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Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm

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Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm

James F. Blumstein
Frank A. Sloan

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TennCare is a Medicaid demonstration project that allows Tennessee to require all Medicaid beneficiaries to secure medical care through a mandatory managed care system. Enrollees contract with private managed care organizations ("MCOs"), which are responsible for organizing a network of care providers and delivering medical care to covered beneficiaries. Driven by rapidly escalating Medicaid costs, TennCare's mandatory managed care program has succeeded in saving money for the state in its Medicaid program.

To secure the federal waiver that allowed the program to proceed, the state included non-Medicaid-eligible uninsured and uninsurable residents as TennCare beneficiaries. Federal matching funds accrue for all TennCare expenditures, including those for non-Medicaid-eligible enrollees, but federal matching is subject to a global cap. Cost savings from managed care were to pay for the improved access. The program covers about 1.3 million persons, 38% of whom are non-Medicaid-eligibles. The Medicaid component of TennCare has been stable, but the non-Medicaid-eligible TennCare population has risen by about 41% in the last two fiscal years, stressing the fiscal capacity of the program.

The Article provides background on the development of TennCare, describing the political effect of the federal matching (cooperative federalism) aspect of TennCare on both state-level and federal-level decisionmaking. The Article identifies what it describes as the political moral hazard dimensions of these federal-state partnerships on state political decisionmaking and the correlative lock-in effect of the program on the state. Federal matching funds make program enhancement appealing and make cutbacks extremely painful. The interaction of state and federal program incentives is considered in depth, and both the state responses (use of private funding and provider-focused taxation) and federal responses (limits on federal matching for those sources of state revenue) to these incentives are described and analyzed.

The Article considers and analyzes elements of TennCare's design and implementation from a legal and policy perspective. It concludes that, in contrast to the contemporaneous Clinton Administration plan for improved access, TennCare's design demonstrated the triumph of pragmatism over ideology. It focused on reform of Medicaid rather than comprehensively encompassing the entire health care market; it adopted a pluralistic rather than a unitary approach; and, at least nominally, it adopted a standard of adequacy rather than equality in defining the scope of the public's obligation to TennCare beneficiaries. Because the 1997 Balanced Budget Act allows states to adopt mandatory managed care for Medicaid, TennCare's managed care features can be replicated by other states without the need for a waiver.

Finally, the Article reports on empirical findings about such issues as quality of care, hospital profitability, and patient and physician satisfaction. The Article concludes that quality of care, in general, has not suffered, that patient satisfaction has been good, that physician participation rates in the program exceed those of the pre-existing Medicaid program, that hospital capacity has been decreasing at levels above the national average, that hospital profitability overall has not suffered, but that levels of physician satisfaction are very low.

Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm†

*James F. Blumstein**
*Frank A. Sloan***

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I. INTRODUCTION AND OVERVIEW

In 1993, the Clinton Administration proposed a plan for comprehensive nationwide healthcare reform (the "Clinton Plan"). It would have covered all citizens—those insured by private plans, the uninsured,¹ and public beneficiaries in programs such as Medicaid² and Medicare.³ By achieving efficiencies in the existing healthcare market, the Clinton Plan sought to capture and re-channel sufficient resources to fund a comprehensive package of benefits (health security) to all Americans, without an overt increase in taxes.⁴ As

1. See The Health Care Study Group, *Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL., POL'Y & L. 499, 501-03 (1994) (emphasizing the desirability of universality in the Clinton Plan).

2. Social Security Amendments of 1965, Pub. L. No. 89-97, §121, 79 Stat. 343 (codified as amended at 42 U.S.C. §1396) (1994).

3. See *id.* § 1801 (codified as amended at 42 U.S.C. § 1395) (1994).

4. For an explanation of the rationale for comprehensive reform and reliance on redistributing healthcare resources (through recapturing and re-channeling efficiencies) rather than redistributing income (through taxation), see generally Richard Kronick, *Redistributing Health Care Resources without Redistributing Income*, 19 J. HEALTH POL., POL'Y & L. 543 (1994). For a

described by one of its architects and proponents, the Clinton Plan relied on “a reconstructed market with new rules, incentives, and limits” to achieve “what government itself cannot easily do.”⁵

The Clinton Plan was not enacted into law. Though the President’s party held majorities in both the House of Representatives and the Senate, the Clinton Plan did not ever come to a vote in either body. The relevant committees in both chambers declined to report the bill out for consideration by either full body.⁶

Also in 1993, Tennessee applied for⁷ and secured approval⁸ of a federal waiver for its Medicaid program so that it could establish TennCare, effective January 1, 1994. TennCare is a Medicaid demonstration, approved for an initial period of five years and renewed for an additional period of three years,⁹ that allows Tennessee to require that all Medicaid beneficiaries secure medical care through a mandatory managed care system. TennCare enrollees contract with private entities, managed care organizations (“MCOs”), which are responsible for organizing a network of health care providers and, under contract with the state, delivering specified medical care services to covered beneficiaries.¹⁰

Because of its focus on Medicaid as a foundation, TennCare is not comprehensive or universal in its thrust, in contrast to the Clinton

somewhat harsher assessment of the Clinton Administration’s approach, describing the complex proposed system as imposing “stealth taxes” to finance “universal coverage,” see CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 75-80* (1995).

5. Paul Starr, *The Framework of Health Care Reform*, 329 *NEW ENG. J. MED.* 1666, 1668 (1993).

6. For a contemporaneous critique of the Clinton Administration’s “comprehensive benefits” and its “comprehensive reform” approach, see James F. Blumstein, *Health Care Reform: The Policy Context*, 29 *WAKE FOREST L. REV.* 15, 34-38, 42-45 (1994). For post-mortem discussions of the Clinton Plan’s failure, see generally HAYNES JOHNSON & DAVID BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* (1996); THEDA SKOCPOL, *BOOMERANG: CLINTON’S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* (1995).

7. See Letter from Ned McWherter, Governor of Tennessee, to Donna E. Shalala, Secretary, Department of Health & Human Services (June 16, 1993) (available in 1 *TENNCARE, A NEW DIRECTION IN HEALTH CARE* (1993)) [hereinafter *McWherter Letter*] (compilation on file with Vanderbilt Law School) (submitting TennCare waiver application).

8. See Letter from Bruce C. Vladeck, Administrator, Department of Health & Human Services, Health Care Financing Administration (“HCFA”) to H. Russell White, Commissioner, Tennessee Department of Health (Nov. 18, 1993) (on file with author) [hereinafter *HCFA Approval Letter*] (approving waiver application).

9. See Letter from Michael Hash, Deputy Administrator, Department of Health & Human Services, HCFA, to Nancy Menke, Commissioner, Tennessee Department of Health (June 30, 1998) in 2 *TENNCARE: A NEW DIRECTION OF HEALTH CARE* (1993) (compilation on file with Vanderbilt Law School) (approving three-year TennCare waiver extension through December 31, 2001).

10. See discussion *infra* Part IV.

Plan. TennCare covers Medicaid patients and, in addition, uninsured and uninsurable Tennesseans. In the sixth year of the TennCare demonstration program, uninsured/uninsurable TennCare enrollees constituted nearly 38% of total enrollment—about a half-million persons who would not normally have been covered by Tennessee's previous Medicaid program.¹¹ That uninsured/uninsurable TennCare patient population grew by 23.7% during fiscal 1998, and by an additional 16.9% during fiscal 1999.¹² In contrast, the Medicaid-eligible TennCare patient population has been stable, actually falling 3.3% in fiscal year 1999.¹³

While TennCare's conception was driven largely by the state's inability to maintain the "enormous" and "unmanageable" growth¹⁴ in Medicaid costs,¹⁵ its birth included as a goal an increase in the healthcare coverage of non-Medicaid-eligible Tennesseans who were either uninsured or uninsurable.¹⁶ The access-to-healthcare agenda of TennCare comported with the access-oriented objectives of the Clinton Plan. Its strategy of capturing efficiencies from managed care for the benefit of improving access for the uninsured was also comparable, although the targets of opportunity were quite different. The Clinton Plan, with its universal coverage focus, sought to capture efficiencies

11. As of June 29, 1999, total TennCare enrollment was 1,312,969. Of that number, 814,181 were Medicaid-eligible patients and 498,788 were uninsured/uninsurable patients. See <<http://www.state.tn.us/health/tenncare>> (visited June 29, 1999) [hereinafter *TennCare Website*]. As of June 27, 1998, total TennCare enrollment was 1,268,887. Of that number, 842,142 were Medicaid patients and 426,745 were uninsured/uninsurable patients. See FISCAL REVIEW COMM., REPORT TO THE 100TH GENERAL ASSEMBLY FOR THE YEAR ENDING JUNE 30, 1998: TENNCARE PROGRAM, at 13-15 (Exhibit E) (Nov. 9, 1998).

12. Compare FISCAL REVIEW COMM., *supra* note 11, at 13-15 (Exhibit E) with FISCAL REVIEW COMMITTEE, REPORT TO THE 100TH GENERAL ASSEMBLY FOR THE YEAR ENDING JUNE 30, 1997: TENNCARE PROGRAM, at 4 (Nov. 24, 1997) [hereinafter *FISCAL REVIEW COMM., 1997 Report*]. These sources show that the uninsured/uninsurable category of TennCare enrollees accounted for 344,867 cases as of June 21, 1997, and 426,745 cases as of June 27, 1998. From June 1998 to June 1999, the uninsured/uninsurable category of TennCare enrollment increased to 498,788, another increase of 16.9% (72,031 additional enrollees). See *TennCare Website*, *supra* note 11.

13. As of June 28, 1996, the Medicaid-eligible TennCare case load was 846,067 (of TennCare's enrollment of 1,180,449). That number decreased slightly in fiscal 1997 to 842,207 (of TennCare's enrollment of 1,187,074) and to 842,142 in fiscal 1998 (of TennCare's enrollment of 1,268,887). See FISCAL REVIEW COMM., *supra* note 11, at 13-15 (Exhibit E); FISCAL REVIEW COMM., 1197 Report, *supra* note 12, at 4. By June 29, 1999, the Medicaid-eligible TennCare case load was 814,181, a 3.3% drop during fiscal 1999. See *TennCare Website*, *supra* note 11; see also *infra* Table 2.

14. See 1 TENNCARE: A NEW DIRECTION IN HEALTH CARE 11 (1993) (Tennessee's TennCare waiver application) [hereinafter *TENNCARE WAIVER APPLICATION*].

15. See McWherter Letter, *supra* note 7 (asserting that "TennCare represents a major initiative . . . to address the uncontrollable growth of costs in the Medicaid program").

16. See *TENNCARE WAIVER APPLICATION*, *supra* note 14, at 7.

(or cutbacks) in the private health insurance market as well as in Medicaid and Medicare to improve the level of access for the uninsured and underinsured. TennCare did not include the private health insurance market, seeking to achieve its access goals through mandatory managed care in Medicaid and re-channeling those savings to expand healthcare coverage for the uninsured.

TennCare's blitzkrieg pace of formulation, adoption, and implementation has made the program controversial. Many administrative problems could not be fully dealt with prior to implementation, spawning some confusion at start-up.¹⁷ Many stakeholders were left outside the loop, and that seems to have made the program continually contentious. This has been particularly true of providers, whose role at the design stage was minimal.¹⁸ Nonetheless, TennCare was approved and implemented. It has been in existence for six years, has increased coverage beyond its Medicaid core by nearly a half-million people, and has achieved its access goals while spending less than the negotiated budget neutrality cap—the projection of expected Medicaid costs had the program not been implemented.¹⁹ The 1997 Balanced Budget Act institutionalized TennCare's mandated managed care approach by authorizing states, without seeking a waiver, to require Medicaid beneficiaries to receive medical care benefits through managed care entities.²⁰

TennCare, therefore, represents a major state-initiated healthcare reform effort. Along with the Oregon Medicaid demon-

17. See Marsha Gold et al., *Medicaid Managed Care: Lessons from Five States*, 15 HEALTH AFF. 153, 156-57 (1996). "TennCare tried to move rapidly from traditional Medicaid to managed care. Experience suggests that this is difficult to do, especially when there is only a limited managed care infrastructure and 'little' time to plan. Tennessee was unable to change in so short a period to a system of well-organized, effectively configured managed care plans." *Id.* at 162.

18. The Tennessee Medical Association ("TMA") challenged implementation of TennCare. Since physicians failed to establish injury to themselves or to their patients, the court denied them standing. Under TennCare, MCOs set physician fees in a negotiation process. Since the state has no responsibility for MCO physician fees, injury from low fee rates would be attributable to MCOs not to the state so any physician injury would not likely be redressed by the TMA lawsuit. Further, TMA and its members did not have standing to represent patient interests since "TennCare recipients ha[d] received abundant and appropriate medical services" and therefore had not been injured. *Tennessee Med. Ass'n v. Corker*, Appeal No. 01-A-01-9410-CH-00494, 1995 Tenn. App. LEXIS 243, at *6-7 (Tenn. Ct. App. Apr. 19, 1995).

19. See Request for Extension of the TennCare Waiver: January 1, 1999-December 31, 2001 (December 30, 1997), at 115 in 2 TENNCARE, *supra* note 7 [hereinafter WAIVER EXTENSION REQUEST] (estimating savings from budget neutrality estimate of \$1.6 billion over initial five-year TennCare demonstration period).

20. Balanced Budget Act of 1997, Pub. L. No. 105-33, sub. tit. H, sec. 4701(a), tit. XIX, § 1932(a)(1)(A)(i), 111 Stat. 251, 489 (1997) (codified as amended at 42 U.S.C. § 1396u-2) (Supp. 1998).

stration,²¹ TennCare is one of the two most far-reaching Medicaid demonstrations.²² A case study and analysis of TennCare is useful because its approach is "highly distinct" from that of Oregon²³ and because it reflects a very different approach toward healthcare reform than the Clinton Plan. TennCare is a paradigm of mandatory Medicaid managed care, which is now a statutory option available to states without a waiver. Historical and analytical consideration of TennCare may point to useful lessons for future healthcare reform initiatives.

At the outset, it is important to note what this case study and analysis does not purport to do. It does not cover the mental health elements of TennCare, which are treated separately (carved out) from the other components of the program.²⁴ Nor does it evaluate comprehensively every detail of the program or its empirical outcomes. Rather, it provides a historical and theoretical context for the program, analyzing it as an important example of one state's effort to reform Medicaid and, indirectly, its healthcare market, through the use of market forces. Empirical research on selected program outcomes, which was carried out as part of this project, shows that quality of care has not suffered from the implementation of TennCare.

In Part II, we consider Medicaid as a system of cooperative federalism. Medicaid's structure, we argue, sowed the seeds of TennCare by inducing states to expand the scope of coverage and benefits for their Medicaid programs. Generous federal matching encouraged states to expand programs through a process of political moral hazard. Political-process constraints built into cooperative federalism pro-

21. See OFFICE OF TECH. ASSESSMENT, SUMMARY EVALUATION OF THE OREGON MEDICAID PROPOSAL (1992).

22. Tennessee and Oregon are not the only states with Medicaid managed care waivers, but their demonstrations are the most far-reaching and are often compared as contrasting paradigms of reform. See generally Marsha Gold, *Markets and Public Programs: Insights from Oregon and Tennessee*, 22 J. HEALTH POL., POL'Y & L. 633 (1997) [hereinafter Gold, *Insights from Oregon and Tennessee*] (describing early experiences of Oregon and Tennessee with health reform and Medicaid waivers). For discussions of Medicaid managed care programs in other states, see generally Gold, *supra* note 17; John Holahan et al., *Medicaid Managed Care in Thirteen States*, 17 HEALTH AFFS. 43 (May/June 1998) (examining the experiences of thirteen different states with the expansion of Medicaid managed care); Jean L. Thorne et al., *State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island*, 16 HEALTH CARE FIN. REV. 121 (1995) (analyzing how various states have overcome identified problems with healthcare reform).

23. Gold, *Insights from Oregon and Tennessee*, *supra* note 22, at 638.

24. Behavioral Health Organizations ("BHOs") contract with Tennessee (the state) to provide mental health services, counterparts to MCOs, which contract to provide non-mental health services. For discussion of the mental health component of TennCare, see generally John A. Flippen, Note, *Current Issues in Mental Health Care: The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Re-evaluate the EPSDT in the Managed Care Era*, 50 VAND. L. REV. 683 (1997).

grams, which require states to contribute a significant share of overall program costs, are relatively weak until the absolute levels of expenditure become sufficiently high so as to make incremental state expenditures burdensome on state budgets.

Once adopted, a cooperative federalism program such as Medicaid has a political “lock-in” effect—the matching formula that makes program enhancements so appealing also makes cutbacks very unappealing. To save a dollar in state funding, a state must absorb program cuts of three dollars since about two-thirds of total program costs are paid for with federal money. The lock-in effect encourages federal program advocates to put in place additional program mandates that, at the outset, might result in states’ unwillingness to participate. But once states are locked in, departicipation is politically unthinkable and program cutbacks are very difficult to contemplate. State-level lock-in, combined with open-ended federal matching funding, allows states to drive federal expenditures.

These fiscal realities led states to seek painless methods of financing the state share of Medicaid, particularly as federal mandates resulted in sharply escalating total Medicaid program costs. These “silver bullet” approaches to financing relied on provider donations and provider taxes, which were matched by federal funding and then recycled back to providers through adjusted Medicaid provider-payment schedules. In 1991, the federal government put substantial limits on these creative financing schemes, which in turn created something of a crisis for states like Tennessee that had become quite reliant on those relatively painless methods of raising federally-matched funds for Medicaid.

In Part III, we review Tennessee’s Medicaid experience and its reliance on provider taxes to raise Tennessee’s matching Medicaid expenditures. We discuss the political and legal threat of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991²⁵ to Tennessee’s system of raising funds, analyzing the 1991 Act and its application to the Tennessee Services Tax Act of 1992.²⁶ We conclude that, as a political matter, the 1991 Act placed in jeopardy political support for the provider tax. Further, as a legal matter, the provider tax was potentially in violation of the 1991 Act. The decision to develop TennCare followed from these financial fault-lines in Tennessee’s ability to cope with rapidly escalating Medicaid program

25. 42 U.S.C. § 1396b(w) (1994).

26. 1992 Tenn. Pub. Acts 913 (codified at TENN. CODE ANN. § 67-4-1801-1815 (1998)) (repealed upon implementation of TennCare program).

costs while facing the potential loss of a major revenue source for funding the state's Medicaid expenditures.

Part IV provides an overview of TennCare. We discuss the strategic considerations that led to the design and objectives of the TennCare program—why a state faced with a perceived fiscal crisis chose to develop a program to cover 50% more people than covered under its traditional Medicaid program. We describe the waiver process, the TennCare waiver application, and the contracts that the state developed for implementing TennCare with MCOs. We also discuss the financial arrangements that underlie and characterize the TennCare waiver. The federal financial obligation for matching TennCare expenditures is capped over the term of the demonstration; any expenditure over the cap must be absorbed by the state. This cap contrasts markedly from the normally open-ended nature of the federal matching obligation.

In Part V, we undertake a policy and legal analysis of TennCare's program design and implementation. We examine the TennCare approach to healthcare reform in terms of issues traditionally considered in debates about such reform efforts. We note how TennCare differed structurally from the Clinton Plan in some ways but how the approaches were similar in a number of dimensions as well. We then provide a critique of TennCare as a market-driven reform effort, noting that the overall level of expenditures was administratively established, not set in a market-validated manner. The lack of market-validation continues to raise issues regarding the adequacy of TennCare funding.

We also observe an emerging political calculus associated with modifications in entitlement programs. Program modifications sometimes seen as limiting program benefits—for instance, a managed care initiative, which to some extent limits patients' choice of provider—were supported by advocates for Medicaid beneficiaries provided that efficiencies secured were used to achieve other access-oriented goals. In this regard, we note the significance of how issues are framed. If they are seen as "either/or," then program advocates may be willing to forgo some benefits in order to achieve other related high-priority objectives such as providing medical benefits to the uninsured and uninsurable. If the issue is framed in "yes/no" terms, then program advocates tend to fight any restraint on benefits because the ability to recapture and reallocate those savings to program initiatives they favor is seen as remote.

We next consider the special characteristics associated with running a public benefits program through use of state purchasing power rather than through the mechanism of administrative rule-

making. Although the contracting purports to be bilateral, the state retains considerable authority through its ability to determine service-provision issues under the rubric of interpreting "medical necessity." In addition, the state retains authority to interpret relevant law and to settle lawsuits brought under state and/or federal law, thereby imposing obligations on MCOs. Since the government does not have an obligation, at least in the short run, to adjust MCO capitation rates when government in effect imposes greater costs on MCOs, the state has an incentive, reinforced by advocacy groups, to compel broader coverage as a form of an unfunded mandate on MCOs.

Finally, we consider the public/private status of MCOs. If labeled private entities, MCOs may have advantages in dealing with issues of fraud and abuse. Whether MCOs are state actors for purposes of 42 U.S.C. § 1983, an open question in the Sixth Circuit, is a threshold issue in determining whether MCO conduct is subject to procedural and substantive constitutional constraints. If MCOs are state actors, then what defenses are available and what behavior triggers liability in such putative litigation? Are MCOs, if deemed state actors, subject to vicarious liability under a respondeat superior theory in an action under § 1983? We also examine whether MCOs or their employees receive qualified immunity as public employees would and whether an affirmative defense of good faith would be available as an alternative to qualified immunity.

Part VI presents some empirical findings about TennCare. The data used is largely from original empirical work done for this project. In general, levels of utilization have not been adversely affected and for some services have been enhanced. Health outcomes in the areas of study have not been impaired, and patient satisfaction has not suffered. On the other hand, physician satisfaction is low, although levels of physician participation in TennCare are apparently higher than under Tennessee's traditional Medicaid program.

TennCare was in part designed to reduce health care costs by streamlining the medical care marketplace in Tennessee. One implicit goal was reducing excess capacity in the hospital sector. In general, our data do not show that hospital profitability has suffered, although certain hospitals have faced lower returns in the TennCare era. However, compared to the experience of other states in the same time period, there has been a reduction in hospital resource use under TennCare. The number of Tennessee hospitals closing has accelerated since implementation of TennCare in comparison to the experience in other states, and overall hospital-related expenditures—e.g., number of hospital beds, inpatient days, average length of stay, emergency room visits, and total hospital personnel costs—have fallen. In the

aggregate, Tennessee's hospitals have become healthier because, while revenues have decreased, total expenses have fallen by more.

After discussing our empirical findings and their implications, we evaluate TennCare in policy perspective. TennCare has substantially increased access to medical care for non-Medicaid-eligibles, has constrained costs, and, in our areas of inquiry, has not resulted in measurably lower quality of care. TennCare, therefore, is worth consideration as a possible vehicle for health care reform, using Medicaid managed care as a platform.

II. MEDICAID AS A SYSTEM OF COOPERATIVE FEDERALISM: SOWING THE SEEDS OF TENNCARE

Medicaid was established in 1965 under the Social Security Act to provide medical assistance for qualified low-income persons.²⁷ "Historically, medical support programs have tended to follow and to be built upon government's income maintenance initiatives."²⁸ This was the case with both Medicaid, whose beneficiaries are low-income persons, and Medicare,²⁹ whose beneficiaries are the elderly. Both Medicaid and Medicare built upon pre-existing programs of income support and, categorically, relied upon the definitions of eligibility in those foundational income maintenance entitlements.³⁰ For Medicare, the

27. The Medicaid Act, Pub. L. No. 89-97, tit. I, § 121(a), 79 Stat. 343 (1965) (originally enacted as Act of Aug. 14, 1935, ch. 531, tit. XIX, § 1901) (codified as amended at 42 U.S.C. § 1396 (1994)). See generally ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974) (describing early experience under Medicaid).

28. Clark C. Havighurst et al., *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW & CONTEMP. PROBS. 122, 183 (1976).

29. Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, tit. I, § 101, 79 Stat. 343 (1965) (originally enacted as Act of August 14, 1935, ch. 531, tit. II, § 226) (codified as amended at 42 U.S.C. § 426).

30. In 1972, Congress extended Medicare coverage to those who qualified for income support under the disability components of Social Security. See generally Robert G. Dixon, *The Welfare State and Mass Justice: A Warning from the Social Security Disability Program*, 1972 DUKE L. J. 681 (discussing procedural issues associated with processing disability claims); Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833 (1976) (discussing the Social Security disability program). In the 1980s and 1990s, eligibility for Medicaid was incrementally separated from eligibility for federal welfare (AFDC). See *infra* note 38. See generally CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 114-15 (1998) (explaining eligibility requirements and coverage under Medicaid). That somewhat piecemeal expansion of Medicaid and its increased uncoupling from AFDC contributed to the financial strain on federal and state Medicaid budgets.

underlying income support program was Social Security;³¹ for Medicaid, it was Aid to Families with Dependent Children ("AFDC").³²

Medicare and Medicaid not only built upon distinct income support programs but also built on the financing mechanisms already in place. Since eligibility for Social Security is based on age and prior payroll tax "contributions," not financial means at the time of eligibility, Medicare beneficiaries were not means-tested. Medicaid beneficiaries, however, were defined in large measure by their income, assets, and also by their categorical status—specifically, their eligibility for AFDC. Thus, from the outset Medicaid was a form of "welfare" medicine,³³ a means-tested categorical entitlement program of medical benefits for low-income (typically AFDC) beneficiaries.³⁴

The differences between Medicaid and Medicare extended beyond the characteristics of the program beneficiaries. The programs' financing mechanisms differed widely and importantly. Social Security is financed federally, primarily by a dedicated payroll tax; AFDC was jointly funded by federal and state general-revenue dollars. Building on Social Security's infrastructure—with its exclusively federal financing³⁵ and program administration—Medicare's implementation is entirely a function of federal government policy³⁶ with minimal state involvement or responsibility. Medicaid, on the other hand, represents one of the most significant cooperative federalism efforts in the United States. The federal program sets minimum

31. 42 U.S.C. § 401.

32. 42 U.S.C. § 601. The AFDC program has now been replaced by the program Temporary Assistance for Needy Families. 42 U.S.C. §§ 601-10, 612, 613, 615-17 (Supp. 1999).

33. See STEVENS & STEVENS, *supra* note 27.

34. "[Medicaid] succeeded earlier cash welfare-linked programs, perhaps the most notable of these being the Kerr-Mills program that provided medical assistance for the aged. Medicaid acts as a vendor payment program; that is, it makes direct payments to medical providers for their services to Medicaid eligible persons." CONGRESSIONAL RESEARCH SERV., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS, at vii (1988) [hereinafter MEDICAID SOURCE BOOK (1988)].

35. Medicare's Part A, which covers hospitalization, 42 U.S.C. § 1395d, is financed primarily from a part of the overall Social Security payroll tax but, since 1993, *see* Pub. L. No. 103-66, § 13207(a), 107 Stat. 468 (Aug. 10, 1993), without a cap on the earned income subject to the tax. 42 U.S.C. §§ 3101(b), 3121(a). Beneficiaries pay a deductible. 42 U.S.C. § 1395e. Part B, which covers physician services, is optional and is funded by general federal revenues and a premium paid by beneficiaries. 42 U.S.C. § 1395j-k.

36. The Health Care Financing Administration ("HCFA") of the United States Department of Health and Human Services ("DHHS") is the federal body responsible for administering Medicare and Medicaid. The federal government contracts with financial intermediaries in each state for administrative management and implementation of Medicare through claims processing. While in theory the intermediaries do not make policy, they can affect policy through such decisions as the amount of reimbursement allowed for certain items or services. Medicaid programs are administered and implemented through state agencies, which have wide discretion regarding scope of coverage and benefits. *See infra* note 38.

requirements for state participation, which is, in theory at least, voluntary.³⁷ Minimum requirements relate to beneficiary and provider eligibility and to such issues as the nature and scope of services offered.³⁸ States have the authority to add beneficiaries (by adjusting eligibility standards) and to add services, within program constraints imposed by the federal government.³⁹

Just as Medicaid is administered cooperatively by federal and state officials, its financing is a joint responsibility. Federal Medicaid contributions are based on a state's program spending and a matching formula.⁴⁰ A state's total Medicaid program budget is therefore composed of a state dollar component and a federal matching component that supplements qualified state spending (termed "federal financial participation" or "FFP").⁴¹

37. All states agreed to participate in Medicaid except Arizona, which now participates under a waiver. See CONGRESSIONAL RESEARCH SERV., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 1 n.2 (1993) [hereinafter MEDICAID SOURCE BOOK (1993)] ("Arizona is the only state without a Medicaid program. Since 1982, it has received Federal funds under a demonstration waiver . . . the Arizona Health Care Cost Containment System, or AHCCCS.").

38. To qualify for Medicaid, applicants must meet income limits based on cash welfare standards. In addition, Medicaid eligibility is subject to categorical restrictions, with most of the coverage classifications falling into one of six groups: (1) current and some former recipients of cash assistance (welfare); (2) low-income pregnant women and children who do not qualify for welfare; (3) the medically needy who do not meet welfare financial standards but meet special state-established medically needy limits; (4) persons requiring institutional care; (5) low-income Medicare beneficiaries; and (6) low-income persons losing employer coverage and entitled to purchase continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986) (codified in scattered sections of the U.S.C.). See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 3-4.

While states have much flexibility in defining packages of covered benefits, federal guidelines specify which services are mandatory or optional. See *id.* at 13-14. When Tennessee applied for its waiver, states had to meet four basic requirements in their benefit package design: 1) the amount, duration, and scope of each covered service must be reasonably sufficient to achieve its purpose; 2) services must be generally equal in amount, duration, and scope for all categorically needy beneficiaries in the state; 3) the amount, duration, and scope of coverage must be the same throughout the state; and 4) beneficiaries must be free to receive services from any participating provider. See *id.* at 15-19. TennCare received a waiver from the free-choice-of-provider requirement, which was altered by the Balanced Budget Act of 1997. See *infra* notes 191-99 and accompanying text.

39. In Medicaid's early years, some states saw the opportunity to expand access to medical care, largely at federal expense, by establishing very generous eligibility coverage standards and levels of service benefits. For a discussion of this early activity, see generally STEVENS & STEVENS, *supra* note 27.

40. The federal portion of a state's payment for services—the Federal Medical Assistance Percentage ("FMAP")—is calculated annually using a formula designed to provide a higher federal matching rate to states with lower per capita income. Participating states are responsible for the nonfederal share of Medicaid payments. See *id.*

41. See *infra* Part II.A.

A. *Cooperative Federalism: Federal Matching and Political Moral Hazard*

FFP depends on a state's average per capita income and can range from a match of 50% to 83% of total qualified program costs.⁴² Because FFP typically represents a larger share than a state's share,⁴³ actual program cost is a highly leveraged proposition. FFP has a multiplier effect, allowing states to draw down from one to five federal dollars for each state dollar expended. These moneys accrue to the benefit of state constituents while externalizing 50-83% of the cost on federal taxpayers.

Under the circumstances, increasing the nature and scope of services offered and broadening coverage with liberalized eligibility standards are politically buffered decisions that rest with each state once federally-mandated floor expenditures are implemented. The multiplier matching aspect of FFP means that the expenditure of matching-qualified state funds allows states to provide benefits to constituents far in excess of funding obligations incurred for each state. State political officials can secure benefits for constituents by leveraging state expenditures with an inflow of money raised at the federal level. This provides a powerful incentive for states to expand their Medicaid programs, possibly at the expense of programs that might have a higher state or local priority, but which would have to be funded entirely by state or local funds and therefore get "crowded out."⁴⁴

Correlatively, the availability of FFP offsets many of the political constraints that restrain growth of state spending/benefits programs. In this sense, cooperative federalism programs create a form of political "moral hazard,"⁴⁵ encouraging states to adopt and finance

42. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 25.

43. In FY 1992 the Federal share of Medicaid payments was estimated at 57 percent. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 25.

44. In other words, the programs may lose out in the competition for state funds.

45. The term "moral hazard" apparently originated in the nineteenth century fire insurance trade and referred to temptations created by the providing of insurance against loss. Economist Kenneth Arrow applied the concept to medical insurance. See generally Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). Individuals with health insurance use more medical services because their costs are largely borne by others. In general, the term "moral hazard" applies to a broad range of circumstances in which the interest of a rational individual is not identical to the interest of the larger collective of which that individual is a member. For example, an individual decisionmaker may not be required to pay the full costs of a choice but nonetheless may accrue the entire benefit. In such circumstances, a rational economic decisionmaker might choose more of a good or service than would be the case if he or she had to bear the full cost of the consumption decision. The larger group therefore benefits from an individual decisionmaker's restraint, but the individual exercising the restraint only benefits indirectly (as a member of the larger group) from the choice not to pur-

programs or components of programs that are "worth" (depending on the applicable matching rate) \$.17-.50 on the dollar to the politically accountable decisionmaking entity—the state.

In this environment, cooperative federalism makes it economically and politically rational to spend state funds that, were the state paying the full bill, might not comport with state priorities. Where federal and state spending priorities are in sync, the multiplier effect of cooperative federalism allows states to enlist the support of federal taxpayers in funding state programs. Political moral hazard encourages expansion of state programs beyond what states would be willing to fund on their own—and to reduce political constraints on expansion by externalizing the cost of funding those expansions.⁴⁶

Since the inception of Medicaid, the savviest states have understood this political/economic calculus.⁴⁷ Aggressive states can achieve state social welfare objectives by externalizing at least half the cost to federal taxpayers. Born in the name of federalism, this type of cooperative arrangement has grown up to create a tremendous vehicle for the expansion of the scope, coverage, and benefits of the categorical program involved. The ride up the escalator—to increased benefits and expanded eligibility—is relatively painless to the state. The availability of FFP allows state-level program advocates to advance an agenda and offsets the normal fiscal concerns that constrain program growth.

Externalization of fiscal impact has resulted in a certain fiscal divide-and-conquer political dynamic. The fiscal design and consequences of the cooperative federalism concept create incentives for program expansion (and cost escalation) at both the federal and state levels. Federal-level program advocates provide a structure that allows state-level advocates to make the very plausible claim that program expansion is a bargain too good to be passed up. Indeed, the argument can reasonably be made that failure to pick off this low-

chase a good or service. Since the individual decisionmaker can use the resources of others to subsidize a decision to consume, that person has a strong incentive to expand usage. When the federal government provides matching funds, a state can tap into a larger (federal) pool of funds. A rational state with access to matching funds is likely to consume more resources. Gains from restraint are shared by all fifty states, while gains from consumption accrue disproportionately to states that aggressively pursue federal funding.

46. See *supra* notes 39, 44.

47. State Medicaid programs have undergone continual changes in eligibility criteria and services offered. "Partly as a result of the changes [in eligibility criteria], the number of beneficiaries . . . increased from 22.5 million in 1986 to 28.3 million in 1991. More States are offering optional Medicaid services. Furthermore, innovations in the types of services provided under the program have continued and become more widespread." MEDICAID SOURCE BOOK (1993), *supra* note 37, at vii; see also *supra* note 39, for further discussion.

hanging fruit is a strikingly irrational state-level political/economic decision.

At the federal level, at least at the outset, the total federal budgetary implications of a cooperative federalism program are necessarily somewhat blurred, unknowable, and therefore subject to considerable errors in estimation. The reason for uncertainty is that a substantial component of federal costs ultimately is derivative, dependent on political choices made in the states and controlled by political officials accountable to state and local constituents. While federal guidelines (typically, and in Medicaid specifically) set floors and ceilings on eligibility criteria and scope of benefits, states have a great deal of flexibility to make policy choices that automatically trigger federal matching dollars through a statutorily-determined formula.⁴⁸ Thus, the normal indeterminacy of federal spending on health care programs is exacerbated because federal officials do not control state-level Medicaid decisions that carry substantial federal budgetary consequences. This uncertainty regarding the magnitude and scope—and eventually the costs—of the federal commitment has made federal authorization of state-driven program expansions easier to implement.

As total Medicaid costs expanded, states learned that ponying up even a fraction of total program costs was expensive and becoming somewhat of a financial and political problem. This is a classic consequence of moral hazard—as the absolute level of costs escalates, even the relatively small percentage of costs borne by the beneficiary (the insured in the insurance industry context or the states in this situation) becomes substantial. As federal Medicaid costs escalated and the federal budget hemorrhaged red ink, federal officials acutely felt the fiscal pain as the consequences of fiscal externalization became increasingly onerous on federal budgetary resources. Predictably, countervailing pressures to do something about escalating Medicaid program costs began to emerge.

B. The "Lock-in" Effect and Expanded Federal Mandates

A key federal-level insight of the 1980s was that the political "moral hazard" associated with cooperative federalism programs such as Medicaid had had a political narcotic effect. A form of state-level political dependency—a political addiction—resulted from state responses to the incentives that stemmed from the allure of federal matching moneys. Federal legislators would then recognize that it would be difficult politically for states, once involved in a cooperative

48. See *supra* note 38.

federalism program, to departicipate from what had been seen as a voluntary partnership. Expansion of Medicaid created a potent political constituency—a coalition among advocates for beneficiaries and provider groups such as physicians, hospitals, nursing homes, and pharmaceutical firms.⁴⁹ Cold turkey departicipation in Medicaid was not a realistic option for states, and program cutbacks were also very difficult politically. As states became more concerned about rising state Medicaid expenditures, they realized that the ride down the escalator (to cost-saving restrictions in Medicaid programs) was excruciatingly painful politically and programmatically. The very leveraging of federal money, so appealing when programs are being expanded, makes the cutback process that much harder to stomach. To save a state-generated Medicaid dollar, a state must reduce program expenditures by anywhere from two to six dollars (depending on the federal matching formula for a given state). The reverse effect of the leveraging phenomenon—the relative modest saving of state dollars but the loss of a multiple of the state saving in overall program funding—makes Medicaid cutbacks a particularly unattractive (albeit sometimes fiscally necessary) political option.

Perceiving the lock-in effect on states, federal legislators in the 1980s adopted a series of mandatory program enhancements that altered the floor for participation required of states.⁵⁰ Federal-level

49. A similar coalition was a critical force in the enactment of Medicare. *See generally* THEODORE R. MARMOR & JAN MARMOR, *THE POLITICS OF MEDICARE* (1973) (discussing the political dynamics of Medicare).

50. Deficit Reduction Act of 1984 ("DEFRA"), Pub. L. No. 98-369, 98 Stat. 494 (1984) (codified as amended in scattered sections of the U.S.C.) (requiring states to provide Medicaid to first-time pregnant women and those in two-parent families whose principal wage earner is unemployed, as well as children up to age 5 born after September 30, 1983, who did not meet categorical tests for eligibility but did meet AFDC financial standards); Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986) (codified as amended in scattered sections of the U.S.C.) (requiring states to cover all women that met AFDC standards); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 (1986) (codified as amended in scattered sections of the U.S.C.) (permitting states to cover pregnant women and infants up to age 1, to be phased in up to age 5, meeting state income standards up to 100 percent of the federal poverty level); Omnibus Budget Reconciliation Act of 1987 (Revenue Reconciliation Act of 1987), Pub. L. No. 100-203, 101 Stat. 1330 (1987) (codified as amended in scattered sections of the U.S.C.) (permitting states to cover pregnant women and infants with families up to 185% of the Federal poverty level and a phase-in for children ages 1 through 5, with incomes below 100% of poverty; extending required coverage to children up to age 7 born after September 30, 1983, meeting financial but not categorical eligibility); Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988) (codified as amended in scattered sections of U.S.C.) (requiring states to phase in coverage of pregnant women and infants under age 1 with incomes under 100% of poverty); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989) (codified as amended in scattered sections of the U.S.C.) (requiring states to cover pregnant women and children up to age 6 born after September 30, 1983, with incomes below 133% of poverty); Omnibus Budget Recon-

program expansion advocates, typically driven by access concerns, shifted Medicaid from its historical reliance on categorical eligibility to encompass indigent persons who fell outside the guidelines of the income-support programs upon which Medicaid had been built. The focus of these changes was to cover more indigent persons based solely on income or age rather than on categorical status.⁵¹

The increased Medicaid mandate strategy allowed federal legislators to impose federal health care priorities on states while substantially externalizing federal tax-raising costs to the state level. The betting at the federal level—and it turned out to be a safe bet—was that Medicaid's political lock-in effect would bar state departicipation despite the federal imposition of substantially higher costs on state budgets. The Federal mandates adapted for federal purposes the tax-externalization strategy used by states for years. Federal health care priorities could be safely established without full federal financing of those priorities. While states often viewed these requirements as unfunded mandates, a fairer characterization is that they were incompletely funded.

A third factor,⁵² price inflation, also contributed to the increase in Medicaid expenditures during the 1980s and early 1990s. The medical care component of the Consumer Price Index ("CPI") rose considerably faster than the general CPI during that period. Although managed care had moderated increases in price and reduced some forms of utilization in the private sector, Medicaid relied on the traditional fee-for-service method of compensation. Managed care did not have much of a role in most Medicaid programs.⁵³ Certainly that was the case in Tennessee prior to TennCare.

By the late 1980s and early 1990s, many states (including Tennessee) were therefore confronted with ever-expanding Medicaid costs. In addition to price inflation and relatively unrestrained increases in utilization, state Medicaid budgets were buffeted by the

ciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified as amended in scattered sections of the U.S.C.) (requiring states to cover all children under age 19 born after September 30, 1983, with family incomes below 100% of poverty).

51. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 37; see also *supra* note 38 for additional support.

52. The first factor was state program enhancements deriving from the political moral hazard phenomenon of Medicaid's cooperative federalism structure. The second factor was the expanded federal mandates, built upon the lock-in effect. See *supra* Part II.A and text accompanying notes 47-49.

53. Holahan and co-authors have found that cost savings from managed care in Medicaid are "in the order of 5-10 percent relative to fee-for-service." They attribute these modest savings in part to the "historically low Medicaid payment rates, which make it difficult to achieve the kind of savings often seen in the private sector." See Holahan et al., *supra* note 22, at 60.

impetus of political moral hazard, which led to expanded state programs and the associated program costs. At the federal level, program advocates more aggressively pursued program-expansion policies that, as a price of participation in the Medicaid program, compelled states to expand their Medicaid programs further.

C. Program Cost Escalation and the Search for the Fiscal Silver Bullet

Faced with expanding Medicaid costs, the political difficulty of substantially trimming those costs, and the reality of the multiplier effect of FFP, states understandably looked for a fiscal silver bullet—a creative financing mechanism to allow for even greater leverage under the generous federal matching formulas.

One way of relatively painless leveraging was to find mechanisms for spending non-tax-raised monies or at least non-general-tax-raised monies on state Medicaid programs and then seeking to qualify those expenditures for FFP. Tennessee was a leader in aggressively leveraging private expenditures or provider-tax-raised revenues to capture FFP. This allowed Tennessee to cope with rising Medicaid costs with modest fiscal pain.

This is how states' creative financing of Medicaid worked.⁵⁴ The more aggressive approach was for a state to secure private funds directly from providers, typically hospitals. The state would, in turn, use these "donated" funds to pay for Medicaid services and, although these "donated" funds were of private origin, qualify those expenditures for FFP.⁵⁵ What made the scheme attractive is that states did not have to absorb the fiscal pain of raising even the state's component that qualified for FFP, yet they received the multiplier effect of the generous FFP matching formula. What made the scheme politically marketable was the ability of states indirectly to transfer the "donated" funds back to the donor hospitals. The states served as a conduit, providing a pass-through mechanism that allowed the "donated" funds to find their way back—with a federal add-on—to the original "donor."⁵⁶

54. For a description and analysis of Tennessee's provider tax legislation, see *infra* Part III.B.

55. "In 1985, HCFA began allowing states to include voluntary donations from providers in calculating federal matching payments under Medicaid. Tennessee was one of the first states to turn to provider donations to fund its Medicaid program." Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 203 n.121 (1995).

56. See generally *The Medicaid Program: Hearings Before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce*, 102d Cong. 7-9, (1991)

Each state designs and operates its own Medicaid program, subject to minimum and maximum federal standards.⁵⁷ Thus, subject to federal standards,⁵⁸ states have wide discretion to determine the rates of provider compensation under their Medicaid programs, so they could adjust payment rates to offset the hospitals' "donations." In addition, and more importantly, because more directly targeted, states were authorized under the Disproportionate Share Hospital ("DSH") program to funnel funds directly to hospitals that served a large number (a "disproportionate share")⁵⁹ of Medicaid patients. DSH payments could be adjusted to reflect the magnitude of a DSH hospital's "donation" of funds to a state's Medicaid program.⁶⁰ In this way, a hospital would be held harmless for its donation, the state was able to benefit from the multiplier effect of FFP without having to raise the state's matching-qualifying share through taxation, and Medicaid could be expanded because FFP provided an infusion of new federal money.

A less aggressive version of the same scenario resulted from state imposition of provider-specific taxes. Instead of seeking voluntary contributions from hospitals, states would raise revenue from providers through targeted taxation rather than through general taxation. This approach was designed to short-circuit the political (or political process) constraints on state program expansion that stem from a state's need to raise its share of the total program cost. Targeted provider-oriented taxes were politically palatable—as were hospitals' voluntary contributions—because states could redirect the tax

(statement of Richard P. Kusserow, Inspector General, Department of Health & Human Services, describing such provider-based programs). Starting in 1990, these provider-tax and provider-donation programs were referred to as funding mechanisms. "At first, [state] legislative leaders were calling it a *scam*, they then began calling it a *scheme*, and now they are calling it a *funding mechanism*." OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., THE USE OF MEDICAID PROVIDER TAX AND DONATION PROGRAMS NEEDS TO BE CONTROLLED 2 (July 1991) (quoting a state legislative staffer).

57. See generally MEDICAID SOURCE BOOK (1993), *supra* note 37, at 1-26; U.S. GEN. ACCOUNTING OFFICE, MEDICAID: TENNESSEE'S PROGRAM BROADENED COVERAGE BUT FACES UNCERTAIN FUTURE 3 (1995) [hereinafter GAO REPORT (1995)]. In FY 1991, Tennessee's Medicaid payments totaled \$1.485 billion, as compared to the highest of \$13.728 billion (New York) and the lowest of \$90 million (Wyoming). See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 116-17. That year, Tennessee's payment per beneficiary was \$2,130, as compared to the highest of \$4,898 (New Hampshire) and the lowest of \$1,607 (Mississippi). See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 119-20.

58. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 1.

59. See 42 U.S.C. § 1396r-4(b)(1) (1994). Congress created the DSH program to allow states to make additional Medicaid payments to hospitals that treated a disproportionate share of Medicaid patients. A state's ability to use DSH payments to provide additional revenue for hospitals was circumscribed in 1993. See *id.* § 1396r-4(g) (amended by Pub. L. No. 103-66, 107 Stat. 312 (1993)).

60. See *supra* note 37.

revenues raised in a straightforward manner (albeit indirectly) back to the hospital taxpayers through adjustments in payment rates generally or through DSH payments. As with voluntary contributions, provider-specific taxes were used to draw down FFP. Their tax payments were indirectly returned to hospital taxpayers, and the additional federal money benefited not only patients but also providers—particularly hospitals.

The result of these methods of creative financing was, as one might suspect, to increase greatly federal Medicaid expenditures.⁶¹ Clearly, political moral hazard had an effect on increasing Medicaid program costs. Similarly, expanded federal mandates resulted in increased expenditures. Creative financing allowed states to expand program costs. At the same time, it empowered private self-interested providers to accelerate program costs even further with boomerang private financing—either through voluntary contributions or through provider-specific taxes. This system allowed states painlessly to draw down federal matching funds and thereby continue to expand Medicaid expenditures virtually entirely at federal expense.

The political-process constraints, contemplated as modest restraints on state-driven program escalation, were effectively circumvented. Moreover, a new form of fiscal externalization arose. States faced political pressures and fiscal incentives to expand program costs and benefits since the local matching dollars were being supplied. These dollars insulated state officials from having to raise the state Medicaid share through general taxation, yet they still qualified for FFP. To paraphrase Ross Perot, one could almost hear the sucking sound of dollars flooding out of the federal Treasury to fund ever-expanding state Medicaid cost increases—many of which were imposed in the first instance by federal mandates that took advantage of the political lock-in effect described earlier.

The structural result of these creative financing schemes was that self-interested providers in league with access egalitarians and other advocates for Medicaid beneficiaries were substantially driving state program increases. Federal Medicaid outlays, in turn, were driven, and on fiscal automatic pilot, not only by non-federal political actors (state governments) but also by a state-based coalition of providers and program beneficiaries not politically accountable to anyone and yet holding keys to the federal treasury.

61. See *supra* note 47.

D. Fending Off the Fiscal Silver Bullet: The Federal Government Fires Back

Drawing on general federal revenues and coming at a time of substantial federal budgetary deficits, these creative methods of states financing their share of Medicaid drew a predictable reaction from federal budgetary authorities. Weak as it is, the political-process restraint on state expansion of Medicaid turned out to be of consequence. When states were able to avoid a considerable portion of their cost-sharing component for marginal program enhancements and were still able to draw down FFP, they had even more incentive to continue broadening the nature and scope of Medicaid program benefits and expanding the standards of program eligibility.

These schemes—voluntary provider contributions and provider-targeted “tax-and-DSH” schemes—raised revenue that could then be incorporated into a state’s Medicaid program and qualify for FFP. Federal contributions were then based on artificially elevated state Medicaid expenditures. That resulted in increased FFP through use of essentially private funds. Further, the private fund providers under the silver bullet financing schemes were held harmless because states could manipulate provider payment formulas under Medicaid to return the private funds to the providers (typically hospitals) that had furnished the money in the first instance—along with a multiplier from the FFP.⁶² Because states did not have to raise Medicaid funds through the normal political process, and because providers had no incentive to resist provider-targeted taxation,⁶³ even the relatively weak political-process constraints of cooperative federalism were eviscerated.

In 1991, the Health Care Financing Administration (“HCFA”) acted to contain what it perceived as the growing abuse of the Medicaid financing process.⁶⁴ HCFA sought to circumscribe the ability of states to draw down FFP by use of provider-specific taxes and donations and to constrain state flexibility to return provider contributions by adjusting DSH payments.

62. These devices, known generically as “pass throughs,” had been authorized by HCFA in 1985 when it permitted public and private donations to be used as a State’s share of financial participation in the entire Medicaid program. 42 C.F.R. pt. 433.45 (1998).

63. *See generally, e.g., West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186 (1994) (representing an example of a boomerang provider-targeted tax scheme, in this case designed to protect in-state industry from out-of-state competition).

64. *See Christine M. Solomon & Jennifer L. Smith, TennCare: Up and Running*, HEALTH SYS. REV., Mar.-Apr. 1994, at 10, 11.

The Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 ("MVCPTA"),⁶⁵ was envisioned by its proponents as the tourniquet on the federal fiscal Medicaid hemorrhage.⁶⁶ It was designed to restore the built-in fiscal and political-process constraints that had always been part of the cooperative federalism Medicaid philosophy. MVCPTA was aimed at the more egregious provider-based "hocus-pocus"⁶⁷ funding schemes concocted by the states to take advantage of the federal Medicaid matching program.⁶⁸ MVCPTA substantially curtailed the ability of states to use provider payments—either voluntary contributions or provider-specific taxes—to qualify for FFP, placing quite specific limits on the type of provider-based financing that would be eligible for FFP.⁶⁹ MVCPTA is an extraordinarily complex compromise between those who saw state-adopted creative financing schemes as abusive, something to be reined in,⁷⁰ and those who saw those schemes as a politically palatable vehicle for the continued expansion of Medicaid program benefits at the state level—in effect, a state-driven engine of growth effectively beyond the control of the effective bill-payer, the federal government.

In addition to MVCPTA's restrictions on creative financing, the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93")⁷¹ contained

65. 42 U.S.C. § 1396b(w) (1994) (amending the Social Security Act to reduce the amount expended under state plans for medical assistance by the sum of various revenues received by the state).

66. For a discussion of the 1991 Act and the politics surrounding its adoption written by a lobbyist against its enactment, see generally Michael O. Spivey, *Patching the Patchwork Quilt: "Reforming" the Medicaid Program—The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991*, 1 ANNALS HEALTH L. 37 (1992).

67. Governor Ned McWherter, Address to the Tennessee General Assembly (Apr. 8, 1993).

68. See *supra* note 56.

69. 42 U.S.C. § 1396b(w). This provision—its statutory waiver for New York and President Clinton's veto of that waiver—was involved in the line-item veto case. See generally *Clinton v. City of New York*, 524 U.S. 417 (1998).

70. The objection to politically-unrestrained state ability to tap into the common federal Medicaid fund can be understood by analogy to Garrett Hardin's well-known parable. See generally Garrett Hardin, *The Tragedy of the Commons*, 162 SCIENCE 1243 (1968). Hardin described a commons in which herdsman were able to graze their animals without limit. Each herdsman had an incentive to add animals to be fed, even though there was an inevitable risk to the commons. The herdsman would receive 100% of the benefit from each additional animal he grazed; the cost in terms of the harm to the commons was borne proportionally by all herdsman. This created a perverse incentive to overutilize the commons and eventually would result in ruin of the commons. See *id.* The analogy to the creative financing schemes under Medicaid is clear. Each state, through provider-based "hocus-pocus" taxes, sought to game the system in order to receive more and more federal matching, imposing ever-increasing costs on federal taxpayers. The rationale was that all federal taxpayers are absorbing the additional cost of each state's Medicaid program. Yet, as in the case of the commons, such behavior eventually can bring ruin to all—namely, budget deficits and/or program cuts in Medicaid or other federal programs.

71. 42 U.S.C. § 1396r-4(g).

further limits. OBRA '93 indirectly limited the use of intergovernmental transfers from public hospitals to state Medicaid budgets. These had been used as a source of FFP when recycled through state Medicaid budgets. OBRA '93 achieved this result by restricting states' ability to transfer DSH funds to hospitals. By limiting DSH payments, OBRA '93 effectively limited one important method through which the state could recycle provider-tax-raised funds back to the provider-taxpayer. Further, the limit on DSH payments left the hospitals with less money available for payment of taxes, since hospitals would presumably need to retain most Medicaid payments to maintain ongoing operations.⁷²

The curtailment of silver-bullet financing schemes meant that states with aggressive Medicaid financing strategies (such as Tennessee) were at risk. This political and financial background is essential to an understanding of what led to the development of TennCare.

III. TENNCARE AS A RESPONSE TO FISCAL STRESS: A THUMBNAIL SKETCH OF TENNESSEE'S MEDICAID EXPERIENCE

While creative Medicaid financing methods were born elsewhere, they were raised and nurtured to maturity in Tennessee.⁷³ Some might say raised to an art form. The combination of expanding program costs—much imposed by federal mandates—and curtailments on creative financing—largely the result of MVCPTA⁷⁴—meant that the state faced serious budgetary problems in Medicaid. TennCare was devised to cope with those budgetary problems.

A. *The Financial Stresses on Tennessee's Medicaid Program*

In 1992, Tennessee faced a serious Medicaid budget problem. The budget problem was caused in large part by growing Medicaid enrollment, escalating health care costs, and an impending threat of loss of federal funds. Throughout the 1980s,⁷⁵ Congress had expanded Medicaid eligibility, shifting away from the AFDC-based (i.e., cate-

72. 42 U.S.C. § 1396r-4(g) (amended by Pub. L. No. 103-66, 107 Stat. 629-30 (1993) (limiting DSH payments to the difference between a hospital's costs and its level of reimbursement from Medicaid, which presumably was below hospitals' costs)).

73. See Gold, *Insights from Oregon and Tennessee*, *supra* note 22, at 651 (noting that the "impetus for TennCare was largely fiscal" and that Tennessee had made "extensive use of provider donations and taxes in conjunction with disproportionate share payments to finance the expansion of Medicaid and the required state contribution").

74. 42 U.S.C. § 1396b(w).

75. See *supra* notes 30, 50 (noting the incremental expansion of Medicaid eligibility).

gorical) eligibility standards to poverty (i.e., income) guideline standards.⁷⁶ The largest expansion, however, came in 1990 despite staggering federal budgetary deficits. As part of the same 1990 budget agreement that resulted in new taxes, Congress enacted a mandated Medicaid expansion to phase in coverage of all income-eligible (i.e., poor) children over a period of twelve years.⁷⁷ Within specified income guidelines, all children, already covered through age six, would become covered under Medicaid through age eighteen at the end of the year-by-year phase-in period. Children aged six who had been covered under Medicaid would maintain coverage until age eighteen if their families met income-qualification guidelines.⁷⁸

The federally-mandated eligibility expansion, which targeted pregnant women and children, resulted in an 85% increase in Tennessee's Medicaid enrollment between 1988 and 1993.⁷⁹ During that same period of time, annual Medicaid expenditures nearly tripled, swelling "from less than \$1 billion in fiscal year 1987 to [over] \$2.8 billion in fiscal year 1993,"⁸⁰—more than a quarter of the state's budget.⁸¹ Officials believed that the state could not sustain an ongoing rate of increase in spending of that magnitude.⁸² Democratic Governor Ned McWherter appointed a task force to recommend substantial budget cutbacks in Tennessee's Medicaid program—in the range of \$250 million in state spending and \$750 million in overall spending.⁸³

76. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 37.

77. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (codified in scattered sections of the U.S.C.) (requiring States to cover all children under age 19 born after September 30, 1983, with family incomes below 100 percent of the federal poverty level).

78. This process was accelerated by the Children's Health Insurance Program ("CHIP") enacted as part of the 1997 Balanced Budget Act. For a description of CHIP, see HAVIGHURST ET AL., *supra* note 30, at 116-17.

79. Tennessee's Medicaid enrollment grew from 410,525 in FY 88, FISCAL REVIEW COMM., 1988 ANNUAL REPORT TO TENNESSEE GENERAL ASSEMBLY, at 31 (1989) to 758,574 in FY 93, FISCAL REVIEW COMM., 1993 ANNUAL REPORT TO TENNESSEE GENERAL ASSEMBLY, at 34 (1994).

80. TENNCARE WAIVER APPLICATION, *supra* note 14, at 11.

81. See Duren Cheek, *State's Health Reform Lacks U.S. Approval*, THE TENNESSEAN, Apr. 6, 1993, at 2A.

82. In its TennCare waiver application, Tennessee stated that growth in Medicaid expenditures in recent years had been so steep as to "threaten [] the viability of all other functions of state government. The growth of the Medicaid program has far exceeded the ability of the State to sustain through normal methods of State revenue generation." TENNCARE WAIVER APPLICATION, *supra* note 14, at 1 (Executive Summary).

83. Dr. William Frist, then a transplant surgeon at the Vanderbilt University Medical Center, chaired the Task Force and in 1994 successfully ran for the United States Senate as a Republican, defeating longtime incumbent Democratic Senator James Sasser. One of the authors of this Article, Professor Blumstein, was a member of the Task Force. In Spring 1993, Governor McWherter submitted a fiscal 1994 budget that called for \$726 million in Medicaid cuts. The Governor linked the Medicaid cuts with the potential loss of revenue from the gross

As the Task Force considered a number of proposed cutbacks during its deliberations, the political pain of the Medicaid cutback approach became manifest. That spurred Commissioner of Finance David Manning and Medicaid Director Manny Martins to proceed along a separate, discrete strategic track. Encouraged by the purported receptiveness of former-Governor and now-President Clinton to approving state-based Medicaid experiments, and confronted with the stark reality of the Medicaid cutback scenario under Task Force consideration, Tennessee officials undertook to develop an alternative approach. This process, which resulted in TennCare, was implemented in secret. Members of the Task Force were not officially included⁸⁴ in the initiative.

B. Tennessee's Medicaid Funding Mechanisms: The Problems Posed by Provider Taxes

When the Medicaid Task Force was appointed in 1992, a centerpiece of Tennessee's Medicaid financing mosaic was a 6.75% gross receipts tax (the Tennessee Services Tax Act of 1992 ("TSTA")).⁸⁵ Originally the tax had been overtly provider-based, levied forthrightly on hospitals.⁸⁶ The provider tax was quite distinct from the state's preexisting broad-based sales tax, which has historically been the state's primary revenue-raising source. For example, the rate (6.75%) was different from the statewide sales tax rate (6.0%), and, unlike the

receipts tax, which had a sunset provision of March 31, 1994, and whose prospects for reenactment were problematic. See Duren Cheek, *State Plans Restructure of Medicaid*, THE TENNESSEAN, Mar. 16, 1993, at 1A.

84. At least two Task Force members were actively involved in the TennCare planning process. Glen Watson, a senior official at Blue Cross Blue Shield of Tennessee ("BCBS"), was an essential player because BCBS was the only entity with a large nearly statewide provider network in place. BCBS's cooperation was deemed essential for successful implementation of statewide managed Medicaid. Gordon Bonnyman, then an attorney with Legal Services in Nashville, a representative of many Medicaid patients, and an influential advocate for Medicaid patients, was included in the discussions because of the McWherter Administration's desire to have his political support (in the state and federally with HCFA) and legal blessing (i.e., not to be sued by Legal Services). The desire to secure support from the Medicaid patient advocates influenced TennCare's approach to access and scope-of-benefit issues.

85. 1992 Tenn. Pub. Acts 913 (codified at TENN. CODE ANN. § 67-4-1801-1815 (1998)) (repealed by TennCare program).

86. For a general discussion of provider-based funding for Medicaid, see Judi Hasson, *States' Funding Loophole Called a 'Scam'*, USA TODAY, Nov. 20, 1991, at 6A. For discussions of Tennessee's use of provider-based taxes, see LaChrisha Butler, *Tenn. Medicaid Fight Heating Up*, GANNETT NEWS SERVICE, Dec. 19, 1991; LaChrisha Butler, *Tennessee Medicaid Program in Trouble*, GANNETT NEWS SERVICE, Sept. 18, 1991.

sales tax, the Medicaid provider tax was not subject to a local-option add-on.⁸⁷

After enactment in 1991 of MVCPTA,⁸⁸ Tennessee revised the tax in an attempt to comply with the law's restrictions with as little change in substance as possible. The revision (TSTA)⁸⁹ was enacted as a temporary stop-gap with a sunset provision after less than two years.⁹⁰

Tennessee modified its then-existing tax structure in such a way as, purportedly, to fall within exceptions carved out by MVCPTA. Tennessee sought, first, to avoid characterizing its 6.75% gross receipts tax as a "health care related tax," which in general did not qualify for FFP under MVCPTA. In the alternative, Tennessee sought to characterize its taxing scheme, if in fact seen as a "health care related tax," as "broad based" and therefore eligible for FFP under MVCPTA.

1. The Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991: In General

As a general proposition, MVCPTA prohibits the use of revenue received by states through provider-specific ("health care related") taxes or through provider-related donations as state Medicaid expenditures that qualify for FFP.⁹¹ However, states can use revenue generated by health care related taxes to pay for Medicaid expenses and to qualify for FFP⁹² if a health care related tax is broad-based and does not contain a "hold harmless provision."⁹³

Under MVCPTA, a tax is health care related⁹⁴ when it (1) "relate[s] to health care items or services,"⁹⁵ (2) relates to the "provision of, the authority to provide, or payment for" such items or services,⁹⁶ or

87. The incidence of the sales tax is nominally on the buyer, as the tax is levied as an add-on to the price of the taxed item. The incidence of the provider gross receipts was nominally on the service provider (e.g., hospitals). Whether the actual incidence of those taxes differed is an empirical question, but one can surmise that the nominal difference would be much greater than the actual difference in incidence (as between sellers and purchasers).

88. 42 U.S.C. § 1396b(w) (1994).

89. 1992 Tenn. Pub. Acts 913 (codified at TENN. CODE ANN. § 67-4-1801-1815) (repealed by TennCare Program).

90. *Id.* §18 (provisions of act were to terminate on March 31, 1994).

91. 42 U.S.C. §1396b(w)(1)(A)(i) & (ii) (1994).

92. *Id.* § 1396b(w)(1)(A)(ii).

93. *Id.* § 1396b(w)(1)(A)(iii).

94. *Id.* § 1396b(w)(3)(A).

95. *Id.* § 1396b(w)(3)(A)(i).

96. *Id.* § 1396b(w)(3)(A)(i).

(3) although part of a generally applicable tax, treats health care providers and non-providers differently in the implementation of the tax.⁹⁷ A tax is considered to “relate to health care items or services” if “at least 85 percent of the burden of such tax falls on health care providers.”⁹⁸ In general, revenues received by a state from a health care related tax do not qualify for FFP even if made part of and spent through the state’s Medicaid program.

On the other hand, if a health care related tax is broad-based, Medicaid expenditures that incorporate those revenues qualify for FFP. A health care related tax on certain “health care items or services” is “broad-based” if it is imposed on all items or services in a class and is imposed uniformly.⁹⁹ The uniformity requirement guards against singling out certain health care providers for more onerous taxation with respect to licensing fees or singling out particular health care items or services for more onerous taxation than others in the class.¹⁰⁰ The underlying compromise reflected by allowing FFP for broad-based health care related taxes is that states can tax health care providers generally as a class and use those revenues to support Medicaid (and receive FFP for those expenditures). Barred is a targeted health care related tax, which is an unreal tax when the state serves merely as a conduit for provider tax dollars and returns a multiple of those dollars (with FFP) back to the particular provider-taxpayer. Thus, DSH hospitals, which disproportionately serve Medicaid patients, cannot be singled out for taxation among hospitals; manipulating Medicaid payment formulas or DSH payments would directly allow states to offset the taxes for DSH hospitals. For other hospitals, the taxes might be indirectly beneficial as a means of paying for Medicaid, but the ability to offset the taxes directly is more attenuated. The compromise was that, as a means of supporting their Medicaid programs, states can tax an industry that serves and benefits from serving Medicaid patients but the tax must be real, not just a disingenuous fiscal pass-through device. It reflects a balance of values—how strong an incentive states should face in constraining Medicaid expenditures.

One other feature of MVCPTA demonstrates how the compromise was brokered. Although revenues derived from a broad-based health care related tax and spent through a state’s Medicaid program

97. *Id.* § 1396b(w)(3)(A)(ii).

98. *Id.* § 1396b(w)(3)(A).

99. *Id.* § 1396b(w)(3)(B).

100. *Id.* § 1396b(w)(3)(C). The classes of health care “items and services” are specifically defined. *Id.* § 1396b(w)(7)(A).

generally qualify for FFP, they do not qualify if the broad-based health care related tax contains a "hold harmless" provision,¹⁰¹ which arises when the taxing unit provides a payment to the health care taxpayer whose amount is "positively correlated . . . to the amount of the tax."¹⁰² Similarly, where the unit of government levying the tax "provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax,"¹⁰³ then the hold harmless requirement is breached.

This hold harmless provision demonstrates the distinction MVCPTA sought to draw. Taxing the health care industry or discrete segments of the industry on a nondiscriminatory basis would be acceptable. Those taxpayers would behave like real taxpayers, feeling the bite of the tax at least to some extent. The political process, however modestly and albeit with considerable political moral hazard, would to some extent resist unbounded escalation in Medicaid expenditures. That type of tax was deemed bona fide. However, where the incidence of the health care related tax was on providers who could rather directly be insulated from the effect of the tax, then that mechanism for financing Medicaid would be discouraged by the withdrawal of FFP from revenues raised in that way. Violation of the hold harmless provision, in essence, means that the tax is not a bona fide tax but a financing conduit for particular provider-taxpayers. In such circumstances, the total lack of a political-process check on program expansion was deemed to warrant the withdrawal of FFP from Medicaid funds raised in that way.¹⁰⁴

2. The "Health Care Related Tax" Issue

Prior to enactment of MVCPTA, Tennessee had a provider-based health care related gross receipts tax of 6.75% on hospital-generated revenues. It also had a broad-based, statewide sales tax of 6.0% on gross receipts. Localities had the option of adding on 2.75% to

101. *Id.* § 1396b(w)(1)(A)(iii).

102. *Id.* § 1396b(w)(4)(A). The "positively correlated" provision applies to non-Medicaid payments. There is a comparable provision disallowing any Medicaid payment to vary "based only upon the amount of the tax." *Id.* § 1396b(w)(4)(B).

103. *Id.* § 1396b(w)(4)(C).

104. Under this statute states could maintain *existing* tax-and-DSH schemes, as long as the provider tax was levied at no more than a 6% rate. *See* 42 C.F.R. § 433.68(f)(3) (1998). Alternatively, states could restrict their scheme to public providers, substituting for provider taxes with the use of intergovernmental transfers. *See* 42 U.S.C. § 1396b(w)(6) (1994).

the statewide sales tax.¹⁰⁵ Hospital services were not subject to the sales tax.

In an effort to comply with MVCPTA, Tennessee amalgamated these two taxes for a period of nearly two years. After that, the sales tax would resume as before, and the tax on hospital gross receipts would sunset. That is, the provider-based gross receipts tax of 6.75% was lumped together with items in the sales tax base. When the tax on hospital revenue gross receipts was combined with the items subject to the state's overall sales tax, the resulting tax, it was contended, was not a "health care related tax" and therefore not subject to MVCPTA.

The state's rationale was that, under MVCPTA, a tax is not considered health care related if less than 85% of the "burden of such tax falls on health care providers."¹⁰⁶ While, by 1993, the 6.75% tax on hospital gross receipts generated nearly 43% (\$382 million) of Tennessee's share (\$894 million) of program expenditures for the Medicaid program,¹⁰⁷ clearly the provider component did not generate 85% of the combined total of receipts for sales tax plus hospital gross receipts tax. If this were accepted as legitimate, then Tennessee would be able to avoid the impact of MVCPTA by characterizing its tax as non-health-care-related. Tennessee's position, however, had problems that placed the taxing scheme in some jeopardy, both legally and politically.

a. Legal Concerns

Initially, the question was whether the 6.75% tax on hospital gross receipts could be properly linked with the items subject to the preexisting sales tax. This issue demonstrates the characterization problems when government legislates a political-process constraint on taxation.

i. The "Burden" Issue

Under MVCPTA, a tax is "health care related" if it is "related to health care items or services" or "related . . . to the provision of . . . or payment for, such items or services."¹⁰⁸ A tax is "relate[d] to health

105. The local-option sales tax was capped at a fixed amount per item purchased, since it applied up to a maximum amount of purchase. This cap applied only to very big ticket items such as automobiles and expensive durables such as household appliances.

106. 42 U.S.C. § 1396b(w)(3)(A).

107. See Duren Cheek, *Governor Rebuilds Medicaid Entirely*, THE TENNESSEAN, Apr. 4, 1993, at A1.

108. 42 U.S.C. § 1396b(w)(3)(A).

care items or services, if at least 85 percent of the burden of such tax falls on health care providers."¹⁰⁹ The threshold analytical question was to determine the baseline from which to calculate whether "at least 85 percent of the burden of [the] tax falls on health care providers."¹¹⁰ Tennessee contended that the "burden" of the revised tax fell not only on health care providers (hospitals) but on all others whose sales were subject to the preexisting statewide sales tax and which were folded into the new services tax. But if one looks to the taxing situation prior to enactment of MVCPTA as the relevant status quo ante, then the two taxes should not be lumped together for "burden" analysis. Nothing of substance changed. All the state did was recharacterize the hospital gross receipts tax as a component of the sales tax. If that would satisfy the political-process requirements of MVCPTA, the federal legislation was pretty much a hollow shell, encouraging artful drafting and statutory recodification rather than providing any substantial political restraint on the use of provider-based taxation.

However, and this is the analytical problem with this type of political-process restriction, if one were to assume that the baseline should be the time before imposition of the 6.75% provider tax (rather than the status quo at the time of enactment of MVCPTA), Tennessee's position might look more persuasive. Starting at that point suggests that Tennessee merely mislabeled its provider tax at its initial enactment. Clearly, it could have characterized the provider tax as a component of the sales tax at that time, and it would have complied with the 85% burden requirement (which, of course, did not yet exist). Tennessee could therefore argue that it should not be penalized for having made a mistake of nomenclature rather than a mistake of substance.¹¹¹

109. *Id.*

110. *Id.*

111. That the tax rates differed is a problem here for the state's position. The provider services tax was set at 6.75% of gross receipts, whereas the state component of the sales tax was 6.0%. Further, the sales tax could be levied, on a local-option basis, by local governments. See *supra* note 105 and accompanying text. That local-option add-on was not available to local governments with regard to the provider services tax. The nominal incidence and the associated legal obligations for payment also differed, with health care providers being legally responsible to pay the services tax and consumers being liable to pay for the sales tax (although retailers that fail to collect the sales tax are legally obligated to pay the tax to the state themselves). In considering the consequences of structural arrangements, courts may be influenced by the technical characteristics of the structural provisions at issue. See, e.g., *Clinton v. New York*, 524 U.S. 417, 446-47 (1998) (holding the line-item veto unconstitutional and, because of the formal structure of the legislation, declining to view the President's line-item veto authority as analogous to a discretionary decision not to spend appropriated funds).

The policy issue, in part, turns on what behavior MVCPTA was trying to constrain. If it adopted a tax version of the political “freezing principle,”¹¹² one must assume the existence of the taxation status quo at the time of enactment of MVCPTA. The status of a subsequently enacted tax would then be measured by the concept of incremental burden. Under such an analysis, the Tennessee tax—which provided for a form of fiscal novocaine rather than political-process restraint—would be at risk. On the other hand, Tennessee could plausibly contend that it in fact repealed its provider tax and then legislated hospital services as a new component of the general statewide sales tax. If viewed in that light, then imposition of sales tax on hospital revenues would not single out health care providers at all—it would just view those services as additional covered items, as part of a very broad-based general system of sales taxation. If a state without a provider tax when MVCPTA was passed can treat a newly-enacted provider tax as an item of added coverage under a preexisting broad-based sales tax—and therefore have it viewed not as a health care related tax—why should a state with a provider tax not be able to repeal that tax and reenact it on the same basis as a comparable state that did not have such a tax in 1991?

The foregoing theoretical discussion assumes that Tennessee’s 6.75% gross receipts tax on hospital revenues was merely folded into the preexisting general sales tax. It demonstrates the conceptual difficulty in judicial or regulatory administration of the type of political-process constraint imposed by MVCPTA by focusing on the burden of a tax.¹¹³ However, Tennessee was not the pure case described above.

112. Section 5 of the Voting Rights Act of 1965, 42 U.S.C. § 1973c, prohibits any “covered jurisdiction,” see 42 U.S.C. § 1973b(b) (defining “covered jurisdiction”), from altering any voting standard, practice or procedure without preclearance from either the Department of Justice or from the federal court in the District of Columbia. This is the “freezing principle,” which bars suspect (“covered”) jurisdictions from any changes in their voting laws until there is either administrative or judicial review and oversight. The status quo is taken as the yardstick; any deviation is subject to scrutiny for discriminatory purpose or effect, 42 U.S.C. § 1973c, with the burden of proof resting with the covered jurisdiction. See *Beer v. United States*, 425 U.S. 130, 140-41 (1976) (holding that election procedures in the covered area cannot be changed unless changes can be shown to be nondiscriminatory); James F. Blumstein, *Racial Gerrymandering and Vote Dilution: Shaw v. Reno in Doctrinal Context*, 26 RUTGERS L.J. 517, 558-60 (1995) (noting that section 5 of the Voting Rights Act was primarily designed as a remedial device and that it imposed stringent new remedies for voting discriminately in covered jurisdictions).

113. In the area of state taxation, courts carefully scrutinize the actual effect and burden of state tax legislation. See, e.g., *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 206 (1994) (holding that state tax which placed heavier burden on out-of-state businesses was unconstitutional); *Oregon Waste Sys., Inc. v. Department of Env'tl. Quality*, 511 U.S. 93, 102 (1994) (same); *American Trucking Ass'n, Inc. v. Scheiner*, 483 U.S. 266, 278-80 (1987) (same); *Armco, Inc. v. Hardesty*, 467 U.S. 638, 641-42 (1984) (same); *Maryland v. Louisiana*, 451 U.S. 725, 753-58 (1978) (same); *Halliburton Oil Well Cementing Co. v. Reilly*, 373 U.S. 64, 70-71 (1963) (same).

Instead, the Tennessee legislation had a number of provisions that raised additional concerns about whether it complied with MVCPTA.

ii. The Differential Treatment of Providers and Non-Providers

Under MVCPTA, a tax is "health care related" when it applies both to health care providers and non-providers but treats health care providers and non-providers differently.¹¹⁴ TSTA¹¹⁵ treated health care providers and non-providers, both covered by the tax, differently in at least two ways. First, it imposed different fiscal burdens on health care providers and non-providers. Second, TSTA's sunset provision terminated the provider-tax but not the non-provider tax component of the law.¹¹⁶ Thus, in the absence of further legislative action, the provider-tax component would be repealed after two years, but the non-provider component would remain in effect as part of the preexisting scheme of sales taxation.

(a) *The Differential Fiscal Burden Concern*

TSTA explicitly repealed the pre-existing sales taxes on non-health-care-related services.¹¹⁷ Entities furnishing those services were taxed under TSTA, exempt from the state sales tax, but subject to the local-option sales tax.¹¹⁸ Health care provider services were not subject to either the state or the local-option sales tax.¹¹⁹ While both health-

Courts examine a state's tax structure to determine where the true burden of a tax falls. Since MVCPTA requires an analysis of "burden," a court would likely look at economic reality rather than empty formalism in determining the validity of a tax. *See generally* Complete Auto Transit, Inc. v. Brady, 430 U.S. 274 (1977) (holding state tax applied on interstate commerce is not unconstitutional because it is fairly related to services provided by the state). Since the true burden of the Tennessee services tax fell exclusively on health care providers, as others subject to the tax were effectively sheltered from its impact, it seems that the incidence or burden of the tax was not broadly on Tennessee's taxpayers but on the health care providers exclusively—a result at odds with the terms and policies of MVCPTA.

114. 42 U.S.C. § 1396b(w)(3)(A)(ii).

115. *See* Services Tax Act, ch. 913 (1992) (codified at TENN. CODE ANN. § 67-4-1801 (1998) (expired because of TennCare)).

116. *Id.* § 18 (1992) (codified at TENN. CODE ANN. § 67-4-1801 (1998) (expired because of TennCare)).

117. *Id.* § 4 (1992) (codified at TENN. CODE ANN. § 67-4-1801 (1998) (expired because of TennCare)).

118. *Id.* § 7 (1992) (codified at TENN. CODE ANN. § 67-4-1801 (1998) (expired because of TennCare)) at.

119. Under TSTA, a "service" subject to taxation was defined to include "health services provided by hospitals, psychiatric hospitals, [and] ambulatory surgical treatment centers." *Id.* § 3(11). The term "health services" was defined to mean "any clinically related services provided to patients, including diagnosis, treatment and rehabilitation, whether provided on an inpatient or outpatient basis." *Id.* § 3(13). *See* TENN. CODE ANN. § 67-6-102(22)(F) (1998).

care provider and non-provider services were taxed under TSTA, health-care providers and non-providers were in fact treated differently—non-providers were subject to local-option sales taxes whereas providers were not.

Further, maximum local-option sales taxes for non-providers were reduced from 2.75% to 2.0%.¹²⁰ This insulated non-providers from greater sales tax liability than under previous law. Prior to TSTA, entities furnishing (1) services (e.g., hotels, garages, and dry cleaners),¹²¹ or (2) amusement services (e.g., fitness clubs, concert promoters, and cable television stations)¹²² were subject to a 6% state sales tax and an optional local sales tax add-on of no more than 2.75%—a maximum sales tax exposure for those “services” and “amusement services” of 8.75%. Under TSTA, the state component of the gross receipts tax on non-providers rose from 6.0% to 6.75%. A local-option sales tax add-on of 2.75% would have resulted in a total tax exposure of 9.5% under TSTA (6.75% + 2.75%) whereas non-providers had previously been subject to a maximum tax liability of 8.75% (6.0% + 2.75%). The reduced local-option sales tax add-on offset any additional state and local tax burden levied on these services and amusement services so that the overall state and local tax on those items remained the same after enactment of TSTA.

To offset the potential revenue loss to local governments from the reduction in the local-option sales tax maximum levy, TSTA required the state to make localities whole by giving them 11.11% of the revenue Tennessee received from service tax levies on non-health-care-services.¹²³ The state was therefore obliged to distribute to localities (in the same manner it distributed the local sales tax it collects for them) an amount of revenue precisely equal to the amount of revenue forgone as a result of the .75% reduction in their local sales tax rate (6.75% x 11.11% = .75%).

TSTA, therefore, can be seen for what Governor McWherter described it—a “hocus-pocus” tax¹²⁴ designed to eliminate any political-process constraint on enacting a tax on health care providers. Non-providers were treated differently because they were subject to local-option sales taxes that did not apply to providers. But those

120. Services Tax Act §§ 6-7.

121. See TENN. CODE ANN. § 67-6-102(24)(F).

122. See *id.* §§ 67-6-102(25)(E), 67-6-212.

123. Services Tax Act § 3 (“[Of] all moneys received . . . pursuant to the provisions of this chapter from charges for amusement services and services other than health care, . . . 11.11% . . . shall be distributed [to local governments].”).

124. Governor Ned McWherter, Address to the Tennessee General Assembly (Apr. 8, 1993), in TENN. HOUSE J., at 1002.

additional taxes were not incremental taxes, since non-providers were subject to the same maximum liability as had been the case under the pre-existing sales tax. The reduced local-option sales tax exposure from 2.75% to 2.0% offset the increase in state-level rates from the sales tax rate of 6.0% to the TSTA rate of 6.75%. In both cases, the maximum liability was 8.75% for non-providers before and after enactment of TSTA. Further, local government revenues were protected since the reduction in local-option maximum sales taxation was precisely offset by a revenue transfer from the state to local governments—but only from revenues collected from non-providers. All services tax revenue derived from taxation on providers was retained by the state, presumably to be spent on Medicaid and to qualify for FFP. In this way, TSTA itself retained the difference in gross receipts tax treatment of provider and non-provider revenues contained in Tennessee law prior to enactment of TSTA, thereby treating providers and non-providers differently.

(b) *The Differential Sunset Provisions*

The taxation of gross receipts on hospital services under TSTA expired in less than two years.¹²⁵ The tax on the other (i.e., non-health-care-related) services of the amalgamated taxing scheme were not scheduled to sunset but to go back after the two-year period to the preexisting sales tax regime.¹²⁶ Whereas the state would have to legislate anew in two years regarding the tax on hospital gross receipts, it did not impose that political obligation on itself with respect to the underlying sales tax base upon which funding of the state and local budgets was so dependent. Consequently, with regard to the sunset provision, TSTA retained the preexisting distinction between hospital revenues and items previously subject to sales taxation. This raised the question whether providers and non-providers were treated differently.¹²⁷ If they were, the tax would be a health-care-related tax, even if nominally covering both providers and non-providers.¹²⁸

125. The tax was scheduled to expire on its own, without any additional legislative action, on March 31, 1994. Services Tax Act § 18.

126. Services Tax Act § 18.

127. See *Jackson-Madison County Gen. Hosp. Dist. v. White*, No. 3-93-0217, slip op. at 6 (M.D. Tenn. May 18, 1993) (unpublished opinion on file with Professor Blumstein, Vanderbilt Law School), *affd. sub nom. Williamson v. White*, 16 F.3d 1223, 1223 (6th Cir. 1994) (denying preliminary injunction against enforcement of TSTA, but noting the “admittedly suspect fact” that non-providers “bear none of the burden” of TSTA and that providers alone bear the “full burden” of TSTA).

128. In addition, there were special provisions in the amalgamated tax legislation allowing for the waiver of penalty and interest for certain hospitals that were in “financial distress” and

In essence, Tennessee's compliance plan for MVCPTA was to borrow a preexisting tax base and attach the provider tax to it so that the tax on provider revenues could be viewed as part of a broader, more comprehensive system of taxation and therefore not a health care related tax. But the temporary character of the plan was manifest by the differential sunset provisions, which, in two years, terminated the tax on hospital revenues and returned other items to their former place in the code as part of the sales tax base.¹²⁹ The provenance of these two taxes—different statewide rates, provider gross receipts taxes not subject to local option add-on, and general sales taxes subject to local option add-ons—was retained and reinforced the point that the scheme was a formalistic sham, a fiscal marriage of convenience akin to a non-citizen obtaining a green card by nominally marrying an American citizen in an otherwise non-existent relationship.¹³⁰

iii. The "Related To" Issue

To qualify as a "health care related tax" under MVCPTA, a state tax need only "relate[] to" one of three health-care-related elements: (a) the provision of health care items or services; (b) the authority to provide health care items or services; or (c) the payment for health care items or services.¹³¹ TSTA arguably "relate[d] to" both the first and third of those elements since the tax was expressly levied on the provision of and the payment for health care services. The term "service" in TSTA explicitly included "health services provided by hospitals, psychiatric hospitals, [and] ambulatory surgical treatment

that received an extension for payment of their services tax liability. Those special provisions did not apply to non-providers who might also be in "financial distress." See *infra* notes 137-38 and accompanying text.

129. The sunset provisions were necessary to assure industry support for the tax on hospital revenues. Preservation of the local-option sales tax on the preexisting sales tax base was necessary to allow localities to collect revenues upon which they depended. Hospitals did not want their revenues to be subject to the local-option sales tax.

130. In litigation challenging the validity of TSTA under MVCPTA, TSTA was labeled a "Green Card" tax, referring to the then-popular movie in which a non-citizen married an American citizen with whom he had had no relationship for the purpose of securing a green card and thereby remaining and working in the United States. In time, it was understood, the marriage would be terminated. One of the co-authors of this Article (Professor Blumstein) was of counsel to the legal team that challenged TSTA. The District Court declined to issue a preliminary injunction, largely on equitable grounds. See *Jackson-Madison*, No. 3-93-0217, slip op. at 6. The case was dropped with the adoption of TennCare, which ended the provider tax. No decision on the merits regarding the validity of TSTA under MVCPTA was further sought or obtained.

131. 42 U.S.C. § 1396b(w)(3)(A)(i) (1994).

centers."¹³² Further, "health service" was defined to include "any clinically related services provided to patients, including diagnosis, treatment and rehabilitation, whether provided on an inpatient or outpatient basis."¹³³ These definitions strongly indicate that TSTA "relate[d] to" the "provision" of or "payment" for health care services.

Support for an expansive interpretation of the term "relate[s] to" in MVCPTA stems from the Employee Retirement Income Security Act of 1974 ("ERISA").¹³⁴ Section 514(a) preempts state laws "insofar as they . . . relate to any employee benefit plan" covered by ERISA.¹³⁵ The "relate to" language has repeatedly been characterized as "deliberately expansive,"¹³⁶ and "conspicuous for its breadth."¹³⁷ Thus, a law "relate[s] to" an ERISA benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan."¹³⁸

The "relate[s] to" language in MVCPTA is the same expansive term used in the ERISA preemption provision. TSTA seemed to have "reference to" and "a connection with" the "provision of" and "payment for" health care services. TSTA, as previously noted, defined the provision of and the payment for health care services as covered items under the services tax. Since TSTA seems to have "relate[d] to" the "provision of" and "payment for" health care services, it would seem to be a "health care related tax" under MVCPTA.¹³⁹

132. Services Tax Act, ch. 913, § 3 (11) (1992) (codified at TENN. CODE ANN. § 67-4-1801 (expired 1994)).

133. *Id.* § 3(13).

134. 29 U.S.C. § 1001 (1994).

135. 29 U.S.C. § 1144(a).

136. See *Pilot Life Ins. Co., v. Dedeaux*, 481 U.S. 41, 46 (1985) (holding that ERISA preemption provisions are deliberately expansive to establish pension plans as an exclusive federal concern).

137. See *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (holding that state law was preempted because ERISA's preemption provision broadly establishes as a federal concern the subject of every state law that relates to a covered benefit plan).

138. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); see also *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992) (holding that state law is preempted by ERISA when it refers to or has connection with covered benefit plan); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (holding state law is preempted because it has connection by reference to benefit plan and, therefore, it "relates to" the benefit plan).

139. A state law can "relate to" an ERISA benefit plan "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co.*, 498 U.S. at 139 (holding state tort law was preempted even though the law was not designed to affect such plans). A common law cause of action regarding unlawful discharge and having no specific reference to an ERISA plan nevertheless can be "relate[d] to" an ERISA plan. See *id.*; see also *FMC Corp.*, 498 U.S. at 56-57 (holding state law was preempted because ERISA's preemption provision broadly establishes as a federal concern the subject of every state law that relates to a covered benefit plan); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 508-09, 525 (1981) (holding state workers' compensation law is preempted because it relates to a benefit plan even though the impermissible intrusion is indirect). For more restrictive views of the scope of

b. Political Concerns

The requirements imposed by MVCPTA created political problems with Tennessee's method of financing Medicaid. As the provider tax had to look more like a bona fide tax, part of a general redistributive scheme of taxation, it became apparent that there would be some "losers" among hospitals—those that paid the tax but could not receive sufficient additional Medicaid-based revenue to offset the tax liability. This resulted in special statutory accommodations for some (primarily rural) hospitals (specifically those in financial distress),¹⁴⁰ which raised problems under the uniformity provisions of MVCPTA if the Tennessee taxing scheme were in fact deemed to be a health care related tax.¹⁴¹ Politically, those accommodations were apparently necessary; from a legal standpoint, those accommodations dictated a strategy of attempting to defeat a characterization of the services tax as a health care related tax.

As intended and contemplated by federal supporters of MVCPTA, political support from hospitals fragmented and began to erode when Tennessee's adaptation to MVCPTA caused real financial impact on some hospital providers.¹⁴² This is manifested by the two-year sunset provision the hospital industry won in TSTA. Once hospitals perceived that they might in fact be subjecting their revenues to substantial taxation, and that the relationship between "sales" tax payments and Medicaid-based benefits was necessarily attenuated, hospitals' enthusiasm for the creative method of financing waned.¹⁴³ The risk was that the tax would remain while the pass-through benefits might be reduced or eliminated, leaving some or many hospitals facing considerable tax liability without assurance that those tax payments would return in Medicaid-derived payments.

Another political complication arose from the need to fold the provider tax into the preexisting broad-based sales tax. Local

ERISA preemption, see *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997) (holding state law imposed some burdens on the administration of ERISA plans, but did not "relate to" the benefit plan); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657-58 (1995) (same).

140. Services Tax Act, ch. 913, § 14 (1992) (codified at TENN. CODE ANN. § 67-4-1801 (expired 1994)).

141. In fact, HCFA found those provisions to violate the requirements of the Act. See Letter from Clarence J. Boone, Regional Administrator, HCFA, to Manny Martins, Assistant Commissioner, Bureau of Medicaid, Tennessee Department of Health, at 1 (Dec. 19, 1994) (on file with the author) [hereinafter Letter from Clarence J. Boone].

142. Bill Lewis, *State Seeks Brakes to Put on Runaway Medicaid Costs*, MEMPHIS BUS. J., Dec. 28, 1992, at 14.

143. *Id.*

governments in Tennessee had traditionally been able to levy a local-option sales tax in addition to the state's sales tax.¹⁴⁴ Hospitals opposed subjecting themselves to that additional levy. So, local government power to tax sales had to be maintained, but hospitals had to be exempted from the local-option component of the amalgamated sales tax. This caused problems with the differential treatment provisions of MVCPTA, as discussed above, and the uniformity requirements of MVCPTA, as discussed below. In short, as MVCPTA mandated that provider taxes be "real" taxes (i.e., somewhat redistributive) the political-process-oriented constraints contemplated in MVCPTA emerged. Even the weak restraints in MVCPTA had an impact on the Tennessee Medicaid funding political landscape.

3. The "Broad Based" Tax Issue

Under MVCPTA, a tax can be "health care related" and still qualify for FFP if it is "broad-based."¹⁴⁵ Tennessee contended that its tax, even if deemed a health care related tax, was broad-based and that revenues generated by the tax therefore qualified for FFP.

To be broad-based, a health care related tax (a) must be imposed on "all items or services" in a class,¹⁴⁶ (b) must be imposed uniformly,¹⁴⁷ and (c) must not contain a "hold harmless"¹⁴⁸ provision. To be uniform, a health care related tax based on revenues or receipts must be "imposed at a uniform rate for all items and services . . . in the class."¹⁴⁹ A tax on a class of items or services is not "uniform" if it provides for "any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid"¹⁵⁰ so that the tax is not "generally redistributive in nature"¹⁵¹ or has a "hold harmless" provision.¹⁵²

144. See TENN. CODE ANN. § 67-6-702 (1998). The local-option sales tax is an important component of financing local governments in Tennessee, and local governments have been very successful in protecting that source of tax revenue. See John Commins, *Solution Sought for Tax Puzzle: Tenn. Legislators Hoping for Deal*, CHATTANOOGA TIMES & FREE PRESS, March 29, 1999, at A1 (discussing success of local governments in protecting local-option sales tax on food in face of governor's proposal to eliminate state and local sales tax on food).

145. 42 U.S.C. § 1396b(w)(1)(A)(ii) (1994).

146. *Id.* § 1396b(w)(3)(B)(i).

147. *Id.* § 1396b(w)(3)(B)(ii).

148. *Id.* § 1396b(w)(1)(A)(iii).

149. *Id.* § 1396b(w)(3)(C)(i)(III).

150. *Id.* § 1396b(w)(3)(C)(ii).

151. *Id.* §§ 1396b(w)(3)(C)(ii) & 1396b(w)(3)(E)(ii)(I).

152. *Id.* § 1396b(w)(4).

TSTA raised concerns under all three broad-based tax requirements. First, TSTA in effect excluded certain “financially distressed” hospitals and ambulatory surgical centers from the tax by granting an extension on paying the tax owed without imposing penalty or interest.¹⁵³ That exclusion raised concerns under the broad-based tax requirement that a health care related tax must be imposed on “all items or services” in a class.¹⁵⁴ Second, the special accommodation for financially distressed hospitals could be construed to conflict with the uniformity requirement that “exclusions” or “credits” not have as their “purpose or effect” the return to providers of “all or a portion of the tax paid”¹⁵⁵ in a manner that is not “generally redistributive.”¹⁵⁶ In addition, the differential rates of taxation of health care services (6.75%) as compared to other items subject to the same tax (up to 8.75% when local-option sales taxes are included) raised potential issues of concern under the uniformity requirement that a health care related tax on revenues or receipts be “imposed at a uniform rate for all items and services . . . in the class.”¹⁵⁷

Third, MVCPTA’s hold harmless provision barred the taxing entity from, directly or indirectly, providing any “offset” or “waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.”¹⁵⁸ Under TSTA, sellers that paid the services tax (which included hospital services) were relieved from their preexisting tax obligations—to pay the general sales tax, which otherwise remained in effect, or to pay the provider tax, which went out of existence. Thus, sellers of items or services previously subject to the sales tax or the provider tax and then subject to the amalgamated services tax were not obligated to pay both taxes. Therefore, the new tax was

153. Services Tax Act, ch. 913, § 14, (1992) (codified at TENN. CODE ANN. § 67-4-1801 (expired 1994)).

154. 42 U.S.C. § 1396b(w)(3)(B)(i). See Letter from Clarence J. Boone, *supra* note 141 (“By excluding certain hospitals and ambulatory surgical centers,” TSTA “does not meet the broad based requirements” of MVCPTA.).

155. 42 U.S.C. § 1396b(w)(3)(C)(ii).

156. *Id.* § 1396b(w)(3)(E)(i)(I).

157. With respect to licensing fees or similar taxes, MVCPTA required uniformity only with respect to the taxation of a defined “class of health care items or services” or providers of such items or services. *Id.* § 1396b(w)(3)(C)(i)(I) & (II). Thus, for licensing taxes, uniformity is achieved if all inpatient hospital services (or providers) are treated alike. The same would be true regarding outpatient hospital services, physicians services, home health care services and so forth. For a listing of separate classes of “health care items or services” that can be treated uniformly, see *Id.* § 1396b(w)(7)(A); 42 C.F.R. § 433.56 (1998). In contrast, the uniformity requirement for taxes based on revenues or receipts applies not only to a class of “health” care items or services but more generally to “a class of items or services” subject to the tax. See 42 U.S.C. § 1396b(w)(3)(C)(i)(III). Thus, differential tax rates for health care related items and other items subject to a sales tax could be problematic under MVCPTA’s uniformity requirement.

158. 42 U.S.C. § 1396b(w)(4)(C); 42 C.F.R. § 433.68(f) (1998).

not an incremental burden for those previously subject to the sales tax. As a structural matter, non-health-care-providers subject to TSTA were not obliged to pay the state's general sales tax. And health care providers no longer paid the provider tax. Such relief reasonably could be construed as a hold harmless provision that insulates non-health-care-related and health-care-related taxpayers from any new burden from TSTA,¹⁵⁹ which folded hospital services into a broader base to defeat its characterization as a health-care-related tax.¹⁶⁰

C. *The Decision to Develop TennCare*

As Governor McWherter's Task Force met to consider possible recommendations for substantial cutbacks in Medicaid expenditures, the state confronted a series of unpleasant alternatives. Although the Task Force never issued a final report with recommendations for cutbacks, senior state officials were aware of the nature and scope of the ongoing deliberations.

Because of the FFP leveraging of Medicaid, the saving of a dollar in state funds would mean the loss of an additional two dollars in FFP. The simple arithmetic was that saving \$250 million in state Medicaid funds required a total program cutback of over \$750 million. While much of that cutback undoubtedly would have hit the provider (hospital) community hardest, some benefits or eligibility cutbacks were somewhat inevitable as well.¹⁶¹ This was not an attractive prospect to the McWherter Administration on policy/political grounds, to advocates for program beneficiaries on ideological grounds, to program beneficiaries themselves on obvious pragmatic grounds, or to providers on economic grounds. Further, the creative financing methods that had softened the political/fiscal impact of Medicaid's cost escalation were in potential peril legally (because of MVCPTA) and politi-

159. Since TSTA was greater than 6%, Tennessee had to meet the twin 75% rules for determining whether a hospital receives an indirect guarantee in violation of the hold harmless provision. HCFA deems a hold harmless provision to exist "if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the hold harmless test is applied in the aggregate to all health care taxes applied to each class." 42 C.F.R. §433.68(f)(3)(i).

160. HCFA charged that Tennessee's nursing home tax violated MVCPTA's hold harmless provision. See Letter from Clarence J. Boone, *supra* note 141, at 1, stating that although the state taxed licensed nursing home facility beds, a grant program offset that tax in violation of MVCPTA, 42 U.S.C. § 1396b(w)(4)(C).

161. Since the Task Force never finalized its report (which was pretermitted by the TennCare proposal), it is impossible to know how the balance of cutbacks would have been struck in the ultimate set of recommendations or in the cutback process itself.

cally (because of waning support for taxing hospital revenues among hospitals). Yet, the state had to plan for and deal with projections of continued escalating costs. To avoid substantial cutbacks, Tennessee faced having to raise very substantial new sums of money through genuine broad-based taxes while losing a source of taxation that had contributed nearly 43% of the state's share of Medicaid funding.

This left the state's political officials a number of conflicting choices and unpalatable political options. With encouraging statements of the newly elected Clinton Administration that it would be receptive to state-based Medicaid experimentation through use of the Medicaid waiver process, Commissioner Manning and Medicaid Director Martins embarked on developing TennCare—an innovative experimental alternative to traditional Medicaid.¹⁶²

IV. TENNCARE: AN OVERVIEW AND A PRIMER

A. Strategic Considerations

Coping with and paying for escalating Medicaid costs were the overarching considerations that led Tennessee to seek a Medicaid waiver and formulate an alternative program.¹⁶³ Significant program cutbacks, which could have adversely affected access to medical care, were politically unappealing to Governor McWherter's Administration and could have triggered legal challenges by advocacy groups for poor patients. Cost savings through mandatory managed care, which were appealing because economies might retain levels of benefits, required a federal waiver of Medicaid's guarantee of patient freedom of choice. Since 1997, states have been entitled to mandate managed care in Medicaid, but that was not the case in 1993. The Clinton Administration, which had campaigned to improve access to medical care and was promoting national health care reform, would not likely have approved a waiver proposal that adversely affected access to medical care for Medicaid beneficiaries.

Accordingly, state officials developed a two-track strategy—restrain program cost while maintaining or expanding access to services. In contrast to Oregon, which systematically determined

162. See Gold, *Insights from Oregon and Tennessee*, *supra* note 22, at 651-54 (noting that TennCare was developed and implemented quickly after HCFA approved the waiver); Duren Cheek, *supra* note 81, at 2A (explaining that the State does not yet have a "waiver" to implement new "radical reform" in Tennessee's health care system); Solomon & Smith, *supra* note 64, at 11-13 (noting that TennCare had received federal approval and was operating).

163. See *supra* Part III.C.

what various levels of program benefits would cost as part of its contemporaneous waiver application,¹⁶⁴ Tennessee started with the assumption¹⁶⁵ that the then-existing Medicaid funding level was adequate.¹⁶⁶ The goal was to determine, programmatically, how to increase access within existing resource constraints and, pragmatically, how to maximize FFP.

Since Tennessee had low levels of managed care, the state believed that a Medicaid managed care strategy could achieve considerable savings, spreading existing dollars over a larger patient population. Again, unlike Oregon (often considered the other major contemporaneous Medicaid experiment), which already had a well-developed managed care marketplace, Tennessee sought to influence the cost of delivering Medicaid services as a clear goal of its managed care strategy. Efficiencies in medical care delivery were sought. In economic terms, policymakers promoted a shift in the production function to a more efficient technology—for the delivery of services to TennCare patients and, perhaps, exporting those efficiencies to non-TennCare patients as well. TennCare might serve as a laboratory for developing, and a yardstick for measuring, improved ways of delivering service. At the same time, one might fear that the cost savings would accrue at the expense of substantial unacceptable reductions in the quality of services provided.

Providers worried that cost savings from TennCare's managed care would result not from securing production-function efficiencies but from reducing provider compensation based on monopsonistic purchasing practices by government or its agents. Under that scenario, TennCare would be a heavy-handed system of income redistribution—away from providers and to low-income patients—using public purchasing power to take advantage of somewhat captive providers.

164. For a discussion of the Oregon approach to Medicaid reform, see James F. Blumstein, *The Oregon Experiment: The Role of Cost-Benefit Analysis in the Allocation of Medicaid Funds*, 45 SOC. SCI. & MED. 545, 547 (1997) (noting that Oregon retained an actuarial consultant to estimate the cost of funding various condition-treatment pairs).

165. This premise was stated explicitly in Tennessee's initial waiver application: "There are sufficient resources now in the overall public-supported health care system to provide an acceptable level of quality care both to the needy who have been traditional clients of public programs and those who are not covered by health insurance through their employment or otherwise." TENNCARE WAIVER APPLICATION, *supra* note 14, at 2.

166. It was not until the sixth year of TennCare that the state commissioned an "evaluation of the actuarial soundness of the rates paid under the TennCare program." That study concluded that "the methods used to develop capitation rates for TennCare are not consistent with generally accepted standards." See PRICEWATERHOUSECOOPERS, ACTUARIAL REVIEW OF CAPITATION RATES IN THE TENNCARE PROGRAM, at i, iii (1999) (on file with author).

Patient advocates tended to see the issue (positively) in these terms.¹⁶⁷ The secrecy in which TennCare was developed and the blitzkrieg with which it was implemented—keeping providers uninformed and out of the policy-development loop—suggest that this pro-patient scenario was not far-fetched at least as one part of the overall program design and implementation strategy.¹⁶⁸

One could project that Medicaid managed care would help squeeze out excess capacity in Tennessee's health care industry. It may particularly squeeze out inpatient hospital facilities, but it could also have affected expensive inputs such as some medical specialties and sub-specialties.¹⁶⁹ The concern, of course, was that too much squeezing could hamper incentives to innovate or to invest in quality-oriented services that contribute to important patient benefits. Diminishing access to physician specialists or sub-specialists could reduce the quality of those services for patients in need of them.

B. Implementation Considerations

1. The Medicaid Waiver Process

Although the federal government promulgates minimum standards for the operation of Medicaid, states can be exempted from compliance with the federal guidelines through a waiver process,¹⁷⁰ which provides for "any experimental, pilot, or demonstration project . . . likely to assist in promoting the objectives"¹⁷¹ of Medicaid.¹⁷² Under Section 1115 the Secretary of the Department of Health and Human Services ("DHHS") can "waive compliance with any of the requirements of [specific sections of the Act] . . . to the extent and for

167. See G. Gordon Bonnyman, Jr., *Stealth Reform: Market-Based Medicaid in Tennessee*, 15 HEALTH AFF. 306, 311 (1996) (noting that the state as purchaser was functioning in a "buyer's market," taking advantage of substantial excess capacity in the system to purchase services at marginal rather than average cost, and using the savings from reduced provider fees to finance TennCare's expansion in coverage).

168. See *id.* at 307 (noting that legislature enacted Governor McWherter's TennCare proposal within weeks of its submission, with the legislature giving the governor "carte blanche to seek a federal waiver and implement TennCare by executive fiat, by the beginning of the following year").

169. See *id.* at 311.

170. See Judith M. Rosenberg, *Managing Medicaid Waivers: Section 1115 & State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 546-57 (1995).

171. 42 U.S.C. § 1315(a) (1994).

172. The general Social Security Act waiver provision applies to Medicaid. See Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 87-543, tit. I, § 122, 6 Stat. 172, 192 (1965) (codified as amended at 42 U.S.C. § 1315(a)(1)) (originally enacted as Act of August 14, 1935, ch. 531, tit. II, § 226).

the period . . . necessary to enable such State or States to carry out such a project . . .¹⁷³ The Secretary has discretion whether to grant waivers, even when a project meets established conditions.¹⁷⁴ A Section 1115 waiver may exempt a state demonstration project from compliance with federal standards or may grant FFP for traditionally excluded expenditures.¹⁷⁵

Procedurally, states submit a waiver proposal to HCFA describing a project, specifying statutory and regulatory mandates to be waived, and explaining the project's impact on program costs, relevant laws, and beneficiaries.¹⁷⁶ A HCFA review panel recommends approval, conditioned approval, or rejection of the proposal to HCFA's Administrator, who decides the matter.¹⁷⁷ Larger projects require approval by the Office of Management and Budget ("OMB").¹⁷⁸ OMB traditionally has required budget neutrality—annual costs no greater under the waiver than projected under Medicaid.¹⁷⁹ Imposed to stop raids on the federal treasury under the guise of innovation, the budget neutrality requirement deterred state waiver applications.

In 1993, President Clinton sought to reduce barriers to Section 1115 waivers. DHHS streamlined the application process, offering greater flexibility in policy changes allowed in the projects, and redefined budget neutrality to be assessed over the life of the project, rather than on an annual basis.¹⁸⁰ This increased flexibility resulted in six states, including Tennessee, receiving waivers and seven pending applications by the end of 1994.¹⁸¹

173. 42 U.S.C. § 1315(a)(1).

174. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 418.

175. See *id.* Because one objective of § 1115 waivers is to inform long-term Medicaid policy, projects are designed for research purposes and must include a research methodology and an independent evaluation. See *id.*

176. See *id.* HCFA is the DHHS agency charged with evaluating the proposal's design, methodology, objectives, costs, and risks and benefits. See Rosenberg, *supra* note 170, at 547-48.

177. See MEDICAID SOURCE BOOK (1993), *supra* note 37, at 418; see also Allen Dobson et al., *The Role of Federal Waivers in the Health Policy Process*, 11 HEALTH AFF. 72, 77 (1992) (noting that a technical review panel rates each proposal submitted to HCFA for final approval).

178. These projects of over \$1 million in federal funds that affect at least 300 Medicaid recipients also require approval from DHHS' Assistant Secretary for Management and Budget. See Elizabeth Andersen, *Administering Healthcare: Lessons from the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 227-28 (1994).

179. Dobson et al., *supra* note 177, at 85.

180. Rosenberg, *supra* note 170, at 549-50 & n.35.

181. *Id.* at 550.

2. Tennessee's TennCare Waiver Applications

On June 16, 1993, Tennessee proposed a five-year Medicaid mandatory managed care demonstration project (TennCare).¹⁸² The application asserted that TennCare could deliver quality medical and mental health care to Medicaid beneficiaries as well as to uninsured and uninsurable persons for substantially less cost than the Medicaid program.¹⁸³ Long-term care (i.e., nursing homes) was expressly carved out, continuing under the preexisting Medicaid program and under its system of financing.¹⁸⁴

HCFA approved Tennessee's waiver request on November 18, 1993, for the period January 1, 1994, through December 31, 1998, then subject to annual renewal.¹⁸⁵ The approval included "Special Terms and Conditions" ("STCs") that helped define the federal oversight role in TennCare.¹⁸⁶ One of the most significant STCs established annual FFP spending hmits, which HCFA set in absolute dollars, rather than on a per capita or percentage basis.¹⁸⁷ Although budget neutrality was to be enforced "over the life of the demonstration,"¹⁸⁸ HCFA defined cumulative annual FFP caps to "ensure that the

182. See McWherter Letter, *supra* note 7.

183. Some dental services were included for a limited group. TENNCARE WAIVER APPLICATION, *supra* note 14, at 19. Program objectives were: increased availability, improved quality of care, a focus on preventive care, continuity of care, incentives for appropriate utilization, and coverage of previously uninsured employees. *See id.* at 7-11.

184. *See id.* A few other items, such as the payment of Medicare premiums for those eligible under Medicaid, were also excluded from the waiver proposal. *See id.* The waiver application included supporting appendices, such as editorial endorsements and letters of support, from a wide range of organizations including the Tennessee Hospital Association, Legal Services of Middle Tennessee, the Tennessee Department of Health, Blue Cross Blue Shield of Tennessee, and the Vanderbilt University Medical Center. *See id.* at Appendices VII-VIII.

185. HCFA Approval Letter, *supra* note 8, at 1.

186. *See id.* HCFA defined 35 STCs in the original November 1993 Waiver Approval. *Id.* at 5-15. On June 21, 1995, HCFA revised these STCs, modifying several of the terms and conditions, withdrawing several implementation-related terms and conditions, and adding new terms and conditions. The result was a total of 37 STCs, which included: notification and reporting requirements, quality indicators and measurement, data collection requirements, funding and budgetary regulations, eligibility and enrollment requirements, requirements for managed care organization capacity, and specific detailed access criteria. *See* TENNCARE WAIVER APPLICATION, *supra* note 14, at App. IX—HCFA Special Terms and Conditions.

187. *See id.* at 5. Federal Spending Limits (Special Term #16) were as follows:

<u>State Fiscal Year</u>	<u>Federal Spending Limits (in millions)</u>
1993 – 1994	\$ 2,108
1994 – 1995	\$ 2,283
1995 – 1996	\$ 2,454
1996 – 1997	\$ 2,594
<u>1997 – 1998</u>	<u>\$ 2,726</u>
TOTAL	\$12,165

188. *See id.*

State does not deviate significantly from the annual caps."¹⁸⁹ Those spending limits, which enforced greater financial responsibility on the state and minimized the financial risk to the federal government, were crucial to HCFA's approval. The implication of the annual caps being in absolute dollars, rather than as a per capita amount or a percentage basis, is the greater financial risk that the state must assume. If, during the period of the demonstration project, the Medicaid situation were to change—enrollment increases, benefits mandated—the state was to bear the financial risk and absorb the added expenditures.¹⁹⁰

On January 1, 1994, six weeks after HCFA's approval, Tennessee implemented TennCare. On August 5, 1997, mandatory Medicaid managed care became an institutionalized alternative available as a matter of statutory entitlement to states that wished to pursue

189. *See id.* Cumulative Annual FFP Limits were as follows:

<u>Program Year</u>	<u>Cumulative Target (FFP in millions)</u>
Year 1 target + 8%	\$ 2,277
Years 1-2 target + 6%	\$ 4,654
Years 1-3 target + 4%	\$ 7,119
Years 1-4 target + 2%	\$ 9,628
Years 1-5 target	\$12,165

Id.

190. To reduce the state's financial exposure, TennCare enrollment was originally capped at 1.775 million. *See* TENNCARE WAIVER APPLICATION, *supra* note 14, at 84, 91. In the Original Agreement with MCOs, the cap was set at 1.5 million (Contractor Risk Agreement dated Nov. 15, 1993, at 26) and was later decreased to 1.3 million (Amendment #3 to the Agreement dated Nov. 15, 1993, at 1). The cap was subsequently raised to 1.5 million. *See* PRICEWATERHOUSECOOPERS, *supra* note 166, at 14-15. By January 1, 1995, TennCare closed enrollment for the uninsured because it had reached 90% of its target enrollment. *See* TennCare Website, *supra* note 11. Enrollment remained open for individuals who are Medicaid-eligible and those who are denied coverage for medical reasons by an insurance company and are determined uninsurable. *See id.* Additional enrollment has been opened in four categories: (1) April 1, 1997: re-opened enrollment in the uninsured category to children under the age of 18 without access to health insurance through a parent or guardian; (2) May 21, 1997: opened enrollment to eligible dislocated workers—i.e., a worker who had health insurance through an employer and became uninsured because of a bona fide closure of a business or a plant; (3) January 1, 1998 - March 31, 1998: opened enrollment for uninsured individuals below the age of nineteen with access to health insurance whose family income is below 200% of the poverty level schedule in effect for calculation of TennCare premiums; (4) January 1, 1998: opened enrollment indefinitely for uninsured children under nineteen who meet TennCare criteria for uninsured. *See id.*

The uninsurable component of TennCare "has grown rapidly since the program's inception in 1994." *See* WILLIAM M. MERCER, INC., EVALUATION OF CRITICAL ISSUES FACING THE TENNCARE PROGRAM—REPORT 3 (1999). For example, from 1995 (when enrollment of the uninsured closed) to 1997, the number of uninsurables in TennCare increased by 91.4%. *See id.* During that same time period, because of the closed enrollment for the uninsured, that category of TennCare enrollees decreased by 28.9%. *See id.* The Medicaid TennCare population declined by 1.3% during that same time period. As a result of these trends, the proportion of TennCare enrollees who were uninsurable rose from 3.3% in 1995 to 4.8% in 1996 and to 6.7% in 1997. *See id.* The financial implications for TennCare are clear since the uninsurable population tends to be more costly to cover than other TennCare enrollees. *See id.*

that approach. In the Balanced Budget Act of 1997, Congress codified the state option to use managed care, providing that, without having to seek or secure a waiver,¹⁹¹ “a State may require an individual who is eligible for medical assistance . . . to enroll with a managed care entity as a condition of receiving such assistance.”¹⁹² Both a managed care entity,¹⁹³ defined as an organization that “provides or arranges for services for enrollees under a contract,”¹⁹⁴ and its contract with the state must meet certain statutorily defined requirements.¹⁹⁵ The state must allow individuals to choose from at least two entities meeting the requirements,¹⁹⁶ provide notice of termination rights,¹⁹⁷ establish internal grievance procedures under which Medicaid enrollees or providers acting on their behalf may challenge the denial of coverage or payment for medical assistance,¹⁹⁸ and annually submit comparative information regarding benefits and cost-sharing, service areas, and quality and performance.¹⁹⁹ The way, therefore, has been paved for replication of Tennessee’s Medicaid managed care program, although the fiscal arrangements undergirding TennCare—global FFP caps and FFP for non-Medicaid eligible patients—still remain unique.

191. See Managed Care Provisions, 63 Fed. Reg. 52,022 (1998) (“Prior to the enactment of the Balanced Budget Act of 1997, States were required to obtain a waiver of a statutory ‘freedom of choice requirement’ in order to operate such mandatory managed care programs . . .”).

192. Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. H, § 4701(a), tit. XIX, § 1932(a)(1)(A)(i), 111 Stat. 251, 489 (1997) (codified as amended at 42 U.S.C. § 1396u-2 (1998)); see also Managed Care Provisions, 63 Fed. Reg. 52,022 (proposing rules for implementing the Medicaid managed care features of the Balanced Budget Act of 1997).

193. See 42 U.S.C. § 1396u-2(a)(1)(B); Managed Care Provisions, 63 Fed. Reg. 52,076 (to be codified at 42 C.F.R. § 438.2) (definition of managed care entity (“MCE”) in proposed rule includes a managed care organization (“MCO”) or a primary care case manager).

194. See 42 U.S.C. § 1396u-2(a)(1)(A); Managed Care Provisions, 63 Fed. Reg. 52,077 (to be codified at 42 C.F.R. § 438.6) (regarding contract requirements for comprehensive Medicaid risk contracts).

195. See 42 U.S.C. § 1396u-2(a)(3)(A); Managed Care Provisions, 63 Fed. Reg. 52,079 (to be codified at 42 C.F.R. § 438.52(b)) (requires choice of at least two MCEs); 42 C.F.R. § 438.52(c) (provides for exception for rural areas to requirement of choice of at least two MCEs, provided that a beneficiary can choose from at least two physicians or case managers and that use of out of network providers is liberally available).

196. See 42 U.S.C. § 1396u-2(a)(3)(A); Managed Care Provisions, 63 Fed. Reg. 52,079 (to be codified at 42 C.F.R. § 438.52(b)).

197. See 42 U.S.C. § 1396u-2(a)(4)(B); Managed Care Provisions, 63 Fed. Reg. 52,079 (to be codified at 42 C.F.R. § 438.56) (regarding enrollee’s enrollment and disenrollment rights).

198. See 42 U.S.C. § 1396u-2(b)(4); Managed Care Provisions, 63 Fed. Reg. 52,079 (to be codified at 42 C.F.R. § 438.400) (requiring comprehensive MCO grievance system).

199. See 42 U.S.C. § 1396u-2(a)(5)(C); Managed Care Provisions, 63 Fed. Reg. 52,078, 52,084 (1998) (to be codified at 42 C.F.R. § 438.10, § 438.318) (proposed Sept. 29, 1998) (regarding duty of MCE to provide information to enrollees).

On December 30, 1997, Tennessee applied for a three-year TennCare extension through December 31, 2001.²⁰⁰ The state described TennCare as an "extraordinarily effective demonstration waiver, resulting in combined savings to the federal and state governments of over \$3 billion during the first four years of the program."²⁰¹ TennCare enrollment had increased by fifty percent, with nearly 400,000 uninsured/uninsurable patients having been enrolled in TennCare in addition to the 800,000 Medicaid enrollees served prior to TennCare.²⁰² HCFA granted the extension on June 30, 1998, retaining the thirty-seven STCs²⁰³ and specifying FFP caps, reflecting "budget neutrality," for the three year extension period²⁰⁴ as they were for the initial five-year period. The annual rate of increase in these caps is 5.1%. TennCare is therefore now in its extension phase and is scheduled to extend as an approved demonstration through 2001.

C. Program Structure and Design: The Contractor Risk Agreements

Under TennCare, the state contracts with managed care organizations ("MCOs") to provide medically necessary services to program enrollees.²⁰⁵ Contractor Risk Agreements ("CRAs"), which comprehensively address the TennCare relationship between the MCOs and the state, oblige MCOs to provide contractually-determined services to eligible persons for a set (capitated) payment per enrollee per

200. WAIVER EXTENSION REQUEST, *supra* note 19 (Letter from Theresa Clarke, Assistant Commissioner, Tennessee Department of Health, Bureau of TennCare, to Sally Richardson, Director, Center for Medicaid and State Operations, Department of Health and Human Services, HCFA (Dec. 30, 1997)).

201. *Id.*

202. *See id.*; *see also infra* Table 2.

203. *See* Letter from Michael Hash, *supra* note 9.

204. The caps during the waiver renewal period are as follows:

FY 1998-99	\$2.865 billion
FY 1999-2000	\$3.011 billion
FY 2000-01	\$3.165 billion
FY 2001-02 (6 months)	\$1.663 billion

See id. (STC #16). For the caps during the initial five-year waiver period, see *supra* notes 187-89.

205. One of the nine MCOs, Xantus (formerly Phoenix), which had the third largest TennCare enrollment, was placed into state receivership in March 1999, because it had suffered substantial losses, faced a large negative net worth, and represented a solvency risk to its TennCare insureds. In one of life's ironies, Commissioner Sizemore of the Department of Commerce and Insurance retained David Manning and Manny Martins as private consultants to take over the operations of Xantus. Manning and Martins had been the public officials responsible for developing, securing the waiver for, and implementing TennCare—Manning as Commissioner of Finance and Martins as Director of Medicaid. *See* Lisa Benavides, *State Takes Control of Troubled HMO to Protect TennCare; Patient Care, Payments to Providers Unaffected*, THE TENNESSEAN, Apr. 1, 1999, at 1A.

month.²⁰⁶ The MCOs are responsible for developing a network of health care providers and negotiating payment rates with individual providers.

The CRAs delineate "Contractor Responsibilities" and "TennCare Responsibilities."²⁰⁷ For example, regarding covered services, the CRAs list the benefits provided,²⁰⁸ establish the required availability and accessibility of services,²⁰⁹ and set minimum functions that an MCO must perform to "be responsible for the management of the medical care and continuity of care for all its TennCare enrollees."²¹⁰ TennCare is responsible for the management of the Agreement,²¹¹ determining enrollee eligibility,²¹² processing of applications and enrollment,²¹³ resolving enrollee grievances,²¹⁴ and calculating the capitation rate.²¹⁵ The CRAs establish guidelines for patients' ability to change MCOs²¹⁶ and include an asymmetrical right of MCO termination.²¹⁷

206. These CRAs are dated November 15, 1993, and September 11, 1995. The capitation rates are flat payments per enrollee per month and do not reflect adjustments based on risk factors likely to increase (or decrease) the costs of providing services. There are different payment rates based on criteria such as age. See A Contractor Risk Agreement Between the State of Tennessee, d.b.a. TennCare and (Name of Contractor) (d.b.a. tradename), Nov. 15, 1993, at 37 [hereinafter CRA I] (on file with author); see also A Contractor Risk Agreement Between the State of Tennessee, d.b.a. TennCare and (Name of Contractor) (d.b.a. tradename), Sept. 11, 1995, at 42 (on file with author) [hereinafter CRA II].

207. See, e.g., CRA I, *supra* note 206 (outlining the agreement between Tennessee and the MCO). Contractor responsibilities include Contractor qualifications, *id.* § 2-2, at 3; benefits/services requirements and limitations, *id.* § 2-3 at 5; enrollee eligibility, *id.* § 2-4, at 22; most aspects of enrollment (including solicitation, open enrollment, caps on overall enrollment, required disclosures to enrollees, and prohibitions on disenrollment by MCOs), *id.* § 2-5 through 2-7, at 23-32; grievance and complaint procedures, *id.* § 2-9, at 33; administrative matters, *id.* § 2-10, at 34; and reporting and other requirements, *id.* § 2-11, at 39. For a review of TennCare's various enrollment caps, see *supra* note 190.

208. CRA I, *supra* note 206, § 2-3 at 5.

209. *Id.* § 2-3.a.3, at 9. There must be an adequate number of providers, no enrollee should have to travel more than 30 minutes one way to a primary care provider, and specialists should be available on a referral basis.

210. *Id.* § 2-3.i, at 15.

211. *Id.* § 3-1, at 50.

212. *Id.* § 3-2, at 50.

213. *Id.* § 3-7, at 52.

214. *Id.* § 3-8, at 52.

215. *Id.* § 3-10, at 52-53.

216. An enrollee's ability to change MCOs has gone through several iterations. Originally confined to periods of open enrollment if the enrollee had been enrolled for at least one year, amended CRA I limited the date to October 1, but withdrew the one-year requirement. See Amendment #3 to CRA I, *supra* note 206, at 1-2. CRA II added a 12-month minimum requirement unless good cause could be shown. See Amendment #2 to CRA II, *supra* note 206, at 2.

Enrollment changes involve conceptually difficult issues. For patients, choice is an important feature of any managed care arrangement. One gives up choice during the course of a contract term by selecting an MCO, but that choice can be altered during re-enrollment periods. Patient choice also is important as a form of market discipline on MCOs and their providers.

The procedures for complaints and grievances has spurred controversy in TennCare as it has in managed care generally. CRA I gave an enrollee the right to request an informal review by TennCare, followed, if necessary, by a formal hearing with the Commissioner of Health whose final decision was binding on an MCO.²¹⁸ CRA II gives enrollees the right, through a grievance process binding on the MCO, to request a "state level review" of an MCO's decision.²¹⁹

The grievance/appeals process was restructured following a successful legal challenge. In 1996, in *Daniels v. Wadley*,²²⁰ Medicaid-eligible TennCare enrollees sought to prevent denial, delay, reduction, suspension, or termination of medical assistance without a timely fair hearing. The 1996 case was a continuation of a 1979 class action in which pre-TennCare Medicaid recipients alleged deprivation of procedural due process rights.²²¹ At issue was the automatic termination of

Just as patients seek some assurance that, during a contract period, they have some form of redress over various MCO determinations through a grievance procedure—a form of "voice"—patients must have the ability to exercise an exit option to switch plans if an MCO or its providers do not perform appropriately. This exit option, a hallmark of a vibrant economic market, is essential for market discipline. For a discussion of exit and "voice," see generally ALBERT O. HIRSCHMAN, *EXIT, VOICE & LOYALTY: RESPONSES TO DECLINE IN FIRMS, ORGANIZATIONS, AND STATES* (1970). The problem comes from the perverse incentive for long-term preventive care that arises from patients exercising their exit option. For example, if it takes an MCO a number of years to benefit from a child inoculation initiative, that MCO is likely to under-invest in that service when patients who receive that service remain healthier but are enrolled in another plan.

217. MCOs can terminate only once per year and are required to maintain operations for at least 180 days from the date of the written notice of termination. See CRA II, *supra* note 206, § 4-2.f, at 69. An MCO may only terminate upon written notice on the twelve month anniversary of each beginning effective date, and the last day of operation must be at least 180 days from the date of the written notice. See *id.* § 4-2.f, at 69. TennCare may terminate an MCO for convenience, giving the MCO thirty days written notice, *id.* § 4-2.e, at 68, or for cause, which requires more elaborate procedures. See *id.* § 4-2.3, at 66. For 1999-2000, MCOs for the first time can leave TennCare by giving six months notice rather than having to stay in the program for the entire contract year. See Bill Snyder, *Blue Cross Gives State 6 Months; Insurance Giant Negotiates TennCare Escape Clause*, THE TENNESSEAN, July 31, 1999, at 1A; see also *infra* note 386. Blue Cross, the largest MCO, exacted this concession because of concerns about the profitability of its TennCare MCO. See *id.*

218. See CRA I, *supra* note 206, § 2-9, at 33-34.

219. CRA II requires an MCO to provide any information TennCare determines necessary to conduct the review and allows TennCare to establish corrective action plans if it determines the MCO did not comply with the grievance guidelines. CRA II, *supra* note 206, § 2-9, at 39. CRA II draws a distinction between a "grievance," which applies when an MCO attempts to deny, reduce, terminate, or suspend coverage, and a "complaint," which is defined as "an enrollee's right to contest any other action taken by the Contractor or service provider" including omissions. See Amendment #3 to CRA II, *supra* note 206, at 8-10. See also *infra* text accompanying notes 226-36 (appeals process litigation).

220. *Daniels v. Wadley*, 926 F. Supp. 1305, 1307 (M.D. Tenn. 1996).

221. See *Daniels v. Tennessee Dep't of Health & Env't*, No. 79-3107, 1985 WL 56553, at *1 (M.D. Tenn. Feb. 20, 1985).

Medicaid, without prior re-determination of Medicaid eligibility, upon the state's notification by DHHS that AFDC or SSI benefits had been terminated.²²² The court held that the automatic termination procedures violated federal regulations, which required states to re-determine a recipient's eligibility for Medicaid and provide Medicaid benefits pending that re-determination.²²³

In September 1992, the court approved a Second Consent Decree that the parties had negotiated.²²⁴ That Decree required the state to provide Medicaid recipients: 1) "written notice upon denial of either their requests for medical assistance pre-authorization or their providers' claims for reimbursement," and 2) "administrative hearings to review such denials."²²⁵

At issue in the 1996 case were TennCare coverage disputes and its appeals process. Prior to *Daniels*,²²⁶ the appeals process took up to 90 days to reach an impartial hearing officer and 120 days total, and allowed for discontinuation of benefits during the appeal.²²⁷ The court held that the TennCare appeals process for disputed health coverage decisions violated the Medicaid Act and due process.²²⁸ The appeals process violated the statute because it did not maintain benefits pending resolution of the coverage dispute and did not provide sufficiently timely resolution.²²⁹ The appeals process violated due process²³⁰ because 1) it deprived enrollees of a predeprivation hearing when Medicaid required continuation of benefits pending hearing or resolu-

222. *See id.* at *10.

223. *See id.* at *13.

224. *See Daniels v. Menke*, No. 96-5887, 1998 WL 211763, at *1 (6th Cir. Apr. 22, 1998).

225. *Id.*

226. *Daniels*, 926 F. Supp. 1305.

227. *Id.* at 1310-11.

228. *See id.* at 1307.

229. Enrollees could be forced to wait over ninety days, violative of 42 C.F.R. § 431.244(f) (1997) (stating that an agency must take a final administrative action within ninety days).

230. For there to be a violation of the Fourteenth Amendment's due process clause, there must be a finding of state action. The district court in *Daniels* held that the MCOs were state actors and that their conduct in making benefits determinations was therefore subject to constitutional scrutiny under due process. *Daniels*, 926 F. Supp. at 1311. On appeal, the Sixth Circuit vacated the judgment of the district court on the state action issue but affirmed the district court's judgment on statutory grounds. *See Daniels v. Menke*, No. 96-5887, 1998 WL 211763, at *2 (6th Cir. Apr. 22, 1998). This leaves unsettled the state action status of TennCare MCOs with respect to other TennCare determinations. For a case holding that Medicare risk-contracting MCOs are state actors, see *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998), *vacated and remanded*, ___ U.S. ___, 119 S. Ct. 1573 (1999). For further discussion and consideration of the state action issue, see *infra* Part V.F.

tion, and 2) TennCare failed to require that the proceedings be presided over by an impartial hearing officer.²³¹

The state agreed to establish a more robust grievance process and did not appeal the merits of the district court's statutory ruling (although it did appeal the holding that TennCare MCOs are state actors).²³² Effective October 28, 1996, Tennessee restructured TennCare to provide for limited continuation of benefits during the appeals process²³³ and to assure enrollees timely access to a state administrative law judge or hearing officer if the MCO or TennCare Bureau failed to resolve the concern to an enrollee's satisfaction.²³⁴ In addition to new grievance rules for coverage issues, Tennessee adopted more procedures, including an expedited appeals process,²³⁵ to handle complaints²³⁶ about consumer coverage and provider payment.

231. This ruling applied to Medicaid-eligible TennCare enrollees. *See Daniels*, 926 F. Supp. at 1312.

232. The district court's state action holding was vacated. *See supra* note 230.

233. An MCO generally must notify an enrollee in writing 10 days before it stops or cuts care an enrollee has been receiving. An enrollee has 30 days to file a grievance with the MCO. To qualify for continuation of benefits already being received during the grievance process, an enrollee must file a grievance within ten days of that notification. Otherwise, an MCO may discontinue benefits already being provided during the grievance process. *See TENNCARE NEWSLETTER*, Vol. 1, No. 1, Oct. 1996, at 3; *WAIVER EXTENSION REQUEST*, *supra* note 19, at 83-86. Grievances involve attempts to deny, reduce, terminate, or suspend a covered service. *See supra* note 219.

234. For a description of the TennCare appeals process regarding adverse decisions, see *Appeal of Adverse Decisions*, Bureau of TennCare Rule 1200-13-12-.11.

235. Where a physician "determines that the care is urgently needed and will write a letter saying so, a grievance is handled on an expedited basis." *WAIVER EXTENSION REQUEST*, *supra* note 19, at 81 (Letter from Judy Regan, Deputy Medical Director, Tennessee Department of Mental Health and Mental Retardation, to BHO Medical Directors and Grievance Coordinators, October 28, 1996). In such circumstances, MCOs must "reconsider and render a written decision within 5 calendar days of receipt of the grievance" and "the entire case must be concluded within 31 calendar days." *Id.* While the Regan letter covered Behavioral Health Organizations, a similar letter was sent from Theresa Clarke, Assistant Commissioner, Bureau of TennCare, to MCOs. *See id.* at 77. For a diagram of the expedited appeal process, see *id.* at 88. The TennCare appeals process and termination policies are again being challenged. The class action asserts that TennCare "routinely denies applications, terminates eligibility and assesses excess premiums without affording individuals a meaningful opportunity to be heard." *See TennCare Faces Class-Action Suit for Allegedly Dropping Members*, *WASH. HEALTH WK.*, July 20, 1998; *Making A Federal Case Out of TennCare*, *THE TENNESSEAN*, July 13, 1998, at 12A. A revised consent decree, entered in October 1999, provides far-reaching and potentially costly procedural requirements for TennCare appeals. *See Grier v. Wadley*, Civ. Action No. 79-3107 (M.D. Tenn. 1999) (unpublished opinion on file with Professor Blumstein, Vanderbilt Law School) (Consent Decree).

236. For the distinction between complaints and grievances, see *supra* note 219. For a description of the administrative appeals process, see *WAIVER EXTENSION REQUEST*, *supra* note 19, at 77-78. Between September 1, 1997 and November 30, 1997, there were 269 administrative appeals—232 provider payment and 37 consumer reimbursement issues. Of those appeals, 243 were resolved at the time of the Waiver Extension Request. *See id.* at 78.

The above aspects of TennCare's structure and design are summarized in Table 1.

TABLE 1

	BEFORE TENNCARE			AFTER TENNCARE	
	Before <i>Daniels</i>	After <i>Daniels</i>	After 2 nd Consent Decree	Before <i>Daniels</i>	After <i>Daniels</i>
Pre-Deprivation Hearing	No	Yes	Yes	No	Yes
Interim Coverage of Benefits	No	Yes	Yes	No	10 days (with option to extend)
Time: Contractor Denial of Claims				30 days	21 days
Time: File Grievance					30 days
Impartial Hearing Officer				No	Yes
Time: Hearing Before Impartial Hearing Officer				> 90 days	90 days

D. TennCare: Fiscal Rationale and Assumptions

Under TennCare the state contracts with MCOs for the provision of services to covered beneficiaries—both Medicaid-eligible patients and other uninsured/uninsurable state residents. MCOs organize the provider network, manage the provision of care to enrolled beneficiaries, and assume financial risk for the provision of services since they are paid on a capitated per-enrollee basis.

In determining the level of payments (the capitation rate) to MCOs, the state's methodology started with a determination of a global budget—the total amount to be expended in TennCare. Tennessee made an initial determination that the funds already contributed by state and local government sources were adequate to provide services under TennCare. That was not an empirically tested

hypothesis but rather a going-in assumption.²³⁷ The payment per enrollee was a derived number, based on an estimate of program enrollment.²³⁸

In developing the capitation rate, the state deducted 5% from aggregate Medicaid expenditures as an estimate of uncompensated charity care already being furnished that would be compensated by TennCare.²³⁹ The state's rationale was that the level of uncompensated care would dramatically decrease because TennCare would provide increased coverage to the uninsured.²⁴⁰ Since providers would presumably receive compensation for patients who in the past would have been treated on an uncompensated basis, the state reasoned that the front-end 5% reduction in levels of compensation actually held providers harmless financially.²⁴¹

To induce HCFA to approve TennCare, Tennessee proposed a global cap on FFP. As discussed above, under normal Medicaid funding federal matching responsibility is unlimited. Once a state's Medicaid program receives federal approval for services provided and beneficiaries eligible, the federal government is obligated to match (at the appropriate statutory matching formula) all qualified state program expenditures. In this way, state decisions regarding eligibility, compensation, scope of benefits, and levels of utilization automatically trigger FFP. No limits on the magnitude of FFP exist once the provisions of a state Medicaid program are federally approved and qualified state Medicaid expenditures are made. The federal government basically is a passive check-writer in that process, with state and local decisions associated with program administration having direct and automatic federal financial implications. This federal fiscal automatic-pilot feature inheres in the nature of a cooperative-federalism entitlement program.²⁴²

TennCare alters this traditional financial arrangement. For the federal government, Tennessee offered to establish a global ceiling

237. See *supra* note 165. In this regard, the fiscal assumptions underlying TennCare were quite different from those used by Oregon in its demonstration. See generally Blumstein, *supra* note 164.

238. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 79-97.

239. See *id.* at 82 ("State studies estimate uncompensated care at 11 percent of total charges . . . [S]ince not all uninsured persons will enroll in TennCare initially, TennCare is premised on capturing only five percent, or slightly less than half of the total charity care being provided in Tennessee.").

240. Given the geography of Tennessee, with cities such as Chattanooga and Memphis adjoining other states, this theory was always subject to some limitation since uninsured indigent patients from out-of-state would always be a reality for the major hospitals of those cities.

241. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 82.

242. See *supra* Part II.

on FFP under TennCare.²⁴³ Instead of facing an open-ended federal commitment, the federal government could limit in advance its annual fiscal responsibility for TennCare.²⁴⁴ Correlatively, the state agreed to assume the financial risk if total expenses exceeded the FFP cap.²⁴⁵ Thus, the state was financially at risk for unanticipated increases in the number of program beneficiaries or in the costs of treating TennCare patients.

Tennessee's Medicaid enrollment rose from 611,993 in fiscal 1989 to 878,961 in fiscal 1992 (and an estimated 1,000,000 in fiscal 1993),²⁴⁶ a compound growth rate in the Medicaid caseload over that four-year period of approximately 12.8%.²⁴⁷ In addition to an increasing Medicaid patient population, Medicaid had a considerable cost-growth per capita of 8.7% per year based on actual prior (pre-TennCare) experience.²⁴⁸ Thus, Tennessee was able to posit that, in the absence of TennCare, overall costs for Medicaid would rise by more than 17% per year as a result of cost and caseload growth. With approval of TennCare, Tennessee estimated that, by the last year of the demonstration, program spending levels would increase by about 5% per year.²⁴⁹

Guidelines governing the granting of Medicaid waivers required budget neutrality.²⁵⁰ For TennCare, HCFA agreed to calculate budget neutrality over the entire five-year demonstration, rather than to examine each year separately.²⁵¹ With the three-year

243. See TENNCARE WAIVER APPLICATION, *supra* 14, at 79 ("Rather than requesting a federal matching share or fixed federal contribution per capita, Tennessee is seeking a total federal dollar budget for the program.").

244. The total five-year FFP amount agreed to was \$12.165 billion. See *id.* at 115. The first year FFP cap (for Tennessee's fiscal 1993-94) was set at \$2.108 billion. For calendar 1994, the first year of the TennCare program, FFP was capped at \$2.227 billion. The difference reflects the fact that TennCare covered only the second half of Tennessee's fiscal 1993-94. For Tennessee's fiscal 1994-95, the FFP cap was set to rise by 8.3% to \$2.283 billion. For the next three years, the FFP cap was set to rise by 7.5%, 5.7%, and 5.1% respectively. See *id.*

245. See *id.* at 79 ("Tennessee is assuming substantial [financial] risk for the TennCare program, a risk it is willing to take because of its belief in the potential for the program's success."); *id.* at 81 ("Because of the nature of the federal dollar commitment sought, it is most critical that the Year One estimates be valid. The federal government is protected thereafter through the control on total spending growth.").

246. The estimated Medicaid enrollment for fiscal 1994, in the absence of TennCare, was 1,128,399. See *id.* at 95.

247. See *id.* at 83.

248. See *id.* at 88.

249. See *id.*

250. See Suzanne Rotwein et al., *Medicaid and State Health Care Reform: Process, Programs, and Policy Options*, 16 HEALTH CARE FIN. REV. at 105, 118 (1995).

251. See WAIVER EXTENSION REQUEST, *supra* note 19, at 55 (STC 16); see also *supra* note 170.

TennCare extension, the budget neutrality calculation was extended to cover the entire eight-year period.²⁵²

Implementing the concept of budget neutrality requires an agreement on a hypothetical issue—what a state's Medicaid expenditures would be if a waiver is not approved. This requires estimation of a baseline of projected expenditures. The typical next question was what expenditures would be projected to accrue under the demonstration. Tennessee's proposed global FFP cap obviated the need for this question, at least from the perspective of the federal government, since, under TennCare, the state was financially at risk if expenditures were to exceed projections.

Agreeing on the baseline of expense for TennCare's first year was particularly important since subsequent years would be based on projected levels of increase from the first year. Tennessee sought a "commitment from the federal government to contribute in Year One what it would have contributed under the present system, and a commitment to increase its contribution in the remaining years of the project by no more than the per capita cost increase historically experienced in the Medicaid program (8.3%)."²⁵³ This "current services" approach to calculating the base line sets the base year without-waiver expenditures equal to what would be necessary to finance the state's Medicaid program on the assumption that pre-existing state laws and policies that were in place remain in effect. Under this approach, the federal government need not determine which Medicaid costs a state would likely have maintained or inaugurated in the absence of the proposed waiver. This approach apparently is advocated by the General Accounting Office²⁵⁴ but has been criticized in general by the Clinton Administration.²⁵⁵

An alternative approach to calculating budget neutrality, the "current law" approach, establishes neutrality by projecting likely expenditures in a state under current federal law, which allows states to expand and contract their Medicaid programs. Accounting for such potential state-based changes requires a judgment on the part of federal officials of likely state behavior in the absence of a waiver. This is the kind of dynamic projection that federal budget officials engage in

252. See Letter from Michael Hash, *supra* note 9 (STC 16) (approving three-year TennCare extension).

253. TENNCARE WAIVER APPLICATION, *supra* note 14, at 80. The 8.3% historical rate of increase in per capita Medicaid expenditures had apparently risen to 8.7% in the most recent three pre-TennCare years. See *id.* at 88.

254. See GAO, MEDICAID: SPENDING PRESSURES DRIVE STATES TOWARD PROGRAM REINVENTION 41 (1995).

255. See *id.* at 70-73 (Clinton Administration's response to draft GAO Report).

on a nationwide basis in estimating (and budgeting for) the aggregate national levels of FFP, which are controlled by state Medicaid programmatic decisions.²⁵⁶

In practical terms, the current law methodology would mean that Tennessee's future plans, absent a waiver, would be evaluated by the federal government in determining budget neutrality. A dynamic political analysis rather than a static straight-line projection would be used in forecasting future without-waiver Medicaid state expenditures in Tennessee. HCFA would have asked whether Tennessee could have maintained Medicaid spending at historical levels beyond fiscal 1994 or whether it could have sustained historical levels of growth in the program for five additional years. For example, some consideration of the effect of MVCPTA²⁵⁷ and of OBRA '93,²⁵⁸ which restricted the ability of states to make DSH payments to hospitals and which was enacted before TennCare was approved, would have been required. In addition, HCFA would have taken into account the likely effect of state plans to cut back on Medicaid expenditures, as reflected in the appointment and deliberations of the Governor's Medicaid task force, charged with recommending program cuts in the range of \$750 million to meet the projected revenue shortfall in the Medicaid budget for fiscal 1995.²⁵⁹ Under a current law approach to setting a budget-neutral baseline, statements in the waiver application that the then-recent historical rate in Medicaid growth was unsustainable²⁶⁰ would have been prejudicial to the state.

HCFA's acceptance of the current services approach to establishing the baseline for purposes of calculating budget neutrality meant that Tennessee received approval of the amount in its fiscal 1994 budget as the baseline for budget neutrality under TennCare. This reflected a significant increase in FFP for the first year of TennCare, an increase of 17% in program allocations over Tennessee's previous fiscal year (1993).²⁶¹ Since all increases in expenditure were based on the first-year FFP level, the federal government's assent to

256. *See id.* at 71-72.

257. *See id.* U.S.C. §1396b(w) (1994); *see also supra* Part III.B.

258. 42 U.S.C. § 1396r-4(g).

259. *See supra* text accompanying notes 79-83.

260. *See* TENNCARE WAIVER APPLICATION, *supra* note 14, at 1 ("For the past several years, the cost of [Medicaid] has grown so steeply that it threatens the viability of all other functions of state government. The growth of the Medicaid program has far exceeded the ability of the State to sustain through normal methods of State revenue generation."); *id.* (Letter of Governor McWherter to Donna E. Shalala, June 16, 1993, stating that in the absence of TennCare, "the current Medicaid program threatens the viability of Tennessee's health care system and the financial stability of the entire state government").

261. *See id.* at 81-82.

the current services methodology for establishing the baseline amount was critical for Tennessee's fiscal stability (and for providing a cushion to allow expansion of the scope of coverage, a clear federal goal).

In approving TennCare, effective January 1, 1994, halfway through Tennessee's fiscal 1994, HCFA agreed that the FFP neutrality cap would increase by 8.3% in Tennessee's fiscal 1994-95, from \$2.108 billion to \$2.283 billion, and by 7.5%, 5.7%, and 5.1% in the remaining years of the demonstration.²⁶² For the three-year TennCare extension period, the budget neutrality cap was set at an annual rate of increase of 5.1%.²⁶³ This conforms remarkably closely to Tennessee's original projection that, through TennCare, it would reduce the rate of overall program expenditure increase to 5% per year.²⁶⁴ Whereas FFP was capped at \$12.165 billion over the five-year TennCare demonstration, Tennessee projected in its TennCare extension application that FFP for the entire five-year demonstration period would be \$10.567 billion, a reduced expenditure of \$1.6 billion compared to the approved five-year budget neutrality cap.²⁶⁵

Ironically, Tennessee did not secure a commitment to a fixed level of FFP as a percentage of qualified state funds expended. Under the statutory formula, FFP varies with a state's relative wealth.²⁶⁶ At the outset (for state fiscal year 1994), FFP absorbed 66.98% of total program cost. Non-federal sources covered the rest.²⁶⁷ In subsequent years, as Tennessee's relative economic status improved, the FFP rate decreased, and the state faced an unanticipated funding shortfall.²⁶⁸

TennCare has reduced the enrollment cap from an original estimate of 1.775 million to 1.3 million before program implementation and then back to 1.5 million.²⁶⁹ On January 1, 1995, one year into the demonstration project, TennCare closed enrollment for the uninsured to assure fiscal stability.²⁷⁰ Enrollment had reached 90% of its

262. See WAIVER EXTENSION REQUEST, *supra* note 19, at 55; see also *supra* notes 187 & 189.

263. See Letter from Michael Hash, *supra* note 9, (STC 16) (approving three-year TennCare extension and noting that 5.1% budget neutrality cost increase was consistent with the dictates of § 4757 of the Balanced Budget Act of 1997 and § 1115(e)(7) of the Social Security Act); see also *supra* note 204.

264. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 80, 88.

265. See WAIVER EXTENSION REQUEST, *supra* note 19, at 115.

266. See *supra* note 40.

267. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 81.

268. Duren Cheek, *Taxing Services May Not Help State: Economist Says Plan Isn't Answer to Revenue Problems*, THE TENNESSEAN, Aug. 3, 1999, at B1; Interview with John Ferguson, Commissioner of Finance, in Nashville, Tenn. (Dec. 17, 1996).

269. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 29, 83-84; *supra* note 190.

270. The state may not close the program to the group who would have been eligible to participate in the state's Medicaid program. See PRICEWATERHOUSECOOPERS, *supra* note 166, at 2-3.

target.²⁷¹ Since under the waiver the state was financially at risk for unanticipated increases in program costs beyond the FFP cap—whether from enrollment increases or increases in per-patient costs of treatment—the state was cautious in managing enrollment to allow for an unexpected increase in Medicaid eligibles for whom TennCare coverage was mandatory. When enrollment for the uninsured was closed, the state estimated that 95% of its population had some form of private or government-sponsored health insurance.²⁷² While Tennessee generally closed enrollment in TennCare for non-Medicaid patients in 1995, TennCare has remained open for those deemed uninsurable²⁷³ and has re-opened for four other specific categories.²⁷⁴ By the end of May 1999, TennCare enrollment exceeded 1.3 million,²⁷⁵ above the original CRA cap.²⁷⁶ From June 1996, to May 1999, the demographic composition of TennCare evolved significantly. The number of more expensive uninsured/uninsurable patients rose from 334,382 to 492,544 while the number of Medicaid-eligible enrollees fell from 846,067 to 816,637. Uninsured/uninsurable patients rose from 28% to 38% of total enrollment during that period.²⁷⁷

271. See TennCare Website, *supra* note 11.

272. See TennCare Website, *supra* note 11. The state has been much less cautious (or at least less successful) in enrollment management since the approval of the TennCare waiver extension. See *supra* notes 11-13.

273. See Bill Snyder, *Patients Plead for Care: TennCare Is Only Option, Officials Told*, THE TENNESSEAN, Apr. 17, 1999, at 1A, 2A. In preparing his budget for fiscal 2000, Tennessee Governor Sundquist announced a major reassessment of eligibility for persons denied insurance by private carriers. The state faced a substantial increase in the state share of TennCare, see Keith Snider, *Hospitals Backing Reforms to Save TennCare Despite Cost*, THE TENNESSEAN, Feb. 12, 1999, at 1A, 13A, and was concerned about abuses that raised costs considerably.

274. See *supra* note 190.

275. See *supra* note 11.

276. See *supra* note 190.

277. See *supra* notes 11-13. Those enrolled in TennCare through other than mandatory Medicaid eligibility categories and who have incomes above 100% of the poverty level pay a premium based on a sliding scale. For a description of the sliding scale concept, see TENNCARE WAIVER APPLICATION, *supra* note 14, at 19-27. This money is channeled back into the TennCare budget and qualifies (based on a formula) for FFP as state expenditures. See Letter from Bruce Vladeck, *supra* note 8, (STC 14) (allowing 90% of first \$75 million, 80% of next \$50 million, 50% of next \$50 million, and 20% of all additional premiums collected to qualify for FFP).

V. TENNCARE'S PROGRAM DESIGN AND IMPLEMENTATION:
A LEGAL AND POLICY ANALYSIS

A. *Institutional Design Considerations: The Triumph
of Pragmatism Over Ideology*

Tennessee formulated TennCare while the nation was debating comprehensive national health care reform. The design of TennCare can be seen as the triumph of pragmatism over ideology. It achieved a bold access agenda through Medicaid cost containment and market improvement reform while avoiding the ideological pitfalls that helped sink the comprehensive Clinton Administration reform proposals.

Health care reform means different things to different people with different agendas, so reform really has three different and quite distinct faces. One emphasizes improving access to medical services for the uninsured and the underinsured. This was the clear focus of the Clinton Plan.²⁷⁸ A second stresses cost containment of public programs such as Medicaid and Medicare. When Republicans gained control of Congress in 1995, they shifted the focus of reform from access (the Clinton agenda) to containing Medicaid and Medicare costs. The denouement was President Clinton's veto in 1995 of budget legislation that reduced the rate of increase in public spending on these programs.²⁷⁹ A third face of health care reform is institutionalist. This theory of reform seeks to identify areas in which the health care marketplace is not functioning properly and warrants some form of corrective action. It then attempts to formulate a strategy of intervention.²⁸⁰

1. The Unitary vs. Pluralistic Issue

To avoid characterization as taxation, the Clinton access-driven plan included all persons within a geographic region. The Clinton

278. The Clinton proposals evolved; initially they were aimed, at least in part, toward improving the functioning of the market—"to solve the problems small groups had in purchasing health insurance." See Alain Enthoven, *A Good Health Care Idea Gone Bad*, WALL ST. J., Oct. 7, 1993, at A18. For a discussion of the "shifting agenda pursued by the Clinton Administration," see Blumstein, *supra* note 6, at 27-29.

279. See Robert Thompson, *Clinton, Gingrich Continue to Fight for Power*, THE WASH. POST, Dec. 31, 1995, at 12 (discussion of budget politics).

280. See Blumstein, *supra* note 6, at 17. ("Regulation-oriented analysts tend to view market imperfections as a justification for substituting a system of government regulation for an imperfectly functioning market In the face of market defects, market-oriented analysts first seek to develop policies designed to improve the functioning of the market . . . [f]or example, [through] enforcement of the antitrust laws.").

Plan would have placed in a single purchasing alliance those privately insured, those on public medical benefits programs (e.g., Medicaid), and those uninsured. The government would have asserted jurisdiction over the entire health care marketplace and focused on creating a unitary health care system (as opposed to allowing a pluralistic market-based industry to exist). The premiums would be set by determining the projected cost of providing mandated services for all citizens of a particular geographic area.²⁸¹ To the extent that cost savings could be obtained in private health insurance plans, those savings would be channeled into funding the care provided through an alliance.²⁸²

Since rechanneling cost savings from private health insurance programs to fund its access agenda was critical to its reform proposals, the Administration had to focus on comprehensive reform. Its plan included all citizens in a single, unitary system. Therefore, the Clinton Administration expressed a governmental interest in cost containment not only with regard to public programs—which is understandable since that directly affects public budgets—but also with regard to private medical insurance. Yet, traditionally the government plays a small role in determining how resources are to be allocated in the private marketplace.²⁸³

The comprehensive approach to reform was driven, in part, by the need to encompass private medical insurance within the single unitary system (the alliances) in order to recapture the cost savings from the private medical insurance market and reallocate those savings to the funding of medical care for the uninsured and the underinsured. It was also driven, however, by ideology.

Critics of the American health care scene have traditionally contended that the only legitimate basis for allocating scarce medical resources is the criterion of medical need.²⁸⁴ As one of us has discussed elsewhere, that “assumption obliterates the distinction between government’s need to ration public funds and its questionable role in

281. *See id.* at 44.

282. Proponents sought to reassure private medical insurance beneficiaries that their coverage would not deteriorate, even though savings from private insurance would fund access to care for the uninsured and underinsured. “Any reform that seeks to ensure security cannot ask Americans to step down to a lower level of coverage than they now have.” Starr, *supra* note 5, at 1670.

283. Blumstein, *supra* note 6, at 21-22; *see also* James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1347-48 (1981).

284. *See* Rand E. Rosenblatt, *Rationing “Normal” Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401, 1411 (1981).

rationing private funds."²⁸⁵ For critics, "this distinction in governmental role is . . . unacceptable" because they "view all medical resource utilization decisions as within government's area of responsibility. Whether a patient pays for medical care with private funds . . . or public funds, . . . government has an obligation to obliterate distinctions other than those based on medical need."²⁸⁶ In essence, that position means that the "consumption of all medical resources, by privately and publicly funded patients alike, is implicitly viewed as a rationing decision on the part of government for which government is responsible."²⁸⁷ However, in a pluralistic market economy, resource allocation decisions are decentralized to households and firms and are not made in a conscious, collective sense.²⁸⁸ "[G]overnment does not have an independent interest in limiting private spending if the system of decisionmaking is unbiased and the aggregate levels of spending reflect unbiased, unsubsidized private choice."²⁸⁹

Thus, the Clinton proposal for comprehensive health care reform was embraced for practical considerations—stealth cross-subsidization of the uninsured and the underinsured by the privately insured—and because of ideology—regarding government's appropriate role in health care regulation.²⁹⁰ But, by focusing on comprehensive reform and providing for expensive comprehensive benefits, which made the cost of cross-subsidization even larger,²⁹¹ the Clinton Plan ran into ideological cross-currents and headwinds that ultimately sank it.

The TennCare proposal, which received remarkably widespread contemporaneous political support, differs strikingly in broad concept from the Clinton Plan. TennCare does not place direct government regulation or controls on the private health insurance marketplace. Instead, its exclusive focus is on TennCare itself, its beneficiaries, and MCOs and providers, which are under contract for the provision of medical care services to TennCare enrollees.

The Clinton proposals contemplated a unitary system for all beneficiaries, folding into the same purchasing alliances persons who already had private health insurance, public beneficiaries, and those with inadequate or without health insurance. TennCare does not ex-

285. James F. Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899, 906 (1982).

286. *Id.*

287. *Id.* at 906-07.

288. See Blumstein, *supra* note 283, at 1347-48.

289. Blumstein, *Distinguishing Government's Responsibility*, *supra* note 285, at 910.

290. See Blumstein, *supra* note 6, at 34-38, 42-45.

291. For discussion of the comprehensive benefits issue, see *id.* at 34-38.

tend its reach to privately insured Tennesseans. It only covers Medicaid-eligible and uninsured or uninsurable enrollees, allowing a private, pluralistic health care marketplace to remain in effect and to flourish.

2. The Equality vs. Adequacy Issue

The TennCare benefits package is defined through a process of political negotiation and accommodation. It is not inherently²⁹² linked to benefits packages available to private-sector insureds²⁹³ and does not, at least directly, aim to level down non-TennCare patients by restricting their ability to purchase whatever coverage might be available in the marketplace. Savings to finance health care coverage for the uninsured are derived, at least nominally, from the overall group of public beneficiaries. Economies in an existing program (Medicaid) expand access to that program, leaving privately covered patients out of the regulatory or financing mix.²⁹⁴

As a distinct government-sponsored program for expanding access to medical care within a pluralistic health care marketplace, TennCare avoided another ideological pitfall. It successfully steered

292. One of TennCare's goals was to offer a "standard package of health care benefits comparable to that offered in the private sector." McWherter Letter, *supra* note 7.

293. The benefits package was in fact patterned after the health plan offered to state employees through Blue Cross, but more generous for children under twenty-one as the requirements of EPSDT for children's health were retained. *See infra* notes 294 & 350; TENNCARE WAIVER APPLICATION, *supra* note 14, at 19-20. The state asserted that the scope of benefits under TennCare were "more generous than those offered under Medicaid." *Id.* at 19.

294. Three qualifications are important here. First, the secrecy of the initial program-formulation negotiations and the blitzkrieg administratively-based implementation of TennCare short-circuited the normal political process. Advocates for Medicaid and uninsured patients were on the inside at the negotiating table, providers were not. Further, those advocates had political leverage with the federal government, which was simultaneously seeking to provide universal access to health care insurance and which had to approve TennCare. *See infra* Part V.C.2. For the McWherter Administration and patient advocates, economies from TennCare were seen as coming from reduced provider revenues, not from lost patient benefits. Second, the political leverage allowed patient advocates to insist on a very generous benefits package, more generous than available in many conventional private-sector plans customarily purchased in Tennessee. Therefore, while there might not be a unitary system, there would be no substantial risk that TennCare beneficiaries would fare more poorly than privately covered patients in the health care marketplace. Third, Blue Cross held the state contract for providing benefits for state (and many local government) employees. About half of TennCare patients enrolled in the Blue Cross TennCare plan. Blue Cross insisted that providers in its network for public employees also provide services to TennCare enrollees folded into that network. This reduced the risk, from the perspective of patient advocates, that TennCare patients would be outside the mainstream medical system. Although that remained a possibility for patients who chose a TennCare-only MCO, the availability of the integrated Blue Cross plan and the ability to switch MCOs annually could reasonably be expected to discipline the quality provided by TennCare-only MCOs in the marketplace.

clear of the equality vs. adequacy debate that swirled around the Clinton Plan and around all other attempts at expanding access to medical care through government programs.²⁹⁵

In discussions about the role of government in promoting improved access to medical care, there traditionally has been a good bit of "symbolic, rhetorical posturing about an amorphous 'right' to medical (or health) care."²⁹⁶ Those seeking broader access to medical care—access egalitarians—have typically advocated equality as the goal.²⁹⁷ But in its influential report, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research declined to adopt equality as the conceptually/ethically appropriate objective in pursuing the goal of improved access to medical care.²⁹⁸

Analytically, equality can be achieved only by leveling down, which is coercive, or leveling up, which is expensive, or some combination of both, which can be both coercive and expensive. The coercive aspect of leveling down—restricting those who choose and are able to expend large sums of money on medical care from spending their own funds on medical services—is troubling as a matter of principle, and some of the most potent criticism of the Clinton Plan stemmed from concerns about its coercive leveling down dimensions.²⁹⁹ The expense of leveling up—and its questionable rationality from a resource allocation perspective—makes that alternative politically unappealing. As we have argued in more detail elsewhere, it should seem "self-evident . . . that the goal of equal utilization of medical services is an unrealistic and probably unwarranted policy aspiration."³⁰⁰

295. See generally Einer R. Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449 (1994) (discussing the difficulties associated with maximizing limited health care given the diverse medical needs of any given group).

296. James F. Blumstein, *Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study and a Paradigm*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 94 (Frank A. Sloan et al. eds., 1986).

297. Equality can mean equality of access, equality of actual utilization of inputs across income groups, need-adjusted equality of inputs, or equality of outcomes. See PRESIDENT'S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 11-35 (1983) [hereinafter PRESIDENT'S COMM. REPORT].

298. See *id.* at 18-19.

299. See, e.g., Elizabeth McCaughey, *No Exit*, THE NEW REPUBLIC, Feb. 7, 1994, at 21-25 (discussing coercive limits on out-of-plan coverage under Clinton Proposal).

300. James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 866 (1981); see also Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & L. 471, 491 (1977) (noting the unreasonableness of demanding absolute equality in medical services distribution).

The President's Commission adopted "adequacy" not "equality" as the appropriate normative standard for determining the nature and scope of public responsibility in assuring access to medical care.³⁰¹ In defining the term "adequacy," one does not ask what level of care are nonindigents getting.³⁰² Rather, as explained elsewhere, the analytical inquiry focuses on "what a decent level of care is—a level that we, as a state or nation, feel would both satisfy our social obligations and deal adequately with the special characteristics of the indigent patient's need for medical care."³⁰³

In the context of TennCare, the benefits package for beneficiaries was set politically through a negotiation process.³⁰⁴ It was not inherently related to private plan coverage³⁰⁵ and made no pretense at restricting availability of medical care to non-TennCare patients. The straightforward issue was what benefits should TennCare provide to its enrollees, and could providers reasonably perform those services with funding levels established in TennCare.³⁰⁶

Of course, one way of finessing the adequacy vs. equality issue—avoiding the value confrontation while reducing the significance of the issue from a pragmatic perspective—is to define adequacy very generously. This reduces the disparity between health care benefits provided at public expense and health care services that can be purchased in the private market. This was ultimately the strategy used by TennCare program designers—the adoption of pragmatism and the sidestepping of ideology.

This issue had its counterpart in the national health care reform debate. Noteworthy by its absence was rhetoric from the Clinton Administration about equal access to medical care. Proponents of managed competition used terms such as "core benefits pack-

301. For precursors of the position advocated by the President's Commission, see James F. Blumstein & Michael Zubkoff, *Perspectives on Government Policy in the Health Sector*, 51 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 395, 411 (1973); James F. Blumstein & Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382, 405 (1979).

302. James F. Blumstein, *Thinking about Government's Role in Medical Care*, 32 ST. LOUIS U. L.J. 853, 862 (1988).

303. *Id.* "The adequacy standard allows for the consideration of trade-offs between medical care and other needs and encourages efficiency, rewarding cost effectiveness with alternative benefits from the savings accrued." Blumstein, *supra* note 6, at 34.

304. See *supra* notes 237-38 and accompanying text.

305. See *id.*; see also Jean I. Thorne et al., *State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island*, 16 HEALTH CARE FIN. REV. 121, 129-30 (Spring 1995) (noting that a political goal was to have benefits comparable to those in private plans; the state employee plan satisfied that objective).

306. In the absence of some type of bidding process, there is ground for skepticism whether there is an appropriate match between resource availability and the provision of specified services. See *infra* Part V.B.

age" to describe the kind of plans that would be made universally available. Government would require payment for "core" services. But that very notion, akin to the adequacy concept embraced by the President's Commission,³⁰⁷ contemplates opportunities for supplementation—and supplementation recognizes the role of a pluralistic marketplace in which levels of service available to consumers will vary. That notion is clearly inconsistent with at least a hard version of equal access.

But the ideological commitment to equal access, relinquished theoretically when the focus is on public responsibility to assure access to core benefits, was in fact "boiling just below the surface" of the debate surrounding the Clinton Plan and emerged in "different rhetorical garb."³⁰⁸ To narrow the range of permissible differences in access, the Clinton Plan subtly shifted from promoting access to a core benefits package, to advocating a comprehensive benefits package. The movement from core to comprehensive benefits reflected the reemergence of the access egalitarian ideal but without the equality of access ideological baggage.³⁰⁹ Thus, in advocating universal coverage, the Clinton Plan sought to avoid the conceptual/ideological problems associated with the equal access rhetoric. It learned from supporters of the adequacy approach that the honest political issue is what constitutes an acceptable level of adequacy.³¹⁰

These ideological issues were never far from the surface in the development of TennCare. The waiver application asserted that TennCare would establish a standard benefit package for enrollees that would set a "benchmark of sufficient coverage."³¹¹ This sounds very much like a core or adequate package of benefits for public beneficiaries. Yet, the TennCare application also asserted that the "reformed system must be unitary; those who have traditionally been the responsibility of public programs should have access to the same level and quality of health care as others covered by the reformed system."³¹² By its nature, TennCare was not designed as a unitary system, despite the rhetoric in the waiver application. It only covered a select group of public beneficiaries and did not claim authority over the private health care marketplace. TennCare did eliminate some class distinc-

307. See *supra* notes 299-306 and accompanying text.

308. Blumstein, *supra* note 6, at 35.

309. See *id.*

310. See Blumstein & Sloan, *supra* note 300, at 866.

311. TENNCARE WAIVER APPLICATION, *supra* note 14, at 3.

312. *Id.* at 2. Noting the careful balance, the waiver application asserted that "the public cannot be asked to provide publicly-supported citizens a greater level of health care than it can secure for itself." *Id.* at 2-3.

tions in medical care, as the waiver asserts, “[b]y combining the publicly-supported groups with other uninsureds.”³¹³ For TennCare beneficiaries who enrolled in the Blue Cross MCO, TennCare also eliminated class distinctions between public beneficiaries enrolled in TennCare and state and local government employees covered in that Blue Cross network which, as a TennCare MCO, would include TennCare beneficiaries.

From a structural perspective, the assertion that TennCare would promote a unitary system³¹⁴ was erroneous—a rhetorical flourish. But in a pragmatic way, advocates for Medicaid and uninsured patients were able to work towards that goal despite the structure of TennCare, which focused only on public beneficiaries. Critics of TennCare have complained that the benefits package is too generous. The plan actually offers more comprehensive benefits than most private insurance plans in Tennessee, but that was a pragmatic strategy to narrow the range of difference between public beneficiaries and private purchasers by raising the level of benefits in the public program.³¹⁵ Provided that public levels of expenditure could be maintained at politically sustainable levels, with savings accruing from an existing public benefits program (Medicaid), the TennCare program was able to secure wide initial support which led to its rapid implementation.

Concerns about the generous level of benefits in TennCare reflect a political complaint about the nature and scope of an adequate or sufficient benefit package. If the political climate changes or if costs become again (as they seem to be) a political and economic challenge to available revenue streams, then the political deal may be revisited either by raising taxes (as Governor Sundquist urges) or by benefits cutbacks.³¹⁶ From an analytical/ideological perspective, however, TennCare asks the correct question—what is the appropriate (“adequate”) scope of benefits given the resources available to the state, the other claims on those resources, and the priority for providing medical care to Medicaid eligibles and non-Medicaid uninsureds?

313. *Id.* at 4.

314. *See id.* at 2.

315. *See supra* text accompanying notes 304-13.

316. In addition to seeking more revenues, the Sundquist Administration has expressed concern about the rising cost of TennCare and has proposed reassessing enrollment guidelines and scope-of-benefit issues. Predictably, this has elicited cautionary protests from patient advocacy groups. *See Snyder, supra* note 273.

3. The Entitlement vs. Obligation Issue

When "[a]ny individual who meets the prescribed standards for the subsidy enjoys a legal right, enforceable in a court, to receive it,"³¹⁷ a public subsidy program creates a legal entitlement. Entitlements respect the dignity of individuals and restrain the exercise (and potential abuse) of discretion by government officials and institutions.³¹⁸ They are legally enforceable, allowing for redress on the part of program beneficiaries and providing for a measure of accountability for the fair administration of a benefits program. Entitlements qualify as "property" and cannot be administratively taken away by government without the procedural requirements of due process.³¹⁹ Politically, entitlements "persist without regard to the annual appropriations process."³²⁰

A drawback to an entitlement approach is the lack of budgetary control. The definitions of eligibility and scope of benefits are built into the fabric of the programs, and the political default rule is the reverse of other political situations. Ordinarily, in the absence of agreement on its details or contours, a program is not enacted or renewed. The political burden is on program advocates. With regard to an entitlement program, the political burden is on advocates of program cutbacks since the result of stalemate is perpetuation of the program in its existing configuration. Thus, since entitlement programs customarily remain on automatic pilot and are funded based on estimates of expenditures needed to satisfy projected program costs under existing criteria, it is more difficult to introduce a "sense of trade-offs . . . into decisionmaking."³²¹

Under an obligation approach, a person may be eligible for a program's benefits but not entitled to that benefit as a legally enforceable matter.³²² There is a clear distinction between eligibility for and entitlement to a benefit.³²³ Persons or programs that satisfy the program criteria or guidelines qualify for program participation, but

317. Peter H. Schuck, *Designing Hospital Care Subsidies for the Poor*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 72, 83-84 (Frank A. Sloan et al. eds., 1986).

318. See Blumstein, *supra* note 6, at 39.

319. See *Board of Regents v. Roth*, 408 U.S. 564, 577-78 (1972) (holding due process safeguards apply only where government deprives a person of a liberty or a property interest); *Goldberg v. Kelly*, 397 U.S. 254, 262-64 (1970) (finding that a public benefits entitlement is protected by due process).

320. See Schuck, *supra* note 317, at 84.

321. See Blumstein, *supra* note 296, at 96.

322. See Schuck, *supra* note 317, at 84.

323. See Blumstein, *supra* note 6, at 39. A block grant with criteria of eligibility would be an example of an obligation approach.

eligibility for a program's benefits provides no assurance that any individual or institution must receive funding.

Under an obligation approach, political control over resource allocation is asserted in determining the overall level of a global budget. This allows the political system to consider trade-offs in the budget context and to exert some overall fiscal restraint. In an entitlement program, budget levels are derived from a technocratic estimate of the costs of fulfilling the demands created by the previously defined right or entitlement. No real balancing of alternatives arises in the appropriating process. Any decision to appropriate less than required by the automatic pilot features of an entitlement program necessitates a revision of the terms of the underlying entitlement itself. In the health care arena, the President's Commission rejected a right or an entitlement to medical care, instead proposing that government shoulder an "obligation to ensure that everyone has access to adequate care without being subject to excessive burdens."³²⁴

TennCare is a hybrid, reflecting features common to an entitlement program but also with features more associated with an obligation approach. The core entitlement is that all Medicaid-eligible persons are entitled to enroll in and receive the benefits of TennCare. However, by setting a global budget cap on FFP, TennCare places an upper limit on total federal funding. Since the state is entirely at risk financially once the FFP limits are met, it has been reluctant to run the program to the point where the federal cap is foreseeably reached. Thus, TennCare closed the program to new eligibility by the uninsured (but not the uninsurable) so as to remain within budgetary guidelines. When re-opening the program to certain children, TennCare did seek to fit eligibility criteria to projected budgetary allocations available, but what has been striking (at least until recently) has been the state's willingness to act aggressively to stay within fiscal parameters. The mindset has been that the non-Medicaid component is a capped entitlement, subject to budget restrictions. And since, beyond a certain point, the state is entirely at risk financially for program costs, the state has taken measures to curtail TennCare expenditures on non-Medicaid eligibles, although these curtailments have been subject to the kind of political restraints that exist on any cutback in an annual appropriations process. But no legislative redefining of an entitlement is required. Administratively, as long as HCFA approves, the state can just suspend new sign-ups for non-Medicaid TennCare participants. Thus, TennCare can be seen as a

324. PRESIDENT'S COMM. REPORT, *supra* note 297, at 22.

hybrid between the entitlement approach and the obligations approach—a “capped entitlement.”

4. Summary

TennCare reflects a subtle compromise of ideological and pragmatic issues. Unlike the Clinton approach, which would have established government hegemony over a unitary system, Tennessee adopted a more modest pluralistic system that allows the private market to continue to function without additional governmental oversight. TennCare established a standard benefits package, but only for TennCare's beneficiaries. The program does not affect the level of benefits otherwise available in the private health care marketplace and does not link its scope of benefits in any direct way to a standardized private sector benefits package imposed by government. Tennessee did model its benefit design on the plan available for state employees, but again did not purport to level up or level down the privately covered non-TennCare population. Further, TennCare continued the entitlement approach for Medicaid eligibles but experimented on a capped entitlement approach for non-Medicaid participants seeking to enroll in the program.

On structural, conceptual, and ideological grounds, TennCare seems at odds with the access-oriented health care reform agenda promoted by the Clinton Administration. Yet, TennCare won support from the federal government and from advocates for Medicaid and uninsured patients in Tennessee. The question is: What accounts for TennCare's political success in securing backing from groups normally committed to the ideal of comprehensive reform and establishment of a unitary system of health care with equal benefits for all individuals within that unitary system?

The key to understanding the answer to this question is a recognition of the triumph of pragmatism over ideology. Having essentially lost the ideological battle, patient advocates recovered in the political backroom what they had lost in the conceptual design of the program. Sophisticated pragmatism, coupled with political leverage of patient advocate groups in the program-design process, achieved broad health care access goals. While not directly controlling private health care benefits plans, the state was able to assure advocates for Medicaid and uninsured patients that TennCare's benefits would be very generous—more generous than many private plans in the state and explicitly more generous than before under Medicaid. Further,

Medicaid cost-savings would be re-allocated to expand coverage to uninsured/uninsurable patients.³²⁵ And the promise of Blue Cross offering TennCare patients participation in the network that served state employees provided assurance that quality would be acceptable.³²⁶ Finally, the prospect of either a significant reduction in Medicaid enrollment or a cutback in benefits was a distinct possibility, and TennCare (realistically) seemed like a reasonable and attractive alternative.

B. Fiscal Rationale and Assumptions: The Conceptual/Political Background Associated with Setting the Level of Expenditures

Underlying TennCare's development was concern with the rapidly expanding state Medicaid program whose cost escalation state officials considered fiscally unsustainable.³²⁷ The state's fiscal goal was to avoid either having to raise substantial tax-generated funds or to avoid substantial program cutbacks. To the extent that overall access to medical services could be improved by covering non-Medicaid patients, that would be an additional benefit of the projected cost savings from mandatory Medicaid managed care.

Tennessee made an initial determination that funds already contributed by state and local government were adequate, along with FFP, to provide services under TennCare.³²⁸ As discussed above, that was not an empirically tested hypothesis but a basic *a priori* assumption. In this way, TennCare's fiscal assumptions were quite different from those used by Oregon in its demonstration.

1. Oregon's System for Setting Expenditure Levels

Relying on the expertise of physicians in the state, Oregon developed a set of condition-treatment ("CT") pairs, relating specific conditions of illness to a course of treatment. Through a complex and controversial process, the state then determined what value to assign

325. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 2, 6.

326. *Id.* at 8, 19. See also Thorne et al., *supra* note 305, at 129-30 ("Crucial to the State's effort to meet the access requirement was a policy linking TennCare to the State employee insurance plan.").

327. See TENNCARE WAIVER APPLICATION, *supra* note 14, at 1 (escalating Medicaid program cost "threatens the viability of all other functions of state government").

328. See *supra* Part IV.D; TENNCARE WAIVER APPLICATION, *supra* note 14, at 2 ("There are sufficient resources now in the overall public-supported health care system to provide an acceptable level of quality care both to the needy who have been the traditional clients of public programs and those who are not covered by health insurance through their employment or otherwise.").

to specific conditions of wellness and illness as a basis for prioritizing CT pairs. Medicaid resources were allocated to CT pairs that received the highest priorities—those services and associated illnesses (CT pairs) above a “pay” line to be determined through the legislative/political process were covered under Medicaid while those CT pairs below that pay line were not covered.

To secure financing data, Oregon planners retained an actuarial firm to estimate the costs of funding specific CT pairs for Oregon’s Medicaid population.³²⁹ This allowed Oregon to estimate the costs of covering specific levels of service above the pay line in its prioritization process.³³⁰ Political decisionmakers would know the cost of funding a certain level of CT pairs, and the legislature could be informed what CT pairs would be above or below the pay line for any given level of fiscal appropriation. Since Oregon already was a mature managed care market, the reduction of costs through adoption of managed care was not an independent objective.³³¹

2. Tennessee’s System for Setting Expenditure Levels

Unlike Oregon, Tennessee’s health care market faced low levels of managed care. Cost savings from mandatory managed care were a clear objective of TennCare.³³² Since systemic change was a critical part of the TennCare agenda, precise estimates of projected cost savings were inherently more problematic and perhaps unknowable *ex ante*.³³³ In any event, the initial level of expenditure for TennCare was assumed as a given based upon existing spending levels.

The level of expenditures, therefore, was an administered price—a political parameter established by the state, not an economically-based price derived from either an Oregon-style estimate of costs or a market-validated price derived from a competitive bidding process. In a market, a party can establish a budget constraint (a

329. See Gold, *Insights from Oregon and Tennessee*, *supra* note 22, at 645.

330. For a brief description of how Oregon went about costing out its program, see *id.*; see also Blumstein, *supra* note 164, at 547. For an overall analysis and evaluation of the Oregon experiment, see Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL., POL’Y & L. 161 (1999).

331. See Thorne et al., *supra* note 305, at 124 (noting that “[t]wo-thirds of the AFDC population were included in prepaid plans prior to . . . implementation” of the Oregon Medicaid experiment and that “Oregon traditionally had heavy managed-care penetration in the private sector”).

332. See, e.g., TENNCARE WAIVER APPLICATION, *supra* note 14, at 87-88 (discussing the reasonableness of expecting “substantial savings” under managed care because of the reduction in the use of hospital care).

333. See *id.* at 84-88.

price) and seek bids on levels of service, or it can establish (e.g., through a bid specification) a level of service and seek bids on price to provide that service. TennCare established a budget constraint and derived a price (the per enrollee capitation rate paid to each MCO) from that overall budget sum.³³⁴ Under economic theory, a market-validated process would have left the specification of services to putative bidders in the market. However, the state also specified the TennCare benefits package with considerable particularity.³³⁵ Tennessee could have used an Oregon-style system of cost estimation to substitute for a market-validated bidding process, but it did not do that.³³⁶ As a result, Tennessee set both terms of the contract—the price and the services to be provided. It may have gotten the price right,³³⁷ but, in the absence of a market-based bidding system or an administrative/actuarial cost estimation, Tennessee had no assurance that TennCare set the proper price for the specified services.

Thus, while proponents described TennCare as a market-based proposal, that was only partly true. It used private networks (MCOs) to organize, take responsibility for, and assume the financial risk for the provision of medical care to TennCare patients. However, both the price (the MCOs' capitation rate) and the scope of benefits were administratively (i.e., politically) determined. Tennessee derived the TennCare capitation rate by assuming that then-current levels of spending were adequate. Further, the scope of benefits was based on Medicaid requirements and political bargaining with patient advocates who had considerable influence with HCFA in the waiver-review process.

Whether the price level was appropriate for the level of services specified in the CRAs was therefore not market-validated. If resources were inadequate, TennCare proponents could contend that

334. *Id.* at 84 (“Because the TennCare program is founded on a global budget, per capita spending is tied to the budgeted amount and caseload estimates.”).

335. *See supra* Part IV.C.

336. Tennessee acknowledged that it had “no direct way to know the precise cost of caring for the expanded population under a capitated system.” TENNCARE WAIVER APPLICATION, *supra* note 14, at 85. Tennessee compared the proposed initial TennCare capitation rate of \$1,641 with per capita costs of the state’s Medicaid program and its public employee health plan. *See id.* It also compared Medicaid experience across regions and compared the age and sex demographics of the uninsured with those of the Tennessee Medicaid population and of Tennessee’s state employee population. *See id.* at 84-88. Based on these rough comparisons, Tennessee concluded that the proposed capitation rate was adequate. Except for the Tennessee state employee experience, the comparisons did not account for possible differences in benefit packages. The TennCare benefit package was patterned on benefits provided to state employees. *See id.* at 85. The adjusted per capita cost of the state employee health benefits program tracked “almost exactly” the capitation rate projected for TennCare’s first year if all eligibles were to participate. *Id.* at 86.

337. *See supra* note 336.

some dissavings were appropriate to eliminate excess capacity. However, there was no market-validated way of knowing at the outset whether the level of resources committed to the program was sufficient to pay for the level of benefits prescribed or whether, if there were to be dissaving, the level of dissaving would be appropriate to achieve economic efficiency or whether it would result in excessive reductions in quality of care for beneficiaries.³³⁸

For some, TennCare could be defended as a way of using government purchasing power as a monopsonist to achieve redistributive goals—reducing provider compensation and redistributing those resources to serve the medical care needs of TennCare beneficiaries—and to benefit general taxpayers. It may be that resources can be extracted from providers to benefit TennCare beneficiaries without the sacrifice of excessive and measurable health-care quality standards. But at some point, resources (capital and personnel) will leave the TennCare market if compensated at non-competitive rates. So even the redistributive story has constraints.³³⁹

C. *TennCare's Access Agenda: The Broader Political Implications*

The design and implementation of TennCare have important political implications. Advocates for indigent and uninsured patients supported the TennCare waiver, thereby accepting some restrictions on patient choice in the Tennessee Medicaid program. Provided that the savings from mandatory managed care in Medicaid were preserved for funding access to uninsured patients, those advocates have been prepared to accept the restrictions necessarily resulting from managed care for Medicaid beneficiaries. This section analyzes that political dynamic.

1. TennCare Design: Political Realities and Constraints

In the development of TennCare, the drafters of TennCare made an important political choice regarding the use of funds to be saved by the adoption of mandatory managed care for Medicaid—those savings would not relieve the state's Medicaid budget, thereby

338. Over time, there can be a process of learning with mid-course corrections made. This has in fact occurred as Tennessee debated, for fiscal 2000, what measures to take to cope with projected increases in TennCare costs. See Bonna M. de la Cruz, *TennCare Chief Will Offer List of Cures*, THE TENNESSEAN, Apr. 6, 1999, at A-1.

339. See Uwe E. Reinhardt, *Resource Allocation in Health Care: The Allocation of Lifestyles to Providers*, 65 MILBANK Q. 153 (1987). For empirical evidence on these concerns, see *infra* Part VI.

freeing up funds for other state priorities such as public education, which, as a result of a state Supreme Court decree, required the infusion of hundreds of millions of state-level dollars.³⁴⁰ Instead, the money saved would remain in the medical care system to increase access for uninsured non-Medicaid patients. This choice, driven by state and national political considerations, became an important component of TennCare and provides insight into a new political dynamic of limiting public benefits entitlement programs.

The political environment in which TennCare was formulated had two distinct components—state and national. At the state level, rapidly escalating Medicaid expenditures dictated cost restraints.³⁴¹ In addition, the provider tax, which had become a major source of revenue for financing the state share of Medicaid expenditures, was at risk both politically and legally because of restraints on state provider-tax levies imposed by MVCPTA.³⁴² Nationally, the Clinton Administration had come into office promising comprehensive reform of the national health care systems and emphasizing expanded access to medical care for the uninsured.³⁴³

Under the circumstances, HCFA would not likely have approved a Medicaid demonstration that focused exclusively on cost savings without addressing access issues. This gave considerable political leverage to state-level advocates for Medicaid and uninsured patients, whose support was deemed by the state to be critical in securing Clinton Administration support for TennCare.³⁴⁴ An essential sweetener in the TennCare formulation stage for Medicaid patient advocates was an understanding that savings from managed care in Medicaid would be applied not only to finance medical services for Medicaid patients but also to fund medical care for other uninsured Tennesseans by expanding TennCare coverage beyond its Medicaid base—all without substantial increases in state expenditures. This would increase the proportion of Tennessee residents who had medical

340. *See Tennessee Small Sch. Sys. v. McWherter*, 851 S.W.2d 139 (Tenn. 1993) (holding that inequality in per pupil expenditures across school districts violated the state constitution and required increased state expenditures of hundreds of millions of dollars per year to reduce per pupil spending disparities across districts).

341. *See supra* Part III.A.

342. *See* 42 U.S.C. § 1396b(w) (1994); *see also supra* Part III.B.

343. For a discussion of various aspects of the Clinton Plan, *see generally* Symposium, 29 WAKE FOREST L. REV. 1 (1994).

344. The state was also wary that Medicaid cutbacks not supported by advocates for Medicaid patients could result in litigation. *See, e.g., Daniels v. Wadley*, 926 F. Supp. 1305, 1306-08 (M.D. Tenn. 1996) (noting pre-TennCare class action regarding Medicaid grievance procedures and the Second Consent Decree entered to settle that case).

insurance, consistent with Clinton Administration health access objectives.

D. Constraining Entitlement: The Significance of an Either/Or Rather Than a Yes/No Perspective

The structure of decisionmaking and the perception of that structure influence the behavior of participants in a political or an economic marketplace. Where economic or political trade-offs are at issue, decisions can either be framed as "yes/no" or "either/or." A yes/no decision confronts a decisionmaker with a choice of deciding only whether, for example, to consume (beneficial) medical services or to forgo use of those services. If the consumer answers "yes," then he or she receives the services and benefits from them. If the consumer answers "no," then no services are received. In such a situation, whether the decisionmaker can recapture and reallocate ("R & R") resources derived from economizing is critical in determining whether economic or political trade-offs will be fairly balanced in the decision-making process.

Where R & R does not apply, a decisionmaker has an incentive to say "yes" to consumption of beneficial services irrespective of cost. Trade-offs are difficult to consider when a decisionmaker confronts uncertainty and lack of control over alternative expenditures—i.e., when decisions are not viewed as "either/or." The incentive to say "no" is therefore diminished when a decisionmaker cannot consider whether a putatively more attractive alternative expenditure might be preferable to the one at issue. Only when decisions are perceived as being "either/or"—either the benefit under consideration by the decisionmaker will be obtained (by saying "yes") or the decisionmaker can choose a higher-priority, more desirable alternative by declining the benefit under consideration (by saying "no")—can a properly functioning decentralized process for considering trade-offs emerge.³⁴⁵ As we have argued in detail elsewhere, "[t]he ability of private decisionmakers to benefit from choosing not to consume an item is critical to the effective functioning of . . . private choice. Given a certain budget, decisionmakers in the private market face 'either/or' rather than 'yes/no' choices—selecting one good or service means foregoing another."³⁴⁶ But this system only works when decisionmakers can "recapture and reallocate ("R & R") resources derived from econo-

345. See Blumstein & Sloan, *supra* note 300, at 857-59.

346. Blumstein, *supra* note 288, at 1350.

mizing.”³⁴⁷ In the absence of R & R, “decisions are seen not as ‘either/or’ but as ‘yes/no,’ and a private decisionmaker will be prone to say ‘yes’ to a given consumption opportunity because he will not gain anything by saying ‘no’ to any outlay of funds.”³⁴⁸

The insight about the difference between an “either/or” and “yes/no” decisionmaking framework applies to the political environment surrounding TennCare. Historically, advocates for Medicaid beneficiaries opposed any cutback in benefits. Politically, these issues were framed in “yes/no” terms—i.e., does one support or oppose a particular proposed cutback in services. From a broader perspective, all such political choices have an “either/or” dimension, but in the context of determining whether to support or oppose a particular cutback, advocates for Medicaid beneficiaries—access egalitarians—routinely opposed such cutbacks.

In the TennCare context, access egalitarians had an important political chip to play. Since the Clinton health reform plan was designed to expand access to medical care, the Clinton Administration was not likely to approve a waiver proposal that impaired access to care. Access egalitarian opposition to a TennCare waiver could have jeopardized or slowed down approval of the TennCare waiver. Under such circumstances, the state’s securing support from the well-organized access egalitarian community was politically important.³⁴⁹

Governor McWherter’s Administration was able to shift the decisionmaking paradigm for access egalitarians from “yes/no” to “either/or.” The state administration assured patient advocates that savings from TennCare would be recycled into the health care system to improve access for uninsured Tennesseans who were not eligible for Medicaid. This transformed the debate. Instead of facing a decision in a “yes/no” framework, access egalitarians were in a position to recapture and reallocate savings from Medicaid managed care to addressing the broader goal of improving overall access to medical care for a group that would not otherwise receive health care benefits. In this light, the potential stringencies from managed care were offset by substantial progress toward another fundamental goal of access egalitarians—universal medical care coverage.³⁵⁰

347. Blumstein & Sloan, *supra* note 300, at 857.

348. Blumstein, *supra* note 288, at 1351.

349. It is noteworthy that the leverage of access egalitarians is now diminished since states have a statutory right to adopt mandatory managed care in their Medicaid programs. *See supra* text accompanying notes 191-99.

350. The political deal for mandatory Medicaid managed care was further sweetened in three ways, all of which suggest that the price on Medicaid beneficiaries exacted by TennCare would not be substantial. First, Blue Cross, which had the only statewide provider network, agreed to

Restructuring the TennCare debate resulted in a shift in perception from that of a “yes/no” potential takeaway to that of a trade-off mechanism for achieving alternative (related) objectives.³⁵¹ As an entitlement program was modified, with flexibility to deny enrollment to some (non-Medicaid) categories of eligible patients, the “either/or” nature of the debate—the ability to recapture and reallocate savings from managed care to achieve other access egalitarian health care goals—changed the political climate between the state and access egalitarians.

E. TennCare: Government by Contract

Under TennCare, the state uses its purchasing power to achieve economies in its Medicaid program. In place of a system of regulation governed by principles of administrative law, TennCare is a system of regulation governed by contracts, known as CRAs, which oblige MCOs to provide medically necessary services to TennCare enrollees. Medical necessity decisions adverse to a patient that are not resolved to the patient’s satisfaction through an MCO’s grievance process can be appealed to a state-level TennCare review, which is binding on MCOs.³⁵²

State and federal law control MCOs, and the CRA is amended automatically and without action by the parties whenever required by

include TennCare beneficiaries in its state employee network, assuring TennCare patients of mainstream quality medical care on a par with that provided to state employees. *See supra* note 294; Thorne et al., *supra* note 305, at 129-30. Second, Blue Cross agreed to require providers who were members of the network serving state employees to accept TennCare patients (even though the financial terms would be different). *See* Thorne et al., *supra* note 305, at 130. Since physician participation levels in Medicaid had always been a concern, this held out the prospect of improving accessibility to mainstream providers. *See id.* Third, the benefits package for TennCare was generous, in particular retaining the specialized services required for children under the Early and Periodic Screening, Diagnostic and Testing (“EPSDT”) program. Under EPSDT, a state’s Medicaid program must provide any service that Medicaid covers and a physician deems “medically necessary” even though the state might not provide that service to adult Medicaid beneficiaries in the state’s program. 42 U.S.C. § 1396d(r)(5) (1994). *See generally* Flippen, *supra* note 24, at 685 (discussing the challenges that EPSDT poses to Medicaid managed care).

351. In February 1999, Governor Sundquist proposed temporarily restricting access of uninsurable non-Medicaid beneficiaries to TennCare, essentially on cost grounds as program costs had begun to pose budgetary problems again for the state. One can predict that support for TennCare among access egalitarians will diminish as savings from managed care are used more to reduce budgetary pressures and less to achieve access goals for non-Medicaid uninsured. *But see* Jon Yates, *TennCare Supporters Speak Up*, THE TENNESSEAN, Mar. 10, 1999, at 4B.

352. CRA II, *supra* note 206, § 3-8, at 61. This state-level review was implemented as a result of and in settlement of litigation. *See Daniels v. Wadley*, 926 F. Supp. 1305 (M.D. Tenn. 1996), *vacated on other grounds sub nom Daniels v. Menke*, 145 F.3d 1330 (6th Cir. 1998).

changes in state or federal law.³⁵³ The state reserves the right to interpret, clarify, and apply all federal and state laws, regulations and policies that affect the CRAs.³⁵⁴ In important ways, then, the state has unilateral authority to change MCO obligations under the CRA—by determinations of medical necessity and by exercise of authority to interpret, clarify and apply federal and state laws. And that unilateral power to impose obligations on MCOs does not impose additional costs on TennCare, at least in the short run, creating an opportunity for cost externalization or decisionmaking moral hazard. Government can achieve program enhancements by mandating their implementation by MCOs and, at least in the short run, without added state-incurred program costs.³⁵⁵ How much effect this “unfunded mandate” potential has had on discouraging MCO entry into the market is difficult to ascertain, but it is true that the major national managed care firms have not entered the TennCare market.

1. The Medical Necessity Issue

Traditionally, decisionmaking authority in medicine has rested with doctors who have dominated the field.³⁵⁶ This professional paradigm³⁵⁷ is justified as a response to perceived market failure in the market for medical care. For a market to function smoothly, information must be available to decisionmakers. Because an asymmetry of information exists between physicians and patients—doctors have scientific expertise, consumers lack such knowledge³⁵⁸—the professional model would bypass the market by substituting the judgment of the physician for that of the patient.³⁵⁹

The professional model transfers enormous authority from consumers, whose judgment controls in a traditional market setting, to professional providers. The ostensibly scientific foundation of medical training and practice provides the justification for professional

353. CRA II, *supra* note 206, § 4-9, at 74.

354. *Id.* § 3-4, at 60.

355. An example of this type of “unfunded mandate” arose in the context of TennCare’s mandated method of treatment of HIV. Recommended AIDS treatment changed in 1996, following the approval of new drugs in December 1995 and February 1996, from AZT alone to a three-drug combination therapy. TennCare obliged MCOs to provide the new AIDS treatment but did not take on additional financial responsibility. See Julie Bell, *HIV Drugs Hold Hope, High Costs*, THE TENNESSEAN, Sept. 18, 1996, at A1.

356. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 226-27 (1982).

357. See James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1463-66 (1994).

358. See ARROW, *supra* note 45.

359. See Blumstein, *supra* note 357, at 1464.

empowerment. Surrogate (and necessarily paternalistic) decision-making by professionals substitutes for the control that consumers exercise in the market where they are sovereign.³⁶⁰ Professional empowerment leads to physician control of costs and output. By shifting control from consumers to physician fiduciaries, the professional model insulates the medical services market from economic trade-offs.³⁶¹ Decisions, in theory at least, are made on the basis of science, not economics.

The term "medical necessity," found in most medical insurance contracts,³⁶² conforms to the ideology of the professional paradigm. It focuses on medical criteria, delegates decisionmaking authority to professional experts (physicians),³⁶³ and deemphasizes traditional economic considerations (such as balancing cost and benefit in consumption decisions). Although some physicians urge incorporation of economic factors in medical decisionmaking protocols,³⁶⁴ the traditional understanding of the term "medical necessity" is that it relies exclusively on medical criteria and omits economic considerations from the decisionmaking calculus.³⁶⁵

On the accompanying figure (Figure 1), which shows a benefits curve and a cost line, the point at which the slope of the cost line and the slope of the benefits curve are the same reflects the point where marginal cost equals marginal benefit—where incremental cost is precisely equal to incremental benefit. This is designated as point "o" for optimality. Beyond point o, the level of benefits continues to increase,

360. *Id.* at 1465.

361. *See id.* at 1466.

362. *See* HAVIGHURST, *supra* note 4, at 125 (noting that "'medical necessity' is ubiquitous as a criterion governing the obligation of the plan to pay for particular services"); Timothy S. Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 ST. LOUIS U. L.J. 1, 1 (1999) (same).

363. *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, & ECONOMICS OF RATIONING MECHANISMS 66 (1997) (noting that "historically, courts have been unreceptive or outright hostile to insurers' attempts to interfere in clinical discretion for any reason, including safety and effectiveness concerns, let alone on account of cost/benefit trade-offs").

364. *See* David M. Eddy, *Balancing Cost and Quality in Fee-for-Service Versus Managed Care*, HEALTH AFF., May-June 1997, at 162, 172-73.

365. *See* HAVIGHURST, *supra* note 4, at 15 (noting that the "Medical necessity" test requires doctors to prescribe only that which is medically beneficial for a patient); Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1531-33 (1996) (arguing that "medical effectiveness," which is the basic goal of health care and which is defined as providing only that care which benefits a patient, is separable from "cost effectiveness"); *see generally* Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992) (examining whether courts should allow health care costs to be controlled by insurers' denials of payments for specific services based on judgments of "medical appropriateness").

but the level of benefits is exceeded by the additional costs incurred to pay for those benefits. At point x, the benefits curve turns flat—this is the “flat of the curve” or zero-benefit medical care. At point y, the benefits curve turns down, showing that additional care can be harmful. The medical necessity standard, with its exclusive focus on medical criteria, pushes levels of utilization to point x on the benefits curve, where benefits turn flat.

Traditionally, reflecting the medical necessity concept, health insurers only addressed the question whether proposed treatments were “safe and effective,” that is, “whether, on balance, the procedure’s medical benefits outweigh[ed] its medical risks.”³⁶⁶ Insurers did not ask “whether a beneficial result might be obtained more cheaply, let alone whether a marginally increased benefit is simply too expensive to be worth the cost.”³⁶⁷ The medical necessity standard has required “only that some medical benefit be demonstrated, however slight,”³⁶⁸ pushing levels of utilization to point x on Figure 1. Under that regime, decisions regarding the “choice of less versus more effective and less versus more expensive modalities” of treatment were left up to the doctor and, acting on the doctor’s advice, the patient.³⁶⁹

The movement toward managed care reflects an attempt to introduce economic considerations into medical care decisionmaking, to push the level of utilization from point x back towards point o on Figure 1. This reflects a challenge to the traditional professional paradigm “under which health care is not regarded, even at the margin, as a consumer good” subject to economic tradeoffs and, consequently, “health care providers . . . prescribe for patients everything that may be beneficial—and nothing but the best.”³⁷⁰ The introduction of economic considerations into decisionmaking suggests that, instead of adopting a purely professional model in response to the market failure of asymmetric information—a strategy of market substitution—an appropriate alternative is adoption of a strategy of market improvement to improve the functioning of the market by increasing access to understandable information.³⁷¹

366. HALL, *supra* note 363, at 67.

367. *Id.*

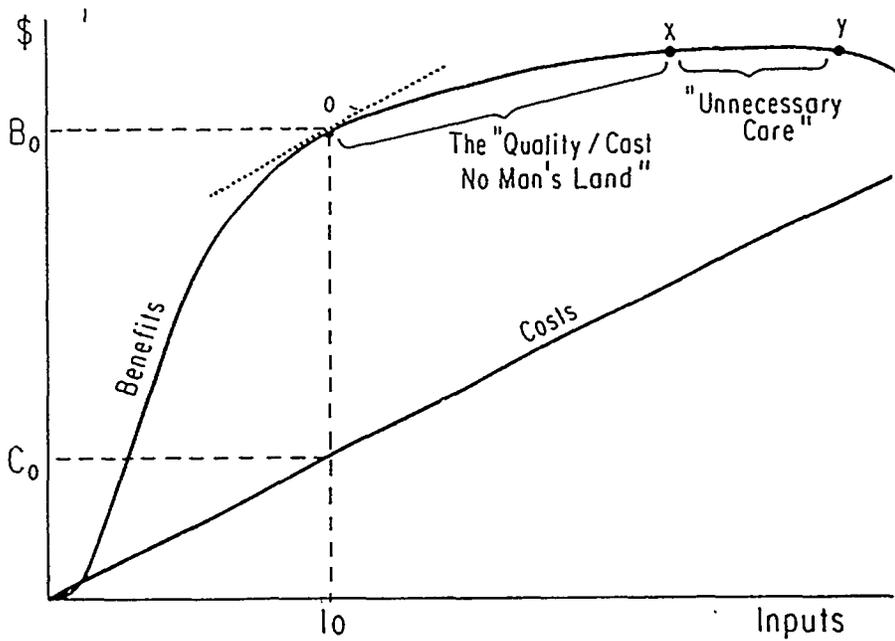
368. *Id.*

369. *Id.*

370. HAVIGHURST, *supra* note 2, at 15.

371. Blumstein, *supra* note 357, at 1464.

FIGURE 1
THE OPTIMAL LEVEL OF HEALTH CARE SPENDING



Source: Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Tradeoffs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 17 (1975).

While managed care aims to balance medical and economic factors in decisionmaking, its retention of the term medical necessity hampers that effort because of its communication that medical criteria continue exclusively to control decisionmaking, that professionals retain exclusive authority to make coverage determinations, and that utilization should approach point *x* on Figure 1 (the point of zero benefits). As a practical matter, a medical necessity standard assures coverage of any reasonable medical treatment decision unless it is deemed "experimental."³⁷² If a procedure or treatment is medically

372. And even treatments conventionally seen as experimental because of insufficient data on efficacy have been ordered to be covered by courts. See, e.g., *Bradley v. Empire Blue Cross & Blue Shield*, 562 N.Y.S.2d 908 (1990) (rejecting "experimental" label based on testimony of treating physician as to theory of treatment and refusing to require empirical evidence of effectiveness). Where a health plan deviates from professional norms in its view of medical

beneficial and recommended by a treating physician, the medical necessity standard provides little opportunity for a plan to deny coverage. Managed care, to be effective in introducing cost factors into medical decisionmaking, must find a third category—medically beneficial but excessively costly under the circumstances or insufficiently beneficial given less expensive available alternatives.³⁷³

In a private benefits program (and for non-indigent patients), a health plan's coverage decision that reflects economic factors need not always correspond to an ultimate decision regarding treatment—whether a patient will purchase a medical service. A plan may not cover a service, but an informed patient with different risk preferences or different levels of resource availability might choose to purchase a service even if the plan does not cover it.³⁷⁴

In TennCare, the state uses an appeals process to determine whether a particular diagnosis or treatment is medically necessary, thereby binding the MCO. For Medicaid beneficiaries, the medical necessity coverage decision will nearly always be coextensive with the actual treatment provided. If the decision is left to the MCO, there exists a risk of conflict of interest on the part of the MCO, which receives a fixed per-patient capitation rate. A decision to provide a benefit under such circumstances, at least in the short run, is made at an MCO's financial peril.³⁷⁵ At the same time, a decision by the state imposes costs not on the state itself, at least not in the short run, but externalizes those costs to private entities (TennCare contracting MCOs), a form of potential political moral hazard.

The political moral hazard problem is exacerbated by the decisionmaking context. The decision is not framed in statistical terms as a resource allocation issue. The health of an identifiable individual is

necessity, courts may impose professional standards of medical necessity on the theory that a contractual standard at odds with the professional standard frustrates the justified expectations of insureds. See *Hughes v. Blue Cross of N. Cal.*, 263 Cal. Rptr. 850 (1989).

373. In recognition of the problem of the "medical necessity" standard in the managed care context, TennCare administrators proposed to define "medical necessity" as "the most cost-effective alternative among courses of treatment that, for practical purposes, are equivalent in effectiveness and safety." See *TennCare Re-Examining Proposed Rule that Would Determine Covered Care*, THE TENNESSEAN, Oct. 15, 1999, at 3B. Advocates for TennCare patients resisted that definitional clarification because of the fear that "when MCOs determine what is most 'cost-effective,' it's likely to mean 'cheapest' as opposed to what's the least expensive way of achieving the best outcome." *Id.* As a result of that opposition by patient advocates, the Sundquist administration withdrew the proposed definition for further review. *Id.*

374. See, e.g., *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997) (holding physician has duty to disclose economic conflict of interest regarding referral and holding that patient has right to be informed of other treatment alternatives even if not covered by an ERISA plan).

375. See, e.g., *Daniels v. Wadley*, 926 F. Supp. 1305, 1307 (M.D. Tenn. 1996) (stating that, under TennCare, MCOs "have financial incentives to deny enrollees health care even when such health care is medically appropriate").

at issue. In such circumstances, a governmental decision to say "no" to medical care bumps into long-held symbolic values regarding the value of health and of life itself.³⁷⁶ The more visible and more directly accountable the government becomes, the more likely that the result of the process would be a subtle form of institutional blackmail, inducing society to spend more resources in this area than it might otherwise choose.³⁷⁷ Institutional blackmail linked to political moral hazard suggests that the state-level review of medical necessity, a term itself that connotes no economic constraints, can produce a strong incentive for requiring, through contract administration, extensive and expensive coverage by the MCOs.

2. The Interpretation of Federal and State Law Issue

By clarifying, interpreting, and applying state and federal law, the state has implicit authority to impose conditions on MCOs. An example is the state's settling TennCare lawsuits imposing additional grievance-procedure obligations on MCOs,³⁷⁸ or adopting compliance standards and procedures for MCO implementation of EPSDT requirements.³⁷⁹ Although their interests as at-risk contractors are

376. See James F. Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, 40 LAW & CONTEMP. PROBS. 231, 250 (1976).

377. See *id.* at 252; see also Havighurst et al., *supra* note 30, at 140-45. An example of the link between the medical necessity standard and the identifiable life context arose in the context of a claim by a TennCare beneficiary for MCO approval of a liver/bowel transplant. See *Hinds v. Blue Cross & Blue Shield, Inc.*, No. 3:95-0508 (M.D. Tenn. 1995) (on file with author, unavailable on-line and not reported). The court held that the procedure was medically necessary and not experimental and therefore had to be paid for by the MCO. See *id.* In determining whether the procedure was safe and effective, the court weighed risks and benefits, noting that the procedure was the plaintiff's only real hope and that greater risk was warranted. See *id.* The court's unit of analysis for the risk/benefit calculation was the patient. No consideration was given to the opportunity cost of the expenditure—the other possible systemic claims on the MCO's resources. See *id.* The court implicitly rejected any interpretation of medical necessity that included alternative uses of the resources, focusing exclusively on the benefits and risks to the patient herself. See *id.* Clearly, the court viewed the issue in yes/no rather than either/or terms. See *id.* Interestingly, the state sided with the MCO, seeing the possible drain on MCO resources if the principle were generalized and the risk to the fiscal integrity to TennCare that could result.

378. See *Daniels v. Menke*, 145 F.3d 1330 (6th Cir. 1998) (noting Tennessee's consent to a modification in claims denial procedures after a district court finding that existing procedures violated due process and further noting the state's failure to appeal that decision). A subsequent consent decree in that litigation acknowledged that the far-reaching procedures adopted extended beyond those required under medical regulations. See *Grier v. Wadley*, Civil Action No. 79-3107 (M.D. Tenn. 1999) (unpublished opinion on file with Professor Blumstein, Vanderbilt Law School) (Consent Decree).

379. See 42 U.S.C. §§1396a(a)(43), 1396d(a), & 1396d(r) (1994); *John B. v. Menke*, Civ. Action No. 3-98-0168 (M.D. Tenn. 1998) (unpublished opinion on file with Professor Blumstein, Vanderbilt Law School) (Consent Decree). For a description of EPSDT, see *supra* note 350.

clearly at stake, MCOs were not formally parties to the litigation. Whether MCOs would have agreed to the same terms (or whether those precise terms would be mandated by HCFA) is unknown, but MCOs reportedly have been concerned about the (purportedly) unanticipated financial obligations of the EPSDT consent decree.³⁸⁰

When changes are not the result of interpretation of state or federal law, they are not contractually binding unless consensual.³⁸¹ Such modifications must be mutually agreed upon in writing by the MCO and TennCare and be incorporated as a written amendment to the CRA prior to their effective date.³⁸² While an informal negotiation process may occur between the state, the MCOs, and patient advocates,³⁸³ formal administrative processes need not be followed.³⁸⁴

The ability to modify and revise the CRAs gives the state tremendous leverage since the MCOs face a purchaser negotiating for 1.3 million lives covered under TennCare. This leverage is enhanced by the asymmetry of the contract termination procedures. TennCare can terminate its contract with an MCO at will by providing thirty days written notice. There is no "for cause" requirement.³⁸⁵ On the other hand, an MCO is subject to much more stringent termination requirements. An MCO may only terminate its CRA with TennCare upon written notice on the twelve-month anniversary of each beginning effective date, and the last day of operation must be at least 180 days from the date of written notice.³⁸⁶ The CRA sets out detailed termination procedures,³⁸⁷ and requires that a terminating MCO submit its final invoice for payment to TennCare within 120 days after the termination. Failure to comply with this time restraint results in forfeiture of payments. The terminating MCO must also continue to

380. See PRICEWATERHOUSECOOPERS, *supra* note 166, at ix (noting that a "significant concern among TennCare MCOs is the EPSDT 'consent decree'").

381. See TENNCARE WAIVER APPLICATION, *supra* note 14.

382. See *id.*

383. See, e.g., Complaint, at ¶ 51, *Newberry v. Menke*, Civ. Action No. 3-98-1127, (M.D. Tenn) (Complaint filed Dec. 7, 1998).

384. Although HCFA has not exercised its authority formally to refuse to approve a proposed change, it does have the right to review and approve changes in the CRA, assuring considerable protection for patient-beneficiary interests. See HCFA Approval Letter, *supra* note 8 (STC 1); Interview by Jennifer Shorb with Steve Hopper, TennCare Official, Nashville, Tenn. (Nov. 10, 1997); see generally Complaint, *Newberry v. Menke*, *supra* note 383, ¶ 33 (noting federal government's power to review and approve any change in the "amount, duration, and scope of services to be provided to TennCare beneficiaries" and the lack of approval regarding the alleged changes in home health care services challenged in that litigation).

385. See CRA II, *supra* note 206, § 4-2.e., at 68; see also *supra* note 217.

386. See CRA II, *supra* note 206, § 4-2.f., at 69-70. But see Snyder, *supra* note 217, at 1A (allowing MCOs to leave TennCare during 1999-2000 with six months notice).

387. See CRA II, *supra* note 206, § 4-2.g.

serve and arrange for the provision of services to enrollees for forty-five days after termination or until they can be enrolled in other plans.

Thus, the state has a lot of leverage over the MCOs since contract termination is the only complete exit strategy for an MCO,³⁸⁸ and that is an extremely costly approach. Since the capitation rate paid to MCOs need not be adjusted to fit new demands imposed by the state, the state has a considerable incentive to impose additional terms or conditions. This financial disjunction provides a ready target for patient advocates, who can plausibly claim, at least in the short run, that the state can improve the quality of services or access to services provided by MCOs without incurring additional state costs. Given the high costs of termination for MCOs, the state may be tempted to push its negotiating advantage to the maximum, mindful, however, that it has an interest in maintaining the financial integrity and solvency of the MCOs and their ability and willingness to stay in the TennCare market. Notably, there has not been entry into the TennCare market by national MCOs, presumably because of the leverage possessed by the state and because of the uncertain risk MCOs are being asked to absorb.

There are examples of the state acting out of concern for the potential fiscal liability of MCOs.³⁸⁹ In *Newberry v. Menke*, TennCare beneficiaries challenged the home care policies of MCOs as approved by the state. Plaintiffs alleged that MCOs provided home health services "for only a few diagnoses, and only for brief periods," excluding from coverage beneficiaries who suffer from long-term chronic conditions and are in need of "custodial [home health care] services" that would therapeutically benefit them.³⁹⁰ In addition, plaintiffs alleged that Blue Care (Blue Cross' TennCare MCO) denied "home health coverage to any beneficiary who does not meet the MCO's requirement that they [sic] be 'homebound.'" ³⁹¹

According to the Complaint, the home health care restrictions were imposed at first informally, then in written communications between Blue Care and the state.³⁹² Plaintiffs complained that the

388. An MCO could call a moratorium on enrolling new TennCare patients as Blue Cross did in July 1996. However, in 1998, Blue Cross agreed to a contract amendment that required MCOs to be open for new enrollment in any area in which they are qualified to serve during the year. Blue Cross re-opened for new enrollment in February 1998. See TennCare Website, *supra* note 11 (Department of Health News Release, January 28, 1998).

389. See *Hinds v. Blue Cross & Blue Shield, Inc.* No. 3:95-0508 (M.D. Tenn. 1995) (on file with author, unavailable online and not reported)

390. See Complaint, *Newberry v. Menke*, *supra* note 383, ¶¶ 44-47.

391. *Id.* ¶ 48.

392. See *id.* ¶¶ 49-52.

denial of custodial home health services and the requirement that TennCare beneficiaries be homebound in order to qualify for home health care were in fact changes in the CRA and required HCFA approval, which Tennessee had not sought or obtained. That would violate the terms of the TennCare waiver. For plaintiffs, the custodial care and homebound requirements were additional terms beyond the medical necessity standard in the CRA.

The state's position seems to be that the policies regarding home health care are not in addition to, but part of, the state's determination of medical necessity in the context of long-term chronic care. As part of its determination of what is medically necessary, the state may make a judgment about the appropriate type of service to meet a patient's medical needs. In this regard, the state says that "TennCare beneficiaries who need long term care may not obtain such care from an MCO, but must seek such care from other sources."³⁹³ That is, nursing home services are TennCare's method for responding to the chronic-care needs of beneficiaries, and those services have been excluded from MCO responsibility.³⁹⁴

The home health dispute nicely shows that the state recognizes some restraints on its ability to impose additional obligations on MCOs when the MCOs can make a credible threat that they will either leave the market entirely or, as Blue Care did, suspend new enrollment. At the same time, *Newberry* demonstrates the impetus for patient advocates to lean on the state to mandate an expansive interpretation of MCO obligations under the CRA since "the cost to the state of the plaintiff's TennCare coverage is the same . . . whether or not he receives home health care."³⁹⁵ And it also shows that patient advocates view the requirement for HCFA approval of all CRA changes as a critical political point of influence for patient interests.³⁹⁶

F. Fraud and Abuse (Antikickback) Issues

In a fee-for-service ("FFS") health care market, financial incentives often result in overutilization because they stimulate increased use of services.³⁹⁷ To combat the problem of financially-motivated

393. *Id.* ¶ 53.

394. *See id.* ¶¶ 39-40.

395. *Id.* ¶ 73.

396. The *Newberry* case may also determine to what extent state flexibility to interpret and clarify program requirements are subject either to HCFA/Medicaid oversight or subject to restraints under the Americans with Disabilities Act, which is one of the causes of action pled in *Newberry*. *Id.* ¶¶ 129-33.

397. *See* James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 205 (1996) (stating that

overutilization, the federal antikickback law prohibits the knowing and willful use of financial incentives ("remuneration"³⁹⁸) in federal health care programs³⁹⁹ to solicit⁴⁰⁰ or to induce⁴⁰¹ referrals of future business.⁴⁰² Since the Third Circuit's decision in *United States v. Greber*,⁴⁰³ courts have interpreted the antikickback provision broadly.⁴⁰⁴ *Greber* held that if one purpose of a payment was to induce future reciprocal referrals, the payment violated the antikickback law, even if the payment was also intended to compensate for professional services (actually) rendered.⁴⁰⁵ The court in *Greber* "assumed that the services were needed, medically appropriate, and reasonably priced."⁴⁰⁶

As the federal enforcement agency—the Office of Inspector General ("OIG") of the federal Department of Health and Human Services—has recognized,⁴⁰⁷ the breadth of *Greber* is quite stunning. It calls into question all market-driven behavior involving federal health care programs,⁴⁰⁸ even where such conduct is valuable in rationalizing the delivery of medical services. Lack of harm to anyone—government, providers, program beneficiaries—is not a defense to an antikickback law prosecution.⁴⁰⁹ The law therefore targets competitive

FFS system); see also Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 15-20 (1975-76).

398. The term "remuneration" includes but is broader than "kickback, bribe, or rebate." The "remuneration" can be "in cash or in kind" and can either be paid or received "directly or indirectly, overtly or covertly." 42 U.S.C. §§ 1320a-7b(b)(1) & (2) (1994).

399. *Id.* § 1320a-7b(f)(1) (Supp. 1997) (defining what qualifies as "federal health care programs").

400. *Id.* § 1320a-7b(b)(1).

401. *Id.* § 1320a-7b(b)(2).

402. Violation of the antikickback law is a felony. See *id.* § 1320a-7b(a). It can also result in a civil monetary penalty of \$50,000 per act of violation. See *id.* § 1320a-7a(a)(7) (Supp. 1998).

403. *United States v. Greber*, 760 F.2d 68 (3d Cir. 1985).

404. The Office of the Inspector General ("OIG") at the Department of Health and Human Services ("DHHS") has enforcement oversight for the antikickback law, shared in the criminal arena, of course, with the Department of Justice. OIG has acknowledged that the antikickback law, as construed, has extraordinary reach and scope (and sometimes can even have perverse effects):

Since the statute on its face is so broad, and the court has recognized its full breadth, concern has arisen among a number of health care providers that many relatively innocuous, or even beneficial, commercial arrangements are technically covered by the statute and are, therefore, subject to criminal prosecution. This section [requiring regulations setting forth safe harbors] reflects the generally accepted view that the language proscribing remuneration that induces referrals is so broadly written as to encompass many harmless or efficient arrangements as well.

54 Fed. Reg. 3088, 3088 (1989) (not codified in C.F.R.).

405. See Blumstein, *supra* note 397, at 212 (citing *Greber*, 760 F.2d at 72).

406. *Greber*, 760 F.2d at 71.

407. See *supra* note 404.

408. 42 U.S.C. § 1320a-7b(f)(1) (1994).

409. See *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996). *Jain*, which involved a criminal prosecution for violation of fraud and abuse (antikickback) and for mail fraud, is especially

behavior aimed at securing improved market share in the same way that it (properly) targets the use of financial incentives that are likely to result in overutilization. On its own, then, *Greber* poses a substantial potential obstacle to the use of competitive market forces to contain costs and promote quality in an evolving health care market environment.⁴¹⁰

At the time of TennCare's approval, the antikickback law applied equally to health care environments characterized by FFS and capitation. Since a substantial component of TennCare's agenda was a shift in the way health care institutions were organized and medical care services were delivered, the antikickback fraud and abuse law potentially stood as an inhibitor in the evolution of the TennCare marketplace.⁴¹¹

poignant in this regard. *Id.* at 438. Dr. Jain, a psychologist, was found to have solicited and received from a psychiatric hospital "remuneration" for referring patients. *See id.* at 439. In the district court, he was convicted of violating both the Medicare/Medicaid fraud and abuse law, 42 U.S.C. § 1320a-7b(b), and the mail fraud statute, 18 U.S.C. § 1341. *See id.* The fraud and abuse conviction was upheld by the Court of Appeals. *See id.* at 438. However, the mail fraud conviction was reversed because an essential element of that charge, according to the court, was that the defendant's act caused "some demonstrable harm or injury to the government, a federal beneficiary, or someone else." *Id.*; CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 475 (2d ed. 1998) (explaining *Jain's* holding and stating that *Jain* emphasizes the unusual position of fraud under the antikickback law). Since "Dr. Jain provided quality psychological services," since "[e]ach hospitalized patient required hospitalization," since the facility to which Dr. Jain referred his patients "was as good as or better than any alternative facility and provided his patients with proper care," and since overall "there was no evidence that any patient suffered tangible harm," the Court of Appeals reversed the mail fraud conviction. *Jain*, 93 F.3d at 442. Thus, while Dr. Jain's mail fraud conviction was overturned, his fraud and abuse conviction was sustained even though the Court of Appeals noted that "Dr. Jain intended to provide and did in fact provide his patients with the highest quality psychological services." *Id.* For a criticism of *Jain*, see Gregory D. Jones, Note, *Primum Non Nocere: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship*, 51 VAND. L. REV. 139, 173 (1998) (arguing that a breach of a physician's fiduciary relationship to a patient occurs when the physician fails to disclose an economic conflict of interest, such as a kickback, that could influence a medical decision and that such a breach of fiduciary duty, in depriving a patient's right to "honest services," causes harm enough to trigger a violation of the mail fraud statute).

410. See James F. Blumstein, *Rationalizing the Fraud and Abuse Statute*, 15 HEALTH AFF. 118, 119 (1996).

411. There are many appropriate payment arrangements that may be considered fraud and abuse violations. Hospitals purchase physician practices and make payments to recruit physicians. Such arrangements may enable a hospital to compete with another hospital on price and quality. Nevertheless, such practices may be interpreted as fraud and abuse violations since a goal is to develop a flow of patients for the hospital. Another activity that could be inhibited is the integration of various health care providers into larger organizations. The primary goal of such integration might be to deliver a broad continuum of care and thereby to compete for managed care contracts. This type of competition among health care providers, which could promote price competition and encourage the formation of organizations to deliver efficient managed care, might enhance efficiency and reduce costs. In the long run, that should be beneficial to third-party payers and to consumers. Such beneficial results, however, are not

While the antikickback law has an important role to play in discouraging overutilization in an FFS environment, and the policy objective in that setting is to reduce the overbreadth of the statute's reach, not to eliminate its application entirely,⁴¹² the policy calculus in a capitated environment is altogether different. TennCare's system of managed care imposes considerable financial risk on MCOs, which receive fixed (capitated) payments per enrollee per month. MCOs organize the network of providers for their beneficiaries and assume responsibility, under contract with the state, for the delivery of specified health care services to those TennCare beneficiaries. Under capitation, the MCO and perhaps providers are at risk financially for the provision of contracted-for benefits to enrollees. Accordingly, MCOs, facing a fixed budget have a financial incentive to underserve (not overserve) their beneficiaries since cost savings to particular patients reduce an MCO's overall financial risk from the aggregate pool of capitated payments.⁴¹³ In short, unlike an FFS approach, which rewards additional utilization with additional payment, a capitated payment methodology constrains overutilization and other costly practices.⁴¹⁴

Despite the fundamental differences in incentives for utilization between FFS and capitation, both types of payment systems were equally subject to the antikickback law when TennCare was implemented.⁴¹⁵ Yet, in a capitated environment, the government's financial

defenses to a fraud and abuse prosecution if the inducement of future referrals is even a part of the motivation. *Id.* at 121.

412. *See, e.g., id.* at 126 (recommending that, through adoption of a safe harbor, a putative defendant be able to establish as an affirmative defense that particular conduct, even if involving remuneration to induce future referrals, be protected from the antikickback law if (a) federal program costs are reduced without significant, unacceptable decreases in quality of care, or if (b) federal program quality or choice is improved at no increased program costs).

413. *See, e.g., Daniels v. Wadley*, 926 F. Supp. 1305, 1307 (M.D. Tenn. 1996) (MCOs "have financial incentives to deny enrollees health care even when such health care is medically appropriate").

414. *See Blumstoin, supra* note 397, at 205 (stating an FFS system's financial incentives stimulate increased service use resulting in overutilization; a capitated health care system's payment system inhibits overutilization).

415. The antikickback law contains no private cause of action. It is enforced by federal authorities, both in its criminal and civil dimensions. There is authority, however, for allowing private whistleblower actions under the qui tam provisions of the False Claims Act, 31 U.S.C. §§ 3729(a), 3730(b) (1994), to pursue violations of the antikickback law. *See, e.g., United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 900-01 (5th Cir. 1997) (overturning lower court's holding that private plaintiff's qui tam action could not be brought under the False Claims Act); *United States ex rel. Woodard v. Country View Care Ctr., Inc.*, 797 F.2d 888, 893 (10th Cir. 1986) (acknowledging availability of False Claims Act suit "in the context of federal-state jointly funded programs such as Medicaid"); *United States ex rel. Pogue v. American Healthcorp, Inc.*, 914 F. Supp. 1507, 1508 (M.D. Tenn. 1996) (declining to dismiss plaintiff's qui tam action under the False Claims Act for failure to state a claim). For a comprehensive and cogent critique of the use of the False Claims Act to enforce the antikickback law, see Lisa

obligation is set by the capitation payment to an MCO. Any other arrangements that might create an incentive for increases in utilization could affect the MCOs, but not, at least in the short run, the governmental payor. The concern expressed by the antikickback law about overutilization and escalating program costs, linked conceptually to FFS, seemed out of place in a capitated payment environment.⁴¹⁶ In managed care financed on a capitated basis, the risk of fraud on the state stems primarily from the systematic underprovision not overprovision of services.⁴¹⁷ Since the state's financial responsibility is established by the capitation payment, any fraud that may be perpetrated on MCOs does not, at least directly and in the short run, affect the state financially.⁴¹⁸

In 1996, during the initial TennCare demonstration period, Congress recognized the analytical significance of the capitation payment methodology for the application of the antikickback law. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA" but often referred to as the "Kassebaum-Kennedy" bill)⁴¹⁹ created a statutory safe harbor from coverage of the antikickback law for any individual (such as a provider) or entity (such as an MCO) that is "at substantial financial risk for the cost or utilization of the items or services . . . which the individual or entity is obligated to provide."⁴²⁰

Michelle Phelps, Note, *Calling Off the Bounty Hunters: Discrediting the Use of Alleged Anti-Kickback Violations to Support False Claims Actions*, 51 VAND. L. REV. 1003 (1998).

416. See Blumstein, *supra* note 397, at 211 (noting that the antikickback law was somewhat anachronistic in its continued application to a capitated payment environment and labeling the failure to adopt some form of safe harbor for a capitated payment situation, when MCOs or providers are at financial risk, "a case of hardening of the intellectual arteries").

417. Fraud can also arise from false reporting of sign-ups, either from persons who have not in fact signed up or from persons who sign up but who are not eligible for TennCare. For a comprehensive description and discussion of areas of fraud and abuse in a managed care environment, see Sharon L. Davies, & Timothy Steltzhus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 GA. L. REV. 373 (1997). In the early stages of TennCare, there were stories of MCOs signing up transients who left the state but whose capitation payments continued. This problem was substantially curtailed when, in January 1995, TennCare stopped accepting new enrollees (the uninsured) unless they received certification of uninsurable status (the uninsurables). For discussions of these issues, see *id.* at 388-89.

418. Of course, fraud that resulted in MCO insolvency could have substantial financial implications for the state, but the requirements for HMO financial safeguards protect against a good bit of that risk. In Spring 1999, the third largest MCO went into receivership, with the state agreeing to pay claims incurred after the date of the onset of the receivership but, at least initially, declining to pay previously incurred claims. See *supra* note 205.

419. 42 U.S.C. § 1320a-76 (Supp. 1997).

420. *Id.* § 1320a-76(b)(3)(F).

As a result of the "financial risk" safe harbor,⁴²¹ activities of MCOs and their providers are not subject to the strictures imposed by the antikickback law, leaving MCOs free to use financial incentives to develop more efficient structures and relationships within the marketplace. The safe harbor places responsibility on MCOs to monitor their providers to assure that the MCOs and their beneficiaries receive the benefits for which the MCO has contracted.⁴²²

*G. The Status of the TennCare MCOs:
State Action and Its Implications*

MCOs that contract with TennCare are nominally private entities. Unless they are deemed state actors (acting under color of state law), MCOs are not subject to constitutional constraints imposed on governmental decisionmakers by the Fourteenth Amendment.⁴²³ The critical question in state action analysis is what "private" conduct is "fairly attributable" to the state.⁴²⁴

1. The Cause for Concern: Some Policy Considerations

The state actor status of the TennCare MCOs is important because a finding that they are state actors would invoke an array of constitutional doctrines that can have a significant effect on their

421. Congress mandated the implementation of this "financial risk" safe harbor through a negotiated rulemaking, Pub. L. No. 104-191, §216(b), 110 Stat. 1936, 2007-08 (1996), in which parties likely to be significantly affected by a rule participate in developing the rule through negotiation. See 5 U.S.C. § 561 (Supp. 1997). After an intense process of consultation and negotiation, a negotiated rule was agreed to and announced in early 1998. In summer 1999, the negotiated rule had not been promulgated, but the statute went into effect despite delay in the adoption of the negotiated rule. 42 U.S.C. § 1320a-76.

422. Based on the literature of reputation from the securities industry, there is some reason to believe that private entities such as MCOs or other independently-developed intermediaries, which have the flexibility and can develop the experience and the expertise to monitor and measure hard-to-detect elements of fraud, can successfully combat poor quality and outright fraud, particularly in a market such as that for medical care where relationships can remain long-term and there is a pattern of repeat business. See generally Stephen Choi, *Market Lessons for Gatekeepers*, 92 NW. U. L. REV. 916, 920 & 924 (1998) (discussing the process of quality monitoring and certification and the role of purchasers and "certification intermediaries" in supplying purchasers "with a means of distinguishing between products containing otherwise unobservable quality differences"); Ronald J. Gilson & Reinier H. Kraakman, *The Mechanisms of Market Efficiency*, 70 VA. L. REV. 549 (1984) (discussing elements that lead to and limit market efficiency); Ronald J. Mann, *Verification Institutions in Financing Transactions*, 87 GEO. L.J. 2225, 2227 (1999) (noting the potential importance of "privately instituted sanctions that operate either partially or wholly apart from the legal system").

423. *Blum v. Yaretsky*, 457 U.S. 991, 1002 (1982) (citing *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948)).

424. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982).

operation. For example, advantages might accrue in combating fraud from the flexible and informal monitoring available to private parties in dealing with providers and suppliers.⁴²⁵ Contractual remedies established in the marketplace govern such private-sector relationships.

If MCOs were to gain a public character as state actors, constitutional principles would apply, adding not just a certain degree of protection to providers and suppliers, but also complexity, red tape, and inflexibility. The financial relationships with providers and suppliers are only one example of the potential for more cumbersome constraints on MCOs if they are deemed state actors. In addition, such matters as physician credentialing, physician de-selection from MCO provider panels, and disputes with beneficiaries regarding coverage issues become potential constitutional lawsuits.

Exposure to liability for damages and, probably more significantly, attorneys' fees,⁴²⁶ poses potentially serious concerns for MCOs that seek, for example, to hold the line on benefits determinations for individual patients, to act aggressively to assure quality by de-selecting providers (physicians or hospitals), to contract selectively with preferred providers to assure access for patients at affordable prices, or to restrain costs either by limiting payment levels for pharmaceutical products or by limiting drug formularies. In each of the foregoing examples, a cost-containment or a quality-assurance decision could be the subject of a constitutional or statutory challenge that could result in increased cost, reduced flexibility, and imposition of the overall bureaucratization that characterizes governmental entities—freedom from which is purportedly a virtue of privatization. Further, this increase in cost would be imposed on an industry that typically measures efficiency in claims processing in terms of pennies per claim. This would be an environment in which expensive procedures and the potential for extensive constitutional or federal statutory liability could take a high toll and further deter entry of MCOs into the TennCare market (and divert resources from the care of patients).⁴²⁷

Aside from the remedial advantages associated with a civil rights cause of action (damages and attorneys' fees), it is questionable

425. See *supra* note 422.

426. See 42 U.S.C. § 1988(b).

427. There is also a question whether using a civil rights cause of action would be feasible as a regular method of adjudicating TennCare coverage disputes. See *Daniels v. Wadley*, 926 F. Supp. 1305, 1309 n.4 (M.D. Tenn. 1996), *vacated on other grounds sub nom. Daniels v. Menke*, 145 F.3d 1330 (6th Cir. 1998) (noting the desirability of a hearing before "an Article III judge" because of his or her impartiality but also recognizing that "such hearings are not plausible" because of the "speed with which disputes regarding health care coverage must be resolved in order to prevent harm to an enrollee").

whether due process fairness advantages would accrue for patients from a finding that MCOs were state actors. As a regulatory matter, Medicaid itself imposes on states the responsibility for maintaining a "hearing system" that comports with the maximalist constitutional due process standards set forth in *Goldberg v. Kelly*,⁴²⁸ which is cited by name in the Medicaid regulations.⁴²⁹ The TennCare waiver does not apply to Tennessee's "obligations to provide for review of coverage disputes," so the state must comply with the federally mandated fair hearing procedures spelled out in the Medicaid program.⁴³⁰ However, the state action status of the TennCare MCOs remains uncertain.⁴³¹

428. *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970) (holding that due process requires an adequate hearing before welfare benefits are terminated).

429. See 42 C.F.R. § 431.205 (1998). The Medicaid regulations require that an opportunity for a hearing be granted whenever any applicant requests one "because his claim for services is denied or is not acted upon with reasonable promptness." *Id.* § 431.220. The Medicaid regulations apply to TennCare, absent a waiver. See *Daniels v. Menke*, No. 96-5887, 1998 U.S. App. LEXIS 7973, at *6-7 (6th Cir. 1998). A finding of state action and of a constitutional violation is not necessary in order for a court to apply the due process requirements of the Medicaid regulations. See *id.* (holding that the district court did not have to decide whether MCOs are state actors or whether the MCOs' conduct violate the plaintiff's constitutional rights).

In *Perry v. Chen*, 985 F. Supp. 1197, 1201 (D. Ariz. 1996), the court faced a procedural due process challenge to Arizona's managed Medicaid program. Like Tennessee, Arizona operates its Medicaid program under a federal waiver. The state contracts with health plans to provide covered health care services to program beneficiaries. See *id.* at 1199. The court in *Perry* noted that federal Medicaid regulations require the state to "provide a fair hearing" which meets constitutional due process standards. *Id.* at 1201. However, the court went on to conclude that the constitutional standards embodied in the Medicaid regulations would only apply to the health plans (comparable to TennCare MCOs) if the plans were state actors. See *id.* As a constitutional matter, that is correct. However, as the Sixth Circuit found in the *Daniels* litigation, see *infra* note 431, the federal Medicaid regulations can be applied to the MCOs either because of contractual obligations or because of a duty imposed by the regulations themselves. This seems to be the conclusion of the district court in the *Daniels* litigation. *Daniels*, 926 F. Supp. at 1307-10.

430. *Daniels*, 926 F. Supp. at 1307.

431. In the *Daniels* litigation, which challenged the TennCare grievance and appeals procedures, the plaintiffs and the state entered into an agreed order regarding hearing procedures after the district court held that the TennCare procedures violated Medicaid and due process. See *supra* notes 226-31 and accompanying text. The state did not appeal the agreed order but did appeal from the holding that TennCare's MCOs were "state actors" and therefore subject to constitutional due process constraints regarding grievance procedures. *Daniels*, No. 96-5887, 1998 U.S. App. LEXIS 7973, at *6. In vacating the state action holding, the Court of Appeals noted that plaintiffs did not oppose vacating the district court's state action holding provided that the provisions of the agreed order (consent decree) remained in effect. See *id.* at *8 n.4. In essence, the position of the *Daniels* plaintiffs, regarding the vacating of the district court's state action holding, reinforces the position in text that Medicaid regulations provide extensive due process protections to patients in the grievance process, reflecting a maximalist view of constitutional due process requirements. Indeed, the result of the district court's due process ruling in *Daniels* was essentially to impose Medicaid regulatory standards on administration of TennCare. *Daniels*, 926 F. Supp. at 1313-14 & n. 11; see also *supra* notes 220-36 and accompanying text.

2. The State Action Issue: Are MCOs State Actors?

In *Grijalva v. Shalala*, the Ninth Circuit held that health maintenance organizations (“HMOs”) that contract with the federal government to provide medical care to Medicare beneficiaries are (federal) government actors subject to Fifth Amendment due process constraints.⁴³² There is a clear parallel between Medicare risk-contracting HMOs, as in *Grijalva*, and TennCare MCOs, also risk-contracting HMOs, but under a state’s Medicaid program. While *Grijalva* has been vacated and remanded,⁴³³ the Ninth Circuit’s decision is worthy of analysis.

The Ninth Circuit found the risk-contracting HMOs engaged with the federal government as “joint participants” in the provision of medical care to Medicare beneficiaries. The HMOs’ failure to provide adequate notice to beneficiaries of service denials could be “fairly attributed to the federal government.”⁴³⁴ The court viewed the disputes regarding provision of services as Medicare “coverage decisions” that effectively interpreted the Medicare statute. These were unlike the “medical judgments” by Medicaid-participating nursing homes that the Supreme Court had found not to constitute state action.⁴³⁵ For the *Grijalva* court, “the government cannot avoid the due process requirements of the Constitution merely by delegating its duty to determine Medicare coverage to private entities.”⁴³⁶

432. *Grijalva v. Shalala*, 152 F.3d 1115, 1121 (9th Cir. 1998), *vacated and remanded*, __ U.S. __, 119 S. Ct. 1573 (1999).

433. *Grijalva*, 119 S. Ct. 1573.

434. *Grijalva*, 152 F.3d at 1120.

435. *See id.*; *see also* *Blum v. Yaretsky*, 457 U.S. 991, 1008 (1982) (stating that the decisions concerning discharge or transfer is not made by the state).

436. *Grijalva*, 152 F.3d at 1121; *see also* *Catanzano v. Dowling*, 60 F.3d 113, 113 (2d Cir. 1995) (holding that determinations by private, licensed certified home health agencies regarding the medical necessity and appropriateness of home health services under Medicaid constitutes state action). Although far from inconsequential, the state-action status of a risk-contracting Medicare HMO does not pose as significant a policy concern as does the state-action status of an MCO in TennCare. While the concerns about constitutionalizing benefits determinations are comparable, the absence of a federal counterpart to 42 U.S.C. § 1983 mitigates some of the concerns. Primarily, the absence of an equivalent of the fee-shifting provisions of 42 U.S.C. § 1988 reduces the likelihood and the costliness of adjudicating claims under Medicare. In addition, the absence of a federal counterpart for § 1983 means that the rule against requiring exhaustion of administrative remedies that characterizes claims under § 1983 would not apply to the Medicare claims adjudication process. *See Patsy v. Board of Regents*, 457 U.S. 496, 512 (1982) (no exhaustion of administrative remedies required in litigation under § 1983). Review through the Medicare claims-review process might therefore be required. *See, e.g., Weinberger v. Salfi*, 422 U.S. 749, 756-57 (1975) (holding § 405(h) bars district court federal jurisdiction over suits seeking to recover social security benefits). Nevertheless, constitutionalizing the service-denial process does risk rigidification and ossification of a process that, to retain the benefits of privatized managed care, should remain informal and flexible.

Grijalva accords with the district court decision, both of which were vacated on appeal, regarding the state action status of TennCare MCOs.⁴³⁷ The questions now to be addressed are (a) whether TennCare MCO decisions regarding “medical necessity” are to be viewed as “medical judgments made by private parties according to professional standards that are not established by the State,”⁴³⁸ or whether they are to be viewed as “coverage decisions—interpretations of the Medica[id] statute” in which MCOs “are making decisions as a governmental proxy . . . deciding that Medica[id] does not cover certain medical services;”⁴³⁹ and (b) what impact the Supreme Court’s most recent foray into the state-action arena, *American Manufacturers Mutual Insurance Co. v. Sullivan*,⁴⁴⁰ might have on state-action analysis in the MCO context.

In *Blum v. Yaretsky*,⁴⁴¹ the Supreme Court held that certain nursing home decisions “to discharge or transfer Medicaid patients to lower levels of care” did not constitute state action.⁴⁴² For the dissent, the nursing home decisions were part of an administrative structure established and imposed by government to implement cost-containment policies. Nursing home determinations regarding discharge and transfer of Medicaid patients involved scope-of-benefits issues, not merely scientific determinations derived from independent professional criteria regarding “medical necessity.” For the dissent in *Blum*, the state had “delegated administration of the [Medicaid cost-containment] program to the nursing home operators,” and “[w]here . . . a private party acts on behalf of the State to implement state policy, his action is state action.”⁴⁴³

In rejecting the dissent’s characterization of the circumstances, the Court in *Blum* acknowledged that the state required review of medical necessity in order to contain Medicaid nursing-home costs. However, adhering to the professional paradigm,⁴⁴⁴ the Court concluded that physicians making determinations of medical necessity were “not employed by the State” and, “more important,” those private physicians (albeit paid by Medicaid) “render[ed] medical judgments concerning the patient’s health needs that the State does not prescribe

437. *Daniels v. Wadley*, 926 F. Supp. 1305, 1311 (M.D. Tenn. 1996), *vacated sub nom. Daniels v. Menke*, 145 F.3d 1330 (6th Cir. 1998).

438. *See Blum*, 457 U.S. at 1008.

439. *See Grijalva*, 152 F.3d at 1120.

440. *American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 119 S.Ct. 977 (1999).

441. *Blum*, 457 U.S. at 991.

442. *Id.* at 1012.

443. *Id.* at 1027 (Brennan, J., dissenting).

444. *See supra* Part V.D.1.

and for which it is not responsible."⁴⁴⁵ While patient transfers to less intensive and less costly nursing home settings were admittedly driven by concerns about efficiency and costs and thus "not mandated by the patients' health needs," those transfers only occurred "after an assessment of those needs."⁴⁴⁶ That assessment, made by private physicians who were "concededly private parties," was deemed to be "a medical one, not a question of accounting"⁴⁴⁷ and did not constitute state action.

In the FFS context of *Blum*, the Court viewed the government's role as payor for services deemed by professionals to be "medically necessary" in accordance with independently established professional standards. Government had no duty to pay for services that did not meet a professionally-developed standard. The decision of the private physician or nursing home regarding medical necessity, therefore, turned on criteria established by private, independent entities—standards developed beyond the scope of governmental responsibility or accountability.

Implicitly, *Blum* held that a government benefits program could define its scope of coverage by reference to private professional criteria. Application of those criteria to particular cases would not then be attributable to the government.⁴⁴⁸ In this regard, the decision in *Blum* has much in common with the Supreme Court's subsequent ruling in *NCAA v. Tarkanian*.⁴⁴⁹ In *Tarkanian*, a public university disciplined a basketball coach (Jerry Tarkanian) for infractions of rules promulgated by the National Collegiate Athletic Association ("NCAA").⁴⁵⁰ The NCAA is an unincorporated national association, comprised of nearly one thousand public and private members that conduct major athletic programs, whose mission is "governing the conduct of the intercollegiate athletic programs of its members."⁴⁵¹ Tarkanian challenged the constitutional validity of the NCAA's rules as applied to him, contending that the NCAA under the circumstances was a state actor.⁴⁵²

445. *Blum*, 457 U.S. at 1006 n.16.

446. *Id.* at 1008 n.19.

447. *Id.*

448. The Court in *Blum* drew an analogy to *Polk County v. Dodson*, 454 U.S. 312, 317 (1981), which held that a public defender does not act under color of law when representing an indigent defendant in a state criminal proceeding. Although employed and appointed by the state, the public defender relied on "professional canons of ethics" rather than on "any rule of conduct imposed by the State." *Blum*, 457 U.S. at 1009.

449. *NCAA v. Tarkanian*, 488 U.S. 179, 199 (1988).

450. *Id.* at 180-81.

451. *Id.* at 183.

452. *See id.* at 182.

The Court in *Tarkanian* first inquired into the relationship between the NCAA and the University of Nevada, Las Vegas ("UNLV"), the public institution that disciplined Tarkanian. Noting that the source of NCAA rules was its "collective membership," the Court concluded that that collective membership was national in scope, "independent of any particular state."⁴⁵³ While there might be de facto authority accorded to the NCAA as a private standard-setting institution, no official authority had been conferred on the NCAA by the State of Nevada.⁴⁵⁴ Therefore, NCAA was not deemed a state actor since Nevada did not "create [] the legal framework governing the conduct"⁴⁵⁵ and did not "delegate [] its authority to the private actor [the NCAA]."⁴⁵⁶

The Court in *Tarkanian* also acknowledged that state action might exist if the public university "by embracing the NCAA's rules, transformed them into state rules and the NCAA into a state actor."⁴⁵⁷ For example, when a state supreme court adopts and implements standards formulated and promulgated by the American Bar Association ("ABA"), that state supreme court's enforcement of those rules constitutes state action.⁴⁵⁸ However, "[i]t does not follow . . . that the ABA's formulation of those . . . rules was state action."⁴⁵⁹ Therefore, "UNLV's decision to adopt the NCAA's standards" is not "sufficient reason for concluding that the NCAA was acting under color of Nevada law when it promulgated standards . . ."⁴⁶⁰ On that ground, the Court in *Tarkanian* also declined to find the standard-setting conduct of the NCAA attributable to Nevada.⁴⁶¹

The analysis in *Blum* is analogous to the subsequent ruling in *Tarkanian*. In *Blum*, the Court viewed Medicaid as adopting the professional standards regarding medical necessity established by a patient's own physician or by nursing home administrators.⁴⁶² Those private standard-setting or standard-implementing decisions were not made by the official entities to which government had delegated authority—the utilization review committees.⁴⁶³ A decision by such an

453. *Id.* at 193.

454. *See id.* at 193-94 (citing *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 501 (1988)).

455. *Id.* at 192 (citing *North Ga. Finishing, Inc. v. Di-Chem, Inc.*, 419 U.S. 601 (1975)).

456. *Id.* (citing *West v. Atkins*, 487 U.S. 42 (1988)).

457. *Id.* at 194 (citing *Lugar v. Edmonson Oil, Co.*, 457 U.S. 922, 937 (1987)).

458. *See Tarkanian*, 488 U.S. at 194 (relying on *Bates v. State Bar*, 433 U.S. 350 (1977)).

459. *Id.*

460. *Id.* at 195.

461. *Id.*

462. *Blum v. Yaretsky*, 457 U.S. 991, 1007 n.17 (1982).

463. *See id.*

officially designated reviewing entity, which is responsible for interpreting the scope of and eligibility for governmentally-conferred legal entitlements, would constitute state action.⁴⁶⁴

In the context of TennCare MCOs, the question is whether MCO decisionmaking on such matters as medical necessity is the implementation of private professional standards which government then chooses to respect, or whether MCO decisions reflect decisions on coverage delegated to MCOs by state government. In the former characterization, *Blum* and *Tarkanian* suggest that those decisions would not constitute state action. Decisions of the latter characterization might, on the other hand, more likely be considered fairly attributable to the state.

The Ninth Circuit in *Grijalva* found that Medicare risk-contracting HMOs differed from the FFS context of the nursing homes in *Blum*. The physicians in *Blum* were independent professionals without financial stakes in the outcome of their independent professional medical judgment.⁴⁶⁵ The HMOs in *Grijalva* were “joint participants” with the federal government in the administration of Medicare.⁴⁶⁶ The federal government was more than a somewhat passive payor, as in an FFS setting. Under capitation, the federal government pays risk-contracting Medicare HMOs a set amount per beneficiary “regardless of the services provided” and “created the legal framework—the standards and enforcement mechanisms—within which HMOs make adverse determinations”⁴⁶⁷ These determinations by HMOs are, therefore, “coverage decisions,” in which HMOs act as a “governmental proxy,” and are fairly attributable to the government.⁴⁶⁸

Grijalva viewed HMO coverage decisions as interpretations of the scope of statutory benefits conferred by Medicare. The court was unwilling to accept the *Blum* characterization of decisions regarding medical necessity as involving independent professional medical judgments. For the *Grijalva* court, determinations of medical necessity were not just technical professional judgments under the professional paradigm, they represented mixed questions of professional judgment and economic (cost-benefit) calculations. Medical neces-

464. See *American Mfgs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 119 S.Ct. 977, 986 (1999) (stating action by private parties constitutes state action if state law provided such significant encouragement that the choices must be deemed to be the states’).

465. Nursing home utilization review committees “must be composed of private physicians who are not directly responsible for the patient whose care is being reviewed.” Physician members “may not be employed” by the nursing home and “may not have a financial interest in any residential care facility.” *Blum*, 457 U.S. at 995 n.4.

466. *Grijalva v. Shalala*, 152 F.3d 1115, 1120 (9th Cir. 1998).

467. *Id.*

468. *Id.*

sity—this admixture of professional and economic considerations—was deemed a legal standard under *Grijalva*. Delegation of implementation could not avoid public accountability. Coverage decisions, as interpretations of government's legal obligation, were attributable to government, even when made by private-contracting HMOs. Since MCOs were financially interested entities and, in the exercise of managed care, do not conform to the pure professional paradigm, *Grijalva* found the rationale of the *Blum* dissent more applicable to the Medicare risk-contracting HMO situation.

The analytical impact of *American Manufacturers Mutual Insurance Co. v. Sullivan*⁴⁶⁹ is still uncertain. *Sullivan* was a challenge to certain provisions of Pennsylvania's workers' compensation regime. Under a 1993 revision to the workers' compensation law, "an employer or insurer may withhold payment for disputed medical treatment pending an independent review to determine whether the treatment is reasonable and necessary."⁴⁷⁰ An employer or an insurer may request utilization review⁴⁷¹ by a utilization review organization ("URO")⁴⁷² and withhold payment of benefits until that review process determines that the proposed medical treatment is medically necessary.⁴⁷³ *Sullivan* held that invocation of the utilization review process by an employer or an insurer, with its attendant delay in the obligation of the employer or the insurer to pay for workers' compensation medical benefits,⁴⁷⁴ did not constitute state action.⁴⁷⁵

469. *Sullivan*, 526 U.S. 40, 119 S.Ct. 977 (1999).

470. *Id.* at 982.

471. The employer requests utilization review by filing a one-page form with the Workers' Compensation Bureau of the Pennsylvania Department of Labor. *See id.* at 982-83. The filing alone, without any substantive review by any public official, triggers the employer's or the insurer's ability to withhold payment of benefits until it is determined that the proposed treatment is reasonable and necessary. *See id.* The Supreme Court held this exclusively ministerial role of government not to constitute state action. *See id.* at 987.

472. A URO is a private organization composed of providers who are "licensed in the same profession and have the same or similar specialty as that of the provider of the treatment under review." *Id.* at 983. The objective of the URO is to determine "whether the treatment under review is reasonable or necessary for the medical condition of the employee" in view of "generally accepted treatment protocols." *Id.*

473. *Id.*

474. The utilization review process must be completed and a determination rendered within thirty days. *See id.* If the utilization review is favorable to the employer, the worker may seek judicial review *de novo* before a workers' compensation judge, but the insurer is not obligated to pay for the disputed services unless and until the decision is overturned by the workers' compensation judge or, under judicial review, by the courts. *See id.*

475. The Court framed the issue as "whether a private insurer's decision to withhold payment for disputed medical treatment may be fairly attributable to the State so as to subject insurers to the constraints of the Fourteenth Amendment." The Court's answer to that question was "no." *Id.* at 986.

The state action inquiry in *Sullivan* was actually quite narrow, focusing on the state-action status of an insurer's decision to invoke a utilization review process authorized by state law.⁴⁷⁶ While an insurer's action to seek independent utilization review was authorized by and taken pursuant to state law, such private conduct was not "fairly attributable to the State."⁴⁷⁷ It was the decision of a private party, taking advantage of an opportunity afforded under state law in resolving a dispute with another private party. The state did not compel the private insurers' conduct and was not "directly involved in [their] decision . . . to withhold payments for disputed medical treatment."⁴⁷⁸ That state law provided private insurers with a remedy was insufficient "encouragement"⁴⁷⁹ of private conduct "to make the State responsible for it."⁴⁸⁰ The statutory scheme, which allowed insurers to withhold medical payment until the dispute regarding medical necessity was resolved against them in the utilization review process, was "state inaction, . . . a legislative decision not to intervene in a dispute between an insurer and an employee over whether a particular treatment is reasonable and necessary."⁴⁸¹

As in *Grijalva*, the plaintiffs in *Sullivan* made a delegation argument. Plaintiffs characterized workers compensation benefits as "state-mandated 'public benefits'" whose provision the state had delegated to private insurers and for which the state must take responsibility.⁴⁸² The Court noted that the state may have established a right on behalf of employees to receive workers' compensation benefits, but that that obligation was imposed by law on private employers not undertaken by the state itself. Where a state's "constitution or statutory scheme obligates the State to provide" benefits⁴⁸³—such as "medical treatment to injured inmates"⁴⁸⁴—the state may not be able to avoid

476. *Id.*; see also *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978) (holding that a warehouseman's selling of property pursuant to New York Uniform Commercial Code § 7-210 was not state action).

477. *Sullivan*, 119 S. Ct. at 982.

478. *Id.*

479. *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982).

480. *Sullivan*, 119 S. Ct. at 986; see also *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478, 485 (1988) (holding totality of circumstances involved in implementing a notice-of-claim statute constituted state action).

481. *Sullivan*, 119 S. Ct. at 987.

482. *Id.* There was a second component to the delegation argument as well. Plaintiffs also asserted that Pennsylvania had "delegated to [private] insurers the traditionally exclusive government function of determining whether and under what circumstances an injured worker's medical benefits may be suspended." *Id.*

483. See *id.* at 988.

484. *Id.*; see also *West v. Atkins*, 487 U.S. 42, 54-56 (1988) (holding that physician hired by State to provide medical services to inmates was acting under color of state law).

responsibility through delegation. Government cannot absolve itself from a duty by "contracting out" its responsibility, and those who are harmed by the regulatory conduct of the delegatee cannot be deprived of their "means to vindicate" their constitutional rights.⁴⁸⁵ *Sullivan* rejects that delegation principle of state action where a state mandates a duty on private parties but has not assumed responsibility itself for the provision of benefits.

In the TennCare context, the delegation principle seems inapplicable to disputes between MCOs and either providers or suppliers. Those relationships do not involve the state's provision of services, and the relationships do not appear to involve the kind of encouragement that *Sullivan* would require. The state-action status of MCOs in the context of services disputes with beneficiaries is a closer question. It does seem, however, that *Sullivan* would support a finding, consistent with *Blum*,⁴⁸⁶ that partial delegation of decisionmaking to MCOs, at least in the first instance, would not be sufficient "encouragement" to result in attributing MCOs' interpretations of medical necessity to the state. MCOs are private entities staffed by private individuals, not government officials, and, while the state has incurred an obligation to pay for medical care services, it has not undertaken to provide those services itself under either Medicaid or TennCare.

A total delegation of the determination of medical necessity to MCOs might qualify the conduct of MCOs as state action, because the state has undertaken to create an entitlement for which it pays. Delegation of final decisionmaking in those circumstances might well vest such traditional governmental power in private hands that the state-action non-delegation principle might attach—even though the state does not itself undertake to provide the medical services to program beneficiaries. *Sullivan* suggests this when it analogizes decisions of the workers' compensation UROs to a decision of a "judicial official," and notes that the decision of the URO itself "may properly be considered state action."⁴⁸⁷ This strongly suggests that a total and final decisionmaking delegation to a private entity regarding eligibility for a public benefits program would be considered state action, even when

485. *West*, 487 U.S. at 56. *West* involved a state's contracting out to a private party the provision of medical services to prisoners in state custody. The Court held that the state could not avoid its constitutional responsibility to prisoners by entering into contracts for the provision of medical services with private parties. *Id.* at 54-56. If this were not the case, the state would be "free to contract out all services which it is constitutionally obligated to provide and leave its citizens with no means for vindication of those rights, whose protection has been delegated to 'private' actors, when they have been denied." *Id.* at 56 n.14.

486. *Blum v. Yaretsky*, 457 U.S. 991 (1982).

487. *Sullivan*, 119 S. Ct. at 987.

there is no tradition of public provision of services. This would constitute delegation of a matter about which government had an affirmative duty—determination of who qualifies and for what benefits regarding public programs.

This interpretation of *Sullivan* is consistent with *Blum*. *Blum* distinguished between patient transfers and discharges initiated by a patient's physician or by the nursing home itself, and patient transfers or discharges initiated by URCs charged with assessing the medical necessity of continued patient stays in a nursing home facility.⁴⁸⁸ At the Supreme Court, *Blum* did not involve "patient transfers to lower levels of care initiated by [URCs]."⁴⁸⁹ That matter had been resolved by a consent decree and was not still at issue.⁴⁹⁰

Blum, therefore, dealt only with "transfers initiated by the patients' attending physicians or the nursing home administrators themselves,"⁴⁹¹ and the Court found that those decisions were not fairly attributable to the state. The state-action status of nursing home URC assessments of medical necessity—an ongoing obligation imposed on nursing homes by federal law⁴⁹²—was not at issue in *Blum*. But an analogous URC in *Sullivan*, charged with assessing medical necessity, acted under color of state law.⁴⁹³ Read together, therefore, *Blum* and *Sullivan* seem to recognize that a governmentally-imposed formal assessment process—even of a technical term such as "medical necessity"—constitutes state action when that determination reflects a delegation by government to a private entity to interpret the "coverage" (scope of benefits) under a public benefits or governmentally-mandated benefits program.

Given this conclusion, the question arises whether, on remand, *Grijalva* can stand in light of *Blum* as refined by *Sullivan*. *Catanzano v. Dowling*⁴⁹⁴ provides a useful analogy. In *Catanzano*, New York required that home health services under Medicaid be provided by certified home health agencies ("CHHAs").⁴⁹⁵ New York required each CHHA to undertake a four-step analysis—a fiscal assessment—to determine "whether and how much home health care should be provided to Medicaid applicants and recipients."⁴⁹⁶ If the projected period

488. *Blum*, 457 U.S. at 1007-12.

489. *Id.* at 1007 n.17.

490. *See id.*

491. *Id.*

492. *See id.* at 994-95 & 995 n.4.

493. *See supra* note 484 and accompanying text.

494. *Catanzano v. Dowling*, 60 F.3d 113 (2d Cir. 1995).

495. *Id.* at 115.

496. *Id.*

of home health care is less than sixty days, the fiscal assessment consists of only two steps. First, the CHHA decides whether the proposed home health care is medically necessary and whether it can be provided safely at home. Second, the CHHA considers the economic factors—whether appropriate but less expensive alternatives exist than the proposed course of treatment.⁴⁹⁷ “If the CHHA determines, as a result of its inquiries under steps one or two, that the patient should receive no home health care, that decision is final and is implemented without administrative review or a hearing.”⁴⁹⁸

Where the proposed home health care is likely to last for longer than sixty days, the CHHA must engage in two additional inquiries. First, it must determine whether the cost of the proposed home health care is excessively costly when compared to the cost of institutionalization. If the answer is yes, then the patient will be institutionalized unless, in the final analytical step, the patient qualifies for one of the exceptions to mandatory institutionalization.⁴⁹⁹

For home health care treatment of less than sixty days, the decision on eligibility rests entirely with the CHHA, a private entity that reviews the proposed service for medical necessity, appropriateness, and cost effectiveness. For treatment of over sixty days, “fair hearing rights” exist only when a local government official (the director of social services) “disagrees with the determination made by the CHHA,” in which case the matter is referred to an independent local physician for evaluation. That person (the “local professional director”) decides whether “to deny or reduce the amount of care prescribed by the treating physician.”⁵⁰⁰ Unless a government official, therefore, disagrees with the decision of the CHHA, no review is triggered.

The Second Circuit concluded that the CHHA reviews constituted state action, in part because there was no provision for “review or ratification of” the CHHA determinations.⁵⁰¹ At least in the context of the shorter-term course of treatment, the “decisions of the CHHAs ‘effectively’ deny or reduce care.”⁵⁰² The state’s delegation of that final decisionmaking authority over a public benefits program did not negate the existence of state action.⁵⁰³

497. *See id.* at 115-16.

498. *Id.* at 116.

499. *See id.*

500. *Id.*

501. *Id.* at 119.

502. *Id.*

503. *See id.* at 120 (“[T]he CHHAs are not independent actors doing business with the state, but are entities that have assumed the responsibility for [the State’s] mandated health care duties.”) (citation omitted).

Applied to the TennCare MCOs, the analysis in *Sullivan*, when informed further by that in *Catanzano*, suggests that MCOs' decisions regarding the provision of services to beneficiaries are not final determinations of eligibility.⁵⁰⁴ As a result of the settlement of litigation, TennCare beneficiaries (or providers on their behalf) may file a grievance within the MCO and may appeal to a state-level official through a state-administered process.⁵⁰⁵ If the TennCare beneficiary files a grievance within ten days of a service denial, the level of service is maintained during the grievance process. As a result, there is not the kind of total delegation that was at issue in *Catanzano*, and determinations of the MCOs' internal grievance process would not seem to have the same impact as the decisions of the UROs in *Sullivan*. No state-run administrative process followed determinations of the UROs; review of URO decisions was through appeal to a workers compensation judge and then to a court for judicial review. Further, if the URO decided in favor of the employer, no payments for medical treatment were required unless the decision of the URO was overturned either by the workers compensation judge or by a court. If appealed in a timely manner (within ten days), the decision of an MCO not to provide treatment does not stop treatment, which continues until the state-level process is completed.⁵⁰⁶

In sum, the state action issue is a close one. The Ninth Circuit in *Grijalva* believed that the Medicare HMOs under review were "making decisions as a governmental proxy . . . deciding that Medicare does not cover certain medical services."⁵⁰⁷ If that were indeed the case, then *Grijalva* would fall within the state action doctrine that we infer from *Sullivan* and *Catanzano*. The question we raise with respect to *Grijalva* is whether it accurately perceives the situation regarding Medicare eligibility since appeal to the Secretary of Health and Human Services is available.⁵⁰⁸ The *Grijalva* court does not ana-

504. *Blum* itself is a bit ambiguous on this finality point since the decisions of the URCs were not at issue and the Court viewed the decisions made by the private physicians and nursing homes to be based on independent professional medical standards for which government did not have responsibility. *Blum*, 457 U.S. at 1005-12. The state disclaimed authority to review "medical necessity" decisions by physicians or nursing homes on individual patients, but there was a process for administrative review by state officials of these assessments. *See id.* at 1010. In fine, the *Blum* Court believed that these determinations of "medical necessity" were not "influenced in any degree" by the State's cost-containment objectives but were made along entirely separate technical (not policy-related) lines. *Id.*

505. *See Daniels v. Menke*, 145 F.3d 1330, 1330 tbl.1 (6th Cir. 1998); *see also supra* Table 1 and accompanying text.

506. *See* WAIVER EXTENSION REQUEST, *supra* note 19, at 77-89.

507. *Grijalva v. Shalala*, 152 F.3d 1115, 1120 (9th Cir. 1998).

508. *Id.* ("Medicare beneficiaries enrolled in HMOs may appeal an HMO's adverse determination to the Secretary, who has the power to overturn the HMO's decision.")

lyze the question that we deem determinative—whether the private entity is in fact a “governmental proxy,” making final determinations on delegation from government regarding eligibility for a public benefits program. In view of the terms of the *Grijalva* remand, which specifically calls attention to revisions in HHS’ review guidelines, it is likely that the Supreme Court agrees with this analysis.⁵⁰⁹ To the extent that government exercises authority, triggered by the initiative of the beneficiary (or the provider on the beneficiary’s behalf), to review on substantive terms the preliminary decisions of MCOs on a case by case basis, then MCOs should not be seen as exercising the final delegated power as “governmental proxy” and should not be seen as acting under color of state law.

As long as government is accountable for its own decision-making process, as it would be, then there is no need to attribute to the state the conduct of the MCOs. In that sense, the government is not depriving public beneficiaries of their “means to vindicate” their constitutional or federal statutory rights by delegating or contracting out its responsibility.⁵¹⁰ Since Medicaid and the federal consent decree mandate a full due-process hearing at the state level for MCO grievances, a finding that MCOs are not state actors would not impair the fairness of the process to which beneficiaries are entitled (although it might alter the remedies that might be available).

3. Some Basic Legal Considerations Other Than State Action Governing § 1983 Litigation Against MCOs

Nominally private parties acting under color of state law are subject to civil rights actions under 42 U.S.C. § 1983.⁵¹¹ This would mean the constitutionalization of contractual relations for MCOs. As the law under § 1983 has developed, some protections for defendants have emerged, but, to a remarkable extent, those protections apply, if at all, with much less force to private entities such as MCOs. This subsection considers some of these issues as they could arise in a § 1983 action against an MCO.

509. See *Shalala v. Grijalva*, 119 S. Ct. 1573, 1573 (1999).

510. *West v. Atkins*, 487 U.S. 42, 56 & 56 n.14 (1988). See generally *NCAA v. Tarkanian*, 488 U.S. 179 (1988) (holding that NCAA’s participation in the investigation and disciplinary process did not constitute state action).

511. See, e.g., *West*, 487 U.S. at 49-57 (holding that a doctor employed by the state to work as a physician at a prison hospital delivered medical treatment “fairly attributable to the state” and therefore acted under color of state law for purposes of § 1983).

a. The Intentional Conduct Requirement

To make out a claim under § 1983, a plaintiff must establish that a defendant, acting “under color of state law,” has deprived him or her of a “right secured by the Constitution or laws of the United States.”⁵¹² The deprivation of rights cannot result solely from a state-actor defendant’s negligence but must stem from intentional conduct reflecting intentional governmental policies or choices.⁵¹³ In the context of a services denial dispute or a claim for coverage through use of an MCO’s grievance procedure, it seems clear that an MCO is acting intentionally. A deprivation that occurs intentionally in that context—that reflects a conscious institutional choice and not just some inadvertent or negligent act—would seem to satisfy this threshold intentional-conduct requirement under § 1983.

b. The Eleventh Amendment and § 1983’s “[P]erson” Requirement

A state is not a “person” under § 1983 and therefore cannot be sued directly under that provision.⁵¹⁴ State officials can be sued in their individual capacity,⁵¹⁵ subject to the qualified immunity they enjoy,⁵¹⁶ and in their official capacity,⁵¹⁷ but only for prospective in-

512. *American Mfgs. Mut. Ins. Co. v. Sullivan*, 119 S. Ct. 977, 985 (1999).

513. *See, e.g., Daniels v. Williams*, 474 U.S. 327 (1986) (holding that due process was not implicated by state official’s negligent act); *Davidson v. Cannon*, 474 U.S. 344 (1986) (holding that protections of procedural or substantive due process of the Fourteenth Amendment were not triggered by lack of due care by prison officials).

514. *See generally Will v. Michigan Dep’t of State Police*, 491 U.S. 58 (1989) (holding that neither states nor state officials acting in their official capacities are “persons” within the meaning of § 1983).

515. *See, e.g., Scheuer v. Rhodes*, 416 U.S. 232, 237-38 (1974) (holding that Eleventh Amendment provides no shield for a state official who deprives another of a federal right under color of state law). “Personal-capacity suits seek to impose personal liability upon a government official for actions he takes under color of state law.” *Kentucky v. Graham*, 473 U.S. 159, 165 (1985). An award of damages in such an action “can be executed only against the official’s personal assets,” *id.* at 166, and, in such a personal-capacity or individual-capacity action, an award of attorney’s fees under 42 U.S.C. § 1988 can only be made against the individual official, not against his or her governmental employer. *Id.* at 167-68. Punitive damages are available against an official sued in his or her individual capacity. *See generally Smith v. Wade*, 461 U.S. 30 (1983) (concluding that punitive damages are available in § 1983 action when defendant’s conduct involves reckless and callous indifference to the plaintiff’s federal rights, and also when defendant’s conduct is motivated by evil motive or intent).

516. *See infra* Part V.G.3.d.

517. *See generally Graham*, 473 U.S. 159 (1985) (holding that finding of liability in official capacity action did not impose monetary liability on the commonwealth); *Ex parte Young*, 209 U.S. 123 (1908) (state attorney general is proper party defendant to a suit for prevention of the enforcement of an allegedly unconstitutional state statute). An official-capacity action “generally represent[s] only another way of pleading an action against an entity of which the officer is

junctive relief.⁵¹⁸ No damages remedy lies under § 1983 against a state when indirectly sued through the vehicle of a lawsuit against a state official in his or her official capacity. This barrier to the recovery of money damages against a state is both statutory—the state is not a “person” under § 1983⁵¹⁹—and constitutional—the Eleventh Amendment bars suit in federal court⁵²⁰ to recover money damages from a state.⁵²¹ Since Medicaid programs are administered by states, the ban

an agent.” *Monell v. New York Dep’t of Soc. Servs.*, 436 U.S. 658, 690 n.55 (1978). Provided that the government entity “receives notice and an opportunity to respond, an official-capacity suit is, in all respects other than name, to be treated as a suit against the entity.” *Graham*, 473 U.S. at 166; see also *Brandon v. Holt*, 469 U.S. 464, 471-72 (1985) (explaining that, provided that the public entity has notice and the opportunity to respond, judgment against a public servant “in his official capacity” imposes liability on the entity).

518. See generally *Quern v. Jordan*, 440 U.S. 332 (1979) (holding that federal court can provide no retroactive award, but only prospective relief); *Edelman v. Jordan*, 415 U.S. 651 (1974) (holding that the Eleventh Amendment bars retroactive payment of benefits).

519. See generally *Will*, 491 U.S. 58 (holding that neither states nor state officials acting in their official capacities are “persons” within the meaning of § 1983).

520. The Constitution’s structure and history have been construed to limit the ability of Congress, acting under Article I of the Constitution, to require state courts to entertain federal claims for damages against a state in the absence of a state’s express waiver of its sovereign immunity. See generally *Alden v. Maine*, 119 S. Ct. 2240 (1999) (holding that Congress could not subject state to suit in state court without its consent); *Florida Prepaid Postsecondary Educ. Expense Bd. v. College Sav. Bank*, 119 S. Ct. 2199 (1999) (holding that neither the Commerce Clause nor the Patent Clause provided Congress with authority to abrogate state sovereign immunity).

521. See generally *Quern*, 440 U.S. 332 (holding that § 1983 does not abrogate immunity of the states from retroactive awards which require payment of funds from the state treasury); *Edelman*, 415 U.S. 651 (holding that a suit by private parties seeking to impose liability payable from public funds of the state treasury is foreclosed by the Eleventh Amendment unless the State consents to the suit). Declaratory or injunctive relief against a state is available by “naming state officials as defendants” in their official capacity. *Graham*, 473 U.S. at 169 n.18. The constitutional bar under the Eleventh Amendment on a damages action against the state applies in the case of official-capacity actions since “a judgment against a public servant ‘in his official capacity’ imposes liability on the entity that he represents.” *Brandon*, 469 U.S. at 471. Congress may not abrogate a state’s sovereign immunity by exercising authority under Article I of the Constitution, although it may under Section 5 of the Fourteenth Amendment. See *Seminole Tribe v. Florida*, 517 U.S. 44, 59 (1996) (“[T]hrough the Fourteenth Amendment, federal power extended to intrude upon the province of the Eleventh Amendment and therefore . . . § 5 of the Fourteenth Amendment allowed Congress to abrogate immunity from suit guaranteed by that Amendment.”). To effectuate an abrogation of a state’s sovereign immunity where it is authorized to do so, the federal government must state its intent to abrogate “unequivocally,” *id.* at 55, or the state must waive its sovereign immunity by expressly consenting to suit. See generally *College Sav. Bank*, 119 S. Ct. at 2219 (holding that sovereign immunity was not voluntarily waived by the State’s activities in interstate commerce). The Supreme Court “has held that § 1983 was not intended to abrogate a State’s Eleventh Amendment immunity.” *Graham*, 473 U.S. at 169 n.17.

on the recovery of retrospective money damages applies—only prospective injunctive relief is available.⁵²²

In a suit against a TennCare MCO, protections afforded state defendants would be inapplicable. The Eleventh Amendment only bars recovery of damages from the state itself—or from an arm or department of state government.⁵²³ It does not bar such monetary recoveries from political subdivisions of a state such as municipalities or counties.⁵²⁴ The Eleventh Amendment, therefore, poses no obstacle to recovery of damages under § 1983 from an MCO. While, as a statutory matter, a state may not be a person under § 1983, cities and counties are person[s] subject to suit.⁵²⁵ Nominally private parties acting under color of state law have been found subject to liability as person[s] under § 1983.⁵²⁶ Thus, the recovery of money damages from MCOs would be potentially available under § 1983 whereas such a recovery would be unavailable against the state as administrator of Medicaid.

c. *The Vicarious Liability Issue*

In a § 1983 action, liability does not attach vicariously under a theory of respondeat superior.⁵²⁷ While a city is a covered person under § 1983,⁵²⁸ a local government “may not be sued under § 1983 for an injury inflicted solely by its employees or agents.”⁵²⁹ Only when “execution of a government’s policy or custom . . . inflicts the injury” is government responsible under § 1983.⁵³⁰ Liability under § 1983 at-

522. See *Edelman*, 415 U.S. at 651; *Daniels v. Wadley*, 926 F. Supp. 1305, 1313 (M.D. Tenn. 1996) (holding that reimbursement of money does not constitute permissible prospective relief based on the principle of sovereign immunity).

523. See *Lake Country Estates, Inc. v. Tahoe Reg'l Planning Agency*, 440 U.S. 391, 401-03 (1979) (holding that an agency created by a state shares that state’s qualified immunity).

524. See *id.*; see also *Alden*, 119 S. Ct. at 2267-68 (holding that a state’s sovereign immunity does not bar suits against lesser entities); *Mt. Healthy Sch. Dist. v. Doyle*, 429 U.S. 274 (1977) (finding that local school board was not immune from suit since it was a political subdivision more like a county or city than an arm of the state). Punitive damages are not available from a city under § 1983. See *Newport v. Fact Concerts, Inc.*, 453 U.S. 247 (1981) (holding that considerations of public policy do not support exposing a municipality to punitive damages).

525. *Monell v. New York City Dep’t of Soc. Serv.*, 436 U.S. 658, 662-63 (1978) (holding that local governments may be “persons” within the meaning of § 1983).

526. See, e.g., *Richardson v. McKnight*, 521 U.S. 399 (1997) (prison guards employed by private firm); *Wyatt v. Cole*, 504 U.S. 158 (1992) (private defendants invoking replevin); *Lugar v. Edmondson Oil Co.*, 457 U.S. 922 (1982) (state officers acting with private creditor to secure disputed property through garnishment or attachment).

527. See *Monell*, 436 U.S. at 694.

528. *Id.*

529. *Id.*

530. *Id.*

taches only if "deliberate action attributable to the municipality itself is the 'moving force' behind the plaintiff's deprivation of federal rights."⁵³¹ Thus, "a plaintiff must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights."⁵³² Liability of a municipality under § 1983 does not arise when a plaintiff "has suffered a deprivation of federal rights at the hands of a municipal employee" unless the plaintiff can show the municipality itself to be directly culpable and to have caused the constitutional or federal statutory deprivation. Otherwise, all a plaintiff will have demonstrated is "that the employee [rather than the municipality] acted culpably."⁵³³ In short, "[t]he city is not vicariously liable under § 1983 for the constitutional torts of its agents: It is only liable when it can be fairly said that the city itself is the wrongdoer."⁵³⁴

The Supreme Court has never addressed the question whether the bar on vicarious liability applicable to municipalities under § 1983 also applies to nongovernmental entities such as TennCare MCOs when sued under § 1983. The issue has come up in a number of court of appeals cases, however, and the courts seem uniformly to have applied the § 1983 ban on respondeat superior to nongovernmental entities. In *Crawford v. Davis*,⁵³⁵ the Eighth Circuit stated flatly the generic proposition that "it is well settled that § 1983 does not impose respondeat superior liability."⁵³⁶ In *Harvey v. Harvey*,⁵³⁷ the Eleventh Circuit stated that "every circuit court to consider the issue extended the [*Monell respondeat superior*] holding to private corporations as well."⁵³⁸ The Sixth Circuit reiterated that statement in *Street v. Corrections Corporation of America*,⁵³⁹ and the First Circuit seems to have adopted that position as well.⁵⁴⁰ Since *Street* is a Sixth Circuit case, it would control § 1983 actions against TennCare MCOs unless overturned.

531. *Board of the County Comm'rs v. Brown*, 520 U.S. 397, 400 (1997) (holding that a municipality may not be held liable under § 1983 solely because it employs a tortfeasor).

532. *Id.* at 397.

533. *Id.* at 406-07.

534. *Collins v. Harker Heights*, 503 U.S. 115, 122 (1992).

535. *Crawford v. Davis*, 109 F.3d 1281 (8th Cir. 1997).

536. *Id.* at 1284.

537. *Harvey v. Harvey*, 949 F.2d 1127, 1129 (11th Cir. 1992).

538. *Id.*

539. *Street v. Corrections Corp. of Am.*, 102 F.3d 810, 818 (6th Cir. 1996) (citing *Harvey* to explain that every circuit has extended *Monell* to private corporations).

540. See *Lyons v. National Car Rental*, 30 F.3d 240, 245-46 (1st Cir. 1994) (noting that *Monell's* bar on respondeat superior liability applied to private party § 1983 defendants as well).

Under *Monell* and its progeny, TennCare MCOs will not be liable vicariously under § 1983 for actions taken by their employees. MCO liability under § 1983 will arise only for an MCO's own primary or direct conduct that causes a deprivation of a plaintiff's constitutional or federal statutory rights. A plaintiff must establish that the MCO "itself is the wrongdoer"⁵⁴¹ by demonstrating "that an officially executed policy, or the toleration of a custom . . . leads to, causes, or results in the deprivation of a constitutionally protected right."⁵⁴² The question becomes "whether there is a direct causal link" between an MCO "policy or custom and the alleged constitutional deprivation."⁵⁴³ And a "policy" would seem to require a conscious, affirmative decision by an entity such as an MCO: "[L]iability under § 1983 attaches where—and only where—a deliberate choice to follow a course of action is made from among various alternatives."⁵⁴⁴

In some limited situations, a § 1983 claim against an entity can be brought for some types of passive conduct or inaction that amount to a "custom." For example, in *Canton v. Harris*, the Supreme Court held that a city's failure to train its police, in some circumstances, could result in § 1983 liability of the city itself.⁵⁴⁵ But municipal liability in a failure-to-train context can only attach "where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact"⁵⁴⁶ and where the "deficiency in training actually caused the police officers' indifference to [plaintiff's] medical needs."⁵⁴⁷ To be liable, an MCO must have notice or constructive notice of the alleged violation. That is, "[t]he evidence must show that the need to act is so obvious" that an MCO's "'conscious' decision not to act can be said to amount to a 'policy' of deliberate indifference" to a plaintiff's constitutional or federal statutory rights.⁵⁴⁸

The nature of the analytical inquiry is to determine when an entity itself has acted (or, through deliberate indifference, consciously declined to act) and therefore faces direct (as contrasted with vicarious) culpability. In some situations, certain individuals will be considered to have acted on behalf of an institution. For example, in *Pembaur v. Cincinnati*,⁵⁴⁹ the Supreme Court held that the county was

541. *Doe v. Claiborne County*, 103 F.3d 495, 507 (6th Cir. 1996) (holding that respondent superior is not available as a theory of recovery under § 1983).

542. *Id.*

543. *Canton v. Harris*, 489 U.S. 378, 385 (1989).

544. *Pembaur v. Cincinnati*, 475 U.S. 469, 483-84 (1986) (plurality opinion of Brennan, J.).

545. *Canton*, 489 U.S. at 378.

546. *Id.* at 388.

547. *Id.* at 391.

548. *Doe v. Claiborne County*, 103 F.3d 495, 508 (6th Cir. 1996).

549. *Pembaur*, 475 U.S. at 469.

responsible for unconstitutional actions taken pursuant to decisions made by the county prosecutor and the county sheriff because they were the "officials responsible for establishing final policy with respect to the subject matter in question."⁵⁵⁰

In sum, for § 1983 liability for inaction to attach to a TennCare MCO, "an official policymaking body" would have to have a "custom" that caused and "reflected a deliberate, intentional indifference to" the underlying violation.⁵⁵¹ Otherwise, § 1983 liability would only attach where a consciously and appropriately adopted affirmative "policy" of the institution exists and causes⁵⁵² the deprivation of a plaintiff's constitutional or federal statutory rights.

In § 1983 claims against TennCare MCOs—e.g., for denial of a service—a plaintiff would have to establish that the MCO had a policy that, as implemented, deprived that plaintiff of a constitutional or federal statutory right. In the alternative, a plaintiff might be able to prevail by establishing that the MCO was deliberately indifferent to his or her constitutional or federal statutory rights and that that indifference caused a constitutional or federal statutory deprivation.

Since TennCare mandates a hearing process approved by a federal court, a plaintiff could not likely establish either a policy or deliberately indifferent inaction that would cause a procedural due process violation.⁵⁵³ A claim against an MCO probably would focus on the substantive aspects of a service denial—e.g., whether the denial violated applicable Medicaid standards. A systematic policy not to provide a class of services⁵⁵⁴ might satisfy the policy requirement, whether adopted formally or implemented informally (but systematically) through a utilization review or grievance process. The inquiry would then turn on whether that policy or custom caused a deprivation of a constitutional or federal statutory right of a putative plaintiff. Since the state provides oversight of MCO grievance decisionmaking, it is arguable that the MCO's decision does not constitute a final deprivation; to the extent that an MCO would be delaying

550. *Id.* at 483-84.

551. *Claiborne County*, 103 F.3d at 508.

552. The inadequacy of the policy must cause the injury. *See Canton*, 489 U.S. at 391.

553. This would not necessarily be true in procedural due process cases brought by providers or suppliers, which are not covered by the court decree.

554. This was the allegation in the TennCare EPSDT litigation, which resulted in a consent decree. *See John B. v. Menke*, Civ. Action No. 3-98-0168 (M.D. Tenn. 1998). This is also the contention in *Newberry v. Menke*, Civil Action No. 3-98-1127 (M.D. Tenn. 1998), which challenges an alleged failure on the part of MCOs to provide medically necessary home health care and asserts that the state has improperly channeled long-term-care treatment exclusively into a nursing-home setting. *Newberry v. Menke*, Civ. Action No. 3-98-1127 (M.D. Tenn. 1998) (court decision still pending as of January 2000).

receipt of a benefit, such a delay might be a sufficient injury to trigger liability.

On the other hand, a decision by a hospital or physician affiliated with an MCO and of which the MCO was not aware (or which did not reflect an MCO policy) might not satisfy the primary liability strictures of § 1983. Therefore, to the extent that the MCO can push risk-taking and decisionmaking down the system to providers, and turn decisions into provider decisions rather than MCO policy judgments, MCOs might be able to avoid culpability under § 1983. But, of course, MCOs cannot by their inaction be deliberately indifferent to ascertainable risks to beneficiaries so that that deliberate indifference causes a deprivation of federal rights.

d. The Qualified Immunity/Affirmative Defense Issue

When sued under § 1983, government officials receive qualified immunity from liability.⁵⁵⁵ Qualified immunity provides government officials with immunity for their conduct unless it violates a clearly established constitutional principle.⁵⁵⁵ At one time, qualified immunity had both a subjective and an objective element. The subjective component focused on whether the public official acted with malice or with knowledge that his or her conduct was constitutionally wrongful. The objective component focused on whether the public official reasonably could have believed that his or her conduct was constitutionally permissible.⁵⁵⁷ *Harlow v. Fitzgerald* eliminated the subjective component, relying exclusively on the objective element.⁵⁵⁸ Not just an affirmative defense, qualified immunity is “immunity from suit” itself;⁵⁵⁹ denial of its assertion is immediately appealable.⁵⁶⁰

In *Richardson v. McKnight*,⁵⁶¹ the Supreme Court held that nongovernmental individuals⁵⁶² subject to suit under § 1983 do not as a

555. See generally *Mitchell v. Forsyth*, 472 U.S. 511 (1985) (holding U.S. attorney general qualifiedly, rather than absolutely, immune from liability).

556. See *id.* Qualified immunity is not a defense in an official-capacity § 1983 action. See generally *Owen v. City of Independence*, 445 U.S. 622 (1980) (holding no immunity for a municipality under § 1983 action).

557. See *Wood v. Strickland*, 420 U.S. 308, 321-22 (1975) (holding that school officials were not immune under § 1983 if they reasonably should have known that their actions would violate the constitutional rights of the affected student).

558. *Harlow v. Fitzgerald*, 457 U.S. 800, 815-19 (1982).

559. *Mitchell*, 472 U.S. at 526.

560. *Id.* at 530; *Wyatt v. Cole*, 504 U.S. 158, 166-67 (1992) (explaining that *Mitchell* and *Harlow* established an objectively determined, immediately appealable immunity).

561. *Richardson v. McKnight*, 521 U.S. 399 (1997).

562. See *Wyatt*, 504 U.S. at 158 (private defendants charged with § 1983 liability do not have qualified immunity).

general rule receive the qualified immunity available to governmental decisionmakers making the same kinds of decisions.⁵⁶³ *Richardson* dealt with a claim of qualified immunity for prison guards employed by a private prison management company that operated prisons under contract with the state. The Court emphasized that, in denying qualified immunity to those privately employed prison guards, it was ruling “narrowly”⁵⁶⁴ and did not purport to establish a uniform across-the-board standard.

There is one potentially important distinction between the TennCare MCOs, which organize provider networks to provide medical care to public beneficiaries, and the privately managed prisons in *Richardson*: the degree of state supervision over functions performed by the MCOs and their officials. The Court in *Richardson* noted that the “context” of the private prison management company involved a situation with “limited direct supervision by the government,” and no “close official supervision.”⁵⁶⁵ Arguably, through the CRAs and through the state-run grievance appeal process, the state exercises greater supervision over the MCOs than the private prisons in *Richardson*. But the *Richardson* Court seemed disinclined more broadly to confer qualified immunity on employees of private firms “systematically organized to assume a major lengthy administrative task (managing an institution) . . . for profit and potentially in competition with other firms.”⁵⁶⁶ The Court contrasted with that ongoing relationship a situation involving “a private individual briefly associated with a government body, serving as an adjunct to government in an essential governmental activity”⁵⁶⁷ TennCare MCOs seem more closely analogous to the private prison management situation at issue in *Richardson* than to the short-term consultant or firm retained by government to perform a specific, narrowly circumscribed task as an adjunct to a governmental office or agency that the *Richardson* Court distinguished. As a result, MCO officials are likely to face liability without qualified immunity for their conduct, essentially

563. *Richardson v. McKnight* held that qualified immunity, available to publicly employed prison guards under *Procunier v. Navarette*, 434 U.S. 555 (1978), is unavailable in a § 1983 claim against employees of a private prison management company under contract to operate a prison for the government. See generally Paul Howard Morris, Note, *The Impact of Constitutional Liability on the Privatization Movement*, 52 VAND. L. REV. 489 (1999) (arguing that the Court wrongly decided *Richardson v. McKnight* and that providers of governmental services in the private sector should receive the same constitutional scrutiny as the government itself).

564. *Richardson*, 521 U.S. at 413.

565. *Id.*

566. *Id.*

567. *Id.*

making them potentially personally liable for deprivations of constitutional or federal statutory rights of adversely affected plaintiffs, provided that they are deemed to act under color of state law in carrying out their duties on behalf of MCOs.⁵⁶⁸

While *Richardson* makes it unlikely that TennCare MCO employees will receive the qualified immunity available to governmental officials, the Court left open, as it had in *Wyatt v. Cole*,⁵⁶⁹ the possibility that nongovernmental individuals or entities, as defendants in § 1983 cases, might be able to assert “an affirmative defense based on good faith”⁵⁷⁰ In the Sixth Circuit, which controls Tennessee, private parties acting under color of law can raise a good faith defense under § 1983.⁵⁷¹ That could provide protection for individual TennCare MCO employees and possibly for MCOs themselves comparable to the qualified immunity enjoyed by public employees.⁵⁷² As the Fifth Cir-

568. Individual liability would attach to MCO officials only where they deliberately violated the constitutional or federal statutory rights of a plaintiff. See *supra* notes 508-09 and accompanying text. Unlike governmental officials, public entities such as municipalities do not receive qualified immunity. See generally *Owen v. City of Independence*, 445 U.S. 622 (1980) (holding that a municipality has no immunity from liability under § 1983 and may not assert the good faith of its officers as a defense to such liability). Although the liability of the employees' employer (Corrections Corporation of America, the private prison operator) was not directly at issue in *Richardson*, the Court seemed to assume that immunity of the firm was at stake, finding no immunity. *Richardson*, 521 U.S. at 402-14. Since § 1983 liability does not attach vicariously, an additional analytical step would be required to determine whether Corrections Corporation, as distinct from the individual guards, was liable under § 1983. A plaintiff would have to show direct, primary liability on the part of Corrections Corporation, not just vicarious respondeat superior liability. See *supra* notes 523-50 and accompanying text. In any event, given the lack of immunity under § 1983 for a city as an institution, as distinct from a public official, who has qualified immunity, and given *Richardson*, it is unlikely that a TennCare MCO as an entity would receive qualified immunity.

569. *Wyatt v. Cole*, 504 U.S. 158, 169 (1992).

570. *Richardson*, 521 U.S. at 413 (quoting *Wyatt*, 504 U.S. at 169).

571. See *Vector Research, Inc. v. Howard & Howard, Attorneys P.C.*, 76 F.3d 692, 699 (6th Cir. 1996) (private defendant retained good faith defense on remand). In *Wyatt*, the Supreme Court stated that the Sixth Circuit earlier had “established a good faith defense” for nongovernmental parties sued under § 1983. See generally *Duncan v. Peck*, 844 F.2d 1261 (6th Cir. 1988) (distinguishing between “good faith immunity,” which is designed to protect defendants from the difficulties of defending a suit, and “good faith defense,” which is based for the most part on facts of the case). On remand in *Wyatt*, the Fifth Circuit held that good faith is an affirmative defense for private parties who act under color of state law. *Wyatt*, 994 F.2d at 1120.

572. An important difference between a claim of immunity and an affirmative good faith defense is that the denial of immunity is immediately appealable, whereas a good faith defense must be asserted at trial. See *Mitchell v. Forsyth*, 472 U.S. 511, 529-30 & n.10 (1985) (explaining that because an immunity ruling is a legal issue that can be decided with reference only to undisputed facts and in isolation from the remaining issues of the case, it is immediately appealable). The nature of a good faith defense might allow its assertion and resolution by summary judgment. See *McKnight v. Rees*, 88 F.3d 417, 426 (6th Cir. 1996) (Nelson, J., concurring) (observing that the “courts’ increasingly benign attitude toward summary judgment proceedings may frequently mean that there will be little practical difference between the good faith defense . . . and the qualified immunity ‘defense’”).

cuit stated in its decision on remand in *Wyatt v. Cole*, "private defendants . . . should not be held liable under § 1983 absent a showing of malice and evidence that they either knew or should have known of the statute's infirmity."⁵⁷³ "Malice" in this context refers to the "subjective state of mind" of the state actor "rather than the more demanding objective standard of reasonable belief that governs qualified immunity."⁵⁷⁴ Thus, under an affirmative good-faith defense, a showing by a private § 1983 defendant, such as a TennCare MCO or its employee, that it subjectively believed that its conduct did not violate plaintiff's constitutional or federal statutory rights would be an affirmative defense to liability.⁵⁷⁵ Despite *Richardson*, therefore, MCOs and their employees might well succeed in asserting a good-faith defense in any putative action under § 1983.

e. Exhaustion of Remedies

As a general principle, the doctrine of exhaustion of administrative remedies does not apply in § 1983 litigation.⁵⁷⁶ A putative § 1983 plaintiff cannot be required to forgo litigation and to pursue administrative remedies such as a grievance procedure as provided under TennCare. Thus, if the other requirements of § 1983 were satisfied, a patient facing a service denial could bring a civil rights action prior to pursuing TennCare's grievance procedures.⁵⁷⁷ Bringing such an action can result in plaintiff being declared a prevailing party if he or she ultimately secures relief through the grievance process.⁵⁷⁸ Filing the civil rights action, therefore, without proceeding through the administrative process first could secure attorneys' fees for a litigant who succeeds through administrative review or even through settlement.⁵⁷⁹ Strategically, this lack of exhaustion could make defending a service-denial claim extremely expensive and risky since an MCO loss in the state-level TennCare appeal process could be construed as

573. *Wyatt*, 994 F.2d at 1120.

574. *Jordan v. Fox, Rothschild, O'Brien & Frankel*, 20 F.3d 1250, 1277 (3d Cir. 1994).

575. The Third Circuit made it clear in *Jordan* that the defense of "subjective good faith" should "make it possible to decide the good faith issue on summary judgment in some cases." *Id.* at 1276 n.30; see also *supra* note 568.

576. See *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982) (concluding that based on the legislative histories of both § 1983 and § 1997e, exhaustion of state administrative remedies should not be required as a prerequisite to bringing a § 1983 action).

577. See *Daniels v. Menke*, No. 96-5887, 1998 WL 211763, at *2 (6th Cir. Apr. 22, 1998).

578. See *Hensley v. Eckerhart*, 461 U.S. 424, 433 (1983) (stating that "[p]laintiffs may be considered prevailing parties for attorney's fees purposes if they succeed on any significant issue in litigation which achieves some of the benefit the parties sought in bringing suit").

579. See *id.*

vindicating the plaintiff's claim and satisfying the requirement of the attorney fee statute⁵⁸⁰ that a plaintiff be awarded fees if he or she is a prevailing party.⁵⁸¹

VI. TENNCARE: SOME EMPIRICAL EVIDENCE ON ITS EFFECTS

TennCare has resulted in a large increase in coverage as compared to Medicaid. At the end of fiscal 1999, total enrollment stood at 1,312,969, an increase over the previous three years from 1,180,449 in 1996. The overall increase reflects a sharp rise in the uninsured/uninsurable category and a slight decrease in the Medicaid-eligible category. In June 1999, Medicaid-eligible enrollment was 814,181 (62%) and uninsured/uninsurable enrollment was 498,788 (38%). In June 1996, Medicaid-eligible enrollment was 846,067 (71.7%) and uninsured/uninsurable enrollment was 334,382 (28.3%). From 1996 to 1999, Medicaid-eligible enrollment fell modestly (3.8%) while uninsured/uninsurable enrollment rose sharply (49.2%),⁵⁸² and, since enrollment during that period was closed to the uninsured, the entire increase of 164,406 fell into the more expensive uninsurable category. The growth in the uninsured/uninsurable category accelerated in fiscal 1998, growing by 23.7%, and in fiscal 1999, growing by an additional 16.9%, while the Medicaid-eligible category was stable in fiscal 1998, and fell by 3.3% in fiscal 1999.⁵⁸³ As a result of that substantial increase in the uninsured/uninsurable category, Governor Sundquist proposed, in early 1999, temporarily freezing enrollment of additional uninsurable patients in TennCare.⁵⁸⁴ These statistics are summarized below in Table 2.

580. See 42 U.S.C. § 1988 (1994).

581. See *Hensley*, 461 U.S. at 433 (stating a plaintiff must be a prevailing party to recover attorney's fees).

582. See *supra* notes 11-13 and Table 2.

583. See *id.*

584. The proposal needed HCFA approval. See Bill Snyder & Keith Snider, *TennCare Is Helping Too Many*, THE TENNESSEAN, Feb. 10, 1999, at 1A. Trends in TennCare enrollment have been of particular concern since the uninsurable category is particularly costly to cover. See *id.* at 9A.

TABLE 2
TENNCARE ENROLLMENT

	Jnne 1996	June 1997	Change '96-'97	June 1998	Change '97-'98	June 1999	Change '98-'99
Medicaid- Eligible	846,067	842,207	-0.46	842,012	-0.02	814,181	-3.31
Uninsured /Unin- surable	334,382	344,867	+3.14	426,757	+23.75	498,788	+16.88
TOTAL	1,180,449	1,187,074	+0.56	1,268,769	+6.88	1,312,969	+3.48

Percent Change, June 1996-June 1999

Medicaid-Eligible	-3.77
Uninsured/Uninsurable	49.17
TOTAL	11.23

Sources: Fiscal Review Committee, Report to the 100th General Assembly for the Year Ending June 30, 1997 (November 24, 1997); TennCare Program at 4; Fiscal Review Committee, Report to the 100th General Assembly for the Year Ending June 30, 1998 (November 9, 1998); TennCare Program at 4; TennCare Website.

In its request for a renewal of its TennCare waiver, submitted on December 30, 1997, Tennessee estimated that FFP for fiscal 1998 would be \$2.35 billion, a 5.1% increase from the previous fiscal year and \$376 million below the budget neutrality cap of \$2.726 billion. TennCare expenditures for the five-year demonstration were projected to save the federal government \$1.6 billion over the budget neutrality projection.⁵⁸⁵ For the three-year renewal period, Tennessee and HCFA agreed on 5.1% as the budget-neutral annual rate of expenditure increase.⁵⁸⁶ The recent unanticipated increase in TennCare enrollment among uninsurables has raised questions concerning whether the projections regarding cost increases contained in the waiver renewal request are now realistic. Despite those current uncertainties, there is no doubt that TennCare serves 61.3% more Tennesseans than would have the traditional Medicaid-only program. Further, over the course of the first five-year demonstration, FFP allowed the coverage of many more people at an expenditure of about \$1.5 billion fewer federal

585. See WAIVER EXTENSION REQUEST, *supra* note 19, at 115.

586. See *id.*; see also Letter from Michael Hash, *supra* note 9, (noting that annual budget neutrality trend rate for three-year TennCare extension under provisions of 1997 Balanced Budget Act was 5.1%).

dollars than would have been spent in Tennessee's traditional Medicaid program.⁵⁸⁷ So, on both access and cost grounds, when viewed in a five-year perspective, TennCare has been a notable success story, although enrollment trends pose a significant financial concern because of the accelerated growth in the uninsurable category.

There have been recurring questions about whether funding levels are adequate, and in the budget review process for fiscal 2000, consultant reports raised questions about the adequacy of TennCare funding.⁵⁸⁸ These questions persist because TennCare's method of establishing a global budget is not market-based but rather administratively imposed.

Appropriateness may be assessed alternatively as (1) effects of a payment rate on availability of care to the intended recipients—in this context, the impact on care delivered to TennCare enrollees—or (2) effects of payments on adequacy of compensation to providers. Most of our evaluation dealt with the former. Our interest has been in determining what effects, if any, TennCare (including its funding levels) has had on such measurable items as utilization of services, patient satisfaction, health outcomes, physician participation, and hospital "profitability." This Part will report the empirical evidence gathered for this project on aspects of TennCare.

A. *Effects of TennCare on Utilization of Care*

In late 1996 and early 1997, we surveyed residents of Tennessee and North Carolina, the latter as a control state, about the quality of their healthcare.⁵⁸⁹ Our survey was limited to residents who had been hospitalized for one of three reasons in 1993 or in 1995 in either

587. See WAIVER EXTENSION REQUEST, *supra* note 19, at 115. For fiscal 1995 under the terms of the original TennCare waiver, TennCare FFP expenditure increases were capped at 8.3%. That percentage fell to 7.5% in 1995-96, to 5.7% in 1996-97, and then to 5.1% in 1997-98. See *id.*

588. See PRICEWATERHOUSECOOPERS, *supra* note 166, at i, ii; WILLIAM M. MERCER, INC., EVALUATION OF CRITICAL ISSUES FACING THE TENNCARE PROGRAM—REPORT, *supra* note 190.

589. The two states are adjacent geographically and once were the same state. In 1996, per capita income in the two states was virtually identical with Tennessee ranking 36th and North Carolina ranking 34th among states. See U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES (1997). Medicaid covered 47% of births in Tennessee and 45% in North Carolina in 1993; in 1995, the corresponding percentages were 48 and 44. See PETER LONG & DAVID LISKA, STATE FACTS: HEALTH NEEDS AND MEDICAID FINANCING (1998). In contrast to Tennessee, North Carolina had virtually no Medicaid recipients under capitated arrangements in 1995. Primary care case management ("PCCM") had been implemented in some parts of North Carolina, but the fee-for-service incentive had been retained. PCCM is about the weakest form of managed care. On PCCM, see Elizabeth D. Schulman et al., *Primary Care Case Management in Birth Outcomes in the Iowa Medicaid Program*, 87 AM. J. PUB. HEALTH 80 (1997).

state—(1) obstetrical care (N=986), (2) heart attacks (N=457), or (3) a head injury (N=248).

We selected these three categories for specific reasons. We focused on obstetrical care because in Tennessee, as in other parts of the United States, a relatively high proportion of recipients of obstetrical care are enrolled in Medicaid.⁵⁹⁰ We selected heart attacks and head trauma as index conditions for adult care.⁵⁹¹ Admission to the hospital for these conditions is not typically elective, and, absent TennCare, some patients hospitalized with these conditions would plausibly have been uninsured. Source of payment for hospital care was not taken into account.

The main comparison in the empirical analysis was between TennCare, in which all Medicaid recipients in Tennessee were enrolled in 1995, and traditional fee-for-service Medicaid, which enrolled all Medicaid recipients in Tennessee in 1993, and which enrolled virtually all Medicaid recipients in North Carolina in both 1993 and 1995. A few Medicaid recipients in North Carolina were enrolled in primary care case management, a relatively weak form of managed care.⁵⁹² Using regression analysis, we controlled the influence of other variables, such as respondent income, race, education, and clinical condition, as well as state (Tennessee versus North Carolina) and year (1993 versus 1995).

1. Obstetrical Care

Overall, during the hospital stay for labor and delivery, utilization patterns for TennCare enrollees and for patients with traditional

590. "Although the TennCare program covered only 28 percent of the total 1995 population in the state, 48 percent of 1995 Tennessee births occurred to women enrolled in TennCare." Raymond H. Phillippi & Karen S. Hamlet, *INFANT DEATH AND PRENATAL CARE AMONG RESIDENTS OF THE STATE OF TENNESSEE: A STUDY OF REGIONAL AND MANAGED CARE ORGANIZATION VARIATION* (1997) reprinted in *WAIVER EXTENSION REQUEST*, *supra* note 19, at 1, as Appendix E; see also LONG & LISKA, *supra* note 589; Wayne A. Ray et al., *Perinatal Outcomes Following Implementation of TennCare*, 279 *JAMA* 314, 315 (1998) (finding that 49.4% of Tennessee births occurred to women enrolled in Medicaid at delivery).

591. By "index condition," we refer to a set of conditions that are representative of conditions more generally. Obstetrical uses are important reasons for hospital admissions. Heart attacks and head trauma represent largely unanticipated health events affecting adults. They are also common reasons for admission to hospitals.

592. See ROBERT E. HURLEY ET AL., *MANAGED CARE IN MEDICAID: LESSONS FOR POLICY AND PROGRAM DESIGN* 37-59 (Ronald M. Anderson et al. eds. 1993). Primary care case management plans are still important in states with little managed care for their general population. However, they are being phased out whenever possible. See Holahan et al., *supra* note 22.

Medicaid were similar.⁵⁹³ In the following areas of inquiry regarding obstetrical care, we found no difference between TennCare and traditional Medicaid: (1) probability of seeing a physician once a month or more during pregnancy; (2) probability of having a regular prenatal provider;⁵⁹⁴ (3) probability of cesarean section; (4) probability of having a regular doctor or an affiliate of the regular doctor deliver the baby; (5) incidence of child readmission to the hospital after the initial discharge; and (6) frequency of infant visits for pediatric care after the initial discharge.⁵⁹⁵

In some areas, such as the important category of prenatal care, testing was more extensive under TennCare than under traditional Medicaid. The differences were especially noteworthy for use of ultrasounds and for alpha fetoprotein testing. Use of ultrasounds was more than twice as likely for TennCare than for traditional Medicaid recipients. Similarly, for alpha fetoprotein, testing was almost twice as likely for TennCare enrollees than for traditional Medicaid patients.⁵⁹⁶

In two respects, pregnant women enrolled in TennCare obtained less care than did those enrolled in traditional Medicaid. First, TennCare enrollees were 54% as likely as traditional Medicaid participants to have been referred to another physician from the provider from whom such patients received most of their obstetrical care.⁵⁹⁷ Second, compared to mothers enrolled in traditional Medicaid, TennCare enrollees were 38% as likely to have initiated prenatal care

593. TennCare mothers were 15% more likely to have stayed in the hospital for one day or less, but the difference was not statistically significant at conventional levels. See Frank A. Sloan et al., *The Impact of Managed Care on Utilization of Obstetrical Care: Evidence from TennCare (1998)* (unpublished manuscript, on file with Duke University).

594. Among those with a regular prenatal provider, pregnant women enrolled in TennCare were 34% more likely to have a nurse as the usual provider than were pregnant enrollees in traditional Medicaid. This difference was not statistically significant at conventional levels, and this evidence says nothing about outcomes or quality of service (whether better or worse). See Sloan et al., *supra* note 593.

595. See Sloan et al., *supra* note 593.

596. Our analysis showed no reduction in the C-section rate attributable to TennCare. This result, however, is consistent with most of the empirical evidence based on comparisons of HMO-enrolled versus other women. For a review of the literature on HMO effects on utilization of personal health services, see Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance since 1980: A Literature Analysis*, 271 JAMA 1512 (1994). A more recent study using California data found no effect of HMOs on C-section rates. See Rachel B. Weinstein & James Trussell, *Declining Cesarean Delivery Rates in California: An Effect of Managed Care?* 179 AM. J. OBSTETRICS & GYNECOLOGY 657, 663 (1998).

597. See Sloan et al., *supra* note 593. Lower rates of referral to other physicians are a logical consequence of financial incentives faced by the plans (and perhaps individual physicians) under TennCare. Our evidence does not purport to establish whether lower rates of referral are associated with any particular set of outcomes or levels of quality of care.

during the first trimester of pregnancy.⁵⁹⁸ Other analysis has linked birth and health records in Tennessee to Medicaid data on all births for the years 1993-96. Compared to 1993 Medicaid, the percent of pregnant women receiving prenatal care increased among TennCare mothers.⁵⁹⁹ However, there was no control state, and no adjustment for other determinants of receipt of care (e.g., education) was reported.

2. Heart Attacks

TennCare increased utilization of health care services following a heart attack. TennCare enrollees hospitalized for a heart attack were as likely as privately-insured patients to have received coronary bypass surgery or balloon angioplasty (both termed "coronary revascularization" procedures)⁶⁰⁰ and were much more likely to have received such procedures than were persons enrolled in traditional Medicaid.⁶⁰¹ The uninsured were also less likely to have had coronary revascularization than were patients with TennCare, private insurance, or Medicare. Heart attack patients on traditional Medicaid were far less likely to have had a regular provider of care after their heart attack than were patients on TennCare or those with private insurance or Medicare.⁶⁰²

B. Effects of TennCare on Patient Satisfaction with Care Received

Our patient survey contained several questions designed to measure satisfaction of care.⁶⁰³ Overall, patient satisfaction with

598. See Sloan et al., *supra* note 593. Ray and coauthors also obtained this result using a different data source. Ray et al., *supra* note 590, at 315-16. Slower initiation of prenatal care may have reflected confusion about enrollment procedures in 1994 and 1995. See Gold et al., *supra* note 17, at 156-57.

599. See Phillippi & Hamlet, *supra* note 590.

600. Coronary artery bypass is a surgical procedure in which obstructed arteries supplying the heart are bypassed by attaching either a vein grafted from the patient's leg or a mammary artery from the patient's chest. Balloon angioplasty is an invasive procedure, performed by cardiologists, in which a balloon embedded in a flexible catheter is threaded up into the heart from a blood vessel in the patient's groin and is gradually inflated to relieve obstruction of an artery supplying the heart. Both procedures are intended to restore adequate blood flow to the heart muscle and prevent the permanent destruction of heart tissue. "Coronary revascularization" is a general term referring to procedures that affect circulation around the heart. For further description of these procedures, see ADAM D. TIMMIS ET AL., *DISABLED CARDIOLOGY* 116-18 (1997).

601. Frank A. Sloan et al., *Impact of TennCare on Patient Satisfaction with Care*, 5 AM. HEART J. MANAGED CARE 765 (1999).

602. See Sloan et al., *supra* note 601.

603. See Christopher J. Conover et al., *The Impact of TennCare on Patient Satisfaction with Care*, AM. J. MANAGED CARE (forthcoming).

TennCare seems to be quite good, particularly when compared to patients with traditional Medicaid and to uninsured persons. In some cases, patient satisfaction among TennCare patients equals that of Medicare or privately insured patients.

1. Pediatric Care

We asked parents of infants about satisfaction with various aspects of their child's care. Parents responded yes or no to the following five questions: "Thinking about the last time you visited the place you usually take your baby for care, were you satisfied with: (a) all care you thought you needed; (b) waiting time for an appointment; (c) waiting time to see the doctor; (d) answers to all of your questions; (e) the care that you received?" Since the children were at least one year of age by the survey date, these questions referred to the child's pediatric care.

Satisfaction among TennCare parents with pediatric care was slightly better than for traditional Medicaid, much better than for the uninsured, but not as high as for those with private health insurance. For no measure of satisfaction was the difference between TennCare and other patients statistically significant at conventional levels.

The foregoing results were based on an analysis that controlled for many potentially confounding factors, such as education, race, and income. The results on satisfaction are also instructive when the controls for these other factors are relaxed. They indicate widespread patient satisfaction with TennCare. Of the five measures of satisfaction with pediatric care, over 87% of respondents indicated that they were satisfied with four of the five aspects.⁶⁰⁴ In each of those four, rates of satisfaction with TennCare were almost identical to those with private or traditional Medicaid coverage and much higher than for the uninsured.

2. Heart Attacks/Head Trauma

For persons who had been hospitalized for either a heart attack or head trauma, we asked about their satisfaction about care overall

604. Over 87% of respondents with children enrolled in TennCare said they were satisfied with four of the five measures of satisfaction with pediatric care. However, only 77% of respondents with children on TennCare were satisfied with waiting time to see the doctor. Percentages of respondents who were satisfied with waiting time to see the doctor for the other payer categories were: 52% for uninsured; 84% for privately insured; and 80% for traditional Medicaid. Thus, even though satisfaction with waiting was lower for TennCare than for the privately insured, satisfaction with waiting was much higher than for parents of uninsured children.

and thirteen separate aspects of care following their discharges for the index conditions: (1) convenience; (2) hours the physician's office is open; (3) getting specialists when needed; (4) access to emergency care; (5) length of time spent waiting in the office to see the doctor; (6) length of time spent waiting for a new appointment; (7) availability of advice over the telephone; (8) attention to what the patient has to say; (9) arrangements for choosing personal physician; (10) amount of time staff spent during the visit; (11) technical skills; (12) personal manner; and (13) cost. Responses to these questions were elicited on a five-point scale: excellent, very good, good, fair, and poor. Again, we used regression analysis to control for other influences on satisfaction with care received.

For "satisfaction with time spent with doctor," 26% of TennCare enrollees said this aspect of their care was "excellent" in contrast to 17% for the uninsured, 22% for traditional Medicaid, and 26% for private insurance or Medicare.⁶⁰⁵ On such indicators as "overall rating of medical care," "satisfaction with the cost of medical care," "satisfaction with access to specialists," and "satisfaction with access to emergency care," TennCare enrollees who had been admitted to a hospital for either a heart attack or head trauma were more likely than were respondents in any of the other source-of-payment categories—private insurance, Medicare, traditional Medicaid, or no insurance—to have stated that their care was "excellent."⁶⁰⁶

605. With regression analysis, we studied determinants of differences in patient satisfaction by payer category. Traditional Medicaid was the comparison group. Compared to traditional Medicaid, there were no statistically significant differences in patient satisfaction with time spent with doctor for TennCare (versus traditional Medicaid) or for the uninsured or privately insured and Medicare patients (also versus traditional Medicaid).

606. In addition to our analysis of satisfaction with time spent with doctor, see *supra* note 604, and accompanying text, we performed regression analysis of satisfaction with care overall and with three other dimensions of care: cost; access to specialists; and access to emergency care. If statistical significance is used as a criterion, the only noteworthy difference was for cost. Not surprisingly, the uninsured tended to be most dissatisfied about the cost of their care. Differences among the other payer groups, including TennCare, were not statistically significant at conventional levels.

C. Effects of TennCare on Health Outcomes

1. Heart Attacks⁶⁰⁷

Our patient survey measured outcomes of persons who experienced a heart attack using the eight standard scales of the Short-Form SF-36, a validated survey instrument for measuring health status, activities of daily living ("ADLs"), and work status at the time of the survey.⁶⁰⁸ Because these are the standards most directly pertinent to heart attacks, we selected for analysis the following five of the SF-36 scales: physical functioning; role physical; bodily pain; general health; and mental health.⁶⁰⁹

Each SF-36 scale asks respondents to agree or disagree with statements about their perceived health or rate several questions relating to their health.⁶¹⁰ The components of each scale are then scored, summed, and inverted to produce a bounded scale across which

607. The outcomes data regarding head trauma did not produce statistically valid results for three reasons and so are not discussed. First, there were many causes of head trauma (gunshot wound, automobile accident, fall, etc.). Second, severity of trauma ranged from a relatively minor injury leading to hospitalization as a precautionary measure aimed at detecting rare adverse effect of the injury to a permanent brain injury from which the patient remained in a coma. Third, the number of observations was insufficient to permit detailed analysis.

608. The eight scales of the SF-36 are the following: 1) physical functioning; 2) role physical; 3) bodily pain; 4) general health; 5) mental health; 6) vitality; 7) social functioning; and 8) role emotional. See JOHN E. WARE, *SF-36 HEALTH SURVEY: MANUAL AND INTERPRETATION GUIDE* (1993).

609. For purposes of our empirical analysis, we excluded SF-36 scales for vitality, social functioning, and role emotional. The elements in the five SF-36 scales we analyzed were:

1) Physical functioning—vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports; moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or golfing; lifting or carrying groceries; climbing several flights of stairs; bending, kneeling, or stooping; walking more than one mile; walking several blocks; walking one block; bathing or dressing yourself.

2) Role physical—cut down the amount of time you spent on work or other activities; accomplished less than would like; were limited in the kind of work or other activities; had difficulty performing the work or other activities.

3) Bodily pain—how much pain have you had in the past 4 weeks?; during the past 4 weeks, how much did pain interfere with your normal work (including housework and work outside the home)?

4) General health—in general, would you say your health is excellent, very good, fair, or poor? I seem to get sick a little easier than other people; I am healthy as anybody I know; I expect my health to get worse; my health is excellent.

5) Mental health—have you been a very nervous person? Have you felt so down in the dumps that nothing could cheer you up? Have you felt calm and peaceful? Have you felt downhearted and blue? Have you been a happy person?

A manual, see WARE, *supra* note 608., provides the method for SF-36 scoring of each dimension on specific items that are answered affirmatively and the method for combining the scores from the subscales.

610. See WARE, *supra* note 608.

patients can be compared. The ADLs referred to whether or not the respondent obtained assistance for various personal activities: walking across a room; getting up from a chair; getting in and out of bed; bathing or showering; eating; and dressing. In this analysis, persons enrolled in private health insurance plans were the comparison group. Explanatory variables were included for enrollment in TennCare, traditional Medicaid, and for the uninsured.

In only one of the five regressions for the SF-36 scales did a difference between TennCare and private insurance reach statistical significance at conventional levels.⁶¹¹ The one category for which there was a significant difference was for "role-physical," which measures the person's ability to work and to perform household activities. On this measure, TennCare enrollees scored worse than privately insured patients,⁶¹² but far better than traditional Medicaid patients. On ADLs, persons on traditional Medicaid performed worse than did persons in the other payer categories, including TennCare.⁶¹³

2. Birth Outcomes

To assess the effects of TennCare on birth outcomes, we used data from birth records merged with death records from Tennessee and North Carolina for both 1993 and 1995. This file contained over 300,000 records. Unlike our patient survey, we did not have data on the patient's source of payment during pregnancy and labor/delivery. Thus, we could only examine whether birth outcomes improved or worsened overall in Tennessee relative to North Carolina after TennCare was implemented on January 1, 1994. Since we did know the location of residence of the mother at the time of delivery, we could identify high poverty areas, which in general and overall are likely to contain relatively high proportions of TennCare and Medicaid mothers. Any conclusions regarding the effect of TennCare are, therefore, necessarily inferences from aggregate data that do not distinguish TennCare from non-TennCare births.

Most importantly, we found no statistically significant differences in infant mortality, measured at various time intervals⁶¹⁴ during

611. See Sloan et al., *supra* note 601.

612. Persons who had low scores on "role physical" were limited in work or other activities. TennCare heart patients were more limited in their activities than were the privately insured ($p < 0.04$).

613. The analysis held a number of other factors constant. Thus, the observed differences by health insurance status with regard to "role-physical" were not attributable to such factors as family income, health before the heart attack, gender, education, or race.

614. The time intervals were at one, two, and twelve months after births.

the infant's first year of life, when Tennessee in 1995 was compared to North Carolina or when Tennessee in 1995 was compared to Tennessee in 1993 (pre-TennCare). This difference remained when we looked at a geographically-based "poverty" subsample. Thus, on the whole and with respect to the "poverty" subsample, infant mortality was not adversely affected in 1995 after the onset of TennCare. In fact, birth outcomes overall were largely unaffected in Tennessee in 1995, at least at the aggregate level at which our data were drawn. For example, we found no statistically significant differences in the following areas of risk: (1) risk of the baby having an abnormal condition at birth; (2) risk of the baby having low or very low birth weight;⁶¹⁵ or (3) risk of transfer of the infant to a facility other than the one at which the delivery occurred.⁶¹⁶

As part of our effort to assess the effects of TennCare on birth outcomes, we examined Apgar scores, which have come to be used as one tool for judging the success of prenatal and perinatal care and which have some predictive value in assessing the future health of the newborn.⁶¹⁷ When evaluated for the entire Tennessee sample, Apgar scores did not decline from 1993 to 1995.⁶¹⁸ Our evidence did not establish any adverse consequences such as low birthweight or higher risk of an abnormal condition at birth resulting after the implementation of TennCare in 1995. This was true for both the whole sample and for a geographically-based "poverty" subsample. Indeed, the probability of an infant having any abnormal condition⁶¹⁹ decreased, suggesting improved outcomes under TennCare.

When, instead of focusing on the entire sample, we examined a sub-group of mothers—those who were not married at the time of the labor-delivery—we found that the probability of a satisfactory Apgar score (greater than or equal to 7 at five minutes after birth) was lower

615. "Very low birthweight" was defined as under 1,500 grams. "Low birthweight" was under 2,500 grams.

616. Such transfers were directly from one hospital facility to another.

617. Developed in 1952 as a standardized assessment tool for evaluating newborns, the Apgar test is a method for estimating severity of oxygen deprivation at birth done by rating certain physical signs, including color, heart rate, respiration, reflex response to nose catheter, and muscle tone. The score is determined at one minute and at five minutes after birth. A lower score is indicative of a more asphyxiated infant. Those infants with low Apgar scores have a greater likelihood of having permanent brain damage. See, e.g., Karin B. Nelson & Jonas H. Ellenberg, *The Asymptomatic Newborn and Risk of Cerebral Palsy*, 139 AM. J. DISEASES OF CHILDREN 1031 (1985).

618. The higher the Apgar score, the more healthy the infant is perceived to be.

619. The abnormal outcome measure was a binary variable if any of the following conditions were reported on the infant's birth record: anemia, birth injury, fetal alcohol syndrome, hyaline membrane disorder, meconium aspiration, assisted ventilation, seizures, or "other." The probability of having an abnormal condition decreased after TennCare by 0.11.

in 1995 in Tennessee than in 1993 in Tennessee or in North Carolina in either year.⁶²⁰ This was also true for the geographically-based "poverty" sub-sample, however.⁶²¹

Although one hesitates to make any firm conclusions given the nature of the data, it seems that the introduction of TennCare was not associated with lower infant mortality, lower birthweight, or increased risk of an abnormal condition at birth. For a "poverty" subsample, there was a reduced Apgar score from 1993 to 1995, but we have no evidence of what might have eventuated from the reduced Apgar scores. Many children with low Apgar scores at birth develop normally. Also, judged on the basis of fewer abnormal conditions evident at birth, outcomes improved after TennCare was implemented.

Evidence on the influence of managed care on birth outcomes from other states is, if anything, encouraging and consistent with the overall findings regarding birth outcomes in TennCare. A recent study of birth outcomes for Medicaid patients enrolled in managed care programs compared Medicaid managed care enrollees to others who remained in traditional fee-for-service Medicaid. Patients in managed care were more likely to have received adequate prenatal care.⁶²² In another study, researchers found that, measured by birthweight, birth outcomes were superior in a Medicaid capitated payment plan than in a traditional FFS setting. That is, in data derived from California's Medicaid ("MediCal") program, the probability of lower birthweight was lower for patients enrolled in managed care as compared to FFS.⁶²³

620. For a sample of mothers located in poverty areas in Tennessee and North Carolina in 1993 and 1995, we estimated that the probability of a good Apgar score was only 0.7 as high after TennCare was implemented.

621. As noted earlier, *see supra* notes 594-95 and accompanying text, our study showed that a lower proportion of women on TennCare in 1995 initiated prenatal care during the first trimester of their pregnancies as compared to women on traditional Medicaid. This confirms a study by Ray et al., *supra* note 590. It may be that the confusion surrounding TennCare's early implementation may have triggered less intervention in the first trimester of pregnancy, with some associated effect on Apgar scores. For a discussion of the problems with TennCare's implementation, see generally David M. Mirvis et al., *TennCare-Health System Reform for Tennessee*, 274 JAMA 1235 (1995).

622. See Arik Levinson & Frank Ullman, *Medicaid Managed Care and Infant Health*, 17 J. HEALTH ECON. 351, 367 (1998) (stating that Medicaid HMO mothers receive prenatal care that is superior to that received by Medicaid FFS mothers).

623. See Denise M. Olenke et al., *A Comparison of Capitated and Fee-for-Service Medicaid Reimbursement Methods on Pregnancy Outcomes*, 33 HEALTH SERVS. RES. 55, 63 (1998) (stating that a significantly lower proportion of low-birthweight babies were observed in the MCC group than in the MFFS group).

D. Physician Satisfaction and Participation in TennCare

Physician complaints about managed care in general, and about Medicaid managed care and TennCare in particular, are well known. However, specific reasons for physician dissatisfaction, actual rates of physician participation in programs like TennCare, and determinants of the decision to participate have rarely been documented in previous studies.

For this reason, we conducted a physician survey of physician satisfaction with and participation in TennCare in mid-1996.⁶²⁴ We surveyed 300 Tennessee physicians in the specialties of general and family practice, cardiology, general internal medicine, obstetrics/gynecology, neurosurgery, general surgery, and pediatrics. The survey instrument contained open-ended questions and objective questions (such as questions about number of years in practice and about perceptions that could be answered on a five-point scale ranging from "very satisfied" to "not at all satisfied"). The open-ended questions were particularly valuable for identifying areas of physician concern that probably would not have been identified had we fully relied on a fixed-response format.

Overall, Tennessee physicians were dissatisfied with TennCare. Only two percent of respondents said that they were "very satisfied" with TennCare. Nearly half said that they were "not at all satisfied" overall with this program. Interestingly, for any individual question relating to professional autonomy under TennCare, rates of dissatisfaction were high but not nearly as high as in their overall assessment of the program.⁶²⁵ The freedom to order tests and procedures whenever needed was the aspect with which physician respondents expressed the highest rates of dissatisfaction. This result, which reveals physician frustration with controls on their ordering tests and procedures, contrasts sharply with the findings that show, in fact, high levels of utilization of specialized procedures under TennCare.⁶²⁶

624. See Frank A. Sloan et al., *Physician Participation and Non-Participation in Medicaid Managed Care: The TennCare Experience*, — S. MED. J. — (forthcoming).

625. Forty-five percent of respondents were not at all satisfied with TennCare. Another 27% were not very satisfied. By contrast, only 10% of respondents were "not at all satisfied" with their ability to control their own work schedule under TennCare, 18% with their ability to hospitalize patients who need such care, 21% with their ability to order tests and procedures whenever needed, and 20% were very dissatisfied with the overall degree of their professional autonomy under TennCare.

626. See Sloan et al., *supra* note 593 (finding ultrasounds and alpha fetoprotein testing were more common for TennCare births than for traditional Medicaid); Sloan et al., *supra* note 601 (TennCare patients with heart attacks were more likely to have been revascularized).

We asked two questions about the physician's perception of quality of care under TennCare. First, the survey asked: "All things considered, what is your impression of the quality of care under TennCare, as measured by patient outcomes?" Responses varied from "significantly better" to "definitely worse." Only 13% of respondents thought that care was better. By contrast, 46% said that care was worse. Second, physicians were asked: "How is the quality provided to TennCare patients compared to other patients you treat?" Here fewer than one percent said that care provided to their TennCare patients was better. Most physicians said that there was no difference, but 36% stated that the care given TennCare patients by other physicians was worse than the care those physicians gave to their other patients. Thus, quality of care problems were more likely to characterize other physicians' practices rather than their own.

When physician-respondents were asked about what the physician would change about TennCare, their most frequent suggestions concerned increasing the level of compensation, reducing the difficulties of obtaining payment, reducing paperwork, and relaxing TennCare's drug formulary restrictions. The physicians complained that securing the right medications for their patients was an "absolute hassle," especially since the formularies differed for the various MCOs. There were some complaints about the difficulties of referring patients to specialists, but these were far less frequent than were the complaints about drugs.⁶²⁷

Another measure of physician satisfaction is actual participation in TennCare. By this measure, satisfaction was high. Eighty-nine percent of physicians surveyed (covering the fields of general and family practice, cardiology, general internal medicine, obstetrics/gynecology, neurosurgery, general surgery, and pediatrics) participated as of the survey date. This contrasts with a physician-participation rate in Tennessee's Medicaid program of under 40% prior to TennCare.⁶²⁸

627. Twenty-one percent of the physician respondents said that they would change TennCare's formulary restrictions. By change, respondents meant "relax." Physicians often complained that obtaining the right drugs for their TennCare patients was an "absolute hassle," especially since the formularies for the various MCOs differed. Specific complaints about ability to make referrals to specialists were far less frequent, with 6% of respondents complaining about that.

628. See Watson, *supra* note 55, at 217. For a discussion of the effect of increased Medicaid fees on rates of physician participation in Tennessee's traditional Medicaid program, see generally Kathleen Adams, *The Effect of Increased Medicaid Fees on Physician Participation and Enrollee Service Utilization in Tennessee, 1985-88*, 31 INQUIRY 173 (1994).

From another perspective, ease of patient access to medical care under TennCare may not be as good as the above trends imply. Stories abound about individual examples of access problems of one kind or another in one location or another.⁶²⁹ Such anecdotal accounts are not necessarily inconsistent with our study's findings about physician participation in TennCare. In our survey, we defined participation in terms of accepting patients in any TennCare plan. Physicians would presumably not participate in all such plans. The anecdotal reports of access barriers do seem inconsistent with results of our patient survey. TennCare patients overall did not experience unusual difficulty in obtaining medical care.

E. The Effect of TennCare on Hospitals

1. Hospital Profitability Before and After the Introduction of TennCare

Using data from the Joint Annual Reports filed with the Tennessee state government, we computed profit levels for three large tertiary care facilities and for non-federal short-term general hospitals in Tennessee as a whole for the years 1990-96. TennCare was introduced on January 1, 1994. The vast majority of hospitals had a January to December or a July to June fiscal year. Thus, 1990 through 1992 are clearly pre-TennCare years and 1995 and 1996 represent years after TennCare was implemented. We only included the hospitals that filed reports for each of the years. In addition, we dropped three facilities because of anomalous values for 1994, yielding a total sample of 119 Tennessee hospitals. These statistics are summarized below in Table 3.

629. See, e.g., Stuart Schear, *A Medicaid Miracle?*, THE NAT'L J. 294, 294 (1995) (noting that the program grew so rapidly that the state froze open enrollment of the uninsured working poor in January 1995, to ensure adequate funds to cover those enrolled).

TABLE 3
 PROFIT LEVELS AND MARGINS FOR NON-FEDERAL
 SHORT-TERM GENERAL TENNESSEE HOSPITALS⁶³⁰

Variable	All Tennessee	Erlanger	The Med	Vanderbilt	
Profit level (mil \$)					
1990	1.6	(3.9)	4.1	-7.1	6.1
1991	1.9	(3.8)	10.1	-7.7	10.7
1992	2.1	(4.7)	20.3	-13.6	12.9
1993	1.9	(4.8)	13.7	0.8	11.5
1994	1.8	(4.9)	7.2	-5.4	8.4
1995	3.0	(7.5)	2.7	-15.1	16.5
1996	3.6	(8.4)	13.2	-38.2	20.7
Adjustments (mil \$)					
1990	3.2	(4.8)	18.8	7.7	19.7
1991	3.4	(5.0)	20.5	7.4	20.4
1992	3.7	(5.5)	21.9	7.4	22.6
1993	3.9	(5.7)	23.8	9.5	23.7
1994	4.3	(6.3)	26.4	11.7	25.8
1995	4.8	(7.1)	28.9	13.2	27.1
1996	5.1	(6.9)	30.4	13.2	29.6
Adjusted profit (mil \$)					
1990	4.8	(7.6)	22.8	0.5	25.8
1991	5.3	(7.8)	30.6	-0.2	31.1
1992	5.7	(9.0)	42.3	-6.3	35.4
1993	5.8	(9.6)	37.5	10.3	35.2
1994	6.1	(9.5)	33.5	6.2	34.2
1995	7.8	(12.8)	31.6	-1.9	43.6
1996	8.7	(13.2)	43.6	-25.0	50.3
Margin (%)					
1990	1.4	(11.0)	2.6	-5.4	2.9
1991	2.3	(11.1)	5.5	-5.2	4.3
1992	3.0	(9.4)	9.3	-8.0	4.5
1993	1.2	(11.8)	5.6	0.4	3.7
1994	0.9	(12.5)	3.0	-2.7	2.6
1995	3.4	(10.2)	1.1	-8.2	4.7
1996	4.0	(15.4)	4.8	-23.7	5.4
N	119		1	1	1

630. All values are in real 1995 dollars. Mean values reported for All Hospitals. The sample was constructed by taking all community hospitals that reported Joint Annual Report data in every year of interest, with three exceptions. Gibson General, Decatur County General, and GW Hubbard hospitals were excluded due to anomalous values for the 1994 JAR. Shaded values identify transition years. The adjustments are interest and depreciation expense. The adjusted profits are profits plus the adjustments. The margin is based on unadjusted profits.

Mean profit per hospital per year ranged from \$1.6 million (1995 dollars) to \$2.1 million during 1990-92 (1995 dollars) [Table 3]. The mean increased to \$3.0 to \$3.6 million during 1995-96. During 1990-92, mean interest and depreciation expense ranged from \$3.2 to \$3.7 million per hospital. This expense increased as well, from \$4.8 to \$5.1 million per hospital by 1995-96. Adding interest and depreciation to profit yields "adjusted profit."⁶³¹ Such adjusted profit also increased from \$4.8 to \$5.7 in 1990-92 from \$7.8 to \$8.7 million in 1995-96. Expressed as a profit margin ((revenue - expense)/revenue), margins increased from 1.4% and 2.3% in 1990 and 1991, respectively, to 3.4% and 4.0% in 1995 and 1996.

The trend toward increasing profitability after implementation of TennCare was also evident for two of the three major tertiary facilities—Erlanger (Chattanooga) and Vanderbilt (Nashville). The Regional Medical Center (Memphis) ("The Med"), a major urban public hospital treating disproportionate numbers of poor and uninsured patients, experienced increased losses after TennCare was implemented. Losses grew appreciably worse in 1996.⁶³² The generalization of increasing profits did not apply to this hospital that serves large numbers of indigents.

We also obtained data on revenue, expenses, and profits for all nonfederal short-term general hospitals in Tennessee for the years 1993 through 1997, from information published by the American Hospital Association. In constant (Consumer Price Index) 1995 dollars, profit for such hospitals as a whole rose from \$203 million in 1993, the year preceding implementation of TennCare, to \$519 million in 1995 and to \$599 million in 1997. Between 1993 and 1995, revenue in constant dollars declined, but revenue rose from 1995 to 1997. The gain in profit between 1993 and 1995 is attributable to decreased expense. Between 1995 and 1997, profit rose because revenue increased more than expense increased.

Thus, data through 1997 reinforce the conclusion that profits of Tennessee hospitals increased after implementation of TennCare. As the number of years following the implementation of TennCare grows greater, many factors other than TennCare, such as the federal Balanced Budget Act of 1997, may affect profit levels adversely. But

631. Interest and depreciation are sometimes added back to profit to provide a better indication of cash flow to the firm.

632. Gold and co-authors reported that TennCare resulted in a substantial reduction in Medicaid revenues at this hospital. By contrast, a plan based around the public hospital system in Minneapolis was "thriving." See Gold et al., *Lessons from Five States*, *supra* note 17, at 163.

attributing such possible trends exclusively to TennCare would become increasingly less appropriate.

2. Other Changes in the Hospital Sector: Comparisons Before and After TennCare and with Other Parts of the United States

Using published data from 1991, 1993, and 1995 Annual Surveys of Hospitals, national surveys of United States hospitals conducted by the American Hospital Association, we assessed other impacts of TennCare on the hospital industry in Tennessee. As with profitability, we limited this analysis to non-federal short-term general hospitals. This information is summarized in Table 4.

TABLE 4
 PERCENT CHANGES IN UTILIZATION, EXPENDITURES, AND REVENUE
 IN SHORT-TERM, GENERAL, NON-FEDERAL HOSPITALS,
 1991, 1993, & 1995

	TENNESSEE		DIFFERENCE IN DIFFERENCE		
	1991-1993	1993-1995	East South Central Census Div.	North Carolina	United States
Hospital Capacity					
hospitals	-2.3%	-3.1%	-2.6%	-2.5%	-1.1%
beds	-2.5%	-9.0%	-5.1%	-3.4%	-2.0%
Inpatient Care					
admissions	-3.7%	-1.0%	-1.1%	-4.2%	1.1%
inpatient days	-4.8%	-9.9%	-2.7%	-4.4%	-0.9%
Hospital Operations					
aver. length of stay	0.0%	-8.8%	-2.9%	-2.0%	-3.0%
surgical procedures	0.6%	0.5%	-6.8%	-5.2%	0.1%
Outpatient Care					
emergency room	11.5%	-9.4%	-10.4%	-17.9%	-19.3%
other	33.2%	5.1%	-22.4%	-26.9%	-27.5%
total	24.9%	0.1%	-17.6%	-23.3%	-24.2%
Newborn Facilities					
bassinets	-0.1%	-9.6%	-21.5%	-10.1%	-9.8%
births	-2.4%	0.4%	0.0%	-0.3%	3.2%
Staffing (full-time equivalents)					
regist'd nurses (FT)	6.0%	-2.4%	-4.6%	-14.9%	-6.8%
LPNs (FT)	-7.0%	-12.7%	-6.0%	-12.5%	-13.0%
total personnel	3.3%	-3.6%	-1.4%	-5.3%	-4.0%
Trainees					
FTE trainees total	-14.6%	25.3%	16.7%	40.0%	39.6%
Expenses					
total labor expense	15.1%	2.6%	-1.4%	-4.5%	-5.7%
total expense	21.7%	-3.9%	-13.2%	-16.6%	-15.0%
total expense adjusted per admission	19.3%	-7.6%	-7.1%	-11.0%	-13.9%
total expense adjusted per inpatient day	20.0%	1.4%	-5.1%	-10.4%	-11.4%
Labor expense/FTE	11.4%	6.5%	-0.2%	0.9%	-1.4%
Total nonlabor expense	28.5%	-9.8%	-24.5%	-28.0%	-23.3%
Revenue					
Number of hospitals	-2.3%	3.1%	-2.6%	-2.5%	-1.1%
Percent of total (gross patient rev)	-5.5%	-4.1%	1.3%	2.5%	2.3%
Percent of total (gross outpatient revenue)	19.5%	11.4%	-4.7%	-9.5%	-8.8%
Net patient revenue	20.4%	0.4%	-8.6%	-19.1%	-9.9%
Net total revenue	18.6%	1.5%	-8.1%	-14.8%	-6.2%

To account for the influence of other factors, we used a difference in difference approach. For example, the number of hospitals in Tennessee declined at an annual rate of 2.3% between 1991 and 1993. Between 1993 and 1995, the number of hospitals decreased by 3.1% annually. Comparing the two percentage changes indicates that the rate of decline increased by 0.8% per year after TennCare (3.1 minus 2.3). However, the number of hospitals also declined in other parts of the United States. Thus, we computed rates of change defined as the difference between the Tennessee rates of change, 1993-95 minus 1991-93, minus the corresponding difference in rates of change for the same years for a reference group. Using hospitals in all other states as the reference group, we found that the decline in the number of Tennessee hospitals was 1.1% per year greater after implementation of TennCare than in other states of the United States. Using other states in the East South Central Division (a region containing Kentucky, Tennessee, Alabama, and Mississippi), we found that the rate of decline was 2.6% per year higher in Tennessee than in the East South Central Division region as a whole. Relative to North Carolina, the rate of decline in hospitals was 2.5% greater in Tennessee after TennCare was implemented.

With other United States hospitals as the reference group, the data suggest that TennCare reduced the number of Tennessee hospitals, beds, inpatient days, average length of stay, emergency room visits,⁶³³ other hospital outpatient visits, newborn capacity as measured by bassinets, registered nurse and licensed professional nurse staffing, and total hospital personnel more generally. Labor expense decreased but not as much as nonlabor expense fell. Patient revenue net of contractual adjustments to hospitals declined in relative terms in Tennessee, but not as much as did total expense with the consequence that overall hospital profits increased.⁶³⁴

633. Although visits to emergency rooms ("ERs") decreased for the hospital sector overall in Tennessee, TennCare could have done better in controlling hospital ER use. Young and co-authors surveyed TennCare patients at one Tennessee hospital ER in the summer of 1994, and again in the summer of 1995. Even by 1995, 37% of respondents did not have a primary care physician ("PCP"). Forty-eight percent had not called a PCP before going to the ER. Sixty-nine percent did not know that they might be responsible for the bill without their PCP's authorization. Of course, under a traditional FFS, far less than half of the persons who visit ERs may have contacted their physician before arriving. The study did not have an FFS comparison group. See generally Carolynn Young et al., *Access to Emergency Care Under TennCare: Do Patients Understand the System?* 30 ANNALS OF EMERGENCY MED. 281 (1997) (discussing a study conducted to determine patient understanding of how to properly gain access to urgent and emergency medical care under TennCare).

634. The only other relative increases in Tennessee were for the number of surgical procedures—a very slight relative increase—and for the number of births. Implementation of

Using other reference groups (East South Central Census Division or North Carolina) does not change the conclusions, although magnitudes of change are sensitive to the choice of reference group. On the whole, Tennessee hospitals appear to have become healthier after TennCare, but evidently not without the pain of some major adjustments in input use. Averages, however, obscure variation in performance of individual hospitals, such as the Med. Since one of the expectations of TennCare was the elimination of excess capacity and achieving operating efficiencies, this form of rationalization should have been anticipated. Whether the downsizing was appropriate, however, in the sense of being market-validated is still unclear since the level of resources allocated to the TennCare system has been administratively determined rather than market-driven. The result is that, while some level of downsizing of hospital capacity was expected and desirable, no firm conclusions can be reached about the appropriateness of the precise level of capacity-downsizing and resource constraint that have resulted.

VII. CONCLUSION: TENNCARE IN A POLICY PERSPECTIVE

The experience in TennCare provides states and other stakeholders with important perspectives if they decide to implement a mandatory program of Medicaid managed care. TennCare started with promise and became embroiled in controversy from the outset. Competing tensions have characterized the implementation of the program and continue to exist. Driven by the need to cope with escalating Medicaid costs and the likely loss of a provider-based tax that accounted for a substantial component of the state share of the Medicaid budget, Tennessee embarked on a mandatory managed care program in place of its traditional Medicaid program. To secure approval of that program, the state agreed to re-channel savings from Medicaid managed care into broadening access to medical care coverage for non-Medicaid patients who were uninsured or uninsurable. The uninsured component of the program has been frozen since January 1995, while the uninsurable component (per capita, the most expensive) rose by 23.7% in fiscal 1998 and 15.9% more in fiscal 1999. Governor Sundquist proposed temporarily freezing the uninsurable component of the program to relieve the cost escalation that was pro-

TennCare may be associated with an increase in the number of births in Tennessee. We are reluctant to make much of this latter point without further analysis.

jected for fiscal 2000 and ordered a major review. So, in fiscal/political terms, the politics of Medicaid in Tennessee are repeating themselves.

TennCare has resulted in health care coverage for over 60% more patients than under Tennessee's traditional Medicaid program; the Medicaid-eligible component of the TennCare population has remained stable for several years while the uninsurable component has spiked upward. Although it is in jeopardy, the original political deal has remained intact, with savings that accrue from Medicaid managed care being rechanneled to improve access to medical care coverage and to secure a comprehensive package of benefits that is comparable to those of Tennessee's public employees⁶³⁵ and superior to Tennessee's traditional Medicaid coverage.⁶³⁶ The renewed budgetary pressure threatens that political understanding.

By proposing to close TennCare enrollment for uninsurable patients as a cost-containment measure—even temporarily—Governor Sundquist sought to include the state's taxpayers as partial beneficiaries of the cost reductions from TennCare. That effort places at risk the perception of patient advocacy groups that economies from TennCare are to be rechanneled into access-oriented programs for non-Medicaid-eligible uninsured or uninsurable patients. That shift in perception would alter the decisionmaking framework from "either/or" to "yes/no"⁶³⁷ and will undoubtedly spur, as it has already,⁶³⁸ protests and eventually undermine the support of patient advocacy

635. TennCare's benefit package is "essentially identical" to the package of medical care benefits Tennessee offers to its state employees, although the EPSDT services provided under TennCare are "more extensive than the preventative services offered to state employees." See Watson, *supra* note 55, at 205 & n.140.

Tennessee provides medical care coverage to state employees under a contract with Blue Cross. Under state law, the state must use a bid process for awarding or renewing that contract. Blue Cross had agreed to participate in TennCare and to make its provider network for state employees available to its TennCare enrollees. The state retained Blue Cross as the contractor for state employee medical care coverage on a sole-source basis without utilizing the statutorily-mandated bid process. This failure to use the bid process violated the statutory bid requirement. *Cf. USA Managed Care Org., Inc. v. Ferguson*, No. 97-2269-III (Ch. Ct., Davidson County 1997) (temporarily enjoining state's subsequent use of "Request-for-Proposal" ("RFP") process as not a "bid" as required by state law). The state did not attempt, in that litigation, to defend its total lack of compliance with the bid requirement provision of state law in previously maintaining its contract with Blue Cross without any bid or RFP process.

636. "TennCare eliminate[d] previous Medicaid limits on the number of hospital days, physician and outpatient visits, and prescription drugs, laboratory and x-ray services." Watson, *supra* note 55, at 205. TennCare also "expanded coverage to include outpatient substance abuse treatment." *Id.* at 205 n.141.

637. See *supra* Part V.C.2.

638. For a description of the protests by potentially affected patients and their advocates at a hearing regarding the proposed temporary closing of TennCare enrollment for uninsurable patients, see Snyder, *supra* note 273.

groups for TennCare. And there is some question whether these restrictions will continue to be promoted by the Sundquist Administration or approved by HCFA.

At the same time, the compromises made by the advocacy groups in the formulation and implementation of TennCare were more symbolic than substantive. Formally, they relinquished the Clinton Administration's ideal of a universal system, which covered all citizens and assured the same medical care services to all. TennCare is not a universal but rather a pluralistic system. In principle it would allow for accommodation of the view that public beneficiaries should receive "adequate" rather than "equal" levels of service with privately insured individuals.⁶³⁹ However, by guaranteeing a generous level of benefits and by piggybacking onto the statewide network of providers developed by Blue Cross to provide services to public employees, the architects of TennCare sought to assure in fact a level of services for TennCare beneficiaries that was comparable to (and even better than) that available to non-Medicaid patients in Tennessee.⁶⁴⁰

So the TennCare program in operation assured a high style of benefits—comparable to mainstream plans available in the state—and extended those benefits to uninsured and uninsurable persons who would not qualify for coverage under traditional Medicaid and who are likely to be a more expensive patient population to cover. Physicians and some hospitals have yielded power and resources to facilitate the process, and now Tennessee taxpayers are faced with the prospect of absorbing additional costs for the generous benefits and expanded coverage. Further, the state's contracts with the MCOs have allowed the state to retain substantial control over interpretations of medical necessity and of the meaning of federal and state program requirements. The result is that the state greatly influences the cost of doing business for the MCOs and, at least in the short run, does not have to absorb the additional costs that are imposed on the MCOs. This is a form of political moral hazard, with the state able, in the short run, to impose costs on MCOs and to establish benefits for beneficiaries for which the state is not financially accountable.

The capitation rate paid to MCOs has not been market-tested, but national managed care companies have not entered the TennCare market, and most MCOs have reported losing money in 1997 and

639. See *supra* Part V.A.2.

640. See Snyder & Snider, *supra* note 584, at 9A (noting that TennCare premiums for the uninsured/uninsurable are relatively low and based only on income and family size, not sex, age or health conditions; there is no cap on pharmacy benefits; and there is no lifetime benefit cap).

1998.⁶⁴¹ This suggests that the state's consultants are correct in concluding that funding levels are marginal for the package of benefits demanded of the MCOs.⁶⁴² And in Spring 1999, one of the largest MCOs went into state receivership because of large losses and a substantial negative net worth.⁶⁴³ For fiscal 2000, costs are projected to increase at more than twice the "budget neutral" rate imposed on the FFP cap when the waiver renewal was approved. Projected cost increases for fiscal 2000 have been reported at 12%,⁶⁴⁴ while the "budget neutral" cap on FFP negotiated as part of the three-year waiver renewal was 5.1%.⁶⁴⁵

As TennCare enters the second year of its renewal period, it faces considerable uncertainty—a bubbling political and economic stew. This stems from unhappy providers and their potential political influence,⁶⁴⁶ and from the renewal of fiscal concerns that threaten to unravel the political deal underlying TennCare. That political understanding was that savings from managed care exacted both by resource economies and production efficiencies and by redistributive income/wealth take-aways from providers would be rechanneled to improve access to medical care for the uninsured and uninsurable. As part of that deal, taxpayers and individuals with private insurance would be held harmless. The reemergence of fiscal concerns is particularly potent politically because the state is locked into an FFP cap so that if TennCare expenses (averaged over the entire eight-year period of the demonstration) exceed the budget-neutral FFP cap provisions, the agreement is that Tennessee will have to absorb 100% of the expenditure overage. This creates an extremely strong incentive for the state to stay within the cap, and the proposals for restraint on utilization must be seen in that fiscal context. If the mandatory-coverage Medicaid-qualified population should increase unexpectedly, the state would be unable to deny coverage to those citizens, so it

641. *See id.*

642. *See* PRICEWATERHOUSECOOPERS, *supra* note 166; WILLIAM M. MERCER, INC., *supra* note 190.

643. *See supra* note 205.

644. *See* Snyder, *supra* note 273, at 2A.

645. *See* Letter from Michael Hash, *supra* note 9 (affirming Tennessee's proposed 5.1% rate of increase in FFP cap under budget-neutrality principle established under BBA of 1997).

646. In contrast, Oregon providers were a critical part of the formulation of the Medicaid demonstration, and, since Oregon was already a market with significant managed care penetration, neither production efficiencies nor income redistribution away from providers was part of the political agenda of the reform effort. *See* Blumstein, *supra* note 164, at 546 (noting that the Oregon plan "very much reflect[ed] a physician's perspective," that the plan "reflect[ed] the medical professional model" and had "physician-based origins," and therefore that non-medical economic considerations "were not part of the . . . process").

understandably needs some cushion as the cap levels approach. The prospect of a 12% spending increase combined with a 5.1% FFP cap rate increase would be a natural signal for precautions in and restraints on program spending.

Nevertheless, despite all the recurrent uncertainty, it is undeniable that TennCare has resulted in major strides in improving medical care services coverage within the state. It also has slowed the rate of growth from the budget-neutral caps on expenditure negotiated with HCFA at the outset; and those caps assumed continuation of the traditional Medicaid program, not an increase of over 60% in program coverage. So, costs have been reduced considerably on a per capita basis from previously projected levels, and coverage has been expanded. In addition, our evidence shows that quality has not suffered, at least in the areas we investigated. And the final element of the political coalition—state taxpayers and citizens with medical coverage—has not been called upon to fund TennCare beyond its normal (slower) rate of growth.⁶⁴⁷

The provider community in general and physicians in particular, however, remain unhappy and, in general, implacable foes of TennCare. Reducing hospital resources in the state is not an easy task, and TennCare's invisible hand has had a role to play in rationalizing the hospital sector.⁶⁴⁸ This is not a painless prescription for the industry, which confronts MCO pressures for lower pricing. And the absence of market-validation for the overall MCO rates raises the question whether there will be long-term overdoing of fiscal constraints on, and downsizing of, hospitals. Through 1997, overall hospital profitability in Tennessee did not suffer, but certain hospitals (e.g., the Med in Memphis) that serve large volumes of TennCare patients are exceptions to that generality with potential political and economic significance to the future of TennCare.

Traditional physician grievances against managed care—insufficient funding and loss of autonomy—are surely present regarding TennCare. Indeed, they are exacerbated because physicians

647. Some would contend that privately insured patients, at least indirectly, are called upon to subsidize TennCare patients through cost shifting—i.e. providers increasing revenues from privately insured patients to make up revenues lost from the stringent level of TennCare payment. But, over time, cost-shifting strategies are unstable and most likely unworkable, particularly in a competitive market with well-informed pro-active payors. See MICHAEL A. MORRISEY, *COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC* (1994) (noting instability of cost shifting and providers' inability to implement such a policy in a competitive market with well-informed, aggressive payors); Blumstein, *supra* note 357, at 1480-81 & n.91 (noting that cost shifting can only succeed in the absence of competition and in the face of "apathy or ignorance" on the part of a "passive payor community").

648. See *supra* Part VI.E.2.

were largely excluded from the initial TennCare formulation and implementation process. When linked to the financial stresses associated with increased reliance on managed care, that initial powerlessness has continued to alienate the physician community from TennCare.

Economically rationalizing the way that medical care is delivered—altering the “production function”⁶⁴⁹ of the industry—is not a painless process. It upsets standard practice and incurs substantial transactions costs, even if eventually successful in achieving economies through improved efficiency.

Physician discontent is probably the largest source of political instability regarding TennCare. Our physician survey showed that Tennessee physicians feel coerced. The state’s use of market power to enforce an administered price on MCOs and indirectly on physicians may smart and it may reflect an imprudent degree of coercion if the supply of physicians unduly contracts.

The redistributive issues that tend to be so poignant for the physician community—loss of income—are potential political motivators. What level of physician incomes is appropriate or fair is a matter of political significance, but there are few productive normative guides. We do note, however, that physician availability is superior to what it was under Tennessee’s traditional Medicaid program, and patients seem satisfied with availability of physicians’ services. So, in the current time frame, at least, the pain for physicians may be felt by them, but it has not had a measurably adverse effect on the system as yet. Whether physicians will secure the additional funding and autonomy they seek and whether physician dissatisfaction will eventually translate into de-participation in TennCare is unknowable at this point. The recent experience that physicians and hospitals have had with an MCO going into receivership and seemingly defaulting on obligations owed to providers may move providers in the direction of de-participation.

As for the future, the Balanced Budget Act of 1997 (“BBA”) allows states to implement mandatory managed care in their Medicaid programs without seeking a waiver.⁶⁵⁰ Unlike the TennCare waiver process, the BBA does not impose an obligation on a state to provide medical care benefits to non-Medicaid-eligible patients as a political

649. A production function describes the way that different inputs (e.g., capital and labor) are combined to produce a product or to deliver a service. When those inputs are combined in a way to produce an outcome at an overall reduction in the use of resources (i.e., in lowering costs), economic efficiency is achieved.

650. See *supra* notes 191-99 and accompanying text.

quid pro quo. And, while the BBA and its proposed implementing regulations provide guidance about what qualifications managed care entities must have, there is not as much federal supervision of the relationship between a state and an MCO as there is in the TennCare waiver.

This tight oversight by HCFA of the MCO-state relationship provides advocacy groups an important point of political leverage under TennCare that would be largely unavailable under the provisions of the BBA. Under the BBA, states can implement a strategy of Medicaid cost containment through managed care, capturing the savings for any state priority, not only for expanding access to medical care for the uninsured or uninsurable. This suggests that the take-away or redistributive dimension regarding the provider community would be somewhat less draconian in a state making use of the BBA. It might also mean that projected Medicaid savings would in part accrue to fund other state priorities such as education. Further, use of the BBA managed care provision does not alter the traditional method of calculating FFP, so there would be no FFP cap as there is under TennCare. That would relax some of the political impetus for keeping program costs in check since a state's qualified share of spending would receive unlimited FFP. There might even be an impetus for a state under the BBA to use a market-validated process for setting MCO capitation rates through a system of price competition (e.g., bidding).⁶⁵¹

Under a BBA managed care regime, however, FFP would only be available for Medicaid-eligible beneficiaries. That would circumscribe the availability of federal financial support for TennCare's uninsured/uninsurable enrollees who would not qualify under a maximally generous Medicaid program eligibility expansion. Under TennCare's global FFP cap arrangement, the state receives FFP for non-Medicaid-eligible enrollee expenditure to the point of the FFP cap. Beyond the cap, no FFP exists. The TennCare arrangement allows the state to economize on its Medicaid program and then to rechannel those dollars to support TennCare enrollment for the uninsured and uninsurable not otherwise eligible for Medicaid. In the absence of such an arrangement, economies from Medicaid would reduce overall FFP, as Medicaid expenditures would decrease. Any state decision to

651. See Bonnyman, *supra* note 167, at 311 n.26 (noting that "managed care organizations in Arizona's Medicaid equivalent compete on price" in contrast to TennCare's MCOs). For discussion of Tennessee's mandatory bidding system for state-funded medical care for public employees, see *supra* note 635.

rechannel those funds to cover the uninsured or uninsurable population would not trigger additional FFP.

From the perspective of achieving improved access to medical care for non-Medicaid-eligible beneficiaries, the managed care provisions of the BBA are therefore not as attractive as the financial arrangements under TennCare. As a means to Medicaid reform and cost containment, however, the BBA provides some considerable opportunity and appeal. As a vehicle to build a model of broader health care reform on a platform of Medicaid reform—by rechanneling Medicaid savings to improving access to medical care for non-Medicaid-eligible uninsured and uninsurable patients and receiving FFP to support that objective—the global budgeting approach of TennCare (using principles of overall budget neutrality) is clearly preferable. But no other Medicaid demonstration has received TennCare's type of global budget feature for the uninsured and uninsurable population.

In the current political climate of reemergent cost escalation, the mandatory managed care option for Medicaid under the BBA provides considerable leverage for Tennessee. To this point, all cost-containment benefits have accrued to achieve broader access to medical care for the non-Medicaid-eligible uninsured and uninsurable. Patient advocates have opposed any restriction on new enrollment for uninsurables, and in response the Sundquist Administration has proposed tax increases to cover increased costs. The BBA provides important leverage to state budget-makers since the state could decline to renew TennCare in its current form and retain the cost-saving mandatory managed care features under the BBA, thereby rechanneling cost savings to taxpayers generally rather than to non-Medicaid-eligible TennCare beneficiaries. Under TennCare, a freeze on new enrollment must secure HCFA approval, but under the BBA a state can adopt mandatory managed care in Medicaid without the need for HCFA's discretionary approval.

TennCare has been and continues to be an important demonstration of Medicaid managed care. The availability of such managed care Medicaid programs under the BBA suggests that more states will pursue mandatory managed care in Medicaid. But the BBA does not offer the same promise as does TennCare of using Medicaid reform as a tool for or model of broader health care reform—achieving broader access goals by recapturing and reallocating Medicaid savings for improved access for uninsured and uninsurable (but not Medicaid-eligible) beneficiaries.