pressure to increase provider rates. However, BHO revenue does not grow with the increase in new enrollees as it would under a capitation method of reimbursement; instead, the only increases are for discrete, new services to special populations (e.g., mental health case management for children in state custody). The BHO also operates with a contractual requirement that it maintain a medical loss ratio of 90%. They have met or exceeded this ratio every month. This functions to limit the incentive to unnecessarily limit spending on direct services.

The reality is that the BHO is probably not able to manage its spending according to these rating categories. Routine BHO reports documenting spending or claims for the Priority Population either were not produced or were not available for this review. These data are just now being collected as a part of the actuarial analysis the State is conducting. Early indications are that spending is much lower than \$319 per month for the priority population and higher than the per capita equivalent for the remaining TennCare population.

As a result of the diminishing profitability of the contract for the existing BHO, and the need to amend the contract, the state recently proposed two options for sharing risk with the BHO. Taking these steps may help to minimize the disincentives to providing care and may limit the BHO's losses and profits. The BHO did elect to enter into one of the proposed risk sharing arrangements, a likely indicator of its belief that the prospect of future profits was minimal under the prior arrangement. Recently, the BHO elected to change the method of risk sharing to one that allows it to make a slightly higher profit, while still providing some downside protection.

**RECOMMENDATIONS:**

- Capitation should be the method of payment to the BHO in the reprocurement. Monthly premiums should be paid for several different rating groups. Rates should not be based upon the priority population definitions currently used in the contract. From a programmatic perspective, and based upon work in other states, the rates should probably include four rating categories: TANF and SSI Medicaid eligibles, TennCare Standard eligibles, and children in state custody. A complete actuarial analysis, however, may indicate that other rating categories are desirable.
- The state should continue or slightly modify the current risk-sharing method in the reprocurement, as it will increase the likelihood that more than one organization would submit bids for the work.

***Contract***

The goal of the contract is to summarize the business relationship between the purchaser and the behavioral health organization in a clear, comprehensive, concise and enforceable manner. The contract is central to the relationship between the state and the BHO. If requirements are not in the contract, they are not likely to be met.

Since 1994 and the implementation of TennCare Partners, the contract changed significantly from one between the state and MCOs with an integrated behavioral health benefit, to one with separate behavioral health organizations that were affiliated with the MCOs. In 1998, as a result of acquisitions among the behavioral health organizations, one BHO was providing the entire behavioral health benefit for TennCare. These major changes were reflected in a series of seven (7) contract amendments.

The current contract between the state and Advocare was completely rewritten in the spring of 2001 to incorporate the terms of the previous amendments, simplify the organization of the document and more clearly specify deliverables and contract requirements. Generally, this rewrite of the contract was successful at simplifying the language and clarifying the different requirements. In addition, the state had prepared another rewrite of the contract incorporating a variety of new program and reimbursement provisions – many of them similar to the changes that are being suggested here – and to reorganize and simplify the document. This new revised draft was never executed.

**RECOMMENDATIONS:**

- Reorganize the contract to make the key provisions more accessible to everyone, including the purchaser, contractor, other state administrators and the general public:
  - Separate program requirements from state general terms and conditions.
  - The current summary of the deliverables required by the contract is useful and should be maintained.

### **RECOMMENDATIONS (continued):**

- Reporting specifications and requirements should be identified in an attachment or separate section of the document. The various purchasing specifications in the contract should be moved into one section of the document (with appropriate attachments). This will help to clarify the programmatic requirements for the prospective contractors.
- EPSDT standards and other federal requirements should be reviewed and incorporated where necessary into the contract.
- Several other areas of the current contract document should also be reorganized or developed. While some of these suggestions may seem to be purely stylistic, implementing them should improve the clarity and utility of the document.
  - First, a new section of the contract should be created, which covers Clinical Management and incorporates expanded specifications for utilization management, case management, clinical necessity criteria and clinical oversight. Standards and requirements for utilization management were minimal in the previous contract, and were primarily summarized in the Quality Monitoring Attachment.
  - A summary of benefits and services should be documented in a single location, which should include a statement of benefits, limitation on benefits, any co-payment requirements, and a list of covered services with any limitations or qualifications on their use.
  - Finally, the specification of performance measures and required reports should be more clear, even as the number of performance measures may be reduced. Building on the foundation of the currently required data elements, a set of reports should be specified (consistent with the current draft Performance Measures), with a required reporting frequency. Reports should consist primarily of data, including graphical presentations (rather than extensive narrative), wherever possible, and should include trend information and measures of central tendency.

### ***Management and Oversight***

One of the strongest complaints heard from stakeholders concerned the lack of management and oversight of the BHO by state staff. This is also true of the physical health plans in TennCare.

Effective state purchasing of managed public behavioral health services requires a clear vision of the way services will be delivered and careful oversight and monitoring of care. While this is certainly true of physical health services, the procurement of managed behavioral health care requires considerably more administrative time and resources in relation to the size of the expenditures for the following reasons:

- The historical business relationship between mental health provider organizations and the state is much closer than with health care providers.



- Mental health services for children involve multiple government agencies, including the child welfare, juvenile justice and education agencies.
- The chronically mentally ill need assistance with housing, employment and other efforts that usually fall outside the responsibility of the Medicaid agency but that are essential to recovery.

Many states that have implemented managed behavioral health care programs have had to add staff to conduct a variety of oversight functions that were unanticipated in the original planning. In the ideal world, purchasing behavioral health services should allow the state to step back from many of the implementation functions, however state agencies can not remove themselves from an active role in developing and approving service policies. Legislators and the general public will continue to hold the public agency responsible for policy issues.

Tennessee has made great progress in empowering consumers and stakeholders to participate in the oversight of the program. The TennCare Partners Roundtable, the Tennessee Mental Health Planning Council and numerous other committees enable provider groups, consumers and others to receive timely information, communicate with state staff and be involved in decision-making. These should continue.

Until recently, there has been insufficient oversight of the BHO and stakeholders did not feel the state was very responsive to their concerns. During the last year there has been significant improvement. Stakeholders reported very positive opinions about the responsiveness of current state administrators in both TennCare and DMHDD. Part of the improved relationship with stakeholders is attributable to the dramatically improved relationship between TennCare and DMHDD in the last year or more. There is a sense of teamwork that is unusual in public, interagency collaborations. This spirit of collaboration, which originates at the top of the organization, extends down through the organization.

Despite the willingness to collaborate and the capability of senior staff, responsibility for TennCare Partners oversight within the two agencies, and particularly DMHDD, was diffused. The scope of DMHDD responsibilities and roles in overseeing the program is spelled out in the draft Memorandum of Responsibility (MOU). It was apparent during this review, that the public perception of accountability, and perhaps also the internal sense of ownership, would be enhanced if resources in a separate organizational unit were dedicated to the oversight of TennCare Partners. As a result, this recommendation was presented to and accepted by senior state officials and quickly implemented. Staff in DMHDD now have a clear “solid line” reporting structure for TPP oversight and “dotted line” reporting to the TennCare Director.

**RECOMMENDATIONS:**

- Develop and publicly announce the creation of the new TennCare Oversight unit in DMHDD and distribute the names, roles and phone numbers of staff.
- Training and organizational development needs should also be identified and plans put in place to address them. In short, the state should use the marketing and public relations opportunity presented by this new unit to emphasize its expanded focus on oversight and accountability. This is particularly important as the procurement process is initiated.

## VI. REPROCUREMENT PLAN

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The current contract with the BHO expires at the end of June 2002. It is clear that it will have to be extended. The state is currently negotiating with CMS and OMB for a renewal of the waiver and renewed federal financing terms. The governor's plan for TennCare and the waiver renewal was announced in early October and after much lobbying on the part of the mental health community, was modified to offer the same set of benefits, through a BHO carve-out, for both the Medicaid and TennCare Standard populations. This basically maintains the behavioral health benefits available to these two populations. The terms of the waiver are expected to be finalized shortly.

All of this has resulted in delays in the reprocurement process and the need to extend the current BHO contract for a 12 to 18 month period. This will result in the initiation of a new contract in mid-2003 or later. Assuming that the state seeks a competitive procurement for the next contract, the state must allow for a sufficient lead-time (six months is ideal) for start up of a potential new BHO. It will take at least six months to accomplish all the necessary steps to prepare the RFP and make an award decision. This timeline is tight. Thus, a minimum of one year of planning is required prior to the next contract

### **RECOMMENDATIONS:**

- At least six months are required for the following steps:
  - Request for Information issued, soliciting input
  - RFP Draft ready for external review and circulated to potential bidders
  - RFP comments received, RFP revised and final review
  - Issue RFP
  - Bidder's Conference
  - Proposals Received
  - Award Decision Announced
  - Negotiations and Start-Up: At least six months are required for contract negotiation and start-up.
  
- The front end of this timeline is extremely tight. Any time delays experienced in the development and approval of the RFP will reduce the time available for start-up and transition. The experience of states across the country is that a start-up period of six months significantly reduces the likelihood of implementation difficulties.

## VII. CONCLUSION

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This review and technical assistance has covered many areas and issues related to the reprocurement of TennCare Partners. Attachment B summarizes all the recommendations to simplify the task for the busy reader.

As a result of its difficult history, the program carries with it some very “heavy baggage” in the form of negative stakeholder opinions, financing problems and organizational issues. As the overview of the history of TennCare Partners tried to show, the instability in the oversight and operation of the program during the early years has had a profoundly negative impact on the public perception of the program. Overcoming this challenging past requires continued efforts by state administrators, patience on the part of the citizenry and press, and a public relations campaign focused on the state’s capacity to oversee the program.

Unfortunately, all of this is occurring at a time of considerable financial uncertainty nationally and particularly in Tennessee. Tennessee has no financial reserves and will have a new administration in 2003. Furthermore, while the TennCare program represents a huge portion of the state budget, reducing the program’s benefits will save minimal if any state funds because of the high federal match. Court decisions continue to adversely affect the program even as this report is being written.

Given the current environment, now is not the time for significant program restructuring. This report has sought to identify the areas where the program is operating well, and to suggest ways of building on them. Problems have also been identified, and possible solutions proposed. The upcoming reprocurement should incorporate any changes made as a result of this consultation. .

The concepts and ideas proposed here are not foreign to state staff. On the contrary, the state has recently made significant progress on many of these fronts. Staff have prepared analyses and committees have prepared reports that touch on many of the recommendations made in this document. Now is the time for decision making and action in the identified areas.

Most of the people contacted for this review demonstrated an extraordinary commitment to the provision of quality behavioral health services to consumers and their families. The framework is in place within the state for effective oversight and measurement, and thus for improved accountability. Expectations that changes will occur overnight are unrealistic, but incremental improvement in operations is feasible and is in fact occurring. The state, the BHO, providers and other stakeholders must continue this progress. The reprocurement provides an opportunity to consolidate many achievements. It can help to enhance value, improve accountability, and increase the public’s confidence in the state’s ability to care for the poor and disabled with dignity and in the most cost effective and efficient way possible.

**TENNCARE PARTNERS:**

**BEHAVIORAL HEALTH  
REPROCUREMENT STRATEGIES**

**ATTACHMENTS**

- A: MATRIX OF SYSTEM DESIGN OPTIONS**
- B: SUMMARY OF RECOMMENDATIONS**

## ATTACHMENT A

<b>TENNCARE BEHAVIORAL HEALTH OPTIONS: COMPARATIVE ANALYSIS</b>			
<b>Type of Plan</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
<p>Integrated BH benefit with MCO Benefit</p> <p>Continue Pharmacy Carve-out</p>	<p>Provides for a clear role for primary care physicians in front line treatment of mental illness.</p> <p>Allows MCO to benefit from medical cost offsets, if any.</p> <p>Potential for better coordination of BH and physical health care.</p>	<p>Behavioral Health services are often an afterthought for the MCO.</p> <p>Generally, less behavioral health specific reporting is available.</p> <p>Services are likely to be more of a medical model.</p> <p>Most national evidence points to better reporting and benefit levels from carve-out plans.</p>	<p>TennCare started with an integrated model then moved to carve-out. There is no compelling reason to switch back.</p> <p>New Mexico was concerned about the lack of specialization in MCOs so they required a BH Carve-out in each Medicaid HMO. This has not worked and has resulted in very high administrative costs/profits to HMOs, BHOs.</p> <p>Other states with integrated options have significantly less data from MCOs available for planning than the carve-out states.</p>
<p>Integrated Basic Benefit with MCO and Special Needs Plan (enhanced benefit) for SPMI/SED</p>	<p>Specialized services for SPMI/SED are available outside MCO benefit.</p>	<p>Enrollment process for SPMI/SED enhanced benefit needs to be developed carefully.</p> <p>There is an incentive for MCOs to ID and refer SPMI/SED to Special Needs Plan.</p> <p>Unclear how SPMI/SED uninsured/uninsurables who do not meet income eligibility will receive BH services – also they will not have access to Medical services under Governor’s proposal.</p>	<p>Block grant could fund services to SPMI/SED who do not meet TennCare eligibility - Medicaid, Standard and Assist (future).</p> <p>This is likely to result in a high number of identified priority consumers.</p>

**TENNCARE BEHAVIORAL HEALTH OPTIONS: COMPARATIVE ANALYSIS**

Type of Plan	Advantages	Disadvantages	Comments
Regional BHOs	<p>May provide more opportunity for provider sponsored plans which can reduce G&amp;A costs and strengthen provider agencies.</p> <p>Useful approach with County governments, though not really an option in Tennessee.</p> <p>Less risky plan for state than some plans because there is less reliance on a single BHO for plan administration.</p>	<p>Increases monitoring requirements.</p> <p>May be divisive among providers in certain regions.</p> <p>Defining the boundaries of the regions may take considerable time.</p> <p>Capitalization requirements may be too high for provider based organizations.</p> <p>Population in some regions may be too small to meet administrative costs and requirements of current contract.</p>	<p>Supported by CMHCs.</p> <p>Arizona RBHAs have had mixed success with this model.</p> <p>Numerous successful examples of County-Based plans, e.g. Washington State, California.</p>
Statewide ASO (State retains the risk)	<p>Eliminates perverse incentives of controlling cost by reducing needed services.</p> <p>May reduce administrative costs by eliminating the risk of the BHO (risk premium).</p> <p>State retains full authority over the services.</p> <p>Similar to new TennCare Select Plan.</p> <p>Depending on ASO scope of services, may minimize consumer disruption compared to other choices (except statewide BHO).</p>	<p>State retains the risk of claims costs which could be high.</p> <p>Depending on scope of ASO services, State must add staff and other expertise to perform certain oversight functions.</p> <p>Requires stronger monitoring by DMHDD and TennCare.</p> <p>Behavioral health services are more subject to political influence than in a risk based plan, particularly given appropriation.</p> <p>Not desirable without ability to retain savings from one year to an-</p>	<p>Many people favor this in the community, particularly providers. It removes perceived bias of the BHO. The BHO would probably prefer this approach also because it minimizes their risk.</p> <p>New TennCare Select plan may make this politically more feasible, i.e. Access Med-Plus enrollees are all being enrolled into the TennCare select plan – so it will be the single largest MCO now.</p>

**TENNCARE BEHAVIORAL HEALTH OPTIONS: COMPARATIVE ANALYSIS**

<b>Type of Plan</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
	Likely to increase the number of bidders for ASO contract.	other.	
<p>Choice of State-wide BHO</p> <p>(Multiple BHOs)</p>	<p>Enhances consumer choice for health plans.</p> <p>Consumer can shift plans if they are dissatisfied with health plan quality.</p> <p>State may be less dependant on a single provider.</p> <p>May increase competition among providers for price and quality.</p>	<p>Increases administrative requirements for providers and for state oversight.</p> <p>In many areas consumers are likely to be served by the same providers anyway.</p> <p>Choice of plans is likely less important to consumers than choice of providers.</p> <p>Require clear rules and oversight of transfers of consumers between plans.</p> <p>Can lead to enrollment bias without effective risk adjustment techniques.</p> <p>May minimize competition in procurement because of perceived risks for enrollment and administrative requirements.</p> <p>Many markets and regions of the state can't support multiple (even 2) BHOs.</p>	<p>Tennessee did this already and the forces of the marketplace resulted in a single plan.</p> <p>We didn't get strong support for this option from consumers and advocates we talked to.</p>

## TENNCARE BEHAVIORAL HEALTH OPTIONS: COMPARATIVE ANALYSIS

Type of Plan	Advantages	Disadvantages	Comments
<p>Single Statewide BHO</p>	<p>Preferred approach by many consumers and advocates, perhaps because they feel that they can exert a greater level of influence.</p> <p>Simpler to administer and monitor.</p> <p>May lead to lower administrative costs due to economies of scale.</p> <p>Eliminates enrollment bias.</p> <p>May be preferred approach by many public sector BHOs because of size of contract but also purchasing power and single relationship with client.</p> <p>Simpler procurement process.</p> <p>Minimizes changes in procedures, e.g. enrollment.</p>	<p>Increased dependence of state on single BHO requires stronger state negotiating skills and should include a back-up plan.</p> <p>Requires strong insolvency protections, performance monitoring and quality improvement.</p> <p>Tends to be less preferred approach by providers.</p> <p>There has been some concern that CMS (a.k.a. HCFA) may not approve this plan – there is a perceived bias towards choice and regionalization.</p>	<p>Status quo may be less disruptive.</p> <p>This is likely to be the most politically acceptable options, because of the risk aversion of the state and the feeling that the costs are likely to be lower under this scenario (We concur with this).</p>



# TENNCARE PARTNERS: REPROCUREMENT STRATEGIES AND TECHNICAL ASSISTANCE

## ATTACHMENT B

### SUMMARY OF RECOMMENDATIONS

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#### ***System Design***

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- The state should procure a single statewide BHO.
- Require the BHO to subcapitate with all the MCOs for primary care services. This ensures that the BHO coordinates care and simplifies the claims process for primary care physicians and the MCOs.
- Consider requiring the BHO to develop a pilot regional provider network or certain lead provider agencies for clinical and service coordination.
- Develop a back up plan.

#### ***Populations and Eligibility***

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- Assure that eligibility verification is ongoing and is done accurately, and that re-verification is timely and effective.
- Create a blended benefit package, so that the need to identify a priority population is eliminated.
- Base all services on clinical necessity rather than priority population status. Use CRG/TPG assessments for reporting and monitoring only.
- Require that quality studies be conducted on high need populations including SPMI, SED, individuals with addictive disorders, those with dual diagnosis and children in state custody. This will require special reporting by population groups, including the current priority populations of adults and children.
- Clarify the differences between DCS funded residential treatment and those funded by TennCare, using a crosswalk and service definitions for each of the levels of care. This is essential to clarify the apparently frequent “boundary” disputes between DCS and TennCare.
- Create special services, and track encounter data and funding, for people with special needs.

#### ***Children with Special Needs***

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- Incrementally continue to improve EPSDT screening rates, setting realistic improvement goals and holding contractors accountable for both accurate reporting and their EPSDT performance.
- Seek to negotiate as much of the EPSDT service requirements as possible into the BHO rates and develop methods within claims systems to identify and track EPSDT related services.

- Continue to develop an active collaboration between TennCare, DCS and the BHO through regular meetings that review and development child related policies, review data on services to DCS children and that troubleshoot and implement quality improvement efforts for the behavioral health services to children in state custody.
- Develop a cross-walk of DCS funded residential services and the residential services funded by the BHO including service definitions and admission criteria.
- Continue to develop wrap-around services (e.g. CCFT) as an alternative to out-of-home placement for children with mental health needs.
- Ensure that the new “mental Health case management services” being developed for DCS children are reviewed periodically (6 months or annually) for continuing clinical necessity and that they are authorized only for those youth who truly need the service. Provide short-term telephonic case management services for those children who do not need to be assigned to a case manager but who need help with care coordination or an acute episode of services.

### ***Services and Benefits***

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- Revise the benefit plan to eliminate the enhanced benefit for a priority population. Services should be authorized based upon the need for the services. Considerable work has already been done by state staff on this area.
- Continue current efforts to expand rehabilitative and recovery based services, including consumer run services.
- Continue the carved-out pharmacy benefit.
- Maintain the independent advocacy line.

### ***Inpatient***

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- The state should consider increasing the rates paid for state hospital inpatient services and supplement the BHO's funding to compensate for this increase. Funds should be drawn from the existing DMHDD subsidies to the RMHIs.
- Distribute information about inpatient service cost, utilization and quality more widely to make the actual inpatient utilization clear to all stakeholders. Begin to focus on length of stay and readmission rates for inpatient facilities.

### ***Crisis Services***

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- The state and the BHO should continue to actively monitor the performance of individual crisis providers including, at a minimum, rates of ER and community assessments, diversion rates and RMHI referrals.
- Efforts should continue to be made to improve diversion rates and increase the number of assessments in the home and community, where possible. The state and the BHO should also seek to develop more crisis respite and residence options for consumers.

## ***Case Management Services***

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- A full review of the current populations served and the services provided through the “bundled” case management rates in TPP should be performed. This review should consider new criteria for authorizing case management services as noted above and consider different levels of care in case management. It may be desirable to “unbundle” some of the services that are included in the current “bundled” rates. The details should be worked out in a planning group consisting of state and BHO officials, providers and consumers. The planning group should begin meeting as soon as possible.
- Case management services should include the following levels of care provided by the BHO and/or providers:
  - Ombudsman: Services should focus on resolution of an issue or brokering a needed service. This service could be provided by the BHO or contracted out.
  - Short-term and Transitional Case Management: The service includes brokering and community support, as well as advocacy for access to needed services on behalf of individual clients. Services may be delivered by telephone or in-person, as needed by the individual client. The service should be available to consumers on an ad hoc basis. Suggested caseload should range from 20 to 30 clients per case manager and should be time-limited to no more than 3 months.
  - Community Support: Community support should provide assistance and skill training to adults, children or children’s families to enhance community tenure. This service should be provided with a suggested caseload of 30 to 50 individuals, in-person and perhaps in small groups. Provision of this service in medication clinics or with peer support programs may be ideal.
  - Intensive Case Management (ACT, PACT, CTT): This service should be provided to people who are at high risk of future hospitalization or placement and who need both community support and treatment interventions. The existing level of this service in TennCare should probably be expanded somewhat and the average caseload should be similar to the current CTT and CCFT services.
- Case Management for Children: The above categories of case management should be implemented for adults and children. For children, however, the services should be focused on the child and the natural or surrogate family. Services should work with multiple systems – education, child welfare, etc. Case management for children has become a focus of some of the litigation involving the program and as a result should be better defined in the new contract. It has also been more fully discussed earlier in the report.

## ***Utilization Management***

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- Admission criteria should be based on a new set of clinical necessity criteria, consistent with a psychosocial rehabilitation philosophy. Using clinical necessity will encourage reviewers to consider environmental and social factors in determining the need for treatment, rather than looking only at the medical condition.

- Consumers should have access to assessments and initial outpatient services without prior authorization. Prior authorization or referral should be required for case management services and for all 24-hour levels of care.
- A new section of the contract should be created to specifically identify utilization management standards.

### ***Service Network and Credentialing***

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- Alternative service strategies should be created for areas of the state, especially rural areas, where geo-access standards cannot be met. The geo-access standards could be augmented with other measures of access, thus creating reasonable exceptions, such as:
  - Geographic service capacity, based on the willingness, availability and past history of a provider to offer needed services in the area
  - Availability of intensive home based services rather than program services to meet the standard.
  - Primary care physicians with experience in treating people with mental illness might be the only reasonable alternative for medication and physician care, if no licensed psychiatrist serves a particular geo-access area
- The state and the BHO should consider implementing an expedited approval process or a policy of “any willing and qualified provider” in certain geographic areas, if such a model can reasonably be expected to close the geo-access gap and if alternatives are not possible. This would mean that in those areas not meeting geo-access standards, the network participation criteria would be similar to those in effect prior to the waiver.
- Since the recruitment of health care professionals to Tennessee appears to be an underlying issue, a broader statewide campaign for recruitment of specialists should be undertaken outside of the TPP program.

### ***Litigation***

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- The costs associated with implementing the existing consent decrees should be reviewed to determine ways in which these consent decrees can be better managed, to account for the costs of legal compliance and also to disclose the requirements of the litigation to potential bidders.
- Additionally, data related to appeals, grievances, and utilization should be reviewed in an effort to assure that members’ rights are protected, that services are accessible and available in a timely manner and to identify opportunities for quality improvement. The findings from this data review and recommended changes in policies, programs or operations should be incorporated into the procurement document.

### ***Claims Payment and Provider Reimbursement***

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- Continue to focus on claims timeliness and include penalties when timeliness does not meet contractual standards.
- The reimbursement methods for case management need to be reviewed as a part of the overall review of case management services. For some levels of case man-

agement, services may return to fee for service (unit rates) and in other cases the blended rates may be much higher. Long term case management services should all be subject to prior authorization and should be focused on a subset of the priority population of SPMI adults, SED children and children in state custody. Encounter data for case management services that are paid on a blended or case rate must be collected and maintained by the BHO. The contract and the RFP should include specific reference to this.

- Rates for state hospitals should be increased in the new contract and the funds that are supplementing the services in the RMHIs should be added to the TPP base.

### ***Quality Improvement***

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- In the future RFP and contract, state staff may want to distinguish quality assurance (licensing, credentialing and certification activities) from quality improvement activities since the differences are significant and often confused. Both activities are essential.
- Certain of the sections included in the Quality Monitoring attachment to the contract should be moved to other sections of the contract (e.g., Utilization Management should be moved to a new Clinical Management section)
- The state should exercise greater leadership over the BHO's QI activities, directing specific activities through annual contract modifications and facilitating interagency improvement activities.
- The contract should contain a limited number of quality improvement initiatives that are mutually agreed upon by the BHO and the state to cover the most important areas. These initiatives should be reviewed annually and revised as necessary.

### ***Performance Measures and Reporting***

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- The existing performance reports should be summarized wherever possible, and trend data should be prepared, similar to the above charts. Key measures of access, cost, and utilization should be included. Considerable work is being done nationally on recommended measures, including the Uniform Reporting System for the Block Grants and the recommendations of certain national benchmarking projects.
- Eliminate unnecessary reports (and reduce the length of many of them) to improve overall efficiency. The current ones are not being used. Implement a sunset policy on reports from the BHO. If they are not being reviewed by the state or used for policy making, eliminate them and provide them only on an ad hoc basis.
- Maintain, and if necessary expand, the level of resources devoted to data reporting and performance measurement in DMHDD. These positions are essential to ensuring public accountability of the program.
- Performance data should also be reviewed at a regular meeting with all senior managers, permitting people with different learning styles to ask questions and listen to a discussion of the data rather than just reading the report.

- Develop a quarterly report card of key measures.

### ***Incentives***

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- The number of existing penalties should be dramatically reduced. Develop a new set of incentives and penalties for the reprocurement that includes no more than 10 to 20 different items. Include rewards for successful performance and implementation of key program initiatives, as well as penalties. Rewards can certainly be “gamed,” but usually produce more reliable and durable behaviors than penalties, and do not produce avoidance behavior. Examples of areas for reward might include the successful implementation of new service standards and reimbursement for case management that expands on the diversity of services available.
- Ensure that the BHO can prepare all necessary reports at a reasonable cost prior to including them in the contract.
- Include provisions in the contract specifying that changes in the incentive provisions will be negotiated annually.

### ***BHO Reimbursement***

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- Capitation should be the method of payment to the BHO in the re-procurement. Monthly premiums should be paid for several different rating groups. Rates should not be based upon the priority population definitions currently used in the contract. From a programmatic perspective, and based upon work in other states, the rates should probably include four rating categories: TANF and SSI Medicaid eligibles, TennCare Standard eligibles, and children in state custody. A complete actuarial analysis, however, may indicate that other rating categories are desirable.
- The state should continue or slightly modify the current risk-sharing method in the reprocurement, as it will increase the likelihood that more than one organization would submit bids for the work.

### ***Contract***

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- Reorganize the contract to make the key provisions more accessible to everyone, including the purchaser, contractor, other state administrators and the general public.
- Several areas of the current contract document that should also be reorganized or developed. (These are outlined in greater detail in the report)

### ***Management and Oversight***

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- Develop and publicly announce the creation of the new TennCare Oversight unit in DMHDD and distribute the names, roles and phone numbers of staff.
- Training and organizational development needs should also be identified and plans put in place to address them. In short, the state should use the marketing and public relations opportunity presented by this new unit to emphasize its ex-

panded focus on oversight and accountability. This is particularly important as the reprourement process is initiated.

### ***Reprocurement Plan***

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- At least six months are required for the following steps:
  - Request for Information issued, soliciting input
  - RFP Draft ready for external review and circulated to potential bidders
  - RFP comments received, RFP revised and final review
  - Issue RFP
  - Bidder's Conference
  - Proposals Received
  - Award Decision Announced
  - Negotiations and Start-Up: At least six months are required for contract negotiation and start-up.
  
- The front end of this timeline is extremely tight. Any time delays experienced in the development and approval of the RFP will reduce the time available for start-up and transition. The experience of states across the country is that a start-up period of six months significantly reduces the likelihood of implementation difficulties.